

SurgicalNews

Volume 23 | Issue 1



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**New role for trailblazing
Orthopaedic surgeon**

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New College name proposed



Royal Australasian
College of Surgeons

Dr Melanie Walker
Breast surgeon, VIC

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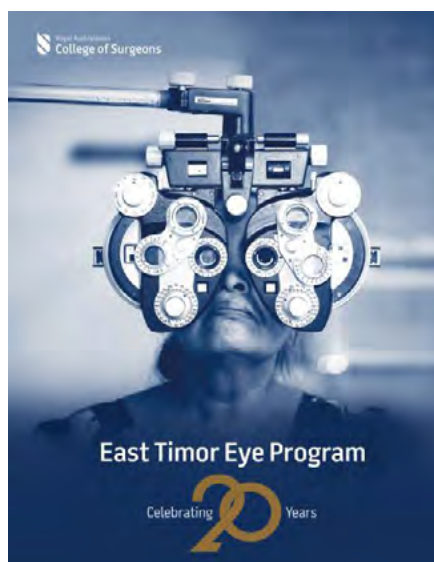


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President's perspective

We continue to be challenged by the ongoing COVID-19 pandemic and the impact it has on our patients and the health system with many healthcare workers tired and rundown. The pandemic has truly exposed many aspects of our healthcare system that need to be fixed to ensure long-term sustainability.

One of the issues that we have been advocating for strongly over the last two years is that of elective surgery. Governments have been banning elective surgery without consultation with surgeons and other experts who can help inform such decisions.

While it is good to see elective surgery resuming albeit in a staged manner in some jurisdictions, governments must have short-term and long-term plans to manage the community need for elective surgery in a more nuanced manner that puts patients first.

As surgeons we understand the different pressures on the public and private health sectors especially in this COVID-19 environment, but we also know that elective surgery closures don't free up hospital capacity. There is absolutely no reason why surgery cannot continue in some areas without impacting the COVID-19 response. Another recommendation we have made is for governments to develop plans that allow

for individual flexibility and decision-making at the local level for a prompt response to patient needs.

An added concern we have shared with governments is the use of terminologies such as 'elective surgery', which could be interpreted as meaning 'non-essential', which is incorrect. In time we plan to address the current categorisation system used and work towards a better system, more relevant to current requirements and to use in the future.

In December 2021, we were pleased that Ahpra and the Medical Board of Australia announced that they will conduct an external review of patient safety issues in the cosmetic surgery sector.

Australians rightly expect all surgical procedures to be performed to the highest possible standards and meet nationally established surgical standards.

We would like the enquiry to focus on the transparency of training. Any surgery entails risk, and it is critical that the enquiry establishes clear guidelines into the training required to conduct surgery. The practices of some health practitioners have caused significant harm to patients.

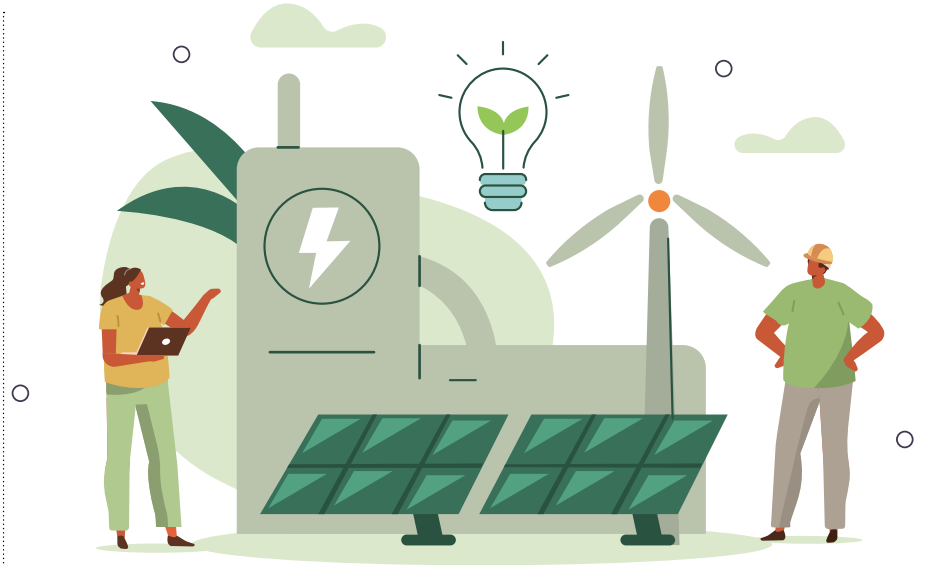
We also welcomed the Australian Health Ministers' commitment to national consultation on changing the national law to protect the title of 'surgeon'. We have been advocating for a long time that only those registered in specialties that undergo Australian Medical Council (AMC) accredited training programs, which include a significant surgical component, should be allowed to use 'surgeon' in their titles.

There is much work to be done in both these areas. It is critical that we work closely together with our specialty societies and other stakeholders such as the Australian Medical Association to advocate for outcomes that will benefit our patients and the community at large. Although this is an Australian enquiry, Aotearoa New Zealand has the same concerns about use of the title 'surgeon'.

As things start to open up, I hope that we will be able to move more freely. The New Zealand government recently announced that by the end of February 2022, fully vaccinated New Zealand citizens and other eligible travellers under our current border settings can travel to Aotearoa New Zealand from Australia without staying in managed isolation and quarantine. Such returnees must have spent a minimum of 14 days in Australia and will still have to spend 10 days in 'home isolation' with Rapid Antigen Testing. I hope we will see some of you travelling between our countries in the next few months as the steps toward easier travel are made. I look forward to visiting Australia and seeing colleagues and our RACS staff in-person.

One of the events that I am looking forward to is the 90th Annual Scientific Congress (ASC) of the Royal Australasian College of Surgeons to be held in May in Brisbane, southeast Queensland.

The Congress theme is 'Sustainability in the Dispersed Workplace'. This brings



in many aspects of our surgical practice such as environmental sustainability, sustainability of the workforce and education of the workforce, as well as the use of telehealth and other information technology methods to aid delivery of surgical care.

In May 2021, we held our first hybrid RACS ASC in Melbourne. Our ability to host a complex multi-stream hybrid event has been proven and has allowed more people to benefit from the presentations. The virtual congress will again be available for those who cannot attend all presentations that they wish to at the time.

Along with this year's conveners, Professor Chris Pyke and Professor Deborah Bailey and the 2022 RACS ASC Brisbane organising committee, I look forward to welcoming you to the Brisbane Convention and Exhibition Centre from Monday 2 – Friday 6 May 2022.

To register visit asc.surgeons.org

In February 2022, I was pleased to host the inaugural Environmental Sustainability in Surgical Practice webinar. The webinar focused on examining the environmental impacts of surgical practice and provided practical tips for how medical professionals can reduce their own carbon footprints. It was good to see such a great turnout at the webinar. Thank you to our presenters, Dr Ben Dunne, Professor Lynne Madden and Dr Rennie Qin for sharing their knowledge and expertise in this area. For those of you who were not able to join us, the

webinar will be available on our website for viewing.

We certainly have a busy year ahead and I am sure there will be no shortage of challenges and opportunities ahead of us, but like many of you, I am looking forward to a more positive year.

I suspect that many of you have been entertained for a few minutes each day by 'wordle', the stimulating and popular daily word game that has become a cultural phenomenon. I wonder whether FRACS will come up one day.



Dr Sally Langley
President

Vice President's perspective

Although it is February, it is my first communication of 2022 and an opportunity for me to wish you a happy and safe new year! I trust you had an opportunity to recharge and enjoy time with your family and friends.

The year 2022 continues the challenges of 2021 with the surge in COVID-19 and Omicron cases around the world. The past two years have been challenging and disruptive. In thinking of RACS' approach, I have been struck by the change in the member-RACS relationship and its focus. Last year, an external expert facilitated 'Strategy in Action' workshops for RACS Council highlighted the rapid challenges and obstructions faced by organisations. Such challenges are swift in implementation, frequent in presentation and confront RACS' risk appetite and management. A massive realisation is that as these challenges arise, RACS needs to quickly and efficiently assess, strategise, and formulate action plans that meet the risk appetite of the Board.

I have little doubt that the current playing field differs vastly to the recent past with the addition of heightened expectations of leadership by members and the patient community that we serve. The disruptions of 2020, 2021, and now into 2022, brought all manner of behaviours to the forefront affecting our teams, our employers, our governments, and the nature of support by organisations. RACS'

membership correctly expects the College to represent their concerns quickly, strongly and in a timely manner. Equally, our patients' expectations are heightened as patients look to us to protect and care for their conditions. This does not mean abandoning appropriate governance and due process.

The pandemic has brought about rapid changes in so many spheres beyond the obvious health care sphere—with accompanying cultural, technological, and legislative changes, all of which create huge opportunities for those who can navigate these changes successfully.

Governments, health jurisdictions, the education system, the childcare system, membership organisations like RACS, businesses big and small, parents, individuals—all have been impacted and forced to look at different ways to manage themselves and what is around them. The playing field, and indeed many of the rules of the game have changed, and from a broad business-based approach it is a case of timely adaptation and management or ignore at your peril.

RACS proudly champions the maintenance of world class and leading standards, assessment and teaching. We stand on the shoulders of the giants who moulded RACS to be an institution for patient wellbeing. I am humbled to witness the effort applied to maintaining RACS' reputation by colleagues, and especially

RACS staff. Much of this work is not visible, but mutual support to negotiate the best path through difficult times is what has made our ultimate success possible.

Another way we have been able to lift the bar to meet the higher member expectations is through our work with the Australian Ethical Health Alliance (AEHA)—a collaboration of professional bodies, industry organisations, hospitals and health services associations, regulators, patient and advocacy groups who have come together to address ethical issues within the health sector. The initiative is government supported but a sector led voluntary initiative which initially began with five bodies (AOA and RACS included) and has subsequently grown to more than 70 signatories. There are 12 ethical principles aimed at promoting public confidence and trust in healthcare sector organisations by demonstrating a shared commitment to integrity and ethics.

Annually, AEHA members, including RACS, self-evaluate and share their progress on implementing the principles through the AEHA Self-Evaluation Form, which RACS completed at the end of 2021.

In our immediate geographical sphere, RACS is saddened by the devastating impact of the recent volcanic eruption



and associated tsunami in Tonga. Our thoughts, prayers and solidarity are with the people of Tonga. We wish the country and its people a quick recovery.

On a positive note, RACS recently published a limited edition book titled *East Timor Eye Program – Celebrating 20 years*. The book celebrates 20 years of great work RACS has undertaken in Timor-Leste graciously assisted by surgeons, doctors, nurses and other health professionals. The book documents first-hand stories of hardship and triumph, challenges and successes and is a must-have for your library. It is available for purchase through the RACS website <http://store.surgeons.org/customer/account/login/>

In the November–December issue of *Surgical News*, I mentioned the proposed RACS name change. In this issue, we have further information on this and an invitation for you to contribute to the debate. You will be asked to cast your vote in 2023 so it is important you have the necessary information to make an informed decision. In the meantime, RACS asks you to share your thoughts by writing a brief opinion piece either in support of, or against the change. See page 11 for more information.

I sincerely hope that we continue to navigate this pandemic smarter, stronger and better as individuals and as organisations. Please be safe and caring — for your sake, your families' sake, and importantly for the sake of your patients.



Dr Lawrence Malisano
Vice President



news in brief

RACS training management platform goes live

The training management platform aims to deliver a single, standard digital channel for surgical training. It will support Trainees, trainers, and supervisors throughout the surgical training program—from start to finish. It replaces the paper-based manual process and Trainees will experience increased support and enhanced engagement in real time.

The training management platform will eventually become a 'surgical passport' for Trainees—enabling them to manage their training requirements as defined by their respective training boards. The platform is easy and intuitive, and Trainees will be able to manage their rotations, view their progress and performance throughout the Surgical Education and Training (SET) program.

The training management platform is part of the College's digital transformation program.

New College appointments

Tamsin Garrod: Executive General Manager (EGM) Education Development and Delivery



Tamsin Garrod was appointed EGM Education Development and Delivery in November 2021.

Having been at RACS for several years, in various roles with the latest being Head of Research & Innovation in the Education portfolio, Tamsin comes to this role with a wealth of knowledge about the College.

Before joining RACS, Tamsin completed her Doctor of Philosophy in Medical Research and Master of Business Administration. She has served as a committee member and Emerging

Leaders board member at the Institute of Managers and Leaders Australia and New Zealand.

As EGM Education Development and Delivery, Tamsin will focus on the development of education and research, including the delivery of courses and exams. She will also help shape the development of a world class surgical training curriculum based on innovative clinical teaching practices to support surgeons in the total life cycle of patient care.

Christine Cook: Executive General Manager (EGM) Education Partnerships



Christine Cook was appointed EGM Education Partnerships in January 2022. She has more than 25 years of business experience, including 14 years

of experience in the healthcare sector. Christine comes from the Royal Australian College of General Practitioners (RACGP) where she was General Manager, Fellowship Pathways, responsible for the development of a new RACGP general practice training program.

Christine was previously the CEO of GPEx, the South Australian GP training delivery organisation and has extensive knowledge in medical education and in developing trusted relationships with key stakeholders such as the Department of Health, ACRRM, AIDA and RDAA.

As EGM Education Partnerships, Christine will focus on training, and on the College's relationship with specialty societies and specialty training boards. She will also be responsible for the Surgical Education and Training Program, education governance, the Reconsideration, Review and Appeal (RRA) process, and Specialist International Medical Graduates (SIMGs).

New role for trailblazing Orthopaedic surgeon

Dr Annette Holian is the first female President of the AOA in the organisation's 85-year history



It takes courage to travel to the scene of a natural disaster and operate without running water or reliable electricity.

But for Annette Holian, the same level of courage has been required to break the many glass ceilings she has encountered as an orthopaedic surgeon.

Dr Holian has in 2021 become the first female President of the Australian Orthopaedic Association (AOA) in the organisation's 85-year history.

The appointment comes 35 years after Dr Holian was one of the first two women to enter the Australian orthopaedic training program in 1986.

In her new position, she plans to create a profession that demands less courage and welcomes greater diversity among the surgeons of the future.

Growing up in Reservoir in Melbourne's north, Dr Holian was originally inspired to pursue a career in medicine as a child after reading the novel *Hills End*.

In the book, an isolated group of children confront extreme challenges. A boy whose friend is injured decides to be a doctor so he can help others. Dr Holian identified with the character and set her sights on becoming a doctor and helping in adverse conditions became part of her story.

Dr Holian's parents had met as patients in a polio clinic and this history also drove her interest in medicine. The disease had left

her mother unable to walk unaided and damaged her father's arm.

"I was very aware of the challenges they faced, and particularly the motor challenges," she says.

After following the typical orthopaedic surgery pathway into private and public practice, Dr Holian embarked on a road less travelled when she began to work providing pro bono surgery for Papua New Guinea children in 1996.

She carried out surgery in Melbourne alongside her colleagues at the then Monash Medical Centre and helped teach local surgeons in PNG.

In this role, she derived great satisfaction from improving the lives of people who had suffered from diseases like polio, club foot, infections of bones and joints and neglected.

These patients would have been unlikely to have received adequate care without the work of Dr Holian and other Australian surgeons.

Among her most memorable cases was that of a 29-year-old woman whose tight Achilles tendons had confined her to a wheelchair from infancy. After a simple 20-minute operation under local anaesthetic, she could walk up a set of stairs.

"Everything we taught and did had a huge impact on the people we were caring for and I found it incredibly rewarding."

Dr Holian was part of the first Australian medical team on the ground after the Boxing Day tsunami in Banda Aceh. She remembers seeing people everywhere searching for family members and witnessing trucks moving bodies into open tips.

Her team operated in extremely challenging conditions, without reliable power or access to running water.

In 2000, she joined the Royal Australian Air Force for service in East Timor and subsequently shifted towards trauma surgery, later serving in the Solomon Islands, Indonesia, and the Middle East.

She has undertaken five deployments to war zones, including three in Afghanistan.

While the work is rewarding, it can also be extremely confronting.

"I remember trying to help save an eight-year-old boy who had been shot, but who died on the operating table despite our best efforts. I was doing the CPR for his arrest, and we had to call it, on a pink warm child in asystole.

"As a first responder at natural disasters, you can rationalise that it wasn't of human making, but it's very confronting to see people hurting other people in this way. And it is particularly emotionally laden when your patient is a child."

Dr Holian was also deeply affected by a helicopter accident that killed members of the medical team providing assistance following an earthquake in Indonesia. After the crash, she had to recover the bodies of her colleagues.

"There were 50 Australians working there and we lost five of them. That accident was a seminal part of my story," she says.

Her work has provided her with first-hand experience of the sense of isolation soldiers feel when they return from a war zone.

"When I got home, I remember being asked if I had 'had a good time'. It made me realise that only people who have been there know what you went through.

"I can't burden others by talking about those overseas experiences, but I love spending time with those who were there with me. We can just be together and know that part of our story is shared. We are not alone."

Her chosen mode of relaxation from an emotionally taxing job is gardening, and she is looking forward to getting her plants that are currently potted into the ground.

Dr Holian's military service was recognised in 2006 when she was appointed a Governor at Melbourne's Shrine of Remembrance.

A circle closed in a surprising way when the author of *Hills End*, Ivan Southall AM, DFC was featured in a recent exhibition at the Shrine. The writer had been a RAAF pilot in World War II, later becoming an author.

Dr Holian stood open-mouthed before the exhibition, astounded that years



after Southall had inspired her to pursue medicine, she had found herself looking after aircrew and keeping them flying.

In 2018, as RAAF Group Captain, she was the first woman serving in the Australian Defence Force to have addressed the ANZAC Day dawn service at the Shrine of Remembrance.

She embraced the opportunity to call for better support for returned service people and encouraged greater dialogue between veterans and the wider community.

“My identity as a military person is very important to me as it proves to me that I am capable of some pretty extraordinary things,” she says.



Dr Holian’s humanitarian and military work has also provided her with an understanding of the importance of access to adequate health care—a primary concern she aims to tackle in her role as a RACS Councillor.

“I am passionate about improving access to medical care as access to health services and outcomes are much worse for people living in regional and rural areas.”



She considers it to be a significant problem that while about 29 per cent of Australians live regionally or rurally only 12 per cent of surgeons live outside metropolitan areas.

She is also committed to creating a more supportive profession for women and promoting diversity.

... she encountered significant challenges juggling parenthood and her career when she became a mother.

The issue came close to home after she encountered significant challenges juggling parenthood and her career when she became a mother during her third year of medical school.

The requirement to be ‘on-call’ day and night for the junior doctor was a grueling experience for the new parent.

“No one cut us any slack because we had a young child and there wasn’t any before or afterschool care at the time. It required a lot of organisation and support from my mum. It was a very challenging time.”

It was 12 years later, after completing her surgical training that she had the second of her three children, and another four years post an overseas Fellowship that she was able to have her third child.

In her career, Dr Holian says that she has constantly had to rail against the bias women face in a male-dominated profession.

“In many ways, women can’t win. They are punished for behaving like men, or on the other hand, for being authentic to their femininity. They are extremely reliant on their—usually male—superiors for selection and training and that means there is a fine line that they have to walk.”

Women currently constitute only five per cent of Orthopaedic Surgery Fellows; it is

the lowest proportion across all medical specialties.

However, there is cause for optimism, with women constituting 22 per cent of the intake for the 2022 Orthopaedic Surgery training program. This is an all-time high, and up from around 15 per cent in previous years.

Dr Holian has now set her sights on the treatment of those female Trainees in their workplaces and whether they will be judged on the male interpretation of ‘confidence’, or the more valid qualities of competence and safety.

The barriers Dr Holian faced as a trailblazer in the profession have provided her with the impetus to drive change through her role with the AOA.

“It’s a great opportunity and I don’t want to waste it,” she says.

For Dr Holian, countering the additional barriers she faced as a woman in her profession meant writing her own script. “I took great courage from my mother and made the decision not to do what was expected of me.”

It is a decision that has resulted in an extraordinary career so far and one that will pave a more better-supported pathway for the orthopaedic surgeons of the future.

Images (this page, from top-left): Annette with CDR Martin Richardson, orthopaedic surgeon; AUSMAT Operating theatre-tent, Tacloban 2013; Annette in uniform.

