

SurgicalNews

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 Royal Australasian
College of Surgeons

Our members have *always* been our highest priority

As the health fund for doctors, it has always been our priority to support members and the wider medical community throughout the pandemic.

We continue to keep our commitment of not profiting from COVID-19 by postponing our 1 April 2022 premium increase and **freezing current rates until 1 October 2022.**

Dr Louise Woodward
Member since 2003

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RACS ASC 2022

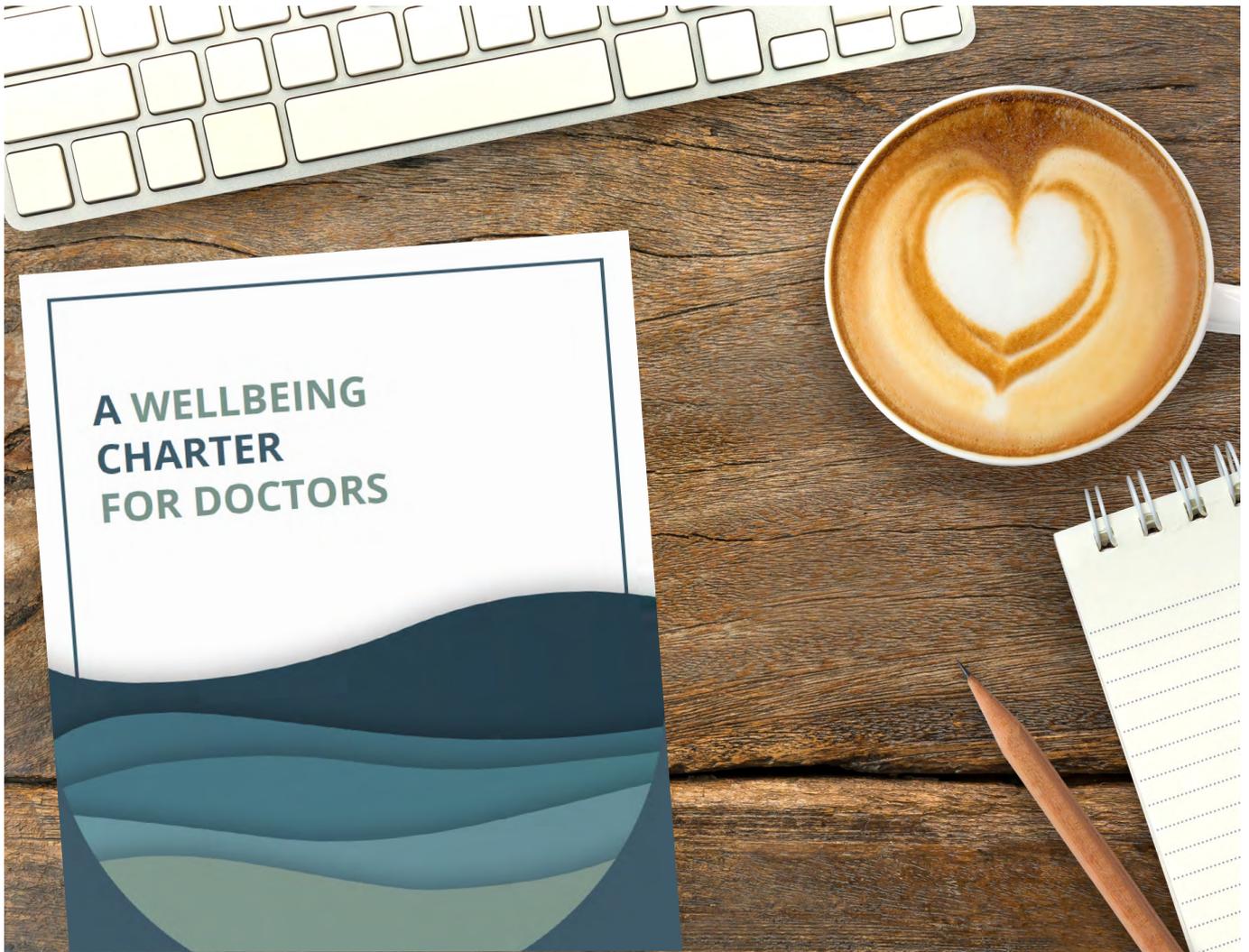
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 Editor: Abderazzaq Noor
 T: +61 3 9249 1200 | F: +61 3 9249 1219
 Publications Lead: Saleha Singh
 Designer: Amy Tanner
 Contributing writers: Fleur Morrison, Najma Sambul, Rachel Corkery and Shima Ibuki
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President's perspective

We recently announced the results of the RACS Council elections for the leadership roles, including those of the president, vice president and treasurer.

I was re-elected as president in accordance with the election process for Council officer bearers and Council Executive. Thank you for your vote.

I look forward to continuing the work we started with your support.

I am pleased to welcome my colleagues Professor Chris Pyke as vice president, Dr Greg Witherow as treasurer, Dr Adrian Anthony as censor-in-chief, and Professor Andrew Hill as the chair of the Professional Standards and Advocacy Committee.

Congratulations to our other Council office holders who were re-elected and a warm welcome to our new Councillor Professor Deborah Bailey and co-opted councillors Dr Sharon Jay, representing our Trainee association, RACSTA, Dr Ailene Fitzgerald, representing ACT Fellows, and Dr Richard Badbury, representing the Northern Territory Fellows. I look forward to working with you to advance the College strategy and priorities.

I'd like to thank Dr Lawrie Malisano, our outgoing vice president for his many years of service to Council and the College. Lawrie has been a great support to me in my role as president and his contributions during his years as a Councillor have been

commendable. Lawrie and I have talked through several problems during the last year and his wise consideration has been extremely important. Thank you, Lawrie.

As we embark on the important work ahead of us, advocacy continues to remain a strong priority area. We have the Australian federal elections taking place most likely in May 2022 and we have sent a list of election priorities to all the main parties contesting the election. If there is one thing the pandemic has taught us, it is that poor health outcomes lead to negative economic and societal outcomes.

This election we are calling for the next Australian government to put politics aside and demonstrate a genuine commitment to health by addressing various issues that range from building respectful and safe workplaces; timely access to essential surgery in the public sector; expanding services for Aboriginal and Torres Strait Islander people; restricting the title 'surgeon' to those with accredited advanced surgical training; and safeguarding the health of all Australians from climate change, among other issues. We have shared our views on the specific actions the next Australian government should take. You can read more about this on page 18 and on our website.

On other advocacy news, our Health Policy and Advocacy Committee held a meeting with the Australian Department of Health to discuss a Private Member's Bill concerning surgical transparency for patients.

We believe this Bill is problematic and have shared our concerns around the funding of registries, the lack of risk adjustments, public vs private data, surgical ethics applications with differing state jurisdictions, complex procedures, geography, and possible gender bias, among other issues.

We sent our feedback through a submission, which was developed with input from the RACS Rural Surgery Section and the RACS Research, Audit and Academic Surgery Section.

Another area where we will continue our advocacy efforts is elective surgery. In the past few months we have been advocating on many issues resulting from the restrictions on elective surgery in Australia and Aotearoa New Zealand. We want elective surgery to continue where capacity in the health system allows.

In Ōtautahi, Christchurch, where I live and work, we are at the peak of Omicron. Many patients are in hospital for reasons other than COVID-19 and elective and planned surgery continues where staffing is adequate.

We are particularly concerned about the growing waiting list exacerbated by COVID-19 in both countries. We need to see a funded plan from governments for clearing these backlogs and supporting public hospitals properly. It then needs

to be backed by real, long-term funding commitments that deliver permanent, expanded capacity in the public hospital system.

We also asked governments in Australia to review the elective surgery categorisation system, and in Australia we also need to review terminologies such as 'elective surgery' as so often these procedures are not elective. In Aotearoa New Zealand we use planned care but the term 'elective surgery' is also used. The incorrect terminology, 'elective surgery', can be interpreted as optional or low priority surgery and this has led to bureaucrats making the wrong decisions about clinical matters.

More recently, I am also pleased to report that the Council of Medical Colleges in Aotearoa New Zealand agreed to endorse the RACS Wellbeing Charter for Doctors. This is a step forward as it recognises the importance of being mindful of our health and that of the people we work with in the healthcare sector. The Charter defines wellbeing and sets out the shared responsibility for supporting doctors' wellbeing. I hope that we will see many more organisations signing up. We all have a part to play in supporting the wellbeing of doctors. The Charter has already been endorsed by Council of Presidents of Medical Colleges and separately by several Colleges.

Some of you may be aware that we will soon start renovating the head office in Melbourne. This is part of a wider renovation project approved by Council that includes renovating the west wing's levels two and three in phase one—bringing the building up to required safety code standards while respecting heritage aspects. This will be followed by the renovation of the east wing's levels three and four in 2023.

The architecturally designed office spaces will also support the hybrid way of work that is becoming the hallmark of the new workplace. It will include comfortable spaces that staff and members can use for meetings and collaboration.

I came across a bit of interesting trivia relating to the renovation. The Melbourne office has an inner courtyard with a massive plane tree. Someone mentioned that it is a descendant of the

celebrated Tree of Hippocrates under which the 'father of medicine' taught his students more than 2000 years ago. Sadly, it turned out not to be true! It is said that a descendant of the Tree of Hippocrates exists in the Greek island of Kos.

In April I will be travelling to Melbourne and later to Brisbane for our Annual Scientific Congress. This will be my first visit to Australia as president and I am looking forward to meeting many people.



Dr Sally Langley
President



Vice president's message

My tenure as vice president of the Royal Australasian College of Surgeons will come to an end soon.

As I reflect on the past year, I am struck by the impact of ongoing changes brought about by the COVID-19 pandemic. While change is a constant in our lives, it also brings opportunities.

During the year, the respected *ANZ Journal of Surgery* transitioned from print to a digital format. This change was facilitated by the pandemic and forced us to look at delivery options. Along with the obvious environmental and sustainability issues associated with printing thousands of hard copies, readership of the online journal has quickly become well-established as the default reading mode for researchers and medical professionals, with more than 360,000 article downloads per year. The first fully digital version of the journal was successfully disseminated in February 2022.

This year Fellows were asked to use the title 'Dr' and promote this change in their practice. Surgery is the only profession that continues to use gendered titles in

Australia and Aotearoa New Zealand. This can be confusing for our patients as it creates the perception of differing qualifications.

Gendered titles can also contribute to implicit bias against women surgeons. As doctors we shouldn't differentiate ourselves, so I encourage you to make this simple change, which will benefit patients and promote equity within our profession.

Culture in the surgical workforce should be a major focus for us to build a more respectful and inclusive environment for our members, work colleagues, staff and patients.

The recently convened RACS Expert Advisory Group (EAG), Discrimination, Bullying and Sexual Harassment includes a group of external specialist advisors. They will examine the findings of the recent evaluation of the Building Respect Improving Patient Safety initiative to develop a new set of recommendations to guide future progress.

The EAG acknowledged the serious impact of the College's ongoing commitment, the significant resources

invested over the last six years and the diligence of staff, Fellows, Trainees and Specialist International Medical Graduates (SIMGs). The EAG commended the College's commitment to progressive changes.

The EAG report and recommendations will be presented to RACS Council. I look forward to our members' response and support of this important work.

An exciting RACS implementation is the College's digital transformation program to improve work capability and efficiency. In April, we launched unique digital usernames for Fellows, Trainees, SIMGs and other groups who regularly use our services. This will enable members to access the RACS systems with a single username and password, rather than several usernames and passwords for various applications.

I hope you have managed to successfully set up your new username. Further developments are planned for 2022 to better support and advance your needs in a professional environment that is constantly changing.

I will soon entrust my role to Professor Christopher Pyke, a highly respected surgeon who is well regarded by his peers. Chris will bring a calm and respectful demeanour to the portfolio. My professional relationship with Chris began many years ago with shared registrar experiences. I confidently and unequivocally support Chris in this role. The College's membership is in good hands.

I welcome another Queensland to the RACS Council. Professor Deborah Bailey is an esteemed surgical colleague with impressive and focused academic management and interpersonal skills abilities. I confidently make these claims after long-standing professional interactions. Deborah is a positive addition to RACS Council.

On a final note, I would like to thank all my colleagues. I have worked with many Fellows, Trainees and SIMGs over the nine years I have spent on the Council. I have valued your friendship, professionalism, intellectual abilities and knowledge, and remain in awe of the group which forms Council. Thank you for the opportunity to work with you. I look forward to our paths crossing again in the future.

It is not a mistake that I close by acknowledging RACS management and staff. While Council provides strategic direction and meters the risk appetite of the organisation, RACS would flounder without its highly trained, skilled management team and staff. Those with whom I have had the pleasure of meeting and working with have been

extraordinarily respectful, pleasant, diligent and delightful. To experience this working relationship has been a highlight of my time at RACS. Thank you for the many contributions you made to my role over the years.

I finish by strongly commending to members that RACS is in the hands of an exceptional group who will develop the College's future.



Dr Lawrence Malisano
Vice President

Standard online training management platform launched

The Royal Australasian College of Surgeons (RACS) is proud to announce the launch of our first online training management platform.

The platform aims to deliver a single, standard digital channel for surgical training and will support Trainees, trainers, and supervisors throughout the surgical training program.

Replacing the onerous paper-based, manual process, which lent little visibility of the complete training journey, the new online platform will provide surgical Trainees and supervisors with an all-encompassing view of the entire surgical training program. Trainees will experience increased support and enhanced engagement in real time and on the go.

We expect the training management platform to eventually become a 'surgical passport' for Trainees. They will be able to manage their training requirements as defined by the curriculum set by the respective training board. Use of the platform will be easy and intuitive. They will also be able to manage their rotations and view their progress and performance throughout the Surgical Education and Training (SET) program.

The initial release of the training management platform on 1 February 2022 is available to early SET Trainees, and their trainers and supervisors from the Australian Society of Plastic Surgeons, the Australian & New Zealand Society of Cardiac & Thoracic Surgeons and the Australian and New Zealand Association of Paediatric Surgeons to use when Term 1, 2022 commences.

The training management platform will allow RACS to continue to support ongoing development, maintenance of expertise and lifelong learning in surgery. We plan to extend the use of the platform to more specialties as we develop capabilities that will allow us to refine our offering to meet each specialty's requirements.

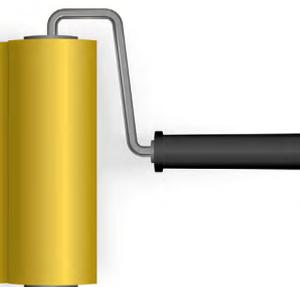
If you are a training manager and would like to learn more about using the training management platform for your specialty, please contact Bill Mezzetti (bill.mezzetti@surgeons.org). If you are a

The screenshot shows the 'My SET' dashboard for a RACS TMP Trainee. The dashboard includes a navigation menu on the left with options like 'My SET Dashboard', 'My Requirements', 'My Trainers', 'My Research', 'TMP Support', 'Instructional Videos', 'Help Document', and 'Contact Support'. The main content area displays a welcome message, a 'Supervisor' section with details for 'RACS TMP Supervisor12', a 'Trainers' section, a 'Rotation Progress' table, and sections for 'Requirements Not Started' and 'Research'.

Rotation Name	Hospital/Post #	Hospital	Assigned Date	Status	SET Stage
2021-R1-AUS-PAE	HP-PAE-2022-28-01-1844	Bentley Hospital	27/01/2022	In-Progress	Early SET One

SET Trainee and would like to investigate using the platform, please contact your specialty society or training board to indicate your interest.

Melbourne office renovations



We will soon start renovating the west wing of the Melbourne office. This is part of a wider renovation project approved by Council that includes renovating the west wing's levels two and three in phase one, bringing the building up to modern standards. This will be followed by the renovation of the east wing's levels three and four in 2023.

The renovation is part of a wider RACS program of work that has seen the updating or move to new office premises for offices in Western Australia, South Australia, New South Wales, and Tasmania.

Why are we renovating?

The Melbourne office consists of three wings and each has various building issues that need to be rectified.

- The west wing was built in the 1960s and is not code compliant for workplace usage and does not have disability access.
- The east wing was built in the early 2000s and services in the building such

as air circulation, electrical, plumbing and security, among others are past their useful life.

- The south wing, which is the heritage listed part of our building, does not have disability access.

The onset of the COVID-19 pandemic has changed our work environments with the rise of hybrid methods of working. This has placed pressures on organisations to change the way they view and use office spaces, including keeping them safe and healthy by reducing or limiting potential virus transmission through the effective management of air circulation and quality. We also need to ensure our workplaces are inviting, allowing effective engagement and collaboration among staff.

We have commissioned Lovell Chen Architects to help us with the design of the offices. Construction of the west wing is expected to start in August 2022 and finish around February 2023. We had to factor a long lead time because our building is heritage listed and the pandemic and other global events meant

that materials tend to take longer to procure than usual.

Our goal is to have a safe, healthy, and attractive workplace that motivates people to come into the office and enjoy the time they spend there.

Some of the benefits of the new office spaces will include:

- modern, spacious, and comfortable office layout with more natural light and windows that open to provide fresh air
- architecturally designed office spaces with ample storage
- flexible meeting spaces and breakout rooms to promote socialising and collaboration
- comfortable spaces for Fellows, Trainees and Specialist International Medical Graduates to use
- purpose built new kitchen and meals area
- latest IT equipment and technology
- disability access
- end of trip facilities
- energy efficient air circulation and heating systems.





news in brief

Results of the 2022 RACS Council elections

Congratulations to the following elected Councillors who take office at the conclusion of the RACS Annual General Meeting on Thursday, 5 May 2022. Thank you to all Fellows who participated in the elections process.

President - Sally Langley

Vice President - Chris Pyke

Treasurer - Greg Witherow

Censor-in-Chief - Adrian Anthony

Chair, Professional Standards and Advocacy Committee - Andrew Hill

Chair, Court of Examiners - Ray Sacks

Chair, Health Policy & Advocacy - Mark Frydenberg

Chair, Board Surgical Education and Training - Annette Holian

Chair, Professional Standards - Kerin Fielding

Chair, Fellowship Services - Christine Lai

Chair, Professional Development - Jennifer Chambers

Chair, Research and Academic Surgery - Henry Woo

Chair, Surgical Audit - Owen Ung

Chair, Global Health - John Crozier

Chair, SIMG Assessment - Ruth Bollard

Chair, Prevocational & Skills Education - Philip Morreau

Chair, Annual Scientific Congress Planning & Review - Mark Ashton

Deputy Treasurer - Rebecca Jack

The ANZH Society Committee for 2022 and 2023

The Australia and New Zealand Hernia (ANZH) Society Committee for 2022 and 2023 has the following composition: David Wardill, Kellee Slater, Jonathan Koea, Anita Jacombs, Hairul Ahmed, Ross Roberts, Rod Jacobs, Harsha Chandaratna, Hugh McGregor, Ken Loi, SuMei Ho, Elan Kaplan, Alex Karatassas, Chrys Hensman and Jonathan Rice.

The Executive will consist of Rod Jacobs, Chairman; David Wardill, Vice Chair; Harsha Chandaratna, Treasurer; and Ken Loi, Secretary.

There will be five subcommittees, encompassing Education, Research, Industry, Engagement and the ANZH CQR.

We encourage all surgeons who perform hernia repair to join ANZH and participate in redefining hernia surgery in Aotearoa New Zealand and Australia.

Visit anzhernia.org or email secretariat@anzhernia.org for more information.

First recipient of the RACS NSW Women in Surgery Award

Congratulations to Associate Professor Amanda Dawson who is "very honoured" to be named the first recipient of the RACS inaugural NSW Women in Surgery Leadership award.

RACS secures funding to increase surgical training in rural hospitals

The College has secured \$850,000 over two years to fund a project to investigate and address barriers to rural hospitals being accredited to carry out surgical training.

