SurgicalNews

Volume 22 | Issue 5

SurgicalNews Volume 22 | Issue 5

Royal Australasian College of Surgeons

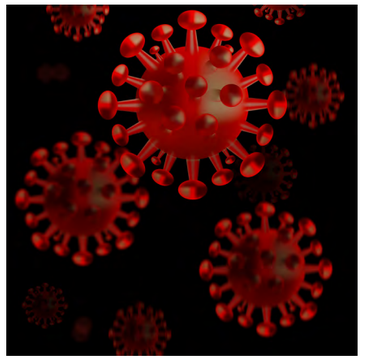
"Our ability to reach unity in diversity will be the beauty and the test of our civilisation."

Mahatma Gandhi

RACS leadership

Spotlight on

Volunteering



Scholarship

Research

Historical

Articles of interest

Trainees

Correspondence and letters to the editor for Surgical News should be sent to: surgical.news@surgeons.org
Editor: Abderazzaq Noor
T: +61 3 9249 1200 | F: +61 3 9249 1219
Editing: Paula Taylor
Designer: Amy Tanner
Publications coordinators: Fay Helfenbaum and Saleha Singh
Contributing writers: Rachel Corkery, Shima Ibuki, Fleur Morrison, Saleha Singh.
www.surgeons.org
ISSN 1443-9603 (Print)/ISSN 1443-9565 (Online).

Cover image: layritten/iStock

President's perspective

The ongoing COVID-19 pandemic and the spread of the Delta strain in many parts of the world continues to result in more lockdowns and disruptions. This shows us that no matter how well we plan our activities, uncertainty remains a key factor dominating our lives.

Living with uncertainty will continue to be our reality until vaccination numbers have reached the desired level, offering protection. Aotearoa New Zealand, New South Wales, Victoria, Queensland, and other parts of Australia continue to be affected by the pandemic. My thoughts are with all those affected.

The pandemic has caused innumerable disruptions in our world, but it has also created opportunities for transformation. Our examination activities are one area that experienced regular interruption and change. It was clear when planning for the clinical vivas for the Fellowship examinations in May -June, that travel would not be possible so a devolved exam for delivery was developed using no actual patients for most specialties and a hybrid model of face-to-face and remote examiners. It was a massive undertaking and we managed to successfully deliver the exams without compromising the quality of the exam or the safety of our candidates. Thank you for the long hours put in by the examination staff and our examiners.

I am pleased to say that following feedback from our stakeholders, we reinstated the Fellowship Examinations with the written exam held on 12 October, and the clinical vivas between 5–7 November. However, not all specialties will hold an exam, and in some instances, not all specialties may be able to accommodate all candidates. The exams will be held across multiple locations in Australia and Aotearoa New Zealand.

The ongoing COVID-19 pandemic means that we must proceed carefully to safeguard the health and safety of candidates, examiners and the many staff who help make the exams possible, as well as the public.

On another matter, we note with concern that the Australian Competition and Consumer Commission (ACCC) has authorised Honeysuckle Health and nib Health Funds to form and operate a health services buying group. The group will negotiate and manage contracts with healthcare providers on behalf of private health insurers and other healthcare payers.

This decision carries significant risk of reduction of choice of hospital and doctor for patients, impacting adversely on quality of care, and a significant risk of unintended consequences. The decision is effectively granting Honeysuckle Health exceptional anti-competitive powers and ultimate control of the potential to control up to 40 per cent of the market share, more than any individual health fund.

There will be significant pressure on hospitals and practitioners to enter into contracts that are based on a funding model that is not independently determined, is not reviewed nor indexed appropriately, and where the determination of performance, quality of care and outcomes are based on analytics that have not been agreed by clinicians or clinical groups.

Patients should have the choice, with the advice of their GPs to whom they entrust their care as to where they wish to be treated. This should not be determined by a group that has been provided an anti-competitive advantage, which can be used to dictate where patients are treated and who treats them.

The College submitted a written submission to the ACCC and made verbal presentations at a hearing outlining our concerns over the buying group.

We also note that there has been unprecedented opposition from other medical groups in addition to RACS on this matter. We will be liaising with these organisations to determine our next steps.

In Aotearoa New Zealand, I and members of the Aotearoa New Zealand National Committee had a meeting with Andrew Connolly, Chief Medical Officer at the Ministry of Health. We discussed the shortage of medical supplies such as diathermy pads, syringes, plaster of paris, dialysis canisters and medications. District Health Boards have been advised to ensure all equipment is used sparingly and to closely monitor all stock, and to notify the Ministry as soon as possible of likely shortages. I am aware that there are supply problems in both countries.

We are planning to schedule further meetings with the Aotearoa New Zealand Chief Medical Officer and other healthcare leaders to discuss ongoing matters such as the new health reform, Health New Zealand, and the new Māori Health Authority.

As always, there is much work for us to do, but I am confident that we have the capability and resources to ensure we can successfully advocate for our College.

In closing, I would like to acknowledge our CEO, John Biviano, for his hard work. We have received accolades from the specialty societies expressing their appreciation for the support and leadership he has provided over the past two years.

Dr Sally Langley
President

Vice president's perspective

After three months as vice president, I have no doubt that this role best suits my focus and abilities – those of advocacy and relationship building.

Of immediate and urgent concern to all members will be recent events surrounding the cancellation of the Fellowship Examination, followed by an extraordinary Council meeting to reinstate it later this year. This presented a challenge for everyone. Additional anxiety, stress and psychological strain were felt not only by candidates but also by their spouses. Consequently, family dynamics were disrupted, affecting their children. The circumstances were unfortunate and are a focus of Council action.

It is, therefore, timely that RACS recently launched a Wellbeing Charter to focus on doctors' wellbeing. The charter is a collaborative effort by the Royal Australasian College of Surgeons (RACS), Australasian College for Emergency Medicine (ACEM), Australian and New Zealand College of Anaesthetists (ANZCA) and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).

We have a history of encouraging our members to maintain their health and wellbeing to better manage the physical and emotional demands of surgical practice. A few years ago, RACS launched the 'Do you have a GP?' campaign to encourage members to make their own health a priority and see a GP on a regular basis. I have to be honest and declare it is only for the past two years that I have engaged a colleague as my GP. I am embarrassed to confess that I should have committed to this many years ago.

Hand in hand with this is the mental health and wellbeing of the surgical profession and the need for targeted support with the necessary resources. RACS partnered with Converge International, which has a specialist focus on psychology, mental health and wellbeing. Converge provides confidential support to Fellows, Trainees and Specialist International Medical Graduates and their immediate family members when required. The service is free to RACS members and is available 24/7.

In August, RACS announced its intention to phase out of the use of gendered titles such as Mr, Ms or Mrs and encourage members to use 'doctor' or an appropriate academic title such as 'professor'.

Surgery is the only profession that continues to use gendered titles. For example, the Australian Defence Force, New Zealand Defence Force, and respective police forces have moved to 'police officer' and no longer use gendered titles. In business, standard boardroom practice is to use the gender-neutral 'chair' or 'chairperson'.

Gendered titles can be confusing for patients and contribute to implicit bias against female surgeons. These titles are not consistent with other RACS initiatives to increase gender equity amongst surgeons through our Diversity and Inclusion Plan, and Building Respect strategies.

Consequently, RACS will welcome newly qualified FRACS surgeons as 'Dr' and no longer provide the option for new Fellows to select their preferred title in College correspondence.

We are all doctors, and I have always used the title of doctor, as do most surgeons in Queensland. I would like to stress that this change is not mandatory, as RACS respects individual freedoms of Fellows to determine the title by which they prefer to be addressed.

Your Council is also considering a proposal to change to the name of the College from Royal Australasian College of Surgeons to Royal Australian and Aotearoa New Zealand College of Surgeons (RAANZCS).

A working party progressed this matter and after discussion at Council it was agreed that an electronic vote of members on the proposed name change will be conducted in 2022, allowing ample time for member and stakeholder education and engagement.

RACS has previously considered a name change due to several related concerns, such as uncertainty about the meaning of the word 'Australasia' and whether it reflects our bi-national status; should we be Australia and New Zealand or Australia and Aotearoa New Zealand: how do we best reflect the Māori and Aboriginal and Torres Straits Islander cultures; how does the prefix 'royal' fit, and what does all this mean for Fellows who use the post-nominal FRACS.

By way of background, this was first mooted in 2004 after a survey conducted by our New Zealand National Board found that the majority of our Aotearoa New Zealand Fellows and Trainees favoured a name change.

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

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

In December 2019, the New Zealand National Board requested that Council again consider a name change. This proposal was referred to the Governance Committee then to Council. A working group was established to scope a College name change and make recommendations.

In January 2021, the New Zealand National Board requested inclusion of both Aotearoa and New Zealand in the College name. We will reach out to you and follow due process on all these matters.

Council, like every board and organisation, is in a phase of progressive evolution aiming to continuously improve and strive to transparently, openly and fairly represent all RACS members. By definition this implies a nimble and agile board and management partnership to proactively deal with the fluid state of of challenges and disruptions facing RACS.

RACS is also working closely with other specialist colleges to formulate COVID-19 related surgical practice, both emergent and elective guidelines with the aim of establishing a sensible, equitable and sustainable health care action plan for the community's future needs.

Dr Lawrence Malisano
Vice President

To contact Converge International call 1300 687 327 in Australia or 0800 666 367 in Aotearoa New Zealand.

HPAC Anti-Racism Working Party

The RACS Health Policy and Advocacy Committee (HPAC) has formed a working party to create a draft position statement setting out RACS' position on anti-racism and examine how Fellows and their patients are impacted by racism. Issues such as systemic abuses and inherent difficulties with providing a health care service based on skin colour, religious beliefs or accent, among other things, will be explored. The working party will also look at various risk assessment analyses, diversity modules, data collection techniques, and the current role of cultural safety and competency.

RACS supports mandatory vaccines for healthcare workers

The Royal Australasian College of Surgeons supports mandatory COVID-19 vaccinations for the entire healthcare workforce in clinical and non-clinical positions.

Healthcare workers have been at the forefront of immunisation and were among the first to get vaccinated while delivering front line services. With the highly contagious Delta variant "vaccination is an ethical obligation and a necessary step for all healthcare workers to protect themselves, their colleagues, and the community they treat," Dr Sally Langley said.

RACS calls for continued elective surgery

The Royal Australasian College of Surgeons (RACS) supports a position where hospitals are allowed to continue some of their elective services in an environment of uncertainty and fluctuation, in conjunction with local health departments.

"The restriction in elective surgery needs to be balanced with hospital specific factors, such as staff shortages, PPE availability and ICU capacity," Dr Sally Langley said.

Surgical Mortality Audit eLearning Module

A Surgical Audit eLearning course has been added to the RACS professional development activities. The course has been developed in a collaboration between ANZASM and the RACS Professional Development department. It is available to all surgeons and takes approximately 40 minutes to complete.

The eLearning course will provide training around the sensitivity of reporting surgical mortalities and the logistics of using the Fellows' Interface and is delivered in four practical sections:

1. The Audit of Surgical Mortality
2. The Audit Process
3. The Fellows Interface
4. Feedback and Evaluation

The course will provide an adaptable and differentiated teaching and learning platform for a broad range of users from different regions, specialities and career stages to access information and gain Continuing Professional Development (CPD) points (via completion of course assessment and award of certificate).

Surgeons urge Māori patients to get vaccinated

The Royal Australasian College of Surgeons' (RACS) Māori Health Advisory Group supports the call by Te Rōpu Kaupapa Urutā, endorsed by Te Ora, for the government vaccination program to prioritise the first dose of vaccine for Māori and Pasifika people.

RACS recently highlighted with a media release that Pasifika families need to be given priority for vaccination, given that they make up 70 per cent of cases of the current outbreak of the COVID-19 Delta variant in New Zealand.

The College also urged Māori patients to get their first vaccination as soon as possible with the highly contagious Delta variant spreading in the Aotearoa New Zealand community.

Dr Maxine Ronald (Nga Puhi, Ngati Wai), a general surgeon working in Whangarei and Chair of RACS Indigenous Health Committee said it is vital that Māori get vaccinated to avoid becoming seriously unwell and protect their whānau.

"We know that Māori have a higher rate of underlying health conditions such as cardiovascular disease or diabetes, so getting infected with COVID-19 means the risk of getting seriously ill or dying is much higher. It is vital that whānau get vaccinated to protect each other especially our kaumatua, tamariki and vulnerable whānau."

It's not Mr, Miss, Ms or Mrs – it's Dr

"This is Mr X, Miss C and Dr T, your surgical team. Miss C will be your lead surgeon."

If you have ever undergone a surgery, you might have been confused by the titles of your surgeons – why is Mr X a Mr, and Dr T the only Dr on your surgical team? Why is Miss C the lead surgeon when her title doesn't include Dr?

It seems like all surgeons have gendered titles; does being a Dr mean Dr T is less qualified than Mr X to operate on you?

In a word – no.

It's confusing for patients to refer to surgeons with a combination of gendered titles and the commonly understood term Dr. It creates a perception that Dr T and Mr X have different qualifications, despite both of them being surgeons in the same department.

This is a challenge particularly for women. There is already an existing perception, unconscious or otherwise, that female surgeons are not 'real' surgeons, or that female surgeons are not as skilled as their male counterparts. While overt discrimination is no longer tolerated, many patients still question the qualifications of female surgeons due to implicit (unconscious) biases.

The use of the term 'Mr' for surgeons dates to the 16th century when 'barber surgeons' performed operations at the direction of physicians. The pre-nominal 'Mr' distinguished the barber from the university-trained physician, or 'doctor', and was retained by the Royal College of Surgeons of London as a label of status to mark the completion of examinations.

The continued use of gendered titles in surgery such as Mr, Miss, Ms and Mrs now connotes a sense of elitism and hierarchy in medicine. It is unnecessary and that's why I was proud of the Royal Australasian College of Surgeons (RACS) for recently announcing that they would be gradually phasing out the use of gendered titles in surgery.

Surgery has changed from the time gendered titles were used to refer to surgeons. Surgeons now must have a university education, like physicians of the past, plus rigorous specialty training before they qualify. It is simply not relevant to continue using gendered terms to differentiate ourselves from the rest of the medical community.

The police and defence forces have moved to gender-neutral terms. In business, we now use 'Chair' or 'Chairperson'. Surgery is the only profession that uses gendered titles in Australia and Aotearoa New Zealand, where respectively 41.7 per cent and about 66 per cent of surgeons use gendered titles.

Surgeons are doctors. I was a doctor before I became a surgeon and I will always be a doctor. My qualification as a surgeon does not make me better or higher in status than a general practitioner or a neurologist or an anaesthetist. All medical professionals work to serve patients and deliver the best patient care we can. Why should a title differentiate us from each other?

Being part of a group that only uses gendered titles alienates me and my surgical colleagues as women surgeons from being part of a larger group of doctors. There is substantial meaning tagged to a gendered title in surgery – it suggests higher status and elitism between surgeons and other medical professionals, male and female surgeons, and between women who are married and who are not. I firmly believe that removing gendered titles will lead to equity in the workplace, where surgeons are part of the medical workforce, not above it.

Dr Christine Lai
FRACS

RACS *volunteers*

RACS is fortunate to have many volunteers who give their time and funds generously to support the College's many philanthropic activities.

164

assessment of scholarship and grant applications to deliver world's second-largest philanthropic funding for surgical research and education worldwide

5

online Papua New Guinea CO-HELP online training modules completed by 97 health care workers

274

May Fellowship examinations administered over two weekends by

246

examiners across 33 venues in six cities across Australia and New Zealand and four time zones

2300

local health workers attended RACS workshops in the Asia-Pacific region

580

hours donated by Faculty delivered over 48 professional development activities

431

health workers trained and 278 surgical procedures carried out Under the Pacific Island Program (PIP)

1000

life-changing procedures delivered in developing Asia-Pacific countries

149

patients provided with access to cataract surgery and 14 patients accessed pterygium surgery under ETEP

1551

online and face-to-face (where possible) Professional Development programs delivered to 1551 Fellows, Trainees and SIMGs

69

skills courses delivered to 969 participants

13,000

hours donated pro bono to teaching RACS skills courses

Information valid at time of publication

Volunteers reap the benefits of giving their time for others

Volunteering might seem like a one-way transaction in which one party gives their time or expertise while the other receives support.

However, research suggests this transaction is not quite so simple. Volunteering can be just as beneficial in terms of improved wellbeing and psychological health for those who volunteer. It is the ultimate win-win situation.

In 2020, research published in the *Journal of Happiness Studies* revealed people who had volunteered in the past year were more satisfied with their lives and rated their overall health as better.

Additionally, those who volunteered more frequently experienced greater benefits. Those who volunteered at least once a month reported better mental health than participants who volunteered infrequently or not at all.

The act of volunteering can also play a protective role during times of hardship or uncertainty. During the COVID-19 pandemic, Australian National University research found that while all Australians surveyed experienced a decline in life satisfaction, there was a smaller drop for those who continued to volunteer compared with those who stopped volunteering or who never volunteered. Levels of psychological distress were also substantially lower among those who continued to volunteer.

Mark Pearce

Volunteering Australia CEO Mark Pearce said the advantages of volunteering included an increased sense of connectedness to communities, self-worth, confidence, networking opportunities, pathways to employment, and mental and physical health.

"We tend to look at volunteering as benefiting the community, and that certainly does happen, but of course, it also offers manifest benefits to individuals who volunteer," Mr Pearce said.

"Volunteering gives us a sense of purpose and an ability to make someone's life better, which contributes to our own happiness. It allows us to reshape our communities so that they are better places to live."

He said that giving time or money could be valuable for the 50-60,000 organisations across Australia that depend on the contribution of volunteers.

Melanie Weir

Langley Group offers workplace courses in emotional intelligence and positive psychology, and promotes the benefits of volunteering. HR Manager and Senior Consultant Melanie Weir believes a culture of volunteering could create a kinder environment in workplaces or communities.

"Volunteering provides people with the opportunity to connect with others, whether it is by volunteering on a board, coaching a sporting team or contributing to animal welfare," she said.

"In a workplace, a tendency to volunteer can be contagious; if someone does something for you, you are likely to respond by passing on that act of kindness. This generates a reciprocity and sense of connection that can be quite powerful."

Ms Weir said that surgeons were well-placed to create a culture of volunteering that could have wide-reaching consequences.

"Imagine the ripple effects across hospitals, the health sector and communities that a culture of volunteering would set off," she said.

Langley Group CEO and Founder Sue Langley agreed that volunteering could have a positive impact on wellbeing and mental health. But she said that not all volunteering is equal when it comes to either community or personal impacts.

Sue Langley

"People who volunteer experience positive emotions from playing to their strengths and making a contribution," Ms Langley said.

"It is important that the volunteering is self-motivated and aligns with your values and strengths," Ms Langley said.

"We tend to experience wellbeing and psychological health benefits of volunteering when that work is aligned with our skills and who we are."

Ms Langley gave the example of an employee who felt pressured into volunteering by their company, saying this was unlikely to lead to the same benefits as it would for someone who willingly volunteered their time and skills.

"It's about someone who loves sport getting involved in coaching, someone who is a great cook contributing to their local bake sale or a parent joining the committee at their children's school. The positive impact on wellbeing only comes if you have autonomy and the work is aligned with your interests," she said.

Dr Alex Hockings Q&A

Perth urologist Dr Alex Hockings talks about the satisfaction she derives from volunteering in the Pacific Islands as part of the Royal Australasian College of Surgeons (RACS) Global Health program.

Dr Alex Hocking's global interest was shaped by her childhood schooling in Perth and Boston, time spent growing up in the Middle East and having a father who worked in international aid. Dr Hockings knew from a young age that she wanted to be a doctor. She studied medicine at the University of Western Australia before completing her Fellowship in Melbourne.

Dr Hockings always knew she wanted to be a mother and she found the freedom to have a family life by pursuing a career in Urology. She loves the diversity of her specialty and is incredibly grateful for a job she loves.

Why do you volunteer?
I enjoy the opportunity to volunteer my time and effort as that's what I feel I can contribute.

My dad did a lot of international aid work when I was young, and my mother is a teacher and has always been generous of spirit, so volunteering is an ethos that I was brought up with.

Volunteering has also given me amazing life experiences. You learn as much about yourself in these places as you do about different cultures.

During your studies you travelled for aid work. Where did you travel?
I have had some interesting times and travelled to some interesting places. As a medical student, I volunteered in Vietnam and Swaziland.

I completed half my medical school elective in Trinidad and half in India, and at the start of Urology training I volunteered in Vanuatu.

Since then, I have gone to the Pacific Islands more regularly with RACS Global Health. I have now been to the Pacific Islands three times, each time for a week.

What have been the biggest challenges you have faced in your volunteer work?
I decided to volunteer in India after learning about an amazing cardiac hospital there on ABC's Four Corners. When I arrived, I realised it wasn't anything like how it was presented on television; there was no running water and electricity was only available at certain times of the day. It definitely wasn't what I was expecting.

Communication and language barriers can also be big challenges, along with access to equipment. You really need to be adaptable and resourceful to be able to use what is available.

During one visit to the Solomon Islands, the clinic ran out of saline bags, so we had to send someone to the local supermarket and had to make do with what we hoped were bottles of sterile water.

What was your first experience with RACS Global Health?
My first trip to Vanuatu with RACS Global Health was in 2012. My work at a clinic involved treating anyone who walked through the door. The most common conditions were urinary retention and kidney stones.

We saw extreme cases, as people had often had to wait a long time before they could get help.

We also taught the local general surgeons how to treat urinary retention so people didn't have to wait until we arrived to be treated.

How important is it to be a role model for other women surgeons, and particularly those in the Pacific?
I think it's important for women to see that it's possible to have the flexibility of surgical life, international travel and family life, but I'm not sure that it's gender specific. I know there are a lot of male surgeons that are very family orientated and that's very important to them.