Examination update 2021

We administered eight major examination events across Aotearoa New Zealand and Australia in 2021:

- three sittings of the General Surgical Science Examination (GSSE)/Surgical Science Examination (SSE) for 1139 candidates
- two clinical exams for 179 candidates
- two Fellowship written exams (Part 1), and two Fellowship clinical exams (Part 2) for a record 425 candidates.

The first clinical exam during the COVID-19 pandemic was a return to paper-based delivery to support multiple locations. The June exam ran with tablet marking for the first time—used concurrently in multiple locations. Only one of the 11 locations was unable to go ahead with the exam due to the June Sydney lockdown. The October clinical exam was also cancelled.

The Fellowship clinical exams were administered across multiple sites for all nine specialties during the 2021 response to the COVID-19 pandemic. A significant number of retired examiners retrained to examine and observe exams. With their help, we supported 231 virtual observations and provisioned an



additional General Surgery Fellowship Exam in New South Wales to ensure all applicants were examined and standards maintained.

Neurosurgery and Vascular Surgery specialties did not participate in the November sitting. Although cancelled in mid-stream planning, the second sitting of the Fellowship Exam was reinstated in seven of nine specialties in response to stakeholder feedback. This was

possible due to the commitment and support across the wider College—from examiners and retired Fellows, local coordinators, volunteers, staff and members of the training boards.

APPLICATION INVITATION

Post Fellowship Training in Upper GI Surgery RACS accredited PFET program

**APPLICATIONS CLOSE
MONDAY 18/4/2022**

\$450

Due on Application
Submission

Interviews 18/6/2022 if invited

The Fellowship in Upper GI Surgery involves a minimum of 24 months clinical training, completion of research requirements, case load achievements and assessments. Successful applicants will be assigned to an accredited hospital unit. All first year placements will be in a different state from which you currently reside.

- You **MUST** be a citizen or permanent resident of Australia and New Zealand.
- You **MUST** have FRACS or successfully completed the FRACS exam in May 2022.

To apply, please complete the online application at aanzgosa.org/fellowship-training

Enquiries

Renee Buckley, Executive Officer AANZGOSA,
24 King William Street, Kent Town SA 5067
or email info@aanzgosa.org



AANZGOSA

Australian & Aotearoa New Zealand Gastric &
Oesophageal Surgery Associated & New Zealand

New College name proposed

Have your say and tell us what you think

RACS is considering a proposal to change the name of the College following a request from our Fellowship.

RACS Council appointed a working party to progress the matter and it was agreed that an electronic vote of members on the proposed name change will be conducted in 2023, allowing ample time for member and stakeholder education and engagement.

The working group identified two viable alternative names:

- Royal College of Surgeons of Australia and Aotearoa New Zealand (RCSAANZ)
- Royal Australian and Aotearoa New Zealand College of Surgeons (RAANZCS).

Most working group members favoured the second name as it was closest to the current name. Options featuring 'ANZAC' were avoided given the military connotation.

RACS had previously considered a name change due to several related concerns, such as uncertainty about the meaning of the word 'Australasia' and whether it reflects our bi-national status. Should we be Australia and New Zealand or Australia and Aotearoa New Zealand: how do we best reflect the Māori and Aboriginal and Torres Straits Islander cultures; how

does the prefix 'royal' fit, and what does all this mean for Fellows who use the postnominal FRACS.

The first request for a name change came in 2004 after a survey conducted by our New Zealand National Board found that most of our Aotearoa New Zealand Fellows and Trainees favoured a name change.

In 2006, a Fellowship survey included an exploratory question about a name change. Less than half of those respondents preferred the College name remain as 'Australasian' and a similar number preferred either the title 'Australian and New Zealand' or expressed no preference. In the same year, Council resolved that a postal ballot of the Fellowship be conducted to determine whether the College should change its name to 'Royal Australian and New Zealand College of Surgeons'.

In 2007, a referendum on the name change was held. Fifty-seven per cent of respondents voted for a name change, which is less than the 75 per cent requirement defined by our Constitution and thus the name remained unchanged.

In December 2019, the New Zealand National Board asked that Council again consider a name change.

This proposal was referred to the Governance Committee then to Council. A working group was established to scope a College name change and make recommendations. In January 2021, the New Zealand National Board requested inclusion of both Aotearoa and New Zealand in the College name, and this was accepted and implemented.



Have your say

We are calling on all Fellows, Trainees and Specialist International Medical Graduates to tell us what you think of the idea of changing the name of the College.

Do you support the change or not? Why?

What are your thoughts on the proposed names below?

- Royal College of Surgeons of Australia and Aotearoa New Zealand (RCSAANZ)
- Royal Australian and Aotearoa New Zealand College of Surgeons (RAANZCS).

Please send your response of up to 500 words to Surgical.News@surgeons.org by 15 March 2022.

We will publish four responses in *Surgical News* – two each on either side of the argument. More responses will be placed on our website.

This is what the proposed names would look like

 **Royal College of Surgeons**
of Australia and Aotearoa New Zealand

 **Royal Australian and Aotearoa New Zealand**
College of Surgeons

New beginnings – going it alone

Setting up Younger Fellows for professional private practice in surgery



In early 2000, The Younger Fellows Forum identified the need for a workshop to prepare younger Fellows for professional practice in surgery.

The aim was to provide Fellows in their first 10 years of Fellowship with an introduction to the planning and ongoing management of non-clinical prerequisites for establishing a professional private practice.

Private practice can be daunting for new Fellows who have been supported by the public system for much of their working lives. The decision of whether to divide their practice between the public and private system—and to what extent—is difficult given the lack of training or experience in private practice.

Over the years, the Preparation (Prep) for Practice workshops have addressed important issues and practical problems that can arise. These included:

- practice administration
- financial and practice business structures
- creating relationships between Fellows and referring doctors, staff, private hospitals and private insurance companies
- medico-legal aspects
- identifying pressures and developing strategies to maintain a healthy and balanced lifestyle.

The key learning outcomes have been:

- understanding issues involved in setting up a private practice
- acquiring practical strategies and tools for practice operation
- developing practice framework and improve practice performance.

The Prep for Practice workshops are run by individual states with their own guest speakers. In 2022, the following states will run their workshops for Younger Fellows.

Australian Capital Territory (ACT)

The ACT holds an annual Younger Fellows evening, which includes an informal networking opportunity as well guest speakers who present topics relevant to Younger Fellows.

Topics can include:

- leadership
- how to set up and manage a private

practice

- financial, legal, Medicare or insurance requirements
- working in private hospitals.

Save the date: 27 October

New South Wales

A two-day face-to-face workshop was held in early February, which focused on practicality and experience of fellow surgeons, consultant speakers and industry.

The information, tips and advice provided included—but not limited to—managing finances, life as a FRACS, legalities of surgical practice, Medicare basics, practice software and marketing skills. Time was also allocated for discussion among participants and experienced Fellows.

The intended outcomes of the workshop were:

- understand issues involved in setting up private practice
- acquire strategies and tools for practice operations
- develop practice framework
- improve practice performance.

This educational activity has been approved in the RACS CPD Program. Fellows who participated can claim one point per hour in Maintenance of Knowledge and Skills.

Save the date: Keep an eye out for the 2023 dates

Victoria

The Victorian Prep for Practice course aims to create a comprehensive and interactive two-day course on practical skills, tips and advice to setting up private practice.

In 2020, during the long Victorian COVID-19 lockdown, Younger Fellows were offered an online version of the Prep for Practice over 12 webinars. These webinars are still available on the College website:

<https://tinyurl.com/mre5p63y>

The course covered:

- practice administration
- financial and practice business structures
- creating relationships between Fellows and referring doctors, staff, private hospitals and private insurance companies

- medico-legal aspects
- identifying pressures and developing strategies to maintain a healthy and balanced lifestyle.

Save the date: 13 and 14 August at the RACS Melbourne office along with a networking dinner

Queensland

The need for a private practice workshop was identified by the New South Wales State Committee.

The Queensland Prep for Practice initially ran every two years and changed to an annual event in 2015. The event is held over two days with a networking dinner on the Saturday evening. The current conveners are Dr Stuart Collins, Dr Rebecca Won and Dr Danielle Wadley.

The aim of the workshop is to provide Younger Fellows with:

- an introduction to the planning and ongoing management of non-clinical prerequisites for establishing a professional practice.

Save the date: 5 and 6 November

Tasmania

Tasmania holds an annual Younger Fellows informal golf event or dinner rotating each year. This year will see a golf event for Younger Fellows.

There will be an informal presentation at the start of the event, which will cover:

- aspects of practice management when setting up
- insurance needed for your practice
- efficient systems for operating your practice.

Save the date: 12 November

South Australia

The South Australian Prep for Practice course is an annual, full day workshop held at the RACS office at the end of each year.

In an informal setting, Young Fellows are given the opportunity to engage and learn from industry experts to better prepare them for their journey into private practice.

Topics can include:

- tips, tricks, and pitfalls of private practice
- cultural practice, resilience, and communication within private practice
- mental health and wellbeing
- finance, contracts, and legal considerations
- Medicare and getting paid
- private hospitals and what they can do for you
- systems and software and My Health Record.

This platform also highlights RACS' role in supporting Young Fellows through the many available resources.

Save the date: late November/early December – date TBC

Western Australia

The Western Australia one day workshop will focus on practicality and experiences provided by fellow surgeons and consultant speakers. Participants will also have the chance to speak to Fellows who have experience in starting up private practice to get tips and advice.

Topics can include:

- finance

- human resources
- referrals
- Indemnity Insurance
- Strategic Marketing: building a social media profile and more.

Save the date: 5 November

Bongiorno & Partners sponsor the Prep for Practice workshops in Victoria and New South Wales. Michael Waycott, Director of Bongiorno & Partners, and a course facilitator says these workshops help Fellows gain knowledge of the various requirements they need before entering private practice. The two-day workshops help them with the where, when, and how to seek advice and what not to do.

"The most important information I share are the various structure options, wealth creation strategies, financial dos and don'ts, and protecting their most important assets," Michael said.

The overall program, for Michael, has been very successful based on the attendance and enquiries he receives every year. "It's a brilliant initiative for Younger Fellows and RACS should be proud of what it offers them," he said.

Going into private practice means you are more than a surgeon—you are an entrepreneur and below are some handy tips for setting up your own private practice.

1. Don't rush the process—do due diligence before making commitments.
2. Plan both your entrance into and exit from private practice.
3. Have a team of trustworthy support including lawyers, financial advisors, software designers to assist you in practice development.
4. Hiring staff takes a good amount of time.
5. Get educated on the private hospitals in your area.
6. Understand what GPs want from a surgeon.
7. Marketing yourself and your practice is a delicate art as both federal and state laws mandate how doctors can advertise themselves.
8. Have an informative and easy to use website.
9. Find a mentor who has been successful in private practice.
10. Thoroughly check all the options including small practice, large practice and group practice.



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International Women's Day event

RACS Tasmania office will host its first ever International Women's Day breakfast

For the first time the RACS Tasmanian office will be hosting an International Women's Day event, when they converge upon Seagrass Restaurant for the Women in Medicine breakfast on 8 March 2022.

The breakfast is a collaboration between the Australian Medical Association and RACS Tasmania. In addition to the AMA, a number of RACS specialty societies are supporting the event including the AOA, ASHONS, ASPS, GSA, ANZSVS and USANZ.

State Chair, Dr Peter Moore, said the breakfast was a great initiative for Tasmania and would help offer greater engagement for the local Fellowship.

"It is a very important day on the calendar, and one we have always been keen to celebrate. Unfortunately, because Tasmania is a smaller state it is often very difficult to generate enough numbers to make hosting these types of events worthwhile for the Fellowship. I know the AMA and other organisations have also had the same problem.

"With the difficulties that we have all faced over the last couple of years, we really wanted a chance to celebrate something important.

"All going well, we are hoping to make this an annual collaborative event. We will also look to combine forces for other similar events throughout the year."

International Women's Day is a global day celebrated annually on 8 March to commemorate the cultural, political, and socioeconomic achievements of women. This year the theme is #Breakthebias. While the event celebrates women, Dr Moore said that everyone is welcome.

"International Women's day is a day for everyone to come together to celebrate and recognise the contributions of women to our society and in our case medicine. It is great to see so many men, women and people from all walks of life already registered."

Across Australian and Aotearoa New Zealand several RACS Offices will be marking the occasion and inviting all Fellows, Trainees, Specialist International Medical Graduates and medical students to attend.

For information about events in your area please contact your local RACS office.



Women in Medicine breakfast

RACS Tasmania together with the AMA Tasmania present Women in Medicine Breakfast for 2022

Come and join us for a beautiful breakfast with female leaders in medicine

Seagrass Long Point in Sandy Bay on
Tuesday 8th of March starting at 7am.

RSVP to the RACS State office: college.tas@surgeons.org to secure your ticket please note - there is no charge to attend for invited guests. Members are welcome to bring a non-member colleague - \$30 per person charge

Please ensure any dietary requirements have been communicated by the 2nd of March 2022

This event is proudly supported by

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TASMANIA

Outstanding work and research celebrated

The Young Investigator Award winner and the DCAS Course winner share a thirst for learning

The work of outstanding, upcoming clinical researchers was celebrated at the November 2021 Annual Academic Surgery Conference as a virtual event.

This event provides a forum for surgical Trainees to present original research and continues a long history of supporting the advancement of surgical research and academic surgery initiated by the Surgical Research Society of Australasia (SRS) when it was established in 1961. SRS Research Funds are used to support the Annual Academic Surgery Conference, and to fund prizes awarded at the event, including the Young Investigator Award, the Developing a Career in Academic Surgery (DCAS) course award, and four Travel Awards.

Among those awarded prizes at the 2021 event were Dr Peter Russell and Mr William Xu. Both recipients have an unquenchable thirst for learning and the desire for their research to have a positive impact on clinical practice.

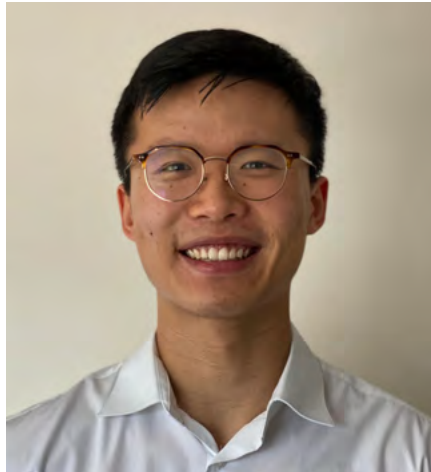
Peter was awarded the Young Investigator Award for his research paper on *Acute pancreatitis causes mesenteric lymphatic contractile dysfunction despite aggressive fluid resuscitation in a rodent model*.

William won the DCAS Course Award for presenting the research paper entitled *The effect of intraperitoneal drain placement on postoperative outcomes after colorectal surgery: A propensity score matched analysis*.

William was also awarded one of four Travel Grants for his paper: *Wearable wrist sensors for continuous ambulatory vital sign monitoring in patients undergoing major abdominal surgery: a clinical validation study*.

Peter and William shared what winning these awards means to them.

"We all stand on the shoulders of those who came before us," explained William, whose award is for a Trainee- and student-led research project run by the EuroSurg collaborative involving hundreds of international collaborators. William completed his Bachelor of Medical



Mr William Xu

Science (Honours) under the supervision of Professor Gregory O'Grady in 2019 and is entering his final year of medical studies at the University of Auckland in 2022.

As he pursues a surgeon-scientist career, the impact of winning the award is two-fold, as he explained: "Having the opportunity to attend DCAS in person is very exciting. Conferences like DCAS and NAASC inspire you to challenge the status-quo and tackle difficult clinical problems." William talked about the momentum that Trainee and student-led research projects have gained over the past decade, and more recently in Australia and Aotearoa New Zealand. "The fact that these projects are winning awards at conferences is a testament to the hard work collaborators put in, and the overall quality of these studies," William said.

For Peter, who is a Clinical Research Fellow and PhD student in the School of Biological Sciences at the University of Auckland, winning the Young Investigator Award is an encouraging experience. "The research [I'm doing] still has a way to go but it's showing very promising signs regarding the potential to modulate lymphatic dysfunction to improve outcomes in patients with acute pancreatitis. Winning the award reminds me that what I'm doing has the potential to translate into a significant improvement in patient care," Peter said.

Having an impact and making the most of the opportunities that come their way are strong motivators that William and Peter share. "The opportunity to go to the Annual Academic Surgical Congress in the United States is one I'll make the most of. It will be a great chance to network with the international research community, obtain feedback on my work, and refine concepts for future research. I'm very grateful to the Section of Academic Surgery and Surgical Research Society, Royal Australasian College of Surgeons," Peter said.

Both researchers have a high level of determination, or what Peter describes as 'stickability'. "It's the ability to stick at something when things start to get tough, which happens all the time in research," he said. For William, it's also the relationship between the researcher and supervisor that's important.

William and Peter talked about the role of mentors in their lives.

"I don't think I would be anywhere near where I am today without the help and guidance of mentors. They probably saw something in me that I didn't yet see in myself," William said. He gives credit to his honours' supervisors, Professor Gregory O'Grady and Dr Cameron Wells, as well as Professor Ian Bissett, for being hugely influential in his clinical and research career.



Dr Peter Russell



William also credits the PhD students, his fellow colleagues at the University of Auckland, and international research-network collaborators, who he says, “push me to improve my scientific reasoning and intellectual rigor”.

Peter is also grateful to his PhD supervisors Professor John Windsor and Professor Anthony Phillips for their mentorship. “Both John and Anthony have made a substantial contribution to improving patient care through seeking answers to the difficult questions arising in clinical practice. I also admire a surgeon named Professor Stephen Rosenberg, whom I’ve never met but who I find really inspirational. He is now 81 years old and is the Chief of Surgery at the National Cancer Institute in the USA. I try to mimic certain things he’s done, such as reading and learning widely, and having a broad knowledge base to draw upon for my research so I don’t feel inhibited by things I’m not familiar with.”

We asked both award recipients what they love most about research, and clinical research in particular.

“Ever since high school I have wanted to carry out a PhD. I’ve always been deeply fascinated by the science behind things. I have an innate curiosity, always wanting to understand how things work and to dive deeply into a topic, which lends itself nicely to clinical research. It’s a very rewarding feeling when something you’re investigating comes together. Also, when you’re doing research or publishing a paper, it’s a privilege to know that you’re contributing to a world-wide community of people who are trying to push the boundaries of healthcare,” Peter said.

... “it’s a privilege to know that you’re contributing to a world-wide community of people who are trying to push the boundaries of healthcare,” Peter

Undeterred by what he describes as an ‘average’ experience of research on a microbiology project in high school, William recognised clinical research as an important skill once he was in medical school and was inspired by many leaders in the field who were both surgeons and researchers. He especially enjoys the challenge of making meaning out of data, particularly the back-end analysis and synthesising the key messages. “And also, the prospect of improving patient care, translating findings ‘from bench to bedside’ to use a classic phrase,” he said.

When asked to reflect on the qualities that have helped them along their professional journey so far, both placed high importance on collaboration, learning how to work well with other people and staying curious. ‘Learning by doing’ has been a very useful approach for William, which he says started in his honours year. “Embracing the fact that you don’t know but jumping in and getting your hands dirty to learn. It’s uncomfortable and the learning curve is steep, but that was definitely something that really got me going in the world of research,” William explained.

For Peter, it’s the ability to see the big picture. “It’s easy to get lost in the fine details when doing research, so if you can

keep the big picture in mind—the clinical background and the fact that you’re helping patients—it helps you focus on what’s relevant.”

When not working, Peter and William enjoy the chance to re-set. Peter has also done some work in ecology and conservation and loves being outdoors, which he says brings balance to the long hours inside doing experimental work and in front of a computer. “I also love spending time with my wife and two daughters who are at a really fun age, going for bike rides, swimming, and spending time with friends and extended family. I enjoy reading all sorts of books. I’m really interested in how the world works and the issues that we face, such as climate change and the pandemic,” Peter said.

William grew up enjoying music and was classically trained in piano. “This dropped off a bit when I entered medical school but I’m starting to pick that up again recently,” he said. “Without my music, I would probably find myself not as mentally sharp. It gives me a chance to de-stress and re-set my mind.” William also drew a parallel between music and surgery, explaining that they both give you the opportunity for “... repetition to get your skills perfected, and to reach a level of proficiency where you reach your flow state,” he explained.

Whether it’s with the help and discipline of exercising in nature or the flow of playing piano, Peter and William are certainly on a positive path along their research and surgical career journeys.