"The project – Rural Accreditation: Addressing Barriers to Rural Specialist Training – is an important step towards understanding the unique characteristics of rural hospitals," said Associate Professor Kerin Fielding, Chair, Rural Health Equity Strategy Committee.

"It will also address reasons why RACS' current training accreditation criteria and processes might not be as relevant to rural hospitals as they are to metropolitan hospitals."

RACS applied for this funding under the new Flexible Approach to Training in Expanded Settings (FATES) budget measure.

"The funding will enable us to kickstart our work on RACS Rural Health Equity Strategy," said Associate Professor Fielding.

"The Strategy's 'Train for Rural' component specifies the need for separate accreditation criteria for rural training post because of the unique value of rural training."

"To enable more rural hospitals to offer surgical training posts we will begin by researching barriers rural hospitals encounter when they apply for surgical training accreditation and carry out consultations to gather first-hand information."

RACS will publish a report on our findings and provide recommendations on areas that can be improved.

RACS will partner with key stakeholders, such as regional training hubs, drawing on their wealth of experience.

Celebrating International Women's Day

On International Women's Day we celebrated our women executives and surgeons in positions of leadership and asked how they #breakthebias every day.

Emily Wooden - Deputy CEO and COO

I started early in my leadership journey, being elected sports colour house captain, much to the surprise of my family! I am not sports inclined or competitive and I don't get a lot of joy out of winning, because if I win someone else loses. While it was a surprise to me at the time, I now see that my peers saw in me what I didn't see myself. They saw someone who included everyone and made sure that everyone in the team felt valued—no matter their sporting ability.

That was a defining moment for me and strengthened my belief later in my leadership journey—the importance of understanding the roles we must play. Great teams need more than just great sports people. At the College, we need more than just good surgeons; we need all of us to work together to make a great team.

Creating great teams requires us to ensure that we access all the talent we have across the College. One way of #breakthebias is removing inclinations we have towards stereotyped attributes we value in leaders, and that is to ask: 'How do we get the most from our talent?' I hope my leadership is based on kindness, inclusiveness and ensuring people feel safe and empowered to do their best work.

Tamsin Garrod - Executive General Manager, Education Development and Delivery

When I think about how to #breakthebias I think about how I found my voice and removed the bias and expectations people had of me. When I was 15, I interviewed at Tesco. While I was standing in the corridor nervously waiting for my interview, a current employee said to me, "You'll be fine, all you need to do is flirt with him (the manager) to get the job." That did not resonate with me, but it influenced my view of society.

Since then I have been fortunate to have learned valuable lessons, which have helped me own my voice. I have identified role models who resonate with me and learned from them. I have compartmentalised positive experiences away from the negative experiences that have shaped my view, undermined my value, and diminished my view of society.

I refocused my energy on finding my voice. You don't realise the societal messages you absorb until you stop and question how you perceive people and situations and start to #breakthebias.

The power of finding my authentic voice was and is important to me. You will find distractions and messages that you don't want. That won't change, but you can break the bias in your own way.

Christine Cook - Executive General Manager, Education Partnership

I have learned many lessons about leadership from my mother—my greatest inspiration. She is 95 years old and survived the second World War, fleeing the eastern sector of Germany. Having got across the border by swimming a river, my mother managed to get to her father with her little sister, both only with their dripping wet clothes. She taught herself English and completed her nursing degree.

She has been an inspiring example and has encouraged me in the same way over the years. When I was put in a leadership position unexpectedly, having inherited underlying issues, I leaned on my mother's values and what she taught me about courage, integrity, commitment, and accountability.

With these values in hand, I embraced a collaborative approach to leadership and sought out people who shared my values. Shared values run deep. The group of





people I had surrounded myself with worked together to build an organisation that was strong, resilient, and relevant. Anyone can be successful—it doesn't matter who you are or what you do.

Dr Rachelle Love, Fellow, Aotearoa New Zealand

The challenge in promoting gender equity in surgery is in recognising that anti-sexist behaviours, just like anti-racist behaviours, are a learned body of skills. They are not attitudes, morals or values. You can be a great person, but still behave in ways that disadvantage women. In my experience, people rarely intend to be sexist, but they haven't yet equipped themselves with the skills to behave in a way that is anti-sexist.

A tip from my tool kit is: every time you are asked to lead something, establish a conference panel, or write a paper, think about the voices that are being represented. Actively making room for women, and for marginalised colleagues, has been shown to increase the quality of outcomes.

Dr Sally Langley, President

I started work as a plastic and reconstructive surgeon in Otautahi Christchurch, Aotearoa New Zealand in 1990. I was the only woman surgeon here for a while but that has certainly improved over the years. Our surgical workforce should reflect the diverse nature of our community. Many people are likely to feel more comfortable presenting for surgery and experiencing surgery or a hospital stay, if their doctors and surgeons are more like them. They are more likely to interact and question in a more appropriate way.

I was a 17-year-old schoolgirl when I had my son, and now I am a surgeon and president of RACS!

Recently I saw a young woman who was a bit angry and might have felt she was having a worse experience than if her surgeon had been a man. She had her first child at the age of 17 and when I said that I did too, she was more interested in me as her surgeon. She has had the surgery now and is the happiest patient I have operated on this year. Sometimes being able to relate to the situation of a patient does help.

I feel women in surgery normalises family life for surgeons. It also allows men to spend more time with their family members, particularly children and elderly relatives. The availability of quality, affordable childcare is important as many families do not have

the extended family network to help them as backup for childcare. I saw the traditional male dominated surgical practice in my earlier years.

Dr Annette Holian, President, AOA

Give equity: promote women based on their potential, not on their track record.

Surgery's six-foot wall that must be climbed for selection or promotion is confidence. Competence, insight, reflection, and continuous improvement are what we really need. Confidence is often inversely proportional to competence.

Stop using shoulder taps for committee member selection, supervisor selection, or directors of training. Call for expressions of interest: write down what skills and attributes are needed, de-identify the applicants and design the points matrix before an interview or assessment of applicants.

Images (From left): Emily Wooden; Tamsin Garrod; Christine Cook; Dr Rachelle Love; Dr Sally Langley; Dr Annette Holian.

Women leading the way

Professor Wendy Brown



Professor Wendy Brown, Professor Silvana Marasco and Associate Professor Sue Liew are leading surgeons who head three departments at The Alfred Hospital in Melbourne. They demonstrate resilience, determination, and leadership as women in surgery.

Professor Wendy Brown is an upper gastrointestinal surgeon who is Director of the Oesophago-Gastric & Bariatric Unit. She was the first woman to be appointed Chair of the Monash University Department of Surgery in 2015. She was also the first woman appointed as Program Director of Surgical Services, Alfred Health in May 2020.

In school, Professor Brown enjoyed studying maths and science, but it was a slide show at church showing missionary work in Africa that inspired her to help people by practicing medicine.

This caring outlook has stayed with Professor Brown, and at one stage, she wondered whether she cared too much. "It's such an extraordinary privilege to help people when they are at their most vulnerable, and to be part of that journey." She has come to think that caring so much about her patients is not necessarily a vulnerability. "I ended up seeing a psychologist who said to me, 'Why do you think crying is a weakness?' And then I got a letter from a patient's wife where she thanked me for crying with her because it meant the doctor

looking after her husband cared enough to cry. Another male mentor said to me, 'You beat yourself up because you don't fit some mould, but you should celebrate that you are Wendy Brown and no one else is Wendy Brown.'"

Professor Brown initially thought about Obstetrics and Gynaecology or becoming a GP. To her surprise two professors in the Monash University Department of Surgery at The Alfred encouraged her to consider surgery. "I think they saw that I was a good problem solver, a hard worker and got along well with people."

Professor Brown acknowledges that while some women surgeons have struggled, she feels she was fortunate to have been given a lot of support. "In fact, when Silvana and I were accepted into the general surgical training program, there was a feeling by some of the male Trainees that we had been favourably treated because we were women. Professor Chris Christophi, the supervisor of surgical training, came to our defence and drew attention to our CVs and how much we had achieved."

This support has made Professor Brown determined to support others in the same way. "I'm really proud that I came through a system where I was given a lot of encouragement. I'm also proud that RACS has looked at our profession and acknowledged that we can do better. The more gender diverse and culturally diverse our profession is, the better."

Professor Silvana Marasco similarly feels she was supported and encouraged. She is director of Cardiothoracic Surgery at The Alfred and a Professor at Monash University.

Her father was an Italian migrant who urged his children to think about careers in law or medicine. A family friend provided work experience in plastic surgery at The Alfred when she was 15.

While Professor Brown moved to an all-girls school in Melbourne where students were encouraged to think they could achieve anything from a co-ed high school

in Aotearoa New Zealand, Professor Marasco's parents moved her from the private girls' school to a private co-ed school so she could be immersed in a stronger maths and science environment.

She decided to specialise in Cardiothoracic Surgery after doing a rotation as a resident. She loved the intricacy of the surgery, the study of physiology and her experience of the patient population. At the time, she was supported by a reasonable cohort of female surgical Trainees. She recalls around a third of the Trainees attending morning tutorials at The Alfred were female.

Like Professor Brown, Professor Marasco said she has only had positive experiences as a female surgical Trainee and then surgeon. "I've read reports of women being bullied and treated badly, but I can't recall myself or any of my colleagues experiencing anything like that."

She laughs recalling a comment directed at her. "The head of a unit I once worked under said I couldn't do cardiothoracic surgery because I wouldn't be strong enough to pull wires out on a redo. I think of him every time I do one! But at the same time, he was also very encouraging."

Professor Marasco doesn't think it's a straightforward matter of women being better carers and having better bedside manners than male doctors and surgeons. But she does remember an unsuccessful



Professor Silvana Marasco

surgery where the patient died on the table, and within 45 minutes of the end of the operation, the hospital's female Chief Operating Officer (COO) had dashed to see how she was. "Would a male COO have done the same? I can't unequivocally say either way."

Professor Marasco had two children five years after becoming a cardiothoracic consultant. "The sleep deprivation was just terrible. Just when you got to sleep, you'd get a hospital call—it was torture. The best thing I ever did was to hire a nanny."

She juggles parenting, three days a week operating and research. Despite the triple load of being a surgeon, researcher and mother, Professor Marasco said it has helped her to come home to a family. "We often obsess over surgery—how we could have done things differently or better. Having children stops me from ruminating all the time. Being a mother also helps me put things into perspective."

Professor Marasco is particularly proud of the legacy she leaves as a researcher. "My surgery saves one life at a time, but my research work positively impacts the lives of many more people."

Associate Professor Sue Liew had a harder journey on her way to becoming director of Orthopaedic Surgery, first at the Austin Hospital and then at The Alfred Hospital.

"I won a scholarship and went to boarding school in Ballarat, which I hated, having grown up in a country town called St Arnaud in

Victoria. At school I wanted to become an engineer—not a doctor! I was planning to go to RMIT."

The headmistress at her school was appalled at the thought of RMIT and arranged a special tour of the University of

Melbourne, where Associate Professor Liew was accepted into engineering.

"I was so unhappy," she recalled. "I was so young. I had no idea what I wanted to do. I had moved from my family and home to a boarding school in another town, and then Melbourne."

She dropped out of engineering and applied for medicine at Monash University. "I just thought, if I was accepted, that's what I'll do next." She was accepted and her life was split between studying at Monash University and working in a restaurant to support herself. Associate Professor Liew believes her experience working gave her resilience and helped her to think on her feet. "I stepped in to do anything that was needed."

At first she was an average medical student and just wanted to graduate, go back to the country as a GP, and support her parents. But in her second year of medicine, she married, and she and her husband decided to stay in the city. She started to think about surgery and was drawn to its decisive nature. By comparison, she found medicine too discursive.

"I looked at many types of surgery and then settled on Orthopaedic Surgery because it aligned with my way of thinking. I particularly like having mechanical, structural, practical problems to solve and I like the cerebral nature of surgery. You can teach almost anyone to do the surgery, but you need to



Associate Professor Sue Liew

be able to know how to work your way out of trouble with options A to Z to be a good surgeon."

Like Professor Brown and Professor Marasco, Associate Professor Liew hasn't felt discriminated against because she is a woman. "Maybe it's because I'm not in the practice of interpreting comments in a gendered way. I've only ever felt supported."

However, she appreciates how hard it can be for women to combine a surgical career with having a family, having had four children in short succession. "You can only do it with help! My parents and my brother lived with us and helped. It was a very Asian arrangement. You can't do the young family on your own. It's not helpful for women to not talk about this."

When asked about the legacy she leaves behind, Associate Professor Liew says she doesn't think of her work in this way. "I've been told I'm a good role model, a good spine surgeon, and mentor. I don't think in terms of legacy. I ended up as director of Orthopaedic Surgery at the Austin and now the Alfred because I love what I do."



Australian federal government funding supports rural initiatives

RACS successful in securing \$850,000 for project

The Royal Australasian College of Surgeons (RACS) advocates for communities to have equitable access to quality healthcare—irrespective of geography. The Rural Health Equity Steering Committee was formed to tackle issues surrounding equitable access to quality healthcare. Their aim is to deliver the Rural Health Equity Strategy (RHES) as a proposed pathway for training specialists so everyone can have equitable access to healthcare.

The RHES activity has been off to a roaring start in 2022. After establishing a governance structure and conducting significant stakeholder engagement activities in 2021, this year we start delivering on strategic actions.

A big win for the College, which will significantly help our delivery, is the announcement of a successful funding proposal under the Australian Department of Health's new Flexible Approach to Training in Expanded Settings (FATES) scheme. RACS was successful in securing \$850,000 over two years to fund the project Rural Accreditation – Addressing Barriers to Rural Specialist Training.

This project will address barriers to hospital training post accreditation in rural hospitals with the aim of increasing rural specialist training and practice pathways. RACS and the Royal Australasian College of Medical



Administrators (RACMA) will partner to form a consortium to undertake a significant review of RACS accreditation criteria and processes, including extensive engagement with internal and external stakeholders.

The objectives of the project include:

- understanding the barriers that rural hospitals face in applying for and meeting hospital training post accreditation standards
- creating a 'supporting evidence' resource to assess performance against hospital training post accreditation standards, within a rural context.

The Northern Territory and the Victorian Department of Health were both supportive in the application for funding. RACS intends to work with both the governments, the regional training hubs, and rural hospitals as part of the external consultation process.

The project and its deliverables were designed to meet not only the recommendations under the RHES, but also the recently released 2021-31 National Medical Workforce Strategy (NMWS) by the Australian Federal Department of Health. The strategy is the result of significant collaboration and input from key medical stakeholders across Australia.



The strategy has identified 25 actions that sit under the five complementary priority areas:

1. collaborate on planning and design
2. rebalance supply and distribution
3. reform the training pathway
4. building the generalist capability of the medical workforce
5. flexible and responsive medical workforce.

In addition, three other cross-cutting issues are described. These are:

1. supporting the Aboriginal and Torres Strait Islander workforce and improving cultural safety
2. changing models of care
3. doctor wellbeing.

The impact on RACS by the NMWS and its themes are substantial and will significantly influence RACS work and specialist societies to ensure the delivery of the desired outcomes.

The following themes have been identified on which RACS will undertake significant action to meet the vision and outcomes of the NMWS:

1. Aboriginal and Torres Strait Islander workforce and cultural safety
2. sharing training data with external stakeholders
3. hospital training post accreditation
4. selection
5. Trainee allocation
6. supervision
7. training pathway
8. generalist specialists
9. culture
10. Specialist International Medical Graduates
11. assessment.

RACS is well positioned to be a leader in the implementation of the NMWS, given its alignment with its own strategic

objectives, and much of what is included in the NMWS is already addressed within the RHES.

The FATES Rural Accreditation project is the first on the list for the Rural Health Equity Steering Committee, and the successful implementation will be a great win for keeping RACS in step with the direction of the Australian and Aotearoa New Zealand's workforce needs.

For more information please contact: rural@surgeons.org

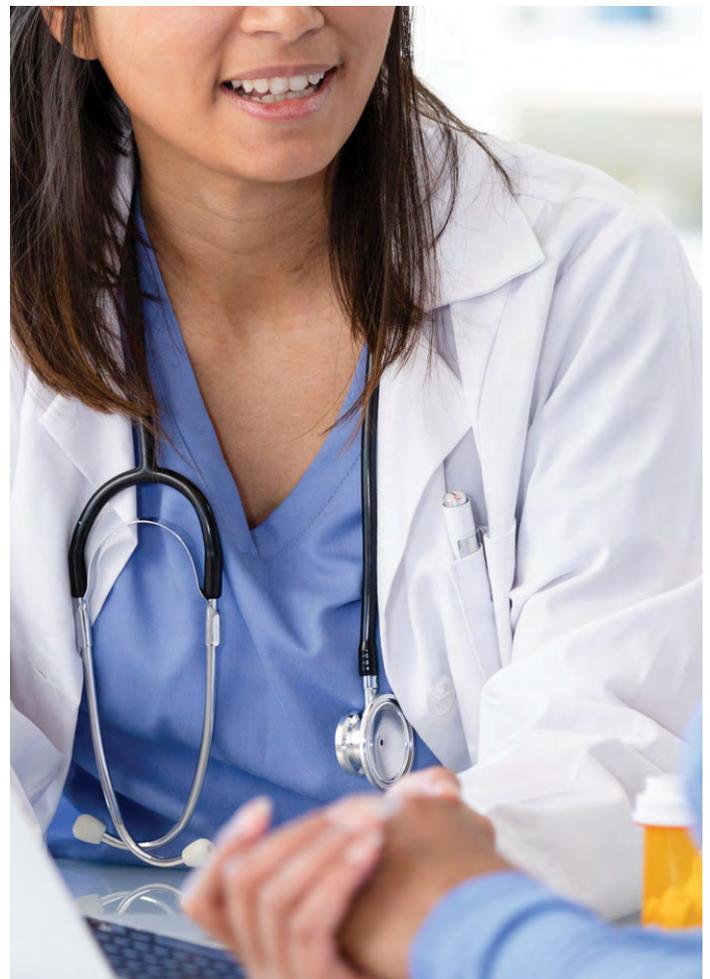
Prostheses List Reform

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.

Find out more, visit:

www.privatehealthcareaustralia.org.au



Building a better profession

As a member of the RACS Māori Advisory Committee, Dr John Mutu-Grigg is helping drive cultural progress

The process of shaping and fitting wood has made John Mutu-Grigg a better surgeon.

The orthopaedic surgeon was attracted to carpentry and building long before he considered a career in medicine.

However, the tides of life pulled Dr Mutu-Grigg in the direction of Orthopaedic Surgery, where he was surprised to find parallels with his original passion.

“I get to go to work and I use hammers, saws and drills all day, and that it is exactly what I want to do,” he says.

He spends his free time using his carpentry skills to repair and build items—from children’s cots to letterboxes—and believes that the precision necessary in carpentry has helped him hone his surgical skills.

“There are many things that I’ve learned in the operating room and I’ve taken into the garage, but there are even more

things that I’ve learned in the garage and taken into the operating room.”

Dr Mutu-Grigg’s pathway into medicine began when he attended Auckland Medical School.

After working across Aotearoa New Zealand, he spent a year at the renowned London Health Sciences Centre at the University of Western Ontario doing hip and knee arthroplasty, before working at Toronto Western Hospital doing hand and microsurgery.

Dr Mutu-Grigg loved orthopaedics from the time he fixed a broken ankle as a first-year house surgeon, but he was never in any doubt about the monocultural nature of the profession.

“I felt I had to deculturalise myself to be accepted, but after experiencing the same at high school I wasn’t surprised,” he says. “I’d found what I wanted to do but realised quickly, that being Māori wasn’t particularly helpful.”

