SurgicalNews

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Royal Australasian
College of Surgeons

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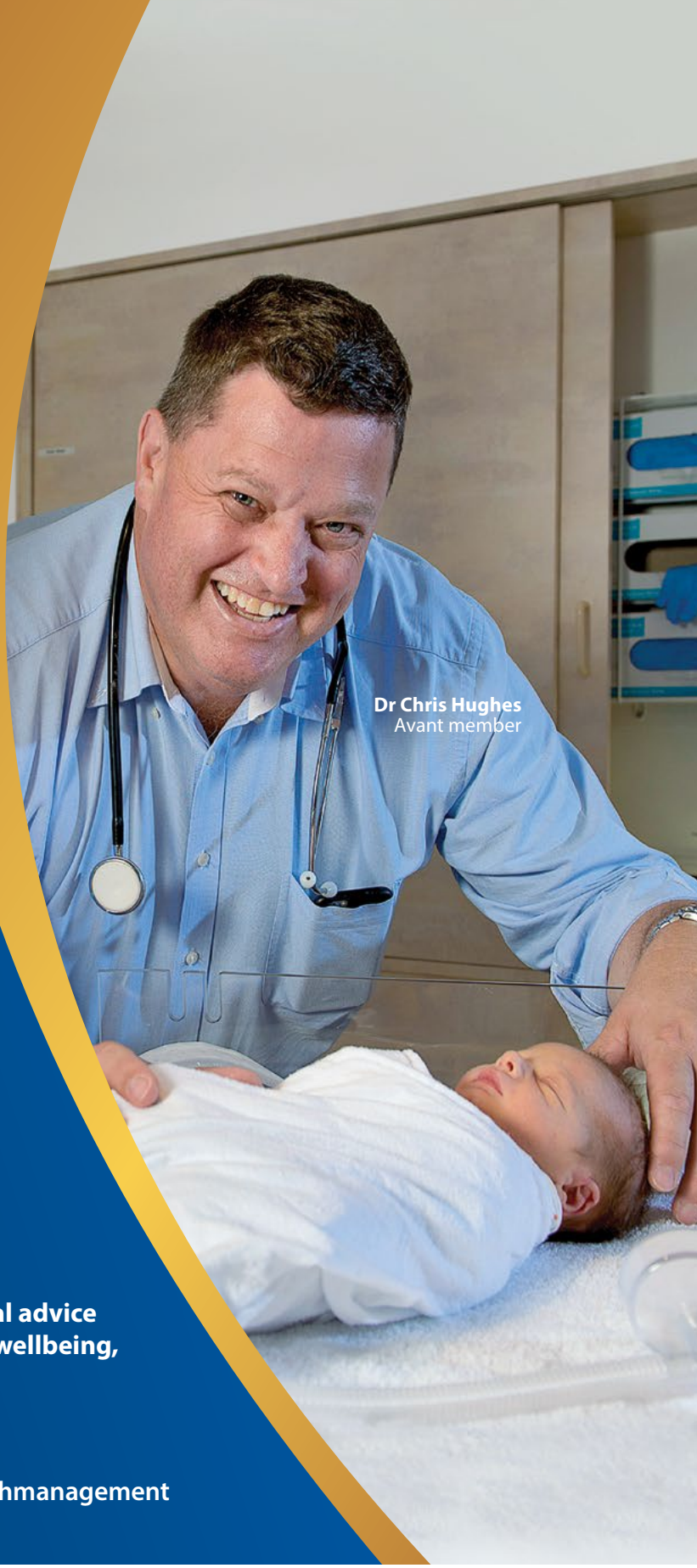

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RACS leadership

Spotlight on

Embracing diversity

Articles of interest

Scholarship

Global Health

Research

Historical

Cover image: *Byron Morning* 20x30 cm. Watercolour on Fabirano paper.
Artist: Professor Mohamed Khadra, Urological Surgeon, NSW, Australia.

"COVID 19 has given us all a chance to see our country through different lens. Instead of Bali and Fiji, our holidays have been in Australia. This was an early morning in the Byron Bay hinterland near Bangalow. The yellows of the dawn sky combined with the layer upon layer of the foreground inspired me to think of the possibilities ahead and the joy of the new day and the sun's promise of warmth."

Professor Khadra's art will be part of a virtual gallery that will be displayed during the Royal Australasian College of Surgeons Annual Scientific Congress 2021. The Congress has the theme of 'Celebrating the art of surgery in a time of disruption'. It combines the science of medicine with the creative elements required to become a great surgeon. The theme also celebrates the important contribution to the arts by surgeons, who continue to excel not only with a scalpel but also in music, painting, design, sculpture, writing and other creative pursuits.