A tale of two surgeons

The Clinical Trials Australia and New Zealand builds on its success with the support and participation of Fellows, surgical Trainees, junior doctors and medical students

The RACS Clinical Trials Australia and New Zealand (CTANZ) continues to build on its successes, which would not have been possible without the support and participation of keen Fellows, surgical Trainees, junior doctors and medical students.

The energy and enthusiasm of our network members have been the key to ensuring that the multicentred national and global collaborative projects that CTANZ has been involved with have delivered on stated outcomes. Put simply, the CTANZ model (a network of multicentred collaboratives) works because of its people.

Associate Professor Tarik Sammour is a Surgical Specialty Lead (SSL) for STARC (South Australian Trainees Audit & Research Collaborative) and Dr Su Kah Goh is Co-Chair (Trainee Lead) for

VERITAS (Victorian Collaborative for Education, Research, Innovation, Training and Audit by Surgical Trainees).

Both have contributed to many collaborative studies including the COVIDSurg series, COVIDCARE, Single Use Negative pPressure dressings for Reduction In Surgical site infection following Emergency Laparotomy (SUNRRISE) Trial, PeRiOperative Timing in EleCtive Thromboprophylaxis in General surgery (PROTECTing), POST operative Variability in anaemia Treatment and Transfusion (POSTVenTT) and Survey to evaluate the Outpatient clinic experience in Surgical education and training using cloud based resources (SOS).

In this Q and A, we ask Associate Professor Tarik Sammour (TS) and Dr Su Kah Goh (SKG) on what it means to be a part of the CTANZ collaborative.

What about a CTANZ supported studies drew you in to participate?

TS: I was inspired to participate because of CTANZ's collaborative nature and adequate power in study designs that are statistically rigorous. That way we are confident about the findings of our studies.

SKG: Multicentre Trainee-led collaborative enables the study of clinically relevant questions. The findings from these studies can potentially improve current clinical practices. Participating in these studies encourages collaborators of all levels — from interns to consultants — to interact and work together.

Why did you put your hand up to be the SSL/Trainee lead?

TS: I was asked to be an SSL and felt it was a privilege to be able to support these projects. It was particularly vital to foster Trainees and students when getting the CTANZ initiative up and running in its early stages.

SKG: VERITAS has a growing track record of successfully conducting multicentre Trainee led collaborative studies including SOS, PROTECTing, and COVID-CARE. Along with my co-chair, David Liu, we were invited to participate in the POSTVENTt study as state leads. It was a privilege for us to coordinate the participation of 14 Victorian regional and metropolitan hospitals and oversee the completion of this unique prospective study on the impacts of anaemia in major surgery.

What learnings can you pass onto the next person who will fill this position?

TS: Always be mindful that CTANZ projects exist to foster Trainee-led and executed projects, with the SSL serving as support, rather than the other way around.

SKG: As a Trainee lead, you will learn that a lot can be achieved in a very short time. Teamwork is key and you will learn the importance of being a team player. Sound leadership and



communication skills are critical in ensuring tasks are appropriately prioritised and research objectives are met.

What areas can we improve on?

TS: Better capture of ANZ hospitals, both small and large. Less reliance on Trainees and students that are already in full-time research roles. Facilitation of ethics applications and minimisation of administration and paperwork to make conducting research easier and more enjoyable, rather than unnecessarily onerous.

SKG: Ethics and governance approval. In my experience, seeking governance across multiple hospital sites can be both challenging and costly. Recognition of collaborative studies and streamlining governance would certainly encourage wider participation.

How has being the SSL/Trainee lead for a collaborative study helped with your communication and leadership skills?

TS: It has opened more possibilities for national and international collaboration and communication.

SKG: Communication and leadership are part of the RACS competencies. Participating in a collaborative study has given me the opportunity to refine these skills and empowered my aspirations to be an academic surgeon.

How would you describe your experience as a participant in a CTANZ endorsed study?

TS: I had fun doing it and enjoyed seeing ANZ Trainees and students being involved in large projects. I felt that some of the paperwork was unnecessary and was more about ticking boxes rather than patient or research advocacy.

SKG: As doctors, we always try to find better

ways to help our patients. By working and learning together, we will be smarter at finding solutions to help our patients recover faster and safer. We meet once a week and we brainstorm ideas. It is fun!

Associate Professor Tarik Sammour FRACS is a colorectal surgeon with a specific interest in colorectal surgical oncology, complex pelvic malignancy and robotics. He holds a position as Associate Professor of Surgery at the University of Adelaide, and a full-time public hospital appointment in the Colorectal Unit at the Royal Adelaide Hospital. He continues to pursue an active research program, focusing specifically on clinical trials to improve patient outcomes after colorectal surgery.

Dr Su Kah Goh is an emerging surgeon-scientist. He completed his general

surgery training in 2020 and he is currently undergoing further sub-specialty training in hepato-pancreato-biliary surgery and liver transplantation. Dr Goh is the current co-chair of VERITAS, a Victorian based trainee-led research collaborative. He is involved in various collaborative research studies including SOS, COVID-CARE, PROTECTing and POSTVENTt. Recently, as the co-state lead for POSTVENTt (a CTANZ study), he coordinated, led and oversaw the participation of 14 Victorian sites.

Author:
Dr Lorwai Tan

Images: Associate Professor Tarik Sammour and Dr Su Kah Goh.



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Fertility and pregnancy

Pregnancy and neonatal complications are higher in surgical Trainees. What are we doing about it?

Medicine can be a demanding profession, with long working hours and years spent training to become a specialist consultant.

The majority of the training time is during a period when many also want to plan and raise a family. This may present as a major impediment to equal opportunity in medicine or specific sub-specialties within medicine. As we rapidly try to move away from medicine being a male dominated profession, there is a need to support women to achieve both family and professional goals.

A recent publication¹ in the USA highlighted not just work-life balance difficulties for women surgeons, but, alarmingly, also markedly increased risks of infertility and pregnancy complications. There are several factors contributing to this including delaying pregnancy because of the demands and inflexibility of surgical training, long working hours, and lack of parental leave options. The mere thought that our surgical training program could be increasing both the risks of infertility and neonatal complications has inspired Dr Jasmina Kevric researched the effects in Australia and Aotearoa New Zealand and started an awareness and mentorship campaign.

Dr Kevric's Australian-first survey investigated the incidence of fertility, pregnancy complications and breastfeeding practices among Australian and Aotearoa New Zealand doctors. The results are currently under peer-review.



Dr Jasmina Kevric



Dr Grace Chu and family

However, the findings indicate a similar worrisome picture to that in the United States.

Delaying family planning due to training requirements can increase age-related pregnancy complications. Long working hours increases the risks of neonatal complications, while options for part-time training are limited and only suit those in early pregnancy who can arrange flexible training for the following year. With the additional systemic stresses brought to bear upon public hospitals due to COVID-19, surgical Trainees and younger Fellows are under pressure to work longer hours—in a busier environment—with reduced time for family planning and safe spaces to breastfeed or express.

Dr Kevric was conscious of the age-related infertility and pregnancy complications and chose to start her family during surgical training. She was lucky to secure a week-on/week-off flexible training position through her training hub (Austin/Northern) and found working in the third trimester demanding, but less physically challenging.

Other issues that have been noticed or experienced by Dr Kevric's research colleagues, Dr Russell Hodgson and Dr Grace Chew, include increased family, fertility, and pregnancy stress associated with rural and remote rotations, and a lack of paternity leave (both inside and outside of medicine) to support new mothers at home or returning to work.

As a female surgeon and surgical mentor, Dr Chew has been privy to the difficulties experienced by Trainees faced with

juggling surgical training and family life. Residents and registrars have shared personal stories of pregnancy-associated complications such as miscarriage, unsuccessful IVF cycles, neonatal deaths, childhood illnesses and marriage stress.

Surgical Trainees need more support to navigate training and parenthood. Education on fertility is crucial early in training. Good access to flexible training allows Trainees to navigate the physical challenges of long working hours during pregnancy, and safe space to express breastmilk will aid in preventing early weaning. In enabling our Trainees and indeed younger Fellows in their quest to start and care for their young families, we will reap the benefits of achieving diversity in surgery, maintaining a healthy balanced surgical workforce and encouraging women to pursue surgery as a sustainable career.



Dr Russell Hodgson and family

To better address this and improve support to medical parents, Dr Kevric has founded a mentorship program ROSE (Resource, Outreach, Support, Education) and is open to all Australian doctors.

More information:

RoseforMedicalParents.com

Reference:

1. Rangel, E., et al., *Incidence of Infertility and Pregnancy Complications in US Female Surgeons* JAMA Surg 2021 Oct 1;156(10):905-915

Authors:

Dr Jasmina Kevric (MBBS, MPH) - General Surgery SET 5 Trainee

Dr Russell Hodgson - Research Director and Hepatobiliary Surgeon

Dr Grace Chew - Breast and General Surgeon

The Indigenous Trainee paving the way in Cardiothoracic surgery

Dr Robert Grant is a Trainee Cardiothoracic surgeon at the Royal North Shore Hospital in Sydney, New South Wales. He completed his undergraduate and postgraduate studies at the University of Sydney and holds a Master of Epidemiology from the prestigious Columbia University in New York.

Dr Grant, who is of Gamillaroi descent, received a SET Trainee One Year Scholarship from Royal Australasian College of Surgeons (RACS) in 2020. The initiative aims to increase the participation of Aboriginal, Torres Strait Islander and Māori doctors in a surgical career.

"The scholarship was pretty useful and got me through one of six years of my training," he said.

As a Trainee surgeon in a busy specialty, Dr Grant performs several interesting tasks.

"Most of our patients are in ICU for the first couple of days after their operation. A typical day involves a variety of different operations from bypass operations to valve replacements from a cardiac point of view, lobectomies for lung cancer, and pacemakers and devices in terms of operating."

Dr Grant also works closely with intensive care doctors, respiratory physicians, and cardiologists.

What drew Dr Grant to Cardiothoracic Surgery is the opportunity to perform intricate surgery.

"Cardiothoracic Surgery is a specialty that's got a huge amount of variety; it's also intricate and interesting surgery. The aim is to restore function of the body rather than resect a tumour or a cancer. For example, doing a valve replacement or a bypass operation, you're trying to restore the function to give people a much better quality of life."

Dr Grant's enjoys performing off pump coronary artery bypass grafting surgery—a challenging surgery that involves operating without a bypass machine and while the heart is still beating.

In 2013, Dr Grant completed a Masters of Public Health in Epidemiology from Columbia University in New York. He chose to undertake this study to help him with research and to understand the subject better.

During Sydney's COVID-19 wave in 2021 Dr Grant worked closely with COVID-19 patients.

"We were heavily involved with the ICU COVID patients in the use of ECMO to artificially do the job of their lungs for them," he said.

One of Dr Grant's passions is to work in Indigenous health. He has been a member of the Australian Indigenous Doctors' Association (AIDA) since 2009. After completing his residency at the Royal Prince Alfred, he looked to rural areas to get experience.

"I worked in emergency for a couple of years in rural areas like Dubbo and Bowral in New South Wales. I would like to work in a regional area in the future. However, Cardiothoracic Surgery is restricted in that regard."

With only three years until his training ends, Dr Grant, who went to the University of Sydney, is a part of a small cohort of Indigenous surgeons in his speciality.

"There is a sense of pride that I'll be able to pave the way forward for other Indigenous people," he said.

The challenge of going through medicine is made more uncomfortable by discrimination in the workplace.

"There are still people that treat you as if you're only there because you're Indigenous. Getting a 'free ride' couldn't be further from the case," he said.

In Australia there are more than 83,000 doctors registered and only 400 are Indigenous. Yet, 760,000 people in Australia identify as Aboriginal or Torres Strait Islanders.

In a month, Dr Grant will be moving to Newcastle with his young family to commence the next part of his training, something he says he is excited about.

"I'm also excited to live near the beach and get back into surfing," he said.

Dr Grant, who enjoys spending his free time in the outdoors, is also a new father to his five-month-old daughter.



RACS Research Scholarships and Grants round opens for applications in March 2022. For more information please go to www.surgeons.org/scholarships or contact the Scholarship and Grant Coordinator at scholarships@surgeons.org

For more information on setting up a scholarship, Fellowship or grant of your own, please contact the Foundation for Surgery at foundation@surgeons.org or +61 3 9249 1110.



November Annual Academic Surgery Conference highlights

The Section of Academic Surgery November Annual Academic Surgery Conference (NAASC) was held as a virtual one-day event on 4 November 2021.

Our program organisers minimised online meeting fatigue by expertly combining the Section of Academic Surgery meeting and the Surgical Research Society of Australasia into a full one-day extravaganza.

The Chair of the Section of Academic Surgery Organising Committee, Associate Professor Claudia Di Bella and her colleagues did an outstanding job curating an exceptional list of speakers on topics relevant and contemporary to the target audience. The program speaker list reflected gender diversity and included discussions on critical issues faced by clinicians contemplating an academic career.

The 2021 Association for Academic Surgery guest speaker, Dr Patrick McGrew, from the Tulane University School of Medicine, presented a fascinating but serious talk on *Trends and Burden of Firearm Injuries Among Children and Adolescents: A National Perspective*.

The Society of University Surgeons guest speaker was Dr Gregory Kennedy from the University of Alabama in Birmingham. He provided the US perspective on addressing the lack of surgeons in rural America in his talk *Strategies to Address Surgical Disparity in Rural America*.

Winthrop Professor Fiona Wood treated the audience to an inspiring Jepson Oratory on *The Role of Interdisciplinary Research in Striving for Clinical Excellence*. The major takeaway points were to be persistent, never give up and invest in networking with like-minded collaborators.

We had 84 abstracts submitted and again the quality of work submitted made it difficult for abstract scorers to arrive at the final 42—selected for either long-form oral (14 abstracts) or quick-shot presentations (16 abstracts). We also had

12 entries that scorers deemed of merit to be included as poster presentations.

It was especially heartening to see that surgical research seems to be in reasonable shape across Australasia despite the disruptive effects of the pandemic, with many excellent abstracts submitted by medical students, Trainees, and Fellows. Congratulations to all six prize winners—five of whom were from Aotearoa New Zealand.

Meet the winners

Young Investigator Award Dr Peter Russell



Acute pancreatitis causes mesenteric lymphatic contractile dysfunction despite aggressive fluid resuscitation in a rodent model.

Developing a Career and Skills in Academic Surgery (DCAS) Course Award Mr William Xu



The effect of intraperitoneal drain placement on postoperative outcomes after colorectal surgery: A propensity score matched analysis.

Travel Award 1 Dr Daniel Cox



Low levels of hepatocyte-specific methylation in cfDNA are a strong

negative predictor for acute cellular rejection following liver transplantation.

Travel Award 2 Dr Keith Teo



Development and validation of a comprehensive pain assessment tool for chronic pancreatitis.

Travel Award 3 Mr William Xu



Wearable wrist sensors for continuous ambulatory vital sign monitoring in patients undergoing major abdominal surgery: a clinical validation study.

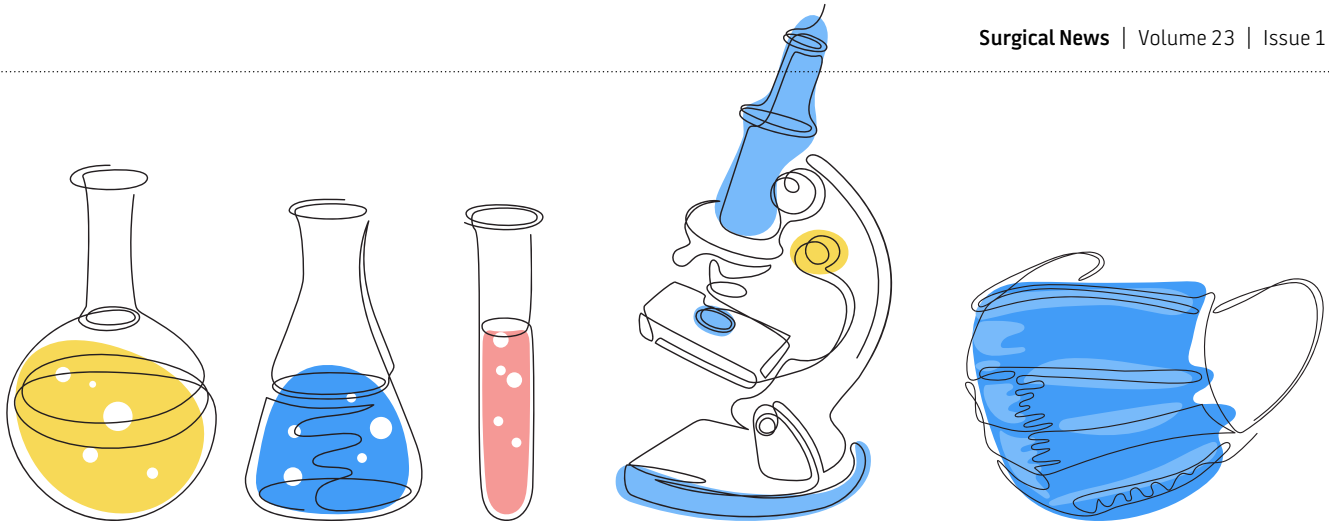
Travel Award 4 Dr Tary Yin



The chronic rhinosinusitis microbiota: a one-year longitudinal observational study.

We look forward to the time when we can meet face to face and return to a full two-day event in the near future.

Authors:
Professor Marc Gladman
Chair, Academic Surgery Committee
Professor Greg O'Grady
Chair, Surgical Research Society of Australasia



Developing a Career and Skills in Academic Surgery Course 2022

The upcoming 13th Annual Developing a Career and Skills (DCAS) course will be held on Monday 2 May 2022, leading into the Royal Australasian College of Surgeons Annual Scientific Congress at the Brisbane Convention and Exhibition Centre.

The course will be delivered in a hybrid format to include virtual sessions to give everyone an opportunity to attend this exciting course in person or online.

All sessions will be available both online and in person to allow delegates the opportunity to attend from wherever they are located. We will provide the delegates with an exciting range of informative topics that promise to engage and inspire.

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

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

The program will begin with a session exploring the academic career—from developing research questions, developing productive mentor-mentee relationships and advice on supervising

surgical higher degree students. Other sessions will include *New Directions and Challenges in Surgical Academia* and *Present Tools for Academic Output*.

Highlights from the program include Hot Topic speaker, Dr Eric Levi, presenting on the topic of Burnout and Mental Health in Academic Medicine. The keynote presentation, *Building and Succeeding in an Academic Career* will be delivered by Professor Mark Smithers from the University of Queensland.

Two concurrent workshops will cater to those new to research or academic surgery. The session *Finding My Fit* will cover a few different types of research. For those looking to develop their career, *Surgical Research Funding* will navigate successful grant writing and locating research funding.

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

Faculty regularly comment on how satisfying it is to see attendees benefit from the experience. For SET Trainees in General Surgery, attendance at this course is acknowledged by General Surgeons Australia as equivalent to attending one compulsory Trainees' Day.

We invite you to attend the DCAS Course, in person in Brisbane or in a virtual space in May 2022. You will be impressed and inspired. Research is about continuous

improvement and progress, so come and be part of this course.

Further details including registration, costs and the provisional program can be found on the DCAS website at: www.tinyurl.com/dcas2022

Associate Professor Jonathan Karpelowsky
– Co-Chair



Terminal care cases in the Australian and New Zealand Audit of Surgical Mortality

The Australian and New Zealand Audit of Surgical Mortality (ANZASM) has observed some variations in the interpretation of the opening question on the Surgical Case Form (SCF), which asks: 'Was terminal care planned for this patient prior to or on admission?'

There has been a gradual increase in the number of cases identified as Terminal Care (TC) that on review, have been found to be inaccurately classified.

The confusion mainly relates to cases where it is decided not to manage the patient with surgery, but to offer an active treatment that is capped short of an operation. When the patient fails to progress, active surgical treatment is withdrawn, and TC commenced. For these patients, TC was not planned prior to or on admission, so it is not appropriate that the TC question is affirmatively answered.

The four abbreviated reports below provide some examples of TC interpretations.

Case 1

A middle-aged patient, with several comorbidities, was admitted to a regional hospital and the clinical diagnosis of gallstone pancreatitis was confirmed

on a Computed Tomography (CT) scan. The patient was transferred by the Royal Flying Doctor Service for management of the gallstone pancreatitis.