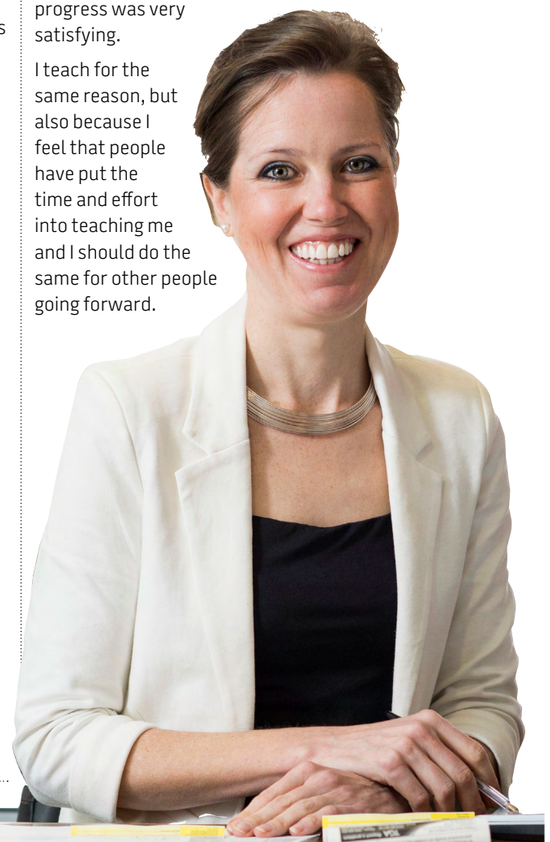
Having positive role models can make a big difference, particularly for Pacific Islanders interested in surgical careers.

In the Pacific Islands, I have seen instances of female patients avoiding treatment for years because there were no female surgeons and it was not culturally acceptable to be examined by a male doctor. This makes it even more important that there are female surgeons, and for women to see that it is possible.

What are some highlights from your Global Health experiences over the years?
There is no one particular highlight but the thing that really strikes me each time I visit is that the Pacific Island people are so appreciative. Often in private practice in Australia, people expect a certain standard of healthcare and you rarely get thanked for your work. In the Pacific Islands, patients are so grateful for any help they get. It really makes you feel what we do is worthwhile.

You also teach through RACS and other universities. What drew you to teaching?
I did a lot of sport at school and afterwards I coached, which I really enjoyed; seeing others improve and progress was very satisfying.

I teach for the same reason, but also because I feel that people have put the time and effort into teaching me and I should do the same for other people going forward.



By teaching, I offer a different perspective to students. I don't believe I offer them the standard approach to being a surgeon because I have set myself up in a way that is not typical of most surgeons. I believe it's important for young students to see that you don't need to work huge hours or be completely job-orientated to be a surgeon.

How do you spend your time when you are not volunteering or working?
Outside work I like to play sport, socialise, or spend time on my parents' farm.

I try to travel for pleasure once a year (before COVID-19). My last trip was to the Middle East with my family, and then sailing in Croatia, which is where my sister-in-law is from. It was a fabulous trip.

What advice would you give other surgeons who want to be involved with international development work?
Without hesitation, do it. You learn so much about yourself and it's as rewarding for you as it is for the people you're helping. Get involved!

Left: Alex Hockings (middle) in the Solomon Islands with Kevin Ramo (left) and Stallone Kohia (right)

RACS and the Colombo Plan

In the late 1940s, post-war Australia, isolated by White Australia policies had little knowledge of our near neighbours in the countries of South and South East Asia. This was to change, primarily due to the efforts of two external affairs ministers – Percy Spender and Richard Casey.

By 1950, Spender, who led the Australian delegation to the British Commonwealth Foreign Ministers' meeting in Colombo, had formulated plans for an international aid program in South and South East Asia.

Developed from the 'Spender plan', the Colombo Plan's original membership of seven countries had increased to 17 by 1954. Casey, who succeeded Spender as Minister for External Affairs in 1951, was an enthusiastic advocate for the Colombo Plan and, through his surgical contacts, involved the Royal Australasian College of Surgeons (RACS) in this initiative.

Casey, who would later become an Honorary Fellow of the College, had several indirect associations with surgery. He was married to Maie Ryan, the daughter of surgeon Sir Charles Snodgrass 'Plevna' Ryan. When Casey was treasurer in the Lyons cabinet, he also met neurosurgeon Douglas Miller and they appear to have become good friends. In Miller's autobiography, *A Surgeon's Story*, he mentions his purchase of Casey's Triumph car and how he was given a 'beautiful cocker spaniel' bred by Maie Casey.

Benjamin Rank, approached by Richard Casey in 1954, was the first surgeon to participate in the Colombo Plan. Rank was an advocate for the training of Asian students in Australian medical schools and post-graduate facilities, so he was an obvious choice.

Following Rank's appointment, *The Age* of 11 November 1954 carried this caption:

'There is a touch of imagination in the decision that Australia should send a distinguished plastic surgeon to Asian countries to help them in correcting disfigurement and deformity resulting from the diseases with which they are cursed.'

Despite the paternalism, the appointment flagged a positive beginning to Australia's surgical involvement in Asia. After visiting Indonesia, Malaya, Singapore and India, Rank was able to report to Casey that he had 'performed 39 operations, carried out 75 consultations and given five lectures', all of them on 'reconstructive' rather than 'destructive' surgery.

Unsurprisingly, Douglas Miller was the next participant in the Colombo Plan: he was asked to demonstrate neurosurgery in Singapore. Miller was inspired by the experience. He even found that 'flying was somewhat of an adventure' and noted there was 'a great deal of interest in brain surgery'.

When he returned to Australia, Miller, who would become President of RACS, suggested that the College become involved in training overseas surgeons for Fellowship. In 1956, the College sent a team to Singapore to train surgeons for the Primary Fellowship exam.

Douglas Miller went to Asia on several occasions during the 1950s – returning to Singapore, visiting China with a group of medical specialists and journeying to India, Thailand, Hong Kong and Japan. China was a new experience for him.

'I asked my neurosurgical colleague in Peking about head injuries. He gave the astonishing reply, 'We don't have head injuries – our chairman says we must not.'

The College's involvement with the Colombo Plan established important links with Asia. The Association of Asian and Australian Neurosurgeons, with Douglas Miller as its first president, and societies such as the Asian Surgical Association routinely involved College representatives in their meetings. Asian patients continued to be sent to Australia for specialised surgery, and training for Asian surgeons continued to expand.

In 2001, a Virtual Colombo Plan, the culmination of the then Foreign Minister Alexander Downer's efforts to revive the 'Casey tradition in Australian Foreign Policy', was launched in Sydney. Its aim was to provide developing countries with access to new technologies – this was another branch to the sapling that was planted over fifty years earlier.

Elizabeth Milford, RACS Archivist

Above: Benjamin Rank, the first surgeon to participate in the Colombo Plan with the late Indian Prime Minister, Indira Gandhi.

Medical student-led research collaboratives create new opportunities

The creation and expansion of Trainee-led collaborative research networks (TCRNs) in Australia and Aotearoa New Zealand has provided the opportunity for surgical Trainees to conduct large multicentre trials. With guidance from the Clinical Trails Network Australia and New Zealand (CTANZ), such trials contribute meaningfully to the surgical literature. [1]

Student-led collaborative research networks have also been key drivers in the shift towards a collaborative research model to generate impactful research. The role of medical students in leading surgical audits has grown exponentially across the last five years and has provided students with sought-after research experience, mentorship opportunities, and skills in data collection, audit procedures and governance approvals.[2]

In 2019, a bi-national student-led collaborative research network was established by members of the Australasian Students' Surgical Association (ASSA) and the TASMAN (Trials and Audit in Surgery by Medical student in Australia and New Zealand) Collaborative. The network was based on the well-established STARSurg collaborative model in the United Kingdom. Since then, other state-based student-led collaborative research networks have also been created, including the Student Research Initiative in Western Australia (STRIVE WA) collaborative.

The TASMAN collaborative aims to unite and empower surgically inclined students, supported by junior doctors, to engage in high-quality collaborative surgical research. It has provided a platform for medical students to upskill and contribute to large-scale regional, national, and international surgical projects.
In collaboration with the Trainee and student-led STARSurg, GlobalSurg and EuroSurg collaborative groups internationally, TASMAN develops and facilitates one major project each year. Students have been actively engaged in leadership, project design, and dissemination.

TASMAN has also made great strides in internal development, growing its team to over 20 passionate medical students and junior doctors who aim to create a sustainable network that empowers the next generation of leaders in surgical research. TASMAN achievements include three publications authored alongside other collaboratives, three oral presentations and three posters at national conferences.

This year's team has developed governance and policy documents based on the Australasian Clinical Trials Alliance (ACTA) guidelines, and has organised several educational events throughout the year, including an upcoming 'shark tank' research proposal competition for Australian and Aotearoa New Zealand medical students.

In 2021, medical students played a key role in the first Australasian-initiated collaborative study, POST operative Variability in anaemia Treatment and Transfusion (POSTVenTT), under the mentorship of Professor Toby Richards. Student involvement included taking on roles in: the steering committee, software and workflow management, communications, ethics and governance, national and state lead, data collection, statistical analysis, and manuscript writing. TASMAN is in the process of submitting the study protocol for Australia's first student-led collaborative study.

Student led collaborative research networks have allowed students to acquire essential skills and competencies in various aspects of surgical research, including networking with the international research community. Students have proven to be capable of leading international multicentre audits with support from CTANZ and TCRNs.

We would like to thank all the College's Fellows, SET Trainees and junior doctors who have provided mentorship and guidance at every stage. This has been fundamental in the success of student-led groups and we would appreciate your ongoing support to minimise barriers to student involvement in multicentred collaborative studies, as TASMAN along with other TCRN/SCRNs continue build momentum across Australia and Aotearoa New Zealand.

Authors:
Davina Daudu, fourth year medical student.
Laure Taher Mansour, fifth year medical student.
William Xu, fifth year medical student.

Image: Members of the POSTVenTT Team at Fiona Stanley Hospital in Perth, WA.
L-r: Dr Uyen (Jess) Vo (surgical registrar and POSTVenTT trainee lead), Bethany Furfaro, Ron Ramos and Davina Daudu (fourth year medical students at the University of Western Australia). Photo credit: Professor Toby Richards

REFERENCES

1.Trainee- and student-led research networks: promoting research skills and competency through collaboration' 2020, ANZ Journal of Surgery, vol. 90, no. 11, pp. 2177–2179.
2.Ibid

Two surgeons share their volunteering experiences

The rewards of volunteering are many and varied.

The rewards of volunteering are many and varied for two surgeons who give their time to educate and support the surgeons of the future.

Urologist Mariolyn Raj and Cardiothoracic surgeon Sean Galvin both volunteer as part of the RACS examination program.

Dr Raj finds the time to volunteer alongside running her own practice and working in hospitals in and around Melbourne. She first considered contributing to the examination program when she saw the positive impact of volunteering on her mentors.

Observing that those who volunteered led full lives and were friendly and positive, she was inspired to dip her toes into volunteering.

"I had fabulous mentors and they really piqued my interest in volunteering. They were friendly, open minded and happy individuals, and as a wonderful adjunct to their careers, they were able to devote time to nurturing up and coming surgeons," she said.

"They motivated me and I still gain so much from our ongoing friendships that began when they were my mentors."

A decade later, Dr Raj hasn't looked back, giving her time as an instructor and director in the Early Management of Severe Trauma (EMST) training program, as an examiner in Fellowship examinations, and as a facilitator in the Foundation Skills for Surgical Educators course (FSSE).

She is also a member of the RACS Victorian Regional Committee, through which she advocates for Fellows and acts as a link between her colleagues and RACS.

Along with her many formal volunteering roles, Dr Raj enjoys the opportunity to mentor the Urology registrars with whom she works.

"It really has come full circle and now I love to share my experience with other people. I find that's one of the best ways to help people work out their own pathways. It's really nice to be able to offer them my perspective on whatever they're trying to work out in their careers."

A well established benefit of volunteering is that it builds a sense of community and connectedness. That is certainly the case for Dr Raj, who values the friendships she has developed with other volunteers and the younger surgeons she has mentored or assisted in their studies. She recognises the cyclic nature of the profession, with those who undertake examinations eventually volunteering to assist with their administration.

Like Dr Raj, role models played a significant part in Dr Galvin's decision to become a volunteer in a range of committees and positions.

Dr Galvin is a consultant Cardiothoracic surgeon in the Wellington Regional Heart and Lung Unit at Wellington Regional Hospital.

He volunteers as Chair of the Cardiothoracic Surgical Sciences and Principals Committee, New Zealand, as Cardiothoracic specialty representative on the Aotearoa New Zealand Committee, as RACS representative on the New Zealand Resuscitation Council, as supervisor of training for Cardiothoracic surgery in Wellington, as clinical leader for the New Zealand Cardiothoracic Clinical Network and New Zealand Cardiac Surgery Registry, and will soon end his tenure as the New Zealand representative on the RACS Younger Fellows Committee.

Mariolyn Raj with the Victorian Regional Committee Pictured together are (left to right) Katherine Walsh and Virginia Cunsolo from the RACS Victoria state office, Dr Mariolyn Raj and Dr Ruth Bollard.

EMST Faculty Workshop dinner

Dr Galvin attributes his decision to volunteer to the example of his father, Ivor Galvin, a fellow Cardiothoracic surgeon, and other role models who contributed to his own development as a surgeon.

"I've had a number of very strong surgical role models who invested a lot of time in training and who became close friends and mentors. Throughout my father's career, he spent a lot of time teaching and supervising surgical Trainees. He was a RACS fellowship examiner and supervisor of training in Dunedin for many years, and he always found that part of his career rewarding. I was lucky enough to work with him when I was a registrar and again as a consultant. I saw the time and effort he put into Trainees and the impact it had on their (and my) development," he said.

He also names Siven Seevanayagam, George Matalanis, John Riordan and July Mundy as surgeons whose contribution to his professional development inspired him to give his time to support the development of future surgeons.

"I was lucky enough to have surgeons throughout my career who invested time in teaching me. I know how important that was to me and feel it is important to make the effort to give the same experience to the current generation of Trainees," he said.

Many RACS training courses depend on the contribution of volunteers, who offer their expertise to the surgeons of the future, and who reciprocate the support and education they received in the past.

Dr Galvin believes in the importance of maintaining a strong professional body, which representes the needs of its members.

"While involvement in RACS activities is rewarding and professionally satisfying, it also ensures the ongoing strength and sustainability of the College as an institution and ensures that its directions and views are influenced and guided by its member fellowship."

In the past two years, COVID-19 has presented some challenges in the education and examination programs. These included technical challenges as meetings and examination preparation were held online, and volunteers lost the opportunity to meet face-to-face with their peers in Australia and New Zealand.

However, the pandemic also offered some improvements to systems that had been in place for many years, making it easier for volunteers from different parts of the countries to be involved.

Despite the technical issues, online preparation of examinations meant that volunteers did not need to travel to be together. RACS is also considering converting the delivery of some modules to an electronic format as a result of the benefits of online education they experienced during the pandemic.

So, how do Dr Raj and Dr Galvin manage to fit volunteering, even in the midst of a pandemic, into their busy schedules?

"It's busy and I don't get many free weekends," Dr Raj said. "But I thrive on the opportunity to be involved in this way, and it is very different from my clinical work.

"I love my job and wouldn't trade it in for any other career, but volunteering adds to the satisfaction in my life. It makes me feel happier, more engaged in my profession and is personally rewarding."

At the start of every year, Dr Galvin blocks out dates on his calendar for volunteering, and attributes his opportunity to be involved in his many voluntary positions to the support of his hospital and department, and his wife.

Both Dr Raj and Dr Galvin encourage other Fellows to become involved in volunteer opportunities for the personal and professional benefits and to foster the surgical talent of the future.

"As Fellows, we need to guide the ongoing growth and development of RACS as an organisation. When as many Fellows as possible are engaged and involved in areas of the College that interest them, from teaching to governance or examinations, it adds to our collective strength as a group," Dr Galvin said.

Would you like to teach on Skills Training courses?

Professional development, networking and mentoring – join our faculty today!

Each year the Skills Training Department delivers approximately 150 courses to more than 2500 Trainees and pre-vocational doctors throughout Australia and Aotearoa New Zealand, across five programs.

ASSET
Australia and New Zealand Surgical Skills Education and Training
Generic basic surgical skills – a compulsory aspect of surgical training

CCrISP®
Care of the Critically Ill Surgical Patient
Useful skills for managing critically ill patients

CLEAR
Critical Literature Evaluation and Research
Critical appraisal of surgical literature to assist in the conduct of clinical trials

EMST
Early Management of Severe Trauma

This course from the American College of Surgeons Advanced Trauma Life Support (ATLS®) provides a systematic clinical approach in the management of patients with traumatic injury

TIPS
Training in Professional Skills
Patient-centred communication and team-oriented non-technical skills in a clinical context

The COVID-19 effect
Intermittent lockdowns and travel restrictions have limited our capacity to deliver courses throughout 2020–2021. Participant demand is now higher than ever, and we need talented faculty members to lead and teach. That's where you come in.

Can you explain complex concepts in an engaging way? Do you have a genuine interest in teaching and have some time to give? We need to hear from you!

Benefits of teaching include:

- Networking with a multidisciplinary faculty
- Rewarding mentoring opportunities
- Travel and accommodation expenses

If you would like to join our dynamic faculty family please visit the Teach on a RACS Skills Course webpage for more information.

For queries relating to Skills Training courses or more information on faculty training, please email the relevant program coordinator on the details below:

ASSET
Caroline Muliaga-Wright
asset@surgeons.org

CCrISP
Michelle Chummun
ccrisp@surgeons.org

CLEAR
Rahul Jamwal
clear@surgeons.org

EMST
Millie Harris
emst@surgeons.org

TIPS
Kathryn Rehor
tips@surgeons.org

What drives our pro bono faculty?

Faculties are an integral part of running courses and examinations for the Royal Australasian College of Surgeons (RACS). The Education Department at RACS recently completed research into the drivers and barriers for Fellows giving their time pro bono and to determine what we can do to encourage and thank these important members of the surgical community. *Surgical News* spoke to RACS Team Leader, Research & Innovation, Dinah Hippolyte, who led the research.

Can you explain the meaning of the term 'pro bono faculty'?
Usually, pro bono is a term typically used for work undertaken without charge, by lawyers. It is now commonly used by other highly skilled professionals.

Faculty is a term we use to describe the group of professionals who volunteer to teach.

Can you describe how you conducted the research?
We began with literature review to find out what are some of the drivers in other Organisation for Economic Co-operation and Development (OECD) countries where the context is similar.

We then developed a research proposal to answer our specific questions. After we received ethics clearance from St Vincent's Hospital Melbourne and designed our study around our proposal. We spoke to 30 faculty members across the Skills and Professional Development courses in recorded, semi-structured interviews lasting between 30 minutes to an hour.

In the semi-structured format, we had specific research questions but also gave people the chance to raise issues that we had not anticipated. In that way it was a free-flowing conversation.

Why do surgeons want to give their time as members of the pro bono faculty?
The overwhelming factor we found was that our pro bono faculty was made up of people who strongly identified with the role of teacher – that came through in all the interviews. There was a strong drive to pay it forward, where people acknowledged the teachers who helped them through their training and thought it was their duty to pass that on to the new surgical Trainees.

Some people were intrinsically motivated to teach, to the extent that I think they would have been teachers no matter what field they were in. Their urge to share knowledge is a powerful motivator for the work they do as faculty.

What can we do to better support surgeons who want to join the faculty?
We can simplify the process for joining. During our courses we identify surgeons who have the potential to become faculty members in the future, but they need time to gain experience and set up their practice. We need to have a more rigorous process to follow up with those Trainees later to make sure that they are encouraged to join a faculty.

We could also be more active in our recruiting. For example, promoting opportunities and using innovative methods to catch people's attention.

What were some things that surprised you while conducting the research?
One thing that surprised me was the extent to which people found running the courses to be a form of development for themselves. We always knew they were providing a service, but many people said that it was also a refresher for them. We had not anticipated that pro bono faculty would see their work as something that they could learn from and that would help sharpen their skills .

The other insight was the need for RACS to do more work in terms of recruitment. People who ran the numerous courses over the years and were about to retire and exit the system were aware that we needed to work harder to replace faculty membership.

There were also numerous calls for backup and support, which is something we can improve for the sustainability of our courses.

What are the next steps for RACS?
We developed the following broad recommendations:

- Improve management practices through training RACS staff.
- Add value to pro bono workforce by providing professional and socialising opportunities.
- Review recognition and awards program and consider introducing smaller milestones, and increasing channels for recognition among peers.
- Measure and communicate faculty impact.

RACS staff will work with our faculty to develop a comprehensive action plan. Our faculty should expect to see improvements and enhancements in the ways we engage with them.

Meet our global health specialty coordinators

Our coordinators who come from various fields of medicine share their stories.

Urology Specialty Coordinator – Associate Professor Philip McCahy (FRACS, FRCS, FRCDS, Consultant, Trainer, Instructor)

Associate Professor Philip McCahy is a consultant urologist in South-East Melbourne and Gippsland, and the Clinical Director of the Victorian Audit of Surgical Mortality (VASM) at RACS. He was appointed to the role of Specialty Coordinator in late 2019 after being nominated by the previous Urology Specialty Coordinator, Mr Alexander Cato (FRACS, AM, RFD).

Associate Professor McCahy has contributed greatly to the Pacific Islands Program (PIP) for almost a decade, with numerous visits to Tonga, involvement in PNG and (before the COVID-19 pandemic) a planned trip to the Solomon Islands focusing on kidney stones. During these visits he has been able to help the local general surgeons hone their urology skills and, in a first for the Solomon Islands, has undertaken many advanced stone operations. Despite travel restrictions, he continues to build on this body of work by participating in remote support webinars.