As a lone Māori student in his high school class, Dr Mutu-Grigg had debated with his teacher and other students about Māori cultural issues, informed by his mother who is a professor of Māori language and culture at the University of Auckland.

Later, the same readiness to challenge those in power saw him form a group of orthopaedic surgeons who demanded equity for Māori within the New Zealand Orthopaedic Association.

His activism resulted in the introduction of Ngā Rata Kōiwi, a group of Māori surgeons and Trainees, using a tuakana-teina system (the relationship between older and younger siblings) in which experienced surgeons mentor their more junior counterparts.

“In the group we want Trainees to have as much say on topics as consultants, and new Trainees can discuss any concerns they have without worrying if it will impact negatively on their future.”

“There are many things I have learned in the operating room that I have taken into my garage, but I have learned many more things in my garage, that I have taken into the operating room.”

This and other initiatives aim to bring Kaupapa Māori, or the Māori way, into the heart of the profession.

As a member of the RACS Māori Advisory Committee, Dr Mutu-Grigg is also helping drive cultural progress.

The group has changed their terms of reference to promote equity within the profession and support the appropriate teaching of Cultural Competency—a crucial element of the RACS competency program.

It also aims to introduce Māori concepts into the College policy, such as the new Koha or Māori gifting policy.

Dr Mutu-Grigg believes the battle for cultural equity within the profession has benefited from the inroads into gender equality made by women in recent decades.

“Isaac Newton said, ‘If I have seen further it is by standing on the shoulders of giants’, and that is certainly the case when it comes to our fight. The arguments are similar and many of the challenges are the same,” he says.

“I can see my role as being to fight for those who cannot fight for themselves to make a better profession for everyone.”

As a father of three girls, Dr Mutu-Grigg is pleased that they will not face the same challenges that he encountered at school or as a medical trainee.

“The fight has progressed significantly and things are continuing to get better. It has so many benefits for individual surgeons and the entire community.”



Change for Indigenous health

Dr Ben Cribb leads the change by enticing more Indigenous doctors into surgical training



The Indigenous people of Australia and Aotearoa New Zealand suffer significant inequalities in health outcomes in all areas of medicine. At present, Indigenous surgeons make up less than one per cent of the membership of the Royal Australasian College of Surgeons (RACS). Increased Indigenous representation among surgeons will improve surgical outcomes for Indigenous people and improve cultural safety and diversity within the profession.

The RACS Indigenous Health Committee (IHC) was formed in 2008 to represent Indigenous College members and oversee the implementation of strategic commitments in Aboriginal, Torres Strait Islander and Māori health.

Dr Ben Cribb, a general surgeon from Aotearoa New Zealand, has been involved with IHC and the Māori Health Advisory Committee since 2016. In 2022, he's grateful for the opportunity to step up as IHC Chair. He says it's a privilege to meaningfully contribute to change for the health of Indigenous Australians and Aotearoa New Zealanders.

Dr Cribb is currently based at Tauranga Hospital in the North Island. His iwi (people) is Ngāti Maniapoto and Ngāti Tamaterā. He was attracted to general surgery because of its technical aspects

and the ability to see critically unwell patients recover after surgery. "I felt general surgery was where I could make the most significant impact and it matched my personality.

"My goal, as IHC Chair, is to ensure that aspiring Indigenous doctors who want to be surgeons know that they are really needed in our specialty and that RACS wants them to be Trainees and surgeons," says Dr Cribb. "I want to help our College evolve so that Indigenous surgeons have support networks and pathways to get into training and can successfully navigate and complete their training. Our Indigenous Trainees need a training program and workplaces that are culturally safe environments."

Currently, there's no reliable data on the number of Indigenous RACS members, but Dr Cribb says it's well under one per cent. He points out that the Medical Council of New Zealand collects ethnicity data together with medical registration, and he hopes that RACS will start to do the same, as the statistics are useful in bringing about change.

Dr Cribb says the barriers for Indigenous Australian and Maori Aotearoa New Zealander surgeons are many and common between the two countries. He admits there's no easy solution but thinks that multi-faceted interventions on multiple levels—guided by Indigenous Fellows who lead by example—can address the imbalance over time.

As IHC Chair, Dr Cribb says his biggest priority is increasing the number of Indigenous surgical Trainees. He plans to ensure that junior Indigenous doctors know there's a real need for them in the surgical profession.

His other priority is to continue improving the cultural safety and competency of all RACS Fellows. IHC has been engaging with training boards to incorporate cultural safety and competency into surgical education and the Trainee selection processes.

"As a College, we must work towards increasing the number of Indigenous surgeons to better serve our Indigenous people and achieve equity in surgical outcomes."

Dr Cribb also strongly advocates for equitable access to elective surgery. He's particularly concerned that, with disruptions caused by COVID-19, inequities are exacerbated, and vulnerable Indigenous people will not get the surgical care they need.

Dr Cribb looks forward to leading the drive for change by enticing more Indigenous doctors into the surgical training program and ensuring they have the support networks they need to succeed. "As a College, we must work towards increasing the number of Indigenous surgeons to better serve our Indigenous people and achieve equity in surgical outcomes."

College raises key issues ahead of the Australian federal elections

The 2022 Australian federal election is almost upon us. This year's contest of ideas will see the incumbent Morrison Government, challenged by the Labor opposition led by Anthony Albanese.

While the early 2022 polling has indicated a lead to the Labor Party, if the last election taught us anything, it is that polling should be treated with caution.

Most pundits have agreed that the outcome of this election will be close. They have also agreed that health will be a central component of the campaign, particularly in the context of COVID-19 management and recovery.

As always, before every state, territory and national election, RACS has provided an opportunity for political parties to outline their policy positions on key issues.

As always, before every state, territory, and national election, RACS has provided an opportunity for political parties to outline their policy positions on key issues. Once we receive the responses, we will distribute these to our membership and make them available to the wider community through our website.

Although this may seem like going through the motions, there have been many examples where RACS has been able to secure firm commitments from political parties prior to an election. One such example was the Tasmanian state election, which was held in 2021. In their election statement the Tasmanian State Committee highlighted issues regarding research governance within the state, which were leading to lengthy delays in the processing of research requests. Based on this advocacy the Committee was able to secure additional support and infrastructure, which has streamlined the process and resolved the issue.

Other examples in the past include the abolition of roads without speed limits

in the Northern Territory, and ongoing funding commitments for the various audits of surgical mortality.

The 2022 election statement was developed by the Health Policy and Advocacy Committee (HPAC). In compiling the list of priorities, HPAC consulted several RACS committees and interest groups. From this consultation HPAC was able to establish the following nine priorities.

Building respectful and safe workplaces for all who work in surgery and the wider health sector

Building respect and improving patient safety has been a priority for RACS over many years. But there is still much work to be done to foster professional behaviour that keeps teams performing at their best and patients safe in health settings across Australia. In some areas, work has only just begun and in others, entrenched problems will be solved only by cross-sectoral commitment and collaboration. Among our recommendations was that the next federal government work to implement the full suite of recommendations contained in the Australian Human Rights Commission's Respect@Work report. This includes legislation to place a positive duty on employers to prevent sexual harassment at work.

Elective surgery

COVID-19 has placed extraordinary pressures on elective surgery procedures. In the short-term RACS has called for a national plan to address the growing and increasingly critical backlog of elective surgeries. More broadly, we have called for long-term funding commitments that deliver permanent, expanded capacity in our public hospital system. Furthermore, we have urged the next Australian federal government to work with state and territory governments on a review of the national definitions for elective surgery urgency categories.

Use of the title surgeon

Although under the *Health Practitioner Regulation National Law* many medical specialty titles are restricted, the use of the title 'surgeon' is not. This means that those who have not undertaken accredited specialist training in surgery can advertise themselves using terms such as 'cosmetic surgeon'. This has been a long-term advocacy priority for RACS, and our election position statement has called on all parties to provide their support for legislative change.

Ensuring the Medicare Benefit Scheme remains contemporary and provides universal access to the best technologies and services

In response to the pandemic, the Australian government introduced temporary telehealth Medicare Benefit Schedule (MBS) items to ensure safe access to healthcare. RACS welcomed the government's announcement of 'permanent telehealth' in December 2021. However, we do not agree with the decision to restrict access to telehealth in certain circumstances. We have urged all parties to ensure all Australians have appropriate access to specialist telehealth from the initial consultation. In addition to this, we requested close consultation with RACS and other peak medical groups on the continuous review of the MBS.

Ensuring our mixed healthcare system continues to thrive

Australia's unique health system, with universal public access supported by a strong private sector, which alleviates pressure on public waiting lists, has made our health system one of the best in the world. However, it is widely acknowledged this system is in trouble with private health insurance rates in a long-term downward trend, particularly among the young. At the same time, especially in the context of the pandemic, public waiting lists are blowing out. The election statement highlighted these concerns and requested policy responses to several specific questions.

Expanding surgical (and other specialist) services in rural areas

On average people living in rural, regional, and remote locations have worse health outcomes compared with people living in metropolitan areas. At present approximately 29 per cent of Australians live in rural and remote locations. But according to RACS census findings only 12 per cent of RACS Fellows live and work rurally in Australia and for five of the nine surgical specialties, fewer than five per cent of surgeons were based outside cities. The reasons for this maldistribution are multifaceted. RACS has requested that the next Australian government establish a federal mechanism tasked with identifying barriers to surgeons basing themselves in rural areas and making recommendations to bring these barriers down where possible.

Ensuring the health of all Australians is protected from the threat of climate change

Climate change is described by the World Health Organization as 'the greatest threat to global health in the 21st century'. Yet, climate action could be the greatest public health opportunity to prevent premature

deaths, increase life expectancy, and to achieve health and economic co-benefits.

To ensure that the health of all Australians is protected from the threat of climate change, our election position statement asked a number of questions centred around ensuring that the health of all Australians is protected from the threat of climate change.

Committing to health security and long-term health systems strengthening in the Pacific

RACS has had a long relationship with the Department of Foreign Affairs and Trade, as the leading donor for clinical services and health workforce development in the Pacific Island Program (PIP) across 11 Pacific Island countries. Amid increased surgical demand due to COVID-19 impacts on specialised clinical service delivery, and an affected Pacific health workforce, RACS has been informed that there is a planned 43 per cent cut to the next iteration of the PIP (2022 – 2027). Our election position statement sought a guarantee that the proposed PIP funding cuts would be reversed, and that a funding envelope of A\$1.7million per annum is allocated for the period 2022 – 2027.

Expanding surgical and other specialist services for Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people continue to have worse health outcomes compared with other Australians. There are barriers to access, which only the government can address. RACS has advocated in our position statement innovative pathways for Aboriginal and Torres Strait Islander people to access surgeons and other specialists. An example we provided was the introduction of higher benefits to regional, rural and remote doctors to bulk bill Aboriginal and Torres Strait Islander people.

Reducing death and serious injury on our roads

Each year across Australia more than 1200 people are killed and 40,000 are hospitalised because of road trauma. This can only be described as a national epidemic, which demands strong leadership and close collaboration from all levels of government and communities. Our election position statement urges the next government to implement a comprehensive action plan to support the latest National Road Safety Strategy. We also echoed our longstanding advocacy priority to prioritise data collection, enhancement, and application, with a specific strategy to enable the provision of data via the new national road safety data hub.

The full RACS election statement is available on: <https://bit.ly/3ubIIX4>



Dr Philippa Mercer – an inspirational leader in surgery

Dr Philippa Mercer is a general surgeon based in Christchurch and the Chair of the RACS Aotearoa New Zealand National Committee.

As a secondary school student who liked science, maths and sports, Dr Mercer applied for medical school after a medical intermediate year at the University of Canterbury. Her alternative career plan was agricultural science if she was unsuccessful in her application. Surgery wasn't a clear career path until after she had explored many different areas of medical practice as a student and as a house surgeon. She believes that students should explore and identify what they most enjoy instead of entering medicine with a preconceived focus.

General surgery was an unusual choice for women at that time. Dr Mercer asked a consultant when she was a second-year house officer whether surgery would be a good career choice. He advised her that it was a hard career path. Undeterred, she applied for a non-training general surgical registrar position, and when her application was not successful applied to a hospital in the North Island. This time she was successful. "The consultant who advised me not to pursue surgery became one of my most fervent supporters."

Dr Mercer is very honoured to be the Chair of the RACS Aotearoa New Zealand National Committee (AoNZNC). "It's a big responsibility overseeing the committee and working with the AoNZNC office. The role includes communications, ensuring we support all our Fellows and Trainees, as well as working to maintain standards and the care of the community."

There are many aspects of the job she enjoys. She recently chaired an International Women's Day Breakfast where attendees heard about a mentoring program called Wāhine Connect that had been established for

women in medicine by public health physician Juliet Rumball-Smith.

Dr Mercer has been working to address the workforce crisis in New Zealand. This has been a major issue for AoNZNC for some years, exacerbated by the pandemic. The AoNZNC has been advocating on behalf of surgeons through talks with Dr Robyn Carey, the chief medical officer with the Ministry of Health, about how government can assist. "RACS, government and the Medical Council need to work together to train more Aotearoa New Zealand Trainees who then become Aotearoa New Zealand surgeons and enable more overseas medical staff to qualify to work in Aotearoa New Zealand to relieve the many shortages in healthcare due to the impact of COVID-19 and border closures."

Mentoring and supporting other surgeons and doctors is another part of Dr Mercer's role as chair of the RACS AoNZNC that she is passionate about. "I try to support as many people as I can—to help them with whatever issues. A surgeon's role should also be about helping people around you and supporting your colleagues and staff. I am happy that my profile provides me with the opportunity to provide advice and support to many surgeons who call me when they need help or guidance."

Some changes introduced under Dr Mercer's leadership include increasing the deputy chair's involvement in the executive office to increase the team's knowledge and make the transition from deputy to chair smoother, and introducing the name Aotearoa for the Committee. "Not everyone agrees with this change but I'm proud of the change."

Dr Mercer looks forward to encouraging more people to take up surgery, including Māori and Pasifika. "We need to create more role models and culturally safer environments. We are introducing



cultural safety training into many of our programs, which we hope will help to remove any racism or cultural bias that Māori or Pasifika may come up against. We have very good Māori doctors and surgeons on our Māori Health Advisory Group who advise and assist the National Committee and the wider College."

Dr Mercer will step down as chair at the end of June, when deputy chair Dr Andrew MacCormick will move into the role. She will continue to stay on the Committee for another two years.

"Dr MacCormick has an interest in reducing environmental impact and protecting community health through reducing energy waste and renewable energy. As surgeons we need to be leading in these areas."



Why more girls should become surgeons

The world is made up of all types of people. Some are doctors, some librarians, some engineers, some are nurses ... the list goes on. I want to encourage girls to consider becoming surgeons.

According to a research conducted by the Australasian Students' Surgical Association in 2020, women represent 11 per cent of consultant surgeons and about 13 per cent of surgeons in Australia.

Considering women make up over half of Australia's population, these numbers aren't anywhere near as representative of the population as they could and should be.

The sentiment or belief, 'You can't be what you can't see', is true to an extent. If girls—early on in their education—saw female surgeons, doctors or scientists in their worlds, following those career paths would seem well within their reach if they were interested. Girls need to know that these careers are real possibilities for them.

I want girls to give themselves the opportunity to find out whether they are passionate about surgery. It can start with a tiny interest, an inkling that they could be good at it, or a little tug on their insides that makes them wonder if they, too, could be a surgeon.

Some time ago I spoke to high school students at a careers evening as an old scholar. It was a new experience for me, and one that I thoroughly enjoyed because I was speaking to young people about a

career that I truly love and have never deviated from.

My father is a general practitioner and my interest in medicine was sparked because of him. I have always been around that environment so maybe it was inevitable that I would choose medicine at university. Watching the 1991 film *The Doctor* clinched the deal for me though!

In medical school I didn't waver on my decision to become a surgeon, even though I was told by non-surgical colleagues that surgery was not a suitable career for women. Apparently, surgery wasn't family friendly, and women would find it hard to start a family and continue their surgical training—or so I was told.

It doesn't matter what job you do, there will always be tension when it comes to starting a family, taking parental leave, and returning to work. The Royal Australasian College of Surgeons has long been advocating for surgical Trainees to have flexible training roles. Many hospitals and surgical specialties are supportive of this. After becoming a Fellow and a consultant, you make your own hours, giving you more time to spend with your family.

I was fortunate to have many supportive mentors and colleagues during my surgical training. Only one of my medical registrars thought I wouldn't make it as a surgeon because I am a woman, and of Asian descent. How wrong he was!

I always say to young people that they should surround themselves with people who are honest and trustworthy, and who know what you are capable of. Take critical feedback and advice as it comes—if you respect the person it comes from.

If you have ever thought, 'Hey, I think I'd like to become a doctor, or a surgeon, and help people,' then I want you to consider doing a few practical things.

Look at university course prerequisites for undergraduate medicine courses. You can also explore undergraduate courses that lead to postgraduate medicine. Speak to your science teacher and find out what subjects you need to be doing to make sure medicine is an option for you in university. When you complete your medical degree, do as many training terms in surgery as you can get to experience the different aspects of surgery. Seek out mentors who will help you and give you advice and guidance.

The world is made up of all types of people. You could be a surgeon in the world if you want to. You will never know if you can do it if you don't try.



Dr Christine Lai

Dr Christine Lai is an Adelaide-based general surgeon specialising in breast surgery

COVIDSurg-3 unites surgical community

COVIDSurg-3 is the latest in a series of studies that has now collected data from more than 140,000 patients from around 122 countries

Surgeons from Australia and Aotearoa New Zealand are part of a large international study that aims to determine the impact of the Omicron variant of COVID-19 on surgical patients and hospitals.

COVIDSurg-3 is the latest in a series of studies that has now collected data from more than 140,000 patients from 122 countries.

The studies have so far involved surgeons from more than 1600 hospitals and healthcare centres. They have provided data on patient outcomes and impacts on services resulting from COVID-19 infections before or after surgical procedures.

The collaboration is the largest of its kind, trumping even the global community involved in the blockbuster physics Large Hadron Collider research.

The latest study, COVIDSurg-3, is collecting data on how the Omicron variant affects respiratory complications in surgical patients when they have been infected pre- or post-surgery, and how the variant has impacted services.

The data will be used globally to better determine the risks of surgery before or after an Omicron infection, the optimal timing of surgery, and the best way for hospitals and healthcare services to manage surgical schedules in the face of this variant.

RACS members helping lead the Oceania arm of the research include Gold Coast upper gastrointestinal surgeon Philip Townend. Other members of the team include Perth junior medical officer Kyle Raubenheimer, and Auckland PhD student and non-SET surgical registrar Cameron Wells.

Dr Townend was connected to the research through his previous work in Birmingham in the UK, where the GlobalSurg series of studies—which includes COVIDSurg-3—originated. He believes the research will provide greater clarity for health professionals when planning surgery.

“We know from the data collected last year and the year before that there is a higher rate of respiratory complications such as pulmonary embolism, pneumonia, admissions to ICU and mortality rate among those with COVID-19, or who catch COVID-19 within 30 days of surgery. But we don’t know if it’s the same with Omicron because we presume it’s milder,” Dr Townend says.

“The idea of the study was to help give clinicians and patients information to manage the risk of surgery so they can manage the risk to the patient accordingly, and hopefully avoid complications if things can be delayed until it is safer for the patient.”

Dr Townend says the research is impressive for many reasons, including its scale, its reach, and its timeliness.

“What makes this research so important is the large volume of patients from across so many countries—from large hospitals to small health centres. The data has also been collected in an extraordinarily short time compared with many other studies.

“The more numbers we get, the more powerful the study will be and the more significant the results.”

The research has given surgeons from Australia, Aotearoa New Zealand, and the Pacific region the chance to collaborate on a world stage. Dr Townend

believes this will breed future research opportunities and provide young surgeons with invaluable experience.