On arrival at the tertiary hospital, antibiotics were commenced and an Endoscopic Retrograde Cholangiopancreatography (ERCP) undertaken. After the ERCP, the patient was admitted to the Intensive Care Unit (ICU). When the liver function tests became deranged, an ultrasound was undertaken. The patient then aspirated, and a chest x-ray was performed, and high flow oxygen commenced. The patient was not progressing and, after discussion with the family, surgical treatment was withdrawn.

The Palliative Care team became involved 12 days after admission, and the patient died 14 days after admission. When completing the SCF, the surgeon excluded this patient from the audit by answering 'yes' to the question: 'Was terminal care planned for this patient prior to or on admission?'

This patient was not admitted for Terminal Care. The patient was transferred from the regional hospital

for an ERCP, to specifically receive active treatment. In the days after the ERCP, the patient had several assessments, including blood tests and an ultrasound, and antibiotics. None of these would have been required, or appropriate, if admitted for TC. The medical notes then clearly record when treatment was withdrawn, and TC commenced.

Case 2

An elderly patient attended the Emergency Department (ED) of an outer metropolitan hospital, with a clinical diagnosis of small bowel obstruction, which was confirmed on a CT scan.

The patient was admitted for conservative treatment and 48 hours after admission, was given Gastrografin. Although this appeared successful, the patient developed a productive cough—perhaps from aspiration—and antibiotics were administered.

Over the next few days, the patient struggled with respiratory problems and developed atrial fibrillation and was admitted to the ICU for intravenous amiodarone. While in the ICU, the patient's abdomen became distended and a CT scan showed large bowel obstruction

(cause not clear). On day 12, surgical care was withdrawn after discussions with the family. The patient died the same day.

When completing the SCF, the surgeon excluded this patient from the audit by answering 'yes' to the question: 'Was terminal care planned for this patient prior to or on admission?'

This patient was clearly not admitted for TC, but for active treatment that was capped when the patient deteriorated, as the patient was not fit for surgery.

Case 3

A young patient was admitted following a fall at work. On arrival in the ED, the patient had fixed dilated pupils and a Glasgow Coma Scale of 3. The neurosurgical opinion was that this was a non-survivable injury and active treatment was not appropriate. The patient's family lived some hours away, so the patient was admitted to the ICU pending the arrival of the family. Once the family had had an opportunity to pay

their respects, surgical treatment was withdrawn, and the patient died shortly afterwards.

Although the patient did not attend the ED for TC, the decision not to offer active treatment was made immediately in the ED. The active care given in the ICU was not to treat the patient, but to give the family time to travel to the hospital. It was therefore appropriate for the surgeon to answer 'yes' to the question: 'Was terminal care planned for this patient prior to or on admission?'

Case 4

An elderly and dependent patient with multiple comorbidities was admitted from a nursing home with sepsis from a severe lower limb soft tissue infection. Urgent debridement was the only treatment option, but the patient was unfit for surgery. The patient's family had an Advance Health Care Directive stipulating no care if such an eventuality occurred. It was not feasible to send the patient back to the nursing home

overnight, so the patient was admitted and died a few hours later.

It was therefore appropriate for the surgeon to answer 'yes' to the question: 'Was terminal care planned for this patient prior to or on admission?'

There is no suggestion that the care of these patients has been anything other than appropriate. However, there is increasing interest in End of Life Care and it is important that ANZASM correctly records those who were actively managed—but without surgery—as opposed to those who had no active treatment.



Professor Guy Maddern,
Chair, Australian and New
Zealand Audit of Surgical
Mortality.

Prostheses List Reform

Prostheses List reform includes financial support for Australia's private hospitals.

This ensures doctors can continue to provide patients with affordable and high-quality care.

Find out more, visit:

www.privatehealthcareaustralia.org.au



A passion for regional medicine

Surgical News talks to mother and daughter team, Dr Roxanne Wu and Dr Helen Buschel

Dr Roxanne Wu and her daughter Dr Helen Buschel are two dedicated doctors who love living and working in their regional communities.

Roxanne Wu is an experienced and highly regarded vascular surgeon, and the Head of Surgery at Cairns Hospital. Helen is just about to start her six-year general paediatric surgical training at Townsville Hospital, where she has already worked for the last four years after growing up and completing medical school in Cairns.

"I'm very excited to be returning to Townsville", Helen said. "When I was first balloted to Townsville as an intern, I was very disappointed, and I planned to move as soon as I finished the first 12 months. But I absolutely loved it and chose to stay for four years." After Helen completes the first year of the surgical training program in Townsville, she will be sent all over Australia and Aotearoa New Zealand over the course of the program—something she is looking forward to.

Roxanne's 'love affair' with regional medicine started in the 1980s. She was training at the Prince Alfred Hospital in Sydney, and like all surgical Trainees at that time, was required to complete a six-month rotation in Papua New Guinea (PNG).

"I didn't want to go to PNG," recalls Roxanne, "and I usually got what I wanted, but not on that occasion. But I actually enjoyed it there. I had a fantastic time," she said. "It was in PNG that I discovered that I could do surgery and also have my own life."

Roxanne spoke about the joy of learning to dive during her hectic surgery schedule; she knew that she wanted to continue leading a life that enabled her to have that kind of balance. "Back in Sydney, they wanted me to become a liver transplant surgeon, but I knew that if I went down that path, I wouldn't have a life," she said.

Roxanne knew that she also wanted to have a family and was determined to pursue a career in surgery and become a mum. When the opportunity to return to PNG as a locum for six months presented itself, Roxanne jumped at the chance. She went on to join the surgical team in Cairns straight after PNG.

"This was a real example of opportunity knocks," said Roxanne, who decided early on in her career that it was best not to over-plan or control her life, but rather to recognise and take opportunities as they arose. "You never know where these opportunities are going to lead," she said. "I've never regretted making the move for a moment."

Roxanne and Helen both value the unique opportunities that working in regional areas provides. "I love living and working in a regional area," explained Helen.

"Being an intern in a regional hospital was great. I had a lot of support there and felt like I was an essential part of the core team. I was able to spend time in theatre, working on emergency cases. I got involved in research and had a lot of responsibility," she said. "I also loved the sense of community. By the end of my first year in Townsville, I felt like I knew almost everyone at the hospital, and they'd become like family," she recalls.

For Roxanne, along with the diversity of medicine and surgery—that you can experience in a regional hospital—it's the opportunity to introduce new fields of thinking and practice to meet the unique needs of the community that holds great appeal. "I've been able to bring all the advances of vascular surgery to a community that would otherwise not have access to it," she explains.

"And that's the thing about regional medicine and regional surgery. You become a vital part of health delivery, not just another cog in the wheel. It's immensely satisfying to be able to have that kind of impact," she said.

Roxanne would like to see more young surgeons consider working in remote locations. "In a place like Cairns, we have medical situations related to the amazing local wildlife—crocodile attacks, moray eel attacks, and so on. And, being in the tropics, we also have unusual tropical diseases." She is proud to have been closely involved in the





development and growth of the Cairns hospital, from when it was considered an ‘outback’ regional outpost with no air conditioning in its surgical ward, to now being a major regional centre undertaking 13,000 surgical procedures a year, and having its own hybrid theatre for vascular surgery.

Now, as Director of Surgery, Roxanne can steer the surgical department to what she describes as “the next level”. “We can be a leading research centre for the kinds of surgical problems that are all around us. It’s a combination of the weather, the remoteness, the large Indigenous population, and where we are situated with our international airport, that gives us so many amazing opportunities to explore the potential of how surgery can be delivered,” she explains.

“I also see massive opportunities in places like central western New South Wales,” she says. “There are so many opportunities for young surgeons to be more forward-looking, to see themselves as leaders in their medical communities.”

Listening to her speak, it’s not hard to feel inspired and motivated by Roxanne, and to imagine the impact that her contagious, unwavering passion would have had on her daughter growing up. We asked Roxanne and Helen if they thought the pursuit of a medical career was genetic (nature), environmental (nurture), or if it was a coincidence that both mother and daughter now work in surgery. “That’s a really good question,” Helen said. “I’ve never thought of it like that.”

Helen’s grandfather—Roxanne’s father—was also a doctor but, according to Roxanne, he didn’t practice medicine

for very long. “He was, however, always interested in the science of medicine,” Roxanne explained. “From the perspective of Chinese culture, it was seen as a very acceptable thing for me to do medicine, but dad didn’t encourage me because he didn’t think it was suitable for girls at that time. In the 1960s and 70s it was just assumed that as a woman you would have children, and how could you possibly have children and fit in doing medicine?” Roxanne explained the thinking at the time. “But I was very strong willed, so my dad just let me do what I wanted to do,” Roxanne said.

According to Roxanne, Helen showed no sign of being particularly interested in science or medicine when she was younger, but always enjoyed small children, was very social, and involved herself in many extra-curricular activities. “I’ve always said to my children, you should do what you want to do,” Roxanne said. “But, having said that, Helen had the lived experience of being a child of a surgeon, so she was exposed to my career all the time, from a very young age.”

Helen recalls the experience of sleeping at the hospital on a few occasions when her mum had to work unexpectedly. “Dad was away a lot for work, so it was often just mum, my brother and me. I didn’t know any different. “We had artery clips around the house as a kid that I thought were just useless scissors, and mum talked about work all the time. But growing up, the most amazing thing about my mum is that although she’s extremely passionate about surgery and she’s a highly regarded surgeon, she came to almost every extra-curricular activity I did. She ran

our swimming club, she came to state swimming championships, she came to my piano eisteddfods, debating meetings, everything!”

Helen didn’t know what she wanted to do for a career when she finished high school, but she knew she wanted to work with people, and specifically children. She considered teaching, physiotherapy, journalism and medicine. “Mum didn’t influence my decision directly, but by her example, I saw that it was absolutely possible to be an exceptional surgeon and an incredible mother who is always there for everything,” Helen said.

“It’s really nice to have someone to talk to about surgery who is also my mum. She has taught me an enormous amount and has always been very supportive.”

Helen and Roxanne speak with each other almost every day. “It’s really nice to have someone to talk to about surgery who is also my mum. She has taught me an enormous amount and has always been very supportive,” said Helen. “And there’s also a degree of expectation that I put on myself,” she went on to say, “because I don’t want to let her down. It’s pressure, but in the best way possible,” Helen explained.

“I’m very impressed with her,” said Roxanne, “and with my son, too.”

Data – the key to meeting road safety targets

Early last year, the Australian government consulted on a new National Road Safety Strategy aimed at reducing the approximately 1200 deaths and 40,000 serious injuries on the nation's roads each year.

The strategy for 2021-30 set targets to reduce these numbers over the next 10 years, setting us on the path to achieve Vision Zero (zero deaths and serious injuries) by 2050.

The strategy includes 2030 targets of:

- a 50 per cent reduction in fatalities—down to fewer than 571 (an approximate reduction in rate per capita of 55 per cent)
- an interim 30 per cent reduction in serious injuries—down to fewer than 29,000 (an approximate reduction in rate per capita of 38 per cent).

If 2021 is anything to go by, we are not going to meet those targets. We won't even come close.

As I write this in mid-December 2021, Australia has already surpassed the number of road deaths that we recorded in 2020. While comparisons are difficult given the impacts of COVID-19 and restricted movements, shockingly we are on target for a higher rate of fatalities in 2021 than we were in 2018. There was no COVID-19

then and movement was virtually unencumbered. We must do better.

In 2021, the College responded to a draft of the National Road Safety Strategy, as well as separate road safety strategies in South Australia and Tasmania. In October 2021, I also wrote to both the Health Minister, the Hon. Greg Hunt and the Deputy Prime Minister and Assistant Minister for Road Safety & Freight Transport, the Hon Barnaby Joyce.

In these letters, I provided the RACS Trauma Committee's endorsement for the World Health Organization (WHO) and United Nations (UN) *Global Plan Decade of Action for Road Safety 2021 – 2030*. Similar to the Australian government's plan, the WHO and the UN Global Plan sets a target to reduce road traffic deaths and injuries by at least 50 per cent over the next decade.

While the WHO and the UN share a similar ambition to Australia's national plan, where it differs is in its much greater prioritisation of data collections linkages. Unfortunately, in 2021, Australia did not have the quality of nationally aggregated road crash injury hospitalisation data delivered rapidly enough to effectively oversight road safety, and it does not look like this will improve any time soon.

Data collections and linkages play an integral role in policy development. We have seen firsthand how the collection and linkage of data during COVID-19 has assisted national governments to monitor and control the pandemic as best they could, and to maintain community awareness.

The uptake of this information within the community demonstrates that the public has an appetite for, and an understanding of, information that affects the health of the nation. A similar approach for precise, consistent, and timely data collection and reporting of road trauma, including the numbers of road trauma patients in ICU beds, could easily be done.

This would raise awareness of the costs of road trauma to families, the community, and the nation as a whole. If we are to come anywhere near meeting our targets, this is critical, and it is something the RACS Trauma Committee will continue to advocate for in the lead up to the federal election and beyond.



Dr John Crozier
RACS Trauma Chair



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

Over the last two months, some of the advocacy work the College has undertaken includes:

TGA Mandatory Reporting Consultation

Earlier in December RACS lodged a response to a Therapeutic Goods Administration (TGA) discussion paper on mandatory reporting of medical device related adverse events by healthcare facilities. Currently only device manufacturers and sponsors are required to report such events.

RACS' view was that healthcare facilities should be required to report certain pre-determined serious device-related adverse events. This is because in many cases, only the users of medical devices will be aware of adverse events, particularly non-fatal adverse events.

However, RACS was clear that the threshold for reporting and the administrative activities needed to make a report, should not make reporting burdensome upon practice. RACS also argued that funding or other support should be provided to ensure facilities have the capacity to fulfil reporting requirements and that practitioners, in the absence of gross negligence should be indemnified to encourage disclosure of all relevant adverse medical device events. RACS' full submission can be provided upon request.

South Australian 2022 state election

As South Australia prepares for its state election, the RACS state committee has sent an

election statement to all major political parties, requesting that they detail their policy positions on six key issues relating to the delivery of surgical services. The six key issues identified are:

- emergency surgery and ramping
- clinician engagement
- infrastructure and technology
- ongoing COVID-19 response
- South Australian Audit of Surgical Mortality
- use of the title Surgeon.

Once responses are received the committee will distribute the responses to the local membership.

Domestic Violence Symposium 10 November 2022

RACS Trauma Week is an annual event incorporating meetings of the Trauma Committees and a symposium on aspects of trauma management and/or prevention.

It was announced that the 2022 symposium will be held in Sydney and the topic for the symposium will be Domestic Violence. The symposium will be convened by Dr Payal Mukherjee FRACS and Dr Ken Harrison FANZCA. Planning is underway for a comprehensive program to address the issue from a surgeon's perspective.

Potential reintroduction of warning signs in NSW for speed cameras

In December RACS highlighted in the media that the possible reintroduction in New South Wales (NSW) of warning signs positioned close to mobile speed safety cameras heralds a backward step in road safety.

Mobile safety cameras—which detect speeding drivers, drivers holding mobile

phones, or failing to wear seat belts—are essential for the protection and safety of all road users but they should not be sign-posted.

Dr John Crozier, Chair of the National Trauma Committee of the Royal Australasian College of Surgeons, warned that failing to demonstrate leadership in this area would result in more deaths on NSW roads.

He said, "Populist appeal and politics are threatening a proven road safety measure, which New South Wales had only recently introduced, following years of leadership by most other jurisdictions in Australia.

"Acting on fake news, claiming the primacy of the measure as a revenue raiser, will result in preventable death and serious injuries on our roads if the warning signs are reintroduced.

"As surgeons, we see the consequences of injuries is significantly worsened by even minor speeding offences. Removing warning signs encourages drivers to comply with road safety rules, reducing the occurrence of financial penalties, or loss of demerit points.

"We are appalled by the prospect of losing the benefit of this reasonable safety measure," he said.

Want to know more about RACS Advocacy?

Every four to six weeks 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



Climate change and Australia's healthcare system

RACS has united with other medical Colleges to highlight the risks posed to human health due to climate change and warned that hospitals will struggle to cope with the increasing burden of climate change unless urgent action is taken.

The calls from RACS and other Colleges comes after the release of a new report titled *Climate Change and Australia's Healthcare Systems*.

The comprehensive report was commissioned by the Royal Australasian College of Physicians (RACP) and prepared by the Monash Sustainable Development Institute. It is designed to provide Australia's peak healthcare organisations with evidence-based recommendations for Australian policymakers, health systems, health professionals and the communities they serve.

Among the report's many dire warnings is a prediction that bushfires could contribute to the deaths of more than 1,000 people in the next 10 years and cost the healthcare system approximately \$69 million.

The report also contains a series of recommendations, including the establishment of a dedicated climate change health resilience fund to support research and innovation.

Emeritus Professor David Fletcher, Chair of RACS' Environmental Sustainability in Surgical Practice Working Party, welcomed the release of the report. He said the health sector must take responsibility in reducing their emissions as well as engaging in climate change advocacy.

"The healthcare community must take a leadership role in advocating for emissions reductions, and to critically examine our own activities with respect to their effects on human and environmental health. Surgeons are committed to reducing the footprint of our practice given it currently accounts for the majority of health's emissions.

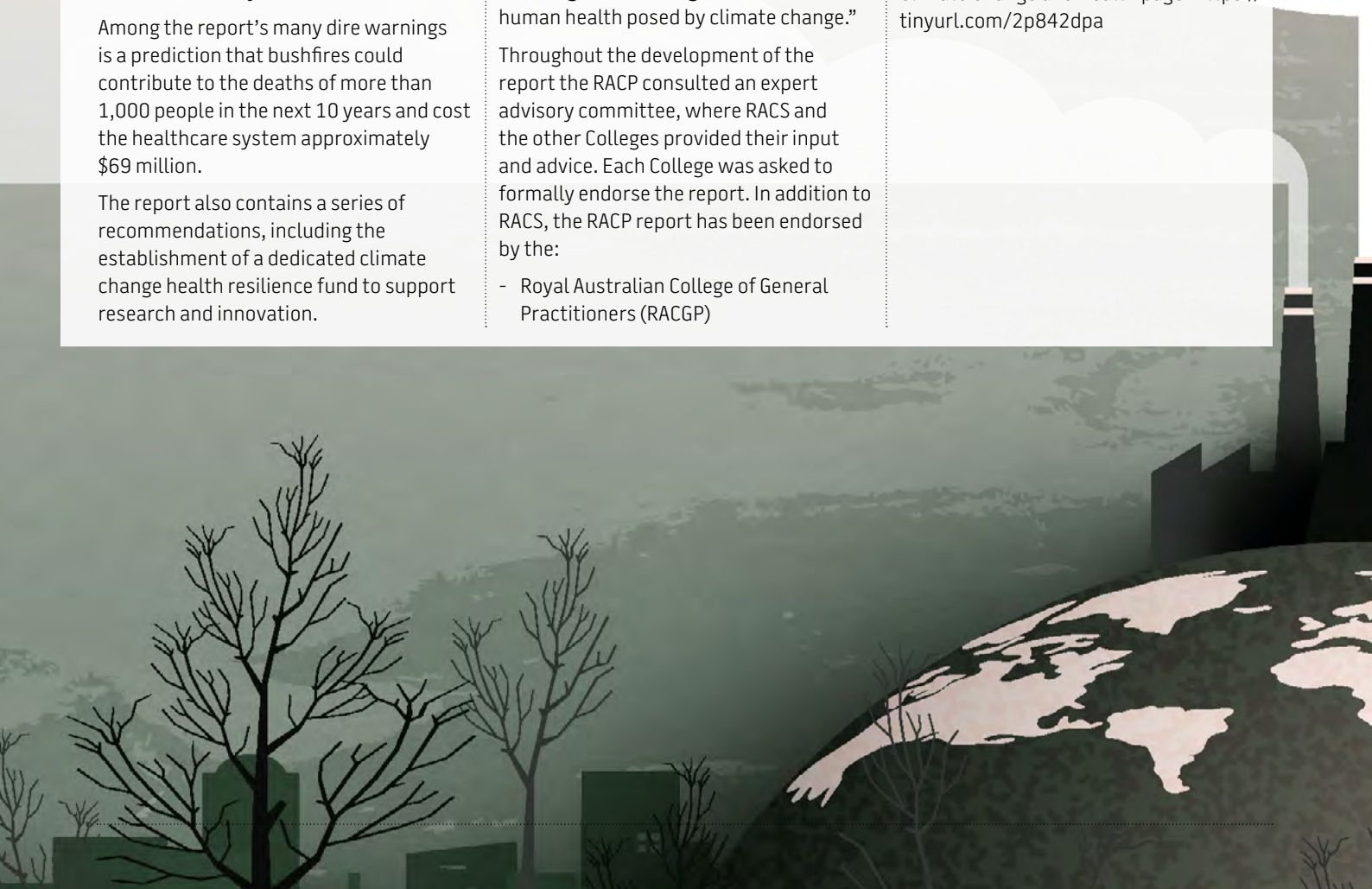
"We commend this report as laying the groundwork for how we can collectively work together to mitigate the dire risks on human health posed by climate change."