He has been a great supporter to the RACS Global Health team and our Pacific clinical partners.

Paediatric Surgery Specialty Coordinator – Mr Jitoko Cama (FRACS, Consultant, Trainer, Senior Instructor)

Mr Cama is a consultant Paediatric Surgeon/ Paediatric Urologist at Waikato Hospital, New Zealand. He was reappointed to the Paediatric Surgery Specialty Coordinator role in 2018 after completing his first three year term beginning in 2015. He has contributed greatly to the Pacific Islands Program (PIP) for over a decade, including as a volunteer surgical registrar in 2004-2008, making multiple visits to Fiji as a volunteer Paediatric surgeon and by providing clinical guidance and support to RACS Global Health since his appointment in 2015. Mr Cama also lived and worked in Fiji during his surgical training, and later returned to teach at the Fiji National University (FNU). This has given him experience of what is happening on the ground and an awareness of issues in the region. This first-hand knowledge has enabled Mr Cama to support and guide RACS Global Health specialist volunteers, program planning, and program monitoring and evaluation.

Nursing Specialty Coordinator – Ms Sally Sutherland-Fraser (RN, MEd, FACORN, MNSWOTA, MACN, Facilitator and Consultant)

Ms Sutherland has contributed greatly to the Pacific Island Program (PIP) since her appointment in 2019. She has participated as a volunteer on a number of nursing activities including the delivery of a seven day face-to-face implementation workshop for Northern Pacific Island Country (NPICs) perioperative nurses on the Pacific Perioperative Practice Bundles (PPPB) and Practice Audit Tools (PATs) in Micronesia. More recently, Ms Sutherland has been co-facilitating, alongside Ms Menna Davies, the mentorship of the 25 Pacific nurses who are completing a Post Graduate Certificate in Perioperative Nursing. As well as being a dedicated nurse educator, Ms Sutherland assists the RACS Global Health team with volunteer selection and recruitment, and activity planning and review.

Oral Maxillofacial (OMF) Specialty Coordinator – Mr Michael Schenberg (FRDS, FRACDS, Consultant, Senior Lecturer, Trainer)

Mr Schenberg is the Chairman of the Overseas and Outreach Aid Committee (OOAC) of the Australian and New Zealand Association of Oral and Maxillofacial Surgeons (ANZAOMS), and has held the role of RACS Oral and Maxillofacial Specialty Coordinator since 2018. Mr Schenberg has brought a wealth of experience to the role having led surgical volunteer teams annually on outreach visits to Vietnam since 2005 under an external funding stream. The teams worked at the Odonto Maxillofacial Hospital in Ho Chi Minh City performing much needed complex procedures. Currently in his role with the OOAC of ANZAOMS he works to develop opportunities to assist isolated rural communities and indigenous communities in Australia with OMFS services. Mr Schenberg has used his extensive experience to assist and support the Pacific Island Program (PIP).

Specialty Coordinator for Pathology – Associate Professor Raghwa Sharma (MBBS,DMM,MD, FRCPA, FIAC, Surgical Pathologist and Diagnostic Oncologist).

Associate Professor Sharma has worked as a specialist for 20 years in Australia and has contributed to providing charitable and volunteer work to developing countries for approximately 15 years. He began providing volunteer support to Pacific Island countries in 2004 and since then he has travelled regularly to the region.

Associate Professor Sharma, with the support of the Royal College of Pathologists of Australasia (RCPA), set up the Post Graduate Pathology training for Pacific registrars in 2011 at the Colonial War Memorial Hospital in Fiji. Since its establishment, more than 10 pathologists from across the region have completed the training.

Associate Professor Sharma has been a valuable asset to the RACS Global Health team and programs providing much needed guidance and expertise.

Specialty Coordinator for Anaethesia – Dr Michael Cooper (FANZCA)

Dr Michael Cooper is one of the anaesthesia coordinators and has been in this role with RACS for quite a few years.

Dr Cooper has been involved in supporting initiatives in Papua New Guinea (PNG) as a paediatric anaesthetist since 2001. Apart from busy days in the operating theatres, he also used his visits to teach paediatric anaesthesia to PNG trainee anaesthetists and also the anaesthetic scientific officers (equivalent of a nurse anaesthetist), who do a lot of the work in PNG especially in provincial hospitals.

Dr Cooper has been part of teams performing major paediatric surgery at Port Moresby, Mt Hagen, Alotau, Lae, and Rabaul Hospitals. He also supported the training and development of PNG Paediatric surgeons and anaesthetists, some of whom have also worked with him at the Children's Hospital at Westmead in Sydney.

Specialty Coordinator for Anaethesia – Dr Rob McDougall (FANZCA)

Dr Rob McDougall is one of the anaesthesia coordinators and has been in this role with RACS for many years. As well as this role, Dr McDougall has also been involved withRACS Global Health as a member of the Evaluation and Monitoring Committee (2015-2020) and with various projects run in partnership with the Australian Society of Anaesthetists and the Pacific Society of Anaesthetists.

Dr McDougall has volunteered in many countries in the Asia-Pacific region including Fiji, Tonga, Cook Islands, Solomon Islands, Cambodia, Vietnam and Mongolia. His particular areas of interest are: paediatric anaesthesia, education for trauma and resuscitation, the World Health Organization Surgical Safety Checklist and pulse oximetry education (via Lifebox).

He has appreciated the chance to meet and work with many enthusiastic people involved with RACS Global Health, particularly those health workers in host countries.

Specialty Coordinator for ENT – Dr Bernard Whitfield (FRACS)

Dr Bernard Whitfield has been working with RACS Global Health for eight years, four of those years as the ENT Specialty Coordinator. His areas of expertise are General ENT & Head and Neck Surgery, adult and paediatric.

In his time with RACS Global Health, Dr Whitfield has volunteered for ten trips in Samoa, as well as visits to Tonga, Kirabati, Micronesia Kosrae, Papua New Guinea and Fiji. His last trip was to Tonga in March 2020 prior to travel embargo due to the COVID-19 pandemic. Since then he has continued his work via Zoom webinars.

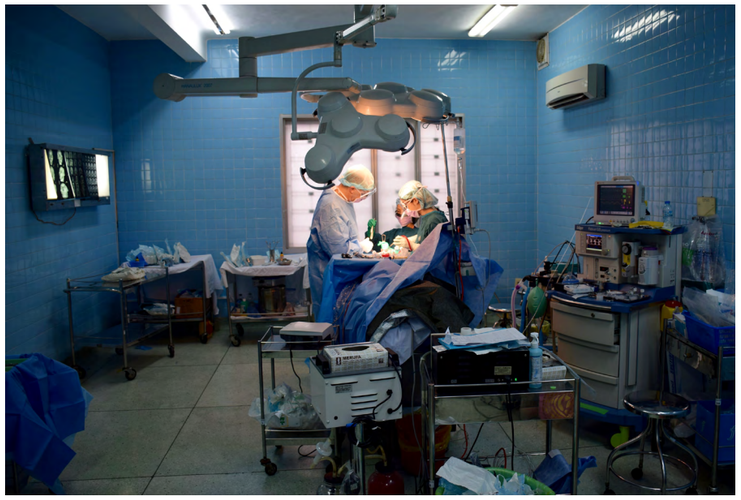
Dr Whitfield coordinates capacity-building for prospective Pacific ENT surgeons, nurses and audiometrists. He is also involved in the implementation of the Samoan Audiology Project funded by DFAT and the mobile Hearing Testing and Ear Health Trailer that was delivered to Apia a few months ago. He is a valuable asset to the RACS Global Health program. We look forward to the time when Dr Whitfield can resume his international trips.

Specialty Coordinator for Emergency Medicine – Dr Colin Banks (FACEM)

Dr Colin Banks has been formally involved with RACS Global Health since 2019 when, as part of the Clinical Services Program, he did a scoping visit for the emergency department (ED) at ANGAU Memorial Hospital in Lae, Papua New Guinea (PNG).

Dr Banks has spent time supporting capacity building in emergency care in PNG over a 12-year period. He has made repeated short visits, predominantly to Port Moresby supporting the University of PNG Master of Medicine (Emergency Medicine) training program, which has undergone significant structural reform over that time. More recently, he has been involved with improving ED processes, with programs centred around the introduction of a three-tier triage system and more robust data collection mechanisms. He has also volunteered as an external examiner for the training program run by Fiji National University.

Dr Banks specialises in supporting the training of emergency physicians. His knowledge has been a great asset to RACS Global Health.



Mr Michael Schenberg in the field

Surgeons working overseas

Exploring surgeons' work in Timor-Leste during the early 2000s.

Surgeons have a long history of working overseas. Using *Surgical News* extracts from the early 2000s, this article focusses on Timor-Leste (often referred to as East Timor) and looks at other projects from that period.

Indonesia relinquished control of Timor-Leste in 1999 and later that year a United Nations peacekeeping force was sent to the country, which in 2002 became the Democratic Republic of Timor-Leste. The Royal Australasian College of Surgeon's (RACS) interest in Timor-Leste began in the late 1990s and in May 2000, past president David Theile and fellow surgeon John Hargrave visited the country.

In February 2001, a specialist scoping mission consisting of David Watters, David Scott and Margaret Gosling visited Timor-Leste. This resulted in a report suggesting a second surgeon and an anaesthetist be posted to Dili National Hospital.

The specialist services project was expected to begin in August/September 2001. However, military surgeons were already working in Timor-Leste. Annette Holian had two deployments to the United Nations Military Hospital in Dili in 2000 and 2001. During her visits, she was concerned by the limited surgical services at the hospital.

The following extract, from an article that appeared in March 2001, gives an idea of the challenges facing medical staff, Jeff Rosenfeld and Rob Atkinson, who were deployed for five months in Timor-Leste:

'You know you're a long way from home when a neurosurgeon is doing an emergency cesarean assisted by an orthopaedic surgeon in the grounds of a museum.'

An interesting aside: the museum and its grounds performed a dual function. During the emergency cesarean, Australian museum experts were cataloguing and photographing specimens in the rear of the museum.

In August 2001, John Hunn was the first general surgeon to take up a position in Timor-Leste under the RACS managed Australia-Timor-Leste Specialist Services Project. In September 2003, Glenn Guest commented in an article:

'It was under this program that I found myself in Guido Valadares National Hospital, working as one of only two surgeons for the whole population. There are many more remote places on Earth, but as a newly qualified surgeon on call for a whole country's population, this felt very much like another world.'

Participation in the early years of the Timor-Leste program was an unforgettable experience but as another short article in September 2003 notes, it was not for everyone.

'This is a unique experience which I would recommend to many people, but not everyone. The challenge of performing difficult operations to a high standard in a country such as Timor-Leste will be exciting for some, and for those people the rewards will never be disappointing.'

David Scott, who was the Executive Director of Surgical Affairs in 2001, reflected that RACS had a 'strong ethos of voluntary service' and in the early 2000s, several surgeons chose to engage with different cultures in remote places.

In 2000, Ken Clezy was in the mountains of Yemen dealing with a number of surgical conditions. He wrote of the prevalence of gunshot wounds:

'Last night I saw a young man with a bullet wound through his right upper chest with a great exit wound medial to his scapula, which was sucking air… Not all gunshot wounds are for the usual reasons. Last year I had three people hit by falling bullets that had been fired into the air at weddings.'

Dr Annette Holian in the field

In Ken Pettit's article 'A Surgeon for Samoa', he stated that instead of retirement, he opted for a six-month stint with Australian Volunteers International. He mentions that 'the highlight was the friendliness and warmth of the Samoan people'.

Surgeons have a long history of involvement in international projects and despite the curbing of programs due to the COVID-19 pandemic, they will undoubtedly continue in the future.

Elizabeth Milford, RACS Archivist

Tristate ASM focus on a safer theatre for all

From 26 to 28 August surgeons from Western Australia (WA), South Australia (SA) and the Northern Territory (NT) finally gathered for the Tristate Annual Scientific Meeting (ASM) to discuss 'A Safer Theatre for All'.

It was two years in the making and was held across several thousand kilometres, as border closures between WA and SA remained in place right up until the eve of the conference. Unfortunately, many SA based delegates were forced to cancel travel plans to Broome where the main conference was held.

An early decision was made to change the format of the conference to a hybrid event to adapt to the uncertainties around travel. As a result, SA delegates were able to participate in the conference via a virtual 'hub', which was established in the RACS Adelaide office.

Over the two days, discussions and presentations addressed a range of different topics including futile surgery, perioperative planning, communication, conflict and mandatory reporting. The program brought together a range of perspectives from across surgical specialties and health care, as well as experts from a wide range of fields including business, science and government.

Below is a brief selection of highlights from the event.

- An opening symposium hosted by the Western Australian Audit of Surgical Mortality. The symposium explored improvements that can be made to pre-operative and post-operative care. A common theme was frailty as an often-overlooked risk factor.
- Investigations into the rapidly changing nature of surgical research -particularly the role that social media has revolutionised the way reseach is promotd and accessed.
- An analysis of the complexities of teaching new and difficult procedures, including the risks involved and the strategies that can be adopted to mitigate such risks.
- Robust debate about what the future holds for public reporting of surgical outcomes, and how the College should engage on this topic.
- Two separate and thoroughly enjoyable conference dinners held in Broome and Adelaide.

The theme of the conference attracted attendees. Sessions were well received with attendances strong on both days. This was particularly true of the main conference venue in Broome where registrations sold out months in advance.

Thank you to all the delegates, presenters and organisers who made this event possible under such challenging circumstances. The ASM will return to South Australia in 2022. We are hopeful that travel restrictions will have eased by then and WA and NT colleagues will be able to join us in the Barossa Valley where the event will be hosted from 25 –27 August. The theme of this event will be 'Artificial Intelligence in Surgery - Superpower of Peril?'

Participants enjoy the welcome function

The dangers of lockdown binge-drinking

A Victorian study has revealed a correlation between pandemic drinking trends and acute pancreatitis cases.

A surge in alcohol consumption, triggered by the COVID-19 pandemic took few by surprise.

However, new research undertaken at Victoria's Frankston Hospital indicates this could have severe public health impacts, with medical teams observing an increase in alcohol-related acute pancreatitis cases during the March-July lockdown in 2020.

The study, led by Associate Professor Charles Pilgrim FRACS, compared lockdown cases to those recorded during the same period in 2019.

While the total number of acute pancreatitis cases were similar between the two years (112 in 2020 compared to 118 in 2019), alcohol onsumption was more commonly attributed as the cause of lockdown cases. It explained 30 per cent of cases in 2020, compared to 17 per cent in 2019.

The observations of Associate Professor Pilgrim's team complemented the research conducted by the Foundation for Alcohol Research and Education during April 2020. It found 70 per cent of Australians were drinking more alcohol during the lockdown and 34 per cent were drinking daily.

"The increase in alcohol-related cases certainly seemed like a real phenomenon," Associate Professor Pilgrim said.

"We wanted to see whether the numbers matched our perception."

The study also found a clear correlation between alcohol consumption and the severity of acute pancreatitis cases, with 6.2 per cent of cases classified as severe in 2020, compared to just 0.8 per cent in 2019.

The majority (71 per cent) of severe cases recorded during the lockdown were caused by alcohol, while there were no alcohol-induced severe cases in 2019.

Associate Professor Pilgrim said it only takes one binge-drinking event to cause acute pancreatitis.

"A lot of people know you can damage your liver if you drink a lot over a long period of time. But very few are aware of the more imminent risk of acute pancreatitis from a single binge drinking session."

Acute pancreatitis can cause considerable damage and pain, and in particularly severe cases, death.

Associate Professor Pilgrim said these serious consequences support the need for more public health messaging, especially during lockdowns.

"No one thinks they're going to end up battling a life-threatening disease just because they had a few too many," Associate Professor Pilgrim said.

"That's why it's so important to reinforce the message about drinking responsibly and in moderation during lockdown."

Boredom binge drinking may not, however, be the only possible explanation for the increase in severe acute pancreatitis cases.

"It's also likely people wanted to avoid hospitals due to the heightened risk of contracting COVID-19," Associate Professor Pilgrim said.

"As a result, many might have waited longer to seek medical attention."

An academic version of this story was published in the *ANZ Journal of Surgery*

Drinking and Acute Pancreatitis study

Ljuhar, D., et al., Alcohol-related acute pancreatitis: Lessons learnt during the COVID-19 lockdown in Victoria. ANZ J Surg, 2021. 91(7-8): p. 1336-1337.

New information sharing protocol with hospitals accredited to train

The Royal Australasian College of Surgeons (RACS) has a duty of care to Trainees that includes providing a safe training environment that supports patient safety and that fosters a culture of respect.

As part of our work to build respect in surgery we've adopted a new information sharing protocol with hospitals accredited as a training posts to help RACS monitor and manage the training environment.

The protocol applies to information sharing in complaints management when concerns have been raised about breaches of the RACS Code of Conduct, including discrimination, bullying and sexual harassment.

It sets out structured information sharing thresholds and details information about surgeons' professional conduct that will be shared between a hospital and RACS, and when it will be shared.

Under the protocol, information:

- will be shared between a hospital (training post) and RACS, when there is a joint review of a concern by a third party, and/or when substantiated findings about a surgeon have been made after a formal complaint
- may be shared after a formal complaint, when there are no findings made or yet determined, and/or if there are repeated allegations made about the same surgeon, but no formal complaint has been received.

The protocol is included in RACS' updated Hospital Post Accreditation Standards and will apply progressively as training posts are accredited against the new standards.

Information shared under the protocol will be used to monitor and manage the training and workplace environment. It will ensure a coordinated approach to tracking and managing concerns about breaches of the RACS Code of Conduct, including concerns about discrimination, bullying and sexual harassment.

De-identified and collated statistical information gathered through the protocol will be used to improve workplace training and shape cultural change initiatives, as well as in the assessment and accreditation of hospital training posts.

The 2016 independent expert report into discrimination, bullying and sexual harassment in surgery highlighted gaps in information sharing between agencies managing complaints about surgeons. The report found these gaps were increasing risks to Trainee and patient safety and recommended changes to complaints management arrangements between hospitals and the College, including a clear framework for information sharing.

Compliance with RACS Code of Conduct is already a condition of College membership. The information sharing protocol will help make the code more effective and requires no action from Fellows, Trainees or Specialist International Medical Graduates (SIMGs). Information sharing as defined in the protocol will be a condition of College membership for all new Fellows, Trainees and SIMGs from 2022.

RACS developed the information sharing protocol in collaboration with employers and consulted widely with Fellows, Trainees and SIMGs to make sure it was workable and fair.

The protocol will be progressively introduced in coming years, as hospitals are re-accredited to conduct Surgical Education Training (SET) in their workplace.

After extensive consultation, RACS adopted the information sharing protocol with unanimous support from Specialty Training Boards, all major Committees and Trainee representatives.

More information about feedback and complaints handling at RACS is published on our website at www.surgeons.org/about-racs/feedback-and-complaints

More details about what information will be shared under the protocol can be found on our website at https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/operating-with-respectcomplaints/information-sharing-protocol.pdf

Introducing the Wellbeing Charter for Doctors

In August we launched the Wellbeing Charter for Doctors – a collaborative effort by the Royal Australasian College of Surgeons (RACS), Australasian College for Emergency Medicine (ACEM), Australian and New Zealand College of Anaesthetists (ANZCA), and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).

The charter is endorsed by the Council of Presidents of Medical Colleges (CPMC), the unifying organisation for specialist medical colleges of Australia.

Dr Ruth Bollard, Chair, RACS Wellbeing Working Group, said, "We all have a part to play to support the wellbeing of doctors – medical colleges, individuals, colleagues, managers, hospitals and health jurisdictions.

"Doctors who maintain and maximise their health and wellbeing can manage the physical and emotional demands of medicine. The charter promotes the importance of wellbeing for doctors.

"Doctors are encouraged to practice self-care, including prioritising their mental health so they can provide the best care for patients. Everyone needs help at some point and it can be as simple as sharing a problem with a trusted friend or seeking professional support."

It is important that doctors thrive in all aspects of life, not only in medicine, and this is a key principle of the charter.

The charter is the beginning of our work on shining a spotlight on doctors' wellbeing. We want it to spark important conversations about wellbeing and demonstrate a unified approach to the issue.

Having the charter cements the need for us to work towards a common goal – advocating with one voice to institutions, governments and policy makers.

The RACS Wellbeing Working Group is continuing to reach out to medical colleges across Australia and Aotearoa New Zealand as well as organisations that support or represent doctors to promote and endorse the charter.

What can workplaces do to support doctors' wellbeing?

While the charter recognises that doctors can individually contribute, workplaces have a strong influence on doctors' wellbeing. It is a shared responsibility between individuals and system partners such as workplaces, medical colleges, medical schools, regulators and quality improvement bodies.

"Workplaces have an enormous influence on doctors' wellbeing and we need to make sure doctors' health and wellbeing are recognised as a patient safety issue. The charter gives teams and managers the opportunity to reflect and discuss how we can all advance doctors' wellbeing," said Dr Bollard.

Workplaces can:

- foster a caring, professional and compassionate culture
- implement safe and flexible working hours
- provide access to healthy food options
- provide access to free and confidential counselling
- ensure doctors' wellbeing is a key component of healthcare strategy and leadership accountability.

RACS Support Program

There are a range of confidential and free support services available to RACS Trainees, Specialist International Medical Graduates and Fellows, including the RACS Support Program, the Doctors' Health Network throughout Australia and New Zealand and Drs4Drs. This additional support can really make a difference. Find out more about the RACS Support Program at https://www.surgeons.org/about-racs/surgeons-wellbeing/racs-support-programhttps://www.surgeons.org/about-racs/surgeons-wellbeing/racs-support-program

For urgent support contact the following services, 24 hours a day:

- Beyond Blue (AU) 1300 22 36 46
- Lifeline (AU) 13 11 14
- Lifeline (NZ) 0800 54 33 54

If you are worried about a colleague, visit R U OK? for resources including videos and conversation starters, or the RACS Surgeon Wellbeing webpage.

