SurgicalNews

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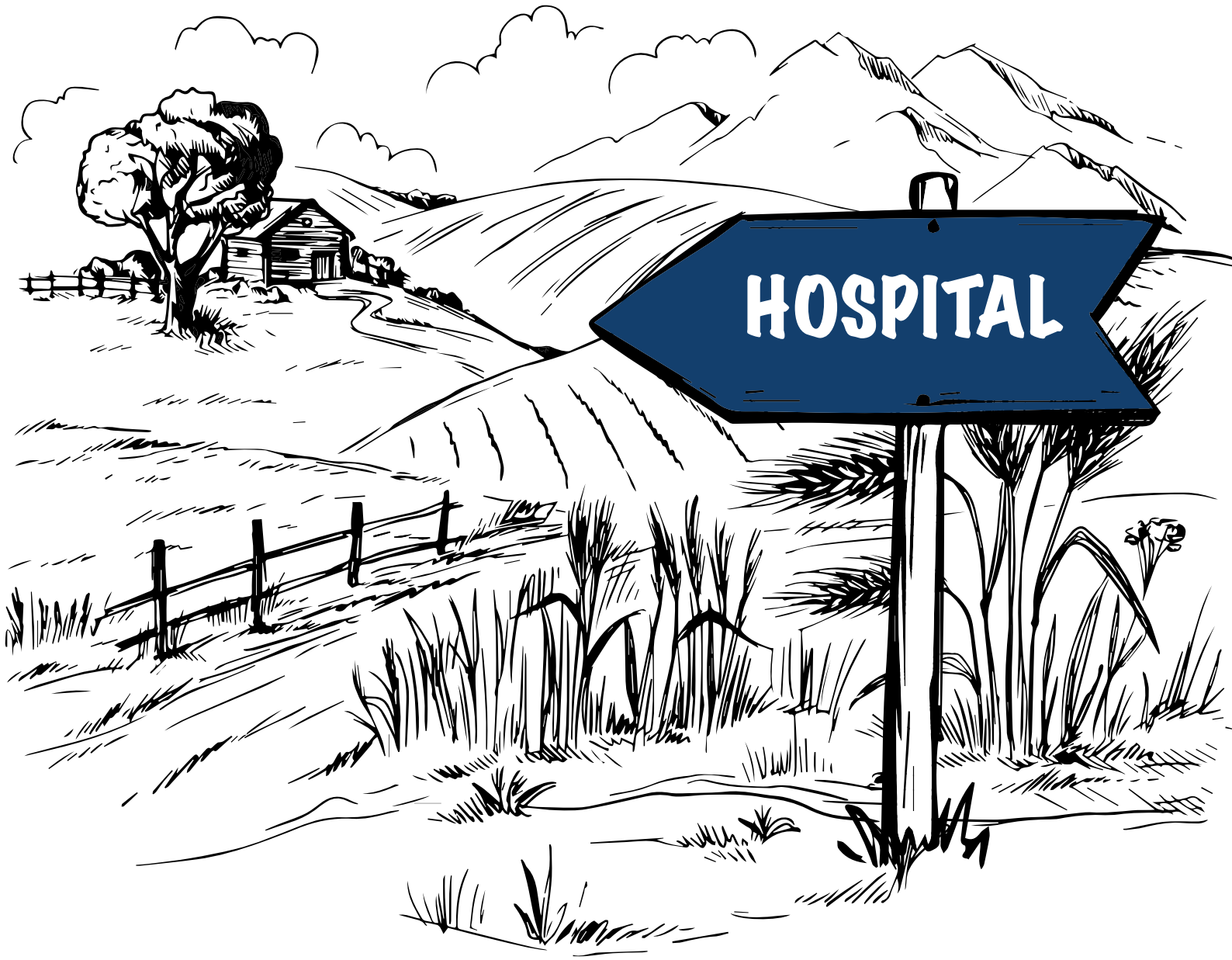

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Royal Australasian College of Surgeons

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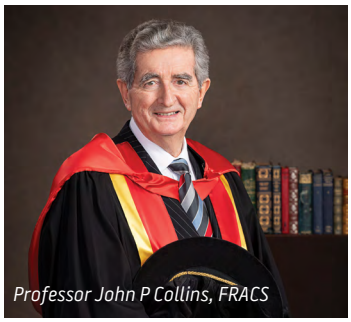
Sue Velovski


Professor John P Collins, FRACS

AIDA Conference


Dr Bhavik Patel

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President's perspective

As the year comes to an end, I would like to take stock of what we've done. While the challenges of COVID-19 continued to impact on us, we've also managed to achieve much.

The pandemic exposed many aspects of our healthcare system that require fixing to ensure long-term sustainability. We advocated strongly over the last few years on the issue of planned surgery bans and recommended consultation with surgeons and other experts to help inform the decision making. We were pleased to see our recommendations accepted by governments, with many jurisdictions allowing individual flexibility and decision making at the local level for a prompt response to patient needs.

We've been watching the developments in Aotearoa New Zealand with the introduction of the new healthcare system - Te Whatu Ora and Te Aka Whai Ora. One of the biggest challenges that the new system faces is the issue of surgical wait lists for planned care. The Planned Care Taskforce released recommendations to reduce the backlog of overdue surgeries and improve equity and access. We believe it is important that the action taken addresses the core issues behind the wait lists, including workforce shortages and pay for allied health workers.

Another challenge, to which we responded, following more than a decade of advocacy, was the review of the cosmetic surgery sector by Ahpra and the Medical Board of Australia. Our position has always been that Australians rightly expect all surgical procedures to be performed to the highest possible standards and meet nationally established standards.

We remain concerned about Ahpra's proposal to establish a new area of practice endorsement for cosmetic surgery. A fundamental tenet that any reform must acknowledge is the inadequacy of surgical training by a number of practitioners performing cosmetic surgery.

If we are truly to protect the patients, we must make sure that surgical procedures are only undertaken by properly qualified surgeons who have Australian Medical Council (AMC) or Te Kaunihera Rata o Aotearoa Medical Council of New Zealand (MCNZ) accreditation. This must be mandatory.

We also look forward to the Australian health ministers formulating clear laws that restrict the title of surgeon to those who are registered in a surgical specialty. This, in addition to the other measures we've called for, is necessary to protect patients.

In the later part of the year, we launched our 'Trust FRACS' campaign to inform and educate the public about the importance of choosing a properly qualified surgeon, a medical practitioner who has specialist surgical training via a program with AMC or MCNZ accreditation. We did this in response to the many reports of patients suffering adverse outcomes when it comes to cosmetic or reconstructive surgery.

The campaign, which seems to be resonating with the public, provides information on what patients should expect from their surgeons, including their qualifications, experience, risks and complications and facilities.

We also launched our first Continuing Professional Development (CPD) mobile app. This is yet another step in our continued efforts to provide Fellows with the best-in-class continuous professional development opportunities.

This much-awaited development will provide a dedicated CPD mobile app that will make it quick and easy for Fellows to record CPD activities undertaken in everyday practice on the go.

Fellows can now quickly create CPD activities, capture evidence, and manage their learning plan on an easy-to-use, intuitive mobile app. This will provide them with the flexibility and support that they have always wanted while maintaining their surgical standards and complying with the regulatory requirements in Australia and Aotearoa New Zealand.

We also made some good progress on the environmental front. We are the first medical college in Australia to sign up to the newly released Green College Guidelines.

The guidelines, which have been developed in collaboration with the Australian Medical Association (AMA) and Doctors for the Environment Australia (DEA), provide guidance to medical colleges on how they can reduce the carbon emissions of their organisation by incorporating practical changes to the way they operate.

I congratulate my colleague and Council member, Emeritus Professor David Fletcher AM, Chair of RACS Environmental Sustainability in Surgical Practice Working Party for taking a lead role in this important initiative.

The healthcare community must take a leadership role in advocating for emission reductions as we also critically examine our own activities. There is a growing awareness within surgery that our profession accounts for the majority of the health sector's emissions and surgeons are committed to reducing the footprint of our practice.

The year 2023 promises to be another busy one as we implement the many initiatives in our strategic plan (bit.ly/3VjZgG2) and deliver value for our Fellows, Trainees, Specialist International Medical Graduates (SIMGs), partners and the communities we serve.

I take this opportunity to thank our Council, committee members, employees, specialty societies and the many other stakeholders who supported us in 2022.

I wish you all a restful break over Christmas and a happy New Year.

Dr Sally Langley
President

Vice president's perspective

It seems like we are always on the move at the College, with so much going on. This is a good thing as it is great to have a purpose and work that keeps you busy and engaged.

In our most recent Council meeting, we continued our discussion on the proposed governance model for the College. We held a workshop to discuss options for new governance models. Participants considered the pros and cons of moving towards these models, incorporating separation of the governance responsibilities (in the form of the Board) from the representative roles (of the Council). We will consider the proposed models in more detail at the February 2023 Council meeting.

On other Council matters, we also considered the findings of the membership category review. The review recommended that the current categories be expanded to encompass those who have committed to a surgical career. Council approved the recommendation that RACS move forward with the categories of Trainee, Specialist International Medical Graduate (SIMG), Fellow and Retired Fellow. While we agreed that the membership categories Fellow and Retired will continue to have voting rights and FRACS postnominal, further discussion is required regarding voting rights and post-nominals for Trainees and SIMGs.

Council also considered and approved a proposal from our Fellows to participate in World Pride 2023 as part of a combined medical colleges float. Participating in this event would demonstrate RACS commitment and support for LGBTIQA+ surgeons, aspiring surgeons, and patients, and that the College is inclusive and welcoming of all.

Research has shown that LGBTIQA+ communities face health disparities that are often linked to societal stigma, discrimination, and denial of civil and human rights. Often patients don't feel safe accessing surgical care for fear of discrimination or stigma.

Our representation at the WorldPride parade is consistent with our values and the focus we have of building a culture of respect, embracing diversity, and serving all communities equitably.

In my previous message I wrote about our ongoing work on the Building Respect, Improving Patient Safety initiative. The Expert Advisory Group report highlighted the need for us to shift from awareness of the implications of unprofessional conduct to action against this, in all facets of our work. This will be a key theme in our communication.

We look forward to announcing our new targets for the selection of women into surgical education training and for the gender makeup of our Council and committees. These will be supported by complementary work in reducing implicit bias, a heightened focus on racism and the active pursuit of cultural safety in our profession.

We also continued to implement digital solutions to improve member experience through the One College Transformation program of initiatives. In the past few months, we launched a new Training and Services system, a digital platform for events, courses and exams registration, and payment.

Members can now search, register and pay for 2023 social events and conferences, skills training and professional development courses and workshops, and Generic Surgical Science Examinations (GSSE), Clinical Examinations (CE), Specialty Specific Examinations (SSE) and Fellowship Examinations (FEX). This is a great example of what we are doing to turn the College into a modern workplace that puts members first.

We will see yet another improvement of the services we provide to members with the transition of *Surgical News,* our member magazine, which will offer readers a fully digital version in 2023. This is also part of our ongoing digital transformation work across the College. More and more people now prefer to access content online as you can read it anytime, anywhere. We will retain the print magazine for those who prefer this format, but we would like more of you to opt-in to receiving the digital magazine when it is ready. You can do this by emailing us to confirm your preference.

We are also making great progress with our *ANZ Journal of Surgery.* The journal will now benefit from a new three-year partnership between our publishers, Wiley and the Council of Australian University Librarians (CAUL) that offers eligible researchers in Australia and Aotearoa New Zealand access to read the full Wiley portfolio of journals and the opportunity to publish open access in all of its hybrid journals. This agreement will help accelerate open access publishing. Articles are already appearing in the journal under this agreement.

Many RACS Fellows, Trainees and SIMGs will be covered by the CAUL transformational agreement through their institutional affiliations and can publish open access at no direct cost. More will be covered by grant funding, which they may receive in the course of their research work.

While I am pleased to report on the many achievements at the College, I know a lot of hard work has been done by our staff and Fellows involved in supporting in our growth. Thank you to each and every one of you.

I am sure that, like me, you are looking forward to having a break during the holiday season. It has been a stressful year with the ongoing challenges of dealing with the pandemic, work, and the impact these have had on us at an individual level as well as the stress imposed on our healthcare workforce.

For those of you who are celebrating the holiday season, I wish you a Merry Christmas, happy Hanukkah, and a happy New Year.

Please take time to rest up and come back refreshed for what I hope will be a great year.

Professor Chris Pyke
Vice president

news in brief

Council highlights

The Council met largely in person at the Melbourne RACS office on 27 and 28 October 2022.

The current members are:

Office bearers:

- Dr Sally Langley (President)
- Professor Chris Pyke (Vice President)
- Dr Greg Witherow (Treasurer)
- Dr Adrian Anthony (Censor in Chief)
- Professor Andrew Hill (Professional Standards & Fellowship Services)

Office holders:

- Dr Annette Holian (Chair Committee of Surgical Education and Training)
- Dr Philip Morreau (Chair Prevocational & Skills Education)
- Dr Ruth Bollard (Chair SIMG Assessments)
- Associate Professor Kerin Fielding (Chair Professional Standards)
- Dr Jennifer Chambers (Chair Professional Development)
- Dr Christine Lai (Chair Fellowship Services)
- Professor Henry Woo (Chair Research and Academic Surgery)
- Professor Owen Ung (Chair Surgical Audit)
- Dr Rebecca Jack (Deputy Treasurer)
- Dr John Crozier (Chair Global Health)
- Professor Mark Ashton (Chair ASC, Conference & Events)
- Professor Mark Frydenberg (Chair Health Policy and Advocacy)

Fellowship Elected Councillors:

- Dr Nicola Hill
- Dr Sarah Coll
- Dr Maxine Ronald
- Professor Deborah Bailey

Specialty Elected Councillors:

- Associate Professor Andrew Cochrane
- Dr Mark Dexter
- Professor David Fletcher

Co-opted Councillors:

- The Hon Rob Knowles AO (Aus Expert Community Advisor)
- Souella Cumming (AoNZ Expert Community Advisor)
- Dr Sharon Jay (Chair, RACSTA)
- Dr Nishanthi Gurusinghe (representing Tasmanian Fellows)
- Dr Richard Bradbury (representing NT Fellows)
- Dr Ailene Fitzgerald (representing ACT Fellows)

Observers:

- Dr Shehnarz Salindera (Chair Younger Fellows Committee)

Apologies:

- Professor Ray Sacks (Chair Court of Examiners)

Wellington's paediatric surgical team won't be fully staffed for two years

Wellington's paediatric surgical team has been short-staffed for a year, with specialists from Christchurch and Waikato helping since April.

The unit, which contains four full-time positions, currently has just one paediatric surgeon on staff.

Starship Hospital surgeon and RACS Paediatric Surgery spokesperson Dr Neil Price said it took eight years to train a paediatric surgeon and "one or two years" to recruit from overseas, but health boards had previously tended to wait until there was a crisis before thinking about succession planning.

More: https://bit.ly/3F4XDW8

RACS launches CPD mobile app

Access your CPD in the palm of your hand!

RACS recently launched Continuing Professional Development (CPD) mobile app represents an important step in the College's commitment to providing Fellows, Specialist International Medical Graduates (SIMG) and CPD subscribers with a best-in-class CPD experience.

With the new CPD mobile app users can:

- view, add or delete CPD activities
- monitor progress against annual CPD requirements
- update personal information
- store supporting documents.

The College anticipates that the app will rapidly become the most popular way for users to access and update their CPD activity.

"The CPD mobile app has been built in response to feedback from Fellows about the importance of having access to an easy to use, on-the-go CPD experience," Sendur Kathir, Executive General Manager, College Transformation, said. "Our new app is designed to offer ease of navigation to the most in-demand features Fellows use to keep their CPD up-to-date."

Those who have used the app so far have only good things to say, especially about the ease of use of this app and the time it will save them. Associate Professor Kerin Fielding, orthopaedic surgeon and RACS Councillor said, "Like many surgeons I am constantly on the move and don't always have easy access to a computer. The app means I can update my CPD when it is convenient for me, which will save me time when I am finalising my requirements at the end of the year."

Getting started is easy.

The app is available within Microsoft Power Apps on the iOS App Store, the Google Play store, and Microsoft Windows store. Scan the QR code provided in the image or search Power Apps on the App/Play store on your mobile.

Follow the prompts to download and install the Power Apps and sign in using your RACS username and password. Once logged in, search for the RACS CPD app to launch it. Allow the app to complete the initial first-time sync to verify your profile details and CPD-related data and settings. You can then begin entering your activities and managing your CPD learning plan.

More information is available on the College website: bit.ly/3VjPCT0.

If you need any assistance with the app or have suggestions on how we can further improve the CPD mobile app, please email the CPD team or call +61 392491282.

Royal Australasian College of Surgeons

The changing face of *Surgical News*

A digital version of *Surgical News* is coming in 2023.

Benefits:

- An attractive digital magazine where you can access content as and when it is convenient for you.
- Read interesting and inspiring stories about surgeons, College updates and more.
- Easily search for articles and share them.
- Support the College's sustainability and environmental impact.

We will continue to print the magazine for those members who prefer to receive them.

If you would like to unsubscribe from the print magazine, please email us on surgical.news@surgeons.org

Role of surgeons in addressing family violence

In November surgeons and other medical professionals discussed the role of health providers in addressing family violence at the RACS/ANZCA/ACEM Joint Symposium: Family Violence–Health System Response.

Family violence, or domestic abuse, is the umbrella term that refers to intimate partner abuse, child abuse or neglect and elder abuse.

It can be difficult to pin down accurate numbers reflecting the impact of family violence, but the most reliable figures available suggest one in three women in Aotearoa New Zealand encounters family violence in their lifetime, and one in four women in Australia will face violence by an intimate partner.

The symposium addressed the responsibility of health professionals to identify and respond to family violence affecting their patients and colleagues.

Family Violence Prevention Chair at The University of Melbourne and Royal Women's Hospital, Professor Kelsey Hegarty, spoke at the symposium.

As co-director of the Safer Families Centre, she conducts research and drives collaborations to improve health sector responses to family violence.

Professor Hegarty said family violence is a health issue that needs to be better understood and addressed within the medical community.

"Part of this work is helping clinicians to understand that this is a health issue; it's not just a justice issue and we can't leave it to social workers and lawyers to do it all."

In 2019, the World Health Organization (WHO) released a 'violence against women' competency-based training curriculum that aims to guide health service and clinicians.

Professor Hegarty said that along with ensuring clinicians are trained to identify and support family violence victims, it is essential that health systems support clinicians.

Professor Kelsey Hegarty

"Is there enough time for clinicians to do this? Is there a private place where these conversations can happen? Do hospital managers support them? Are there protocols to follow and do I have connections with referral services?

"To move forward we need health practitioners to understand that domestic and family violence could be the underlying cause of clinical presentations; we want them to be trained in how to ask about their patient's safety and to provide a WHO recommended frontline response.

"We want them to be supported by a team, both within the health setting and connecting them to specialist services. And we need an organisational culture of trauma and violence-informed care."

On an individual level, New South Wales Ministry of Health Sexual Assault and Medical and Forensic team manager, Dr Mayet Costello, says there is a range of ways medical professionals and members of the wider community can help address family violence.

"What we like to call bystander interventions can be really important, and that's about people holding perpetrators of domestic violence to account.

"When it comes to the victim, often there has been a sustained campaign by the perpetrator to undermine their confidence and being told that they won't be believed.

"It is fundamental that we demonstrate belief and respect, that's incredibly important to the person who is disclosing.

"For people who have experienced violence, it has been an experience of disempowerment, so their choices and their control of their body have been taken from them.