Throughout the development of the report the RACP consulted an expert advisory committee, where RACS and the other Colleges provided their input and advice. Each College was asked to formally endorse the report. In addition to RACS, the RACP report has been endorsed by the:

- Royal Australian College of General Practitioners (RACGP)

- Royal Australian and New Zealand College of Psychiatrists (RANZCP)
- Australian and New Zealand College of Anaesthetists (ANZCA)
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
- Australasian College for Emergency Medicine (ACEM)
- College of Intensive Care Medicine (CICM)
- Royal Australian and New Zealand College of Ophthalmologists (RANZCO)
- Australasian College of Sports and Exercise Physicians (ACSEP)

The full report is available on the RACP Climate Change and Health page: <https://tinyurl.com/2p842dpa>



College publications making transition to digital

Surgical News will follow the ANZ Journal of Surgery move to digital

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

As an organisation RACS supported these calls, and in recent years the environmental sustainability of surgical practice has become an increasing advocacy priority for RACS. In 2020, we developed an Environmental Sustainability in Surgical Practice Working Party (ESSPPW).

Before this the College published a position paper on the *Environmental Impacts of Surgical Practice*. The position paper states:

RACS recommends surgeons and hospitals consider the principles of effective waste management to take suitable steps to reduce the impact of surgery on the environment.

One suggested approach is to implement initiatives underpinned by the five Rs: Reduce, Reuse, Recycle, Rethink, Research.

The College has previously mailed out more than 8000 copies of *Surgical News* on a bi-monthly basis. Each copy is placed in a plastic sleeve and mailed out across Australia and Aotearoa New Zealand. How many of these are discarded to landfill without being opened is uncertain.

Plastic, which gets from landfill to oceans has catastrophic impact.

The ESSPPW, therefore believes that transitioning *Surgical News* into a predominantly digital format provides a practical example of how RACS is taking tangible steps to implement the actions promoted in our position paper.

Given that healthcare in Australia contributes seven per cent to pollution and surgical practice a major part of that, the ESSPPW expects that small actions such as this one, will be just the beginning of setting longer term actions and goals.

Everyone's reading habits are different, and there may be some RACS members who prefer a physical copy of the magazine. The College has provided an option to continue mailing out physical copies to those who request it. However, if the recent transition of the *ANZ Journal of Surgery* is any indication, we do not anticipate the number of these requests to be significant.

There is debate as to whether a purely digital magazine will reduce emissions—given that digital magazines produce CO₂ from their electricity use and storage. This difference is difficult to measure and even if it turned out to be of only small benefit, other considerations in going digital are the major reduction in waste decomposing in landfill and the reduction in volume of emissions from transporting

the magazines. Given that *Surgical News* is already published and stored online for nearly a decade, extending the publication to be exclusively digital can only result in a reduction in emissions.

Furthermore, this argument over the use of electricity underlines the importance of advocating for the increased use of renewable energy wherever possible. We would recommend to everyone an excellent article from the July–August 2021 issue of *Surgical News* written by Melbourne anaesthetist, Dr Forbes McGain. In this article Dr McGain outlines the significant reduction in carbon emissions, which can be achieved simply by generating our energy from a higher concentration of renewable sources.

We would like to thank those who supported the proposed digital transition of *Surgical News*. We look forward to providing further updates on the work of the ESSPPW in the future issues of *Surgical News* and would encourage anyone who would like to know more or become involved in the working party to contact the RACS Policy and Advocacy team.

Emeritus Professor David Fletcher AM FRACS
RACS.Advocacy@surgeons.org

On behalf of the RACS Environmental Sustainability in Surgical Practice Working Party



Astley Cooper's *Illustrations of the Diseases of the Breast*

1768-1841. Baronet FRS



Astley Cooper was the son of a country clergyman; his father was Rector at Brooke in Norfolk. Born on 23 August 1768, Astley was the fourth son and sixth child, to be followed by one more son and three more daughters.

His mother, a descendant of Sir Isaac Newton, was a talented and charming woman: his paternal grandfather was a surgeon at Norwich and his uncle, William Cooper, Senior Surgeon to Guy's Hospital.

Astley was no scholar and in fact did not go away to school, receiving lessons at home from his parents and the village schoolmaster. His father said of him: 'He is a sad rogue, but in spite of his roguery, I have no doubt he will yet be a shining character.'

In his early teens Astley was present when a young friend fell, as a wagon was passing, and as he lay prone, a wagon wheel compressed his popliteal fossa resulting in exsanguination and death.

Astley Cooper later recalled: 'This seems to have made a strong impression upon my mind, as it was the first death I had witnessed, and I was directly convinced how valuable a member of society a well-informed surgeon must be, and how great a curse an ignorant surgeon was.'

He left home to begin work at Guy's Hospital in August 1784, when he was just 16 years of age and began to attend John Hunter's lectures early in his

apprenticeship. He went year by year to Hunter's course as the lectures were not repetitions, being constantly added to and modified, in parallel with Hunter's studies and experiments.

Cooper once asked Hunter, had he not the year before, stated an opinion on some point, directly opposite to the one, he had just put forward. John Hunter replied: "Very likely I did; I hope I grow wiser every year!"

Cooper's life was essentially modelled on that of John Hunter. He wrote: 'Mr Hunter was a man who thought for himself, but he was more; he was the most industrious man that ever lived. He worked from six in the morning till 12 o'clock at night and sometimes later.'

Cooper was elected a Fellow of the Royal Society in 1802, for his papers suggesting that certain forms of deafness might be relieved by myringotomy.

Cooper successfully removed a scalp cyst for George IV in 1821 and was made a Baronet. Although he married twice, he had no son of his own and requested that the baronetcy be entailed upon his nephew, Astley.

The first number of the *Lancet* was published on 5 October 1823, at the beginning of the academic year; it

contained an account of Sir Astley Cooper's opening lecture:

'At half-past seven the theatre was crowded in every part by upwards of four hundred students of the most respectable description; in fact, we never before witnessed so genteel a surgical class; the sight was most pleasing, for they all appeared gentlemen of cultivated manners and good education.'

Astley Cooper was not a prolific writer, neither did he hurry to publish his work, but his publications are impressive in their number and size, and most of all, in their quality. His first papers appeared in 1798 and his last book, the *'Anatomy of the Breast'*, was published in 1840, his publications extending over a period of 42 years.

He followed the principle of neither teaching nor writing of things that he had not observed or verified himself by practice. This condition demanded much labour in dissection and in animal experiment, in addition to onerous clinical activities.

In the Bradshaw Lecture for 1893, '*Sir Astley Cooper and His Surgical Work*', Sir William MacCormac noted that the chief repositories for morbid anatomy were private collections, such as those of William and John Hunter, and that of



ILLUSTRATIONS
OF THE
DISEASES OF THE BREAST;

BY
SIR ASTLEY COOPER, BART. F.R.S.

Serjeant Surgeon to His Majesty;
Consulting Surgeon of Guy's Hospital; Lecturer on Anatomy and Surgery, &c. &c. &c.

IN TWO PARTS.—PART I.

LONDON:

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1829.

Sir Astley Cooper. He considered, that of all specimens in the Royal College of Surgeons (RCS) Museum in London, 'none displayed so perfectly as Sir Astley Cooper's, the art of showing to the naked eye, morbid changes of structure in the most demonstrative manner; they remain not only as illustrations of his written works, but as admirable examples of skill in injections and in well-planned sections.'

Astley Cooper was elected President of the Royal College of Surgeons in 1827 and again in 1836, when he altered the candidates' examination. The candidates were no longer to be examined by the whole court, but by three members only. Any doubtful pass, to be given a written examination; this being a first.

Cooper was thus described in his prime: 'a stately presence, tall and well-proportioned in figure, broad of chest and broad of brow, with bright complexion, clear candid eyes, and a refined and gentle but firmly cut mouth.'

In 1828 Cooper was appointed Sergeant-Surgeon to George IV, and on the death of the King, was appointed Sergeant-Surgeon to William IV, and subsequently to the young Queen Victoria. The life of no surgeon had been more fulfilled. He was successful, beyond all rivals, in the practice of his profession, but his health had begun to fail.

He resigned from the staff of Guy's Hospital in 1825 and retired temporarily from practice in 1827. He moved to the country, however, could not settle into life as a country gentleman, and as his health improved, he returned to active

professional work in 1828. He published in succession over the following years his works on '*Illustrations of Diseases of the Breast Part I*' (1829), the '*Diseases of the Testis*' (1830), the '*Anatomy of the Thymus Gland*' (1832); his last completed work being the '*Anatomy of the Breast*', published in 1840, not long before his death.

In Sir Benjamin Brodie's words: 'His published works will remain as long as surgery is cultivated, filled, as they are, with important facts, and containing the clearest rules of diagnosis.'

Cooper had intended that '*Illustrations of the Diseases of the Breast*', be published in two parts: Part 1 published in 1829, was devoted to non-malignant diseases of the breast: the text in ten chapters and the magnificent chromolithographic illustrations reproduced on nine plates were all based on dissections contained in his personal museum. The production was 'state of the art' for the time.

In the preface he writes, 'In this part, I have confined myself to the description of the diseases which are not malignant; great advantages may be derived from the examination of morbid structures, and from a comparison of their external



Fig. 2 shews the anterior view of a breast similarly affected: at *a*, in its centre, the nipple is seen, and near the areola at *b*, two large Hydatids, marked *c*; also, near the nipple, a cluster of small Hydatids; and in other parts of the bosom, at *d d d*, several minute Hydatids' cells.

character and symptoms, with their internal appearances.'

'The difference between the experienced and scientific, and the ignorant and unobserving member of the profession, is manifested, in the former readily discovering the distinctive character of disease as soon as it is presented to his attention; while the other guesses at its nature, and if right, is right only by accident.' Sadly, Part II, on malignant disease of the breast, was never published: Astley Cooper's death supervened.

On 12 February 1841, aged 72 years, he died peacefully. His last words to family and friends, 'Good-bye, God bless you!'. His fame was vast: his practice extended from the lowest to the highest in the land, he earned in 1822, the equivalent today, of £3 million and *The Times* called him the richest professional of any kind that had ever lived.



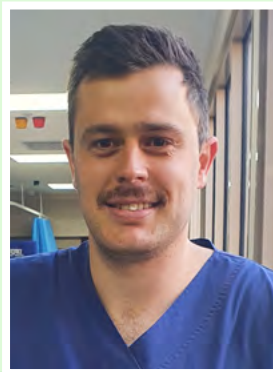
Mr Peter F Burke
FRCS FRACS DHMSA

Images (l-r): Astley Cooper. London. Published May 1825 by Geo. Lawford, Saville Place; Guy's Hospital and statue of Thomas Guy Drawn by Thos. Shepherd c1825; Frontispiece of Cooper's book; Illustration of benign mammary dysplasia.

Mt Gambier's rural surgical team lead by example for change



Associate Professor Matthias Wichmann



Dr Matt Watson

Advisory Group (which provides advice to the Steering Committee) and are based in Mt Gambier, South Australia. The Surgical News team talked to them about their rural experiences, how they've been successful, and how this has informed their recommendations for RACS rural health plans.

Associate Professor Wichmann, a general surgeon with a long list of special interests including colorectal and emergency surgery, came to Australia from Germany 15 years ago. As a Specialist International Medical Graduate (SIMG), he was required to settle in a rural area of need, so he had little choice in the dramatic leap from a busy Munich university hospital to Mt Gambier, where his small hospital cares for a town of 25,000 people, with no line up of specialists on hand when the going gets tough. He says he learned to make phone calls for advice, and relied on the internet, books and his training to solve problems because there was no one else.

Despite its challenges, the rural life quickly grew on him. "I'd never do anything else now," he admits. His family have a spacious home and he can be present for his three kids. The surgery is always varied and interesting. He thrives on the continuity of care and a strong sense that he's contributing meaningfully to the community. "I see the patient before, during and after surgery. It's much more of a doctor's life than a specialist's life, while still being able to do reasonably major surgery within the areas of my special interest."

Dr Watson is a SET Trainee training to be a general surgeon. He says his own rural upbringing on a sheep station, along with an inspiring rural surgical rotation as a medical student based in Whyalla, SA, have been the main drivers for his interest in becoming a rural surgeon.

He received plenty of exposure to city medicine while training at the University of Adelaide, then explored rural medicine with clinical rotations in Mt Gambier, Whyalla, Port Lincoln, Ceduna and Port Augusta in SA, as well as a placement in Whitehorse, Yukon, Canada, as a medical student and then junior doctor.

For Dr Watson, the broad scope of practice in rural general surgery, drawing upon skills from a variety of specialties, makes the career path very appealing, as

One-third of Australians live in rural areas and don't get the same access to healthcare as those in the cities. Australia is spread across wide rural, regional and remote areas, as well as coastal cities, and we are struggling to attract enough surgeons to rural healthcare. Change must happen at a structural level to train, recruit and retain enough surgeons in rural areas so that all Australians can access high quality surgical services close to home.

In response to this urgent need for change, the Royal Australasian College of Surgeons (RACS) established the Rural Health Equity Steering Committee to deliver the Rural Health Equity Strategy to remedy surgical challenges in remote and regional areas of Australia and Aotearoa New Zealand.

Associate Professor Matthias Wichmann, a general surgeon, and Dr Matt Watson, a SET Trainee, are both members of the Rural Health Equity

well as challenging. “The wide range of patients you care for means the specialty of rural general surgery is difficult to master and you must be committed to lifelong learning. This variety in work is what appeals to me.” The drawback, he says, is that it’s difficult to gain such broad knowledge and exposure in your training. Dr Watson has invested time in building wide networks across a number of specialties and subspecialties while working as a junior doctor, to grow his knowledge and peer contact list.

He likes the hands-on, intense nature of rural training. “As a registrar, you have a greater degree of clinical responsibility for your patients. Due to the smaller number of junior doctors working on a unit, you are taught to be more accountable for patient care at an earlier stage of training. There is less hierarchy in the unit and less competition for training opportunities.”

So what needs to change to bring health equity to all Australians? Associate Professor Wichmann says it’s about attitudes. “If registrars think they’re getting shafted when they’re ‘sent to the country’ for training, then there’s no way we’re going to change attitudes.” The solution, he says, is to make every registrar do at least one rural rotation, regardless of their future professional destination. “If registrars have five years of training, and if rural areas represent one-third of Australians, then at least a quarter of surgical training should be

done in the country. Then attitudes will change because it will be an accepted part of training.”

What are other likely barriers to surgeons choosing rural? Associate Professor Wichmann thinks some registrars, although curious about rural surgical life, are too scared to try it out of fear they’ll find themselves alone without support and feel trapped in a small, under-staffed hospital.

He says the College and General Surgeons Australia (GSA) should mandate rural surgical teams, rather than solo surgeons, who can support and learn from each other. “If a hospital only has one surgeon, it’s not sustainable. There’s more pressure, a risk of burnout, and bias in decision making because you don’t get immediate feedback or a second opinion.”

He also says that strong networks with larger city hospitals are vital. His hospital in Mt Gambier has a ‘hub and spoke’ system set up with The Queen Elizabeth Hospital (TQEH) in Adelaide. They meet via video link every Saturday to discuss patients, have regular audits, and have a locum system in place. “For us, this relationship with TQEH is an essential part of our routine patient care.” He thinks this kind of hub and spoke network should link all rural units with metropolitan hospitals, helping rural surgical teams feel supported and better connected with peers, while sharing pivotal knowledge.

Dr Watson and Associate Professor Wichmann agree that ongoing support and regular upskilling opportunities are crucial to attracting and retaining versatile, highly-skilled surgeons in rural areas.

Associate Professor Wichmann’s advice for aspiring rural surgeons is: “If there’s an established unit you want to join in future, look at what they do and what they need. If you can identify an area of interest early, talk to the hospital and make sure you are on their horizon.”

He also emphasises the importance of networks for good rural surgical practice. “During your training, develop a wide network of friends in different subspecialties who you can rely on when you’re working in the country. It may help you seek timely advice or make it easier to organise a patient transfer, for example.”

Dr Watson feels very grateful to the surgical team in Mt Gambier for support during his training and hopes to return after graduation to join them as a consultant general surgeon.

“To aspiring rural surgeons, I say take the daring first step,” says Associate Professor Wichmann. “Rural surgery is more a service to the wider community than to a specific disease process that you operate on. It’s a very fulfilling life.”

APPLICATION INVITATION

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RACS accredited PFET program

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- You MUST be a citizen or permanent resident of Australia and New Zealand.
- You MUST have FRACS or successfully completed the FRACS exam in May 2022.

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Enquiries

Renee Buckley, Executive Officer ANZHPBA,
24 King William Street, Kent Town SA 5067
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Interviews 18/6/2022 if invited

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New Perioperative Mortality Committee for VASM

After many years of discussions and numerous meetings with lawyers, members of Safer Care Victoria (SCV) and representatives of various consultative councils, the *Commonwealth Health Insurance Act (1973)* was amended in June 2021. It now includes the Victorian Perioperative Consultative Council (VPCC) in the Qualified Privilege (QP) granted to the Victorian Audit of Surgical Mortality (VASM).

The genesis of this change dates to the 2016 report *Targeting Zero*, produced in response to the cluster of perinatal deaths that occurred at Djeriwarrrh Health Services in Victoria. Among its many findings, the report detailed duplicate reporting between the surgical and anaesthetic consultative councils and VASM, resulting in siloed work with administrative and legislative barriers, and little capacity for specific case feedback to hospitals on mortality and morbidity.

VASM is recognised as an effective way to improve quality of care by providing formal and confidential feedback to individual clinicians, and reporting deidentified cases in case note booklets and seminars. However, where a surgical or anaesthetic death involves various multidisciplinary inputs within a hospital (e.g. gastroenterology, radiology, cardiology) there is a risk that important lessons may be missed. Likewise, events occurring post-procedurally, as opposed to post-operatively, are not systematically captured.

The QP change will address a limitation of the current arrangement, which has no mechanism to ensure the hospital itself reviews surgical deaths, thus the 'audit loop' is not closed. The VPCC will work with relevant hospitals to support them in undertaking a more significant review and providing a report to the VPCC. The reports will allow the VPCC to identify recurring issues and trends in morbidity and mortality, and rapidly react to developing

problems. Reports issued by the VPCC will not identify the hospital, the patient, or the surgeon.

A new Perioperative Mortality Committee of VASM will soon be operational, with membership including surgeons and anaesthetists from VASM and VPCC, non-surgical specialists, consumer representatives and support staff. The committee will review cases referred from VASM comprising:

- multidisciplinary involvement
- transfers
- serious clinical management issues (VASM-defined area of concern/adverse event)
- cases not returned by a surgeon within six months.

The committee will have access to the VASM Surgical Case form and any peer review assessments. Under the QP amendments it will be safeguarded from civil liability (freedom of information requests, subpoenas, *Privacy Act* proceedings etc.), with any identifying information protected from disclosure. If a formal review is deemed to be necessary, the only information released to VPCC will be the name of the health service and the patient record number. If the case has already been the subject of a root cause analysis in the health service (e.g. as a result of it being a sentinel event), then VPCC will request access only to that report.

The new committee has the following objectives:

- Surgeons and identifying information produced as part of the VASM process will still be protected, with no discernible change in the VASM process for users.
- Assessments will be performed in a timely fashion, with fewer incomplete cases. This will eliminate duplicate reporting from health services to SCV and VASM and allow enhanced

opportunities to address system issues affecting the safety and quality of healthcare services in Victoria.

- There will be greater—yet protected—information-sharing, allowing more opportunities to improve perioperative care and identify issues of concern.
- There will be increased educational and learning opportunities for surgeons, anaesthetists and all those involved in perioperative care by connecting issues, red flags, and outcomes to enhance the value of VASM reviews.
- VPCC will be promoting a greater need for consistency of morbidity and mortality processes and participation within health services. This will encourage health services to increase perioperative mortality and morbidity reviews on patients (as per RACS guidelines), with the opportunity to have the findings peer-reviewed by the VPCC and its sub-committees.