Online resources

- A free micro activity called 5 to Thrive is available on the College's Surgeons Wellbeing webpage (https://www.surgeons.org/surgeons-self-care/). The module encourages you to consider how the hours you work can impact your overall wellbeing and to reflect on how you can carve out an extra five hours a week for self-care activities. The activity is eligible for Continuing Professional Development (CPD) Program credit points.
- The Pandemic Kindness Movement was launched in 2020 by the New South Wales Agency for Clinical Innovation. The website is curated by clinicians who are wellbeing experts and present support options in the domains of Maslow's hierarchy of needs. It features online courses and toolkits covering self care, managing anxiety, talking tips on COVID-19, the importance of sleep, and leadership resources. Find out more on : https://aci.health.nsw.gov.au/covid-19/kindness

You can register to support the Wellbeing Charter for Doctors on our website: https://bit.ly/3lamTAo

Image: Dr Ruth Bollard takes her wellbeing seriously and takes time off work to spend with her friends. This is a shot from a bike trup to the Mawsen Mountain Trail Adelaide to Blinman South Australia.

View with three riders and bike against a log: Lunch rest near Parachilna, South Australia

Snow field is Falls Creek, Victoria High Country

Location in Burra, South Australia made famous by the 'Midnight Oil ' album cover

Surgical snips

Some highlights from recent *ANZ Journal of Surgery* articles

Intra-operative identification and preservation of parathyroid glands
Intra-operative identification and preservation of parathyroid glands is an important but challenging aspect of thyroid surgery. Learn more about intra-operative modalities used to identify parathyroid glands with a particular focus on near-infrared autofluorescence.

Read more here: https://onlinelibrary.wiley.com/doi/full/10.1111/ans.17117

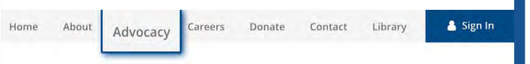
Conservative fluid resuscitation and aggressive enteral nutrition: A potentially lethal combination in patients with critical illness
Intravenous fluid resuscitation and enteral nutrition are key early treatments in critical illness, but the interaction between them has not been investigated.

Read more here: https://onlinelibrary.wiley.com/doi/full/10.1111/ans.17015

The doctor will see you now: Eye gaze, conversation and patient engagement in the surgical outpatient clinic
Surgical outpatient consultations are demanding for the surgeon and patients without a definite formula for success. Various factors have been identified regarding factors that influence patient satisfaction and engagement. Researchers aimed to examine the modern-day surgical outpatient consultation and report on these factors.

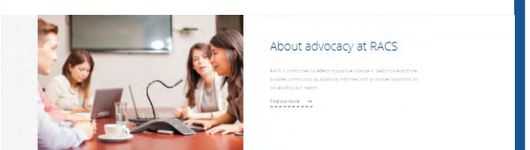
Read more here: https://onlinelibrary.wiley.com/doi/full/10.1111/ans.17163

Advocacy content improved on RACS website



Have you noticed that you can now access advocacy information and resources from the RACS website home page?

Advocacy has been made more prominent on the website with a homepage main navigation tab and the content repurposed for clarity. We are pleased to say that we have seen a massive 4700 per cent increase in visitation from April to September 2021.



Visit the page to find out more:
https://www.surgeons.org/media-centre/advocacy

Advocacy at RACS

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

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

We have outlined some of the advocacy work the College has undertaken in the past two months.

Pasifika community must have vaccine priority
RACS recently published a media release highlighting Pasifika families need to be given priority for vaccination, since Pasifika people make up 70 per cent of cases of the current outbreak of the COVID-19 Delta variant in New Zealand.

The full media release is available on the RACS website.

Road Safety Advocacy
RACS has long recognised that road trauma is a serious public health problem of epidemic proportions. Every year around 1,200 people are killed on Australia's roads, and almost 40,000 are seriously injured. That is the equivalent of the population of a medium-sized country town, seriously injured.

We regularly advocate on issues of road safety, and over the last two months the College provided a submission to the Australian Government's Inquiry into Road Safety, as well as separate submissions to inquiries held by the South Australian and Tasmanian governments. These submissions are available on the RACS website.

Response to AEHA draft Strategic Plan
RACS became a proud signatory to the Australian Consensus Framework for Ethical Collaboration (ACF) in the Healthcare Sector, now known as the Australian Ethical Health Alliance (AEHA).

The AEHA is a collaboration of professional bodies, industry organisations, hospitals and health service associations, regulators, and patient and advocacy groups who have come together to tackle ethical issues within the health sector. It is a government supported but sector-led voluntary initiative, which initially began with five bodies (RACS included) and has subsequently grown to more than 70 signatories.

Since February 2021, the AEHA Steering Committee – in consultation with the AEHA membership – has been developing a strategic direction for the Alliance. RACS recently reviewed the draft Strategic Plan and provided feedback. Our submission focussed on the three central pillars of the draft plan:

- Advocacy and Awareness
- Embedding Ethics
- Organisational Sustainability.

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, please email the RACS Policy and Advocacy Team at RACS.Advocacy@surgeons.org

All submissions are available to read in the Advocacy section of the RACS website at surgeons.org/media-centre/advocacy

Education activities

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

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

Face-to-face courses

Course	Date	Region
Foundation Skills for Surgical Educators	Saturday 6 November	Melbourne, VIC
	Friday 12 November	Perth, WA
	Friday 12 November	Brisbane, QLD
	Saturday 20 November	Melbourne, VIC
	Friday 3 December	Brisbane, QLD
Leading Out of Drama	Friday, 19 November	Noosa, QLD
Non-Technical Skills for Surgeons (NOTSS)	Friday 26 November	Perth, WA
Operating with Respect (Fellows)		
	Saturday 13 November	Perth, WA
	Thursday 18 November	Adelaide, SA
Surgeons as Leaders in Everyday Practice	Friday 5 – Saturday 6 November	Christchurch, Aotearoa NZ

Online courses

Course	Date
Process Communication Model Key2Me	Saturday 16 October – Thursday 4 November
Conflict and You	Monday, 18 October
Clinical Decision Making	Monday 11 October - Wednesday 27 October
Academy Forum featuring A/Prof Andrew Kurmis and Prof Guy Maddern	Thursday 4 November

Our 2021 professional development program is constantly monitored and we are adapting the delivery and schedule of our courses to continue supporting your learning.

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

QASM Seminar program

Time	Presentation title	Presenter
09.00 – 9.30	Registration Coffee and tea	
09.30 – 9.45	Welcome Surgery - timing is everything	Dr John North Clinical Director, Queensland Audit of Surgical Mortality (QASM),RACS
09.45 – 10.15	RACS Update – Surgery, COVID, Timing, Everything	Dr Sally Langley President, RACS
10.15 – 10.45	Do it now, do it later, or don't do it – the consumer perspective	Ms Melissa Fox Mr Graham Reeks Consumer Representatives
10.45 – 11.15	Challenges and surgical outcomes in Darwin	Dr Manimaran Sinnathamby Director of General Surgery, Consultant Breast and General Surgeon, Royal Darwin Hospital
11.15 – 11.45	For the brain, timing is everything	Prof Marianne Vonau
11.45 – 13.15	Lunch and live simulation at 12.30pm	
13.15 – 13.45	Timing is of the essence - even in low resource settings	Mr Neil Wetzig Consultant and Advisor of Surgical Training Programmes HEAL Africa Hospital, Goma Democratic Republic of Congo Emeritus Senior Surgeon, Princess Alexandra Hospital Brisbane Director AusHEAL Congo Project
13.45 – 14.15	Vascular time to theatre & outcomes	Dr Jill O'Donnell Staff Specialist Vascular Surgery, Sunshine Coast University Hospital
14.15 – 14.45	Timefulness: Expanding time from a surgeon's perspective	Dr Emilia Dauway Consultant General Surgeon with specialisation in Breast and oncoplastic surgery, Wide Bay Health Service Hervey Bay Hospital.
14.45 – 15.15	It's time to join the dots	Dr Sanjeev Naidu General Surgeon & Surgical Stream Lead Metro South HHSD
15.15 – 15.30	Summary and close	Dr John North Clinical Director, Queensland Audit of Surgical Mortality (QASM),RACS
15.30 – 16.00	Live simulation	

Museum showcases medical and surgical adaptability

The Dancer Binocular Microscope, Paddy Cotter's favourite item because he thinks it is a magnificent looking piece.

Plus ça change, plus c'est la même chose, the French phrase meaning the more things change, the more they stay the same, rings throughout the Cotter Medical Museum, housed at Christchurch's Hillmorton hospital.

Retired surgeon and museum volunteer Dr Rob Robertson says he loves "seeing our history back in a real timeframe and realising how adaptive our forebears were. They were challenged by the diseases that they faced and worked out all sorts of options to help overcome them, a bit like what we face presently.

"Some of the design and engineering was novel and farsighted and we need to be grateful as they have helped us in our modern times to make things a little more certain and straightforward. Reminding ourselves of that and how we are able to adapt helps doctors chart the way ahead."

Dr Robertson has been associated with the museum as a trustee on behalf of the Royal Australasian College of Surgeons (RACS) for many years, and now retirement has enabled him to spend more time there. "I'm trying to help with sorting and cataloguing the surgical instruments in the collection," he said.

The museum is governed by the Cotter Medical History Trust, which was set up in 1998 by the late Dr Pat Cotter, who worked as a general surgeon from the early 1950s to 1985, and his wife, Prue. They intended the Trust to take ownership of the enormous collection of medical and surgical items Pat had collected over the previous 50 years.

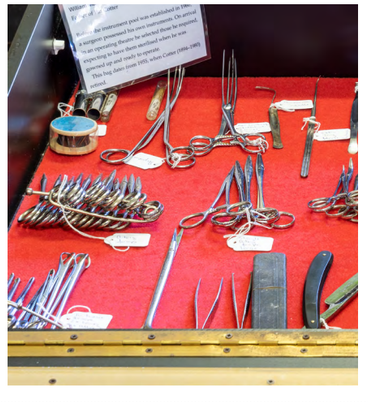
Philippa Mercer, Chair of RACS' Aotearoa New Zealand National Committee and a general surgeon in Christchurch, says Dr Cotter was her first surgical consultant. She visited the museum for the first time recently and was impressed with the collection.

"There are several rooms packed with medical history: nursing, surgical, hospital, community, microscopes, photos, equipment and a significant library. You can easily spend several hours exploring the museum. The team are carefully documenting the thousands of items and displaying them. It is definitely worth a visit and ideally should be a stand-alone museum in the city," she said.

Paddy Cotter, Pat and Prue's son and Chair of the Trust, says the Trust was formed with the support of the Canterbury District Health Board (CDHB), Otago Medical School, RACS, and the Canterbury Medical Research Foundation.

Paddy notes, "The CDHB has provided enormous support for the Trust, initially accommodating the Trust's collection in the Nurses' Hostel on Hagley Avenue and subsequently moving it to its current location at Hillmorton Hospital after the 2011 Earthquakes.

"Following the setting up of the Trust and having a base at the Nurses' Hostel, a huge influx of items were donated from a variety of sources, especially from the CDHB, and included a huge range of medical, surgical, nursing items and photographs. The Canterbury Medical Library donated the library's older medical book collection, and this is now housed at Hillmorton. The Trust now holds an enormous volume of CDHB archival material, and it continues to receive material from departments within the CDHB requesting that it hold items that may have historic value."



Paddy says his father, in his later years, started collating information on all medical practitioners who had practised in the Canterbury region. "Currently, there are files on over 1000 people in our collection. This resource is frequently used by relatives researching their family history.

"In 2017, the Trustees asked Te Papa (Aotearoa New Zealand's national museum) to assess our collection and they assessed it as being a 'Collection of National and International Significance'."

Of particular importance is the Clark Microscope Collection. The Trust purchased this collection from Stephen and Margaret Clark. Stephen was a pathologist based in Nelson with a lifetime's interest in microscopes. These microscopes are now on display at the Ground Floor of the Medical School in Christchurch and at the Cotter Museum. Kerry Swanson has written a book about the history of the microscope featuring the Clark Collection.

The Trust has facilitated the publication of a number of books relating to the collection and medicine generally in Canterbury. The authors include Claire Le Couteur, Bramwell Cook, John Morton, Kerry Swanson and Stan Darling.

The museum is open from 9 am -12 pm Monday, Wednesday and Friday and can open at other times by appointment. If you cannot physically visit the Cotter Medical Museum, you can get a taste of it at www.cottermuseum.co.nz

Top: RACS AoNZNC Chair Philippa Mercer, third from left, with Cotter Museum volunteers from l-r, Claire LeCouteur, Rob Robertson, Paddy Cotter, Raewyn Turner, Rachel Milner, Cath Smith.

Left: William Cotter's surgical bag

RACS ASC 2022

Monday 2 May to Friday 6 May

Brisbane Convention & Exhibition Centre
Brisbane, Queensland, Australia

Sustainability in the Dispersed Workplace

CALL FOR ABSTRACTS

IMPORTANT INFORMATION

To submit an abstract go to asc.surgeons.org and click on 'Abstract Submission'.
The closing date for all scientific paper abstract submissions is 8:00am Thursday 27 January 2022.

Please note that paper or facsimile copies will not be accepted, nor will abstracts submitted by College staff on behalf of authors or industry partners.

If there are any difficulties regarding this process please contact Binh Nguyen for assistance.
T: +61 3 9249 1279
E: binh.nguyen@surgeons.org

SCIENTIFIC POSTERS

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

IMPORTANT DATES

Abstract submission opens	October 2021
Closure of abstracts	8:00am Thursday 27 January 2022
Closure of early registration	Sunday 20 March 2022

Royal Australasian College of Surgeons

asc.surgeons.org #RACS22

ABSTRACT SUBMISSION WILL BE ENTIRELY BY ELECTRONIC MEANS.

This is accessed from the Annual Scientific Congress website by clicking on Abstract Submission.

Several points require emphasis:

1. Authors of research papers who wish to have their abstracts considered for inclusion in the scientific programs at the Annual Scientific Congress must submit their abstract electronically via the Congress website having regard to the closing dates in the call for abstracts, the provisional program and on the abstract submission site. **Abstracts submitted after the closing date will not be considered.**
2. The title should be brief and explicit.
3. Research papers should follow the format: Purpose, Method, Results and Conclusion. Non-scientific papers, e.g. Education, History, Military, Medico-legal, may understandably depart from the above.
4. Excluding title, authors (full given first name and family name) and institution, the abstract must not exceed 1750 characters and spaces (approximately 250 words). In MS Word, this count can be determined from the 'Review' menu. Any references must be included in this allowance. If you exceed this limit, the excess text will NOT appear in the abstract book.
5. Abbreviations should be used only for common terms. For uncommon terms, the abbreviation should be given in brackets after the first full use of the word.
6. Presentations (slide and video) will only have electronic PowerPoint support. Audio visual instructions will be available on the Congress website and will be included in correspondence sent to all successful authors.
7. Authors submitting research papers have a choice of two sections under which their abstract can be considered. Submissions are invited to any of the specialties or special interest groups participating in the program except cross-discipline.
8. A 50-word CV is required from presenting author to facilitate their introduction by the Chair.
9. The timing (presentation and discussion) of all papers is at the discretion of each Section Convener.
10. Notification of the timing of presentations will appear in correspondence sent to all successful authors.
11. Tables, diagrams, graphs, etc CANNOT be accepted in the abstract submission. This is due to the limitations of the computer software program.
12. Authors must be registrants at the Congress to present and for their abstract to appear in the publications, on the website or the Virtual Congress.

Please ensure that you indicate on the abstract submission site whether you wish to be considered for the following paper prizes:

BEST RESEARCH PAPER PRIZE

- Bariatric Surgery
- Breast Surgery
- Burn Surgery
- Cardiothoracic Surgery
- Colorectal Surgery *(The Mark Killingback Research Paper Prize for Younger Fellows & Trainees)*
- Craniomaxillofacial Surgery
- Endocrine Surgery *(The Tom Reeve Paper Prize – Trainees)*
- General Surgery
- Global Health
- Hand Surgery
- Hepatobiliary Surgery *(The David Fletcher Research Paper Prize)*
- Indigenous Health
- Military Surgery
- Orthopaedic Surgery
- Otolaryngology Head & Neck Surgery
- Paediatric Surgery
- Pain Medicine & Surgery
- Rural Surgery
- Surgical Oncology
- Transplantation Surgery
- Trauma Surgery *(The Damian McMahon Research Paper Prize for Trainees)*
- Upper GI Surgery *(The Mark Smithers Research Paper Prize)*
- Vascular Surgery

BEST NON-CLINICAL PAPER PRIZE

- ANZ Chapter of the ACS Scientific Forum *(Best Paper Prize)*
- Bariatric Hepatobiliary and Upper GI Surgery: The Les Nathanson Translational Research Prize *(For research that has been conducted as part of a higher degree and relates to the fields of HPB, UGI or Bariatric Surgery)*
- Endocrine Surgery *(The Best Basic Science Paper Prize)*
- Medico-legal
- Quality and Safety in Surgical Practice
- Surgical Directors
- Surgical Education
- Surgical History
- Women in Surgery

The submitting author of an abstract will ALWAYS receive email confirmation of receipt of the abstract into the submission site. If you do not receive a confirmation email within 24 hours, it may mean the abstract has not been received.

In this circumstance, please email Binh Nguyen at the Royal Australasian College of Surgeons to determine why a confirmation email has not been received.

E: **binh.nguyen@surgeons.org**

Supporting breastfeeding surgeons

Surgeons share their thoughts on breastfeeding at work.

Two surgeons share their perspectives and tips on how to support breastfeeding surgeons – and what employers and RACS can do to help.

As more women choose surgery as a career, individuals, organisations and professional bodies need to normalise breastfeeding. It is important to dismantle barriers and advocate for the health and wellbeing of our children and mother surgeons.[1]

The World Health Organization and UNICEF recommend children be exclusively breastfed for at least the first six months of life, preferably continuing for two years.[2] Breastmilk supply is reliant on frequent and effective breast emptying. Women need to express milk approximately every three hours for about 10-30 minutes. Long gaps between pumping sessions lead to engorgement, discomfort, mastitis and a drop in milk supply with the risk of premature weaning.

"Remember that registrars need to express before scrubbing for a long case and will need time for pumping breaks built into their schedule, as well as time to eat and drink regularly," Dr Tracey Barnes, a General Surgery SET Trainee said. "When a breastfeeding registrar is on-call, plan ahead at handover and offer to take the phone or scrub them out for breaks." Because of this difficulty, Dr Barnes chose nine months of leave to enable breastfeeding. "Trainees usually work for multiple consultants and have less scheduling autonomy," she explained.

Dr Nadya York, a consultant urologist in Aotearoa New Zealand, had more flexibility. "All New Zealand employers are legally mandated to provide breaks to express milk during work hours," she said. "I worked with my manager to drop one mid-clinic session and adjust my operating list schedule to allow pumping breaks for all three of my children."

Then there is the issue of where to pump. Some women may prefer to use a designated private space while others find it more convenient to pump where they are working. The most important thing is to support surgeons with their preference. Both Dr York and Dr Barnes believe feeling supported is the most important thing for breastfeeding surgeons. "Recognise that feeling supported in the workplace helps women and their babies meet their breastfeeding goals – offer your understanding and encouragement," Dr York said. She explained that "new wearable in-bra pumps now allow surgeons to pump during long cases as well."

Dr York and Dr Barnes also have practical tips to offer other surgeons interested in breastfeeding while working. "A good portable double electric breast pump and a handsfree pumping bra are a must," Dr York said. She found walking to the single hospital lactation room impractical and "instead, I pump where I am working with scrubs top or nursing cover on. I've pumped in clinic between patients, the dictation bay between operations, staff tearooms, the charge nurse office, meetings, or commuting." She also has her baby visit her at work for a feed when appropriate.

Dr York recommends joining a breastfeeding doctor support groups such as Dr Milk and MMAMTB Lactation Interest (for any Australian or Aotearoa New Zealand doctor regardless of gender) on Facebook. "The support, advice and encouragement have been invaluable," she says. She also recommends the book *Work. Pump. Repeat.* by Jessica Shortall for practical tips.

Dr York and Dr Barnes believe there is more the Royal Australasian College of Surgeons (RACS) can do to support breastfeeding. "RACS could adopt a policy to normalise breastfeeding in clinical workplaces and throughout training programs, similar to the American Academy of Family Physicians' policy[3], " Dr Barnes says. "RACS courses and conferences also need to be breastfeeding friendly, with the understanding that making attendance possible means the infant and potentially a caregiver will need to attend."

Dr Barnes and Dr York recommend joining the Women in Surgery Section. Membership is open to all Fellows, Trainees, SIMGs, junior doctors and medical students with the aim of providing advice, support and guidance to remove barriers and combat issues faced by all individuals in the surgical field.

REFERENCES

1. Royal Australasian College of Surgeons. Surgical Competence and Performance: A guide to aid the assessment and development of surgeons. Melbourne; 2020.
2. World Health Organization. Health topics: Breastfeeding. Available from: https://www.who.int/health-topics/breastfeeding#tab=tab_1
3. American Academy of Family Physicians. Breastfeeding and Lactation for Medical Trainees. 2021. Available from: https://www.aafp.org/about/policies/all/breastfeeding-lactation-medical-trainees.html?fbclid=IwAR1NugTjADvb0sZlp2oe_g5rj2Yd5Mv4XBf7TheTj9adnx_c2-

Useful resources

Dr Milk Facebook group

MMAMTB Lactation Interest Facebook group for any doctor regardless of gender

Work. Pump. Repeat. by Jessica Shortall

World Health Organization articles and guidelines
www.who.int/health-topics/breastfeeding

World Breastfeeding Week 2021
waba.org.my/wbw/

Women in Surgery
surgeons.org/en/Resources/interest-groups-sections/women-in-surgery

Tips for breastfeeding at work
https://education.possumsonline.com/blog/breastfeeding-and-returning-work

AAFP policy for medical trainees on lactation
www.aafp.org/about/policies/all/breastfeeding-lactation-medical-trainees.