Dr Mayet Costello

"It's important not to replicate that dynamic and to try to empower someone who has experienced violence. Don't tell them what to do but give them options and support their decisions without being judgemental."

Dr Costello describes victims of family violence as 'experts' in their own situations, with the best understanding of the complex risks they face that inform their decision-making.

She said it is crucial for healthcare providers to be trustworthy—without making promises they can't keep—such as to keep disclosures secret if there is a risk of significant harm to the victim or their children, and to take a trauma-informed approach to patient care.

"We can't say, 'I'm a surgeon who only operates on feet, so I'm not going to deal with anything else'. That's not good practice and it's also not holistic medical care.

"We don't expect surgeons to have all the knowledge or understanding of domestic violence, but they can work collaboratively with people within the health system who may be able to bring in greater levels of knowledge or expertise.

"It's not just about referring people on but working together in a collaborative way."

NSW Health has identified the issue of family violence as a key social determinant of health and is working to improve integrated responses.

This includes partnering with Primary Health Networks in New South Wales to develop a statewide pathway to address family violence, abuse and neglect, and facilitate collaboration between medical professionals and the wider network of support services.

University of Auckland Social and Community Health, Associate Professor Janet Fanslow, says family violence is a significant problem in Aotearoa New

Associate Professor Jane Fanslow

Zealand, with higher estimated rates than in Australia.

She believes that along with improved education and support across the healthcare sector, international evidence-based initiatives can also help tackle family violence.

"The number of people affected doesn't surprise me, but that doesn't stop me from being horrified.

"As a population health scientist, I can say it is one of the issues that many women are going to come across in their lifetime, and it has a whole array of physical, mental health and reproductive health consequences, as well as economic and social consequences," Associate Professor Fanslow said.

"The fact that we are only now really starting to talk about it—although there have been several attempts to put it on the table through the centuries—is a problem."

Associate Professor Fanslow said the range of individual and societal factors that contribute to family violence make it difficult to find one solution.

However, she points to a desire for power as being at the heart of much of family violence. Initiatives that shift attitudes to power within relationships and communities have been successful in various countries, including Uganda.

"There are some really good international programs, which have shown substantial reductions in perpetration of intimate partner violence, coming from a more difficult context than Australia and Aotearoa New Zealand.

"They've managed to get a 50 per cent reduction in perpetration of intimate partner violence in four years by doing a lot of work around understanding community norms and how power plays out in relationships between men and women, and that deep understanding of power."

Associate Professor Fanslow would like to see similar evidence-based programs introduced in Australia and Aotearoa New Zealand.

"Health providers need to see family violence as a priority and addressing it as a benefit to the work they're trying to do.

"If they're really trying to improve the health of the person in front of them, they need to find out about the social circumstances they are dealing with, otherwise they can't treat them appropriately."

Along with the many inspirational women who spoke at the symposium, the event also featured excellent male presenters. Among them was Dr John Sammut, emergency physician and Chair of the New South Wales Medical Council.

In his presentation, Dr Sammut provided an overview of the medical regulator's role in preventing family violence. In particular, he discussed how the regulator responds in cases where medical practitioners have either engaged in family violence or have not responded in a professional manner after being made aware of family violence.

"Unfortunately, it's a reality in the Medical Council that over the very recent years, we've seen a significant and increasing number of notifications related to medical practitioners who have either failed to respond appropriately to requests for assistance by survivors of family violence, or who have unfortunately themselves been perpetrators of family violence.

"The Medical Council of New South Wales takes these notifications very seriously and believes in the importance of ensuring perpetrator accountability—most importantly for the protection of the health and safety of the public, but also to maintain the standards of and trust in the profession," he said.

The symposium also benefited from the insights and contributions of co-convenor Dr Ken Harrison, both an ANZCA Fellow and member of the RACS Trauma Committee.

As well as hosting the symposium, Dr Harrison co-facilitated an excellent working group discussion on the role of men as champions of change. The open conversation among the working group included an analysis of what role men have in challenging the violence of other men, including the importance of continually striving for more equitable and respectful relationships across society.

Associate Professor Payal Mukherjee

Symposium convenor Associate Professor Payal Mukherjee said RACS can play an important role in educating and training the surgeons of today and the future to better identify and respond to family violence.

"Both WHO and the Victorian Royal Commission demonstrated a huge lack of education among healthcare professionals," she said.

"As health care professionals, we repeatedly fail to inquire about a history of violence, assess risk factors, detect red flags in our examination, and are often unaware of what to do to prevent future trauma or engage with referral networks for support.

"We do not understand the implication of laws and rules that protect or prevent victims, whether it is our patients or colleagues."

The adult and paediatric ENT surgeon said the diversity of surgical specialties, meant that it was necessary for RACS—as an umbrella organisation—to educate surgeons to improve their response to family violence.

"This needs to be led by the College to work with its subspecialties to drive a centralised education platform," she said.

"RACS upholds the importance of professionalism and standards. The joint college symposium was being held in New South Wales Parliament house on the same day as a landmark bill on coercive control was being heard within the very walls.

"It was an important reminder that the College must be actively involved in understanding its responsibilities in this space around the changing laws in different jurisdictions."

Family Violence – Health Systems Response Reading List
bit.ly/3gtgmCK

Surgeons question Medicare rort claims


Professor Mark Frydenberg


Professor Owen Ung

RACS surgeons have questioned the accuracy of media claims that Medicare rorts are widespread across the medical profession.

News stories published in *The Sydney Morning Herald, The Age* and the ABC's *7.30* program in October suggested doctors were incorrectly claiming for procedures, costing taxpayers $8 billion per year.

RACS Health Policy and Advocacy Committee chairman, Professor Mark Frydenberg does not believe the problem is nearly as prevalent as media reports suggest.

"From a pure ethical standards point of view, if there is credible, deliberate rorting of the system, obviously we can't condone that," Professor Frydenberg said.

"We would view that as a breach of the code of conduct of the College.

"But we don't have the sort of evidence that these media reports were alleging—that there was deliberate, misleading rorting of the government to the extent that they're talking about."

Professor Frydenberg said there are two main issues that might have led to the perception of rorting as it was presented in the media.

One is the confusion over what might be considered 'high value' or 'low value' care.

He says that a surgeon who is face-to-face with a patient might have a very different perspective on 'high value' care to the Medicare expert Dr Margaret Faux, who made the rorting claims in the media.

Professor Frydenberg points to the example of a Prostate Specific Antigen (PSA) test provided to a man aged over 75 who was anxious about prostate cancer.

In this circumstance, a surgeon might deem it beneficial for a patient's mental health to provide a test, even though PSA testing might not be recommended more widely due to their age.

"There might be some who say a situation could have been handled in a different way, but at the end of the day, you've got a surgeon seeing patients and making decisions about testing and providing recommendations about procedures for the welfare of their patients.

"The reality is doctors don't get a financial benefit by ordering a blood test or X-ray and the vast majority of people are trying to order the tests that are appropriate for the care of the patient," he said.

Another reason for a perception of rorting comes down to simple user error in the determination of item numbers.

Professor Frydenberg attributes this to the complexity of the Medicare system and poor communication surrounding recent changes.

"A lot of this so-called rorting could come down to one-off administrative errors. Or they could be due to confusion regarding exactly which MBS number to use for a particular procedure or consultation.

"Since the recent MBS reviews, lots of changes have been made, and not every one of those changes has been effectively communicated with the doctors."

Royal Brisbane and Women's Hospital surgeon and Metro North Comprehensive Breast Cancer Institute director Professor Owen Ung, who was in private practice for more than 30 years, also questions the amount of rorting that occurs within the health system.

He said many of the problems referred to as 'rorting' could be attributed to flaws in the Medicare system.

Like Professor Frydenberg, Professor Ung says it isn't always clear which item number best suits which procedure.

The other area of opaqueness arises when multiple procedures, by necessity, are performed at one operative sitting, sometimes with the involvement of multiple specialists.

"By and large, most of the procedures we do should have an item number that matches that procedure, but in reality, there are some situations where there isn't a number that exactly matches what has happened.

"Someone might be accused of using an inappropriate item number, but if you're a surgeon, you just have to choose one that matches the procedure as much as possible. The definitions aren't always clear."

Occasionally the surgeon only discovers Medicare does not agree with the assigned item number to a procedure, when the patient's claim is rejected, causing distress for all concerned.

A Department of Health review in November supports the surgeons' doubts about the widespread nature of rorting.

The review found no evidence to support the claim that 30 per cent of the Medicare budget was being defrauded by doctors and other health professionals.

In a press release welcoming the findings, the Australian Medical Association (AMA) highlighted the complexity of the Medicare system as a cause of incorrect billing.

'The Medicare Benefits Schedule runs to hundreds of pages and the advice provided by the Department of Health is often confusing and inconsistent,' the media release said.

The AMA called for support for health professionals to navigate the complex system without leading to more red tape.

According to Professor Ung, along with its complexity, another problem facing the Medicare system is its age and failure to have been appropriately indexed and keep pace with inflation and indexation.

"Perhaps everyone's recent experiences with current inflation problems will finally help many to understand the impact of rebates, such as Medicare, not keeping up," he said.

"Either the provider (doctor) carries that financial burden, by mirroring Medicare rebates, or they raise their fees in line with inflation, as does the rest of the community, and the patient carries the burden in the form of out-of-pocket gaps.

"Gaps will only get larger if Medicare rebates remain stunted."

He said while the majority of doctors continue to work ethically, this situation leaves many in a difficult position where perceived rorting could occur.

"The problem is that when Medicare was introduced in the mid-70s, Medicare rebates pretty much matched the common fee charged to patients.

"That has never been indexed properly by Medicare and the AMA recommended fees are now nearly two and a half times what the Medicare schedule is," he said.

This issue is exacerbated by a system that encourages quantity of consultations over quality of treatment.

"Some of the larger practices might be looking at creative ways of billing because Medicare is remunerated on occasions of service. There's no remuneration for how well you do something or how long it takes. It's really just how many procedures that you do.

"It's a problem for surgeons and it is probably the same across the whole medical profession.

"If Medicare rebates for patients actually matched the complexity of the medical service being provided, I suspect there'd be less of a problem."

Professor Ung feels that media coverage promulgated the misconception that Medicare benefited doctors, rather than the reality that it is a rebate system that assists patients.

"There's a perception that Medicare is a payment for a doctor, but in fact it's a rebate for a patient. We've lost sight of that."

He would like to see the government overhaul funding of the medical system to at least provide adequate Medicare rebates for patients.

This would have a significant effect on out-of-pocket costs as private health fund rebates are also linked to the Medicare item.

If not, there is a risk that doctors will not have the capacity to continue to provide the community the voluntary services they offer.

"If the medical profession doesn't charge fair professional fees that provide adequate remuneration for time spent, we would likely see less available time for the public sector. This includes the many pro bono activities that we've come to expect from professionals such as teaching, research and community activities.

"We can only afford to do that if we get paid fairly for our other work."

Another impact of the negative media attention could be a loss of future surgeons and doctors from the profession, according to Professor Frydenberg.

"We're very short of doctors literally all over the country, so this is not a time where we would really want to be losing a lot of doctors and have people not wanting to join the profession," he said.

"RACS is very keen on maintaining appropriate standards, but at the same time, I think we also need to ensure that we don't damage the reputations of good quality surgeons who are doing the right thing, and I suspect that that's the vast majority of our Fellowship."

Independent review into Medicare compliance

The Australian federal government has appointed health economist Dr Pradeep Philip to conduct an independent review into the integrity of Medicare and its compliance mechanisms.

As the Lead Partner at Deloitte Access Economics and a former Secretary of the Department of Health and Human Services in Victoria, Dr Philip has a long history working at the highest levels of public policy in Australia.

The independent Philip Review will assess the possible value of fraudulent, non-compliant or over servicing risks in Medicare and provide a methodology and evidence-based estimate of the likely value of non-compliance in Medicare.

More than 500 million Medicare services are delivered each year totalling around $32 billion in government spending.

After nine years of cuts and neglect, the review comes at a time of great pressure on the health system in Australia.

Dr Philip will provide an interim report to the government by 31 January 2023, with the final report to be submitted by 28 February 2023.

Source: bit.ly/3hQrtWr, November 2022

Sue Velovski - RDAA joint Rural Doctor of the Year 2022

Dr Sue Velovski is a Specialist General Surgeon based in the Northern Rivers region of New South Wales. She is the joint recipient of the Rural Doctors Association of Australia (RDAA) Rural Doctor of the Year Award for 2022.

Dr Velovski received the award for her significant medical contribution during the flood disaster. She provided assistance in many ways: transporting medical supplies and treating patients in places as unlikely as petrol stations, helping to relocate staff and supplies, sandbagging, and setting up partnerships within the medical community to maximise medical care.

When the floods receded, Dr Velovski realised tetanus boosters would be crucial but discovered from her GP colleagues that they were only allocated five vaccines per month. Dr Velovski contacted the Rural Doctors Association (RDA) to advocate on their behalf and with their help secured delivery of 2000 shots.

Dr Velovski was invited to represent the Northern Rivers on the Natural Disasters Emergency Response Group, which had been formed after the 2019 bushfires.

She provided on-the-ground insight to more than 60 influential bodies about the flood and its impact on the community.

Dr Velovski was able to use her positions as an elected specialist member of the RDA (NSW) and a member of the New South Wales Australian Medical Association to help GP clinics that had lost equipment and practices. She realises how important it is to support GPs for the role they play in keeping people out of hospital.

Dr Velovski grew up in what was then blue-collar Newcastle. Her parents migrated to Australia from Macedonia and were community leaders. She has inherited her down-to-earth attitude and willingness to help others in many practical ways from them.

She has memories of many evenings spent at the Royal Newcastle Hospital with her parents and twin brother.

"We would go there after my parents finished work. They would find a space for us and say, 'Sit over there and do your homework' and then they would be in separate units interpreting and helping other Macedonians."

When her young mother passed away, there were a thousand people at the funeral. Two men introduced themselves to Dr Velovski. They had been bank managers and wanted to acknowledge Dr Velovski's mother and how she had helped hundreds of people to open bank accounts and loans by interpreting for them when she was only 14 years old.

Dr Velovski is also driven to improve the wellbeing of registrars and surgeons. She was greatly affected—when she was a surgical registrar—by the suicide of a friend in her study group.

She has helped introduce a model of practice at Lismore Hospital using standards in the airline industry after talking about the long hours registrars and surgeons work with two friends: Anthony Lock, a former Squadron Leader RAAF and Director of Human Performance,

and Stuart James, a training captain for a major international airline.

Dr Velovski said, "They said," 'surgeons compare themselves to us but they work 46 hours straight! That's just not safe'."

Dr Velovski points out that there are many similarities in safety and performance, but the airline industry has designated training, hours, stops and rest; by comparison hospital surgical hours are not as regulated. Airlines work towards competency standards, and do not presume this comes from working excessive hours.

"Around 18,000 deaths (pre-COVID-19) occur each year in Australia due to non-technical skill errors… drug errors etc. This number could be much lower if we had competency-based training in safe environments."

Additionally, pilots during COVID-19 had to maintain skill levels but many surgeons stopped operating for two years, without a need to maintain skill sets.

Dr Velovski said that in the airline industry there is a culture of actively identifying errors using a black box model, and a debrief after each flight. "We don't have that. I see registrars uncomfortable disclosing details because they don't want to get anyone into trouble. We should want to help to change that culture for our patients and our Trainees."

This includes changing the culture around behaviour and communication in hospitals. "We now have whole academic departments researching 'civility' in medicine. Why isn't civility just seen as the required behaviour of a decent human being?"

With all her work around natural disasters and helping to improve conditions and the wellbeing of her colleagues, Dr Velovski remains committed to living and working in the Northern Rivers.

Dr Velovski reflects on her career and on receiving her recent award: "I have been lucky enough to have developed some amazing mentors and friends in and outside of medicine and surgery, in Australia and overseas. This award acknowledges all of those people—and the absolute professionalism and care they display to me every day of my busy working life. Thank you."

Dr Jaeme Zwart

A champion for rural plastic surgery

A third of Australians live outside cities but many surgical specialties are still not well-represented in regional and rural areas. New surgeons train primarily in the cities, maybe visit for a rural experience, then most return to metropolitan surgical units to grow their careers. How do we change deeply ingrained attitudes about regional and rural surgery, support our hard-working rural surgeons, and move closer to achieving health equity for all Australians?

Dr Jaeme Zwart, a plastic surgeon based in Cairns, Queensland, is an ardent champion for rural surgery. He's been working in Cairns for 18 years and is committed to serving the local communities for the long haul. He says a few other plastic surgeons have worked in Cairns for extended periods of time, but for various reasons they have left.

He's a member of the RACS Rural Health Equity Advisory Group and the Australian Society of Plastic Surgeons (ASPS). Through his work, he's determined to help drive change for rural surgeons and their communities.

"One third of the Australian population live outside a metropolitan city. Just nine per cent of plastic surgeons work in a rural setting. So, a very small number of overworked plastic surgeons are servicing a third of the population," Dr Zwart said.

There's no plastic surgery training outside Brisbane, and, to Dr Zwart's knowledge, he's the only long-standing Fellow in his specialty in far North Queensland. "At one point, I was the only public plastic surgeon for about 10 years, servicing a large area of about 250,000 people. Thankfully, I now have three other colleagues who are as passionate as I am about delivering rural plastic surgery."

What steps are being taken to change the future for plastic surgery outside the big cities? ASPS has a rural and regional committee that brings like-minded surgeons together as a voice to advocate for rural plastic surgery. It's also a much-needed support network to combat professional isolation.

In a monumental step in the right direction, ASPS established the Darwin Workforce Strategy two years ago. Metropolitan plastic surgeons work in Darwin on rotation, volunteering their time to do surgery and help augment a sustainable service. This fly-in-fly out system has brought plastic surgery back to the Northern Territory.

Unfortunately, it's not a sustainable long-term solution to the dire shortage of plastic surgeons in regional and rural Australia. ASPS is a not-for-profit organisation. The Darwin Workforce Strategy relies on the goodwill of surgeons to disrupt their city lives and volunteer their time without pay. However, Dr Zwart hopes the value of this model of service will eventually be recognised by the government, attracting funding for paid surgical rotations, and be replicated sustainably in other regions.

In another positive step, ASPS has recently undertaken quantitative analysis of the plastic surgery workforce to identify the most pressing problems. The results will be released soon and should help guide advocacy and progress for the rural workforce.

ASPS is also developing a guide for plastic surgeons who will work in a rural setting. Among other useful information, the resource focuses on experiences and problems encountered by rural plastic surgeons and the steps they took to find solutions.

The next crucial step, Dr Zwart said, is to establish opportunities for plastic surgery Trainees in regional and rural hospitals. "They all move to the city to train, where they establish their lives and then feel drawn to stay. If new surgeons can train at home, they might be more likely to stay home to build their careers."

RACS is working on adapting the surgical training program and training facility criteria so regional and rural Trainees can learn their specialties near home, without the need to move to the city.

Dr Zwart was initially drawn to Cairns for family, the relaxed lifestyle, and the incredible mountain biking opportunities. Although it has been tough at times professionally, he's committed to his local communities and is determined to be a voice for change for rural Australians and their surgeons.

For the future, he has his sights set on an established plastic surgery team based in Cairns that accommodates Trainees, and better health equity for far North Queensland communities, with timely access to plastic surgery near home.