“It [COVIDSurg-3] has really opened the door to international collaborative research,” Dr Townend says.

“That has not happened extensively in Australia in the past—we have lagged behind the research side of surgery. The exciting thing is that it will open the door to other major surgical collaborations.

“This isn’t just about COVID-19; it has also brought the international surgical community together.”

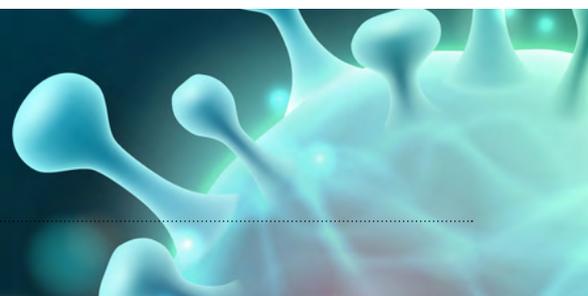
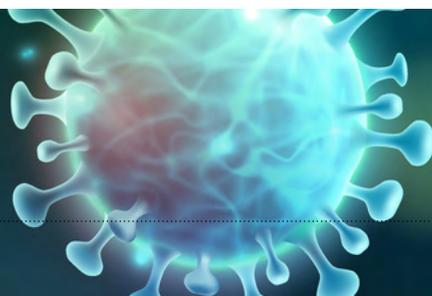
While Dr Townend recruited Australian hospitals to the study, he says junior doctors, including medical students, registrars, and junior medical officers, had been instrumental in the study’s success.

“The diversity of people involved is fantastic and junior doctors have really taken the lead. It has provided them with the leadership skills to start their own collaborative research.”

Dr Raubenheimer is one of the junior medical officers who has been closely involved with coordinating data collection for COVIDSurg-3 in Australia.

He has helped coordinate hospitals and health centres, supported them to register and collect data, and ensured the relevant ethics and governance protocols were in place.

“Seeing that the surgical community can really band together and provide high quality data that could really impact the evidence base and hopefully lead to better provisional surgical care is really quite exciting.





Dr Philip Townend

“It’s also been fantastic to be able to collaborate with the consultants all around the world.

“There’s communication between everybody within Australia and Aotearoa New Zealand, but then also on an international scale, in the true spirit of collaboration,” Dr Raubenheimer says.

The research has provided Dr Raubenheimer with the opportunity to indulge in a passion for medical research that he had even before he entered the medical field.

Originally from South Africa, he studied Exercise and Movement Science at Queensland University of Technology with the intention of becoming a fitness trainer.

“I really enjoyed the fact that I could improve people’s health by getting them to exercise,” he says.

However, realising that there was a ceiling to what he could achieve in that job, he completed his Exercise and Movement Science degree and entered into a Biomedical Science Honours year. During this time he studied the effects of beetroot juice on people’s coagulation profiles and cardiovascular health, before studying medicine.

“I’ve been loving medicine and research ever since, especially academic medicine and academic surgery. In academia, you generate better evidence that people use to treat patients and you don’t only impact people you’re treating directly,



Dr Cameron Wells

but you also impact the health of a much broader base.”

In 2018, he became involved with a collaborative research project run by the student-led STARSurg UK collaborative, which studied the respiratory complications following major abdominal surgery.

COVIDSurg-3 was a natural progression for him, and one which he hopes saves lives.

“If we know when is the best time to operate on patients, and how many procedures we’ve had to cancel, we can plan for the future in terms of making sure that there are enough services to ensure patients get the right type of care they need, when they need it, and don’t suffer adverse health effects from having their surgery delayed,” Dr Raubenheimer says.

Fellow junior surgeon Dr Wells agrees that being involved in COVIDSurg-3 has provided the opportunity for international surgeons to collaborate to improve patient outcomes.

“Ultimately the most important thing is the generation of high-quality evidence for our patients, and that has been a huge success of this model of research,” he says.

Dr Wells became an Aotearoa New Zealand lead for the project after being involved in other international research studies.



Dr Kyle Raubenheimer

He recognises the personal benefits of being involved at an early stage in his career.

“This study has helped me and other emerging leaders develop important leadership and organisational skills, which I hope will support the ongoing development of collaborative research in Aotearoa New Zealand, Australia, and the rest of Oceania.

“We have also shown that medical students, junior doctors, and Trainees can learn research skills, and lead and contribute to these projects, and this is increasingly recognised by RACS through their support of CTANZ (The Clinical Trials Network Australia and New Zealand) and other collaborative networks,” he says.

Like Dr Raubenheimer, Dr Wells would like to pursue further research during his career. He hopes that the quality of data, and the benefits of its practical application, will encourage future collaborations of a similar scale.

“I hope this research will help improve perioperative care and decision making for surgical patients during the COVID-19 pandemic,” he says.

“I also hope that the international networks and collaborations we have developed through this study will persist and continue to grow, allowing us to answer important surgical questions in the future.”



Revolutionising trauma surgery in Adelaide

Dr Peter Bautz's career is full of remarkable experiences around the globe



The sign on the office door simply says: Clinical Lead, Consultant Trauma Surgeon.

It gives no hint that its occupant, Dr Peter Bautz, had applied for both medicine and engineering on completing secondary school in South Africa. And it was a stroke of luck that he chose the medical path as it led to a journey full of remarkable experiences. This has also contributed to his success in revolutionising trauma surgery at the Royal Adelaide Hospital.

Dr Bautz recalls surviving the brutal medical training in South Africa and feels that completing his internship in surgery was a pivotal moment. "I decided I wanted to focus on surgery because in comparison to medicine, it was so dynamic and exciting."

Soon after graduating, Dr Bautz was drafted into compulsory military duty as a ward doctor in the Border War against Cuba. This influenced his outlook and determination as a doctor, and later as a surgeon.

Dr Bautz found himself often working without supervision, in extreme circumstances, doing whatever he could to keep war casualties alive, including surgery and anaesthetics. "I resolved that in the future any junior that works under me will not be left alone." Intense officer

training and army service cemented a resolve that would help him in war, and later in Saudi Arabia and Adelaide. 'Never retreat. Never give up' became his motto.

Dr Bautz completed two years of military service and returned to Johannesburg to qualify as a surgeon.

As a surgical registrar, with his wife Dr Dee McCormack, a medical officer in the same training unit, Dr Bautz performed South Africa's first surviving thoracotomy on a police officer who had been shot in the groin, hitting a femoral artery. In those days, under Dutch-Roman law, married couples were not allowed to work together so they achieved notoriety for a brief period.

A further 10 years of compulsory part-time military duty as a surgeon ensued. At that time, the war was essentially over so his team ran word of mouth clinics that serviced the local population wherever they were posted for months at a time. Following this, Dr Bautz returned to work in South Africa before following his wife to rural Africa for two years. Saving patients with injuries from wild animals such as hippos, crocodiles, and wart hogs gave him a unique perspective on trauma.

They returned to Cape Town where Dr Bautz started working at the Groote Schuur Hospital (where the world's first successful human heart transplant was performed in 1967). Dr Bautz converted the trauma unit from a non-surgical unit to a full surgical unit in four years—the first dedicated surgical trauma unit in the Western Cape.

The work was intense. "In South Africa, 70 to 80 per cent of all surgical work is trauma related," Dr Bautz said. "There is a never ending, overwhelming supply. We received around 400 stabbing victims each month, with gunshot victims averaging 110 a month. They came from drug wars, vigilante groups, crime, territorial disputes."

One weekend the hospital received 18 stabbed heart victims. Dr Bautz and a Dutch military surgeon opened 14 chests that weekend. All survived except one patient who died three days later of cause unknown.

An offer to set up a trauma unit at the King Faisal Hospital in Riyadh, Saudi Arabia, saw Dr Bautz and his family relocate to Riyadh. They planned to stay for two years but ended up staying for five and a half years. He performed the first successful thoracotomy on a stabbed heart victim in Saudi Arabia.

Unfortunately, the dramatic escalation of violence in Riyadh as the result of 9/11 resulted in major bomb attacks by Al-Qaeda targeting the western compounds close to where Dr Bautz and his wife worked, the family lived, and the children went to school. Management of bomb and blast trauma injuries, therefore, became a part of his extensive surgical repertoire.

From his numerous experiences in Saudi Arabia, he remembers accompanying the royal convoy into the desert as an astonishing, if not a surreal experience. But the incident that had international impact was when he saved the life of Middle East BBC correspondent Frank Gardner. The journalist was shot six times when his crew was ambushed by Al-Qaeda. Dr Bautz retrieved the correspondent from a small hospital in an ambulance with a major police convoy and performed multiple surgeries. The incident was captured in Frank Gardner's book *Blood and Sand*.

An email from Dr Bill Griggs from the Royal Adelaide Hospital inviting Dr Bautz to join the trauma department arrived at the right time. Previous RACS president Dr Ian Civil had audited the trauma department and recommended that a surgeon be appointed to the non-surgical unit. The offer was accepted. His wife, Dee, joined the Adelaide Women's and Children's Hospital as an obstetrician and gynaecologist.

“I brought in first world trauma practices and revolutionised the department, which, from a trauma perspective, was outdated. It was a tough journey, and I faced a lot of resistance,” Dr Bautz said. “It was not easy being a path finder.”

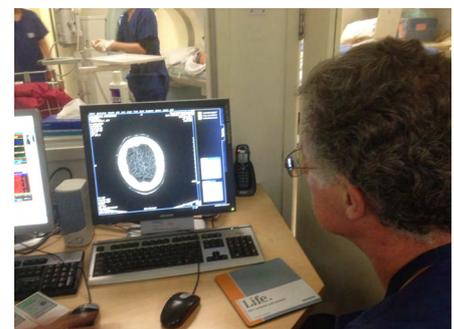
Dr Bautz led by example. For the first 18 months he was the first on-call to personally handle nearly all trauma cases. He demonstrated the improvement in outcomes when a surgeon attends and treats patients from resuscitation to recovery in ICU and then the ward. Mortality rates from major trauma halved during that time. Another trauma surgeon joined Dr Bautz, easing his on-call load. This allowed him to finally enjoy some of his hobbies—amateur photography and scuba-diving.

A two-tier call system was introduced: one for general surgery and one for trauma, rostered 24/7. Dr Bautz also faced fierce resistance when introducing new methods of damage control in trauma, such as performing thoracotomies for arresting trauma patients, open abdomens for damage control and non-operative intravascular embolisation.

Today, Royal Adelaide Hospital is a Level 1 Trauma Centre and Quaternary Referral Centre for the state. It provides exemplary trauma surgical training for registrars and Fellows with the current trauma surgeons on the unit trained by Dr Bautz.

It is immensely satisfying for Dr Bautz to see that the initiatives he introduced 17 years ago are now part of standard surgical training and practice in trauma across Australia. His success in transforming trauma management in Adelaide can be attributed to his fortitude and determination, extraordinary experiences in South Africa, Angola, and Saudi Arabia, and the unwavering support of his wife, Dee.

‘Never retreat. Never give up.’ The motto has stood him in good stead.



Images: Dr Peter Bautz; scuba diving; resus room; trauma unit scenes.

Trainees prioritise learning outcomes when choosing placements

Rural placements often lead to Trainees working in rural areas as Fellows

Rural Australians experience a mortality rate 1.1 to 1.4 times higher than those living in metropolitan areas. They have a potentially avoidable death rate of up to 2.4 times higher than their metropolitan neighbours.

This is an unfair and inequitable situation, which the Royal Australasian College of Surgeons (RACS) wants to address as an urgent priority by increasing the number of surgeons who take up practice in rural areas. We decided to begin with the first step of a surgeon's journey—the RACS Surgical Education and Training (SET) program.

In a recent study (Volume 9, Issue 3) published in the *ANZ Journal of Surgery* RACS researchers reported their findings on Trainees' preferences for placements during their surgical training.

"We know that having a rural placement, particularly of a longer duration, during surgical training often leads to Trainees taking up roles in rural areas when they qualify as Fellows.

"So, finding out the incentives and barriers they face in taking up rural placements is an essential component of the body of work required to increase the number of rural surgeons," says Dr Dinah Hippolyte-Blake, Manager, Innovation & Research at RACS.

To understand the incentives and barriers that influence surgical Trainees' decisions to undertake repeated placements in rural locations during their training, RACS researchers interviewed surgical

Trainees and Fellows. We identified four incentives and six barriers to Trainees taking up rural placements and developed recommendations to strengthen incentives and counter the barriers.

The findings were published in the *ANZ Journal of Surgery* in January 2022 (<https://bit.ly/3DL0mTD>)

"What the research tells us is that Trainees are focused on learning outcomes, and that influences what these barriers and incentives look like over the lifecycle of their surgical training," lead author Dr Hippolyte-Blake says.

Surgical Trainees place utmost importance on meeting their learning outcomes throughout all stages of their training. This impacts how they identify and prioritise incentives and barriers when it comes to selecting rural placements. Three of the four incentives we identified were related to Trainees being able to achieve their learning outcomes and requirements.

A conducive working environment that produces a culture of support provides the psychological safety and allows new learners to ask and respond to questions, make and learn from mistakes, and initiate additional learning opportunities.

"However, we found that even if a placement offers a supportive and conducive learning environment, unless the placement also meets the learning needs of the Trainees, they will not choose that placement again.

"This research is an important initial step in understanding Trainees' needs, and their perception of rural placements and working in rural areas," Dr Hippolyte-Blake says.

Along the same vein, Trainees will forego any lifestyle incentives if they can choose a placement that will better service their training requirements.

"When speaking to Trainees who had completed rural placements, we found that those from metropolitan areas of Australia felt they were at a greater disadvantage than Trainees who already lived rurally when it came to preparing for their placement.

"This is a significant barrier because if Trainees feel they are not sufficiently supported in the early stages of a new learning environment, they may feel anxious. This may affect their training, and inevitably affect their perception of rural placements," Dr Hippolyte-Blake says.

One of our recommendations—to help Trainees choose rural placements with confidence—is to strengthen existing regional training hubs and develop new hubs to improve the coordination of surgical training. "This will provide Trainees with access to learning opportunities, which is high on their list of priorities.

"They will receive an appropriate range of cases and structured and formal learning. They will also receive access to peer-assisted learning networks,



“I opted to go to a rural location because I really enjoyed the smaller hospital, the more intimate and close-knit working environment and the smaller teams, and how they worked together and were on a first name basis with each other.”

Interview participant

which we know, based on existing research, provides Trainees with a positive experience that helps close the gap between theory and practical experience,” Dr Hippolyte-Blake concluded.

Read our [Rural Health Equity Strategic Action Plan](#) to find out how we plan to increase the rural surgical workforce, reduce workforce maldistribution, and build sustainable surgical services in Aotearoa New Zealand and Australia.

Read our article ‘A qualitative study of the incentives and barriers that influence preferences for rural placements during surgical training in Australia’: <http://doi.org/10.1111/ans.17523>

Incentives for Trainees choosing rural placements:

- a broad scope of learning opportunities
- high-quality supervision
- positive workplace environment
- lifestyle.

Barriers to Trainees choosing rural placements:

- inadequate preparation for placement
- limited case mix to support learning outcomes
- workload and safe hour concern
- lack of formal structured learning opportunities
- lack of peer support
- family unit considerations.

The East Timor Eye Program – an evaluation

ETEP has been effective in building and maintaining partnerships in the eye care sector

Since its establishment in 2000, the East Timor Eye Program (ETEP) has supported the government of Timor-Leste and the National Hospital (HNGV) to manage and develop eyecare services focusing on cataracts, refractive error and ocular trauma.

The ETEP delivers a wide-ranging set of in-country training activities in ophthalmology, optometry, eyecare 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 various ETEP activities are largely donor-funded eye health and development projects, with the Royal Australasian College of Surgeons (RACS) managing the administration of the funding.

In 2021 the ETEP underwent an independent evaluation, which was undertaken by the Nossal Institute for Global Health (The University of Melbourne). This evaluation was reflective of the ongoing commitment of RACS Global Health to ensure independent and rigorous monitoring, evaluation, and learning processes that ensure quality and sustainable development programming.

The evaluation noted that the ETEP:

... 'has been remarkably effective in building and maintaining a partnership among the many players in the eye care sector, both international and national; and in building and maintaining an effective relationship with the MoH and government of East Timor. There would be few programs that successfully brought together such an array of partners over a period of nearly two decades. Key informants strongly agreed that much of this success grew out of the commitment and support provided by long term advisors to the program and the continuity of oversight that they have contributed has been the core of the program since its inception.'



RACS Global Health has played a major role in enabling and supporting these partnerships through the management and administrative functions, and this continuity in management role has contributed to the stability.

It is important to acknowledge the long history and the key roles of the personal and professional commitment of international visiting ophthalmologists and the trained eyecare professional in Timor-Leste in the development and implementation of the ETEP.

Parallel to and interconnected with these programs has been a long-term and ongoing significant personal and professional commitment from a small team of ophthalmologists and optometrists, principally from Australia, Switzerland and Portugal. This has provided the direction and continuity of professional and institutional support to the program.

Dr Nitin Verma, FRANZCO, has led the Australian support and engagement since the program was established. He conducted the first visiting eye health services to Timor-Leste following its independence from Indonesia. Since its establishment, the ETEP has engaged

support from a range of eyecare professionals, international training and ophthalmology institutions, and development agencies.

This commitment has enabled and supported the progressive transition of the leadership, direction, and resourcing of the program from international eyecare professionals and international development funding to the Ministry of Health in the government of Timor-Leste and to East Timorese eye care professionals.

The ETEP is now focusing on the ongoing management and support of transition of the program to the Timor-Leste government and supporting integration of eyecare activities into the broader primary, secondary and tertiary national health programs and services.

End gender inequality

Gender inequality is recognised by the global community as a major driver of poverty and marginalisation around the world

The different opportunities and expectations for women and men, girls and boys affect every dimension of life, including health. The international development community has recognised the significance of gender equality by establishing Sustainable Development Goal 5: 'End gender inequality and empower all women and girls', which is critical in achieving all other goals. These include Sustainable Development Goal 3: 'Ensure healthy lives and promote wellbeing for all at all ages'.

RACS Global Health is committed to promoting gender equality and recognises gender as a major driver of health access and quality of care. RACS is committed to effective action in gender inclusive health programming to maximise operational and organisational effectiveness and improve our contribution to sustainable health outcomes. We seek to achieve the policy's objectives through actions focused on our programming and on our corporate practices and culture.

The Australian aid program has identified gender equality and women's empowerment as one of its core

investment priorities, noting that gender inequality persists in Australia and in the Indo-Pacific region, which is the focus of Australian aid.

RACS is committed to the design and implementation of inclusive and gender equitable programming. For RACS to remain a current development partner, gender is a core consideration in programming, with goals and strategies to address gender inequality articulated, data collected, and results monitored and managed. RACS is a signatory to the Australian Council for International Development (ACFID) Code of Conduct—the highly regarded standards for development practice that have been developed and adopted by the aid and development sector. A commitment to human rights, and to building gender equality and gender equity are central to the code.

Gender equality is a key concern in health access and by better understanding disparities, it can be more effectively addressed. RACS is currently in the process of developing a gender position paper, which will articulate a clear and

consistent message on our commitment to gender equality in global health. The paper will include:

- background information and a critical analysis on gender and health for RACS Global Health in the Asia-Pacific region
- exploration of the barriers women face in accessing health based on evidence, including women in the health workforce and opportunities for training and health systems
- RACS Global Health's approach to gender mainstreaming in health, including key strategies across the three organisational priorities: advocacy, capacity building (including local leadership and education), and partnerships.

There is significant opportunity for strategic alignment between RACS Global Health's efforts to strengthen the approach to gender within international and RACS broader initiatives to support women in surgery, described in the Building Respect, Improving Patient Safety Action initiative and supporting programs. This provides opportunities for solidarity and support for change.