How to support breastfeeding patients
https://www.liebertpub.com/doi/10.1089/bfm.2021.29190.mba

Academy Breastfeeding Medicine
https://www.bfmed.org/

A refreshed Pathology Museum at the University of Papua New Guinea

The Pathology Museum at the University of Papua New Guinea was established in the 1960s.

Martin Ata'o has been the curator of the Pathology Museum in Port Moresby since 2016, and after winning a scholarship to study medicine he is now also a fourth-year medical student, doing very well in his studies.

As the curator, he is responsible for preparing practical classes and recently completed a rejuvenation of the Pathology Museum, a project funded by the Royal Australasian College of Surgeons with support from James Cook University (JCU) and the University of Papua New Guinea (UPNG).

Not long ago, Martin emailed me to say that he had applied for a small student research grant from the Royal Australasian College of Pathologists, a process which is quite competitive. As he had completed a Bachelor of Science degree his medical course was shortened to four years, which enabled himto apply for the student research grant. I encouraged him to apply and he received one of two grants.

As his supervisor, I suggested a project for him to complete. I have some thousands of 35 mm photographs taken of pathology specimens and clinical photos from 1958 to 1970. I have digitised these and though labelled, they are not catalogued.

Dr Stephen Ellis, former Director of the National Archives of Australia, and I also have about 5000 specimens in paraffin blocks which are in good order.

Martin will complete this cataloguing work during his Christmas vacation under my supervision.

We can't plan any further investigations on this material until we know what is there,

and it is properly recorded and stored in a robust database, so Martin's work will be of great use.

Professor Robin Cooke, OBE OAM
Pathologist

Images (Clockwise from top left): Martin and Robin; Martin and his assistant Ms Clara Sindigaim; Martin in Brisbane 2017 for further study meets Executive team of APNGA; Martin Ata'o with new display cabinet.

Fellow profile: Dr Omgo E Nieweg

A winding path to surgery leads to innovations in cancer research.

The adage that every cloud has a silver lining has been particularly true in Omgo Nieweg's carer pathway in surgery.

Professor Nieweg holds positions at the Melanoma Institute Australia, Royal Prince Alfred Hospital, Sydney Day Surgery and Mater Hospital, and is Clinical Professor of Surgery at the University of Sydney.

It has been the deviations in his path, which he originally believed to be setbacks, that led him to new opportunities and to make scientific contributions to medicine.

Professor Nieweg gained his medical degree and PhD at the University of Groningen in the Netherlands after completing his internship in Aruba and Curaçao in the Dutch West Indies. His passion for surgery was temporarily thwarted on his return to the Netherlands when training in the specialism was halted due to a surplus of surgeons. He trained in nuclear medicine and subsequently had the opportunity to complete his specialist training in his main area of interest – surgery.

Professor Nieweg's experience in nuclear medicine was useful later in his career, playing a part in what he considers to be one of his most noteworthy scientific efforts. It occurred while he working as a Fellow at the MD Anderson Cancer Center in Houston Texas in the early 1990s. He demonstrated that the then emerging PET scan with fluorodeoxyglucose (commonly known as FDG, a mildly radioactive substance injected into the body) could detect lymph node metastases of breast cancer and be used to monitor the effect of systemic therapy. Back in the Netherlands, his team proved in a lab study the hypothesis that breast cancer, in relation to melanoma, disseminates in a sequential fashion through the lymph node field. He also introduced internal mammary sentinel node biopsy.

Professor Nieweg's second apparent setback occurred during the Global Financial Crisis, which hit the Netherlands particularly hard. Together with a leadership change, this event caused his hospital to terminate his research. Unfazed, he accepted the invitation to move to Australia and began working at the Melanoma Institute Australia.

Despite the challenges of carrying out surgery in a new country, he maintains a sense humour about the many times his name is spelt incorrectly, and the massive amount of paperwork required to enable him to work as a surgeon in Australia.

> He considers treating patients to be a privilege: "Is there a more gratifying job than curing people of cancer?"

Professor Nieweg prioritises building an effective doctor/patient relationship. "I see it as my task not only to treat the disease but also to make the patient feel good. In the follow-up outpatient clinic, in many cases, I know a bit more of the patient as a person beyond the disease. I tend to believe that most patients leave my rooms feeling good. I learned this along the way."

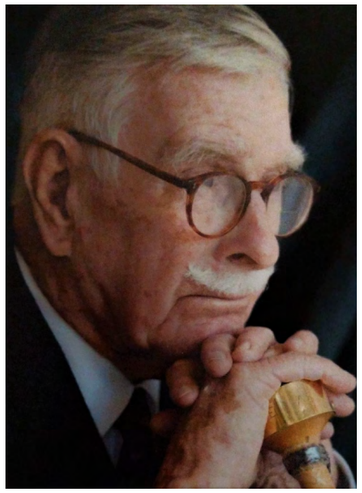
One of Professor Nieweg's most memorable cases was a patient who presented with ferocious melanoma on her scalp with in-transit metastases doubling in size and number every week. When the patient was admitted for the wide excision more than a week later she claimed that the lesions were shrinking. Physical examination confirmed this was the case, and after the wide excision the pathologist found inflammation and pigment but no viable tumour cells. Dr Nieweg concluded it was a rare case of spontaneous remission. Years later, the woman admitted that, while waiting for the operation, she had seen a faith healer who had mentally radiated a bottle of tap water and that she had passed the time with a wet cloth on her head.

Despite claiming that the four great virtues of a melanoma surgeon are scepticism, distrust, mistrust and suspicion, Professor Nieweg clearly greatly admires both his peers and his patients. His most treasured advice to junior Trainees came from his father, a professor in haematology: "Surround yourself with people who are better than you are."

What are you:

- Reading?
  Time magazine
- Watching?
  Late in the evening, when the last email has been answered, my wife and I sit on the couch, legs up and watch both the Australian news bulletin and the Dutch news, while enjoying a glass of Australia's great Shiraz. What a way to conclude the day. We watch reruns of sitcoms from *Open All Hours* in the 1980s to *How I Met Your Mother*. I'm a big fan of *Seinfeld* and *MasterChef*. The most recent movie I saw was *Green Book*.
- Listening to?
  1970s style music

Wylie D Gibbons MStJ MBBS (Qld) MS FRCS (Edin) FRACS MCICD (Rome)



In the 1950s and 1960s, bleeding peptic ulcers were the responsibility of surgeons; in the United States, there was an associated annual death rate of almost 10,000 people. Different surgical treatments evolved with the common goal of reducing erosive gastric acid in the stomach.

No approach worked perfectly and Professor Owen H Wangensteen, of the University of Minnesota, a leader in academic surgery and a pioneer in surgical research, was looking for answers. In January 1962, he delivered the Moynihan Lecture, *The Stomach Since the Hunters: Gastric Temperature and Peptic Ulcer*, in London, at the Royal College of Surgeons of England.

This was an epic lecture, encompassing all that was then known about the aetiology and history of both gastric and duodenal ulcer disease. Professor Wangensteen's laboratory studies had confirmed an apparent temporary role for local gastric mucosal cooling in cases of massive gastric haemorrhage, achieved by circulation of cooling fluids through an intragastric balloon. By 1963, the local application of hypothermia with a rectal balloon was even being used in the control of bleeding from the prostate bed after prostatectomy, and in uterine bleeding.

Around this time, Dr Wylie D Gibbons, a 1951 University of Queensland (UQ) medical graduate, having practised as a general practitioner in Rockhampton for seven years, decided on a career in surgery. He gained his Master of Surgery in late 1959 and passed the Primary Fellowship examination in Melbourne in 1961. With his Scottish ancestry in mind, he travelled to Edinburgh and gained Fellowship of the Royal College of Surgeons of Edinburgh in 1962.

As a result of both visiting and working at various hospitals in Scotland and England, Dr Gibbons, interested in both stomach and breast surgery, decided to investigate new developments in Minneapolis. He spent two months there working in Professor Wangensteen's laboratories, studying the basics of gastric mucosal hypothermia in dogs, utilising intragastric balloons which allowed both the influx and efflux of cooling fluids.

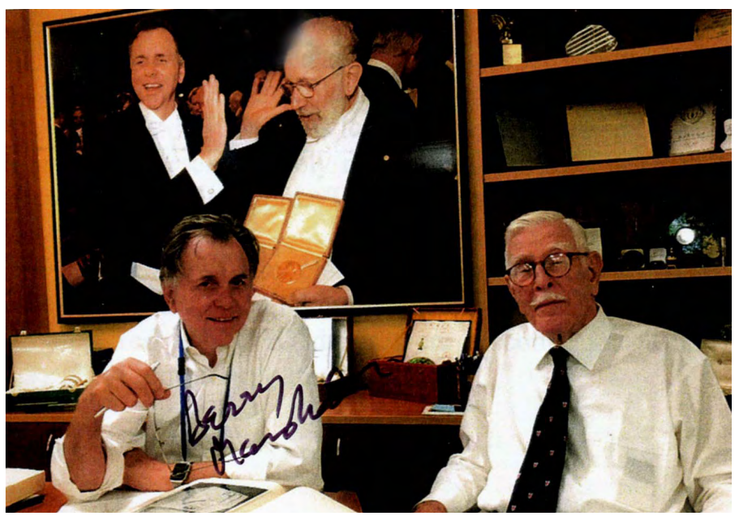
During the early 1960s, gastroscopy was continuing its evolution, and Dr Gibbons was working with original instruments produced by Herman Taylor and Rudolph Schindler. Prior to WWII, Taylor, an English general surgeon, held a research scholarship in Heidelberg, Germany, where Rudolph Schindler and Georg Wolf had developed a gastroscope with a slightly flexible tip. Herman Taylor purchased a prototype, but as export was forbidden by the Nazis he slipped it down his trouser leg and limped stiff-legged through customs!

Returning to Australia, Dr Gibbons practised in Rockhampton for more than 30 years as a consultant surgeon and pioneer gastroenterologist. Here one of his greatest challenges as a country general surgeon was the control of major haematemesis.

In April 2017, Professor Barry Marshall, Nobel Laureate in Medicine, 2005, for his joint discovery of Helicobacter pylori, brought to light the pioneering research of Dr Wylie Gibbons in a major book, *Gastric Hypothermia for Major Haematemesis*.

As Dr Gibbons wrote in the preface to this work: '*I had the problem of dealing with extremely ill patients who were referred late and in desperation. It was the practice at the time to continue with massive quantities of transfused blood until deterioration demanded referral often in moribund condition.*'

In Minneapolis, the *Swenko* gastric freezing machine had been developed and was in use. However, its cost was prohibitive. Undeterred, Dr Gibbons and his friend Mr D H McKay, an electrical contractor, developed their own Gibbons-McKay gastric cooling machine, utilised in clinical studies of haematemesis, the management results being published in the *Medical Journal of Australia* between 1964 and 1975.



In view of the importance of his pioneering and self-funded research into the control of gastric haematemesis, Dr Gibbons was encouraged to present his research as a Doctor of Medicine (MD) thesis. Both his 1965 thesis, *Gastric Hypothermia*, and his 1971 thesis, *Investigation of Controlled Intragastric Temperature Depression in Man* were not acknowledged, coming to nought, leaving Dr Gibbons embittered.

Professor Marshall, having swallowed Helicobacter pylori and self-inoculating, obviously saw parallels between himself and Dr Gibbons: Dr Gibbons had also tested several of the gastric cooling technologies and strategies, including the gastric cooling balloon, on himself. Professor Marshall, with a view to covering all aspects of the history of management of peptic ulcer disease, took it upon himself to publish Dr Gibbons' work in his book.

Dr Gibbons' theses are presented in three volumes: *Volume 1. 2016 Thesis: Background, A Retrospective View, and Conclusions; Volume 2. 1965 Thesis: Gastric Hypothermia; Volume 3. 1971 Thesis: Investigation of Controlled Intragastric Temperature Depression in Man.*

In his foreword, Professor Marshall wrote:

'I enjoyed reading the saga of gastric cooling in Gibbons' thesis. It encouraged me to pursue other angles to the story of gastric cooling.

'The expensive machines became all the rage in the USA in the early 1960s and the newly formed funding agency, Medicare, was being pressured to pay for these gadgets.

'Wisely, they held off until a double-blind study was completed which showed no major difference between cold water and body-temperature water in the gastric balloon.

'That study continues to be cited when the United States Government needs an excuse to not fund some new advance in medicine until it has been proven to be cost-effective (USA National Academies of Sciences: Medical Technology in the Health Care System; Committee on Technology and Health Care: 1979)'.

At the suggestion of Professor Marshall, Dr Gibbons forwarded a copy of Gastric Hypothermia to Nobel Laureate Professor Peter C Doherty, in Melbourne, who replied that his training at UQ was in veterinary science, not medicine, and that the work encompassed in the volume was '*way out of my area*'.

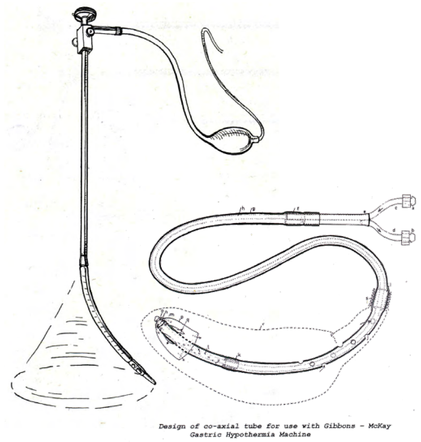
In turn, Professor Doherty passed on his copy of Dr Gibbons' book and correspondence to Associate Professor Felix Behan, noting: "*Felix writes regular historical pieces for Surgical News and is also doing a lot of medical/legal work in retirement. He is very outspoken and as straight as they come. He loves to tell a good story!*"

Felix immediately contacted Professor Julian Smith, Editor-in-Chief of the *ANZ Journal of Surgery*, to discuss possible options for appropriate recognition of this work.

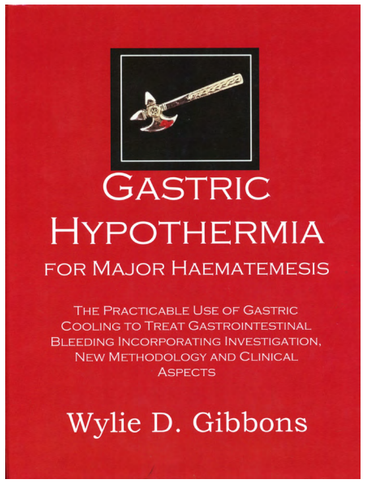
Communication next occurred between Professor Smith and myself, in my role as the journal's Specialty Editor in Surgical History, so that all the material could be reviewed, enabling appropriate recognition of Dr Gibbons' work.

That review has been undertaken and it involved frequent communication with Dr Gibbons and his wife Erika, over the telephone, via email and via written correspondence. The hope was to provide an appropriate record of Dr Gibbons' self-funded research into an acute problem faced by a rural general surgeon in solo practice.

Sadly, while this work was in progress, the death of Dr Wylie David Gibbons on 2 August 2021, at the age of 93, was announced. His magnificent service to the medical profession was recognised on 5 August in a service honouring his life and his 60-year involvement in Masonry.

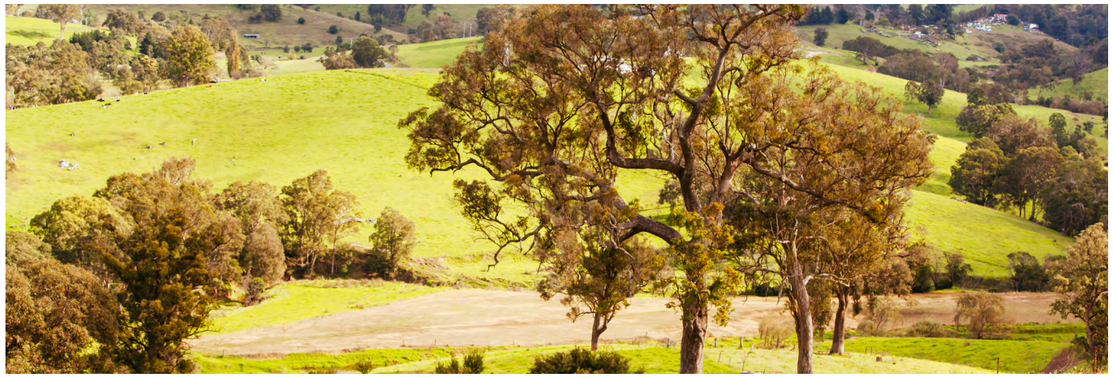


As a result of personal communications with Dr and Mrs Gibbons, I was presented with my own copy of *Gastric Hypothermia*. The presentation copy addressed to Nobel Laureate, Professor Peter Doherty, will be donated to the College library.



Mr Peter F Burke
FRCS FRACS DHMSA

Images (from left): Wylie D Gibbons; Professor Barry Marshall and Wylie Gibbons; Herman Taylor gastroscope; Taylor-Schranz flexible gastroscope with the Co-axial tube design; Gastric Hypothermia.



Supporting Trainees to pursue rural surgical careers

Reflections on the Provincial Surgeons of Australia 2021 Annual Scientific Conference.

The 56th Provincial Surgeons of Australia (PSA) Annual Scientific Conference was held in August this year.

Advances and controversies in General Surgery offered a broad focus, as did General Surgery in the country. The interactive programwas highly relevant to both rural and metropolitam attendees .

For the past few years, General Surgeons of Australia (GSA) has generously given a Rural Surgery Grant to Trainees, SIMGs and junior doctor who have applied to attend the PSA Conference.

GSA, in conjunction with the Royal Australasian College of Surgeons (RACS) Rural Coach Program, offered 15 Rural Surgery Grants to eligible applicants who are interested in a career in Rural Surgery.

These participants have found the opportunities for networking invaluable. They share with *Surgical News* their reflections on the PSA Conference.

Dr Yuen-Ting Wong, junior doctor, New South Wales
The PSA virtual conference was well organised despite the difficulties due to the COVID-19 pandemic. It was my first PSA experience, and I greatly enjoyed it. The PSA provided an excellent platform for the rural surgery community to share their knowledge and expertise. The conference was educational and inspiring, I was impressed by the number of fantastic research papers presented during the conference. The highlight of the program for me was the Women in Surgery presentation by Dr Deepali Poels. Even though more than 50 per cent of medical graduates are women, the surgical world remains extraordinarily male-dominated. With the great effort from the many remarkable female surgeons who worked as pioneers in the surgical field, opportunities for junior female doctors in surgery have now greatly improved.

Dr Danielle Taylor, junior doctor, Victoria
Despite being virtual, it is the great sense of community and comradery I remember from the 2019 PSA ASM. This year, Dr Gordon McFarlane provided insights into the rural General Surgery in Shetland, where they have many similar challenges to Australia. I was really impressed with the presentations on oncoplastic breast surgery and the amount of quality research being done in regional and rural centres is fantastic. I will definitely encourage my colleagues to come next year, hopefully in person.

Dr Susmit Roy, SET Trainee, New South Wales
While I was disappointed that I could not be present at the Bega Valley physically (I was envious looking at the pictures Sandra and Adrian shared from their practice location there), I loved every bit of the online version.

I have worked in surgical services in rural Australia in Queensland and New South Wales and I know the challenges and boundaries a surgeon is faced with in rural/regional settings. However, I feel the rewards are far greater: no long commutes to work, knowing almost everyone in your town, a huge house with an endless backyard, and the best place to raise a family. Last, but definitely not least, you are helping the people who keep Australia running.

This conference described nicely the surgical issues that can be encountered in a regional setting and how to master them.

Dr Romy Mondschein, junior doctor, Victoria
I'd like to thank everyone involved in holding the PSA 2021 conference – it was an interesting and enjoyable time.

For me, the resounding message was regarding health advocacy. Presenters advocated for their communities in a variety of ways. One presenter organised funding for new technology that would improve pre-operative logistics for rural patients. Another described the efforts to develop treatment protocols that maintained efficacy, while improving accessibility for rural patients. Advocacy is integral to the health and survival of our rural communities; it cannot be assumed that the gap between rural and urban health care outcomes will dissipate spontaneously. I found the persistence and innovation of presenters very encouraging.

The benefits and difficulties of generalist training is a topic that would benefit from intergenerational consideration within the surgical community, as part of service provision planning for the future.

I also enjoyed the collegiality demonstrated by panellists and presenters. Many offered their expertise post-conference, with a willingness to provide a second opinion to anyone around the country. This insight into the rural support network was lovely to see.

Dr Aadil Rahim, SET Trainee, Australian Capital Territory
The only good thing to come out of the COVD-19 pandemic was that the GSA PSA 2021 Conference proceeded as a virtual experience, meaning I could still attend from my regional training placement. Throughout the day, multiple different healthcare professionals and members of the MDT heard the talks playing in the common room and stopped to listen. The experiences of the surgeons starting new techniques in their regional hospitals was both inspiring and insightful. Highlights included the 'How I Do It' presentations by Dr Cindy Mak and Dr James Kollias, which described key techniques by two very experienced breast surgeons that I hope to incorporate into my future practice. I would highly recommend the conference to all my colleagues and look forward to attending in 2022, hopefully N95-free.

Dr Ben Scott, SET Trainee, Victoria
When the registration for the Bega PSA came around, I was excited by the prospect of travelling interstate to meet with like-minded colleagues from around Australia. Then, another COVID-19 outbreak. As cases escalated, it became clear that the conference would not go ahead in its original format and would be delivered online. Was this going to be the same PSA I remembered from previous years?