Left to right: Dr Shaheen Hasmat, Dr Francesca Rannard, Associate Professor Payal Mukherjee, Dr Danette Wright, Dr Anna Giles, Ms Caitlin Reid and Dr Soni Putnis

Surgeons' Month wraps up in style as inspirational surgeons recognised

For the first time in two years New South Wales Surgeons' Month returned to its traditional month of November. The event brings together New South Wales Fellows, Trainees, Specialist International Medical Graduates, prevocational doctors, medical students, and other College stakeholders. It is designed to promote a sense of community and diversity within the profession through a series of social, cultural and professional events.

The pinnacle event on the program was the Surgeons' Evening. This event took place on Friday, 25 November at View By Sydney. The night featured the Graham Coupland Lecture, 'The importance of interpersonal skills and attitudes in surgery' presented by the 2022 Graham Coupland Medal Recipient Dr Francesca Rannard.

The night also featured the presentation of a series of awards to New South Wales Fellows, Trainees and medical students who have shown exceptional leadership throughout the year.

2022 award winners

Medical Student Award – Ms Caitlin Reid

Service to the Community Award – Dr Anna Giles and Dr Soni Putnis

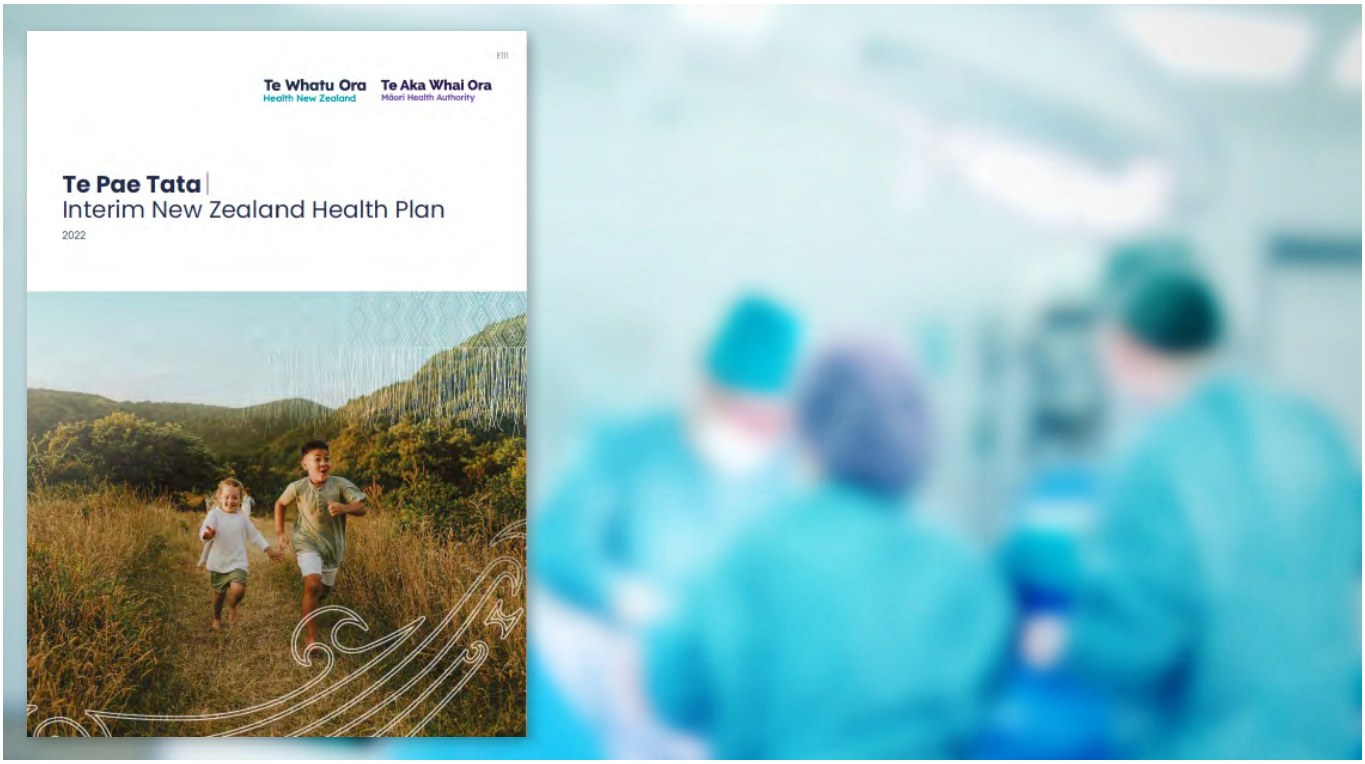
NSW Merit Award – Dr Danette Wright

Michael Donnellan Award – Associate Professor Payal Mukherjee

Innovation Award – Dr Shaheen Hasmat

Women in Leadership Award - Associate Professor Payal Mukherjee

Graham Coupland Lecture and Medal – Dr Francesca Rannard



A unified system with a focus on equity

The new healthcare system in Aotearoa New Zealand (AoNZ) continues to take shape with two new announcements.

The first aims to find solutions to long surgical wait times, while the second lays the foundations of a unified health system with a roadmap for 2022 to 2024.

On 1 July 2022, the Pae Ora (Healthy Futures) Act came into force in the biggest shake up of AoNZ's health service in 20 years.

It established Te Whatu Ora - Health New Zealand (http://bit.ly/3tsmkGP), a national body to replace the 20 district health boards. It also created Te Aka Whai Ora - Māori Health Authority (bit.ly/3EtX09E) to improve health equity.

The aim of the reforms is to lift overall public health—shifting the emphasis to illness prevention, improving access and equity, unlocking innovation, and building up the workforce.

Pandemic increases the urgency to solve planned care backlog

One of the major challenges facing the new system is surgical waitlists for planned care. Estimates suggest it could take between three and five years to clear the backlog, with the number of patients waiting more than a year for their first specialist appointment increasing 17-fold during the COVID-19 pandemic. There are an estimated 28,500 people waiting longer than four months for planned care.

A taskforce was established in May, headed by RACS Fellow and Counties Manukau's Chief Medical Officer Dr Andrew Connolly.

On 25 October, the Planned Care Taskforce released its 101 recommendations (bit.ly/3U0rqFY), which aim to reduce the backlog, and improve equity and access.

Recommendations include giving GPs the ability to diagnose without the need for a specialist, reducing the number of times patients see specialists, moving patients between regions for care, and greater use of capacity in the private sector for public patients.

The taskforce also suggests expanding Māori and Pacific-focused provider services.

Lack of targets – capacity issues persist

While there is widespread agreement of the need to tackle planned surgery wait lists, some have noted the lack of clear time targets for change.

Others, including RACS Fellow and New Zealand Association of General Surgeons president Dr Vanessa Blair, said the proposals don't address the core reasons behind the wait lists, including workforce shortages and pay for allied health workers.

Dr Blair said she wants the nursing crisis addressed by allowing nurses to come in more easily from overseas, with a four-year plan to train more nurses, including free training.

"At its core we just need to pay these people more. Nurses and other allied professions do not earn enough."

The College of GPs chair, Dr Samantha Murton, warned of capacity issues in primary care. While she said family doctors can help, they are already under the pump.

"There'll be a lot of people in the workforce going, 'Oh another job to do'."

Interim plan to build momentum around a unified system

A few days after the Taskforce recommendations were released, Te Whatu Ora and Te Aka Whai Ora unveiled the first national plan, which will underpin the new health system for the next two years.

The interim plan, Te Pae Tata (bit.ly/3DtmbHD), will serve as a roadmap until a more comprehensive strategy is developed. It has six priority actions and lays out how the government broadly plans to deliver on its health reform aims.

Among its aims is to tackle hospital capacity, surgery wait times and workforce shortages. It seeks to address inequities for Māori and Pasifika, immunisation coverage and accessing specialist care. It also aims to improve outcomes for maternity and early years, people with cancer, people living with chronic health conditions, and people living with mental distress.

Te Pae Tata's priority is to place whānau (family/communities) at the heart of the system to improve equity and outcomes. Other priorities include:

- embedding Te Tiriti o Waitangi, Treaty of Waitangi, across the health sector
- developing an inclusive workforce
- keeping people safe and well in their communities
- developing digital services to provide more care in homes and communities
- establishing the new health authorities as financially sustainable systems.

The planned unveiling comes amid major pressure on the health system. Not only are planned care wait lists an issue but new data shows one in four people are waiting six hours to be seen in emergency departments.

Where is the action?

Similar criticism to that levelled at the Planned Care Taskforce's recommendations have been raised in response to Te Pae Tata.

The opposition National Party dismissed it as little more than a 'discussion document' and asked where the 'action, dates and accountability' are.

Sarah Dalton, executive director of the Association of Salaries Medical Specialists, said Te Pae Tata will do little to address chronic workforce shortages plaguing the sector and fuelling backlogs and workforce discontent.

She said, "big conversations need to be had" about how to stem the flow of senior doctors, who can double their salaries in Australia.

GPs say the new national health plan falls well short of helping overrun rural practices.

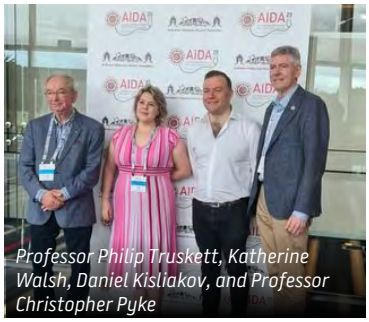
RACS position

RACS in AoNZ agrees the government needs to move faster and develop a long-term plan to recruit and retain a sustainable supply of skilled healthcare workers.

Responding to an earlier announcement by the Planned Care Taskforce, AoNZ National Committee Chair Associate Professor Andrew MacCormick said, "The focus should not be diverted from the root cause of long waitlists and [we] have encouraged the government to accelerate plans to relieve worker shortages across the healthcare sector, address lack of resources, and develop alternative models of care."

Read the full article on the front page of the latest issue of AoNZ newsletter *Cutting Edge* (bit.ly/CuttingEdgeOct2022).

AIDA Gala dinner


Professor Philip Truskett, Katherine Walsh, Daniel Kisliakov, and Professor Christopher Pyke


Adam Goodes in conversation


Surgical Skills workshop

AIDA Conference 2022

A RACS delegation attended the Australian Indigenous Doctors' Association (AIDA) conference, which was held at the RACV Royal Pines Resort on the Gold Coast, Yugambeh Country. The first AIDA conference since the pandemic, the theme was Celebrating the Past Challenging the Future.

The conference, which took place between 4 and 6 October 2022, started with Welcome to Country, followed by a traditional smoking ceremony, led by a local Aboriginal cultural group.

Katherine Walsh, Manager of Fellowship Services, and Daniel Kisliakov, Senior Project Officer Indigenous Health, attended a RACS stand that showcased Surgical Education and Training (SET). Prospective Trainees from different locations and universities, particularly from universities with strong Indigenous support programs—James Cook University, the University of Newcastle, Flinders University and Griffith University asked questions. A range of Indigenous health merchandise was distributed in RACS show bags.

Exhibitors from different colleges, universities and Aboriginal and Torres Strait Islander health organisations attended the conference. Various training options from diverse medical specialties were showcased, while networking opportunities were available for stakeholders to engage with, collaborate and form synergies to facilitate progress in Indigenous health.

A highlight of the conference was the wide range of souvenirs and merchandise offered by participants. These featured work from Aboriginal and Torres Strait Islander artists from various locations and displayed the diversity of Indigenous culture.

Attending the AIDA conference is of critical importance to Indigenous health at RACS. The ongoing development of stakeholder relationships facilitates support for Aboriginal and Torres Strait Islander Trainees across surgical specialties—serving the RACS objective of equity, including attaining proportionate representation for Indigenous surgeons compared with the general population.

On 5 October, RACS hosted a surgical skills workshop with vice president Professor Christopher Pyke and Professor Philip Truskett, past president of RACS attending. We received positive feedback from several participants.

A gala dinner was held on 5 October, which was a huge success. Due to the past pandemic restrictions and the inability to host graduation ceremonies, Aboriginal and Torres Strait islander medical graduates and new specialists from 2019 were presented with AIDA stethoscopes. Dr Anthony Murray, a new RACS Fellow, was acknowledged as the first Aboriginal and Torres Strait Islander orthopaedic surgeon.

Australian of the Year in 2014, dual Brownlow medalist and premiership player for the Sydney Swans, Adam Goodes, presented a keynote address on 6 October. Adam shared his experiences, outlined his advocacy for Aboriginal and Torres Strait Islander Australians, and reminded medical students and junior doctors to pursue their goals in medical careers.

Overall, the conference was an outstanding success and beneficial for the betterment of Indigenous health at RACS.

The connections that were formed will progress the RACS Reconciliation Action Plan and strategic planning moving forward. Partnerships will also grow to support Indigenous Trainees achieve equity and representation proportionately when compared to the general population.

Supporting the next generation of rural surgeons

RACS surgical Trainees share their impressions of the Provincial Surgeons of Australia (PSA) 2022 conference

Held on the sunny grounds of Mackay, Queensland, 15 rural aspiring surgeons were supported to attend the 57th Provincial Surgeons of Australia (PSA) conference through the Rural Coach - General Surgeons Australia - Rural Surgery Registration Grant. These Trainees and junior doctors share their thoughts on how enriching this experience was and the lasting positive impact it has had on their training.

Featured below are highlights from the reports provided by some of the recipients. The full report by all the recipients can be read on bit.ly/3g0TPg7

Dr Lash Wickramasuriya SET 5 Queensland

PSA 2022 brought with it a return to Mackay, where I had been posted for my first year of surgical training. As a first-year registrar in a regional setting you are thrust into the spotlight that comes with suddenly being responsible for managing your clinical team, residents and consultants. I was glad to see old friends, colleagues, and mentors while enjoying an educational scientific program filled with domestic and international speakers that highlighted the ongoing importance and challenges faced by rural and regional surgeons in Australia.

Dr Andrew FitzDowse SET 5 Victoria

The conference provided an ideal mix of practical surgical information, and a reminder of the friendly nature of rural surgeons. The talks imparted pearls of information that I wish I had received before sitting the Fellowship exam. Of note were the talks given by Dr Todd Heniford—a world leader in hernia surgery research. It was amazing to meet the developer of the CeDAR App I've been using on my phone for some years! The get practical tips and tricks for complex hernia management from such an inspiring surgeon, was unrivalled.

The social events showed the community that the PSA fosters and offers an opportunity to develop a rural support network for my future practice.

Dr Brianne (Bree) Lauritz SET 4 Victoria

It was a great opportunity for metropolitan, regional, and rural surgeons to gather in person after the last two years. Regional and rural speakers spoke about their subspecialty interests, with sessions focusing on colorectal, hepatobiliary, and breast surgeries. The RACS Rural Coach Dr Damian Fry gave a special talk detailing his career pathway from the military to becoming a surgeon. He emphasised his enjoyment of rural rotations during his training and the variety of experiences encountered being a rural surgeon. I look forward to next year's PSA!

Dr Tzu-Yi (Arron) Chuang SET 2 Queensland

Early in the year I was in Mackay as a general surgical registrar and there was a sense of pride in seeing the PSA being held to such a high standard. It was a great learning experience as many of the presentations focused on managing surgical emergencies in the rural setting, which is one of the main aims of the PSA!

It was wonderful listening to Associate Professor Kellee Slater, one of Australia's pioneer hernia specialists, on her experience in complex abdominal wall reconstruction and hernia repair. Dr Pranavan Palamuthusingam from Royal Brisbane and Women's Hospital presented on updates to the Barcelona guideline for hepatocellular carcinoma management. Dr Scott Whiting from Townsville discussed how to manage bariatric surgical complications in regional and rural setting.

Dr William McSweeney SET 1 Queensland

Attending the PSA was invaluable to continue to develop my understanding of the place rural surgery plays in surgical care. I found the sessions particularly engaging—both in terms of relatable surgical content that I can apply in practice, and in hearing from metropolitan-based experts in these fields. It was these talks by surgical subspecialists from larger centres that were so appealing and gave an impression of connection between the regional practice, and the referral centres we are so often speaking with. The social events were a highlight and impressed upon me a sense of community and mentorship, which is key in moulding how I think about future practice. The presentation by Dr Fry was a meaningful and grounding insight into the challenges and opportunities of training. I strongly recommend the PSA to other junior doctors and would like to continue to attend as I progress through training.

Dr David Toro Tolle JDoc Northern Territory

I'm incredibly grateful to the GSA Rural Coach Grant for supporting me in making the trip to the PSA conference. I live and work in Darwin, and the journey to Mackay is certainly not a short one. As someone who is interested in rural general surgery and surgical research in rural and remote Australia, I knew this trip would be an excellent opportunity to learn and connect. I was given the opportunity to present on real-time research I'm conducting with Dr Richard Bradbury. We are exploring optimal (and evidence-based) surgical techniques to treat carbuncles—a condition disproportionately affecting rural and remote Australians. I really appreciated feedback and insight from attendees, and the overwhelmingly positive response to our study. I left Mackay feeling enriched with both new ideas and knowledge, as well as colleagues.

Two remarkable surgeons in life and practice

Dr Adrian Fernandez and Associate Professor Sandra Krishnan are celebrating 25 years of marriage. They are a dynamic husband and wife surgical team who have raised a family amid busy schedules, and for the past three years, maintained separate bases across Bega, Canberra and Sydney.

Dr Adrian Fernandez is a senior consultant general surgeon with special interest in colon and rectal surgery. He is the ex-co-president of the Provincial Surgeons of Australia and is a co-opted member of the RACS ACT committee where he co-convened the August 2022 RACS ACT Annual Scientific Meeting (ASM). Dr Fernandez practices in Bega, New South Wales, and Canberra in the ACT.

Clinical Associate Professor Sandra Krishnan is a consultant surgical oncologist and breast, melanoma and general surgeon with breast oncology fellowships at Breast Cancer Institute, Westmead Hospital and Breast and Endocrine Unit, Concord Hospital. As well as working with her husband in Canberra, she is Clinical Associate Professor at the Australian National University and practices at the Northern Surgical Oncology at the Sydney Adventist Hospital. Associate Professor Krishnan co-convened the August 2022 RACS ASM with her husband.

Associate Professor Krishnan grew up in Malaysia, and throughout high school was a distracted student who wasn't achieving her potential. That turned around when her grandfather was admitted to hospital when she was a teenager. In that busy environment, she remembers observing how difficult it was to engage doctors.

"I became determined that I would become a medical specialist who would be accessible and focussed on the patient's needs," she said. "Before that, I thought I would become a teacher, but a seed was planted due to my grandfather's experience. I am so grateful that my parents had a lot of faith in me and supported my new ambition by sending me overseas to pre-medical school in India."

Studying medicine gave her a sense of purpose and belonging. "I felt as though this was what I was meant to be doing. I felt as though I had arrived. Everything made perfect sense to me from my first lecture, which was in anatomy."

Dr Fernandez was a more consistent high school student but did not have the same early calling. He arrived at medicine from a process of elimination, not wanting to do law or engineering. He decided on medicine over architecture and found the first two years of study challenging and laughs remembering he sat at the back of the lecture theatre while his wife sat in the front row, often annoying other students and prolonging lectures by asking additional questions. Today, the story is different, "I plan and execute an operation like a work of art, it gives me a great sense of satisfaction."

Even though they were fellow medical students, Dr Fernandez and Associate Professor Krishnan formally met each other in a different context: through the local church where they regularly attended mass. He was the choir master and she presented the readings and commentary—their friends called them Mary and Joseph.

The two medical students began studying together and decided to complete their internship at the same hospital. Despite rumours, they remained good friends until a mutual friend took aside each one separately to suggest the obvious: they would make good partners in life as well as fellow students and surgeons. This special friend earned a speech at their wedding!