The proposed improvements aim to enable a more effective and frequent sharing of information between VASM and VPCC and the hospital sector. The goal is to improve perioperative review and overall patient outcomes.

Hopefully, this initiative will also pave the way for the Australian and New Zealand Audit of Surgical Mortality to implement analogous measures across its national network of region-based audits.

Associate Professor Philip McCahy
Clinical Director, VASM

Cosmetic surgery review underway

Dr Dan Kennedy speaks about patient safety issues

In January the Australian Health Practitioner Regulation Agency and the Medical Board of Australia began a review of patient safety issues in the cosmetic industry.

The review comes after the Australian media highlighted the lack of regulation in the cosmetic surgery industry, causing serious injuries to patients.

Australian Society of Plastic Surgeons (ASPS) President Dan Kennedy has welcomed the review and would like to see it lead to the introduction of new safeguards to protect patients.

“We have been pushing for a review for years and we trust that the government and their experts will come to the correct conclusion and make it very clear to the public who is a surgeon and who is not a surgeon,” Dr Kennedy says.

“Public safety has to be the absolute principle focus when it comes to cosmetic surgery.”

The review will explore how to strengthen risk-based regulation of practitioners and aims to ensure the regulatory approach keeps pace with rapid changes in the industry.

In recent years, there has been a proliferation of inadequately trained practitioners offering cosmetic procedures. At the same time, demand for cosmetic surgery has increased due to various factors, from the influence of social media to the use of Zoom during the COVID-19 pandemic.

An article in the *Australian Financial Review* in August 2020 claimed that

demand for beauty treatments including face lifts, breast enhancements, wrinkle relaxers and dermal fillers increased by more than 50 per cent during the pandemic.

Current regulations fail to protect these patients and as the law in Australia stands, practitioners with little or no surgical training can call themselves ‘cosmetic surgeons’ in their marketing materials.

In October 2021, RACS and specialty societies involved in cosmetic surgery released a media statement calling for restrictions on the title ‘cosmetic surgeon’.

The statement read: ‘A relatively minor but potentially effective reform would be one which prevented medical practitioners not registered in a specialty with a significant surgical scope, and who have not been trained in an AMC accredited surgical training program from representing themselves as ‘cosmetic surgeons’ and advertising to the general public as such.’

The lack of oversight of the industry has meant that sub-optimal premises are used for surgical procedures, which further risks the health of patients.

Dr Kennedy says many patients have no idea of the lack of regulation in the cosmetic surgery industry and are seduced by the practitioner’s website and membership of a group of cosmetic surgeons.

“Patients say they believed their doctor had been a bona fide surgeon and they’re surprised when they hear they weren’t,” he says.

“It’s the practitioners’ fault that they represent themselves as something they are not, and they don’t appreciate the



danger of what they are doing or realise the trouble they can get their patients into.”

The situation is vastly different for the more than 500 members of the ASPS. Each member is required to hold a specialist qualification from RACS, have undertaken a minimum of 12 years of medical and surgical education, including at least five years of specialist postgraduate training, and be a RACS Fellow.

As part of this process, they have undergone extensive training, testing and supervision to ensure they have the skills to operate, properly assess the risks of surgery and manage complex recovery processes.

Crucially, they are also trained in the ethics around consultations, procedures, and patient management, including determining whether surgery is a safe and ethical option for individuals.

Dr Kennedy hopes the review results in greater protections for patients to ensure their cosmetic surgery does not result in ongoing health problems.

“I think it is incredibly important that cosmetic surgeons are fully trained to be able to provide cosmetic surgery services. It has to be regarded as any other surgery as it carries the same risks.”

The review is due to be completed in mid-2022.

Image: Dr Dan Kennedy, ASPS President

Fellowship Services – supporting RACS Younger Fellows

More than 1500 Younger Fellows are supported by the Younger Fellows Committee, with representatives from Australia and Aotearoa New Zealand.

The annual mentoring program, matches Younger Fellows to an experienced surgeon within the College.

What are Fellowship Services?

One of the benefits of becoming a RACS Fellow is that it opens a wide range of opportunities to engage with peers and access specialised support and knowledge. The Fellowship Services department was created in 2005 to bring together various parts of RACS that support Fellows in engaging with the College, each other, and the wider surgical profession.

Fellowship Services assists RACS Fellows with the administrative aspects of Fellowship—from admission to retirement. It also maintains our valued library services, which add to the wealth of knowledge of our Fellows—be it for research or for practice.

The department also facilitates opportunities for Fellows to connect with their peers in their speciality or interest group, promotes standards and professionalism within those areas, and helps collaborate and share knowledge, all of which will shape the future of the surgical workforce. Fellowship Services also looks after the Indigenous Health Committee, which promotes and supports Aboriginal and Torres Strait Islander and Māori health equity and cultural safety.

RACS Younger Fellows

One of the largest speciality groups supported by Fellowship Services is the Younger Fellows section. Each newly admitted Fellow automatically becomes a member of the Younger Fellows section, remaining a 'Younger Fellow' of the

College for the next 10 years. More than 1,500 Younger Fellows are supported by the Younger Fellows Committee, with representatives from all regions of Australia and Aotearoa New Zealand. Specific services are available for Younger Fellows and they are encouraged to participate in the activities, governance and development of the College. The Younger Fellows are represented by the Younger Fellows Committee, whose members represent each state and region, and includes representation from interest groups such as academic surgery, the RACS Trainee's association (RACSTA), and the RACS Council.

Pecky De Silva, Chair of the Younger Fellows Committee, explains: "The Younger Fellows Committee represents the needs of the Younger Fellows of RACS and ensures that their specific early career concerns are kept front and centre by the College. We try and highlight to the Younger Fellows the opportunities to become involved in the College through committees, teaching, and attending courses".

The Younger Fellows section provides important opportunities for Younger Fellows to network, collaborate and share knowledge. One of these is an annual mentoring program, which matches Fellows to an experienced surgeon within the College. These mentoring pairs meet regularly—either over video conference or face-to-face—to discuss issues they may be facing in their surgical careers and to share wisdom. In 2021, the program matched 13 mentor-mentee pairs.

Dr Edwina Moore, a Breast and Endocrine Surgeon from Victoria says of the program: "I was fortunate to be matched with an excellent mentor in my same subspecialty and I have enjoyed getting to know them through email and phone conversations. The conversations have been fruitful," Edwina says. "It's great to have someone I can talk to informally about clinical conundrums, difficult

patients and practice management."

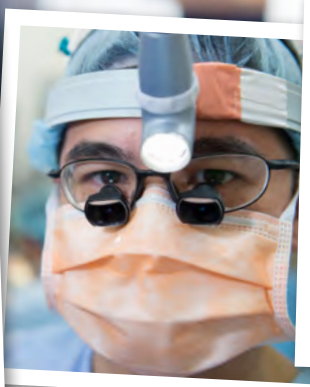
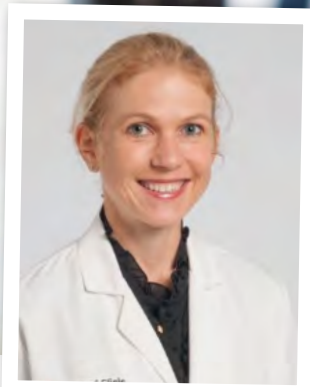
The Younger Fellows Committee also provides several travel grants sponsored by the Medtronic and Bongriono groups. These grants fund overseas travel for Fellows who wish to undertake speciality training, bringing back valuable knowledge to Australia and Aotearoa New Zealand. The grants assist the RACS Fellows in their careers and add to the rich expertise of our surgical workforce.

Dr Ryash Vather, who won a Younger Fellows travel grant in 2020, said: "I was fortunate to receive a Bongiorno Younger Fellows Travel Grant in 2021 to undertake an advanced Pelvic Exenteration fellowship at St Marks Hospital, London. The volume and complexity of the work here has made for a rich learning experience to date, and I look forward to bringing these newly acquired skills back to serve the population of South Australia."

Younger Fellows Forum

An annual three-day forum for Younger Fellows takes place during the weekend prior to the RACS Annual Scientific Congress in May. This forum provides a valuable and unique opportunity for Fellows to immerse themselves in issues facing Younger Fellows and the workforce in general. By the end of the forum, attendees from Australia and Aotearoa New Zealand formulate several recommendations that are taken to the RACS Council. Some examples are issues of sustainability or workforce burnout. The forum is an opportunity to shape the future of the surgical workforce.

Associate Professor Jason Chuen, a vascular surgeon based in Melbourne, recalls attending the Younger Fellows Forum in 2008, shortly after he was admitted to the College. He said it "opened my eyes to the fact that there is a whole section of our College that welcomes engagement with its members with open arms. Up until that point the



College had seemed like an abstract organisation that told me where to go, what hurdles I had to jump over, and how high to jump.” After attending the forum, he came to think of RACS as a “member-led organisation that is only as good as what we put back into it.”

Associate Professor Chuen encourages newly admitted Fellows to get involved in the College as a way of broadening horizons, learning new skills, and shaping the College for the generations to come. “It is very common to think that RACS is a stick-in-the-mud organisation bound up in tradition and ceremony,” he says. “But the truth is that all of those things are true only if we don’t do anything to change them.”

Younger Fellows and Digital Health

The Younger Fellows Committee maintains a wide engagement with other stakeholders and organisations in Australia and Aotearoa New Zealand. Through its partnership with the Federal Australian Digital Health Agency (ADHA), the committee ensures it is on the forefront of technological innovation in healthcare. The ADHA creates and

supports healthcare professionals in using products such as My Health Record (MHR) and Electronic Prescribing technologies.

In 2021, the ADHA and the Younger Fellows Committee created several ‘Digital Health Champion’ roles, where RACS Fellows use these technologies, including My Health Record. These champions provide feedback to the ADHA as well as sharing knowledge with other RACS Fellows. This ensures that the ADHA and the surgical profession continues to share knowledge about how Fellows use health technologies and innovations.

Dr Nipu Jayatilleke has signed up to be a RACS digital health champion. She says that using digital technologies in everyday work is second nature to many younger surgeons. “My generation is arguably one of the first generations of surgeons who grew up in a world where information technology was a natural part of our lives as children. For us, being digitally connected in your work is not an imposition—it’s a natural extension to how we conduct many aspects of our lives.”

Getting involved in the Younger Fellows section and in other speciality interest groups can enrich your career in surgery and add to your skillset in many ways.

Associate Professor Chuen says that participation in committees and interest groups make “a great introduction to the mechanics of working with other people, getting ideas and projects through an organisation, and taking on other points of view” after being consumed by surgical practise and study in the process of becoming a Fellow.

He says that getting involved in RACS is “an enjoyable and low-stress environment to learn about those systems that really change the organisation. Many of our Younger Fellows Committee members have gone on to hold very influential positions in RACS and initiate important programs, as well as serving as RACS Councillors.”

Images (l-r): Dr Edwina Moore, Dr Pecky De Silva, Dr Jason Chuen, Dr Ryash Vather.



Education activities

The RACS Professional Development team wish to acknowledge and thank the faculty members who generously volunteer their time, knowledge and experience.

Their dedication to furthering the education of fellow surgeons enables RACS to provide a variety of professional development courses to members.

Face-to-face courses

Course	Date	Region
Operating with Respect (Fellows)	Thursday, 3 March 2022	Melbourne, VIC
	Thursday, 17 March 2022	Perth, WA
	Saturday, 19 March 2022	Sydney, NSW
	Wednesday, 23 March 2022	Adelaide, SA
	Saturday, 2 April 2022	Melbourne, VIC
	Friday, 8 April 2022	Auckland, AoNZ
Conflict and You	Friday 18 March 2022	Adelaide SA
Foundation Skills for Surgical Educators	Thursday, 10 March 2022	Sydney, NSW
	Friday, 22 April 2022	Brisbane, QLD
Leading out of Drama	Friday, 11 March 2022	Melbourne, VIC
Non-Technical Skills for Surgeons	Friday, 25 March 2022	Auckland, AoNZ
Process Communication Model 1	Friday, 25 March 2022	Brisbane, QLD
Promoting Advanced Surgical Education	Friday, 1 April 2022	Melbourne, VIC

Online courses

Course	Date
Process Communication Model Key2Me	Monday 7 – Monday 14 March 2022
Clinical Decision Making	Thursday 10 March 2022
Difficult Conversations with Underperforming Trainees	Monday 14 February – Sunday 20 March 2022
Keeping Trainees on Track	Online module, accessible via Keeping Trainees on Track course page
Leading out of Drama	Wednesday, 16 February – Monday 28 February 2022
Educator Studio Session	Thursday, 24 February 2022
	Tuesday, 8 March 2022
	Wednesday, 27 April 2022

Our 2022 professional development program is constantly monitored and we adapt the delivery and schedule of our courses to continue supporting your learning.

For more information email PDactivities@surgeons.org or visit our website <http://www.surgeons.org/for-health-professionals/register-courses-events/professional-development/>



New professional development opportunities

COVID-19 presented the Professional Development team with new opportunities and value generation

It has been a challenging yet a fruitful couple of years for the Professional Development (PD) team, with reduced activity and participation across many PD courses. Yet, while COVID-19 presented us all with new conditions and challenges, it also presented us with new beginnings and opportunities for value generation.

In rising to the challenge, PD underwent a strategic realignment, assessing the traditional face-to-face delivery and content. We developed more online course offerings and enhanced our in-house capability around online content creation.

The potential benefits of offering online courses include:

- a more inclusive solution for rural health surgeons
- reduce time and travel burden for faculty
- improve participant numbers
- improving the participant experience

– aligned with contemporary practices for learning

- self-paced courses as there is zero impact from time-zone challenges between Aotearoa New Zealand through to Perth, Australia
- mitigate risk regarding the current and emergent COVID-19 conditions and how this impacts course numbers and logistical challenges for faculty and participants (being geographically dispersed across Australia).

The Professional Development team now welcomes a dedicated Instructional designer to the team, equipped with the capabilities to create any form of online content. Other members of the Professional Development team have also upskilled to enable the creation and updating of course content. Collectively, the team can now create large online courses while attending to smaller jobs simultaneously meeting the demands

of transitioning further into the online space.

From the shorter courses right the way through to more foundational offerings, the team has reviewed, redeveloped and piloted several online courses, including Keeping Trainees on Track, Foundation Skills for Surgical Educators, Difficult Conversations with Underperforming Trainees, and Clinical Decision Making.

This year will see further exploration into online material, piloting new course offerings as well as reviewing existing courses to assess their suitability for transition to online or blended deliveries.



East Timor Eye Program evaluation

The East Timor Eye Program (ETEP) is one of the RACS Global Health Programs and is supported by the RACS Timor-Leste Country Office. It is situated in Hospital Guido Valdares Nacional (HNGV)—the national hospital in Dili.

In 2021, this successful program was independently evaluated by the Nossal Institute for Global Health with the evaluation noting: 'Perhaps the most impressive element of the approach, and a major contribution to efficiency, has been the extent of collaboration and partnership among those organizations and individuals engaged in supporting the eye health sector, including local and international NGOs, WHO, and international eye care professionals. This has resulted in a consistent and integrated approach to the development of eye care.'

Since its establishment in 2000, the ETEP has supported the Government of Timor-Leste and the HNGV to manage and develop eye care services focusing

on cataracts, refractive error, and ocular trauma.

The ETEP delivers a wide-ranging set of in-country training activities in ophthalmology, optometry, eye care nursing and allied eye health specialties. It also facilitates capacity building of the national eye health workforce through education and clinical service delivery coupled with on-the-job mentoring and training.

The context for eye care and health services in Timor-Leste has been evolving over the period of support provided through the various iterations of the eye care projects. The key aspects of that evolving context have been the development of eye care and health system strategies by the Ministry of Health (MoH) and the increasing capacity of the ministry to deliver health services, including eye care services.

The current ETEP program for the period 2017 – 2023 sets out to achieve the

reducing of preventable blindness in Timor-Leste. The program aims to help Timor-Leste build a sustainable and effective eye health system for the East Timorese people. The current focus of the ETEP is to:

- work with the National Eye Centre and MoH to establish district clinics
- focus on workforce planning and capacity building of the eye health workforce through formal education and participation in clinical services. This includes scholarships for domestic postgraduate studies and overseas specialist training in ophthalmology
- support the provision of general and sub-specialty eye health equipment and instruments, improvements to patient record management systems, and referral pathways including training for district GPs.

In assessing the contribution of the ETEP, the evaluators have considered the longer trajectory of the program

in the context of the support and contribution of the previous programs. The ETEP has contributed to building the capacity to provide eye care at all three levels in Timor-Leste. This has been necessary, as the three levels of care are interdependent. The ETEP contribution has also evolved and developed, in line with the progressive development of Timor-Leste's health system.

The ETEP delivered a range of training activities in ophthalmology, optometry, eye care nursing and allied eye health specialties i.e. eye care technicians and a national ocularist. It also facilitated capacity building of the national eye health workforce through education and clinical service delivery coupled with on-the-job mentoring and training.

A key element of the ETEP success and sustainability was to bring together the various international donors and individuals with technical expertise, and the key international organisations—notably the WHO office—in a coordinated program, rather than a series of potentially competing programs. The various iterations of the ETEP provided a coordinating framework that encouraged and enabled this cooperation.

Limited-edition book *East Timor Eye Program, celebrating 20 years released*

The East Timor Eye Program (ETEP) was founded by Australian ophthalmologist, Professor Nitin Verma, a Companion of the Royal Australasian College of Surgeons and President of the Royal Australian and New Zealand College of Ophthalmologists (RANZCO).

Initially, the focus of the ETEP was to provide essential ophthalmic services in the post-independence era. Over the years, the scope of the program has expanded beyond service delivery and now focuses on training, capacity building and supporting the strengthening of health systems.

To recognise and celebrate 20 years of great work, a limited-edition book *East Timor Eye Program, celebrating 20 years* was created.

Full of firsthand stories of hardship and triumph, challenges, and successes it's a must-have for your library. You can buy the book and support the Global Health's work by logging into the website and visiting the RACS shop (<http://store.surgeons.org/customer/account/login/>)

If you would like more information about ETEP, or RACS Global Health initiatives please visit <https://www.surgeons.org/about-racs/global-health>

Since 2000, the ETEP has:

- supported the training of Timor-Leste's first three national ophthalmologists
- trained nine East Timorese doctors in country with a postgraduate Diploma in Ophthalmology
- trained eye specialist nurses, eye care workers, biomedical technicians, hospital administrators and community doctors in primary eye care
- equipped the Hospital Nacional Guido Valadares Department of Ophthalmology with a full range of sub-specialty ophthalmic equipment
- established the national Prosthetics Eye Lab and trained the first East Timorese ocularist
- provided ongoing mentoring support to East Timorese eye health workers across the health system
- played an integral advocacy role, which culminated in the launch of the National Eye Health Strategy 2020-2050 by the Timor-Leste Ministry of Health in September 2020.



Code red for humanity

Stop the talk and step up to the global crisis that is not COVID-19

We are in the grip of a global crisis and while our health system must be prepared for the onslaught of COVID-19, we can't forget the other crisis that's been described as 'code red for humanity'.

A 2019 report¹ found healthcare is responsible for nearly five per cent of the world's global net emissions—meaning if healthcare were a country, it would be the fifth-largest emitter on the planet. Irony isn't it, that an industry that exists to help people is causing significant harm?

The New Zealand government has issued a directive for all public hospitals to be carbon neutral by 2025. There's one entity that already is. Forté Hospital in Christchurch is Aotearoa New Zealand's first carbon zero hospital.

Now, a disclaimer here. I am a member of Forté Hospital's sustainability committee and am proud to be a small part of a big team dedicated to achieving carbon zero status. I also have sustainability in my genes.

From a very young age, I recall my family protesting for the 'Save Manapouri' campaign in homemade japara parkas. Both my parents have community service awards for their 'green' efforts, with dad awarded a knighthood. With that past inspiring me forward, it's time to issue an environmental challenge to hospitals and health organisations around Aotearoa New Zealand and the world. Do more and do it now.

It's not easy, especially as COVID-19 is derailing the focus on sustainability as increased infection control requires more disposables. So, we need to think smarter. Think harder. Be more innovative. Set clear goals and explicit targets. Question processes, re-look at systems and ask



if there's a better way for our people, our patients, and our planet. Often, the answer is yes.