Thankfully, it lived up to the hype. The talks were highly informative, interesting and practical. The presentations on pancreatitis, surgical site infections and management of umbilical hernias had an immediate impact on my daily practice.

As a Trainee keen to practice in a regional area it was great to hear from the local surgeons in Bega and the Viking surgeons in Scotland. It gave context to the life of a provincial surgeon and the challenges they may face. I thoroughly enjoyed the PSA for 2021 and would encourage all to consider attending the 2022 conference.

Dr Janaka Balasooriya, SIMG, ACT
I participated in PSA Annual Scientific Meeting as a SIMG and it was a great opportunity to see a variety of aspects important in practicing in rural areas. The range of surgical pathologies encountered by general surgeons in peripheral areas, management options when subspecialty colleagues are not available, facilities and resources available, and upgrading knowledge and skills as rural surgeons were the main themes I was looking for, as most SIMGs will continue their careers in this type of environment. Bega ASM covered most of these topics and it was good to hear the rural surgeon's firsthand experience. There were also many tips for preparation for the Fellowship examination and the procedural videos were great learning opportunities. Although it was ultimately delivered as an online program amidst lockdowns across multiple states, I couldn't see a major difference except for missing the air of Bega valley. I take this opportunity to thank the organisers and, with all these positive experiences, I am looking forward to joining the next conference.

Dr Clara Betcu, junior doctor, Queensland

I am so lucky to have been able to attend the 2021 PSA conference in its virtual format. The conference going virtual brought rural surgery that little bit closer to home and, more importantly, showed us the future possibilities of remaining connected and up-to-date with our skills regardless of remoteness.

As a current junior house officer, I found myself feeling motivated and encouraged by the strong junior doctor and training registrar presence at the conference. I truly appreciated all the posters, articles and mini lectures, and the support shown to all presenters by their senior mentors. My personal highlights were the Common Bile Duct Masterclass involving a fantastic discussion about maximising resources to increase service provision in rural centres, as well as the Viking surgeons' lecture and discussion about rural surgery on an international level.

Finally the PSA 2021 conference served to highlight exciting new research and innovative techniques becoming available in rural centres, breaking the old rhetoric of rural surgery as limited surgery. I hope more surgeons and future surgeons get to experience this conference and come to understand that rural surgery is never the end of the line, but rather the beginning of an adventure.

Bucking the trend

Global studies documented a dramatic decline in Emergency Department admissions during the first lockdown of 2020 with a notable exception in New South Wales.

The Lismore hospital Orthopaedics team (l-r): Dr Ariella Smith, Professor Herwig Drobetz, Dr Elise Woo and Dr Benjamin Pfister

When COVID-19 first hit Australian shores, Emergency Department (ED) presentations plummeted – but not in the Northern Rivers region of New South Wales.

The Orthopaedics team servicing the ED at Lismore Base Hospital and the Health District's Trauma Director, Professor Herwig Drobetz, FRACS, were run off their feet.

"Despite a lot of the major centres seeing a significant decrease in cases, we were really busy," Professor Drobetz said.

"We wanted to see if the numbers painted a similar picture to what we thought was occurring at the time."

In collaboration with Orthopaedic Registrars – Dr Elise Woo, Dr Ariella Smith, Dr Benjamin Pfister and Dr Dominic Mah – Professor Drobetz conducted a study comparing orthopaedic presentations data from 1 February to 17 May 2020, to the same period in 2019.

The results revealed a 77 per cent increase in orthopaedic presentations, totaling 496 during the study period compared to 280 in 2019.

"Being a regional area, many locals live on large properties and still had ample opportunity to get outside, even during lockdown," Professor Drobetz said.

Falls remained the most common cause of injury (29.3 per cent), followed by sports and recreational activities (20.8 per cent).

"We saw a lot of injuries from farm work and DIY projects around the house.

"Kids were also being home schooled, so they had more time for sport and outdoor activities," Professor Drobetz said.

The number of presentations requiring admission to hospital was also higher during the 2020 study period. However, ED teams had to be more discerning about who was admitted, due to the heightened risk of COVID-19.

"We did many more minor procedures in the ED, such as nailbed repairs or treating lacerations," Dr Woo said.

Where possible, patients were sent home for 24–48 hours before returning to hospital to undergo surgery.

"The threshold for admitting people to hospital was much higher because of the threat of COVID-19," Professor Drobetz said.

"Patients also didn't want to come to the hospital unless it was absolutely necessary."

Orthopaedics staff were split into teams to reduce the risk of multiple practitioners being infected with COVID-19.

A telehealth fracture clinic was also rapidly implemented in March 2020 to prevent disease transmission.

This initiative has since been the subject of further research, published in the *ANZ Journal of Surgery*.

From 17 March 2020 to 8 May 2020, 191 patients collectively attended 390 appointments, of which 23.1 per cent were conducted via telehealth over the phone.

"Telehealth patients were carefully selected to ensure this method of consultation was appropriate," Professor Drobetz said.

"However, the majority of patients still required face-to-face consultations for at least part of their follow up."

Interestingly, the patients who used telehealth were older (48.6 years) than those who attended consultations in person (32.7 years).

The Orthopaedics department hoped the telehealth clinic would reduce their workload, however, the transition to virtual consultations had minimal impact from a time perspective.

"Our experience found that the amount of time dedicated to reviewing patients over the phone was roughly equal to a standard clinic," Professor Drobetz said.

With New South Wales now dealing with ongoing restrictions, Professor Drobetz said telehealth will continue to play an important role.

"We service a large regional population, so telehealth is a positive step forward for those who face geographical barriers," Professor Drobetz said.

Anecdotally, orthopedic presentations at Lismore Base Hospital's ED have eased since the study period.

"It will be interesting to see more research emerge to show how trends have evolved throughout the pandemic," Dr Woo said.

An academic version of this story appeared in the *ANZ Journal of Surgery*.

Lismore orthopaedics study - Woo, E., et al., Increased orthopaedic presentations as a result of COVID-19-related social restrictions in a regional setting, despite local and global trends. ANZ J Surg, 2021. 91 (7-8): p. 1369-1375.

Fellow profile: Dr June Choo

From English and Literature to Surgery

For someone whose first interest was English and Literature, June Choo's latest read – Hilary Mantel's *The Mirror and the Light* – has been sitting on her bedside table for an awfully long time.

Dr Choo is an ENT surgeon with her own practices in East Melbourne and Moonee Ponds. She also works as a surgeon at the Royal Victorian Eye & Ear Hospital, Royal Melbourne Hospital and the Alfred Hospital.

She admits that her job, combined with her role as Chair of the Surgical Education and Training (SET) for ENT surgery, leaves her little time to indulge her love of literature.

But despite the demands of her profession, Dr Choo feels fortunate to have the opportunity to do a job that gives her so much satisfaction.

"It is a privilege to work in this job. Sometimes it feels like I'm being paid to spend time doing my hobby."

Since beginning her rounds as a trainee surgeon, Dr Choo has enjoyed being a member of a welcoming and supportive community.

Specialising in obstructive sleep apnea and voice disorders, she enjoys the diversity of conditions and patients she treats. However, one of the main challenges of her role is convincing patients that surgery is not the best solution for them.

"Many patients are happy to go through some amount of pain and recovery so that their conditions can be fixed, but for some, surgery will not deliver the outcome they are hoping for. A big part of my job is explaining to people that surgery won't help them."

Dr Choo was born in Singapore to Malaysian and Singaporean parents. Rather than pursuing a career that followed her interest in the arts, she chose to train in a profession with a clear career pathway.

She studied Science in Sydney before enrolling in Medicine at the University of Adelaide. She was surprised by the racism she encountered in both cities when she arrived in the 1990s.

"Singapore is in Asia but has many structural similarities with Australia. But 30 years ago, Australian society was quite different, and I really felt like I was part of a racial minority. There was a lot more explicit racism than there is now."

Dr Choo remembers seeing racist graffiti on toilet doors in Sydney. In Adelaide she felt there was a sense that non-Caucasian students were 'foreign', while US exchange students were more readily welcomed into the student community.

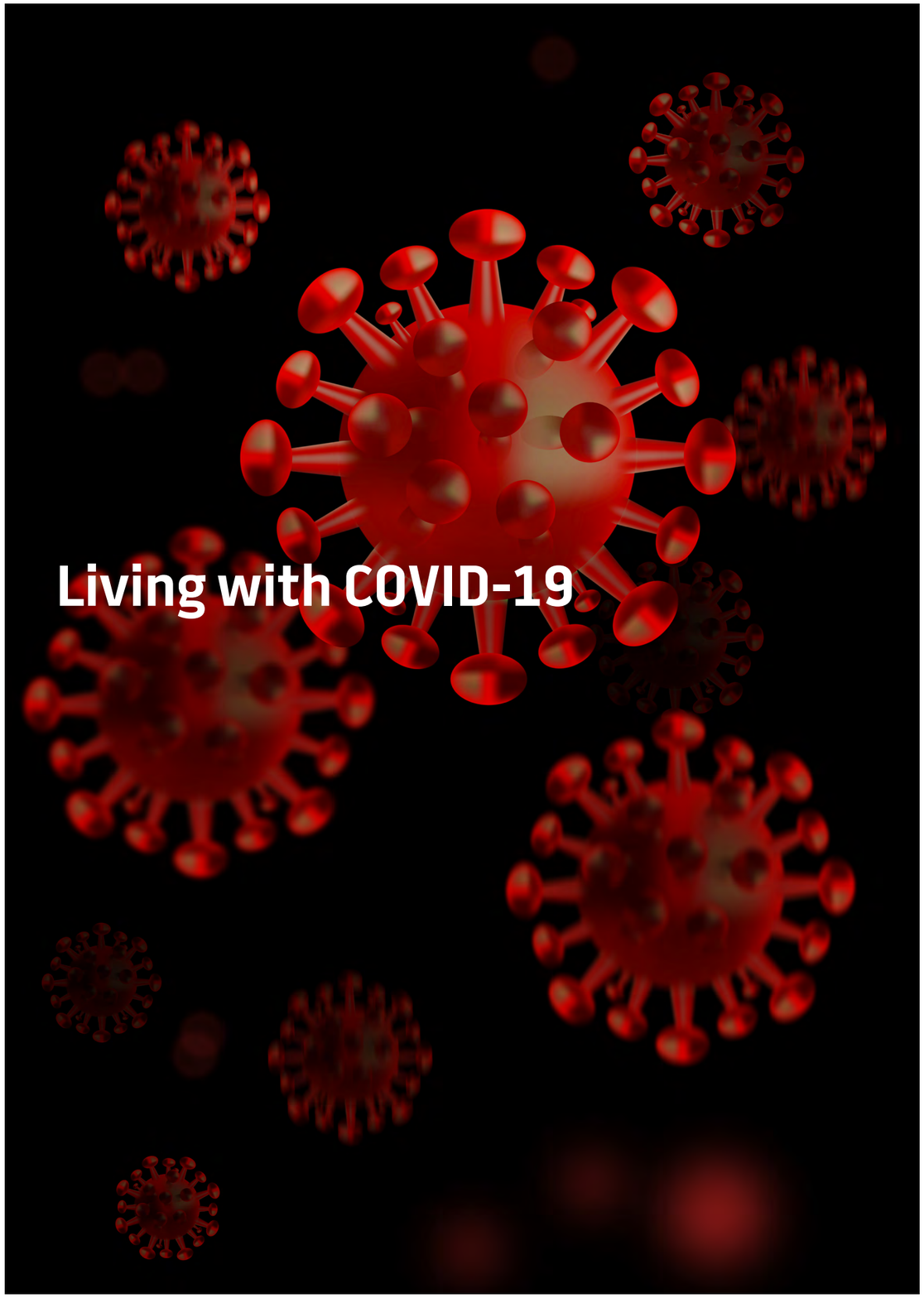
A piece of advice that Dr Choo would like to give medical students is to have realistic expectations about the demands of the job. While work-life balance is important, this is not always compatible with a role in which the patients' needs do not always run to a schedule.

To relax, Dr Choo loves to travel and some of her favourite destinations are Europe, Southeast Asia and Japan. In fact, the only time she feels entirely relaxed is when she travels with her husband, an anesthetist.

"The one time when I can be sure that I can't be called in to work is when I'm away. There is no such thing as a holiday at home," she said.

What are you:

- Reading?
  Hilary Mantel's *The Mirror and the Light* has been sitting on the bedside table for so long it has become part of the furniture.
- Watching?
  An old Korean series, *Sky Castle*, on Netflix.
- Listening to?
  The 80s music coming from my husband's laptop.



Living with COVID-19

Surgical News talks to Aotearoa New Zealand and Australian state and territory committee chairs about their perspectives on getting used to living with COVID-19.

Queensland

Adjunct Professor Deborah Bailey is a paediatric surgeon and Chair of the RACS Queensland State Committee. She said that although the COVID-19 case numbers in Queensland are low, many hospitals in the southeast, and particularly the Gold Coast, are significantly impacted by border issues with New South Wales.

"Hospitals in the south-east corner of Queensland service around 65 per cent of the Queensland population in addition to northern New South Wales. The nearest tertiary hospital south from the Gold Coast is in Newcastle," Adjunct Professor Bailey said. "This means ongoing administrative and physical border negotiations for surgeons getting patients across the border, including nurses and allied health staff who live and work across the two states."

Every patient from New South Wales is treated as if they are COVID-19 positive.

"To operate on a baby from New South Wales, I book a theatre for most of the day, even though the operation may not take all day. The theatre undergoes a terminal clean. The effect of patient flow on our emergency and elective surgery are major."

Hospitals away from the Gold Coast and Brisbane in Queensland have different concerns. Geographically isolated rural hospitals are challenged with associated risks within the Indigenous communities and with having fewer resources to cope with COVID-19 implications – if they occur.

Looking forward, Adjunct Professor Bailey said there are decisions to be made around patient protocols once vaccination rates reach 70 to 80 per cent. "How do we treat unvaccinated patients? COVID-19 detrimentally affects surgical outcomes. I expect there will be changes to surgical practices with ongoing impacts on patient flow.

"While we are frustrated and weary with the implications of COVID-19, we are fortunate in Queensland. We are concerned for and supportive of our colleagues in Victoria, New South Wales and Aotearoa New Zealand."

Aotearoa New Zealand

Aotearoa New Zealand is currently in the middle of a Delta variant outbreak. Dr Andrew MacCormick is a general surgeon in Auckland, which is on high alert at Level 4, the country's highest restriction level.

When rostered in acute care, Dr MacCormick sees different patterns of illness presenting because of Level 4 lockdown.

"People are delaying presenting to hospital and simultaneously we are seeing variations in the types of traumatic injuries. There are less motor vehicle and increased interpersonal/domestic violence trauma. It was the same last year during lockdown," Dr MacCormick said.

Some Aotearoa New Zealand hospitals are not operating at 100 per cent capacity as non-urgent surgeries have been delayed.

"I'm pleased that in Aotearoa New Zealand restrictions have preserved healthcare capacity in case COVID-19 infections explode," Dr MacCormick said. "It's important that we do all we can to continue to offer the best quality care. This despite additional measures related to COVID-19 safety protocols and increases in the number of infected patients."

Many colleagues, nurses and allied health workers are stressed. At the Aotearoa New Zealand RACS Annual Scientific Meeting – held online – discussion was focussed on burnout in healthcare workers. This is likely to continue with the 'catchup' work after lockdown.

"It's important we talk about this," Dr MacCormick said. "We need to ask and check in with people and then take real and tangible steps to look after our colleagues."

Dr MacCormick is anticipating different models of care in the future, for example continued follow-up consultations delivered via technologies like telehealth. He is part of the RACS working group that is developing COVID-19 guidelines in this area.

"There will be different models of care in the COVID-19 era, with us potentially being in and out of lockdown. On top of that we have the emergence of variants. The future is uncertain. However, we must ensure that new ways of working don't lead to ethnic disparities in health outcomes."

New South Wales

Associate Professor Payal Mukherjee is a Sydney ENT surgeon and the Chair of RACS NSW Committee. She has been challenged with the ethics of autonomy and equity during COVID-19.

"ENT surgeons perform a high amount of Aerosol Generating Procedures, even in routine examination of patients in rooms. Therefore, navigating care models when staff and patients were not fully vaccinated created a great degree of stress. As mandates and supply increased vaccination rates, ethical challenges of managing immunocompromised elderly patients alongside unvaccinated children continued. I see this as today's ethical dilemma in balancing the autonomy and care of an individual against the safety of the community."

Associate Professor Mukherjee is bracing herself, as her backlog of surgeries increases with the cessation of elective surgery. She continues to consult in her rooms and mitigating complications of delayed care.

"Elective surgery does not mean optional surgery," Associate Professor Mukherjee said. "The prolonged pressure of COVID-19 on our hospitals, means that alongside this pandemic of the unvaccinated, we are also experiencing unprecedented pressure on non-COVID-19 surgical care –acute, urgent and elective."

In New South Wales, areas of Sydney worst affected have a higher representation of patients from lowersocioeconomic demographics. To compound matters, lower socio-economic areas also lack the density of private hospitals that can take the overflow from public hospitals.

Associate Professor Mukherjee copes by "feeling inspired that there are so many surgeons in NSW committed to working collaboratively with the government to manage this crisis. I won't forget the stories of the patients who have challenged my ethics the most. It motivates me to fight for a 'leave no one behind' strategy to health policy – whether rich, poor, young, old, rural, metropolitan, vaccinated or unvaccinated."

Victoria

Dr Matthew Hadfield, Vascular Surgeon and Chair of the RACS Victorian State Committee, is based in Ballarat in regional Victoria, which has recently come out of lockdown. However, like the rest of Victoria, hospitals there remain on the highest risk rating, COVID Peak (Black), despite low local infection numbers.

He said that Victoria is anxious about the latest numbers. "Surgeons and hospital staff are holding their breath expecting that in the next two to three months we will have a wave of cases coming through. We don't know what to expect. We haven't yet had overload across the hospitals in the state due to COVID-19."

In the meantime, Dr Hadfield is grateful he is able to continue operating as he has a large backlog of surgeries from the first lockdown. He said it was important that normal healthcare remains optimal alongside COVID-19 care.

"The College worked very hard with the Victorian Department of Health Victoria to minimise the impacts on elective surgery. We developed a system where individual hospitals can determine surgical activity based on the prevalence of COVID-19 in their respective areas."

However, Dr Hadfield expects it will take years for the state to eliminate the backlog accumulated last year.

Looking forward, Dr Hadfield anticipates work will continue around improving PPE protection and ensuring ventilation upgrades are made to hospital buildings. He believes the medical profession has adapted well. "I think in the future we will continue to practise as do in surgery, maintaining precautions around COVID-19 aerosol safety in both consultation rooms and operating theatres for a long time to come."

Dr Hadfield emphasised the importance of communicating with other colleagues, state RACS Chairs and specialty societies in this new pandemic affected environment. "The various RACS State Committees know each other much better than we did 18 months ago. It's brought that community together in a big way."

A career dedicated to better outcomes for trauma patients

Dr Mike Hunter recognised for his contributions to trauma care.

Dr Mike Hunter, a general surgeon from Dunedin, Aotearoa New Zealand, recently received the Gordon Trinca Medal, a prestigious honour that recognises and promotes contributions to trauma care with particular emphasis on trauma education and teaching.

Dr Hunter's entire professional career has been dedicated to the provision of trauma education and service to ensure better outcomes for trauma patients. As a general surgeon, an intensive care unit (ICU) consultant and Trauma Medical Director for the Southern District Health Board in Dunedin, Dr Hunter has held numerous roles in trauma and trauma education. He took part in the first Early Management of Severe Trauma (EMST) course in Aotearoa New Zealand in November 1989 and went on to become a senior instructor, course director and active member of the EMST committee. He has been an invited speaker at many international scientific meetings on trauma.

Dr Hunter says what he loves most about trauma education and teaching is that it enables him and his students to make a difference. "The structured methodology and application of at least some educational science to both advance trauma life support (ATLS) and our Australasian version, EMST, appealed greatly to me right from the beginning. It meant that even those doctors who had minimal experience in dealing with serious injury were given a systematic approach that led them through the most important early steps if lives were to be saved. You could see them growing in confidence and competence over the course of two-and-a-half days and you could also observe those in the workplace who had had this training and see how much better they functioned both individually and in trauma teams."

Without a doubt, the highlight of his extensive and dedicated career has been 'he tangata, he tangata, he tangata' (the people, the people, the people). "I love coming to work most days because I enjoy my patients and their stories and have a lot of fun with them, even in some pretty challenging situations. I have a strong sense of belonging in the Southern community, and I get a lot of love and respect back from that community.

"I really value most of the people I work with. When I walk into the hospital, a cheery greeting by name from one of the orderlies or security guards or cleaners brings a camaraderie into the day that is worth a lot. I particularly enjoy the young people around me with their thirst for knowledge and gaining skills, and their ability to challenge old ideas - it gives me enormous pleasure to teach. I often get the greatest satisfaction from doing small things well – a satisfied patient with a sound hernia repair no longer in pain and able to work is but one example. And every so often we get a win in some small way with systemic change; that is particularly rewarding."

Unlike many surgeons, Dr Hunter has chosen to practise only in the public hospital sector. "I guess the early example was set by my father who always believed that people should receive healthcare based on need rather than ability to pay. It didn't take me long to appreciate that state-run taxpayer-funded systems are not only more equitable but are also considerably cheaper than systems paid for by insurance or out of pocket expenditure.

"That is not to say that working in the public sector doesn't have its share of intense frustrations, indeed it does. Having also served for 35 years in the Defence Force I am acutely aware of the inertia, frustrations, and often waste that any large organisation, public or private, inevitablyexperiences to a greater or lesser degree. My response to that has been to strive to improve it, rather than turning my attentions elsewhere."