Both believe there have been many benefits of being married to someone who understands the pressures and the unpredictability of being a surgeon. When the children were young, the two job-shared so they were able to—as much as they could—ensure one parent would be available at home before and after school.

"There is the common understanding of the clinical handover. Adrian and I not only handed over patients, we handed over the children, we handed over the home, and for the past few years, we've handed over our dog as well! We try to be as accommodating as we can for each other. No judgements, no questions asked. We have a lot of mutual respect for each other and it helps that we have been friends for a long time."

Associate Professor Krishnan said Dr Fernandez would often do more than what was expected of him to make the handover easier for his wife—clinically and at home.

For the past three years, Dr Fernandez has remained based on the south-east coast in New South Wales while Associate Professor Krishnan has been largely based in Sydney, initially moving there to support their son who relocated to study for his Higher School Certificate (HSC). They meet in Canberra where they consult and operate together and spend weekends with their children whenever they can.

Now that their children are young adults, both surgeons are appreciating the opportunity to focus on more than co-sharing clinical practice and parenting.

For Dr Fernandez, this means being able to take up more research and to be more involved with the Australian National University's Rural Medical School, which is based in Bega. As many meetings have shifted online, Dr Fernandez is enjoying the opportunity to meet more regularly with other Canberra specialists and surgeons.

Associate Professor Krishnan feels that she is now able to build her profile, particularly as an ethnic woman of colour in surgery. "It's important to tell people about the difficulties I've overcome to inspire and help other women and Trainees succeed in surgery. I get a great deal of satisfaction preparing students for a life in surgery after they graduate."

They co-convened the ASM in Canberra and Associate Professor Krishnan said, "I'm so proud of the innovative program we presented. We assembled an array of speakers, which included registrars and medical students in addition to the usual specialists, presenters and Chairs."

"We wanted to address environmental sustainability in surgery and the effects of climate change," Dr Fernandez added. "It generated a lot of interest. We involved cross-surgical specialties such as Orthopaedic Surgery, Plastic Surgery, ENT, and by doing so attracted a broad spectrum of surgeons. We had a good team around us and were well supported by the RACS ACT Committee."

Associate Professor Krishnan particularly liked the call to action regarding sustainability. "Think about what you can do. Every day. Mindfully. Think about better ways of working that minimise harm on the planet."

Both surgeons relax by staying active. Dr Fernandez enjoys the outdoors while Associate Professor Krishnan switches off by playing badminton. They both share a love for music, and take time off to attend concerts with their children.

The sense of achievement in working alongside each other as surgeons in a shared practice while raising a family is enhanced by the time and freedom they now have in being able to work in different locations, meet more people and feel part of a wider community.

"There are many advantages working in the country. It's always interesting: you never know what bizarre injuries you're going to get—farm injuries or shark bites. Because it's a small community we know many people so there's a personal touch in our practice. Traffic isn't a problem, housing is affordable, and the setting in southern New South Wales is so beautiful. We have the best of both worlds," Dr Fernandez said.

He believes he and his wife have discovered a better balance being able to combine regional and metropolitan work. He feels that enabling surgeons to similarly work rurally and in metropolitan settings might help attract more surgeons into regional hospitals and hopes they will be an example of how to achieve this.

After 25 years working and living alongside each other, it's easy to think Dr Fernandez and Associate Professor Krishnan are experts in making things work wherever they are and in whatever they do.

On-call surgeon responsibilities need to be clarified

Case summary

A comorbid elderly patient presented with haematemesis found to be coming from a proximal gastric source, likely erosions. The patient underwent multiple endoscopies and ultimately died of massive bleeding from the stomach.

Case notes

A 70-year-old patient presented with haematemesis on a background of multiple medical comorbidities impacting daily function, including recurrent lower respiratory tract infections, bronchiectasis, diffuse scleroderma, osteoarthritis, hypertension, and recent unintentional weight loss. The patient was on multiple medications including mycophenolate, prednisolone, meloxicam, and pantoprazole.

The patient's haemoglobin was 82 g/L on admission and two units of packed red cells were given. The patient underwent two gastroscopies. The first (day one of admission) found a large volume of semisolid blood with poor views. The second gastroscopy, on the following day, demonstrated erosions in the proximal gastric body. An adrenaline injection was placed into a gastro-oesophageal junction lesion and Endoclot was applied to the gastric erosions. There were poor views of the duodenum due to blood. Two days later (day four of admission), a medical emergency team (MET) call occurred at 17:05 for further fresh haematemesis and haemodynamic instability (haemoglobin 48 g/L). The patient was intubated on the ward at 17:30 and transferred to ICU at approximately 17:52.

Documentation following this is sparse. There appears to be no running documentation from the medical registrar or the surgical registrar—who was presumably involved to assess and liaise with the surgeon and on-call surgeon. There is only a retrospective note from the reporting surgeon regarding their version of events:

- being contacted during the MET call despite not being on call and being unable to attend expeditiously
- suggesting that the on-call surgeon assist in performing an endoscopy and the on-call surgeon not attending to help
- discussing with the on-call surgeon in the theatre tea-room prior to the second gastroscopy who should be responsible for the gastroscopy—both feeling that the other should have done the endoscopy.

A third gastroscopy was performed at approximately 19:00 by a gastroenterologist who found a large volume of clot in the proximal stomach. The duodenum was visualised and appeared to be normal.

The assessment was a large proximal gastric bleed not amenable to endoscopic intervention due to adherent clot despite extensive wash and repositioning of the patient. A multidisciplinary discussion between the surgeon, the gastroenterologist and the intensivist concluded that intervention with proximal gastric surgery would not be appropriate given the patient's comorbidities. The patient subsequently died overnight from bleeding.

Area of concern

The major area of concern is the potential delay to the third endoscopy (approximately one hour) caused by the lack of a clear plan regarding who would perform the gastroscopy.

The surgeon who had been involved with the patient's care felt that the on-call surgeon should have performed the procedure, whereas the on-call surgeon reportedly did not want to be involved because the reporting surgeon had performed the two prior endoscopies.

Comments

The standard of care before the time of deterioration appeared appropriate. Management of the bleeding medically and endoscopically occurred in a timely fashion. The deterioration was also clearly recognised on day four with another endoscopy required. The issue of concern pertains to who was responsible for performing the procedure and the communication surrounding this.

The delay to theatre of approximately one hour may not have made a difference to the outcome in this case—given that the pathology did not appear to be endoscopically manageable—but regardless of the outcome, on-call responsibilities should be clear within the hospital to prevent confusion and delay. When there needs to be handover of care (due to a surgeon no longer being on call), this should be communicated clearly to avoid delays in time-critical interventions such as this. Communication could have been improved in this case.

Professor Guy Maddern
Chair, ANZASM

Royal Australasian
College of Surgeons

College's events management system now live

The long-awaited events management solution, which will help us move towards a more streamlined experience for registration and payment of College events is live now.

RACS members can search, register, and pay for 2023 events, courses and exams using the Training & Services platform in eHub.

At this stage, the platform is open for registration of Skills Training and Professional Development courses and workshops: Generic Surgical Science Examination (GSSE), Clinical Examination (CE), Specialty Specific Examinations (SSE) or Fellowship Examinations (FEX), and some social events and conferences.

The solution is built on the existing Microsoft Dynamics365 platform and post Council's approval of the 2023 fee schedule, the platform is now ready for member registrations.

This marks a significant improvement in how you search and register for events, including payments, withdrawals, refunds, and post-event activities—such as downloading invoices and certificates.

The platform will be further enhanced to cater for the College's Trainee Association, RACSTA, Aotearoa New Zealand and Australian state and territory offices, and Trauma and Academic Surgery in the coming months. The Training & Services platform will eventually become the digital one stop for all RACS events and courses, enhancing member experience.

Read more: bit.ly/3GHRx04

Postoperative mortality at 30 days: an outdated surgical outcome standard

Postoperative mortality at 30 days has long been a key surgical outcome. It has been used to compare variation between surgeons and hospitals and triggered numerous enquiries. However, there is increasing evidence to suggest that 30-day postoperative mortality is no longer a suitable outcome standard for surgeons, hospitals and, most importantly, patients.

In the elective setting there is plenty of time to assess perioperative risk and improve modifiable risk factors. There is also time to discuss operative risks with the patient and acknowledge that in some cases the risks may outweigh the likely benefits. Elective cases that do not proceed to surgery are not admitted, thus the impact of case selection on elective postoperative mortality is unclear. Surgeons have long known that the surest way to reduce postoperative elective mortality is to not operate on high-risk patients.

If a patient has a complication following elective surgery, modern medicine means a patient who would previously have died within 30 days now may survive beyond that—perhaps only to die within 90 days. So, 30-day mortality is no longer an adequate outcome standard for elective surgery mortality.

The emergency setting is different. Historically, the options were often an operation or certain death. The understandable default option was to offer surgery. Modern preoperative assessment, notably contemporary radiology, means many facing very high-risk surgery can now be identified preoperatively. The surgical adage 'better to look and see than wait and see' is now rarely appropriate.

There is no doubt that patients in the past have undergone very high-risk surgery when death was almost inevitable. Both patients and clinicians often had unrealistic expectations of modern medicine (e.g., better drugs and intensive care). Patients were less informed. Surgeons, often under pressure from the family, sometimes operated against their better judgement.

This is no longer the situation. Clinicians now have a greater awareness of when treatment is unlikely to be successful. Patients have a greater understanding and are seeking greater input as to whether they have surgery or not. Central to this is an increasing appreciation that patient priority is often not focused on mortality, but on postoperative quality of life, especially if it is associated with a loss of independent living. So, for many, high-risk surgery offers minimal gain despite great patient and societal cost.

The Australian and New Zealand Audit of Surgical Mortality (ANZASM) records all patients who die under the care of a surgeon, regardless of whether they have an operation or not. In its latest annual report, the Western Australian Audit of Surgical Mortality (WAASM) reports its experience over 20 years [1]. Initially, about 20 per cent of those who died under the care of a surgeon did not have an operation (non-op). This has progressively increased to an overall non-op rate of about 50 per cent. Unsurprisingly, this change has been driven by the management of emergency admissions and has been observed in all specialties admitting high-risk emergencies (General Surgery, Orthopaedic Surgery, Vascular Surgery and Neurosurgery).

The reasons for the non-op rate and its impact, are now a matter of considerable debate. There is an appreciation that the true mortality denominator for those who die are all those eligible for a specific operation, regardless of whether they had an operation or not.

The two operations that contribute the most to postoperative mortality are fractured neck of femur and emergency laparotomy (EL). In Australia and Aotearoa New Zealand, the numbers and mortality for hip fracture and EL are similar.

Regardless of the likely mortality, most neck of femur fractures will be managed surgically, as it provides the surest pain control, lowest mortality, and the only realistic chance of rehabilitation. Many countries, including Australia and Aotearoa New Zealand, have well established hip fracture registries, which have improved care and outcomes.

That is not the situation for those being considered for EL, and the non-op rate is gaining increasing attention. For some, the preoperative risk of EL may be deemed prohibitive; these operations have been variously described as futile or inappropriate, with some now preferring the less prejudicial description of non-beneficial.

A major driver of the interest in EL outcome over the last 10 years has been interhospital variation, notably for mortality. International EL audits have typically reported mortalities of 10 to 15 per cent, often higher. This is substantially greater than the six to eight per cent mortality reported by at least 10 contemporary Australian EL studies, with the highest being 10.5 per cent.

Why is the Australian post-EL mortality lower?

Australian general surgeons will obviously claim that—like their sports men and women—they have superior skills! An alternative and more likely explanation is the education that Australian surgeons receive through ANZASM. Even a small increase in the non-op rate can profoundly decrease postoperative mortality. Only five EL publications have included non-op data, of which three are from Australia—

the only country with a national mortality audit. It seems unlikely these observations are a coincidence.

There are other changes that have diminished the value of 30-day mortality. Interventional procedures may now be the preferred—or even the best—treatment, but although many interventions are an operation in all but name only, they do not appear as such in postoperative statistics. Interventional procedures may be unsuitable for complex cases, so surgical outcomes are likely to be assessed against a denominator that does not include those with a probable low mortality (unless, of course, the surgeon is called upon to rescue a complication of an intervention).

On the other hand, an interventional procedure might be considered sufficiently low risk that it can be offered to patients unlikely to survive an open operation. Thus, patients who previously did not have an operation (non-op) now have surgery. This changes the mortality pattern. The development of endovascular surgery may explain the changing non-op pattern seen within Vascular Surgery in the WAASM report.

A legitimate question is whether some Australian patients are now being denied surgery that they might have survived. In the absence of overseas non-op data there is no comparative benchmark.

A further confounder is goals of care (GoC) documentation. The 2015 national end of life consensus document [2] published by the Australian Commission on Safety and Quality in Heath Care placed great emphasis on defining GoC. These GoC forms are now universally used in Western Australia, where patients who do not have surgery have an opportunity to document their wishes. Similar forms are used in other Australian states, but perhaps not as consistently. They do not appear to be widely used overseas.

ANZASM reports emphasise the importance of GoC documentation. This article was prompted by the significant feedback received following publication of the ANZASM *Case of the Month June 2022*. Several assessors commented that if a GoC form had been completed, a futile operation might have been avoided. (*The ANZASM National Case Note Review Booklet* [volume 22 April 2022] was devoted to the avoidance of futile surgery.)

There is now awareness of a lack of information after patients leave the hospital. Post-discharge quality of life can be poor for many patients and associated with multiple care episodes unknown to the surgeon. This may be a particular problem in Australia, where a high proportion of patients are transferred for surgery, placing them at a distance from their surgeon and other specialist support services for post-discharge care.

It is known that mortality often increases up to 90 days and increases further up to a year. Because modern medicine has a much greater opportunity to rescue patients who have a complication, mortality beyond 30 days may also reflect surgical complications. These need to be captured in any assessment of surgical quality. Although it must be remembered that this later mortality may also reflect advancing medical comorbidities or progression of the underlying surgical pathology (e.g., cancer). In many of these cases surgery may not have been beneficial, and perhaps best avoided.

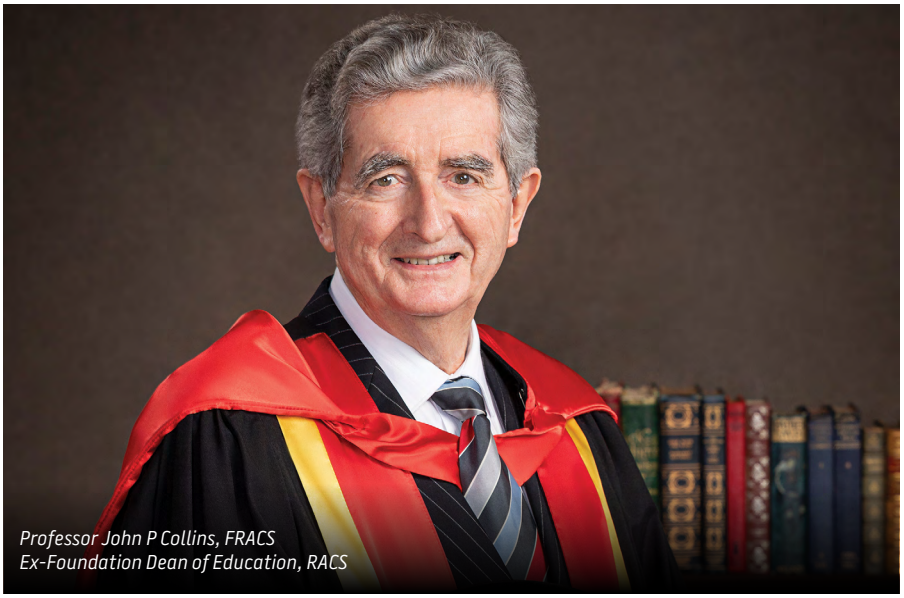
For the time being, 30-day mortality remains an important measure of surgical care; however, its limitations are clear. With better data-sharing, other parameters will be routinely reported and are likely to provide a better measurement of surgical care.

Reference

1. Royal Australasian College of Surgeons. Western Australian Audit of Surgical Mortality (WAASM) 2022 Annual Report [Internet]. Perth: Royal Australasian College of Surgeons; 2022 [cited 2022 Oct 15]. p.73. Available from: bit.ly/3UXnaYd
2. Australian Commission on Safety and Quality in Heath Care. National Consensus Statement: Essential elements for safe and high-quality end-of-life care [Internet]. Sydney: Australian Commission on Safety and Quality in Heath Care; 2015 [cited 2022 Oct 15]. p.44. Available from: bit.ly/3ET4NOD

Dr James Aitken
Clinical Director, Western Australian Audit of Surgical Mortality

The importance of non-operative surgical interests for surgeons



Professor John P Collins, FRACS
Ex-Foundation Dean of Education, RACS

Surgeons usually have varied interests and hobbies outside their surgical practice. These activities often form the basis of an active retirement. However, life can spring unexpected surprises and hasten the significance of such pursuits.

My career as an operating surgeon ended prematurely in 2003 when I injured my hand. I was fortunate to fall back on my other interests, particularly in medical education. This provided me with new opportunities and a new career.

In 2004, I moved to Melbourne to take up my appointments as Foundation Dean of Education at RACS, and Associate Professor of Surgery and Surgical Education at the University of Melbourne. I joined the College at a time of unprecedented criticism of its educational practices and processes, including accusations that certain specialties were limiting opportunities for surgeons to train. Reviews of all aspects of the College's activities were undertaken by the Australian Competition and Consumer Commission and later by the Australian Medical Council (AMC). I became intimately involved in these reviews. Although no evidence was found to substantiate the original major criticisms, both the reviewers and the College identified opportunities for improvements.

This stimulated the development of more transparent processes and evidence-based educational principles for the selection, education, training, and assessment of Trainees, including more uniform criteria and standards for the accreditation of hospitals and posts for training. In addition, an Academy of Surgical Educators was established with a focus on equipping and supporting surgical trainers, without whom no education and training can occur!

This experience enabled me to assist in the AMC reviews of other medical colleges and of Postgraduate Medical Councils and to chair its Joint Standing Committee for Overseas Trained Specialists.

My appointment at the University of Melbourne involved teaching medical students and surgical Trainees, and research in medical education. Students greatly appreciate those who are supportive and committed to their learning. The highlight of my time in this beautiful city was being awarded Teacher of the Year by the final year medical students in 2007.

After being awarded honorary appointments at the University of Oxford as Visiting Professor of Surgery, and as Visiting Fellow at Green Templeton College, we moved to the UK in 2009.

I was once again able to participate in teaching medical students and surgical Trainees and had unlimited access to Oxford's famous libraries and colleges. Living in Oxford provided my wife and myself with many social, cultural, and other memorable experiences.

Based on my previous experiences, Medical Education England invited me to chair an Expert Advisory Panel formed to evaluate the UK Foundation Programme. This program was established five years earlier for the education of UK doctors in Years 1 and 2 after their graduation. This culminated in a formal report—*The Collins Report*. All but one of the key recommendations were implemented. These varied experiences and findings from my research provided the basis for a Hunterian Lecture, which I delivered on surgical education at the Royal College of Surgeons of England in 2010.

My longstanding interest in medical history stimulated my participation in the annual course organised by the Worshipful Society of Apothecaries in London. This rewarding course encouraged me to later enrol for a PhD in history at the University of Auckland. My thesis explored how surgery was transformed from a manual trade into a profession. I was awarded my Doctorate in 2021.

I hope this brief account of my enforced career change following an injury, will encourage other colleagues to develop complementary interests outside operative surgery. The potential for a successful and fulfilling career change should not be underestimated.