Please contact the RACS Head of Global Health Philippa Nicholson (philippa.nicholson@surgeons.org) if you would like more information.

Image: Naomi Asi and Rowena Faaiuas-Brown are strong female leaders working towards greater access and inclusivity for all. They work for the SENESE Inclusive Education Hearing Program.



Australian Aid 

Global health online learning continues

These sessions provided a great space for clinicians from the Pacific region to gain a greater sense of connection and camaraderie

Over the last two years the Royal Australasian College of Surgeons (RACS) Global Health team has been working closely with partner countries and program specialists to provide online learning opportunities and complex case support to clinicians across the Pacific.

These sessions provided a great space for clinicians from around the Pacific region to come together and feel an increased connection and camaraderie within their profession while we were separated by border closures.

A series of 13 online education webinars were presented in 2021 covering a diverse range of specialties and topics including: Cardiothoracic Surgery, ENT Surgery, Urology, and Paediatric Surgery. A total of 402 Pacific clinicians joined these webinars with each receiving a participation certificate from RACS. This makes them eligible to claim one CPD point consistent with the Pacific Island Surgical Association CPD framework. The introduction of course participation certificates has significantly increased attendance rates over the year. Clinicians have engaged in robust and in-depth conversations with Australian, Aotearoa New Zealand and Pacific Island presenters and clinical experts.

“Excellent and useful sessions especially for us and new registrars. I am currently trying to train the junior and young surgeons in Samoa locally. We are not able to travel for post grad in Fiji or anywhere, so these are a great help for all of us. There are about four new registrars joining the unit and these sessions will be a must for us in Samoa.” (Online education webinar participant)

Challenges related to internet connectivity still impact the ability



of some clinicians to join sessions, particularly those from smaller island countries. RACS has been disseminating webinar recordings and copies of the presentations to the clinicians who register, which can be watched later when the internet connections are stronger.

Confidence in Pacific clinicians to present as part of the online education webinar series has also increased. Seven out of the 10 online sessions included presentations from one or more Pacific clinicians. This has offered increased opportunities for colleagues to learn from each other and discuss issues that arise in their similarly resourced settings.

“I appreciated discussing the trends and challenges we face in the ‘blue continent’ that the PI presenters showcased and more so the support that is available from our regional experts.” (Online education webinar participant)

Online evaluation surveys were conducted by RACS. The survey responses highlight the importance of Pacific clinicians

continuing to come together as a group, as key to learning currency.

The evaluations also provided valuable insights from Pacific clinicians on priorities for future online education. These include paediatric gastrointestinal surgery, reconstructive breast surgery, and ear nose and throat imaging and diagnosis training. RACS will continue to offer online education opportunities though the Pacific Island Program in 2022.

Image: Dr Trevor Cullwick and Dr John Batten undertaking clinical work and training face to face in Vanuatu prior to mentoring and training pivoting to online learning formats due to COVID 19.

New device could help ileostomy patient outcomes

Dr Chen Liu is a research fellow and PhD candidate at the University of Auckland



In 2020 Dr Chen Liu was a recipient of the Aotearoa New Zealand Research Scholarship. The prestigious scholarship is valued at \$66,000 and supports Aotearoa New Zealand-based surgeons and Trainees to undertake a research project within a higher degree.

Before pursuing full-time research, Dr Liu worked as a Trainee surgeon in General Surgery at Rotorua Hospital in Aotearoa New Zealand.

“I was very grateful for the scholarship. It solidified my interest and passion for research and motivated me even more to incorporate research into my future career.

“I decided quite early on in my training that I would take some time to complete a post graduate qualification,” he says.

Dr Liu’s PhD was focused on the morbidity of ileostomies and colorectal surgery, and a potential strategy to mitigate those morbidity risks. The COVID-19 pandemic meant Dr Liu recruited patients locally in Aotearoa New Zealand with the study conducted in Auckland and Dunedin hospitals.

“A big chunk of the year was spent working from home, and I was fortunate there was still enough research work, and I could still work on writing manuscripts and conference presentations,” he said.

The study included a randomised controlled trial of a novel stoma-output

recycling device to reduce the length of post-operative stay in patients undergoing reversal of loop ileostomy.

“People living with a stoma are at risk of dehydration and kidney impairment due to fluid loss and there is a high rate of delayed bowel recovery. The bowel, if you don’t use it for a while, gets weaker and doesn’t work as well,” Dr Liu says.

In the study, a possible way of fixing this issue was to use a device, which takes the liquid from the stoma and pumps it back into the downstream bowel to stimulate it before the surgery to aid faster recovery and shorter hospital stays.

“The randomised control trial is trying to prove that using this device makes a difference by randomly allocating recruits who have a loop ileostomy into either getting the device or just carrying on as usual. We then see what their outcomes are in terms of the rates of hospital re-admission, the rates of dehydration, and look at how fast they recover after surgery.”



Because of funding and logistic limitations, the study focused on people who were two weeks out from surgery to

get their stoma reversed.

“We know from a similar study done in Spain (2014) that the two-week time frame yields good outcomes for patients, like significantly shorter stays in hospital, and much lower rates of delayed bowel recovery,” he says.

Another limitation was that the study didn’t include all possible stoma patients in order to keep the participants as similar as possible. Most of the recruited patients had colorectal or rectal cancer.

“Unfortunately, a large group of patients had inflammatory bowel disease, and we couldn’t include them in the study, meaning the pool of patients was limited.

“In the future, a possible area of further research would be to focus on patients with inflammatory bowel disease,” he says.

Dr Liu is halfway through his current research and expects to complete it next year.

Outside of study and medicine, Dr Liu enjoys music and exercise and is an avid runner.

“I enjoy spending time outdoors and my wife and I play squash regularly.”

Dr Liu is expecting his first child with his wife later this year.

From the archives

Frederic Wood Jones – an anatomist, teacher, and anthropologist

Born in England in 1879, one of Frederic Wood Jones' most enduring qualities was his extraordinary ability to teach anatomy.

Helen Ingleby, one of his students at the London School of Medicine for Women, noted: "His lectures were brilliant. The class hung on his words; you could literally hear a pin drop. In other schools anatomy was considered a dull subject but not with us. To me it was fascinating ..."

Wood Jones graduated in MBBS in 1904 and became a Fellow of the Royal College of Surgeons in 1910. However, he was not destined for a career in medicine, which he found 'cramped and small when compared to biology' and influenced by the anatomist, (Sir) Arthur Keith, he chose a career in anatomy.

Wood Jones did not confine himself to anatomy. He was interested in the natural world and after a stint as medical officer to the Eastern Extension Telegraph Company in the Cocos-Keeling Islands (1905-1906), he published his doctorate in 1910 on corals and atolls. Anthropology was another interest and in 1907, he joined (Sir) Grafton Elliot Smith in the archaeological survey of Nubia in Egypt.¹

When he returned from Egypt, Wood Jones had teaching posts at the Royal Free Hospitals (London School of Medicine for Women) where he became Professor of Anatomy in 1915, and the University of Manchester. He joined the Royal Army Medical Corps in 1918 and in 1919, sponsored by Henry Newland and Arthur Keith, he succeeded Archibald Watson as Elder Professor of Anatomy at the University of Adelaide.

During his time in Adelaide, Wood Jones not only rearranged and improved the anatomy department at the university, but he also studied the local flora and fauna and kept a range of Australian marsupials for observation. Like his predecessor Archibald Watson, he was concerned for the welfare and living conditions of the Aboriginal people.

Wood Jones left Adelaide in 1927 to take up the Rockefeller Chair of Physical Anthropology at the University of Hawaii. Somewhat disillusioned by his experiences there he returned to Australia in 1930 to take up the Chair of Anatomy at The University of Melbourne.

Wood Jones was already known in Melbourne—the surgical fraternity in Australia was small and he had given lectures in Melbourne in the 1920s. During the 1930s, his links with the College were formalised. In 1935 he attended the opening of the Spring Street building and was appointed an Honorary FRACS and during the 1930s, he served as examiner for the Fellowship examinations that were held under the auspices of the English College.

Significantly, he began to influence a generation of important Australian surgeons and anatomists. R.J. Last was impressed by him and commented:

"... He was a superb teacher, full of trenchant phrases, a splendid blackboard artist and he made his subject a living and fascinating reality ..."

Another student, Sydney Sunderland succeeded Wood Jones as Professor of Anatomy at The University of Melbourne. James Guest and Kenneth Russell were also his appreciative students and were recipients of Wood Jones' practice (inspired by Arthur Keith) of having students visit him at home.

Wood Jones returned to the United Kingdom in 1937 to become Professor of Anatomy at the University of Manchester and in 1945, he secured the position of Professor of Human and Comparative Anatomy and conservator of the anatomy museum at the Royal College of Surgeons. The Hunterian collection had been damaged by bombs in 1941, so restoration of the collection was a challenging task.

Frederic Wood Jones' career ended with his death in 1954 but as a man 'possessed of a restless curiosity', it is important to reflect on his life and especially, his extraordinary teaching abilities.

Elizabeth Milford, RACS Archivist

¹ The survey was necessary because raising the height of the Aswan Dam would affect archaeological sites in the valley below.





Images (from left): Frederic Wood Jones c.1930s; Frederic Wood Jones (second from left) with examiners on the steps of the College 1937; Wood Jones with a penguin c.1934 (University of Melbourne archives).

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RACS name change – your opinions

We received many opinions from the Fellowship regarding the proposed name change for the Royal Australasian College of Surgeons.

The name put forward by Council is Royal Australian and Aotearoa New Zealand College of Surgeons.

The College will invite Fellows to vote later in 2022. As per the RACS Constitution, a yes vote of 75 per cent is required to pass the change.

Opinions approved by the author are shared in *Surgical News* with more on the [College website](#).

Sirs,

I could, without extreme discomfort, add an extra A to the name of our College and become a FRAACS. But not an extra ANZ. If the Kiwis are feeling guilty about calling their country by a non-Indigenous name, I shall oblige to aid their redemption. But what next? AANZAC Day. New Zealand is already central in that acronym that we share. But adding three letters suggests a claim for higher rank in the order of precedence. Should that claim succeed in its entirety we might become the RANZACS. It would infuriate the Physicians of course, so perhaps there is some merit in that option.

Dr Robert Black (retired)

While I can see some wisdom in the change from Australasian, as this does create some confusion and erroneous interchange with Australian for many, I do feel New Zealand should make a choice between New Zealand - my preference - and Aotearoa. I believe it is cumbersome to use both names.

Dr Chris Edwards

I love the idea of changing our name to give Aotearoa a more prominent position in our title, and I am envious that they are able to find a First People's name to include in their national identity. If the lands we now call Australia could agree on such a name for our nation, I would support that, but I imagine my Eastern states' colleagues would not be keen to be known as a Noongar nation.

I don't pretend to know the plans for ANZ's name in the future, but I would love to be able to refer to them as Aotearoa (and drop the NZ bit). That would allow us to be the RAACS, which fits into postnominals much better.

Creating the logos for the two proposed College names does make the long titles easier to swallow. I prefer mainly because it abbreviates to RCS quite comfortably. Perhaps old Fellows like me will have the option to remain FRACS, and newer ones will be FRCS?

The alternative would be acceptable if it could be abbreviated to RAACS (one of the 'A's referring to Aoteroa-New-Zealand), but I wonder if that is pushing abbreviation a bit too far?

Thank you for not requiring a boolean response at this stage. I would like to support a change, but fear that if we are presented with too many options, the vote will never reach the required level.

Clinical Associate Professor Susan Taylor

Our College has been named the Royal Australasian College of Surgeons (RACS) for nearly 100 years. The name is its beacon, its very identity and should be changed only for compelling reasons and with clear majority support.

Having said that, I agree with a change to Royal Australian & New Zealand College of Surgeons (RANZCS,) which more accurately reflects its composition and is an overdue change for our New Zealand colleagues.

However, I cannot support Aotearoa (Māori name for New Zealand) being included in a new College name, a change which in my view would be controversial, cumbersome, and confusing.

If the name Australasia is (apparently) baffling to some in the community, how is Aotearoa going to be regarded?

As one of my colleagues put it: "If you have to Google a name, or how to pronounce it, it is not going to work".

In my opinion it is unlikely to find general favour with the RACS Fellowship.

This also might set a precedent for a further change to include an Indigenous name for Australia. Where will it end?

Therefore, at the present time my choice is: Royal Australian & New Zealand College of Surgeons (RANZCS). This represents a minimal change, inclusive of New Zealand.

A name change must be accepted by 70 per cent of the Fellowship to be enacted. I believe this is the only change that would have a chance of acceptance, otherwise I suspect it will be a pointless exercise.

I also suggest that any new name be quarantined for a significant time period.

There is also the matter of the Royal prefix, but this is a whole new argument that I will not enter into at this time.

Dr R S Williams

I am opposed to any change in the name of the College. The Royal Australasian College of Surgeons is the appropriate name precisely covering both countries, and continuing the work focusing on excellence in surgical practice. Both Australia and New Zealand have diverse populations, with an indigenous component, and these populations have changed over time. An attempt to represent all populations in any name would be senseless. Including any one

ethnicity over others is inappropriate in the modern world. The nomenclature should be the common language recognisable across the globe - the English language. I am pleased that the name change requires a 75% level of support. I certainly don't recall being asked if the New Zealand National Board name should be changed, as it was recently.

Dr Peter Robertson

Sir.

I consider neither name change proposal is appropriate.

For balance across the Tasman, if Aotearoa were to be included, then ATSIC should also be there.

Hence the name would become Royal ATSIC Australia and Aotearoa New Zealand College of Surgeons. This would then be a sentence full of sound and fury, signifying nothing.

When Australia becomes a republic, the 'Royal' will probably be deleted.

So why not reduce the whole word salad to simply the College of Surgeons?

Dr Bruce Rigg

Royal Australian and New Zealand College of Surgeons.

Dr Dean Schluter

Thank you for the chance to comment on a proposed college name change.

I applaud the attempt to give the College a more authentic and inclusive NZ feel and identity.

The proposed name however is clumsy.

Acronyms are supposed to be catchy and memorable - RCSAANZ and RAANZCS - are neither and only the dedicated will remember what it stands for.

I do not have a good alternative, but changing from an average branding in the form of RACS to a bad alternative because we cannot think now of a more elegant way of encompassing our aspirational identity is not a good reason to change I would advocate for pausing, thinking again and not advancing a name change until a more inspired alternative can be imagined.

Dr John De Waal

Dear Sir,

Being a Fellow of the College, I am struggling to understand this complex name change proposed by the NZ board to include their Maori culture in the name.

This political correctness does not extend to include Aboriginal heritage from the Australian side.

I am not in favour of this political correctness gone mad.

Why do we need to be politically correct all the time when the reality is, all we want to be identified as the College recognised in Australia and New Zealand? Everything else is irrelevant.

Are Maoris and Aboriginal people not a part of these two sovereign nations?

When is this individual identification for each political group is going to stop?

I am one for uniting people and not splitting and identifying as individuals. This union needs to happen under the national flags and nothing else is my opinion. Everyone knows history, but the more we give air to history more division it will create, I feel.

Anonymous

Hi

Emailing feedback about proposed RACS name change after listening to Postop Podcast.

Great to see Aotearoa in the name.

Can we drop "royal"? May be a good opportunity to decolonise the institution RAANZCS is too long!

Could it just be RAACS for short and Royal Australian and Aotearoa New Zealand College of Surgeons?

Dr Bridget Clancy



RACS name change : your opinions (contd.)

As a surgeon with international experience and Māori affiliation and lineage, I have been concerned about the process, which is developing within RACS around name changes. The current example is the New Zealand National Board now frequently referred to Aotearoa New Zealand National Committee. Staff also seem to have been directed to extend that name change anywhere they see the name New Zealand. This name change, has been done without the wider consultation it deserves, potentially creating certain cultural and ethical issues.

This is especially important given the possibility that sometime this year, Australian and New Zealand Fellows will be asked to vote on name change options for our College. The name of our binational College currently is the Royal Australasian College of Surgeons. It is widely recognised internationally, as representing all surgeons in Australia and New Zealand. Officially changing or replacing those words requires a referendum of all Fellows across Australia and New Zealand. In addition, according to College articles of association, any name change needs to be passed by a 75 per cent majority vote of the Fellowship. Therefore, introducing a name change for the New Zealand National Board should follow similar principles—allowing debate, and consideration by all Fellows. This would allow all cultural aspects to be considered within surgical specialties, thereby effectively representing the wishes of all Fellows in any name change. It is also worth noting there has been no

official name change for the country of New Zealand. Changing the board name to Aotearoa, without a country name change, potentially creates international confusion, as well as confusion academically.

My experience of having taught in the local Wananga (Ngati Awa) and worked with the Tuhoe Iwi, has reinforced the need to recognise that whakapapa (consultation), is an essential part of the Māori culture. In addition, having established Specialists without Borders, an international not for profit medical and surgical education organisation for developing countries, and teaching in Africa for more than 10 years, the exposure to different cultures has reinforced my understanding of cultural consultation—a prerequisite to any change, big or small. These experiences strongly suggest that the current name change of the New Zealand National Board and any others being considered, should be suspended by RACS Council and the executive leadership management team of the College pending further input from all parties.

Considerations of other cultures within New Zealand surgical specialties, should also be seriously considered, especially as name imposition without consultation, demonstrates an insensitivity to the feelings of other cultures. In the 2019 data, ethnic composition of New Zealand based Fellows and Trainees showed other than European, 2.8 per cent Māori, 7 per cent Indian, 3.4 per cent Chinese and 22 per cent other nationalities. These other ethnic groups should be sensitively

considered. Without that consultative process, the arbitrary imposition of the term Aotearoa, not a name recognised by all for New Zealand, bears invidious comparison to colonial times, where names were imposed on Māori by colonialists without consultation.

Dr Paul Anderson MBChB. F.R.A.C.S./F.R.C. S (Edin) MA /PhD. Dip Tch. Dip Te Reo(L2)
Ngati Whakaue

General and Upper Gastrointestinal /
Hepatobiliary and Bariatric surgeon
Special Clinical Advisor
Eastern Bay of Plenty Primary Health
Alliance
Consultant/ Specialist Review Clinic
NZ Government ACC Clinical Adviser
Senior Lecturer Health Sciences/Anatomy
and Physiology

Out and about in Brisbane

If you are attending the RACS 90th Annual Scientific Congress (ASC) in Brisbane from 2 May to 6 May, you may want to see some sights around the city and its surrounding.

RACS ASC Convenor, Professor Deborah Bailey, who has spent most of her life in Queensland shares some of her favourite things to do in and around Brisbane.

River cruises

One of the best ways to catch the Brisbane sunset is taking a river cruise. There's something magical about the beautiful shades of orange, pink and blue that are reflected in the water.

The Brisbane City Council's City Hopper lets you discover the city for free with ferries running from 6 am to midnight every day at 30-minute intervals.

For a fee you can travel up and down the Brisbane River or go up to the Moreton Bay to watch some marine life. The river cruise also offers high teas and dinners as a bonus.

More information: <https://tinyurl.com/yn8rvx3b>

Queensland Art Gallery / Gallery of Modern Art (QAGOMA)

If you are an art lover, you can immerse yourself at QAGOMA—one of Australia's dynamic galleries.

Located at the riverside, QAGOMA is a short walk from the city and close to the South Bank. Book your experience here: tinyurl.com/4zcs7fr5

Queensland Performing Arts Centre (QPAC)

QPAC is in the South Bank precinct and is a short walk over the Brisbane River from Brisbane's CBD.

QPAC's programs feature artists from different performing genres and is a place of major events and regular seasons by Queensland Theatre Company, Queensland Ballet, Queensland Symphony Orchestra, and Opera Queensland.