Mr Mike Hunter is presented with the prestigious Gordon Trinca Medal by his trauma surgeon colleague Professor Ian Civil at RACS' Aotearoa New Zealand Convocation and Awards ceremony in May.

CTANZ powers up home-grown research opportunities for our next generation of surgeons

The Clinical Trials Network Australia and New Zealand (CTANZ) is an initiative that seeks to provide structure for Royal Australasian College of Surgeons (RACS) Trainees, junior doctors and medical students to carry out investigator-led multi-centre clinical trials. It was formed in 2017 by the RACS Council in response to the need for higher quality surgical trials to drive improvements in surgical care in our region. CTANZ was also established to ignite a much-needed culture of inquiry and shared learning among our surgeons.

For Trainees, junior doctors and medical students, CTANZ is a prime opportunity to be engaged in, and lead research. Such research will have far greater impact than if carried out individually, as those involved benefit from valuable mentoring and network-building with experienced Fellows. Through CTANZ, Fellows can contribute to shaping the next generation of surgeons and give back to their profession, while committing as little or as much time as they choose. It's a win-win for the surgical profession and for the crucial field of surgical research in Australia and Aotearoa New Zealand.

All surgical training boards mandate a research training component, but often this is limited to a small audit paper. Some boards have now recognised the value of research collaboratives by restructuring this research training requirement to formally recognise and value participation in collaborative multi-centred trials. CTANZ networks now provide the vehicle for many Trainees to complete their research training.

Professor David Watson has been the Clinical Director of CTANZ since 2018. He is a General Surgeon with a special interest in esophageal and gastric surgery, and Head of Flinders University Discipline of Surgery in Adelaide. Professor Watson is hoping CTANZ will stimulate a culture of inquiry among the next generation of surgeons. "If surgeons are involved in collecting and interpreting evidence, then they'll be better able to interpret the evidence put before them for what we currently do in practice. Hopefully, they will be able to see if it's appropriate evidence or whether questions need to be asked," he says.

Dr Lorwai Tan is the RACS Coordinator of CTANZ. She's also the Manager of Research and Academic Surgery at the College. Dr Tan's background in clinical medical research, as well as publicity and marketing in the commercial sector, means she's well-equipped to grow CTANZ and ensure the organisation runs smoothly. "Whole communities – patients, clinicians, and health departments – gain so much from the work CTANZ is doing in terms of evidence-based treatment for patients. You can confidently draw up clinical guidelines supported by real-world evidence, not because a system was adopted without asking why," she says.

As an umbrella organisation, CTANZ currently consists of 18 Clinical Trials Networks (CTNs) within RACS. Of those networks, there are 10 different surgical specialties or subspecialties. CTANZ's unique structure and close working relationship with its sister organisation in the UK, the Royal College of Surgeons Clinical Trials Network UK (CTN-UK), allows the group to conduct large investigator-led clinical trials across Australia, New Zealand and internationally.

How does a CTN get started within CTANZ? "We identify the leaders within the Trainee groups - those who are great organisers and have the writing skills, and they naturally coalesce to form the nucleus of a Trainee network. It's an organic process, the way these networks come together. Usually, it's a small core group and, when these Trainees become consultants, they bring this collaborative culture that has the potential to become the normal practice in their organisation," says Dr Tan.

CTANZ is still young, but the last three years have seen some great achievements. The organisation has expanded from six to 18 CTNs. Funding was secured through Medical Research Future Funding (MRFF) for the Australian arm of the UK-led SUNRRISE Trial. There was also a great win for public relations with CTANZ to the global COVIDSurg studies, one of which was awarded a Guinness World Record for the most authors on a single peer-reviewed academic paper.

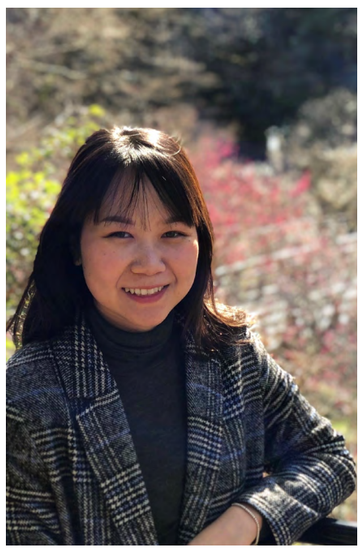
Professor Watson ponders CTANZ's goals for 2022. "We've contributed, as junior partners if you like, to the UK for a number of randomised control trials. We want to increase the number and impact of studies that originate in Australia and New Zealand," he says. "We'd like to replicate what they've achieved in the UK, which is a complete coverage of all specialties and all regions." Dr Tan wants to see clinical trial units established in our region to provide administrative support and assist with the establishment and growth of local research ideas.

Surgical News spoke to three CTANZ participants about their experiences.

Dr David Liu

Dr David Liu is a Post-Fellowship Trainee and current Chair of the Victorian collaborative for Education, Research, Innovation, Training and Audit by Surgical trainees (VERITAS). Two large studies he's currently involved in are: POST operative Variations in anaemia treatmenT and Transfusions (POSTVenTT) and Perioperative Timing of Elective Chemical Thromboprophylaxis in General Surgery (PROTECTinG).

"Practically, I've learned how to develop an organisational structure to carry out clinical trials, set up communication channels, navigate research ethics and secure project funding. I've also learned about the importance of steering committees and project management groups. In particular, their constituent roles, the flow of information, and what works and doesn't work." Dr Liu adds,



"We learn how to manage large datasets and construct robust databases, so it's easy for data collectors, statisticians and end users to enter and extract data, and make full use of it."

Chris Varghese

Dr Jess Vo, a pre-SET Trainee from Western Australia, says that before CTANZ there were no clear pathways for medical students and registrars to get involved in research, and certainly not to lead, large international clinical trials. Dr Vo joined CTANZ through participation in the UK-led SUNRRISE Trial via her Master's degree. She's currently contributing to the POSTVenTT study, which is the first prominent international study of its kind led by Australia and New Zealand. "CTANZ helped usdevelop the trial and form the steering committees, and they gave us advice. However, everything from developing the protocols for ethics through to writing up the study is led by the surgical Trainees."

Chris Varghese, a fifth-year medical student from the University of Auckland, is a strong advocate for CTANZ. He thinks it offers powerful benefits to medical students. "CTANZ gives you the infrastructure to deliver things that might not be typically expected of medical students and Trainees." He has most recently been involved in the POSTVenTT study and COVIDSurg studies. He says one of his biggest learnings is the art of time management. "I learned from mentors to prioritise my efforts and focus on things that will help patients and positively impact clinical practice. Rather than dividing my attention on smaller projects, CTANZ gives me an outlet to aim high."

What do Fellows get from being involved with CTANZ? "You'll be part of changing the culture of how the next generation of surgeons think," says Professor Watson. Dr Tan thinks the opportunity to collaborate in worthy trials without hefty time commitments is a draw card. She says, "You're part of a larger group that's collaborating to make life better for patients. You don't have the responsibility and time burden of leading heavy-duty research, but you can be involved in guiding surgeons in their research and driving cultural change." Professor Watson says the idea is for Fellows to take a back seat with trials. "We don't want Fellows to see this as an opportunity to do their own research project. This works from a bottom-up approach, not a top-down approach."

Why is the continued presence of CTANZ important for surgical research in Australia and New Zealand? Dr Liu says it's hard for surgeons, new and experienced, to do it alone.

"To get something big off the ground, you need to find like-minded people who are enthusiastic, knowledgeable and well-connected. CTANZ connects people who are motivated and interested in asking clinically relevant questions. CTANZ also provides the personnel support to enable collaborative research to happen."

COVIDSurg study awarded Guinness World Record

A COVIDSurg study supported by RACS Clinical Trials Network Australia and New Zealand (CTANZ) was recently awarded a Guinness World Record for the 'most authors on a single peer-reviewed academic paper'.

The Clinical Trials Network Australia and New Zealand (CTANZ) is an initiative that provides a structure for the Royal Australasian College of Surgeons (RACS) Trainees, junior doctors and medical students to carry out investigator-led multi-centre clinical trials in our region. CTANZ's close working relationship with its sister organisation in the UK – the Royal College of Surgeons Clinical Trials Network UK (CTN-UK) – allows it to contribute to large international clinical trials, as well as conduct local trials across Australia and Aotearoa New Zealand.

CTANZ was recently involved in a study delivered by the UK-led GlobalSurg-COVIDSurg Collaborative. This global collaboration of more than 15,000 surgeons included Fellows and Trainees from RACS, who were part of 43 hospital teams in Australia and 11 in New Zealand. Globally, data was collected from more than 140,000 patients who underwent surgery during October 2020; more than 5,000 of them from Australia and New Zealand.

The study found that recent or current COVID-19 infection is linked to an increased risk of dangerous blood clots during surgery. The new research, published in Anaesthesia,(1) shows that venous thromboembolism (VTE), a known complication of surgery, is 50 per cent more likely to occur in patients with current COVID-19 infection and almost twice as likely in those who've had a recent infection. The study also found that having a VTE was associated with five times increased risk of death within 30 days following surgery, compared with patients with no VTE.

This study, closely linked to an earlier study which looked at overall outcomes and risk of death, is a more focused analysis of blood clots following surgery. To the delight of all involved, the GlobalSurg-COVIDSurg Collaborative has been awarded a Guinness World Record for the most authors on a single peer-reviewed academic paper. This achievement highlights the scale of the global partnership, which aims to contribute to understanding COVID-19 and help save as many lives as possible.

Dr Deborah Wright, a Consultant Colorectal Surgeon based in Dunedin, provided leadership and governance for the study from behind the scenes, while Trainees led the charge. She supported teams in Aotearoa New Zealand and Australia, along with Adjunct Associate Professor Peter Pockney, a Consultant Colorectal Surgeon based in NSW, and other willing Fellows. They helped Trainees with ethics processes, locality assessments, general advice, and other support as needed.

Dr Wright is a strong advocate for CTANZ's framework that promotes Trainee-led research guided by Fellows in mentoring relationships. She says, "We now have 599 surgical collaborators in New Zealand (99) and Australia (500) who've experienced the processes involved in this type of study. They've learned how to build a team, get locality assessments, enter data into a REDCap database, and make sure their data is complete. That individual and collective experience builds our capacity to deliver these studies locally."

Dr Daniel Cox, a General Surgical Trainee based in Melbourne, and Chris Varghese, a fifth-year medical student from Auckland, helped lead the Australian and New Zealand arm of the study, with support from Dr Wright and other Fellows.

In 2020, Dr Cox was the Chair of VERITAS (the Victorian collaborative for Education, Research, Innovation, Training and Audit by Surgical Trainees). As part of this role, he encouraged junior doctors, Trainees and surgeons to become involved in the study and consulted with CTANZ on how to recruit nation-wide, using primarily social media and word of mouth. Dr Cox and the VERITAS trainee network, under the mentorship of Associate Professor Vijayaragavan Muralidharan, were available to help study participants with problems or questions. Dr Cox acknowledges the many surgical collaborators in Australia and New Zealand who volunteered their time and contributed to the success of the study.

Dr Cox says his experiences working on the COVIDSurg studies with CTANZ have taught him how to communicate well, manage logistics, achieve goals and share knowledge. "CTANZ is developing this supportive culture where you help the next person one rung down the research ladder up to the next step. Now that rhythm seems natural and the pattern will continue as we progress through our training."

Dr Cox's advice for Trainees and medical students is not to be intimidated by the magnitude of large trials. "The only prerequisite is that you're keen to do some research. CTANZ will help guide you, whatever level you are at. It doesn't matter if you've never done research before. CTANZ is there to guide people at various stages along the career pathway, so just get involved."

RACSTA – a strong voice for surgical Trainees

Surgical News talks to RACSTA Chair Dr Charles Jenkinson.

The Royal Australasian College of Surgeons Trainees Association (RACSTA) represents Trainees from all surgical specialties across all states and territories within Australia and Aotearoa New Zealand.

Chair Dr Charles Jenkinson said his involvement with RACSTA counted as some of the most rewarding work he has completed in his medical career. He is proud of the advocacy work RACSTA has undertaken and the many positive outcomes achieved for surgical Trainees.

Dr Jenkinson joined RACSTA as the specialty representative for cardiothoracic surgery three years ago, and soon after found himself on the Executive Committee as Communications Director. He has represented RACSTA on the Australian Medical Association (AMA) Council of Doctors in Training, focussing on industrial relation issues, and was a member of the Operating with Respect Committee, an initiative aimed at improving work behaviour and stamping out bullying, discrimination, and sexual harassment within surgery.

As Chair of RACSTA, Dr Jenkinson ensures Trainees' interests are well represented at various College committee meetings, including the Education Board, Fellowship Exam Working Group and the College Council.

"RACSTA acts as a portal of communication between Trainees and the College. Our advocacy work has achieved change in many areas, including the quality of training and the conditions under which Trainees work," Dr Jenkinson said.

"Up until fairly recently, for instance, it was difficult for Trainees to access flexible training arrangements. Working with the College, RACSTA has changed attitudes within Training Boards and hospitals – there is now a culture of acceptance and, dare I say, encouragement around it. We lobbied for arrangements that can accommodate doctors who are returning to work from parental leave, or who may have commitments around childcare or care of other relatives. Now the vast majority of Trainees who apply for flexible training are accommodated, without fear of any detriment to their future careers."

Recently, RACSTA helped to ensure Fellowship exams continued despite the upheaval around COVID-19 pandemic.

"Many Trainees contacted us recently in relation to the cancellation of the Fellowship exam. As Chair of RACSTA, I attended the Extraordinary Meeting of the College Council and represented to the Council the critical impact this would have on Trainees. We acknowledged that holding exams in this environment would take ingenuity, imagination, and agility. Our very strong working relationship with the College, meant we were one of the voices that helped Council make the decision to hold a COVID-safe Fellowship exam."

Dr Jenkinson is looking forward to becoming a Fellow soon. The RACSTA Committee has a high turn-over due to the brevity of membership; Committee members move on to life as consultant surgeons after qualifying and this is a huge challenge for RACSTA.

"RACSTA has a strong voice that is respected, and it is common in various RACS meetings that our opinion is the first one requested," he said. "However, we need Trainees to participate and be active in RACSTA to maintain its presence and effectiveness on behalf of all Trainees."

There are advocacy projects that Dr Jenkinson hopes will be delivered after he leaves.

"Transfer of leave entitlements has been another significant issue involving the state-based representatives. The previous RACSTA chair, Dr Imogen Ibbett, made significant gains but it has been a lengthy process. We are continuing to work with other bodies, including the AMA, to develop a framework around a portable leave policy that will benefit many doctors, like myself, who are required to complete training in interstate hospitals. We have it secured in some states and it's nearly complete across all states and territories, which will be a great outcome."

Dr Jenkinson said the Association welcomes all enquiries, feedback and suggestions. He encourages Trainees to contact RACSTA if they have issues, require support, or would like to know more about being active on the Committee.

"As Trainees, you are automatically members of RACSTA, but not yet members of the College," he said, hinting that this dichotomy was the subject of current advocacy work.

"RACSTA is the primary platform for Trainees to influence decisions within RACS, and improve training for both us and future generations."

RACSTA can be contacted via email: racsta@surgeons.org or call us on: +61 3 9249 1212.

Aotearoa hospital takes a novel approach to boost Māori surgeon numbers

Northland Hospital aims to increase Māori surgeons and improve Maori health outcomes.

A new position at Northland Hospital in Aotearoa New Zealand aims to increase numbers of Māori surgeons and improve health outcomes for the Māori community.

A one-year position as Te Tai Tokerau Research fellow and Clinical Senior House Officer General Surgery – Supernumerary for Learning/Research (non-SET) will provide clinical and research experience to a Māori doctor considering specialising in surgery.

The research component of the position will be conducted according to Kaupapa Māori principles with an emphasis on building relationships and connections within the broader community and on developing a wider understanding of health from a Māori perspective.

With only 15 Indigenous surgeons working in New Zealand, it is also hoped the position will ultimately increase Māori participation in the profession.

Māori general surgeon Maxine Ronald (Nga Puhi, Ngati Wai, Ngati Hine) developed the position in conjunction with the Māori Health Directorate and Northland District Health Board. The initiative was championed by the late Māori Health General Manager Harold Wereta.

Dr Ronald said she hoped it would play a part in creating a more equitable health system for the region's Māori community.

"Like for almost all lndigenous communities around the world, Māori people in New Zealand suffer from health inequities. We suffer poorer outcomes in surgery when it comes to trauma, cancer and more benign operations such as amputations caused by vascular problems and diabetes."

This inequity and the need to address its causes through the health care and educational systems has been recognised by RACS in its Te Rautaki Māori RACS Maori Health Strategy and Action Plan 2020-2023, which highlights the statement:

"Colonization, racism and privilege are fundamental determinants of Indigenous health that are also deeply embedded in Western medical education. To contribute effectively to Indigenous health development, medical education institutions must engage in decolonisation processes and address racism and privilege at curricular and institutional levels. Indigenous health curricula must be formalised and comprehensive and must be consistently reinforced in all educational environments." *(Educating for Indigenous Health Equity: An International Consensus Statement 2019).*

Dr Maxine Ronald with a patient

RACS health strategy and action plan aims to build a culturally safe and competent surgical workforce and to achieve the vision of Māori health equity.

As Chair of the RACS Indigenous Health Committee, Dr Ronald believes that part of the solution to health inequity lies in ensuring Māori people are supported to become part of the medical profession.

"As there is a low proportion of surgeons who identify as Māori, young Indigenous people are not seeing themselves reflected in the surgical workforce. So, they don't consider it to be an option for them.

"We want to create a pipeline for junior doctors who know they will be supported during their surgery training and beyond. Our aim is to create a training environment free from racism, where Trainees are secure in the knowledge that their cultural needs will be respected in their workplace. This program demonstrates in a concrete way that we are committed to supporting a Māori interested in a surgical career. We are creating role models for the future," Dr Ronald said.

The participation of Māori surgeons will build trust and understanding in the profession between the wider health system within the Māori community. It will increase understanding of the health care needs of Indigenous people,

Dr Moea Nimmo

creating greater uptake of preventative health measures, and improving outcomes.

Dr Ronald says, "I think it is important for the community to see itself reflected in the surgical workforce, to have people of a similar background involved in their medical experience, and this will improve health equity and outcomes. By being cared for by someone with a similar background, there is a greater level of trust and a shared understanding. It also creates a culture of cultural awareness."

The program has already reaped benefits, with the first successful candidate undertaking research into barriers Māori face in accessing bowel cancer screening.

In the past 12 months, Dr Moea Nimmo has worked closely with the Northland Māori community to explore the reasons why testing rates for bowel cancer were not reaching target levels and find ways to improve participation rates.

"In many ways and for many people, the existing bowel screening program is perfect. People can receive their kits, collect a sample and send it off, all from the comfort of their home. But while that is the case for people who live in cities, who read English and are enrolled with a local GP, it is not necessarily the case for these communities, which are quite isolated and where there are language barriers," Dr Nimmo said.

"In my research, I spoke with small groups of Māori people to get their opinions, ideas and feelings about how they would prefer the delivery of the bowel screening program to look. The bottom line for me was that the screening program wasn't necessarily designed for those living in rural communities and didn't take into account the barriers these people might face."

As a result of the research, Dr Nimmo set out recommendations to increase participation in the screening program, and she hopes that her work will save lives within the Māori and broader community.

Along with contributing to the future health of the Māori community, she said she is grateful for the professional opportunities the position provided.

"It was an absolute privilege to work with Maxine and develop research skills that will be really valuable in my career. I had the opportunity to work in an area that I'm passionate about, and hopefully to make a difference. It was also a real highlight to work with the local community," she said.

Dr Nimmo will now apply for surgical training and if successful, she would like to inspire future members of the Māori community to follow in her footsteps.

"I would love to be a role model for other aspiring surgeons," she said.

The position follows the introduction of the pilot Indigenous Surgical Pathway Program at the Royal Darwin Hospital in Australia's Northern Territory, which aims to boost the number of Indigenous surgeons.

Dr Ronald encouraged other New Zealand hospitals to consider introducing a similar position to ensure the benefits were experienced by Māori across the country.

"We all know about the health inequities for Māori and as surgeons, we cannot say it is not a problem in our backyard. It is something we all need to address. A position like the one at Northland is something that all hospitals can achieve, and you don't need a Māori surgeon to do this," she said.

The RACS Māori Health Advisory Group can provide information and support to any hospitals interested in introducing a similar position. More details on the position and on how to apply are available at: www.kiwihealthjobs.com

Portrait of Sir John Ramsay by Hugh Ramsay 1898

This portrait was donated to the College in 1997 by Diana Ramsay AO in memory of her late husband, James Stewart Ramsay AO, son of Sir John Ramsay. The work is the earliest portrait of a Fellow in the College's collection.

John Ramsay (1872–1944) was born in Glasgow. The family migrated to Australia in 1878 and settled in Melbourne. Ramsay attended Wesley College and the University of Melbourne, graduating with a Bachelor of Medicine, Bachelor of Surgery in 1893.

After a year at the (Royal) Melbourne Hospital and time spent in Auckland, he was appointed as House Surgeon at the Launceston General Hospital. He was to retain close ties with the hospital until his death. When he arrived at the hospital, Ramsay was influenced by the work of the innovative Surgeon-Superintendent, Dr Francis Drake. In 1896, Drake and Ramsay participated in a demonstration of X-rays by the homeopathic pharmacist and photographer, Frank Styant Browne. In the same year, Drake purchased the hospital's first X-ray machine.

Ramsay succeeded Drake in 1898 and pursued his interest in X-rays, especially the use of deep X-ray therapy to treat cancer. Until the appointment of an X-ray operator in 1914, doctors made all the X-rays for medical diagnosis and this, coupled with Ramsay's experiments in deep X-ray therapy, resulted in permanent scarring on his face and hands.