Year 13 students as part of Pūhoro

Dr John Mutu-Grigg

Māori college students try their hand at surgery

College students performing total hip replacements might sound a little scary, but it turned out to be a fun and engaging way to open the eyes of Māori teens to new career options.

Dr John Mutu-Grigg, an orthopaedic surgeon and Chair of the RACS Māori Health Advisory Group, visited the Auckland University of Technology (AUT) where the event was held in September to promote surgical careers to Year 13 Māori students as part of a RACS collaboration with Pūhoro (bit.ly/3P0gmHb).

Pūhoro was launched in 2016 to increase engagement of Māori in STEMM-related (science, technology, engineering, mathematics and mātauranga Māori) career pathways. It is a fast-growing initiative currently comprising of more than 1500 students from 90 different iwi (tribes/extended kinship groups) and 54 schools from around the motu (country).

Dr Mutu-Grigg talked to the Year 13 students about RACS nine surgical specialities and the pathways students can follow to take them from college to operating theatre.

His key theme was, "Māori can achieve whatever they dream, with the aid of whanaungatanga (kinship and community support) and manaakitanga (kindness and care)".

He also let the students get hands-on, using pelvis and femur saw bones, supplied by Mathys Medical, to perform the acetabular and the femoral components of a total hip replacement.

"The students were fantastic. At least half of the two-hour session was questions and interaction with the students.

"They were a bit shy at first to perform the hip replacement but when they saw others doing it, they realised that they could do it too and were very enthusiastic. The hands-on aspect seemed to really engage the students and opened their eyes to more career options."

Dr Mutu-Grigg's comments were echoed by feedback from the students. One student said doing the practical to repair a fake bone was a highlight.

"It was inspiring to hear how Māori can achieve it, even if we don't have the best grades, as long as we set our mind to it and put in the hard mahi (work)."

In a RACS first, work is underway to establish a Memorandum of Understanding (MoU) with Pūhoro as part of the Māori Health Advisory Group's work to establish pathways for Māori into surgical careers.

Bhavik Patel – MAIC-RACS Trauma Research Scholarship recipient

Dr Bhavik Patel is a two-time RACS scholarship recipient. He describes the scholarahip program as a "fantastic opportunity" that allows surgeons to do something for the community after they finish training.

Originally from Mumbai, India, Dr Patel completed his MBBS degree and Master of General Surgery there. While he did not initially think of pursuing surgery, he found "with some hard work, things kept on moving, opening this pathway for becoming a surgeon".

In 2006, Dr Patel came to Australia to upskill in minimally invasive surgery and completed his Master of Research (MPhil) from the University of Queensland.

He then trained at various hospitals and gained his Fellowship of the Royal Australasian College of Surgeons (FRACS) before becoming a visiting Fellow at the R Adams Cowley Shock Trauma Center, University of Maryland, Baltimore, USA.

Once he returned to Australia, Dr Patel completed another trauma and acute care Fellowship at Gold Coast University before moving into his current role of consultancy.

For Dr Patel, choosing trauma and acute care as his specialty stemmed from an interest in an upcoming field.

"Trauma and acute care are different from the other specialties because you expect the unexpected. You have no clue as to how things will progress without the help of various experts in that room," he said.

"This system of a shared care model, plus the excitement of helping the sickest patient in the hospital attracted me to the field."

Fortunately, in countries like Australia and Aotearoa New Zealand, the burden of trauma numbers is not phenomenal. "However, if you combine it with acute case surgery, we have the two most important fields of dealing with severely ill patients who come to the hospital. That is why I chose to specialise in acute care and trauma," he said.

In 2020, Dr Patel received the MAIC-RACS Trauma Research Scholarship that supports trauma research aimed at benefiting Queenslanders.

Earlier in 2018, he received a scholarship from the College for management of blunt splenic injuries in Queensland. "I got two in a go," he said with pride.

For Dr Patel, the 2020 scholarship was particularly meaningful given that the average Australian life expectancy has reached 80 years of age. "We are getting people who are living longer with an increasd incidence of chest wall injuries from falls."

Before the scholarship, he was putting together a research paper locally looking into the pathways for the geriatric population who present with blunt chest wall injury.

He found there was minimal morbidity and mortality with a functional trauma unit. A major conclusion was that age should not be a criterion for surgical stabilisation of rib fractures. The research was published in the *ANZ Journal of Surgery* in 2021.

During that period, Dr Patel wanted to study all the institutions around Australia with regard to the outcomes on geriatric patients presenting with blunt chest wall injury.

"So, with the scholarship, we wanted to involve all trauma centres and look at management of rib fractures and the outcomes with an attempt to reduce morbidity and mortality.

"The most important thing that I want to do is to avoid disparity of care. A trauma patient should receive standardised care at all hospitals around Australia," he said.

The RACS scholarship also gave Dr Patel the opportunity to network and meet people "who are pioneers in research".

"If you are a budding surgeon with an interest in research, you must look for these scholarships as they give you a wider perspective of what is happening around the country and in Aotearoa New Zealand," he said.

Dr Patel currently works as trauma and acute care surgeon at Gold Coast University, Princess Alexandra and St Andrew's War Memorial Hospitals. He lives with his wife and two children, but work life balance for him is "all about management skills".

"Ultimately, as a surgeon you know exactly how much you can do and how much you can't."

RACS offers more than 70 scholarships and grants valued at more than $2 million annually through its Scholarships and Grants Program. To learn more, visit www.surgeons.org/scholarships

Royal Australasian
College of Surgeons

SAVE THE DATE

RACS NT, WA & SA Annual Scientific Meeting 2023

10 - 11 August, 2023
Darwin Convention Centre, NT

Contact RACS WA Office
+61 6389 8600
college.wa@surgeons.org

Majestic Jim Jim Falls, Kakadu

Sunset over Darwin Harbour

Momentum starting to build in climate space

In November RACS became the first medical college in Australia to sign up to the newly released *Green College Guidelines* (bit.ly/3Gi1Pem).

The guidelines have been developed in collaboration with the Australian Medical Association (AMA) and Doctors for the Environment Australia (DEA). They provide guidance to medical colleges on how they can reduce the carbon emissions of their organisation by incorporating practical changes to the way they operate.

Sixty three recommended actions are outlined in the guidelines. These actions cover several aspects of RACS core operations, and are aimed at College staff and facilities, including broader initiatives to improve the environmental sustainability of surgery, mainly through education and training activities.

RACS has already completed many of the identified actions in the guidelines, and there are many more that we will be able to achieve over the next 12 months. There are other actions that are a little more complex and I am confident we will be able to complete these. But they have to be longer term priorities for the RACS Environmental Sustainability in Surgical Practice Working Party (ESSPWP).

I would like to congratulate the AMA and DEA for their leadership and commend the guidelines for laying the groundwork for how medical organisations can collectively embed more sustainable practices.

The College had earlier called for greater action on climate change at a government level, and for us to be able to advocate with credibility it is important that as an organisation we have our own house in order. These guidelines will certainly assist us with this, and I am looking forward to working with the various areas of the College to ensure we meet our commitments.

In other news, I was delighted by the announcement in the October federal budget of the funding for a National Health and Sustainability Climate Unit, and also the development of a National Health and Climate Strategy.

This is something that the College has advocated for individually and also collectively with other Colleges and likeminded organisations. We expect that consultation on the strategy will take place in early 2023 and will be one of the key priority areas for the ESSPWP to contribute towards.

There are also plenty of policy activities taking place in Aotearoa New Zealand (AoNZ) and at a state and territory level in Australia. Many governments have already acted or signalled their intention to strengthen their policy and legislative frameworks. The ESSPWP looks forward to working closely with our state and territory and AoNZ colleagues and supporting them in their advocacy efforts.

On a final note, for those interested in following the progress of the ESSPWP and RACS environmental advocacy, we recently launched an environmental webpage on the College website. The website will continually be updated with updates, information, and research. I will also endeavour to keep you informed on the latest developments in future issues of *Surgical News.*

I know that many of our Fellows, Trainees and SIMGs are passionate about environmental sustainability. If you would like to find out more or become involved, I encourage you to please email the RACS Policy and Advocacy team.

Emeritus Professor David Fletcher

Chair RACS Environmental Sustainability in Surgical Practice Working Party

Family violence is a medical issue, symposium hears

Family violence was the focus as medical professionals from around Australia and Aotearoa New Zealand gathered at New South Wales Parliament House for a joint symposium on 10 November 2022.

The symposium was hosted by the Royal Australasian College of Surgeons (RACS) and was part of the annual RACS trauma week program. The symposium was also co-hosted by the Australian and New Zealand College of Anaesthetists (ANZCA) and the Australasian College for Emergency Medicine (ACEM).

The key focus for the day was to take a critical look at the health system's response to family violence. A range of speakers from across the medical profession, including politicians and public policy experts provided insights.

The symposium heard that one in six women have experienced physical and or sexual violence by a current or previous partner since age 15 (according to the Australian Institute of Health and Welfare). There are approximately 6500 admissions a year in Australia due to domestic and family violence and every couple of weeks women are killed by a current or former partner. In fact, domestic and family violence is the greatest health risk factor for women aged 25 to 44 years.

Despite the shockingly high incidence of domestic and family violence, it often goes unnoticed by those in critical positions, prompting many experts to describe it as a hidden epidemic.

Those speaking at the symposium urged for greater education and awareness among medical professionals. This included the co-convenor of the symposium Associate Professor Payal Mukherjee.

"The perception among surgeons in general is that domestic and family violence is a social issue not a medical issue, but as clinicians we are trained to not just treat the trauma but to set in place ways to mitigate future harm of trauma. Trauma prevention needs to be a focus rather than just trauma treatment."

RACS President Dr Sally Langley also attended and spoke at the event, and said she hoped the constructive discussions at the symposium would result in longer term change.

"I am impressed by the commitment right from the top from numerous arms of the profession in making this event possible. It is important that we make sure that these discussions filter through to our workforce and we are accountable for the outcomes that we set.

"I am hopeful in the long term that through initiatives such as the symposium and other similar collaborations, we are able to make addressing family violence the core of what we do."

The National Critical Care and Trauma Response Centre generously supported the symposium and RACS Trauma Week. Thank you to Len Notaras, Michelle Foster, and all at the NCCTRC for the continuing support and commitment they have provided over many years for trauma prevention and trauma care.

The POSTVenTT collaborators

POSTVenTT study offers multiple benefits

A new method of collaborative research has enabled a groundbreaking study across Australia and Aotearoa New Zealand. The POSTVenTT (POST operative Variability in anaemia Treatment and Transfusion) study involved more than 600 students and Trainees in surgery who collected data from 2730 patients across 56 hospitals in just four weeks.

It was the first time such a project has been coordinated by RACS Clinical Trials Network Australia and New Zealand (CTANZ) in collaboration with researchers at the University of Western Australia. The study aimed to assess the adherence to Australian National Blood Authority perioperative anaemia guidelines.

Follow up was complete in more than 98 per cent of patients and showed a novel finding that two-thirds of patients were discharged with anaemia after surgery. Discharge anaemia was associated with a significant (59 per cent) increased risk in the rate of 30-day re-admissions.

The results, published in *The Medical Journal of Australia* (MJA) in September, support the need for the standardised management of perioperative anaemia after major abdominal surgery and highlighted the underused role for operative tranexamic acid to reduce bleeding in surgery.

RACS Fellow and University of Western Australia Vascular Surgery Professor and Clinical Trials Unit Director Toby Richards proposed and launched the project through the CTANZ network.

Professor Richards said the study provided a solid foundation for collaborative research in Australia and Aotearoa New Zealand and the benefits for the 600 students and Trainees involved—and their future practice—are even more significant.

"This study enabled 600 junior doctors and medical students to be part of a good quality clinical trial, with meaningful outcomes, and gave them a rewarding experience," Professor Richards said.

"After all, the results from this study were of such quality they were published in the *MJA*, providing cutting edge data with reach that can impact change internationally.

"By understanding clinical trial methods and participating in all the steps needed to deliver a research project, they can better understand data and interpret research evidence, develop their own opinions, and ultimately inform their future practise.

"The results of this study, conducted with 98 per cent follow up in 2730 patients, provide high quality data and a solid rationale for future research into tackling post operative anaemia, which may lead to improvements in patient recovery after surgery and reduce emergency readmission."

It was for this purpose of providing surgical Trainees, junior doctors and medical students the chance to lead and participate in clinical studies that enhance patient care that CTANZ was established in 2017.

Professor Richards would like to see the recognition of the value of collaborative research such as the POSTVenTT study recognised for research training within RACS SET training and for selection into training.

He would also like to see development and support for the infrastructure to enable the collaborative research platform created during the study—bringing together surgeons, students and Trainees—to reap its benefits for future Trainees and studies.

Kenneth Macpherson, a final year medical student at the Fiona Stanley Hospital (Perth) took part in the research as a member of a team that piloted the protocol for the study to ensure its smooth rollout to other regions.

He also helped monitor and support the data collection and record-keeping in Western Australia and contributed to the recruitment of patients to the study.

Kenneth said he benefited from being part of a study in which the data collected was of such high quality, with the potential for influencing clinical processes.

He also believes there are varied advantages of being involved in collaborative studies, both for him personally and for the profession, more widely.

"I think it's beneficial in multiple ways—for the research field, and clinical practice, because we're able to collect large volumes of data that are going to have a significant impact on patient management in the future," he said.

> "It was a really useful learning exercise, and the experience and knowledge will improve my surgical skills in the future."

"However, there is also benefit on the ground. Speaking from my own experience, for medical students and junior doctors, it allows them to get involved with research, even if they have minimal experience, and develop their skills so they can have a greater involvement in research going forward."

Kenneth aims to continue to pursue research opportunities in the future.

"I'm definitely keen on getting involved with research going forward, and the way I describe it to people is that having done this, I feel like I can now reach out to a consultant to see if they have any research projects going on, and I can get involved without them having to hold my hand through it."

The professional relationships forged through collaborative research are also a major benefit in the eyes of Middlemore Hospital (Auckland) pre-SET surgical registrar Dr Cameron Wells.

Dr Wells was a member of the project management group overseeing the running of the study in both Aotearoa New Zealand and Australia.

He helped organise the administration of the study, contact collaborators, run weekly online meetings and write the first manuscript.

Dr Wells is grateful for the mentorship he received from senior surgeons throughout the study.

"There aren't many times when you are on a weekly online meeting with surgeons from across Australia and Aotearoa New Zealand," he said.

It was not the first international study that Dr Wells had been involved with, although it was the first collaborative research to be locally-led.

"As part of doing the analysis for the project, I had the opportunity to deep dive into a big data set, with more than 2000 patients in it.

"It was interesting seeing the data and then trying to present it in a way that would make sense to surgeons and doctors, and help answer important clinical questions," he said.

"It was a useful learning exercise, and the experience and knowledge will improve my surgical skills in the future. I'm definitely a better doctor for having been a researcher as well."

Like Professor Richards, Dr Wells would like to see the many benefits of being involved in collaborative studies recognised for research training in SET and selection into training.

"The support these collaborative studies have had from CTANZ and from RACS has been really positive," he said.

"In the future, I would like to see participation in these studies to be recognised in the research requirements during training or for selection onto surgical training."

Dr Wells believes that alongside the clinical progress and professional skills that collaborative studies like POSTVenTT provide, is the sense of making an impact.

"In these studies, we have the potential to tackle some questions that would be impossible to answer in a small single-centre study," he said.

"Collaborative studies can have a big impact on clinical practise and it's really meaningful to be part of that."

Fiona Stanley Hospital surgical registrar Uyen (Jess) Vo had a similarly positive experience.

Dr Vo who was a member of the project management group who designed the protocol and set up the study in Western Australia.

She was also part of the Ethics and Governance (E&G) sub-committee responsible for helping other Australian sites with E&G application processes.

Dr Vo appreciated the opportunity to develop her research skills but found the most beneficial element to be the leadership experience she acquired. She hopes to be involved with similar research in the future.

"Collaborative studies not only produce high quality research output and generalisable results that will improve our patients' care, but also empower Trainees and medical students to be better clinicians with evidence-based practise and competence in clinical research," she said.

"CTANZ has been an excellent platform that showcases collaborative output and connects networks in different regions."

Dr Cameron Wells

Professor Toby Richards

Kenneth Macpherson

From South Africa to Aotearoa New Zealand – a SIMG's journey

Dr Lodewikus Vermeulen (third from right) with his team in Tauranga Hospital

Urologist Dr Lodewikus (Wikus) Vermeulen gave up a lucrative but hectic private practice in South Africa and moved his family to a slower-paced life working in a public hospital in Tauranga in Aotearoa New Zealand (AoNZ).

The realisation life could pass in the blink of an eye in 16-hour workdays prompted him to make the move to Tauranga, in the upper North Island, nearly two years ago.

After 18 months of supervision, Dr Vermeulen is now fully registered to practice in AoNZ and is seeing opportunities to innovate and bring positive change to the health system in his adopted homeland.

Overseas trained surgeons like Dr Vermeulen are an important addition to the healthcare workforces in Australia and AoNZ. They help ease staffing shortages and bringing diversity, new expertise and knowledge.

RACS plays an important role. The College makes decisions on the suitability of Specialist International Medical Graduates (SIMGs) to work in Australia. The process in AoNZ is different, where the Medical Council of New Zealand (MCNZ) makes that call but with advice from RACS.

The process can be long and not always straightforward. Initial assessments, both paper-based and sometimes via interview, can take several months in AoNZ.

Depending on the outcome, a SIMG may be required to undergo additional surgical training; attend RACS courses; make their logbooks available for regular review; or work under supervision once on the ground in AoNZ.

The whole process, from application to full registration, usually takes around two to two-and-a-half years.

Was his 18 months of supervision justified? Dr Vermeulen said, "totally…I completely support it."

He understands the frustration of some who have practiced as surgeons without restriction overseas, including in countries that may be considered similar to AoNZ, such as the UK or the United States. However, he says the risks to patients of taking a less cautious approach outweigh the inconvenience.

"RACS and MCNZ take on a huge responsibility as gatekeepers and to be less than thorough with the evaluation process would be risky. How do you know how someone will perform in a new healthcare system? What if something happens to a patient? Where does the buck stop? I understand why RACS is super rigorous when doing its due diligence on a new doctor."

Dr Vermeulen went further than merely accepting the RACS recommendations. He chose to take as many RACS courses as he could, including Operating with Respect, Conflict and You, and Intercultural Learning for Medical Specialists to learn about the culture of the AoNZ healthcare workforce. He also found MCNZ's course introducing overseas doctors to AoNZ practice extremely helpful.

"I had gone from working in a largely private system, where money could buy any procedure, technology or drug, and you had the luxury to be able to perform all procedures in a theatre with no limitation on resources.

"The system is so completely different over here where theatre time, hospital beds and staff shortages create challenges," he said.

One of the things he learned under supervision was how to navigate a new network of support structures, including Allied Health and district nurses—services he praises.

Dr Vermeulen suggests the supervision period could be reviewed at 12 months, and this might be enough for some SIMGs, but said, "I don't see how someone could learn or adapt to the complex public health system in a shorter period than that."

He found the supervision period "helpful and enriching".

He also found RACS in AoNZ to be a great support to him through the process, although the move itself was not always smooth.

"I went from being in a position of power and respect to being right at the bottom [in terms of] status. I had to prove myself all over again and earn respect."

It was worth it though. He said he has more time for his patients now and is wasting no time making a difference.

Dr Vermeulen points to the huge wastage in systems in countries like South Africa and the United States and says they are neither sustainable nor equitable.