More information: <https://www.qpac.com.au/>

Direct train to Gold Coast

As the name suggests Gold Coast is famous for its sandy beaches, surfing, inland canals, and waterways. It is also home to Dreamworld, Sea World and Wet'nWild. Queensland Rail has direct services with more information here: tinyurl.com/yckmz67d

You can catch an Airtrain from Brisbane airport direct to the Gold Coast. During peak hours, the train runs every 15 minutes and every 30 minutes during off-peak hours.

More information: tinyurl.com/2nuyhx38

Sunshine Coast

Situated 101 kilometres north of Brisbane, the Sunshine Coast is comprised of a string of small towns and localities along the coast from south to north.

The hinterland is located inland and on top of a mountain range, with forested mountains and great views of the coast.

Queensland Rail operates an electric train service between Brisbane and the

Sunshine Coast, which takes about an hour and 30 minutes from Brisbane's Central Station.

More information: tinyurl.com/bdem7fnw

Bike rides

Want to stretch your legs or take in some exercise? Try some bike-riding along the Riverwalk, foreshores, Brisbane River loop or even around the CBD.

More information: tinyurl.com/3rv9aejf

Scenic Rim

This is a thriving rural paradise set in the foothills of the Great Dividing Range and surrounded by world heritage-listed national parks. The region measures 4254 sq./kms and is south of Brisbane. It takes about an hour to travel from both Brisbane and the Gold Coast.

Be prepared to be taken in with Scenic Rim's majestic beauty, which boasts 30,000 hectares of parklands. Don't miss the Tamborine Rainforest, the Glow Worm Caves and the three dams—Lakes Moogerah, Maroon, and Wyaralong.

More information: tinyurl.com/6aw4x3st

Stanthorpe

A perfect getaway after the RACS ASC is a road trip from Brisbane to Stanthorpe. Your spirits will lift when you sniff, swirl, and sip your way through this exquisite town: home to full-bodied reds, cafes, galleries and vineyards.

Famous for its Pinot Noir and handmade artisan cheeses, Stanthorpe will be the perfect end to five days of the RACS ASC.

More information: tinyurl.com/3x6xajde



When surgeons are severed from their records

Dr Darren Molony



Medical records were once composed of hand-written notes and annotations but over time they have evolved into complex records.

Current records are likely to include demographic data, correspondence, hospital discharge summaries, pathology, radiology, clinical images and videos, medical certificates and medicolegal reports, as well as attendance records and associated Medicare billing data.

The question of who owns medical records has previously been legally resolved. In *Breen vs Williams*, High Court of Australia, 1996, Justice Brennan states, 'Documents prepared by a professional person to assist the professional to perform his or her professional duties are, ... the property of the professional'. In the same case, Justices Gaudron and McHugh state, 'statute or contract apart, medical records prepared by a doctor, are the property of the doctor'.

Increasingly, surgeons change practice locations, business structures and/or business partners over the course of their careers. Historically, moving practice involved picking up boxes of patient cards, the booking diary and hanging up a new shingle on another building. Today many

surgeons use electronic health records exclusively—with these records housed on a shared server within a group or associate practice. Moving practice may therefore require a database extraction of records created by that surgeon. It is crucial that a surgeon is able to retain access to their patients' medical records in their entirety, throughout their career with ongoing access to them, even after ceasing practice.

All surgeons have an obligation to monitor their own performance and outcomes and the medical records represent the most powerful audit tool available to undertake this.

Electronic records link Medicare Benefits Schedule item numbers, health insurance fund billing data with patient and procedure data, and importantly, patient outcomes. Across a career, a sub-specialist surgeon will accumulate a significant and valuable dataset. There may be ethical and professional obligations to share these datasets with national or international peers, contribute to specialty databases on an ongoing basis—particularly if patients have been involved in research and/or clinical trials. Additionally, medical indemnity providers recommend that all clinicians maintain their records for at least seven years (or, in the case of paediatric patients, seven years post the 18th birthday of that patient). Further, in the case of patients treated for cancer, some indemnifiers recommend indefinite maintenance of the records.

For these reasons, it is unacceptable for a surgeon to be provided with no, or restricted access to their case notes, or access on an ad hoc, patient by patient basis, simply for choosing to move practice or business structure. Medical indemnity providers should support their surgical members in accessing and maintaining their complete patient

records, as not to do so exposes surgeons, indemnifiers, and most importantly, the patients to significant risk. Arguments that extracting the records is a breach of privacy are unfounded given there is no third party involvement.

It is imperative that surgeons entering into private practice make contractual clarifications of ownership of their medical records and establish the terms of access to, and storage of, electronic patient records. Should the surgeon choose to move practice, any restriction to the surgeon's access to the medical records of their patients—either from a commercial or professional perspective—is not acting in the best interests of the patient.

I would recommend taking the following approach:

1. When joining a practice as an associate or as a partner include a section in the contract specifically for the medical records.
 - a. Clarify the rights to ownership of any intellectual property or copyright of any records created during the care of any patient.
 - b. Include entitlement to a copy of previously existing notes provided within the practice where they formed part of a professional consultation, and contributed to professional opinion, as they constitute an extensive referral correspondence.
 - c. Where more than one surgeon has contributed to the overall care of a patient, all surgeons should be entitled to a complete copy of the records.

- d. Ensure the practice policy includes notation of 'third party' advice given to patients (e.g. records of postoperative phone calls by nursing staff, nursing staff care, and cancellations by reception staff etc.)
- e. Clarify entitlement to and costs associated with undertaking an extraction of records on departure.
2. Ensure that the entire practice is aware of and adheres to the obligations as outlined by the appropriate medical indemnity provider regarding:
- patient access to their own medical records
 - cyber security
 - data breaches

- storing, retaining and disposing of medical records
- providing medical records to a third party

Note:

Undertaking a database extraction of a surgeons' patients' medical records is not transferring to a third party (as the creator and owner of the intellectual property/copyright contained within those medical records, there can be no breach of privacy in that surgeon being the holder of such records).

Clarification of these issues prior to starting in practice can help avoid unnecessary costs, disruption and angst, should a surgeon decide to change

practice at some time in the future.

It is in the best interests of the surgeon, indemnity provider and most importantly patients that ownership and protection of medical records are maintained by those who create them.

Dr Darren Molony, BMBS, FRACS
Plastic and Reconstructive Surgeon



November Annual Academic Surgery Conference 2022

The Surgical Research Society of Australasia would like to invite you for this year's November Annual Academic Surgery Conference.

Date: 3-4 November 2022

Location: Sydney, NSW

For more information:

W: tinyurl.com/NAASC2022

E: academic.surgery@surgeons.org

T: +61 8 8219 0900



Australian and New Zealand Post Fellowship Training Program in Colon and Rectal Surgery 2023

Applications are invited for the Post Fellowship Colorectal Training Program, conducted by the Australia and New Zealand Training Board in Colon and Rectal Surgery (ANZTBCRS). The ANZTBCRS is a Conjoint Committee representing the Colon & Rectal Surgery Section, RACS, and the Colorectal Surgical Society of Australia and New Zealand (CSSANZ). The program is administered through the CSSANZ office.

For details about the Training Program and the application process, please see our website: <https://cssanz.org/training/>

A Notaras Fellowship, a Medtronic Research Scholarship and a Fred Stephens Fellowship for full-time researchers will be awarded for participation in the 2023 program.

Applications for the 2023 Program will be accepted from 1 April 2022 to 1 May 2022.

Applications: All applicants must use the ANZTBCRS Application Form 2023 (available on our website, see address above).

Please email your application to:

Prof Alexander Heriot

Chair, Australia and New Zealand Training Board in Colon & Rectal Surgery

Email: admin@cssanz.org

Phone: +61 3 9853 8013

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 educators.

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 a Professional Development or Skills Education course.

The 2022 nomination portal is open from 1 March to 15 April 2022. You can submit your nomination here: <https://bit.ly/3qVbsiX>.

Professor Jeganath Krishnan is a RACS Fellow based in Adelaide, South Australia. He specialises in Orthopaedic Surgery. The ASE awarded Professor Krishnan with the SET Supervisor/SIMG Supervisor of the Year (SA) Award in 2021.

1. Why is surgical education important to you?

Surgical education is very important to me because it is a privilege to be able to share knowledge and experience. It is also important to remember and appreciate that the reason we are in this position to teach is because of the time and effort that has been invested in us by our teachers.

2. Tell us a memorable moment in your journey as a surgical educator.

Many of my memorable experiences relate to sharing in the success of the students with whom I have been involved.

3. What advice do you have for health professionals who are passionate about surgical education?

Continue to be passionate and remember the value of the return of investment back to the community for long-term sustainability and improvements in healthcare and its delivery.

Dr Christopher Roberts is a RACS Fellow based in Canberra, Australian Capital Territory. He specialises in Orthopaedic surgery. The ASE awarded Dr Roberts with the SET Supervisor/SIMG Supervisor of the Year (ACT) Award in 2021.

1. Please tell us something about yourself.

I am an orthopaedic surgeon with a focus on upper limb conditions. I completed my undergraduate training at the University of Sydney and worked at Concord Hospital where I met my wife Kerri. I did my orthopaedic training in Sydney and completed my overseas Fellowships in Derby, England and in Hong Kong. I started my practice in Canberra in 1994. I have two sons—Jack and Sam—and a gorgeous granddaughter, Lucy.

I have been teaching throughout my entire career. Ever since the ANU Medical School commenced, I have taught undergraduate students and was appointed Clinical Associate Professor in 2020. I have been teaching orthopaedic Trainees since 1994 and was a supervisor of training from 1996 to 1999. I established the first AOA Fellowship training position in Canberra, which has played a major role in training, recruitment and retention of high-quality orthopaedic surgeons in Canberra. Recently, I have established a yearly program of lectures for orthopaedic registrars.

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

My proudest moment was when the medical students I taught decided to take up training in orthopaedics. The compact environment of Canberra provides a unique chance to see doctors progress on their career paths. For example, I have seen second-year students who I taught graduating as doctors, then progressing to orthopaedic training, and finally graduating as orthopaedic surgeons. Another moment is when doctors tell me they finally understood something because of the way I taught them.

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

Surgery is busy and your life gets swept up with work, patients, staff and family.



These are all important. However, teaching can be very rewarding. If you like it, you are probably good at it.

Professor Igor Konstantinov is a RACS Fellow based in Melbourne, Victoria. He specialises in Cardiothoracic surgery. The ASE awarded Dr Konstantinov with the SET Supervisor/SIMG Supervisor of the Year (VIC) Award in 2021.

1. Please tell us something about yourself?

I graduated from the Military Medical Academy in St. Petersburg, Russia. I completed most of my post-graduate training in the United States and Canada, including the Mayo Clinic, Toronto General Hospital and Hospital for Sick Children, and obtained my PhD from the University of Toronto.

I have been working as Consultant Cardiothoracic Surgeon at the Royal Children's Hospital for the last 15 years. I am a professor at The University of Melbourne and Director of Melbourne Centre for Cardiovascular Genomics and Regenerative Medicine.

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

I feel very honoured as I have always been very proud to see my Trainees grow and develop into prolific writers and academic surgeons with emerging international recognition and high standing. I feel that my former and current Trainees will change the face of academic cardiothoracic surgery in Australia and New Zealand and, most importantly, the Supervisor of the Year Award is not so much about my personal achievement, but rather a recognition of my Trainees' dedication, persistence, and admirable hard work.

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

My proudest moment as a surgical educator was when I felt that my Trainee will be a better academic surgeon than I am.

Images: Dr David King, SA State Committee Chair (L) presenting the award to Professor Jeganath Krishnan (R); Dr Christopher Roberts; Professor Igor Konstantinov (L) and Mrs Evgeniia Konstantinova (R) at the Order of Australia award ceremony in the Government House

ASOHNS ASM 2022

The Australian Society of Otolaryngology Head and Neck Surgery Annual Scientific Meeting, 10 – 12 June 2022, Adelaide Convention Centre, South Australia

The Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS) Annual Scientific Meeting (ASM) is the premier education and networking event for the otolaryngology head and neck surgery community in Australia. This year marks the 72nd anniversary of the society's Annual Scientific Meeting.

The organising committee members have developed a fantastic program and are looking forward to meeting each other in person—with the virtual element still available for those delegates who are unable to travel to Adelaide.

Thanks to RACS support, one of our keynote speakers, Miss Michelle Wyatt (pictured)—a Consultant Paediatric Otolaryngologist and Head of Department from Great Ormond Street Hospital for Children in London, United Kingdom—will be present in Adelaide.

Miss Wyatt will conduct multiple presentations, including The Management of Type 1 Laryngeal Clefts on Friday, 10 June, and The Overview of Paediatric Airway Reconstruction on Saturday, 11 June.

Miss Michelle Wyatt graduated from Cambridge University in 1992 with a first-class honours degree. After completing her training in the South East of England, she was appointed as a Consultant Paediatric Otolaryngologist at Great Ormond Street Hospital for Children in 2004. She has been a departmental lead since 2015 and is also an Associate Professor at University College London.

Miss Wyatt's practice is paediatric, with specific interest in the management of complex airway pathology. She is the ENT surgeon to the nationally funded craniofacial team at the hospital.

Miss Wyatt is the President Elect of the British Association of Paediatric Otolaryngology and has recently completed a term as vice president of the Section of Laryngology and Rhinology of the Royal Society of Medicine. She has also served on the council of the British Laryngology Association and the



Academic Committee of the European Society of Paediatric Otolaryngology. As an inaugural member of the UK Paediatric National Tracheostomy Safety Project she co-wrote their guidelines, which are now accepted as standard practice across the country. She is a Specialist Advisor to the National Institute for Health and Clinical Excellence and has been an examiner for the Intercollegiate FRCS examination.

Miss Wyatt has published more than 60 peer-reviewed papers, mainly reflecting her interests in laryngology and management of patients with craniofacial abnormalities. She has been part of the faculty for the British Paediatric Otolaryngology Course for 17 years and has been an invited speaker at several national and international conferences throughout her career.

Physical and virtual registrations are currently open.

For more information visit:
asm.asohns.org.au

New South Wales surgeons scrub up for Surgeons' Month

The annual RACS New South Wales Surgeons' Month was held successfully despite a later than usual start date and the many challenges brought on by the ongoing pandemic.

The event brings together New South Wales Fellows, Trainees, Specialist International Medical Graduates, prevocational doctors, medical students, and other College stakeholders to collaborate about surgical education, research and best practice.

The popular event is typically scheduled for November, but a decision was made to postpone the 2021 event until February 2022 due to uncertainties surrounding the COVID-19 outbreak across the state.

Despite the many challenges faced, RACS New South Wales Chair Associate Professor Payal Mukherjee, said that holding the event had been worthwhile and she was delighted by the support it received.

"This Surgeons' Month has been particularly difficult to plan, but it has been so well supported by the local Fellowship. Many events sold out very early, which demonstrated the value of the social, cultural and educational events that comprise Surgeons' Month."

The RACS New South Wales Surgeons' Month concluded with the pinnacle event of the program—NSW Surgeons' Evening. The highlights of the Surgeons' Evening included the Graham Coupland Lecture, which was presented by Associate Professor Kerin Fielding. Associate Professor Fielding, a RACS Councillor and Wagga-based surgeon, presented an enlightening lecture on The Great Divide: Rural Generalist and Urban Specialist.

It also included the launch of Beyond Science, which is a state-wide surgical innovators program, an initiative supported by the Passe & Williams Foundation. Developed by Associate Professor Mukherjee and Professor Gordon Wallace initially for Ear, Nose and Throat (ENT) Surgery, Beyond Science brings together surgeons and scientists from many institutions across New South Wales to help ENT medical technology development, translation and commercialisation, accelerating research translation from bench to bedside.

"Despite a rich history of biomedical innovation in Australia, there are limited training opportunities for surgeons to develop these skills. Within New South Wales, there are no formal surgeon-scientist training pathways in Otolaryngology, Head and Neck Surgery. Our limited understanding of technology commercialisation has impeded our ability to translate fundamental scientific breakthroughs to the bedside," Associate Professor Mukherjee says.

"Therefore, as research becomes more and more technology focused, developing these industry-ready skills will be essential so that Australian otolaryngology will continue to deliver innovations to the community. Beyond Science is a clinician-led and clinician-run training program, which aims to incrementally develop a comprehensive Australian-first medical technology translation program for Otolaryngology, Head and Neck Surgery.

"What we are hoping is that innovation appetite is targeted towards health service needs. We have a real disparity in health care access in rural and

remote areas as well as in Indigenous healthcare.

"ENT has a great future and the foundation will have a key role in ensuring that it evolves."

Another highlight of the evening was the presentation of the Inaugural RACS New South Wales Women in Leadership Award. This award is presented to a female New South Wales Fellow who exemplifies the values of RACS New South Wales in promoting and achieving equality.

Congratulations to Associate Professor Amanda Dawson who was presented with the award by New South Wales Health Secretary Elizabeth Koff. Associate Professor Dawson is particularly recognised for her dedicated and sustained commitment to training and academic surgery leadership. This was evidenced by her innovative Trainee-led research and Near Peer Teaching collaboratives, among her many other leadership roles.



Images (clockwise from top-left): Health Secretary Elizabeth Koff speaking; Health Secretary Elizabeth Koff handing an award to Associate Professor Amanda Dawson and Associate Professor Payal Mukherjee; Associate Professor Payal Mukherjee handing an award to Associate Professor Kerin Fielding; Associate Professor Payal Mukherjee handing an award to Matthew Fadhil; mingling guests.

Advocacy at RACS

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

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

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

Diabetes management in adults

There are now 1.2 million Australians living with diabetes, mostly Type 2, but the numbers of both major types of diabetes continue to rise. Diabetes is now estimated to cost this country \$2.9 billion per year. Much of this cost comes from the management of the complications of the disease—more than the disease itself. This is demonstrated by the fact that the lifetime cost of managing diabetes in someone who suffers complications is five times that of someone whose diabetes is well managed and hence is uncomplicated.

Insulin pumps and continuous glucose monitors have been shown to improve blood glucose control, reducing complications, but are currently only funded for children—funding is removed at age 18 and 21, respectively. South



Australian Committee Chair Dr David King and RACS President Dr Sally Langley wrote to the federal health minister lending support to a campaign by the Juvenile Diabetes Research Foundation seeking funding for these technologies for all Australians.

RACS recently wrote to the Australian health minister to raise awareness of the increasing epidemic of diabetes and diabetes-related complications, many of which are unfortunately surgical diseases. Our letter supported a campaign seeking funding for insulin pumps and continuous glucose monitors (CGMs) for adults.

The letter is available on the [RACS website](#).

South Australian 2022 state election

The South Australian state election was held on 19 March 2022. Prior to the election RACS sent an election priorities document to all the main parties contesting the election. Their responses were posted on the RACS website and shared with the local membership. The Malinauskas Government was elected and replaces the Marshall government. The new Minister for Health and Wellbeing is the Hon. Chris Picton, who was previously the opposition health spokesperson.

Health Legislation Amendment (Medicare Compliance and Other Measures) Bill 2021

RACS recently completed a submission to the *Health Legislation Amendment (Medicare Compliance and Other Measures) Bill 2021 [Provisions]*.

Our submission covered RACS concerns regarding the legislative interpretation of 'inappropriate practice' and 'Notice to Produce' evidence in document form and the clash with privacy laws.

Our submission supported procedural fairness and the right to an appeal. We are concerned if errors are misconstrued as false or deliberately misleading practice by a surgeon or their practice. You can read the RACS submission on our website.

National Medical Workforce Strategy

After three years of consultation, the Australian National Medical Workforce Strategy (NMWS) was quietly released on 20 January 2022.

The strategy aims to guide long-term medical workforce planning across Australia. Recommendations arising from this strategy are in close alignment with RACS Rural Health Equity Strategy.