Direct carbon emissions from hospitals come mainly from electricity use and waste. At Forté Hospital, better segregation of waste has resulted in a 47 per cent reduction in medical hazardous waste requiring emission-producing heat treatment (2016 - 2021) and a 1.6 tonne reduction in waste to landfill (2019 - 2020). All single use food packaging has been removed, medicine trays have been replaced with compostable alternatives, staff uniforms have been recycled and, by questioning what's really required for individual surgeries, 3300 fewer pairs of disposable knickers are going to landfill each year. Innovative lighting, heating and cooling systems have also seen electricity usage cut by 12 per cent (2019 - 2021) despite increased throughput.

Further emissions reduction initiatives are underway, including using reusable sterilisation crates and a trial of reusable drapes for patient surgeries.

And patients remain at the heart of it all. Improved patient outcomes and greater hospital efficiency are vital to meeting emissions goals.

It's a start, but others, including our public health system, need to follow suit because if, as an industry, we don't show true environmental leadership, our future and that of future generations is in the balance.

Maybe it's time to dig out that homemade japara parka again.

¹ Arup and Health Care Without Harm's Health Care's Climate Footprint, published September 2019.

Stephen Mark is a founding surgeon of Forté Hospital and is a member of the Hospital's sustainability committee.

Save the date

Resilience, Respect, Refinement -
A Positive Adaption to the COVID-19 Era



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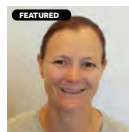
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Diversity and Inclusivity



Keynote Speakers



Jacqueline Allen
Auckland, NZ



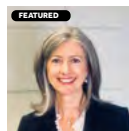
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San Diego, USA



Raj C. Dedhia
Pennsylvania, USA



Stefan K. Plontke
Halle, Germany



Nicola Spurrier
Chief Health Officer,
South Australia



Elina M. Toskala
Philadelphia, USA



Michelle Wyatt
London, UK

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online now
asm.asohns.org.au

Important Dates

Abstract submission: Open now

Abstract submission: Closes Monday 21 February 2022

Abstract notification to authors: Monday 21 March 2022

Early registration: Closes Sunday 24 April 2022

Standard registration: Valid Monday 25 April - Sunday 15 May 2022

Late registration: Valid Monday 16 May 2022 onwards

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RACS ASC 2022

Monday 2 May to Friday 6 May

Brisbane Convention & Exhibition Centre
Brisbane, Queensland, Australia

RACS ASC 2022 HIGHLIGHTS

As this is being written, we are in the middle of the Omicron COVID-19 surge. What could focus our attention on sustainability more than issues with supply chains of PPE and Rapid Antigen Testing? Nothing more could highlight the dispersed workplace than the current mandates for remote consultations. How have we adapted? How have we prepared for further challenges? What are our strategies for service delivery, research and education in view of mass migrations, including to regional areas due to COVID? Many of these changes to address evolution in workplace expectations, definitions of beneficial care, distance and imposts on health economics were already in play but the pandemic has brought heightened attention to change.

The Brisbane RACS Annual Scientific Congress (ASC) brings together the brightest and the best to engage you in these pressing issues. We have keynote lectures and plenary sessions addressing remote examination delivery, dispersed and home-based simulation training, rural service delivery, and service delivery from the extremes. Sustainability of inclusive diverse workplaces will be addressed in plenaries that discuss cultural competency, compassionate care and binational First Nations' concerns.

Some individual highlights will include: Dr Michael Wagels who will address the opportunities that bio-fabrication will bring, Dr Bridget Clancy who will deliver the ANZJS Lecture with her clear vision for the future of rural surgical workforce support, and Professor Stefan Hajkowitz from CSIRO who will share his captivating data-based predictions of mass population and future technological changes.

There will be many opportunities to discuss the latest advances that will continue to bring sustainability of the highest surgical care to all our communities. It will be a great chance to reconnect with your peers, and a peerless chance in these times, to hear international input with the ANZ counterpoint. For those attending in person, it will also be a spectacular social occasion, as Brisbane showcases its warmth, hospitality and academic life.

We look forward to welcoming you to Brisbane in May 2022.



Professor Chris Pyke FRACS
ASC Convener



Professor Deborah Bailey FRACS
ASC Scientific Convener

Sustainability in the Dispersed Workplace

The provisional program is now available and includes detailed programs from our specialties and sections.

Click below to view the program and to register online now.



RACS ASC 2022
RACS 90TH ANNUAL SCIENTIFIC CONGRESS
Monday 2 May to Friday 6 May 2022
Brisbane Convention & Exhibition Centre
Brisbane, Queensland, Australia

Provisional Program
Sustainability in the Dispersed Workplace

Royal Australasian College of Surgeons
asc.surgeons.org

Session	Program	Scientific Sessions	Plenary Session	Plenary Session	Plenary Session
Session 2 10:30am – 12:00pm		Keynote and Named Lectures	Keynote and Named Lectures	The President's Lecture	Keynote and Named Lectures
12:00pm – 12:30pm	Transplantation Surgery Program	Lunch with the Industry	Lunch with the Industry	Lunch with the Industry	Lunch with the Industry
12:30pm – 1:30pm		Keynote and Named Lectures	Keynote and Named Lectures	Keynote and Named Lectures	Keynote and Named Lectures
1:30pm – 2:00pm	Global Health Program	Scientific Sessions	Scientific Sessions	Scientific Sessions	Scientific Sessions
2:00pm – 3:30pm		Afternoon Tea with the Industry	Afternoon Tea with the Industry	Afternoon Tea with the Industry	Afternoon Tea with the Industry
3:30pm – 4:00pm		Scientific Sessions	Scientific Sessions	Scientific Sessions	Scientific Sessions
4:00pm – 5:30pm	Convocation Ceremony 5:00pm – 6:30pm	Section Dinners*	Section Dinners*	Congress Dinner*	
Evening Functions 7:00pm – 11:00pm	Welcome Reception 6:30pm – 7:30pm				

*Dinners are subject to change and government restrictions. Please check the website asc.surgeons.org for the most accurate information.

Sustainability in the Dispersed Workplace

RACS ASC 2022
Monday 2 May to Friday 6 May
Brisbane Convention & Exhibition Centre
Brisbane, Queensland, Australia

Sustainability in the Dispersed Workplace

SECTION CONVENERS & VISITORS
Correct as of time of release (December 2021). May be subject to change.

Section	Convenor	ASC Visitor	City/Town	Country
Bariatric Surgery	Michael Hatzifotis	Professor Kelvin Higa Professor Carle le Roux Professor Amir Dhaferi	Fresno Dublin Ann Arbor	USA Ireland USA
Breast Surgery	Ben Green Heidi Peverill	Dr Yazan Masamnat Dr Anna Peled	Aberdeen San Francisco	UK USA
Burn Surgery	Carl Livec	Professor David Greenhalgh	Sacramento	USA
Cardiothoracic Surgery	Anil Prabhu Masashi Ura	Professor Anson Cheung Dr Kohel Abe	Vancouver Tokyo	Canada Japan
Colorectal Surgery	Chris Gillespie Andrew Warwick			
Craniofacial Surgery	Yun Phua Richard Lewandowski	Dr David Gillett Dr Mark Moore	Perth Adelaide	AU AU
Endocrine Surgery	Justin Gundara	Dr Peter Campbell Professor Carmen Soldano	Sydney Nashville	AU USA
General Surgery	Adam Frankel	Assistant Professor Melissa Red Hoffman	Asheville	USA
Global Health	John Tuffrey	Professor Martin Zielinski	Rochester	USA
Hand Surgery	Michael Wagels	Dr Anthony Berger Dr Jayme Berteli	Melbourne Florianopolis	AU Brazil
HPB Surgery	David Cavallucci	Professor Andrew Hart	Glasgow	UK
Indigenous Health	Justin Cain Rhea Liang			
Military Surgery	Michael Lamparelli Michael Rudd Edward Yeboah	Captain Urno Boonstra	Monter	The Netherlands
Orthopaedic Surgery	Martin Lowe Scott Sommerville	Dr Stephen Sims	Charlotte	USA
Otolaryngology Head & Neck Surgery	Francois Malan Chris Dosthuizen	Professor Johannes Fagan Professor Darlene Lubbe	Cape Town Cape Town	South Africa South Africa
Paediatric Surgery	Jennifer Ah Ioy Chris Bourne Kelvin Choo	Dr Micle Mathew Associate Professor Colin Martin	Lao Birmingham	PHG USA
Pain Medicine & Surgery	Norman Ma	Dr Malcolm Hogg Associate Professor Andrew Zaccst	Melbourne Adelaide	AU AU
Quality & Safety in Surgical Practice	John North	Dr Graham Beaumont Dr Bernadette Eather Dr Karen Murphy	Sydney Sydney Mount Isa	AU AU AU
Rural Surgery	Brian Kirby	Dr Rajiv Choudhrie	Bethul	India
Senior Surgeons	Frank Gardiner	Emeritus Professor Teik Oh	Perth	AU
Surgical Directors	Brian McGowan Sanjeev Naidu	Dr Mark O'Brien	Brisbane	AU

Register here

View the program here

Imitation - a sincere form of plagiarism

An alternative perspective



OPUS LXXIII (73)

I must admit that I was formerly critical of the plagiarism concept until further reading clarified my mind. The word comes from the Latin *word plagiarius*—to kidnap—hence that element of subterfuge. My mind now has been opened to possible alternative explanations, thus eliminating deceit.

Plagiarism may embrace other people's ideas, images, language, compositions, and thoughts but I have become more tolerant. Is it the subconscious talking from previous forgotten experiences? And let us not forget what Coco Chanel once said, "In fashion only those with no memory insist on their originality!"

There are historical reasons for apparent misconceptions in this range of illustrations, from published material to artistic refinements. In surgery we are mentored by our masters, emulating their skills and publishing materials, all with their supervision.

The concept of plagiarism is not new—even the Greek Ponticus in the 3rd century BC was accused of plagiarising Homer. The Harold Gillies story and the cross-leg flap may have been an original thought, even a co-discovery. However, incidentally it is a repetition of Ombredanne's (illustrated) published work of 1907, as I have explained in my earlier publication of Aug, 2017 issue, Opus 49.



The Gillies needle holder (below) and the midwife forceps for the umbilical cord also have similarities to cut and tie the cords as already discussed in an earlier publication (Nov. 2019 issue, Opus 61). But Gillies had an inventive mind.



He developed a new instrument combining pincer activity and a scissor cutting mechanism (illustrated). It avoids any assistant in tight surgical timeframes—a wartime necessity and now part of our plastic surgical kit.



As plastic surgeons, this has been our number one driver—in golfing parlance—because Gillies also was a superb golfer. A Cambridge Blue from 1903-1905, he subsequently won the British Amateur Golf Championship. He even designed his own golf tee, the idea originating from the ball sitting on an upturned bottle. This subsequently needed approval from the golfing mecca at St Andrew's, which was successful. Thus, this inventive mind presumably applied his talents to create the Gillies needle holder.

In the academic world, more stringent rules exist with the departmental head supervising published material. Even the Yale University guidelines on such issues states: 'we have a strict zero-tolerance policy for infractions in the academic honesty code'—reflecting a worldwide dictum. Thus, the use of ideas and concepts, words and structures

must always be accompanied by acknowledgement as I endeavour to do.

Earlier multiple examples exist and Newton always springs to mind, 'standing on the shoulders of others' to develop new concepts—when in fact he was quoting John of Salisbury who attributed this saying to Bernard of Chartres from the 12th century. (Thanks to Earle Brown for this reference.) One initiates and even unknowingly replicates.

Listening to *ABC Classic FM* and the comprehensive opinions of the presenters, many examples of tuneful similarities fill the airwaves. They often recount the story of musical origins stemming from folklore. An example is Joseph Canteloube's *Songs of the Auvergne*. Thanks to his musical talent, he's captured the folklore of the countryside that has existed for generations and with his acknowledgement, these tunes are now part of musical history. Who could call this plagiarism? Percy Grainger did the same with the folk tunes in Denmark in his *Denmark Suite*, recording for posterity.

Poulenc, the French master, had a different interpretation of outside influences. He once said, "I write the same style of music as Mozart, but we have different melodies", before reverting to his later characteristic of dissonance, minus rhythm, and disharmony. Like Picasso who tired of repetitive likenesses and dived into cubism, then Poulenc dived into modernism.

And while writing this piece, Arvo Pärt's piece *Spiegel im Spiegel*, (Mirror in the Mirror) surfaced on the airwaves. It is a marvellous piece of compositional development where three notes, three chords, and three bars are musically intertwined. This piece exemplifies a style Pärt invented and termed it *tintinnabuli*, which synthesises the fragments of sound resembling the ringing of bells—the thoughts of an originator.

Now to visuals: I love seeing the glass pyramid at the Louvre, designed by the Chinese American architect Ieoh Ming Pei, where the visual perspectives of the Louvre are unrestricted. This public access allows 10 million visitors a year, without any intrusions into the elegance of the Louvre courtyard. Thank God for the Pharaohs as this glass concept has repeated their designs of 2500+ years BC.



The Palladian design is another replicated architectural concept. Multiple colonnaded structures had their origins from the Acropolis. From a more modern perspective in Paris, the 18th century L'église de la Madeleine in the 8th arrondissement is a version of the same—designed by Vignon and originally a memorial for the Napoleonic army, yet the Church managed to get its hands on the prize.



I attended Sunday services here regularly in those former days in Paris with my wife, Mariette. On one occasion I was asked to read the lesson by a senior sacristan as I was a regular visitor. He was quick to perceive my conversational French did not have the diplomatic fluency required and suggested I revert to English.

As design repetition acknowledges the originators, variations occur and I refer you now to the image of the 1801 Duke of York's Battalion Headquarters in Chelsea, London, now the Saatchi Gallery. Was this a coincidental resemblance or a subconscious emergence of experience? Look at the similarity between the College of Surgeon's Spring Street and its Street Architectural Award in 1937 and the 1801 English structure.



Image 1: The College of Surgeons Spring St of 1935

Let us now explore the art world. I recently came upon a van Gogh copy of an oriental woodblock matching word-for-word or should I say brushstroke-for-brushstroke in the artistic realisation of Hiroshige's work. Vincent and his brother Theo collected more than 400 such Japanese illustrations which made him "happier, returning to nature, away from the world of convention".

Who would have thought the woodblock by this artist would have striking appeal for the great impressionist van Gogh, repeating this Asian design? Let us not forget, we see art students in the Louvre and other galleries copying the strokes of the masters. In surgical training we replicate our masters' techniques until we find a better alternative—originators.

As another example of plagiarism, I almost bought a signed Monet for a song years ago during my London days, but the artist neglected to put 'copy' behind it. His prize was ending up in Sing Sing Prison in New York.

They say that the Chrysler collection of the 1930s of French Impressionists—owned by one of the wealthiest carmakers in America—had a similar fate, as the majority of the pieces were fakes. A classic example of plagiarism but this time with a commercial link.

The story below is the basis of my change of heart about plagiarism. In *Harper's* magazine in 2007, Jonathan Lethem offered an alternative perspective on this subject. He wrote, 'The kernel, the soul—let us go further and say the substance, the bulk, the actual, and valuable material of all human utterances—is plagiarism. Don't pirate my editions; do plunder my visions. The name of the game is Give All. You, reader, are welcome to all my stories. They were never mine in the first place, but I gave them to you'.

Hence, we copy masters, we follow the rules, we enjoy the outcomes when



Image 2: The Duke of York's Battalion Headquarters of 1801

the mixture of experience and teaching allows us to develop our talents. And the French Impressionists and their plein-air experiences once forced Monet to observe, 'I ran out of black pigment, I used blue and impressionism was born'—innovation.

As in surgery, we learn from our mentors and repeat the tradition because the surgeons that have gone before us are eminently classified as the exponents of great technique. The need for academic lineage adds authenticity for ongoing development and research, maintaining the combination of technical aptitude—replicators with scientific advancement.

Regarding technical aptitude, I still remember the story of the Parotid expert from the MAYO Clinic in the 60s, Oliver Beahrs, who could manage up to eight Parotidectomies in an afternoon rotating between sequential theatres. His assistants would prepare the case, expose the tumour, and he would come in to execute the surgical removal—defining the facial nerve with absolute confidence and leave his team to close the wound. But in his spare time, he was a magician, entertaining many, which reflected his manual dexterity—eventually mirroring his surgical skills.

As is noted in biology, a structural gene that replicates a specific replicon is believed to be initiated. In surgery we replicate before we initiate, as a continuation of our experiences. But, most importantly, experiences advance our knowledge.

Oscar Wilde says it more succinctly, "Imitation is the sincerest form of flattery that mediocrity can pay to greatness". So, copying the masters validates authenticity.



Associate Professor
Felix Behan

The Educator of Merit Award

Some of our winners share their experience of being educators

Every year the Academy of Surgical Educators (ASE) presents the Educator of Merit Award to recognise exceptional contributions by our surgical educators. Some of the 2021 winners share their experience of being an educator.

The Educator of Merit awards consist of the SET Supervisor/SIMG Supervisor of the Year Awards, which recognises the exceptional contributions by a SET supervisor/ SIMG Supervisor towards supporting Trainees and Specialist International Medical Graduates (SIMGs). The second award—The Facilitator/ Instructor of the Year Award—recognises the exceptional contribution by a course facilitator or an instructor teaching Professional Development or Skills Education course.

The 2022 nomination portal will be open from 1 March to 15 April 2022. Please view on <https://bit.ly/3qVbsiX> to submit your nomination.



Image: Dr David King, South Australia State Committee Chair (L) presenting the award to Associate Professor Andrew Kurmis (R)

Associate Professor Andrew Kurmis is a RACS Fellow based in Adelaide, South Australia. He specialises in Orthopaedic Surgery. The Academy of Surgical Educators awarded Associate Professor Kurmis the Facilitator/Instructor of the Year Award in 2021.

1. What inspired you to pursue surgical education?

I have had the personal privilege of training under and working with some simply outstanding mentors and surgical teachers across my career. These were often individuals who gave their time and wisdom selflessly, and often at critical points in my own journey. I think that, like most of my colleagues, the 'good' teachers and educators really did inspire you and stood out from the rest. Aspiring to one day be a surgeon who contributed in some way as they had, and 'give something back' has long been a motivation for me. I was always cognisant that many good teachers had given up their time to teach me, and that has always made it easy to then pass that on and teach others.

2. What is your proudest moment as a surgical educator?

I'm not sure I could pick just one. Any time I've received positive feedback and thanks from those we teach is a proud moment. There are many educators in surgery, but to know that those we teach have valued in some way the time and effort spent in teaching them is always a rewarding feeling. To cross paths years later with colleagues who I've taught at a much earlier stage and have them recount stories of how something they had learnt made a positive difference to their own experiences/decisions or patient outcomes is also a wonderful feeling.

3. Any advice for new surgical educators just getting started?

I think that for a long time, 'education' or 'teaching' was under-recognised as a specific skill in the surgical pathway and we were very rarely 'taught' how to teach or what constituted a good teacher. Like so many other facets of our role, teaching is usually something that takes practice, refinement and dedication. Sometimes I get the sense people underappreciate how much hard work goes into being a good surgical educator. My advice for someone new to formal surgical teaching would be to try and align yourself with a good senior mentor (the College does a good job of this with many of the major skills training programs). Be attentive to which elements of the teaching of others you see as positive. Your ultimate teaching style will be a hybrid of the good things you've witnessed along the way. Prepare thoroughly and well. Seek constructive feedback when you can from your audience and colleagues alike.

Dr Suresh Mahendran is a RACS Fellow based in Darwin, Northern Territory. He specialises in Otolaryngology Head & Neck Surgery. The Academy of Surgical Educators awarded Dr Mahendran with the SET Supervisor/SIMG Supervisor of the Year (NT) Award in 2021.

1. How do you feel receiving the SET Supervisor/SIMG Supervisor of the Year Award?

I feel humbled to receive this award; it was totally unexpected. My perspective is that there are trainers far more deserving than me. Receiving the award fills me with a great sense of pride and satisfaction to note that my simple efforts are appreciated.

2. What inspired you to pursue surgical education?

I have always found teaching very rewarding from my early days as a demonstrator in Human Morphology at Southampton University, through Registrar training in Cambridge, East Anglia, and since as a Consultant, a SIMG and a RACS Fellow. The satisfaction of knowing that I've contributed towards the betterment of healthcare delivery to our population is beyond measure. Shared knowledge is a precious gift that, through motivated learners benefits more people. It must be encouraged.