Ramsay's work at the Launceston General was exceptional. He was an early advocate of the theories of Lister, and after obtaining his Master of Surgery in 1902, he visited medical centres in America and the United Kingdom. When he returned, the Launceston General Hospital was transformed by the erection of a suite of operating rooms (1905–1906) on top of a service block with a hydraulic lift for moving patients. Ramsay pioneered the use of intravenous fluid replacement for surgery of the prostate and investigated pancreatic grafting for patients with diabetes. A prolific writer, from 1898 he produced 24 papers, including several about the treatment of hydatid disease. In 1906, he was the first surgeon in Australia to resuscitate the heart by massage when he opened the thorax of a patient who had died on the table. He also designed and built his own hospital – St Margaret's Hospital in Launceston.

During World War I, Ramsay worked at the Hornsey Military Hospital and the 12th Australian General Hospital. He continued to work as Honorary Consulting Surgeon at the Launceston General Hospital and his administrative skills were utilised when he joined the hospital's Board of Management in 1929. He was appointed Chairman in 1933. A Foundation Fellow of the Royal Australasian College of Surgeons, he was associated with a large number of organisations, including Red Cross and the Medical Council of Tasmania. Ramsay was knighted in 1939, the first medical practitioner in Tasmania to receive this honour.

The artist

Sir John's younger brother, Hugh Ramsay (1877-1906), is generally regarded as the finest portrait painter Australia has produced. Although his brief but brilliant career was tragically cut short by his early death from tuberculosis, he exercised a profound influence on Australian artists. He attended Essendon Grammar School and the National Gallery schools, studying painting under Bernard Hall and Frederick McCubbin. He also found a friend and mentor in Sir John Longstaff.

In 1900, Hugh Ramsay departed for Europe and took up residence in a dilapidated artist's studio in Montparnasse. Here he worked tirelessly for almost two years, achieving international acclaim with his exhibition at the New Salon in 1902.

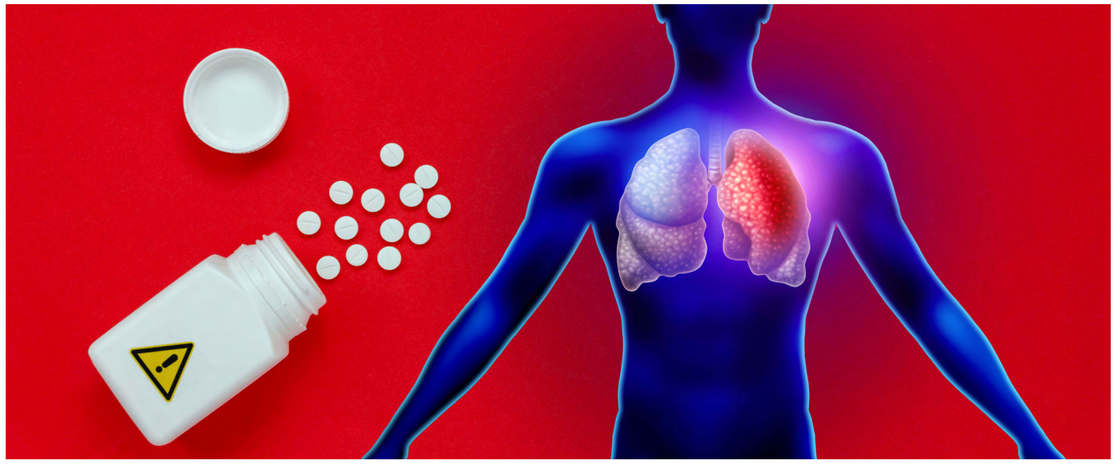
Elizabeth Milford, RACS Archivist

A recent retrospective of Hugh Ramsay was held at the National Gallery of Australia in 2020. See more of his work here: https://nga.gov.au/ramsay/

Another collection of his work can be found at the Potter Museum of Art at the University of Melbourne: https://art-museum.unimelb.edu.au/collection/the-hugh-ramsay-collection/

The James Ramsay Project Grant supports surgeons and Trainees to undertake an innovative project or purchase state-of-the-art equipment. Sir John's son, James Ramsay AO, donated $60,000 upon the 60th anniversary of RACS to establish the James Ramsay Fellowship for Provincial Surgeons, now known as the James Ramsay Project Grant. For more information and to apply go to: https://www.surgeons.org/en/Resources/member-benefits/lifelong-learning/scholarships-and-grants-program/all-scholarships-and-grants/james-ramsay-project-grant

This extract is an enhanced version of the entry found in *Unveiling the Collections* by Geoffrey Down and Elizabeth Milford. The book can be ordered via the pdf form: https://www.surgeons.org/about-racs/about-the-college-of-surgeons/our-heritage-archives/archives



Case note review

Death occurred after minor foot surgery on a patient prescribed Lyrica.

Important follow-up regarding use of Lyrica in November 2020 ANZASM Case of the Month

The November 2020, the Australia and New Zealand Audit of Surgical Mortality (ANZASM) case of the month reported a death that occurred after minor foot surgery on a patient prescribed Lyrica.

This follow-up report is being published because of further information that has since emerged, which has led to medication alerts in Australia and overseas. These multiple medication alerts suggest the use of Lyrica in settings such as this case is associated with a risk of severe respiratory depression. Many surgeons will not be familiar with the interactions when Lyrica is used in combination with other drugs and so may not be fully aware of the associated risks.

This additional report emphasises ANZASM's important educational role. It demonstrates the great value of ANZASM's independent external review.

A middle-aged patient with respiratory problems (prior treatment for sleep apnoea) had previously undergone a sleeve gastrectomy but was still obese. Medications on admission included amitriptyline, mirtazapine and pregabalin (Lyrica).

A nerve block of ropivacaine was administered preoperatively and hydromorphine patient-controlled analgesia (PCA) prescribed for use after return to the ward. Supplementary oxygen was required. Subsequent breakthrough pain was managed with anti-depressant drugs, Lyrica and other opioids. Some10 hours later the patient was found unresponsive and unable to be resuscitated.

The second-line assessor (SLA) observed that the preoperative assessment failed to document important risk factors. In addition, some aspects of the postoperative management were inadequate. The SLA attributed the death to drug-induced respiratory arrest likely to be secondary to the use of Lyrica in conjunction with other drugs including opioids. The SLA recorded the death as preventable.

This case of the month cited two related reports. The first was a 2014 South Australian coronial inquest that concluded the death was a result of a respiratory arrest following ankle surgery in the context of obesity and the use of Lyrica. The second was a December 2019 US FDA Drug Safety Communication that noted 'serious breathing problems' when Lyrica was used with other medications. Since then, in February 2021, the UK Medicine and HealthCare Products Regulatory Agency has issued a similar alert warning of the rare but significant risk of respiratory depression.

Additionally, and in response to this case of the month, the Western Australian Department of Health undertook its own internal review. After an extensive review the Western Australian Department of Health issued a medication safety alert in late May 2021. Safer Care Victoria has since issued a similar alert.

Although the Western Australian medication safety alert includes links to relevant Australian Therapeutic Goods Administration product information, it is focused on drug abuse and the pertinent information relating to the issue raised in this case is likely to be missed by clinicians.

The use of Lyrica in conjunction with other opioids is a widespread practice. It is now clear that this combination can cause severe respiratory depression. The magnitude of this risk has prompted publication of a number of national medication alerts.

ANZASM wishes to highlight this risk to all surgeons. It is suggested that surgeons discuss this risk with their anaesthetic colleagues and alert the relevant committee at their hospital.

Professor Guy Maddern, Surgical Director of Research and Evaluation incorporating ASERNIP-S

How to mend a broken heart

Dr Krish Chaudhuri's love for the medical profession started early, while riffling through his late mother's nursing textbooks. Achieving 99.95 percent in his Victorian Certificate of Education (VCE) exams and a full scholarship to study medicine at Melbourne's Monash University sealed the deal.

Dr Chaudhuri is a Cardiothoracic surgeon at the GreenLane Cardiothoracic Surgical Unit at Auckland City Hospital.

As a junior doctor, Dr Chaudhuri travelled regularly to Kolkata, India, to visit an orphanage, where his mother had grown up. During one visit at the orphanage, he met a young girl who was suffering from cyanotic congenital heart disease. A surgeon – based in Bangalore – was going to operate on the girl and Dr Chaudhuri was invited to be part of the team. "I spent five weeks in Bangalore and that clinched my decision. I like the style of operating in cardiac surgery – the anatomy, the pathophysiology as well as the outcomes for the patients," Dr Chaudhuri says.

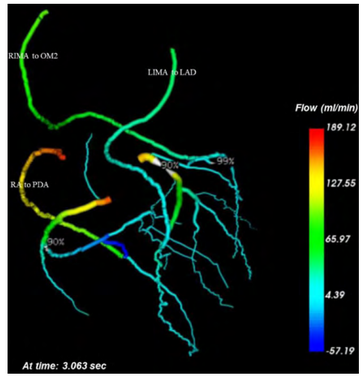
In 2017, Dr Chaudhuri was awarded the three-year Surgeon Scientist Scholarship that supports Fellows and Trainees to undertake a PhD. He had first heard about the scholarship from a surgical Fellow when interning at the Alfred Hospital in Melbourne. Around the same time, he was reading a book called Surgeon-Scientist by Prof Graham L Hill. The title stuck with him – it was the same as the name of the scholarship. He completed a Master's degree in research and travelled to the US – working at John Hopkins, Massachusetts General, Cleveland Clinic, and other small hospitals. While in the UK he worked at the Papworth Centre and the Liverpool Hospital.

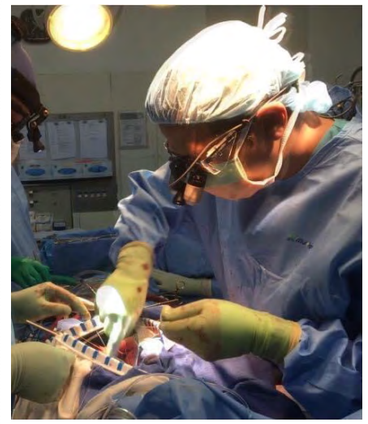
Dr Chaudhuri's research is in COMCAB – Computer Modelling Informed Coronary Artery Bypass graft surgery. "I've made a predictive computer model, the basic premise of which is that it can tell a cardiac surgeon the best way to arrange the bypass grafts for a particular patient with coronary artery disease. The computer model helps to avoid situations where there are poor flows going down the bypass grafts due to competitive flow going down the native coronary artery or steal of flows between grafts. This is particularly important for total arterial revascularisation using anaortic techniques requiring multiple composite grafts."

Dr Chaudhuri's study demonstrated that everyone's diseased coronary circulation is different and unique.

Thus, surgical revascularisation requires a patient-specific approach. The computer model was able to determine ahead of time whether a grafting arrangement would be unsatisfactory, satisfactory, or optimal – based on mean graft flows and pulsatility indices. Most of the surgeons were receptive to the computer models' information and suggestions.

The computer model can help decrease uncertainty by providing predictive quantification and help in decision making. It can be used as a tool to learn from, as computer-aided decision-making is the way of the future.





"My study is on a spectrum of level 3 or 4 automation where a computer narrows the selection of alternatives down to a few or even suggests one. My model says out of all the grafting arrangements that these are the options that will work the best or won't work. The surgeons can then decide what works best for them," Dr Chaudhuri says.

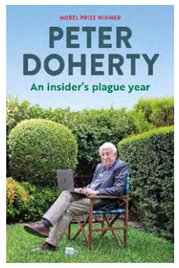
Outside of work, Dr Chaudhuri spends time building and deconstructing Legos, watching sports, hiking, socialising with friends, and being immersed in everything space related.

"I've always been interested in space exploration, especially astronauts going to the moon. I read books and watch movies about it. When I was in the US, I visited NASA and various space centres, including buying a replica astronaut helmet, which has pride of place in my study. I also have woken up early to see a rocket being launched during my time there," Dr Chaudhuri says.

Nobel Laureates and some unsung heroes

There are many unsung heroes like Pinder, the Greek lyrical poet and thinker of 450 BC. These are their stories.

OP – LXXI (71)



I recently spoke to Peter Doherty, Nobel laureate and author of *An Insider's Plague Year*. He said, "Felix, I will drop a signed copy to you."

Peter is a member of the Parkville brigade, a group of medical professionals ranging from Nobel Laureates to scientific academics and university hierarchy. How did I sneak in?

Peter, Australian of the Year in 1997, presented a lecture at the university focussing on T-cells. He concluded with this humble remark: "I just happened to get it right 40 years ago".

Peter and Rolf Martin Zinkernagel laid the foundation in establishing the mechanism of cellular immune responses. Their studies and their experimental work focussed on lymphocytes to recognise both the self-molecule and histocompatibility antigen. With the killer T-cells destroying infected cells – this became the basis for immunity and vaccinations as we presently experience.

Another Nobel Laureate was Sir Peter Medawar, whose research focussed on transplantation in the mid-40s. As Professor of Zoology at the University of Birmingham he became Director of the National Institute for Medical Research at Mill Hill.

Now let me diverge for a moment because the words Mill Hill have a strong plastic surgical link with Benny Rank. He gave this name to his new home in Heidelberg in the 1950s. Could Benny have worked at Barnet Hospital, next door to Mill Hill? And was he aware of the Mill Hill and the Oxford English Dictionary (OED) connection? The Winchester novel *The Surgeon of Crowthorne* describes Murray the lexicographer, who compiled a list of words and meanings through letters to the editor based on Johnson's original dictionary of 1755. The main contributor was a retired American army surgeon called Minor, housed in a psychiatric institution for one of his misdemeanours in the East End of London. His American war pension allowed him to execute his other foible, a love of old books and old words and his backyard storage shed had multiple boxes for multiple words all alphabetically aligned.

Sir Frank MacFarlane Burnet was another Australian virologist who was best known for his contributions to immunology and also for developing the theory of clonal selection.

He established the principle of culturing viruses using hen's eggs, something I think of regularly when I eat one. This is one of the few facts I can recall from his college pathology lectures for Fellows.

Now let us pass onto some unsung heroes:

Professor Thomas GIBSON was a plastic surgeon from Canniesburn in Scotland. Gibson made the initial observation about graft rejection and its subsequent success with repeat grafting after a delay. His observations originated from seeing the Pinch grafting technique becoming successful on the second bounce.

Gibson's is first paper, "The Fate of Skin Homografts in Man", was co-authored with Nobel prize-winner Sir Peter Medawar in the *Journal of Anatomy* in 1943. In 1986, Gibson's second paper, "The Second Effect" appeared in the *British Journal of Plastic Surgery*. In it he reminisced about transplantation after that initial paper with Medawar. After winning the Nobel Prize, Medawar apparently personally wrote to Tom Gibson acknowledging this link.

Biologists Rupert Billingham and Robert L Brent, along with Medawar, demonstrated it was possible to induce selective immune acceptance of skin grafts in mice. This became the basis of what Tom Gibson said was "the establishment of immune tolerance", and I am grateful to both Earle Brown and Wayne Morrison, both Canniesburn graduates, for alerting me to these facts.

Rosalind Franklin and the DNA crick phenomena

Rosalind Franklin's observation as an X-ray crystallographer training in Paris under Jacques Mering, was significant. Photograph 51, taken by her student Raymond Gosling, became central to Francis Crick's laureate success in the DNA and RNA story. The double helix spiral idea was an additional observation from the model on Crick's desk of a spiral staircase (illustrated below) which seemed to unify all observations in the development of this concept.

This became the basis for the shared Nobel Prize with James Watson and Maurice Wilkins in 1962. There was no reference to Franklin until recently, regretfully after her death, and no Nobel laureates are given posthumously, despite Watson's appeal.

Franklin really deserves a Nobel Prize in absentia.

Peter Doherty recommended *The Dark Lady of DNA* written by Brenda Maddock for more on this subject.

Heatley in the penicillin story

My colleague Andrew Sizeland told me recently about Norman Heatley. Oxford University bestowed upon him an Honorary Doctor of Medicine, the first ever in its 800 years, for his unrecognised contribution to the development of penicillin. He was one of the scientific quartet who cultured mould in multiple receptacles in the lab – bedpans were commonly available. Alexander Fleming's 1928 observation of irregular staphylococcus growth on a petri dish confirmed the evidence of bacterial necrosis caused by a mould.

This all began from some incidental finding of an aerial spore through an open window at St Mary's during an August holiday long weekend. Fleming wrote his observations up in the *British Journal of Experimental Pathology* in 1938. Florey, at the Dunn School of Pathology at Oxford, reviewed Fleming's old articles and subsequently, with Ernst Chain, a wartime German refugee biochemist, they unravelled the penicillin mystery which led to its therapeutic applications. This trio – Florey, Fleming and Chain – received the Nobel Prize in 1945.

The financial constraints in wartime Britain were such that only £25 was allocated to develop the penicillin drug. Chain suggested seeking a patent but Florey disagreed, saying it was for the good of humanity.

Heatley is the *unsung* hero in this story, with an ingenious mind, mechanical aptitude and a biochemical degree. He worked out how to salvage the penicillin concentrate from beneath the growing mould. This soluble extract became the basis for the first clinical trial at the Radcliffe Infirmary.

Florey and Heatley sought funding from American drug companies, and so they flew, shivering, in a Lancaster bomber to America via Spain in 1942. They had Penicillin mould sewn into the lining of their overcoats should they be captured by the Germans. The Americans relished the concept of a new wonder drug, as their war commitment suddenly arose after the Pearl Harbour episode on 8 December 1941.

Curiously there was a delay of six weeks between the arrival of the mould, the agreement being signed and production commencing. As an aside, another lucky stroke was that a lab tech stumbled across a decaying cantaloupe at one of the New York markets and Florey said this was superior to anything he had used to date.

Merck and Pfizer, among others, caused the delay as they had secretly applied for American patents, which were successful. Paradoxically, the British Government then had to pay royalties to the American drug firms for their use of their own discovery of penicillin. Fleming and Florey received international awards while Heatley's contribution was left unrecognised. Heatley's recalled his student days at Cambridge, where her saw the simple observation by Louis Pasteur etched in stone: *La chance ne sourit qu'aux esprits bien préparés* – no profit if you are not prepared.

Associate Professor
Felix Behan

Royal Australasian College of Surgeons
Foundation for Surgery

Thank you for your extraordinary compassion and generous support to the Foundation for Surgery in August and September.

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

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

Gold/Silver

Mr John Albrecht	Anonymous donor	Dr Durham Smith
Mr William Hallwright	Anonymous donor	Mr Hugh Tighe
Mr Henley Harrison	Anonymous donor	
Mr Mark Hehir	Mr Andrew Roberts	

Bronze

Miss Sophia Ao	Mr Simon Ceber	Mr Dennis Gyomber	Mr Bernard McCusker	Anonymous donor
Mr Gordon Arthur	Dr Jennifer Chambers	Mr George Halliday	Mr Richard McMullin	Anonymous donor
Dr Margaret Beevors	Ms Helen Christidis	Mr Brian Haymet	The University of Melbourne	Assoc Prof Prem Rashid
Prof Michael Besser	Anonymous donor	Mr Nigel Henderson	Dr Tracey Merriman	Dr Henry Slater
Mr Robert Black	Anonymous donor	Anonymous donor	Mr Neville Minnis	Mr Graeme Thompson
Mr Laszlo Borbely	Mr Harvey Coates	Prof Alan Kerr	Dr Cindy Molloy	Mr Andrew Thompson
Miss Ingra Bringmann	Mr David Cottier	Mr Doug Knight	The University of Notre Dame	Anonymous donor
Mr Stephen Brough	Mr James Davidson	Dr Henry Knipe	Prof Helen O'Connell	Mr Simon Tratt
Ms Belinda Brown	Deakin University	Mr Matthew Lawrence	Mr Olubukola Oloruntoba	Anonymous donor
Assoc Prof Anthony Buzzard	Mr James Drummond	Mr Tristan Leech	Prof Richard Page	Dr Pauline Waites
Mr Peter Byrne	Ms Jordi Elliott	Mr K Lever	Assoc Prof Marinis Pirpiris	Anonymous donor
Dr Amy Cao	Mr John Farlow	Mr Waisani Mar		Anonymous donor
Mr William Castleden	Mr GarryGrossbard	Dr Ian Martin		Dr James Wynne
	Mr Stan Guilfoyle	Mrs Elizabeth Mazzei		Anonymous Donations

All costs for the Foundation for Surgery are provided for by the College so that that 100% of your donation can achieve its maximum benefit to the community.

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

100% of your donation assists in addressing critical surgical need

REGISTERED CHARITY

November Annual Academic Surgery Conference 2021

Register Now: surgeons.eventsair.com/naasc21/registration

SAVE THE DATE

Date: 4 November 2021
Venue: Virtual
Time: 9:00am - 5:00pm Australian Central Daylight Time

Presentations on:

- CTANZ Update
- Trends and Burden of Firearm Injuries Among Children and Adolescents: A National Perspective
- The early, the mid and the late academic career
- Role of RACS in supporting Academic Careers
- Clinican Researcher Pathways
- Strategies to address surgical disparity in rural America
- Predatory Publishing
- Editorial and Reviewers' Duties
- The role of interdisciplinary research in striving for clinical excellence

For more information:
W: tinyurl.com/NAASC2021
E: academic.surgery@surgeons.org
T: +61 8 8219 0900

#SAS2021 #NAASC2021

Royal Australasian College of Surgeons

Medtronic

"Strength lies in the differences, not the similarities."

Stephen R. Covey

A strong workplace is an accepting workplace

Speak in total confidence to a Converge International consultant.

Australia 1300 our eap (1300 687 327) | **New Zealand** 0800 666 367

convergeinternational.com.au

Converge international