He is enjoying the thinking outside the box that comes from having fewer resources and has, along with a SIMG colleague from Brazil, Dr Flavio Ordones, initiated projects expected to save Tauranga Hospital up to NZ$450,000 per year.

They are using new equipment and technology to enable more procedures to be performed as day cases or in outpatient settings. Not only a cost saver, but the innovations also free up theatre time and reduce surgical wait lists.

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Congratulations to Educator of Merit award recipients

Every year the Academy of Surgical Educators (ASE) presents Educator of Merit awards to recognise exceptional contributions by surgical educators

The Educator of Merit awards consist of the Surgical Education Training (SET) Supervisor/Specialist International Medical Graduate (SIMG) Supervisor of the Year Awards. This recognises the exceptional contributions by a SET supervisor/ SIMG supervisor towards supporting Trainees and Specialist International Medical Graduates (SIMGs).

The Facilitator/Instructor of the Year Award recognises the exceptional contribution by a course facilitator or an instructor teaching professional development or skills education courses.

Educator of Merit - SET Supervisor/SIMG Supervisor of the Year

- Dr Sarah Aitken, New South Wales
- Dr Angela Butler, Aotearoa New Zealand
- Dr Rick Catterwell, South Australia
- Dr Joseph Hockley, Western Australia
- Dr Paul Joice, Aotearoa New Zealand
- Dr Murray Ogg, Queensland
- Dr Jens Peters-Willke, Tasmania
- Dr Rebecca Read , Australian Capital Territory
- Dr Adam Zimmet, Victoria

Educator of Merit - Facilitator/Instructor of the Year

- Dr Dave Sainsbury, South Australia

Some of the 2022 winners shared their experiences on being an educator.

Dr Adam Zimmet

Dr Adam Zimmet is a RACS Fellow based in Melbourne, Victoria. He specialises in Cardiothoracic Surgery and was awarded the SET Supervisor/ SIMG Supervisor of the Year (VIC) Award in 2022.

What inspired you to pursue surgical education?

I was always keen to teach even before becoming a surgeon and looked for an opportunity to teach any junior medical officer or student while I was training. My father was a doctor and had a busy academic public and private practice, so I feel it probably runs in the family!

When I became the Supervisor of Training at The Alfred Hospital, I felt I was young enough to be able to relate to the current issues of a Trainee as I had only just completed the training program. Now I feel I also have the experience of a few years under my belt as a surgeon to pass on some tips and tricks in the operating theatre as well.

What is your proudest moment as a surgical educator?

It is always nice to see the students/ residents/registrars you are teaching reach their goals—whether it's getting a high preference in their intern placements, success in getting onto the training program of their choice, or the ultimate of passing a final exam. As an educator it is very fulfilling to see the hard work pay off.

Any advice for new surgical educators?

Be patient! It does take time to teach, and you need to have that time spare in your practice to be a successful educator. This could mean taking extra time during a case to explain the anatomy of the area to be operated on, or taking a Trainee through a difficult anastomosis that you could do yourself much quicker. One needs patience to allow a junior Trainee/student to go through the motions and allow them to develop whatever skills are required.

Dr Paul Joice

Dr Paul Joice is a RACS Fellow based in Dunedin, Aotearoa New Zealand. He is an Otolaryngology Head & Neck surgeon. The Academy of Surgical Educators awarded Dr Joice the SET Supervisor/ SIMG Supervisor of the Year (AoNZ) Award in 2022.

What inspired you to pursue surgical education?

Unlike many careers outside medicine, the transition from Trainee to trainer in surgery is a linear one—all that separates the surgical Trainee from becoming the surgical trainer is time. In due course each successful Trainee becomes a consultant

colleague. The reward for contributing to this process as a trainer is to be embedded in a community that you have helped to shape, and which hopefully shares your values.

When I was a Trainee, I did not appreciate this obvious relationship. But on completing training it became clear that when I discussed matters with my previous trainers, it was done with genuine friendship. The realisation that my trainers had provided all their effort because they wanted to, in anticipation of future working relationships, rather than from some sense of duty, was my single biggest inspiration to pursue the role of a surgical educator.

What is your proudest moment as a surgical educator?

Two of the most recent Fellows produced from the Aotearoa New Zealand training scheme worked as registrars in my department before applying to the SET training scheme. To see Trainees you have personally encouraged pass the exam, successfully complete their training, and take up subspecialty Fellowships feels like a vindication of your effort and judgement. Their success is one of my proudest moments as a surgical educator.

Any advice for new surgical educators?

Each year the selection criteria, teaching methods, approved courses and the curriculum are assessed and adjusted to improve surgical training. With this continual effort, it follows that the total process of surgical training should get better year on year. The longer an individual's career span, the greater the difference between the training they received and the one currently being delivered.

Accepting this means recognising if the training scheme you work in is not producing Trainees who are better than you were at their equivalent stage, then it is probably failing. You may feel you are a giant in your specialty but as a trainer your only purpose is to let others onto your shoulders so they can see further.

Dr Dave Sainsbury

Dr Dave Sainsbury is an anaesthetist based in Adelaide, South Australia. He is one of the faculty on the Training in Professional Skills (TIPS), Non-Technical Skills for Surgeons (NOTSS) and Safer Surgical Teamwork (SST) courses. The Academy of Surgical Educators awarded Dr Sainsbury with the Facilitator/ Instructor of the Year Award in 2022.

What inspired you to pursue surgical education?

In 2008, I was head of the department of Children's Anaesthesia at the Women's and Children's Hospital in Adelaide, South Australia. I 'volunteered' our department to trial Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) as part of a World Health Organization initiative. TeamSTEPPS is designed to improve communication and teamwork skills and was developed by the U.S. Department of Defence in collaboration with the U.S. Agency for Healthcare Research and Quality. The primary modules were situation monitoring, mutual support, communication, and leadership.

These were similar to the modules developed by a team at the University of Edinburgh and the College of Surgeons of Edinburgh. They named their program Non-Technical Skills for Surgeons (NOTSS). Professor George Youngson was one of the founding members of the Edinburgh group. We were both invited as speakers at a combined meeting of paediatric surgeons and anaesthetists in Coolum in 2011, the theme of which was safety.

I discovered that Professor Youngson was talking to a group of surgeons who were planning to teach NOTSS in Australia. They kindly allowed me to attend one of their early courses. By 2012 I was admitted to the NOTSS teaching faculty. One of the highlights was learning from David Birks, one of the founders of the course, and a highly skilled and gracious educator.

Francis Lannigan was the next surgeon to take me 'under his wing' when he took over as director of the NOTSS program. Alongside the NOTSS program we realised the importance of bringing all the 'tribes' of the operating theatre together on a single course. With funding from the Rural Health Continuing Education through the Department of Health we developed a program titled Safer Australian Surgical Teams. This program continues to this day under the new title Safer Surgical Teamwork with faculty consisting of surgeons, anaesthetists, and registered theatre nurses. I recently had the privilege to reconfigure the course into a workshop style rather than didactic presentations.

What is your proudest moment as a surgical educator?

The final highlight of my engagement with RACS was the welcome I received from Professor Phil Truskett in 2013 when I expressed an interest in the Training in Professional Skills course. Once again, I was welcomed onto the teaching faculty. I was given the opportunity to learn how to debrief scenarios alongside skilled, compassionate and extraordinary faculty.

Any advice for new surgical educators?

My advice to anyone considering donating time as a surgical educator would be this: Don't delay, you will have the opportunity to learn from the very best. Whatever you put in will be returned tenfold. I am confident you will enjoy the experience as much as I have.

The 2023 nomination portal will be open from 1 March 2023. More information will be available in the relevant issues of *Fax Mentis* and *Surgical News*.

RACS Global Health supporting Pacific-based clinicians to overcome barriers

RACS Global Health works in partnership with ministries of health, hospitals, universities and clinicians to support delivery of health services and strengthen the surgical and medical capacity of national health personnel, partner health organisations, and systems in the region. The RACS Global Health vision is that safe surgical and anaesthetic care is available and accessible to everyone.

RACS Global Health implements the Pacific Island Program (PIP) that engages across 11 Pacific Island countries. It works closely with obstetrics and gynaecological specialist Dr Yin Yin May, who has overcome barriers to earn a distinguished career as a leading woman surgeon in the Pacific.

Dr May is the current Director of Hospital Health Services and Chief Medical Officer at Rarotonga Hospital, Cook Islands, and has been involved in the Pacific Islands Program for some time.

She has resolutely pursued her lifelong interest in women's health, specifically focusing on reproductive health.

Since leaving behind her homeland of Burma in 1989 with her two sons, she joined her physician husband in the Cook Islands and soon started working in the Obstetrics and Gynaecology department at Rarotonga Hospital.

Dr May continued to work at the hospital, serving as the Head of the Obstetrics and Gynaecology department at Rarotonga Hospital from 2005 to 2016.

Although not a Cook Islander herself, Dr May is a well-respected member of the community she has served for several decades.

"I was the only obstetrics and gynaecology clinician, and I was on call every day for 11 years, delivering every baby born at Rarotonga Hospital," she said.

Her presence in the public still evokes a degree of stardom from her former patients whom she treated as far back as the early 90s.

"It's very special to me because I still run into the mothers and their adult kids, and they tell them 'look that's the doctor that delivered you'," she said.

Dr May has carried enormous responsibility and faced immense pressure as the only obstetrics and gynaecology specialist—serving not only Rarotonga but also some of the 15 islands that make up the Cook Islands nation.

"I once had a mother who had gone into labour in a remote part of the Cook Islands, she had been in labour for two days and was experiencing an obstetric emergency," she recalls.

The logistical challenges to service these remote areas feature as a routine obstacle preventing the delivery of positive patient outcomes in the Pacific.

"It is extremely difficult to get to the remote regions and islands. Usually, we must charter a flight and bring expectant mothers to Rarotonga, or I have to travel by air or sea to labouring mothers."

On this occasion, Dr May was successful in saving the lives of both the mother and baby. However, there are always risks involved when acting on her good intentions.

Dr May's entry into the male-dominated surgical profession in the Pacific is a story of overcoming barriers to mobility, where she has subsequently emerged as a leader in her field.

"I believe that despite my gender and background I am respected by my colleagues and the nursing workforce and, I feel I deserve my place here."

Dr May continues to be a strong advocate for women in surgery and stresses to the next generation of female clinicians that determination is key to succeeding.

"I always tell the young women I work with that they need to have perseverance, be strong-willed and always be honest and fair when dealing with people. I never minimise the difficulties and pressures that come with my job."

Over the span of her career, Dr May has performed countless life-saving surgeries and deliveries, and developed the National Deployment and vaccination plan, which has resulted in a 98 per cent COVID-19 vaccination rate for the Cook Islands.

Dr May hasn't had a vacation in years but shows no signs of slowing down.

"I haven't had a chance since December 2020. I think the next break I will have is when I retire," she said.

Dr May continues to work with RACS Global Health and the PIP, most recently attending the PIP Annual Reflections event in September in Nadi, Fiji, where national clinicians from 11 Pacific Island countries engaged with the Global Health Team to reflect on the effectiveness and outcomes of the program. RACS looks forward to continuing the successful partnership with Dr May as we enter the 'Phase 2 Pacific Specialised Clinical Services & Health Workforce Program'.

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References

1. Silver, D., Kaye, A. and Slakey, D., 2020. Surgical Flow Disruptions, a Pilot Survey with Significant Clinical Outcome Implications. Current Pain and Headache Reports, 24(10).
2. Blikkendaal, M., Driessen, S., Rodrigues, S., Rhemrev, J., Smeets, M., Dankelman, J., van den Dobbelsteen, J. and Jansen, F., 2018. Measuring surgical safety during minimally invasive surgical procedures: a validation study. Surgical Endoscopy, 32(7), pp.3087-3095.
3. Parker, S., Laviana, A., Wadhera, R., Wiegmann, D. and Sundt, T., 2009. Development and Evaluation of an Observational Tool for Assessing Surgical Flow Disruptions and Their Impact on Surgical Performance. World Journal of Surgery, 34(2), pp.353-361.
4. Koch, A., Burns, J., Catchpole, K. and Weigl, M., 2020. Associations of workflow disruptions in the operating room with surgical outcomes: a systematic review and narrative synthesis. BMJ Quality & Safety, 29(12), pp.1033-1045.
5. Blikkendaal, M., Driessen, S., Rodrigues, S., Rhemrev, J., Smeets, M., Dankelman, J., van den Dobbelsteen, J. and Jansen, F., 2016. Surgical Flow Disturbances in Dedicated Minimally Invasive Surgery Suites: An Observational Study to Assess Its Supposed Superiority Over Conventional Suites. Journal of Minimally Invasive Gynecology, 23(7), p.S86.

EM 1370-06-22 ANZ. #11426-082022

The art of a rural surgeon

David Freedman's story

Dr David Freedman FRACS

The career paths of surgeons are unique and follow no prescribed course. In *The Art of a Rural Surgeon*, Dr David Freedman outlines his progression towards obtaining his FRACS in 1974, and subsequently, his extraordinary post-fellowship life as a surgeon and artist.

Dr Freedman writes, 'I managed to pass the final fellowship examination after 18 months of registrar training, despite not having achieved much operative experience other than as an assistant. Apart from demonstrating admiration and respect for my superiors, my primary function during an operation had been to watch, hold retractors, cut sutures, and close the wound at the end of a procedure. It was the same for all of us.

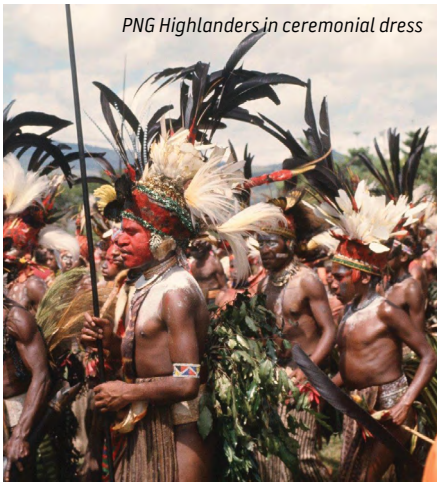
'To be adequately trained with the necessary operative experience, it was necessary to travel to England or the United States of America'.

Aged 30, married and with two small children, Dr Freedman, lacked the necessary funds to travel abroad. As an interim move, the Freedman family accepted a three-month general surgical locum position at the Port Moresby Hospital, Papua New Guinea (PNG), airfares provided.

On arrival at the hospital, no arrangements had been made for the family or their accommodation. Dr Freedman found himself designated as receiving surgeon for the day, and was immediately required in the emergency department, to review a five-year-old boy with advanced peritonitis.

While his family waited patiently in a taxi outside the hospital, Freedman quickly found a motel for them and then organised theatre for surgery. Laparotomy confirmed an established intussusception with necrotic bowel. This was the first time he had performed a bowel resection as the principal surgeon, and he had no paediatric surgery experience: the obstruction was relieved and surgical anastomosis completed—the patient making an uneventful recovery.

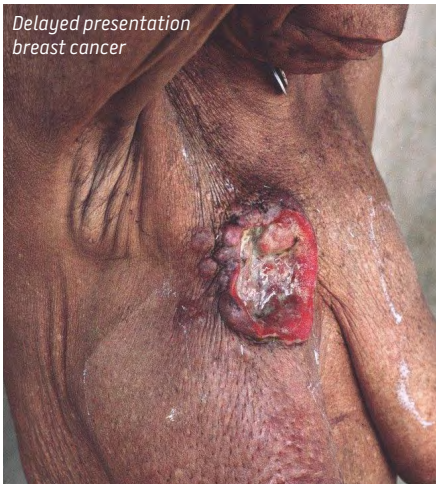
As Dr Freedman observed, 'It was clear I would have to quickly adjust from being an assistant and registrar to the greater responsibility of an operating surgeon!'


PNG Highlanders in ceremonial dress

The three months locum became a three-year stay in PNG, at a time when there were about 12 surgeons in a country of more than 2.5 million people; four surgeons were in Port Moresby with a population of 80,000. There were no representatives of other surgical specialities resident in PNG, just infrequent visits from Australian-based ophthalmologists.

The Freedman family was housed in a government-owned house situated close to the hospital: apart from mattresses on the floor, no other furniture was provided. There were also no curtains, kitchen utensils or hot water, and the high incidence of house burglaries and violence, posed an additional challenge.

Following that initial three-month locum, Dr Freedman accepted a temporary position at Mount Hagen Hospital, which, as the centre for the Western and Southern Highlands, served a population of 450,000 persons. After three months there, with no permanent replacement surgeon available, Dr Freedman signed a two-year contract, abandoning earlier plans of travelling to England.


Delayed presentation breast cancer


Road trauma PNG

Surgery now involved dealing with a plethora of tropical surgical conditions, particularly septic conditions, including osteomyelitis, pyomyositis, septic arthritis and tuberculosis (TB). Malaria was often present as an underlying condition reducing patients' resistance to other illnesses.

It was essential to learn many new operative skills, as well as new differential diagnoses for most clinical presentations. Those new skills included techniques for drainage of tuberculoma of the thoracic spine, surgical procedures for patients suffering leprosy, and operations for intracranial haemorrhage.

As PNG independence approached in 1975 there was turbulence and instability in the highlands. A surge in coffee prices had led to an increase in the wealth of many villagers: much of this new prosperity was spent on motor vehicles and alcohol.

No road safety rules, such as, prohibition of drink-driving, wearing of seat belts or motorcycle helmets, were enforced. Villagers usually travelled in the back of trucks called public motor vehicles, and with unmade muddy roads passing through steep mountainous terrain, accidents were frequent: it was not unusual to have multiple trauma victims present simultaneously.

Fights with sticks resulted in many presentations, some involving fractures, both compound and simple. Penetrating eye injuries often presented late when repair of the cornea was impossible. It was necessary to extirpate the eyeball to control chronic infection and its associated purulent discharge: a tray of ocular prostheses proved useful.

Congenital abnormalities, involving cleft lip and palate, talipes equinovarus, anorectal, penile, and scrotal abnormalities were common. Urinary tract calculi were common, even in children.

Gifts of expired medicines were regularly posted to the hospital from European countries, their labels usually in foreign languages, leading to little or no idea of the nature of the therapeutic contents. Some of these products eventually made their way, illegally, to the weekly market in Mount Hagen where the price of the medication was arbitrarily based on its colour, size, and packaging.

In 1978 Dr Freedman commenced the next phase of his career in Swan Hill, where he had first worked in 1970, on rotation from Saint Vincent's Hospital, Melbourne. Rural surgery appeared to be the perfect solution for him, as starting a practice in Melbourne would have been not only highly competitive, but also very restrictive, compared with his previous operative range.

He was employed as an assistant in a group of 15 doctors, which comprised another general surgeon, a gynaecologist, and general practitioners (GPs). The 'resident' surgeon had worked in Swan Hill for 35 years and was well-established, undertaking the bulk of what little elective surgery was available.

Dr Freedman found himself involved in GP work, performing routine examinations, smear tests and dealing with patients suffering from anxiety. Among other things, emotionally, this was the most difficult time in his career: he felt shame and frustration, only seldom performing surgery.

Over this time, Dr Freedman noted that painting helped to fill the void he felt when working as a GP and surgeon; it also provided him with the challenge of developing new skills.