The government's strategy presents many opportunities for RACS to have an impact. As such, we are assessing how it will affect surgical training and service delivery with the goal of supporting our workforce to ensure the current and emerging health needs of the communities we serve are met equitably.

The National Medical Workforce Strategy report can be accessed at the Department of Health website.

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, and 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

IT'S LIVE!
in Queensland

3SCTS 2022

The inaugural Tri-Society Cardiac & Thoracic Symposium (3SCTS)
A meeting of Cardiac & Thoracic Surgeons, Anaesthetists and Perfusionists of
Australia & New Zealand - In conjunction with the ISMICS 2022 Workshop

Wednesday 16 - Saturday 19 November 2022
Cairns Convention Centre, Cairns, Queensland, Australia

Abstract Submissions Close
Friday 29 July 2022

Thank you to our
Symposium Supporter



Early Registration Closes
Sunday 16 October 2022

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Australian and New Zealand
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www.3SCTS.com

Abstract submission
and registration
now open

ANZHNC ASM 2022

Australian and New Zealand Head & Neck Cancer
Society 23rd Annual Scientific Meeting

26 - 28 August 2022
Gold Coast Convention and Exhibition Centre
Gold Coast, Australia

*Evolving Paradigms in
Head and Neck Cancer:
Escalation, De-escalation
and Everything in Between*

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**RACS ASC IN BRISBANE
2 - 6 MAY 2022**

Innovations in trainee-led surgical training



Trainee-led surgical training is the spirit in which the Austin-Northern Surgical Trainees Association (ANSA) is run. Originally conceived in 2016 as the Austin Surgical Trainees Education Committee, this approach gave trainees opportunities to coordinate and improve their own training. Six years and a name change later, ANSA now stands as an association of 61 trainees with more than 100 alumni from the Austin-Northern Training Hub—the first of its kind in Australia.

The Austin-Northern general surgical training hub is one of Australia's largest, with a vibrant and comprehensive education program catering to a variety of registrars. Thrice-weekly 'Shock and Awe' fellowship examination preparation tutorials are coordinated by education officers at the Austin and Northern, while the highly sought-after fellowship practice exam 'Wake-Up session', started in 2017, has become a staple in Victorian Fellowship exam candidates' preparation.

For non-SET trainees, a series of practical clinical knowledge workshop series is coordinated and run by interested SET trainees. This is interspersed with interview preparation and CV crafting

sessions, which have helped many of our non-accredited surgical trainees, with more than half the applicants being selected into the SET training program in 2021.

Originally dependent on the hub and hospital supervisors, ANSA now works independently of the hospital hierarchy, with democratically elected officers selected from the Trainee pool working in parallel with the supervisory staff. These Trainees give their time voluntarily to assist in non-clinical aspects of the training program—with officers sitting on hospital committees to offer junior doctor opinions and insight into the impacts of new initiatives.

As an independent organisation, ANSA organises *Gratias Cena*, a yearly dinner to thank their consultants and

mentors for the work that they put into training. With more than 100 attendees each year, this popular event showcases the vibrant and extensive community that support the training of these young registrars.

ANSA's trainees have generated several spin-off programs. The Victorian collaborative for Education, Research, Innovation, Training and Audit by Surgical trainees (VERITAS) have been prolific researchers, authoring a host of publications following projects such as COVIDSurg, PROTECTinG, SUNRRiSE, SOS, and POSTVenTT.

All trainee organisations have their fair share of social events and welfare initiatives. At ANSA, these include informal orientation events, peer support catchups, and the yearly trivia night—attended by registrars and consultants alike from Victoria, Tasmania and the Northern Territory. These have paved the way for larger, more formal programs, such as ROSE for medical parents—a mentorship and peer support group encompassing all stages of parenting and family planning.

The Austin-Northern general surgical training hub encompasses 48 positions over 14 sites in Victoria, Tasmania and the Northern Territory. With 61 registrars





rotating through the network, it can sometimes feel isolating to have such transient colleagues and connections. ANSA helps bring trainees together to foster and maintain that sense of community across vast distances and maintain clinical expertise and experience between frequent rotations.

It is this collegiality and spirit of fellowship that led to ANSA's conception, growth and maturation, and continues to provide trainees with the opportunity to develop as surgeons in their technical and non-technical skills. In that same spirit, we would be happy to help other

training networks in the establishment of local trainee associations, and future collaborations.

Images (from left):

Hernia workshop; Online interview preparation; Gratiis Cena Dr Stephen Kunz, Dr Jasmina Kevric, Associate Professor Vijayaragavan Muralidharan; Mentors Associate Professor Vijayaragavan Muralidharan, Professor Christopher Christophi, Dr Su Kah Goh.

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

The organising committee are now accepting abstracts for consideration. Abstract submissions close Sunday 26 June 2022. For more information please visit anzsvs.com

Registrations are now open
Register online at anzsvs.com



ANZSVS Conference 2022

21 - 24 October 2022

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In Association with the ANZSVN

anzsvs.com



ASOHNS 72ND ANNUAL SCIENTIFIC MEETING

Friday 10 June to Sunday 12 June 2022

Adelaide Convention Centre | Adelaide | South Australia

Diversity and Inclusivity



The registration brochure is now available online which includes the program, our invited speakers and other important information. Both physical and virtual registrations are available. For more information visit asm.asohns.org.au

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

Register online now
asm.asohns.org.au



RACS ASC 2022

RACS 90TH ANNUAL SCIENTIFIC CONGRESS

Monday 2 May to Friday 6 May 2022

Brisbane Convention & Exhibition Centre
Brisbane, Queensland, Australia

Sustainability in the Dispersed Workplace

 Royal Australasian
College of Surgeons

asc.surgeons.org    #RACS22

IT IS ON!

We are hoping to welcome as many of you as possible to Brisbane in May, for our first real RACS ASC in three years. I am (cautiously) optimistic that Omicron is our pathway to endemicity and that borders will remain open. We even had the good news very recently that the restrictions are lifted and our AoNZ colleagues can join us.

We are also excited to share that many international visitors have confirmed their physical attendance in Brisbane. Professor Carel Le Roux (Ireland), Professor Amir Ghaferi (USA), Mr David Jenkins (UK), Associate Professor Neil Smart (UK), Professor Carmen Solórzano (USA), Captain Onno Boonstra (Norway), Professor Johan Fagan (South Africa), Professor Darlene Lubbe (South Africa), Associate Professor Colin Martin (USA), Associate Professor Christina Roland (USA), Professor Jeffrey Gershenwald (USA), Professor Kenji Inaba (USA), Professor Han-Kwang Yang (South Korea), Associate Professor Shipra Arya (USA) and many more will be with us throughout the week and share with us their journeys through COVID and their visions for the new normal. Professor Mike Griffin, known to many of us, will attend the ASC as the president of the Royal College of Surgeons of Edinburgh. He will also receive his Honorary Fellowship of RACS this year. Alongside Professor Griffin, Professor Kean Ghee Lim, president of the College of Surgeons of Malaysia and Professor Flavia Senkubuge, president of the Colleges of Medicine of South Africa, will be present, just to name a few. Many interstate visitors will also be making their way to Brisbane. What an occasion it will be.

I encourage you all to come to Brisbane so we can enjoy all the aspects that make the RACS ASC special – reconnecting with old friends, freely exchanging ideas, supporting our Trainees and enjoying evening functions together. A virtual registration option is still available, but I think we would agree that the online experience is just not the same.

In addition, we have a great theme which reflects the changes we have all experienced over the last two years. Plenary sessions will focus on sustainability in education, cultural safety, as an everyday event, and as practiced in the dispersed workplace. An impressive array of speakers has been lined up to deliver a great selection of masterclasses and combined scientific sessions.

On Tuesday 3 May, Colorectal Surgery scheduled a ‘wellness’ masterclass where delegates can choose to go kayaking or do yoga. Professor Jeff Dunn is the Chief of Mission and Head of Research at the Prostate Cancer Foundation of Australia. He is also Chair of Cancer Survivorship and Professor of Social and Behavioural Science at the University of Southern Queensland and is a Board Member and Chair of the Audit and Risk Committee for the West Moreton Hospital and Health Service. He will deliver a keynote lecture titled, Survivorship Essentials, in the Senior Surgeons program. On Wednesday 4 May, Associate Professor Stephen Stathis will speak at the Christian Medical Fellowship Breakfast on the joy of working in the unknown and uncertain as a child and adolescent psychiatrist. Deputy Director-General of Queensland Health, Ms Haylene Grogan will deliver a message in the Indigenous Health Breakfast. The Indigenous Health section will also convene a ‘yarning circle’ session. The yarning circle/ hui whakawhānaungatanga is open to everyone to connect, learn from each other, and share cultural knowledge. The session has no set program and will be facilitated by Indigenous surgical leaders. On Thursday 5 May, Indigenous Health will host a masterclass to explore how to assess if one is culturally competent or safe and what is cultural safety anyway? Professor Mark Smithers will deliver the President’s lecture and Professor Chelsea Watego (formerly Bond) will deliver a keynote lecture titled, ‘Encounters of racial violence in the health system, the client, the clinician and the College’. On Friday 6 May, Dr Bridget Clancy will deliver the ANZJS lecture titled, Workplace extreme in Australia, in the plenary session and Mr Harry Stalewski will deliver the Peter Jones oration. The list goes on.

The organising committee, led by Professors Chris Pyke and Deborah Bailey, is working tirelessly to finalise the programs, having gone through nearly 1000 abstract submissions. The final program will be available online soon. When you are reading this, the results for abstract submissions would also have been released so make sure you check your emails.

The excitement is in the air and we are really looking forward to seeing you soon!



Dr Liz McLeod FRACS
RACS ASC Coordinator

Register now via asc.surgeons.org

Congratulations to our learning and development grant recipients

This year's grants provide an opportunity to exchange knowledge, gain further clinical experience and generate outcomes that contribute to improving surgical care.

The Foundation for Surgery is proud to announce the recipients of the 2022 RACS Learning and Development Grants round of the Scholarships and Grants Program.

Thank you to all applicants and congratulations to our recipients.

RACS offers learning and development grants in August each year for RACS Fellows, SET Trainees, junior doctors, and other health professionals to pursue professional development, training, and short-term research activities.

The Foundation for Surgery and the Australia and New Zealand Scholarships and Grants Committee are pleased to support this year's recipients in their professional development endeavours. The grants provide these outstanding individuals with the opportunity to exchange knowledge, gain further clinical experience, and generate outcomes that contribute to improving surgical care.

The 2023 RACS Learning and Development Grants round opens for applications in August 2022. For more information visit surgeons.org/scholarships

Bongiorno National Network Younger Fellows Travel grant

"The Bongiorno National Network is proud to support the advancement of surgical care through our annual Bongiorno National Network Younger Fellows Travel Grant, developed in partnership with the Younger Fellows Committee.

"Congratulations to the well-deserving recipient of this year's grant—Dr Ruth Mitchell—whose overseas Fellowship promises to provide valuable surgical experiences. We wish Dr Mitchell the very best with her Clinical Fellowship in Paediatric Neurosurgery at the British Columbia Children's Hospital in Vancouver."

Tony Bongiorno, Director and Founding Partner of the Bongiorno Group



Anwar and Myrtha Girgis SIMG Grant
Dr Fernando Picazo Pineda, SIMG



Aziz Hamza Rural Surgery Grant
Dr Yuchen Luo, SET Trainee



Bongiorno National Network Younger Fellows Travel Grant
Dr Ruth Mitchell, FRACS



Hugh Johnston Travel Grant
Dr David Coker, FRACS
Dr Connor O'Meara, SET Trainee



Medtronic Younger Fellows Travel Grant
Dr Yogeesan Sivakumaran, FRACS
Dr Varun Harish, FRACS



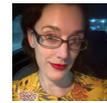
Morgan Travel Fellowship Grant
Dr Andrew Gray, FRACS
Dr Kasmira Wilson, FRACS



Murray and Unity Pheils Colorectal Travel Grant
Dr Liesel Porrett, FRACS
Dr Jonathan Chua, FRACS



Pickard Robotic Training Grant
Dr Tarik Sammour, FRACS



Queensland Younger Fellows Grant
Dr Annelise Cocco, FRACS



Rural Junior Doctor Surgical Skills Course Grant
Dr Sarah Cowan



Rural Surgery Fellowship for Provincial Surgeons
Dr Jared White, FRACS
Dr Mohammed Khaleel, FRACS
Dr Emily Davenport, FRACS



Skills Training Faculty Grant
Dr Bhavik Patel, FRACS



Stuart Morson Neurosurgery Grant
Dr Phoebe Matthews, FRACS



Younger Fellow Leadership Exchange Fellowship
Dr Eugenia Ip, FRACS

Indigenous program



Annual Scientific Congress Award (Australia)
Dr Mikayla Couch, medical doctor



Annual Scientific Congress Award (Australia)
Mr Mitchell Smith, medical student



Annual Scientific Congress Award (AoNZ)
Ms Nasya Thompson, medical student



Annual Scientific Congress Award (AoNZ)
Ms Toriana Murray, medical student



Career Enhancement Grant - Medical Student
Mr Jesse Thompson, medical student



Career Enhancement Grant – Junior Doctor (Australia)
Dr Nikki Burnett



Career Enhancement Grant – Junior Doctor (AoNZ)
Dr Reece Joseph



Career Enhancement Grant – Junior Doctor (AoNZ)
Dr Cherrelle George



Career Enhancement Grant – Junior Doctor (Aus)
Dr Nathanael Leavy



J&J MedTech ANZ SET Trainee One Year Scholarship (AoNZ)
Dr Lincoln Nicholls, SET Trainee



J&J MedTech ANZ SET Trainee One Year Scholarship (AoNZ)
Dr Jamie-Lee Rahiri, SET Trainee



J&J MedTech ANZ SET Trainee One Year Scholarship (Aus)
Dr Justin Cain, SET Trainee

J&J MedTech ANZ SET Trainee One Year Scholarships

Sue Martin, Managing Director, Johnson & Johnson MedTech Australia and New Zealand.

“Since 2016, Johnson & Johnson has partnered with RACS to develop a strong pipeline of Aboriginal, Torres Strait Islander and Māori doctors. Our Trainee scholarship program provides support throughout the journey from medical school into specialty training.

“Since that time, more than 12 scholarships have been awarded to surgeons across Australia and Aotearoa New Zealand. I extend my congratulations to Drs Lincoln Nicholls and Jaime-Lee Rahiri—both from Aotearoa New Zealand—and Dr Justin Cain from Australia on being awarded this prestigious scholarship. I look forward to hearing about the outcomes of their work.”

The J&J MedTech ANZ SET Trainee Scholarships are offered annually with generous support from Johnson & Johnson MedTech Australia and New Zealand. The scholarships are open to Aboriginal, Torres Strait Islander and Māori surgical Trainees and valued up to \$20,000 each.



Education activities

The RACS Professional Development team wishes 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
Difficult Conversations with Underperforming Trainees	Thursday, 2 June 2022	Melbourne, VIC
Foundation Skills for Surgical Educators	Friday, 22 April 2022	Brisbane, QLD
Non-Technical Skills for Surgeons	Wednesday, 8 June 2022	Sydney, NSW
Operating with Respect (Fellows)	Friday, 29 April 2022	Brisbane, QLD
	Thursday, 19 May 2022	Sydney, NSW
	Saturday, 4 June 2022	Melbourne, VIC
Operating with Respect (Trainees)	Friday, 3 June 2022	Melbourne, VIC
Process Communication Model 1	Friday, 20 May – Sunday, 22 May 2022	Sydney, NSW
Surgeons as Leaders in Everyday Practice	Friday, 17 June – Saturday, 18 June 2022	Melbourne, VIC
Younger Fellows Forum	Friday, 29 April – Sunday, 1 May 2022	Mt Tamborine, QLD

Online courses

Course	Date
Conflict and You	Tuesday, 10 May 2022
	Saturday, 25 June 2022
Educator Studio Session	Wednesday, 27 April 2022
	Thursday, 12 May 2022
	Wednesday, 22 June 2022
Induction for Surgical Supervisors and Trainers	Tuesday, 3 May – Tuesday, 17 May 2022
Keeping Trainees on Track	Online module, accessible via Keeping Trainees on Track course page
Leading out of Drama	Wednesday, 15 June – Monday, 27 June 2022

For more information email PDactivities@surgeons.org or visit: <http://www.surgeons.org/lifelong-learning>

Beneficial partnership yielding value

The relationship between TASM and DoH has enabled many initiatives to be developed

The Tasmanian Audit of Surgical Mortality (TASM) was established in 2004. The governance arrangements for TASM fall under a committee of the Royal Australasian College of Surgeons (RACS), with members comprising of RACS Fellows and Fellows of the Australian and New Zealand College of Anaesthetists. A project manager from the Hobart RACS office oversees the audit.

RACS entered administrative arrangements from the inception of the audit with the Department of Health (DoH), Tasmania. In return for financial support to TASM, the project manager sits on the Clinical Governance and Quality and Patient Safety Service team within Clinical Governance, Clinical Quality Regulation and Accreditation.

The relationship between TASM and DoH has enabled many initiatives to be developed that have enhanced the value of TASM reporting within the Tasmanian public hospital setting. A recent example is the Tasmanian public health system prescribing the Safety Reporting and Learning System (SRLS) as its default incident recording and management system. The mortality module of the SRLS was implemented in February 2020 and was a ground-breaking project. It replaced manual forms with automated electronic notification of death certificates to Births, Deaths and Marriages—the same process applies lodging a ‘death report to coroner’ to the Magistrate’s Court of Tasmania Coronial Division. Note that, for the purposes of TASM, the SRLS captures all deaths, including deaths that form part of the audit.

Manual completion of death certificates was subject to many potential sources of error and delay—reflecting poorly on doctors and the health service. At times, this had an impact on grieving families

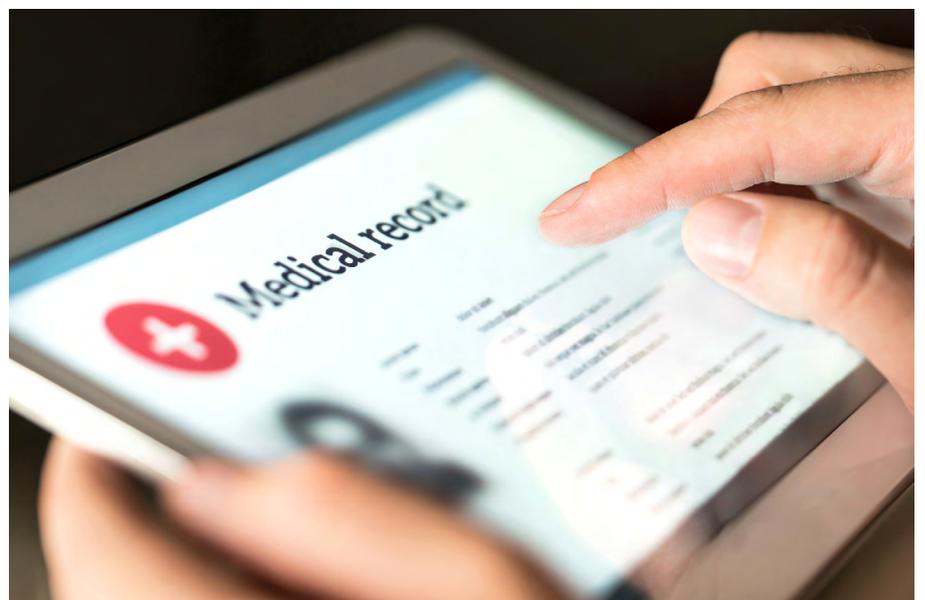
due to delays, lost forms or incorrect information.