3. What do you hope to see in the RACS Surgical Education scene moving forward?

I was not aware that this section of RACS or the awards scheme existed. Receiving the award has enlightened me to the possibilities for Surgical Education through RACS. I have since completed the FSSE course and applied to become a Member of the RACS section. I would strongly advocate for learners to nominate those trainers worthy of recognition as it will serve to improve the effort and quality of teaching through positive feedback. I hope to see the RACS Surgical Education scene growing in stature over the coming years.



Image: Dr Suresh Mahendran

Prostheses List Reform

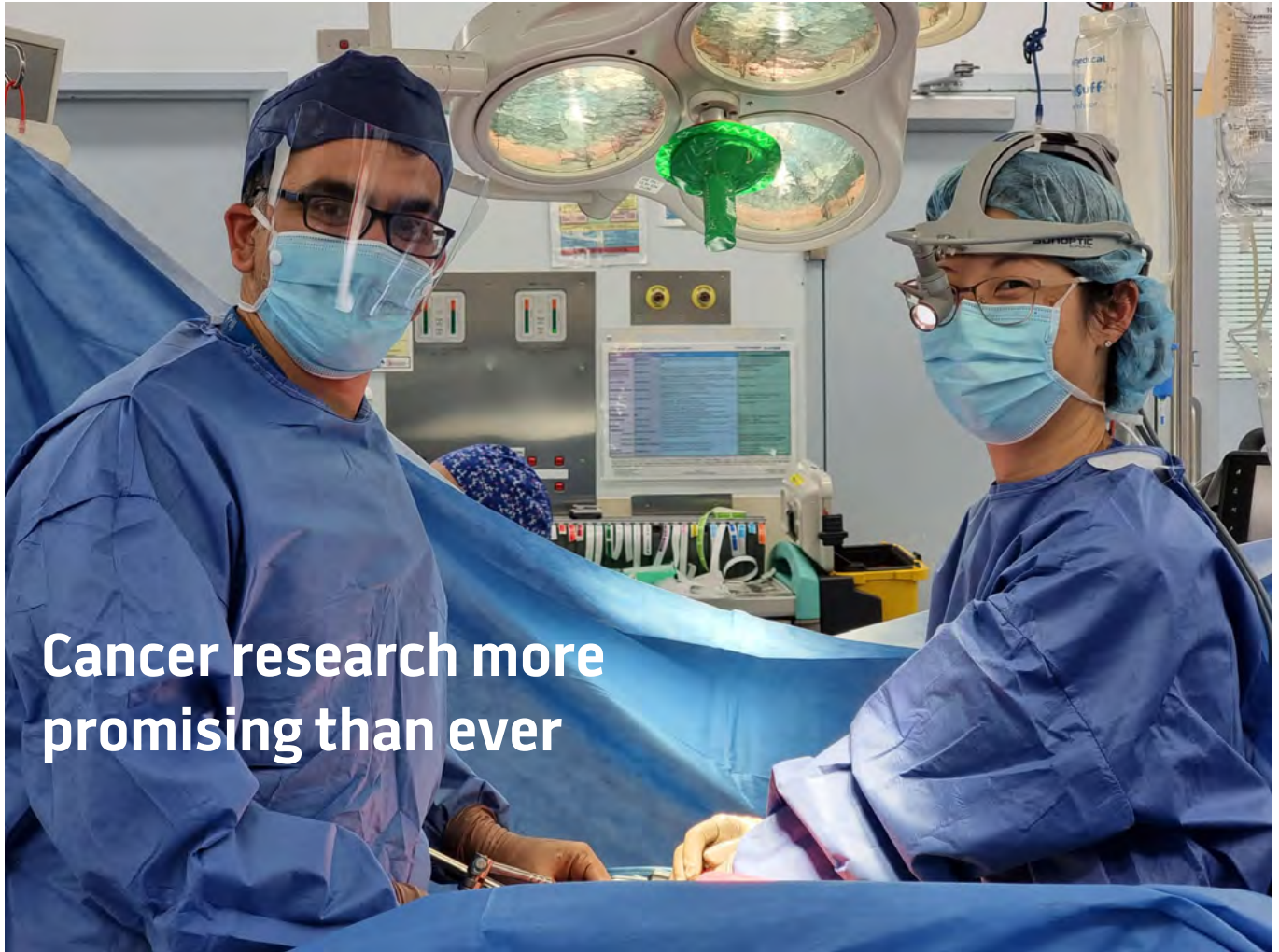
Prostheses List reform will have no impact on a doctor's choice of medical devices or technology for use in surgery.

This ensures patients will continue to receive affordable and high-quality care in Australia's private hospitals.

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Cancer research more promising than ever



Dr Vignesh Narasimhan is a Colorectal Fellow who undertook a PhD at the Peter MacCallum Cancer Centre in Melbourne. He was a recipient of the prestigious Tour De Cure Cancer Research Scholarship, a scholarship that is awarded annually. Dr Narasimhan was awarded the scholarship in 2019.

“Research was something I was keen on doing during my training as well. However, when you're training, a PhD is not something you do part-time—you

need to dedicate a full-time schedule to it”, Dr Narasimhan said.

He spent three years, from 2017 to 2019, completing his PhD at the Peter MacCallum Cancer Centre in Melbourne. His research focused on personalised therapy and exploring the immune landscape for patients with colorectal peritoneal metastases.

“You're doing something completely different every three or four months—it's always very challenging. But once you find your feet it is very rewarding,” he said.

Dr Narasimhan's attraction to cancer research came from an interest in the available treatments being offered to patients with metastatic colorectal cancer. Over a quarter of patients with bowel cancer present with stage 4 disease, where the cancer has spread to other sites. The cancer usually spreads to one of three sites—the liver, the lung, and the peritoneum. The peritoneum is the lining over the organs and what he says is an often ignored area.

“This is one area that has been left behind for many, many years. A small proportion of patients, if they have very limited disease, are eligible for aggressive surgery that clears all the disease from the peritoneal cavity,” he said.

The treatment for most patients with non-operable peritoneal disease, has been limited to systemic chemotherapy, which doesn't work very well in peritoneal disease.

“The reasons for poor response to standard chemotherapy in peritoneal disease are believed to be multifactorial; such as poor blood supply to the peritoneal lining, inability of the chemotherapy to reach there, or chemo-resistance due to altered tumour biology,” Dr Narasimhan said.

A large part of Dr Narasimhan's research was to try and develop a personalised medicine platform for patients with peritoneal disease and who failed standard treatment. He set up an international collaboration between Peter MacCallum Cancer Centre in Melbourne,

Queen Elizabeth Hospital and SAHMRI in Adelaide as well as a team in Seattle and New York.

“What we did was sample the peritoneal tumours and grow them in the lab as novel mini tumours, called organoids. We subsequently sequenced them to evaluate their mutation profile and then drug tested them across more than 100 drugs, including chemotherapies, targeted therapies and clinical trial drugs—many of which were not used normally in bowel cancer treatment,” he said.

What Dr Narasimhan found was many of the tumours were very resistant to standard drugs, in keeping with what we see in clinical practice. More importantly, some patients had a good response to drugs that were not normally used in bowel cancer treatment. “One patient in their 40s who had failed all standard lines of treatment and was not eligible for any clinical trials was found to have good response to a drug often used in pancreatic cancer. The early data was very promising.”

While the prospect of a clinical trial requires more funding and getting

pharmaceutical companies on board, Dr Narasimhan is optimistic that it can be established soon.

“I think curing cancer is some time away, but we are chipping away at this massive mountain. And every chip offers people new hope.”

Another crucial aspect of Dr Narasimhan’s research was on the immune landscape. “We used various lab-based techniques to evaluate the immune makeup of colorectal peritoneal metastases, and to see if altering the immune microenvironment can provide a therapeutic option. This was something that had never been done before,” he said.

The results, which are promising, need to be expanded and validated with a larger cohort.

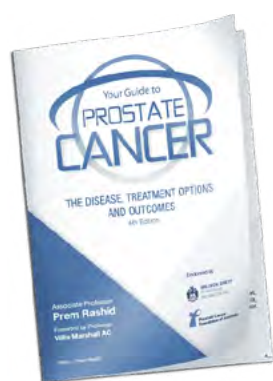
In his free time, Dr Narasimhan enjoys spending time with his wife and their two-year old son. He is also an avid tennis player, but says his skills are “average, not great.”



RACS Research Scholarships and Grants round opens for applications in March 2022. For more information please go to www.surgeons.org/scholarships or contact the Scholarship and Grant Coordinator at: scholarships@surgeons.org

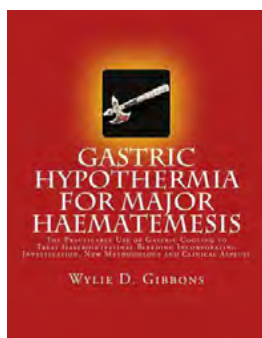
For more information on setting up a scholarship, Fellowship or grant of your own, please contact the Foundation for Surgery at foundation@surgeons.org or +61 3 9249 1110.

Good reads



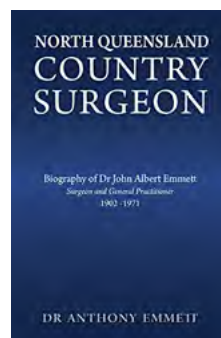
Your guide to prostate cancer: the disease, treatment options and outcomes
4th edition

Associate Professor Prem Rashid



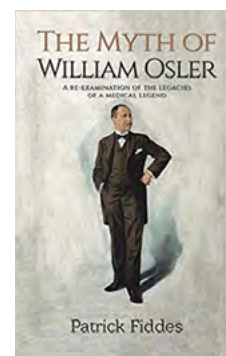
Gastric hypothermia for major haematemesis: the practicable use of gastric cooling to treat gastrointestinal bleeding incorporating investigation, new methodology and clinical aspects

Wylie D. Gibbons



North Queensland Country Surgeon: Biography of Dr John Albert Emmett

Dr Anthony Emmett



The Myth of William Osler: a re-examination of the legacies of a medical legend

Patrick Fiddes

Research scholarship and grant opportunities for 2023

If we knew what we were doing it would not be called research, would it?
- Albert Einstein

Applications open 1 March 2022 and close 13 April 2022

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

RACS and the Foundation for Surgery are proud to offer up to 28 research scholarships for funding in 2023. Including seven continuing scholarships from 2022, the total funding for 2023 is valued at more than \$2.2m. This represents a significant philanthropic contribution to surgical research and training in Australia, Aotearoa New Zealand and the Asia-Pacific region.

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



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

The Scholarships and Grants Program year

Research and Learning and Development opportunities

Scholarships and grants are offered in two rounds each year – Research (opening in March) and Learning and Development (opening in August).

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

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

Scholarship recipients are required to report on their activities.

Improving the digital experience

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

Promoting social inclusion and gender equity

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

Boosting our marketing and promotion

Our marketing and promotion efforts will be boosted as we include multimedia to promote scholarships through our partner networks, social media and online, raising the program's profile and encouraging high-quality applications.

Research Scholarships, Grants and Fellowships

Research applications open 1 March and close at midnight ACST 13 April 2022

Are you thinking of undertaking research in 2023? The Scholarships and Grants Program is offering the following 28 research opportunities.

We encourage applications from Aboriginal, Torres Strait Islander, Maori and female applicants as we support RACS' focus on:

- removing barriers to the participation of women in surgery
- recognising that some people can experience disadvantage
- continuing and enhancing initiatives designed to increase the participation of Aboriginal, Torres Strait Islander and Māori doctors in the practice of surgery.

In August 2022, Learning and Development grants will be advertised and open for applications.

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

The values of these awards are in Australian dollars and are for a tenure of one year unless otherwise stated. Where a higher degree is required, it is for a Masters, PhD or the equivalent, or as indicated.

Early-career surgeons are Trainees or Fellows within 10 years of obtaining Fellowship.

FRACS applicants may apply where eligible for all opportunities listed for Fellows, subject to providing evidence of completing all Fellowship requirements by 1 December in the year of application.

SET applicants may also apply where eligible, subject to providing evidence of acceptance into the SET Program by 1 December in the year of application.

John Mitchell Crouch Fellowship

\$170,000

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

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

Tour de Cure Cancer Research Scholarship

Value: \$125,000. The scholarship will fund \$100,000. Recipients are required to gain co-funding of \$25,000 from their research department.

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

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

Academy of Surgical Educators Research Scholarship

\$10,000

This Scholarship supports research into the efficacy of existing surgical education or innovation of new surgical education practices.

Who can apply: RACS Fellows, SIMGs, SET Trainees and SET applicants.

Aotearoa New Zealand Research Scholarship

\$66,000

The Aotearoa New Zealand Research Scholarship assists Aotearoa New Zealand-based surgeons and Trainees to undertake a research project.

Who can apply: Aotearoa New Zealand RACS Fellows, SIMGs and SET Trainees residing in, and are citizens or permanent residents of, Aotearoa New Zealand. Applicants must be enrolled (or intending to enrol) in a higher degree.

Brendan Dooley and Gordon Trinca Trauma Research Scholarship

\$15,000

The Brendan Dooley and Gordon Trinca Trauma Research Scholarship encourages research into the prevention and treatment of trauma injuries.

Who can apply: RACS Fellows, SIMGs, SET Trainees, SET applicants and medical scientists who have not previously received this scholarship.

Eric Bishop Research Scholarship

\$66,000

The Eric Bishop Research Scholarship supports surgeons and Trainees who wish to take time away from clinical positions to undertake a research project focusing on medical research. This scholarship was made possible by a donation from the late Eric Bishop, a Queensland pastoralist.

Who can apply: RACS Fellows, SIMGs and SET Trainees enrolled (or intending to enrol) in a higher degree.

Foundation for Surgery Research Scholarship

\$66,000

The Foundation for Surgery Research Scholarship supports surgeons and Trainees who wish to take time away from clinical positions to undertake a research project.

Who can apply: RACS Fellows, SIMGs and SET Trainees enrolled (or intending to enrol) in a higher degree.

F & P Thornell-Shore Research Scholarship

\$50,000

The Francis and Phyllis Thornell Shore Research Scholarship supports RACS Fellows, SIMGs, Trainees and SET applicants who wish to take time away from clinical positions to undertake a research project with a focus on medical research. Applicants must be enrolled (or intending to enrol) in a higher degree.

Who can apply: RACS Fellows, SIMGs, SET Trainees and SET applicants enrolled or intending to enrol in a higher degree.

Herbert and Gloria Kees Scholarship

\$66,000

The Herbert and Gloria Kees Research Scholarship supports the advancement of surgical research, technologies, techniques, and treatments. It was established through a generous donation from the estate of the late Gloria Joyce Kees. Up to three scholarships are offered.

Who can apply: Early-career RACS Fellows, SIMGs and SET Trainees.

Ian & Ruth Gough Surgical Education Scholarship

\$23,000

The Ian and Ruth Gough Surgical Education Scholarship encourages surgeons to become expert surgical educators. It was established through the generosity of RACS past president Professor Ian Gough and his wife Ruth.

Who can apply: RACS Fellows and SET Trainees. SET applicants are ineligible for this scholarship.

Lumley Surgical Research Scholarship

\$66,000 plus \$3,000 travel expenses

The Lumley Surgical Research Scholarship supports surgeons and Trainees to undertake research in the United Kingdom. It is offered in partnership with the Royal College of Surgeons of England and is supported by the Henry Lumley Charitable Trust.

Who can apply: RACS Fellows and SET Trainees. SET applicants are not eligible for this scholarship.

MAIC-RACS Trauma Research Scholarship

\$66,000

This Scholarship was established with a grant from the Queensland Motor Accident Insurance Commission (MAIC) and matched by the Foundation for Surgery to support trauma research. The proposed research may be in the areas of epidemiology, prevention, protection, rehabilitation and immediate or definitive management in trauma. While it is not a requirement of this scholarship that the research be conducted in Queensland, the potential benefits flowing from the research must assist Queenslanders.

Who can apply: RACS Fellows, SIMGs and SET Trainees.

Margorie Hooper Scholarship

Value: \$90,000 plus \$10,000 accommodation and travel expenses.

This scholarship was made possible thanks to a bequest from the late Mrs Margorie Hooper of South Australia to enable successful applicants to either travel outside South Australia to learn a new surgical skill, which will benefit the South Australian community (preference), or to undertake postgraduate studies and reside temporarily outside South Australia.

It is mandatory for the recipient to make a presentation at the South Australia, Northern Territory & Western Australia Annual Scientific Meeting in the year following the conclusion of the scholarship. Applicants must also intend to return to South Australia to live and work after they have completed the scholarship.

Who can apply: RACS Fellows, SIMGs and SET Trainees who reside permanently in South Australia. SET applicants are not eligible for this scholarship.

Professor Philip Walker Vascular Research Scholarship

\$24,000

Professor Walker was a pre-eminent teacher, researcher, and clinically active vascular surgeon. This scholarship is funded by a generous bequest from Professor Walker and supports vascular surgery research.

Who can apply: RACS Fellows, SIMGs and SET Trainees, enrolled (or intending to enrol) in a higher degree with research related to vascular surgery.

R & M Edwards Research Scholarship

\$45,000

The Roy and Marjory Edwards Research Scholarship supports medical research conducted at a South Australian university.

Who can apply: RACS Fellows, SIMGs and SET Trainees and SET applicants enrolled or intending to enrol in a higher degree.

Reg Worcester Research Scholarship

\$66,000

The Reg Worcester Research Scholarship supports research, preferably with relevance to the surgical care of patients. It was established following a donation from the late Alan Worcester, FRACS, in memory of his brother, Reg, a great educator, doctor and humanitarian.

Who can apply: RACS Fellows, SIMGs and SET Trainees, enrolled (or intending to enrol) in a higher degree.

Richard Jepson Research Scholarship

\$66,000

The Richard Jepson Research Scholarship supports deserving researchers, early in their career. The late Professor Richard P Jepson was the foundation Chair for Surgery at the University of Adelaide and the scholarship was established in his honour by his late wife, Dr Mary Jepson.

Who can apply: SET Trainees and SET applicants enrolled or intending to enrol in a higher degree.

Sir Roy McCaughey Surgical Research Scholarship

\$66,000 per annum

Tenure: Up to three years

This scholarship was founded thanks to a bequest from the late Sir Roy McCaughey, a grazier in the Riverina district of southern New South Wales. It is open to surgeons and Trainees enrolled (or intending to enrol) in a PhD.

Who can apply: RACS Fellows, SIMGs and SET Trainees enrolled (or intending to enrol) in a higher degree undertaking research in New South Wales.

Small Project Grant

\$10,000

This grant is for a surgeon or Trainee who wishes to, or is already undertaking, a small clinical or research project or requires some funding to purchase equipment to carry out a research project. Up to five grants will be offered. Previous recipients can receive this grant up to four times.

Who can apply: RACS Fellows, SIMGs and SET Trainees.

Surgical Education Research Fellowship

Value: \$77,000 per annum

Tenure: Up to two years

This Fellowship is offered in partnership with the Southeastern Ontario Academic Medical Organization and may be used to fund travel, accommodation and living expenses. In addition, tuition and related expenses are funded by Queen's University. The start date of the degree is determined by Queen's University within 18 months of being awarded.

Who can apply: RACS Fellows who intend to enrol in a Master's Degree in Health Professions Education Program at the faculty of Health Sciences, Queen's University, Canada.

Surgical Ethics Research Scholarship

Value: \$66,000

The Surgical Ethics Research Scholarship supports surgeons and Trainees who wish to undertake higher degree research into ethical issues confronting surgery.

Who can apply: RACS Fellows, SIMGs, SET Trainees and non-RACS members who are sponsored by a RACS Fellow, enrolled or intending to enrol in a higher degree such as a Masters or PhD.

W G Norman Research Scholarship

Value: \$66,000

The W G Norman Research Scholarship supports RACS Fellows and Trainees to undertake research in South Australia. Preference is given to research with a focus on trauma.

Who can apply: RACS Fellows, SIMGs and SET Trainees enrolled or intending to enrol in a higher degree.

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

For any other queries, please contact the Scholarships and Grants Team on +61 8 8219 0924 or at scholarships@surgeons.org.

**Applications close midnight
ACST 13 April 2022**



Royal Australasian College of Surgeons

Foundation for Surgery

**Thank you for your extraordinary compassion and generous support to the
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