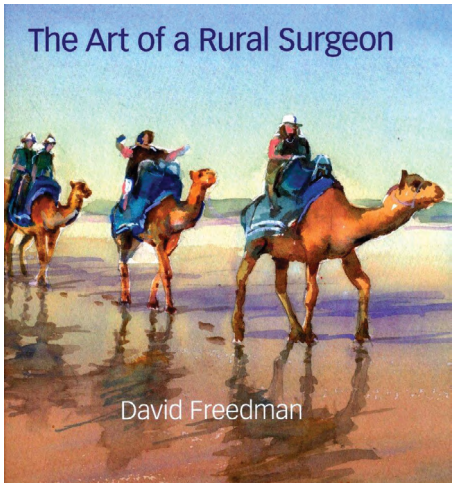
He observed that painting provided the opportunity to escape from the stress of his profession and allowed him to become fully absorbed in another world. He realised the importance of being able to distance oneself from the emotionally draining life of a general surgeon, and then, to return to it with enthusiasm and a fresh outlook.

In 1984 he and another general surgeon, both unhappy, left the group to form their own specialist surgical clinic in Swan Hill. Over the next 33 years many dramatic surgical cases and emergencies were dealt with, including a wide range of complex orthopaedic procedures. Necessary support had been provided through attendance at the annual Provincial Surgical Association meetings and RACS workshops. By the time he left in 2010, all major trauma was transferred to Bendigo or Melbourne.

Dr Freedman's decision to fully retire from surgery in 2016, aged 72, was difficult. However, it soon led to new challenges, which have been met and overcome with an entirely new paradigm of writing, illustrating, and publishing books—all in one way or another connected with painting.

The remainder of this fascinating book describes his most successful transition from surgery; in all, a most genuine account, from the pen of a modest and very talented surgeon.

The *Art of a Rural Surgeon* should be essential reading for any surgeon, at any stage of their career—primarily, surgical Trainees, providing them with a vision of what the surgical path ahead of them might entail: not for the fainthearted!



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Several points require emphasis:

1. Authors of research papers who wish to have their abstracts considered for inclusion in the scientific programs at the ASC must submit their abstract electronically via the online abstract submission form having regard to the closing dates in the Call for Abstracts, the provisional program and on the abstract submission site. **Abstracts submitted after the closing date will not be considered.**
2. The title should be brief and explicit.
3. Research papers should follow the format: Purpose, Methodology, Results and Conclusion. Non-scientific papers, for example, Education, History, Military, Medico-legal, may understandably depart from the above. Surgical History authors are advised to check some additional advice on the Surgical History page of the College website.
4. Excluding title, authors (full given first name and family name) and institution, the abstract must not exceed 1,750 characters and spaces (approximately 250 words). In Microsoft Word, this count can be determined from the 'Review' menu. Any references must be included in this allowance. If you exceed this limit, the excess text will NOT be captured in the submission or appear in the Australian and New Zealand Journal of Surgery.
5. Abbreviations should be used only in common terms. For uncommon terms, the abbreviation should be given in brackets after the first full use of the word.
6. Presentations (slide and video) will only have electronic PowerPoint support. Audio visual instructions will be included in correspondence sent to all successful authors.
7. Authors submitting research papers have a choice of two sections under which their abstract can be considered. Submissions are invited to any of the specialtie s or special interest groups participating in the program except cross-discipline.
8. A 100-word CV is required from each presenter to facilitate their introduction by the chair.
9. The timing (presentation and discussion) of all papers and posters is at the discretion of each Section Convener. Notification of the timing of presentations will appear in correspondence sent to all successful authors.
10. Tables, diagrams, graphs, etc. CANNOT be accepted in the abstract submission. This is due to the limitations of the computer software program.
11. Authors must be registrants at the Congress to present, and for their abstract to appear in the publications, on the website or Virtual Congress.

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Please indicate on the abstract submission site if you want your abstract considered for a research prize. Each abstract may only be submitted for one prize and it is the author's responsibility to ensure they conform to any preconditions (e.g. only open to trainees). Section Conveners will select the best abstracts for presentation to be adjudicated. The awarding of a prize is at the discretion of the adjudication panel.

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- The Professor Mark Smithers Award for clinical research for oesophagogastric or bariatric surgery
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- Cardiothoracic Surgery
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- Endocrine Surgery: The Tom Reeve Prize – Trainees
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- HPB Surgery
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- Paediatric Surgery
- Pain Medicine & Surgery
- Plastic & Reconstructive Surgery
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- Surgical Oncology
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- Trauma Surgery (Damian McMahon Prize for Trainees)

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- The Leslie Nathanson Award for translational research and/or innovation in the field of oesophago gastric or hepato-pancreato-biliary surgery
- Quality and Safety in Surgical Practice
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- Jenepher Martin Surgical Education Research Prize
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- Women in Surgery

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- ANZ Chapter of the ACS Scientific Forum Best Paper Prize (for clinical and non-clinical)

The submitting author of an abstract will ALWAYS receive email confirmation of receipt of the abstract into the submission site. If you do not receive a confirmation email within 24 hours, it may mean the abstract has not been received. In this instance, please email the ASC team at the Royal Australasian College of Surgeons to determine why a confirmation email has not been received. E: asc.registration@surgeons.org

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THE CLOSING DATE FOR ALL SCIENTIFIC PAPER ABSTRACT SUBMISSIONS IS 8:00AM FRIDAY 27 JANUARY 2023.

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SCIENTIFIC POSTERS

All posters will be presented electronically during the Congress and will be available for viewing on plasma screens in the industry exhibition. Posters will be placed on the Virtual Congress in addition to the abstract.

IMPORTANT DATES

Abstract Submission opens	October 2022
Closure of Abstracts	8:00AM Friday 27 January 2023
Closure of Early Registration	Sunday 19 March 2023

RACS ASC 2023 SECTION CONVENERS AND VISITORS

Correct at time of preparation (September 2022). May be subject to change.

Section	Convener	ASC Visitor	City/Country
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HPB Surgery	Dr Eu Ling Neo Dr John Chen		
Indigenous Health	Professor Kelvin Kong Dr Maxine Ronald		
Medico-legal	Dr Orso Osti	Associate Professor David Cherry	Adelaide
Military Surgery	Dr Abhilash Chandra Associate Professor Brendon Coventry	Colonel Wylan Peterson	Corpus Christi, USA
Neurosurgery	Dr Catherine Cartwright Associate Professor Andrew Zacest	Professor James Rutka	Toronto, Canada

Section	Convener	ASC Visitor	City/Country
Otolaryngology Head & Neck Surgery	Dr Andrew Foreman	Dr Eric Moore	Rochester, USA
Paediatric Surgery	Dr Sanjeev Khurana	Professor Mark Davenport	London, UK
Pain Medicine & Surgery	Associate Professor Andrew Zacest	Professor Kim Burchiel	Portland, USA
Plastic and Reconstructive Surgery	Dr Nicholas Marshall Dr Vani Prasad Atluri	Dr Edward Buchel Dr Lay-Hooi Lim	Winnipeg, Canada Penang, Malaysia
Quality & Safety in Surgical Practice	Dr Andrew Luck Dr Iain Skinner		
Rural Surgery	Dr Chetan Pradhan Associate Professor Mahiban Thomas	Dr Jesudian Gnanaraj	Tiruchirappalli, India
Senior Surgeons Program	Associate Professor Rob Atkinson	Dr Cherie Holmes	New Hampshire, USA
Surgical Education	Dr Gavin Nimon Dr Robert Whitfield Associate Professor Peter Smitham	Dr Lisa Hadfield-Law	Charlbury, UK
Surgical History	Dr Richard Hamilton Dr Philip Game	Associate Professor Susan Neuhaus	Adelaide
Surgical Leaders	Dr Trevor Collinson Dr Markus Trochsler	Professor Simon Paterson-Brown	Edingburh, UK
Surgical Oncology	Dr Richard Smith Dr Robert Whitfield	Dr Myles Smith	London, UK
Trainee Association	Dr Angie Arnold Dr Hoang Ha		
Transplantation Surgery	Dr Santosh Olakkengil	Dr Philip Thomas	McAllen, USA
Trauma Surgery	Dr Shivangi Jog Associate Professor Joseph Dawson	Dr Martin Griffiths	London, UK
Upper GI Surgery	Dr Conrad Stranz Dr Harsh Kanhere	Dr Suzanne Gisbertz	Amsterdam, the Netherlands
Women in Surgery Program	Dr Catherine Cartwright Dr Sonja Latzel		
Younger Fellows Program	Dr Philip Britten-Jones		

*Please check the website **asc.surgeons.org** for the most up to date information.*

The value of convalescence

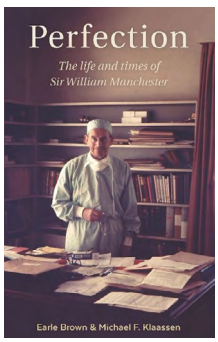
OPUS LXXVIII

The French have an expression le récupération to convalesce and recover from injury, physical or emotional. I have had some experience in this domain recently and appreciate the value of rest—allowing nature to heal itself. Even Voltaire in the 1600s had a great quote about medical practitioners in a non-surgical vein: 'The art of medicine consists in amusing the patient, while nature cures the disease'.

Historically, two important surgical names emerge: Aelius Galenus, often anglicised to Galen, attended to the surgical needs of Caesar Augustus' troops and was one of the first to use animal intestine into twisted twine known still today as cat gut. Ambroise Paré, surgeon to four French kings (operating on Louis XIV to remove an arrowhead from his shoulder, thus receiving a knighthood) dealt with amputations by using soothing oils as an alternative to the hot metal haemostatic technique providing relief—something that continued into the Napoleonic era.

Ambroise Paré

Recently, Dr Earle Brown from the Middlemore Hospital in Auckland, Aotearoa New Zealand— where he was a protégé of Bill Manchester and a staff member from 1970-2005—sent me a copy of *Perfection* (illustrated), which he co-authored.



Perfection

The book is a synopsis of Bill Manchester's surgical career from East Grinstead to his definitive post at Burwood Hospital, Christchurch. Manchester was the Benny Rank of Aotearoa New Zealand and had a better exposure to plastic surgical training from the likes of Harold Gillies, Archibald McIndoe, and Rainsford Mowlem.

The book is full of historic memorabilia and the point that caught my eye was that Gillies preferred novices for Trainees in plastic surgery whose general surgical traits were not entrenched. This was the reason Gillies selected Manchester as a junior protégé having an open mind - a habit that Benny also adopted.

War creates injuries and on the first day of the Battle of the Somme up to 67,000 British casualties were recorded and using the 10 per cent rule this would leave thousands injured requiring surgical repair by Gillies at East Grinstead in West Sussex—the focus of WW1 repairs.

It was during my convalescent period that I became acquainted with the erudition of the ABC FM announcers, quoting pearls of wisdom about the composers, which I will now include with relevance to surgical teaching—quite apt.

Chopin's compositions reflect the elegance of simplicity particularly noted in his Polonaise compositions. He said, "Simplicity is the final achievement and having played a vast quantity of notes, simplicity emerges as the crowning element." This made me think of John Hueston's word 'fenestration', which he used to describe a simplified process of graft drainage. John would say, "You cannot beat a holy graft"—unusual for someone with atheistic tendencies. Then some clever guy amplified this idea creating a tennis net for grafting, which became the basis of the mesh grafts used in extensive burns management.

We must include the Russians in their musical compositions, especially Shostakovich, whose musical eloquence Reilley, Ace of Spies from the Gadfly I love. He said, "A creative artist works on his next composition because he was not satisfied with the previous one." One of my earlier registrars observed I had the same problem of multiple unfinished papers because of time restraints.

I cannot quote musical stories without Gershwin's introductions to jazz. The glissando of the clarinet keys going up the scale in his 1924 Rhapsody in Blue was never part of his original composition. But hearing this practice scale in the corridor by the clarinettist from the Paul Whiteman Orchestra as a warmup before the Carnegie Hall performance he exclaimed, "This must go in as a jazz component in the Rhapsody." Gershwin's adaptability in composition occurred when ideas sprung out of the blue: "I hear music in the heart of noise", and it was the rhythmic rattle of the train wheels that gave him the basis for the Rhapsody composition.

Surgically, ideas spring out of the blue based on necessity. At a Fiji Interplast meeting with Don Marshall in the 90s and when requiring a Penrose drain for a complicated hand repair, the theatre sister said, "We don't have that specialised equipment sir". So, with a pair of Mayo scissors I slipped off a 2x10cm piece from my surgical glove, washed it and inserted it into the wound—a simple solution.

Le Madeleine Altar

Le Madeleine - 1867

Rachmaninov, another Russian composer, once said, "I compose music because I must express my feelings, just as I talk to express my thoughts".

John Hueston established the combined consultative clinic at the RMH in the 70s having visited the Bekamjian Unit in Buffalo, New York where Don Marshall and Michael Long trained. John managed to get the diverse sub-units of ENT, Plastic Surgery, Oral and Maxillofacial and Ophthalmology together looking for clinical solutions every Monday at 7.30am. This too has been my habit over the years; coffee lubricates the conversation.

Tchaikovsky warrants a mention as he had a great quote about inspiration when he stated, "Inspiration is a guest, that does not willingly visit the lazy".

Then Picasso followed his dictum of 'breaking rules create art' and we should look at his Guernica painting (illustrated) of the Spanish Civil War, regarded by many art critics as the most moving and powerful anti-war painting in history.

Leonard Bernstein, the composer of Candide and West Side Story fame said, "Work on a plan but invariably you don't have enough time." This was my experience with John Hueston when he personally took my original Angiotome paper for publication at the International Meeting in Paris in 1975. This became the basis of the Keystone concept. My paper was edited by John and Daniel Marchac—eminent forces in the plastic surgical domain—and the published transactions of 1975 were available for the attendees.

Bach, the father of classical music said, "Whoever is equally industrious will succeed equally as well." This should be the motto above our desk whenever we have before us another unfinished symphony. And the best quote about an industrious personality comes from the late ESR Hughes who had the biggest colorectal practice in Australia where the numbers were questioned by the American Society of colorectal surgeons. He even found time to become President of the College, and his famous adage is, "If you want something done give it to a busy surgeon."

Now back to Chopin and his great friend the mezzo soprano Pauline Viardot, the toast of Paris as queen of the romanticism movement in the 1850s. She was friends with all the great composers even refining Chopin's mazurkas.

This friendship caused Chopin's partner, George Sand, to separate when he was dying of tuberculosis and still living at No. 12, Place Vendôme in Paris, around from the Madeleine Church. His dying wish was to have Mozart's Requiem Mass and the Te Deum sung by Viardot. Church regulations forbade the female presence near the alter and permission from Rome had to be obtained.

Performance was granted provided Viardot sang behind a black curtain, which is still there in the present day measuring 3x3x3 metres. I have touched it during my time in Paris in 2016.

The Madeleine Church, a Napoleonic memorial for his troops, was subsequently redesignated and dedicated to Mary Magdalene as a Church in 1842. One Sunday morning, the parish priest recognised me as a regular and asked me to do the reading at the altar but gauged by my response that I lacked the French fluency we agreed to read 'en Anglais'. The sacristan explained to me the Viardot story and the history of the black curtain and Chopin's Requiem Mass saga that occurred on 31 October 1849, the same day I was penning these final lines.

Carl Orff's quote on composition equally applies to surgery: "Experience first then intellectualise."

He also said: "Tell me and I forget, teach me and I might remember, involve me and I learn."

Associate Professor
Felix Behan

Picasso's Guernica painting of the Spanish Civil War

Dr Osamu Yoshino – Small Research Project Grant 2020 recipient

Hepato-Pancreatico-Biliary (HPB) and robotic surgeon Dr Osamu Yoshino was the recipient of the Small Research Project Grant from the Royal Australasian College of Surgeons (RACS) in 2020. "I think I was very lucky," Dr Yoshino said.

The reason Dr Yoshino considers himself lucky is because apart from it being a coveted grant, it came just before his American HPB Fellowship program at Medical College of Wisconsin and Robotic HPB fellowship at Carolinas Medical Centre, USA. "So, I had 12 to 15 months to complete my research. I really appreciate that I got that grant and managed to publish the data," he said.

Dr Yoshino's research topic was on the role of mitochondrial DNA (cmtDNA) and damage associated molecular patterns (DAMPs) in liver transplantation.

The Small Research Project Grant is designed to help new researchers, Dr Yoshino said. And given that researching into mitochondria DNA is very difficult, he is happy to have done this study. "It was very good laboratory study for a team to learn and work together. It was a good start-up and worked very well in that limited timeframe."

Dr Yoshino moved to Australia in 2007 after completing his Doctor of Medicine (MD) from Tohoku University, School of Medicine in Sendai, Japan. It was here that he became interested in the HPB surgery unit.

But it was an intense student life. "We would start at 7 am, the operation would happen after lunch break and would go on until midnight. We would grab dinner by 2 am and start the rounds again after a few hours," he said.

That's when he decided not to become a surgeon, opting for a more flexible, rostered life in emergency medicine and surgery. "So, my training in Japan was to be a physician."

But Dr Yoshino felt he was getting detached from patient care. "You know you try to help the patient but, in the end, you hand over the patient to the next one on the roster. I didn't like it."

When the opportunity to work with Dr Zsolt Balogh, a well-known trauma surgeon and professor at the University of Newcastle, New South Wales, came up, Dr Yoshino took it. "I was a trauma specialist in trauma surgery, I was young, and this was a good opportunity.

"Coming to Australia, the memory of those earlier days came back, and I said let's go back to surgery. That's how I became a surgeon."

Dr Yoshino completed his surgical residency with Austin Health, Melbourne, and obtained his fellowship in General Surgery from RACS. He completed his HPB/transplant training in the US and Australia.

"I am in the same field I started," Dr Yoshino said, who currently divides his time between Austin Hospital, Melbourne, as a visiting medical officer, and Epworth Richmond and Warringal Private Hospital as a HPB surgeon.

Despite the workload on medical professionals, Dr Yoshino believes research is very important. "Research and medicine should go together. Medicines are established based on numerous efforts from scientists, medical practitioners, and specialists around the world. That's why we know how to treat cancers. Any research can potentially contribute to the future.

"The surgical community is aware of the importance of research, but research is very complex. You need finance to start research, and if you get the opportunity, you should take it because you might see the different views of medicine and science.

"Today we use evidence, based on what has been done in the last 100 years. We should contribute to that path so that the evidence we create today can be of use in the future. Retrospectively, research means working potentially towards providing better care for patients."

Dr Yoshino lives with his wife and three sons. The family enjoys outdoor activities such as hiking—a challenge he enjoys with his boys as a form of teaching them appreciation, adaptability and coping with trouble.

With a job that keeps him on his toes, Dr Yoshino said, "I am still trying to get that work-life balance."

RACS offers more than 70 scholarships and grants valued at more than $2 million annually through its Scholarships and Grants Program. To learn more, visit www.surgeons.org/scholarships

The consequences of different approaches to allegations of DBSH

In 2015, allegations were made public that our College had a culture of bullying and harassment. There was a media frenzy. It was politically awkward and had the potential to do reputational damage to our institution.

RACS responded quickly, acknowledging the concerns, and set up an independent Expert Advisory Group (EAG) to advise the College.

The EAG made several recommendations, which were accepted and implemented by our College. Since then, our College has altered many of its processes and invested huge resources into reducing discrimination, bullying and sexual harassment (DBSH). We believe the culture is changing for the better, and it has now become safer and easier for surgeons (Trainees, Specialist International Medical Graduates and Fellows) to report their experiences, concerns, seek advice, or to make a complaint.

In 2021, allegations were made public that the Liberal Party in Australia had a culture of bullying and harassment. Allegations of a culture of harassment and disrespect for women were denied. One allegation by a staffer proceeded to court. Then a separate allegation surfaced, and a cabinet minister eventually resigned from their ministry. Internal investigations found no wrong-doing in the latter case. The party lost the general election, perhaps in part because of the perceived party culture. No systematic changes seem to have occurred and it is questionable how safe it is for anyone to speak up against DBSH for fear of denigration.