Electronic reporting of all deaths via an online platform has delivered process improvements and better outcomes for varied stakeholder groups, including reporting doctors, patient families, hospital executives, patient safety staff, and the Patient Administration System (PAS) team. More recently, this included clinicians in general practice. An enhancement was made in July 2021 whereby a general practitioner (GP) is automatically notified of their patient’s death during an episode of care, affording the listed GP awareness and oversight of their patient’s journey in real time.

This project has been a resounding success as evidenced by post-evaluation surveys. These indicate that the system is easy to use and a vast improvement, with electronic forcing functions for reporters, mandatory fields, and detailed integrity checks in place before forms are distributed.

The system can boast of 100 per cent legibility, fewer amendments and much more timely distribution of both death certificates and coroners’ reports.

‘The death of the paper death certificate’ has been presented at local forums and was accepted as a poster presentation at the International Forum on Quality and Safety in Healthcare in 2021. A working group is currently leading improvements for use of the mortality module to include coroners’ findings. This will help ‘close the loop’ by streamlining their management in one state-wide electronic location, documenting coroners’ recommendations and evidence of actions taken and, most importantly, sharing learnings across the state.



The Aotearoa New Zealand Rural Health Equity Strategy

The Aotearoa New Zealand Rural Health Equity Strategy is being tailored specifically to meet the country's unique needs

Regional and rural communities in Australia and Aotearoa New Zealand face worse health outcomes because of where they live.

It's a well-known fact that healthy communities are more cohesive and more productive. It's also a fact that the more rural a community is, the less access they have to critical services such as trauma care, elective surgery, and general health care.

The Royal Australasian College of Surgeons (RACS) established the Rural Health Equity Steering Committee (RHESC) to address the inequity of surgical services experienced by people living outside metropolitan areas. The RHESC will, in consultation with a wide range of Fellows and specialist societies, develop the Rural Health Equity Strategy. It's a collaborative, itemised plan to work towards equal access to surgical care for all Australians and Aotearoa New Zealanders, regardless of where they live.

The two countries face different regional and rural challenges but, fundamentally, these communities have the same set of problems with access to timely surgical care. The Aotearoa New Zealand Rural Health Equity Strategy is being tailored specifically to meet the country's unique needs and will be officially launched in April.

Dr Nicola Hill is an otolaryngology surgeon based in Nelson, a regional town of about 56,000 people, in the South Island. She's a RACS Councillor, and the immediate past chair of the Aotearoa New Zealand National Committee (AoNZNC), representing them on the RHESC. She's proud to contribute to the country's first surgical rural health plan, which will systematically address longstanding access issues with surgical care faced by regional and rural communities.

"I grew up regionally and still live there, so I see a lot of the stresses and problems



firsthand in regional health. The Rural Health Equity Strategy is an exciting plan and it's got some very tangible outcomes," Dr Hill says.

Dr Mark Stewart, also based at Nelson Hospital, is a general surgeon with a special interest in upper Gastrointestinal and Bariatric Surgery. He's a member of the New Zealand Association of General Surgeons (NZAGS) Executive Committee and is their representative on the RHESC. Having grown up in a small regional South Island town, he's a strong advocate for attracting general surgeons with diverse skillsets to regional areas.

"While a degree of specialisation is good, generalist surgery has its merits," Dr Stewart says. "I see the need for balance, to ensure that more remote sections of our population don't miss out. For me, engaging with the Rural Health Equity Strategy is a great way to make progress, share my passions for General Surgery, and collaborate with other surgeons who share my concerns."

Dr Hill stresses that keeping in mind Aotearoa New Zealand's compact geography, we are talking mostly about regional rather than truly remote communities. Under the Functional Urban



Areas classification system(1), towns and cities with a population of less than 100,000 are regional. Communities of less than 1,000 people are classified as small regional centres or rural.

"As surgeons, it's our role to treat the population, wherever they are."

According to the Ministry of Health New Zealand, one in four people live in small towns or rural areas. The 2018 census found that approximately 26.5 per cent of people live in regional areas and 11.6 per cent are rural. This means more than 10 per cent of Kiwis are rural with no functional urban access. Regional and rural areas are also home to a higher proportion of Māori.

Lack of access to health care for regional and rural people is multifactorial: geographical distance, terrain and weather can create challenges for travel in emergencies, and for general care. For some people, traveling to access health care can be impractical or impossible.



Some of the planned actions in the Aotearoa New Zealand Rural Health Equity Strategy are to:

- agree on a definition of ‘regional’ and ‘rural’ relevant to Aotearoa New Zealand
- develop specific principles set in accordance with Te Tiriti o Waitangi (Treaty of Waitangi) and Te Rautaki Māori (Māori Health Strategy and Action Plan)
- support curriculum review
- adapt accreditation standards to better suit regional and rural centres
- invest in Specialist International Medical Graduate (SIMG) support
- explore the Hub and Node model to support regional and rural training and isolated surgical teams
- foster closer relationships with other specialist medical colleges in rural health equity initiatives
- establish a rural RACS representative in the AoNZNC
- employ a dedicated program officer to support RACS in implementing the strategy in Aotearoa New Zealand.

Each participating specialty society is completing a gap analysis in the four key areas identified in the strategy: Select for Rural; Train for Rural; Retain for Rural; and Collaborate for Rural. The results

will help figure out what each specialty is doing well and where the deficits are. This process will be completed by mid-2022 and will take Aotearoa New Zealand a step closer to implementation of the strategy.

The launch of the Aotearoa New Zealand Rural Health Equity Strategy will coincide with the New Zealand government’s plan to restructure the national health system over the next few years. Health NZ has been proposed as a shift back to a single, central health service designed to provide consistent, high-quality healthcare, administered from several key locations.

This is a great opportunity for surgeons to influence health reforms at a government level. “With our transition to Health NZ, I see our biggest New Zealand-specific responsibility over the next two years being advocacy for provision of services close to home, or as close to home as possible, for regional and rural people,” Dr Stewart says. He would also like to see a national trauma transport system implemented to ensure timely access to care for all urban, regional and rural communities.

What does success look like for the Rural Health Equity Strategy? Dr Hill and Dr Stewart hope to see a change in the shape of the surgical workforce and health outcomes, including trauma outcomes and cancer survival, for regional and rural people. The end goal, they say, is better maintenance of quality of life achieved

for all people outside metropolitan areas. “Key to the Rural Health Strategy’s success is supporting surgeons through their career arc,” Dr Stewart says. “It starts with publicity towards rural and regional high school students who want to study medicine, through recruiting and training them as surgeons in regional and rural settings, and then keeping them connected and collaborative in their rural clinical practice, as well as being involved in research and auditing data in rural settings.”

Dr Hill says the Rural Health Strategy will work because it’s well-researched and, for the first time, there’s a list of clear, definitive actions broken down into achievable steps. “Success will mean we’ve worked through the recommended actions, we’ve acted on them, and we’ve tied it in to the key performance indicators that are currently being developed by the RHESC.

“As surgeons, it’s our role to treat the population, wherever they are,” says Dr Stewart. “A well-designed national healthcare system should make it easy for all communities to access care and get the right outcomes, no matter where they live.”

Reference

1. <https://www.stats.govt.nz/methods/functional-urban-areas-methodology-and-classification>

Recollections of a dodo



OPUS LXXIV

This title may cause a little confusion—a double entendre—and I beg your acquiescence. This is not a senile moment but one in which I recall history and the title is apt—it is all about a dodo.

My first acquaintance with this extinct bird was with the articulated skeleton on Jessie Dobson's desk in her role as curator of the Hunterian Museum in London back in 1971. Fifty years later I was fortunate to be given, from one of the hospital librarians, a book about to be recycled called *Anatomical Eponyms* by the same Jessie Dobson. This sparked a phase of recollections and my association with the College of Surgeons in London in the early 70s.

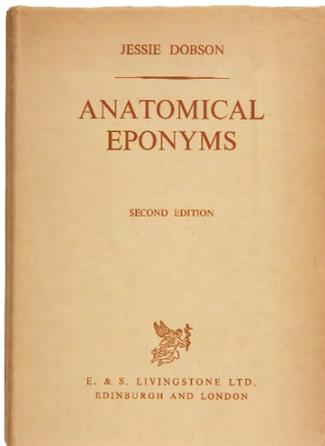


Image: The Jessie Dobson book salvaged from the recycling bin

This amazing book was retrieved from the scrap heap and was a font of knowledge! Who would have thought historic eponyms like Alcock's canal, Bell's nerve, Darwin's tubercle of the ear, Dupuytren's additional discovery of the diploic veins of the skull and then Galen who was the physician to Marcus Aurelius (of Gladiator fame) and then the tendoachilles named after Hippocrates called Tendochorda—all featured in the publication. Space limits me from quoting more but I must conclude with a comment about Leonardo Da Vinci. It was he, who with his artistic talents and his gifts for observational portraiture, was the first to figure out the existence

of the frontal and maxillary sinuses, in a person's physiognomy—all detailed in the Dobson book.



Image: Jessie with a pygmy type skeleton at the RCS

I spent three years at the Royal College of Surgeons of England, one of which was doing investigative research into the vascularity of flaps, using the radiographic facilities at the London Zoo. Yes, exempt from the caged inmates, visiting every day, and what a way to enjoy lunch!



On that initial occasion, discussing the dodo, Jessie—the curator—gave me a Darwinian account, of the origin of species and evolutionary extinction. I make that point about the dodo, a flightless bird, because it was the island feast for mariners around the world who could catch these and enjoy a gourmet feast, having lived on salted beef and fish and dry biscuits for months.

Jessie was a warm personality. She graduated from Manchester University in 1927 with a Bachelor of Education and

became an assistant in the Department of Anatomy at The Royal College of Surgeons under Professor McMinn, Ray Last's successor. Her curatorial work began at the Hunterian Museum following Wood Jones' passing in 1954.



Image: Jessie conducting a tutorial at the RCS

She continued her work as an anatomy demonstrator and lecturer and became an expert in the methods of museum display, compiling catalogues and became an archivist for the Worshipful Company of Barbers—a livery company in London. Let us not forget our surgical origins. Our craft has metamorphosed from a Barber's league, who by reputation had the sharpest knives and would initiate bloodletting in the streets to release the evils of internal disorders. Hence, the basis of the red, white and blue barber poles we still see not infrequently, especially in the UK, even in North Melbourne.

Historically, the Fellowship of Surgeons merged with the Barbers' Company in 1540, forming the Company of Barbers and Surgeons, but with our rising speciality, broke away in 1745 to form what would become the Royal College of Surgeons.

Jessie had the personality trait of the quiet observer. Dr Edit Danos remarks in his obituary of her in 1984: She reflected wisdom and counsel, witty but never wounding. She continually revisited the John Hunter philosophy of wondering 'why', seeking explanations to establish facts as the evolutionary basis of surgical science, again reflected in her book.

During our regular tête-à-têtes over morning tea, no doubt with Twinings, we played with anatomical ideas. She revealed, during one of these sessions, that she had the privilege of residing in Charles Darwin's house in Kent as its live-in curator, as The Royal College of Surgeons owned this establishment. Incidentally, Darwin married the daughter from one of the upper classes—the owners of Wedgewood pottery—and the residence reflected this state of affluence.



Darwin's study in Down House

Ray Last's successor in the Department of Anatomy at The Royal College of Surgeons, Professor McMinn, acknowledged the contribution of this Antipodean often over our morning tea social gatherings. He remarked how Last had furthered the science of surgical anatomy. Last's textbook *Last's Anatomy* is now into its ninth edition. He was a practical man and whenever he could, used illustrations to emphasise the importance of living anatomy. I still remember that statement when describing muscles of the lower limb that the flexor hallucis longus acts as a type of overdrive in any long-distance running.

Jessie Dobson and I became close associates at a scientific level, and I was amazed at her wide range of knowledge and experiences. She was a likeable personality who welcomed strangers (my luck) inclined to her academic speciality.

As a Bernard Sunley Research Fellow in 1972—investigating vascular patterns of the deltopectoral flap in combination with clinical work—this became the basis of the angiotome concept and eventually the keystone perforator island flap reconstructive tool.

In that research year, Ian Wilson—my boss at St George's Hospital Hyde Park Corner—wanted some patterns of vascular perfusion with arteriographic studies to observe the lines of flow in the deltopectoral flap (DP) of Bakamjian

fame. With the fascial base, an essential prerequisite in the design of the DP flap, it was based on the second, third and fourth intercostal perforators, with the second being the largest, my discovery in 1972. It was published in 1975 in the Transactions of the 6th International Plastic Surgical Congress in Paris. This fact was recently rediscovered and quoted in the 2020 article by Seong, a Korean plastic surgeon, in the Archives of Plastic Surgery titled *The internal mammary vessels at the second intercostal space had more favourable anatomic features for use as recipient vessels in DIEP flap breast reconstruction than those at the third*. This rediscovering the wheel keeps occurring as Geoffrey Hallock, a senior plastic surgeon of Pennsylvania recently observed to me.

Another recollection of my RCS experiences is worth recording during that research year. I learned photography from Ralph Hutchings, the RCS photographer. He is still listed in the latest McMinn's publication on *Anatomical Illustrations*. I had to photograph the X-ray arteriography of the injected forehead and chest wall flaps at the London Zoo. He introduced me to this specialised art and its clinical significance, focussing on the object as well the background, observing the rules of placement and composition, to give a harmonious image—with the object a little off centre—in keeping with the French Impressionist tradition.

So, in all my clinical shots over umpteen cases over the years and rolls of Kodachrome, before digital, my experience improved and the photographic department at Peter Mac with the late Arthur Wills and Charlie Frewen were my ongoing tutors. Clean wounds and fresh green drapes became the keynote of this success, being accused by one of my registrars of being the biggest user of green drapes in Melbourne.

Another photographic comment is worth repeating when Steve Doig was my registrar in the 70s before he changed direction into an orthopaedic specialty. He once remarked that my repeat photography merely reflected my addiction to the whirring sound of the motorised drive on the new Olympus OM4. Yes, it was quite a rewarding experience creating rhythm—an essential theatre requirement.

The next phase in this dissertation links last with John Curtin. I recently phoned him on receiving his Australia Day award and in the conversation remarked that he once had lunch with Ray Last at RCS in London in the mid 80s. Last recalled that if you know embryology, you know anatomy. I respect Last's comments on such issues because in all my Keystone work, my flaps are designed within the dermatomal precinct—an embryological concept—based on a nerve supply, which must have an accompanying blood supply. The limitations of skeletonising perforators is obvious, which may damage the adventitial contribution of neural, vascular and lymphatic elements—somewhat analogous to the bark on a tree. In the forthcoming Blondeel third edition on perforator flaps, I have been invited to contribute a chapter on the Keystone concept, where a series of 30 cases will successfully illustrate the principles detailed above.

Without librarians we would be floundering. But this modern concept of electronic data accumulation, valuable as it is for quick reference, has no comparison with the physical contact of the written word when turning the pages and marginating the columns and highlighting points making items quickly retrievable—as I have done with the Dobson book, emulating the Mark Twain habit. The facility of accessing the internet and its invaluable contribution at the press of a button, however, has immediate scientific advantages—who did what and when?

Hence the book becomes the bricks and the foundations of knowledge, whereas the internet provides immediate access and speed for reference retrieval.

Is dead as a dodo having a resurrection? The current press has just revealed a recent article to *Surgical News* about the dodo that Professor Shapiro, Professor of Ecology and Evolutionary Biology at the University of California, announced that the entire genome of the dodo has been sequenced. Another 'Dolly' event is on the horizon.



Associate Professor
Felix Behan

In memoriam

RACS publishes abridged obituaries in *Surgical News*.

We reproduce the opening paragraphs of the obituary. Full versions can be found on the [RACS website](#)

Dr Belinda Mary Scott **FRACS - General Surgeon**

8 November 1957 – 16 May 2021

Belinda Scott was born in New Plymouth in 1957 and completed her secondary education at Wellington Girls College and graduated from Otago University in 1981.

In 1995, Belinda became the first woman to start her own breast clinic in New Zealand. For many years she remained a member of the Board of Trustees and for seven years the Chair of the Medical Advisory Committee and a long-time member of the Board of Trustees.

In her own practice, she advocated for less radical breast cancer surgery and performed New Zealand's first sentinel lymph node biopsy, now a standard procedure for breast cancer patients.

Dr Eric Graham Holmes **FRCS (Edin) FRACS, Urologist Surgeon**

1 February 1939 – 1 November 2021

Graham Holmes was born in Bundaberg and raised in Sarina North Queensland. He completed his MBBS in 1964.

During the following two years, he served as a resident at the Royal Brisbane Hospital. He worked in Nottingham and Edinburgh Royal Infirmary, UK.

In 1971 he achieved his FRACS (Urol). In 1991, he was elected president of the national Urological Society and set a new standard for the conduction of the Annual Scientific meeting of the Society. He instigated the concept of a joint.

Dr Giovanni Lucchese

Otolaryngology Head and Neck Surgeon

28 October 1938 – 26 October 2021

Giovanni, always known as Gino, was a migrant success story. He immigrated to Australia with his parents at the age of 15, unable to speak English, and at 17 attended Sydney University Medical School.

He travelled to the UK in 1971 to pursue ENT studies. Gino returned to Australia

and entered the ENT training program. As a general ENT surgeon with a full range of skills, he was tutor and mentor to many of our current ENT surgeons, many who were his registrars.

From 1992-2000 he was secretary of the ENT Society of Australia, a post he carried out with distinction.

Dr Edward Lloyd Fleming **FRACS, FRCSE - General Surgeon**

20 January 1925 – 27 November 2021

Edward Fleming was educated at Wesley College, Melbourne and studied medicine at Mildura and Melbourne. He entered general medical practice at Traralgon, Victoria.

Edward joined the Royal Australian Air Force (RAAF) Reserve as a senior surgical specialist and was deployed as locum surgeon to 4 RAAF Hospital, Butterworth. He was also involved in medevac flights from Vung Tau. Fleming retired from the RAAF Reserve in 1980.

Edward volunteered at the Australian War Memorial—assisting visitors to discover family members who had served; indexing First World War nominal roll; compiling and publishing an index for the late Alan Storr's 38 volumes of Second World War RAAF fatalities. He also worked on the nominal and awards registers of the Malayan Emergency and Indonesian Confrontation.

Dr David Nott **FRACS, FRCSE - General Surgeon**

17 May 1931 – 21 December 2021

David Nott was born in Canberra and completed his medical training at Sydney University.

He worked for several years in general practice in Hay before going to England to complete a Fellowship in surgery. He worked in England for four years and America for a year then came back to Canberra, where he set up a practice.

From 1962 Dr Nott worked at the Royal Canberra Hospital as a Chest Surgeon.

He did that until the hospital was demolished when he transferred his practice to Woden. Dr Nott remained in practice there until the mid-1990s.

Mr William 'Bill' Norman Gilmour AM **FRACS, FRCSE - Orthopaedic Surgeon**

14 June 1922 – 2 December 2021

William Norman Gilmour was born at Lockhart, NSW, and completed his education at Wagga Wagga and the University of NSW. He qualified as an Orthopaedic Surgeon in the UK in 1952.

In 1954, during the poliomyelitis epidemic, Bill was appointed junior consultant at Royal Perth Hospital and Shenton Park annexe, which was the infectious diseases hospital for polio.

Bill taught many orthopaedic surgeons, operating room nurses and physiotherapists, who are beneficiaries of his analytic mind.

He was a stalwart of the Australian Orthopaedic Association and was its president in 1984.

Bill passed away peacefully on two December 2021 and more than 400 people attended a celebration of his life.

Informing RACS

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

ACT: college.act@surgeons.org

NSW: college.nsw@surgeons.org

NZ: college.nz@surgeons.org

QLD: college.qld@surgeons.org

SA: college.sa@surgeons.org

TAS: college.tas@surgeons.org

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Professor Randy Bindra
Orthopaedic Surgeon, QLD

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