In 2022, allegations were made public that the parliamentary Labour Party in Aotearoa New Zealand had a culture of bullying and harassment. This had the potential to do reputational damage to the party, and to the parliamentary process more widely.

The Labour party denied the allegations and openly challenged the complainant. Eventually, the member of parliament who had raised the concerns was relieved of their role within the party and a few months later resigned. It seems unlikely that the culture will change significantly, but in the shorter term the issue has disappeared from public scrutiny. From all accounts, it has now become less safe for members of parliament to report their experiences, concerns or to make a complaint about DBSH for fear of denigration and excommunication.

RACS has survived and remains respected by the public.

Professor Spencer Beasley
RACS Surgical Advisor

The 2023 Scholarships and Grants Program

Congratulations to our research scholarships 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 this year, Fellows, Trainees, SET applicants and other health professionals from across 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 process was particularly competitive, and the applicants were very impressive. They were well supported by the references from their senior Fellows.

Fellows should encourage applicants to re-apply when opportunities are next offered as applications improve and research projects evolve to become more competitive and relevant.

Thank you to 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 number of applications and scholarships were at their highest this year, with our selection panel members stepping up to the challenge. These projects lead us to greater surgical excellence on the shoulders of these giants who help patients daily.

The success of the Scholarships and Grants program is measured not only by the benefits 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 feasible 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

Meet our 2023 research scholarship recipients

Scholarship tenure is for a year unless otherwise indicated.

John Mitchell Crouch Fellowship

Value: $170,000
Associate Professor Jonathan Karpelowsky (New South Wales)
Specialty: Paediatric Surgery
Topic: New monitoring strategies for osteosarcoma – the utility of ctDNA as a putative biomarker for risk-stratification and treatment response

Tour de Cure Cancer Research Scholarship

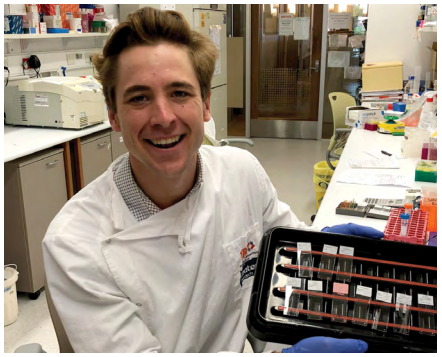
Value: $125,000 including $25,000 procured externally
Dr Helen Mohan (Victoria)
Specialty: General Surgery
Topic: Simulation in Robotic Colorectal Surgery: Development of a Multimodal Training and Assessment Tool with Cognitive and Technical Simulation

Margorie Hooper Scholarship

Value: $100,000
Dr Vikram Padhye (South Australia)
Specialty: Otolaryngology
Dr Padhye's aim is to establish a multidisciplinary sleep clinic that will adequately service metropolitan and regional South Australia

Foundation for Surgery Research Scholarship

Value: $66,000
Dr William McGahan (Queensland)
Specialty: General Surgery
Topic: PET imaging of the tumour micro-environment: A new modality to improve early diagnosis, staging and therapy for pancreatic cancer



Aotearoa New Zealand Research Scholarship

Value: $66,000|
Dr Anantha Narayanan (Aotearoa New Zealand)
Specialty: Vascular Surgery
Topic: The effect of music on the operating surgeon

Eric Bishop Research Scholarship

Value: $66,000
Dr Sireesha Koneru (New South Wales)
Specialty: General Surgery
Topic: Assessment of low anterior resection syndrome (LARS) using high-resolution anorectal manometry (HRAM) and Magnetic Resonance (MR) defecography

Lumley Surgical Research Scholarship

Value: $69,000
Dr Katherine Suter (Victoria)
Specialty: General Surgery
Topic: The impact of lifestyle factors on survival after colorectal cancer diagnosis: A platform for behavioral change

F&P Thornell-Shore Memorial Trust for Medical Research Scholarship

Value: $50,000
Dr Anton Lambers (Victoria)
Specialty: Orthopaedic Surgery
Topic: Implant breakage in proximal femoral nails: Usage, damage patterns and rates of failure

Herbert and Gloria Kees Research Scholarship

Value: $66,000

- Dr Jocelyn Lippey (Victoria)
  Specialty: General Surgery
  Topic: Stakeholder perspectives on the future implementation of risk stratified population breast cancer screening in Australia

- Dr Alex Papachristos (New South Wales)
  Specialty: General Surgery
  Topic: Exploring a novel cyto-immuno therapy in advanced medullary thyroid cancer

- Dr Andrew Wood (Aotearoa New Zealand)
  Specialty: Otolaryngology
  Topic: A multi-centre randomised controlled trial of post-operative doxycycline assessing recovery in patients undergoing endoscopic sinus surgery for the treatment of chronic rhinosinusitis

Reg Worcester Research Scholarship

Value: $66,000 per annum
Tenure: Up to three years
Dr Odette Hart (Aotearoa New Zealand)
Specialty: Vascular Surgery
Topic: The management and outcome in diabetic foot disease

R & M Edwards Research Scholarship

Value: $45,000
Dr Nicholas Candy (South Australia)
Specialty: Neurosurgery
Topic: The pituitary gland membrane and potential targets for fluorescence guided surgery

Brendan Dooley/Gordon Trinca Trauma Research Scholarship

Value: $15,000
Dr Christopher Mulligan (New South Wales)
Specialty: Orthopaedic Surgery
Topic: Paediatric injury and trauma from off-road vehicles

Richard Jepson Research Scholarship

Value: $66,000
Tenure: Up to three years
Dr Luke Traeger (South Australia)
Specialty: General Surgery
Topic: Pyridostigmine to Reduce the duration of postoperative Ileus after Colorectal Surgery – a double-blinded Randomised Controlled Trial (PyRICo-RCT)

WG Norman Research Fellowship

Value: $66,000
Dr Shwe Phyo Han (New South Wales)
Specialty: General Surgery
Topic: New era of diagnosis and treatment of liver and pancreatic tumors: Application with artificial intelligence (AI) innovation

Academy of Surgical Educators Research Scholarship

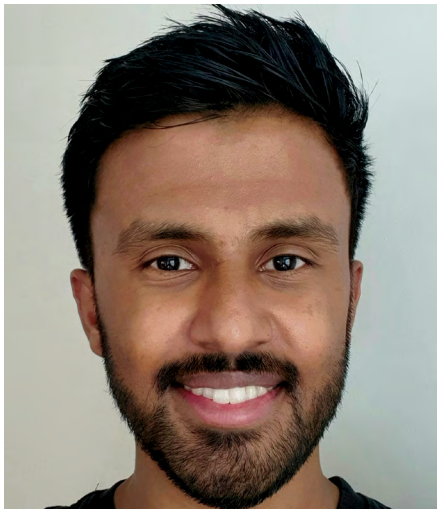
Value: $10,000
Dr Jamie-Lee Rahiri (Aotearoa New Zealand)
Specialty: General Surgery
Topic: Establishing a Rural and Provincial Surgery (RAPS) Wānanga to enhance the regional general surgical experience for registrars in Aotearoa New Zealand

Sir Roy McCaughey Surgical Fellowship

Value: $66,000 per annum
Tenure: Up to three years
Dr Mark Ly (New South Wales)
Specialty: General Surgery
Topic: Long-term ex-vivo normothermic machine perfusion and transplantation of rat livers can rescue grafts previously considered unusable

Professor Philip Walker Vascular Surgery Research Scholarship

Value: $24,000
Dr Cheyaanthan Haran (Aotearoa New Zealand)
Specialty: Vascular Surgery
Topic: Presentation and management of acute aortic syndromes in Aotearoa New Zealand



MAIC-RACS Trauma Research Scholarship

Value: $66,000
Dr Benjamin Hardy (NSW)
Specialty: Orthopaedic Surgery
Topic: Epidemiology and outcomes of the most severely injured trauma patients

Surgical Ethics Research Scholarship

Value: $66,000
Dr Jazmin Eckhaus (Victoria)
Specialty: Cardiothoracic
Topic: Permission to refuse: A core problem in the ethics of consent

Ian and Ruth Gough Surgical Education Scholarship

Value: $23,000
Dr Kathryn McLeod (Victoria)
Specialty: Urology
Topic: Improving remediation processes of underperforming surgical Trainees

Small Project Grant

Value: $10,000

- Professor Catherine Birman (New South Wales)
  Specialty: Otolaryngology
  Project: Closing the neural gap: Cochlear implant-based neurotrophin gene augmentation therapy

- Dr Adam Cristaudo (Queensland)
  Specialty: General Surgery
  Project: Unraveling the mystery behind the disparity in the proportion of liver metastases between appendiceal and colorectal adenocarcinoma

- Professor Andrew Hill (Aotearoa New Zealand)
  Specialty: General Surgery
  Project: Diagnostic accuracy of procalcitonin for the early detection of anastomotic leakage after colorectal surgery.

- Dr Lawrence Kim (New South Wales)
  Specialty: Urology
  Project: Establishment and implementation of renal mass clinical outcomes registry

- Dr Shinuo Liu (New South Wales)
  Specialty: Neurosurgery
  Project: Cerebrospinal fluid flow in pathological models of syringomyelia

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 the media, public campaigns, by negotiating directly, or providing written submissions to both government and non-government agencies.

In the past two months some of the advocacy work the College has undertaken includes:

Aotearoa New Zealand firearms registry

Following terrorist attacks at the Christchurch mosque in 2019, Aotearoa New Zealand's firearms laws were changed with the intention of greater control and knowledge of gun owners and guns. One addition was the establishment of a registry of legally owned firearms and certain firearm parts. Draft regulations for this registry were circulated recently for comment. The Aotearoa New Zealand National Committee intends to express concern over the proposed five-year timeframe for owners to register their arms and to recommend a far shorter time period.

Victorian 2022 state election

The Victorian state election was held on 26 November 2022. Before the election RACS sent an election priorities document to all the main parties contesting the election. Their responses were posted on the RACS website (bit.ly/3Xqi88a) and shared with the local membership.

Congratulations to the government on their election. We look forward to working with both the health minister and opposition health spokesperson over the next term of government to address the priorities raised in our election statement.

MBS Review Advisory Committee - Surgical Assistant Working Group Draft Report

In 2021, the Medicare Benefits Scheme (MBS) Continuous Review was established to ensure the MBS remains contemporary. The MBS Continuous Review involves reviews of Medicare items and services by experts and is guided by the Medicare Benefits Schedule Review Advisory Committee (MRAC).

The Surgical Assistant Working Group (SAWG) was established as a subgroup of the MRAC to consider two issues:

- surgical assistant billing arrangements
- access to surgical MBS items for non-medical surgical assistants.

RACS recently welcomed the opportunity to provide comment on the SAWG Draft Final Report. Read the RACS submission here: bit.ly/3V54S7g

Independent health and aged care pricing authority (IHACPA) on 'bundling arrangements' for general use items on the prostheses list

In late March the Department of Health confirmed that 400 'General use' items would be taken off the Prostheses List (PL). 'General use' items include sutures, surgical staples, sealants and other consumables. The IHACPA was tasked with developing advice on 'alternative bundling arrangements' for general use items that are due to be removed. The purpose is to support the private health sector in establishing alternative arrangements for the payment of benefits for these items once they are removed.

RACS recently joined with various specialty societies in responding to a consultation paper released by the IHACPA. The submission expressed concern that the removal of general Use items would result in surgeons (and patients) having less choice of general use products.

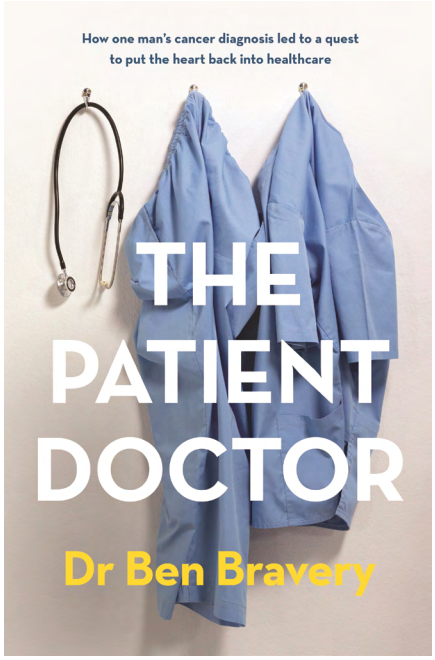
The submission also argued that if the reforms continue as planned, it would be appropriate for access to, and use of, devices removed from the PL to be independently monitored.

Want to know more about RACS Advocacy?

RACS distributes an Advocacy in Brief 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

Good reads



The Patient Doctor

By Dr Ben Bravery

The Patient Doctor is an inspiring memoir that shares the unique perspective of the writer who experiences the Australian health system first as a patient and then as a doctor.

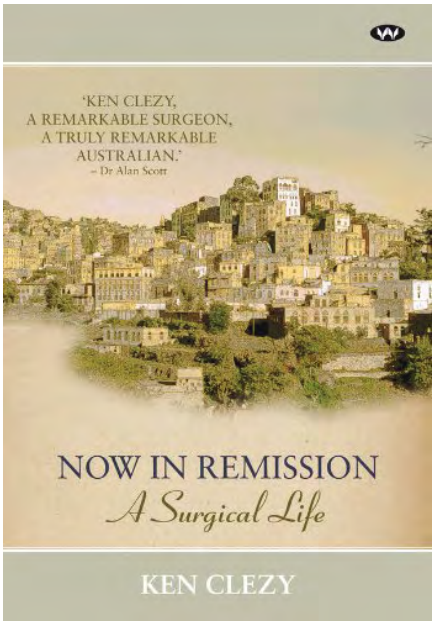
Dr Bravery writes about his journey from diagnosed with stage three colorectal cancer in his late 20s to making the life-changing decision to become a doctor. He brings to life the anxiety, frustration and confusion that many patients feel when they are diagnosed with a life-threatening illness—the harrowing 18 months of radio therapy, chemotherapy and surgery that he underwent, and the sometimes de-humanising side of healthcare. These experiences spurred his decision to become a doctor.

As a doctor, Dr Bravery also sees what happens on the other side of the fence—the pressures of becoming a doctor and a system focused on seeing as many patients as possible.

Some of his most pivotal moments in the memoir come from his growing realisation that the technical knowledge medical practitioners have should be coupled with seeing patients as people and treating them with kindness and compassion.

Dr Bravery writes in a lively and engaging manner that pulls the reader in and explains complex scientific issues simply—not surprising considering his background as a scientific communication professional.

The Patient Doctor is available at leading bookstores in Australia and Aotearoa New Zealand and from online retailers.



Now in Remission: A Surgical Life

Dr Ken Clezy, AM OBE

Dr Ken Clezy is a surgeon whose vocation has taken him to many places, not all of them safe. When three colleagues were shot dead at a Yemeni mission hospital, he escaped only because he had gone home for breakfast.

In Port Moresby, where Dr Clezy was the first professor of surgery at the University of Papua New Guinea, doctors and nurses still say, 'Dr Clezy did it this way'. He performed brain and spinal tumour surgery in that country for many years, and was a pioneer of non-operative management of the ruptured spleen in adults, but his expertise was in the reconstructive surgery of leprosy deformities.

In the book Dr Clezy shares the joys and sorrows of his family and professional life in the Third World, most recently in Yemen during the Second Gulf War. His story is rich in character and place and tells of a remarkable life dedicated to those in need.

Now in Remission: A Surgical Life is available here bit.ly/30efM8j

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 since 10 June 2022.

Dr Frank George Hugh Stening

Dr Harry Lawrence McIntyre Smith

Dr Stuart Whitaker Brown

Dr John Dixon Hughes

Dr (Duncan) Scott Stevenson

Dr Francis Breslin

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

Remo 'Sid' Cantamess, FRACS, Urologist
10 June 1926 – 23 June 2022

Sid was born in Proserpine, Queensland in 1926 to a sugar cane farming family who emigrated from Italy in 1921.

He graduated from the University of Queensland (UQ) in 1949, demonstrating his athleticism in sport as a rugby union player, representing the state of Queensland as a breakaway.

After spending his early resident years at The Mater Hospital, Brisbane, Sid went to the UK and obtained his FRCS in 1955. In 1957 he re-joined the Mater as Honorary Clinical Assistant Urology, obtaining his Master of Surgery degree from UQ in 1957 and later in the year the FRACS.

Professor Brian Foxwell Buxton, AM, FRACS Vascular and Cardiothoracic surgeon
15 April 1940 – 20 May 2022

Brian was born at Melbourne on 15 April 1940 and attended Scotch College where he showed leadership skills in cricket. He matriculated with first class honours in mathematics and chemistry. He studied medicine at The University of Melbourne, graduating in 1962.

His postgraduate career started at Royal Melbourne Hospital, where he specialised in surgery, gaining Fellowship of RACS in 1967 at the age of only 27. His medical career subsequently was one of brilliance.

Dr Kush Shrestha – FRACS, Orthopaedic surgeon
22 November 1972 – 11 September 2022

Kush was born in Kathmandu, Nepal, where he spent his childhood before being awarded a prestigious scholarship from the Australian government to study medicine at the University of Adelaide. This opportunity was provided only to the most promising students across the Commonwealth of Nations.

He moved to the UK for a couple of years and then returned to Adelaide where he worked as a non-accredited orthopaedic registrar before being accepted into the South Australian Orthopaedic Training Program. After completing his training, Kush went to London, Ontario for a 12-month lower limb arthroplasty Fellowship. He joined the Royal Darwin Hospital on his return where he headed the orthopaedic department, including being the director of orthopaedic training.

Dr Justin Kelly, FRACS, OAM, Paediatric surgeon
22 June 1936 - 30 October 2022

Justin trained in paediatric surgery at the Royal Children's Hospital where he was significantly influenced by the thoughts and work of the Head of Urology, Dr Douglas Stephens.

His life work was centred around bladder exstrophy, where bladder, genitals and pelvic bones are completely separate and exposed to the surface. Over 35 years he studied this problem with a genuine desire to understand the issues and design better solutions. He believed that each child had their own unique anatomy, and it was his task to understand their particular maldevelopment and tailor a solution accordingly.

Dr Trevor Pickering OAM, MBBS (Adel), FRCS (UK), FRACS, FAM, General surgeon
30 April 1934 – 29 July 2021

Trevor earned many accolades over his career, as an OAM for services to medicine, an eminent surgeon, a member of Australia's first successful renal transplant team, and president of the Australian Medical Association (AMA) South Australia (SA), and federal AMA.

Dr Pickering held many positions, including the last medical president of the Council of the Physiotherapy Association in South Australia, vice president and president of the AMA (SA), and treasurer, vice president and president of the federal AMA – the only South Australian to have achieved the double presidencies. He was a stabilising force in a combative period of medical politics following the introduction of Medicare in 1975, advocating for measures to maintain high standards of care.

Dr John Dixon Hughes, OAM, FRCS, FRACS, FAMA General surgeon
20 April 1924 – 14 September 2022

John attended Coogee Prep and Sydney Grammar School and joined the RAAF on matriculation where he qualified as an Air Gunner. On discharge he studied medicine at Sydney University, graduating seventh in his year in 1953. He moved to London to train with the Royal College of Surgeons, becoming an FRCS in December 1957.

His distinguished career as a general surgeon spanned more than 60 years, with a focus on breast, thyroid, hernia, and gastro-intestinal conditions, including trauma and emergency surgery. He transitioned to medico-legal work towards the end of his career, while continuing to support his long-term patients.

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