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President's perspective

Due to the lockdowns across Victoria, the February meeting of Council was held predominantly outside Melbourne for the first time in the history of the Royal Australasian College of Surgeons (RACS). Our brand new South Australian office was the meeting point for the majority of the Councillors, with small hubs in our offices in Wellington, Melbourne and Sydney, where others assembled to join the meeting.

While we have held many face-to-face meetings over the years and have also become accustomed to virtual meetings, the hybrid approach used for this Council meeting was another first. Arranging the logistics of this, particularly at such short notice, was no small feat and I would like to thank the many people, especially staff in Melbourne and Adelaide, who ensured that the meeting ran smoothly.

At the meeting, elections were held for office-bearing positions. Congratulations to Dr Sally Langley who will be the next RACS President, and to Dr Lawrie Malisano who will take on the role of vice president. Sally and Lawrie will commence their leadership roles during the RACS Annual Scientific Congress (ASC) in May.

During the meeting, the RACS Business Plan for 2021 was approved. This includes information on the planned upgrades to the Spring Street offices in Melbourne.

The previously approved plans agreed on before the onset of COVID-19 have been put on hold and our position needs to be reassessed. Many of our Melbourne staff have begun returning to work, but we expect the working environment to look significantly different to 18 months ago. As such, Council has decided to re-evaluate the whole project and we expect that any new proposals will differ significantly from what was originally envisaged.

The meeting also saw the renaming of various boards and committees, and the establishment of a new Health Policy and Advocacy Committee (HPAC). The New Zealand National Board will

now be known as the Aotearoa New Zealand National Committee (AoNZNC), and the Professional Development and Standards Board has been renamed to the Professional Standards and Advocacy Committee. The name changes reflect a decision in recent years to move away from using the term 'board' to describe our various governing bodies, with the exception of the Board of Council.

The role of HPAC will be to identify and advise on advocacy initiatives and priorities. It will ultimately work with the offices of the president and vice president in managing health policy and political advocacy. The committee will meet regularly, and it is expected that there will also be a significant amount of out-of-session work. This will allow the College to generate content quickly and respond to the often very short turnaround times of government consultations.

Another flagship area of our Business Plan is the Rural Health Equity Strategic Action Plan. For those who are unaware, the Strategic Action Plan embeds actions for rural health equity in all RACS activities and across all specialties and is available on our website.

Thank you to Dr Bridget Clancy and the Rural Surgery Section Committee, who were instrumental in developing this key RACS strategic action plan. Council has now approved a Rural Health Equity Steering Committee for managing the principles outlined in the action plan and prioritising the actions for implementation.

Since the Council meeting, we celebrated International Women's Day in March and RACS offices held various events across Australia and New Zealand. As you know, the College has made a number of specific commitments to promote greater gender diversity and we are working towards these as part of our Building Respect and Improving Patient Safety initiative. This work is incredibly important and will remain an ongoing priority for the College, particularly in the context of the national and global conversations that are occurring regarding gender equity, discrimination, bullying and sexual harassment.

I was pleased to see a number of our highly talented female surgeons profiled through our online social media campaign during International Women's Day.

I hope this type of visibility will inspire the next generation of female surgeons and help us achieve the goals we aspire towards.

I would also like to announce that the President's Meeting Room in Melbourne is to be renamed the Anne Kolbe Room, in honour of our first female president. More changes are being discussed to recognise our diverse Fellowship.

I would like to draw your attention to our updated complaints process. As many of you know, our position as a member organisation does not provide us with the powers that a hospital or medical centre that employs surgeons has, or that a regulator such as the Medical Council of New Zealand (MCNZ) or the Australian Health Practitioner Regulation Agency (Ahpra) holds.

With this in mind, we have taken steps to revise our approach. We learned from the way we used to address complaints. We have developed a process that supports professionalism in surgery and makes sure that all complaints and concerns are handled by the agency best placed to manage them.

I would like to finish by thanking you all for the support that you have extended to me over the past two years. This was especially appreciated during the extraordinarily difficult circumstances we faced in 2020 and 2021.

I have had the great honour of working with some exceptional people during my time on Council. There are far too many to name, but I would like to make particular mention of the two vice presidents that served during my term, Mr Richard Perry and Associate Professor Julie Mundy, as well as Associate Professor Phill Carson, Censor-in-Chief, who, like Julie and myself, will be finishing his time on Council during the RACS ASC in May.

Finally, I wish Sally and Lawrie all the best in leading our College forward. I have known them both for many years, and they are incredibly passionate about surgical standards and education. They will make exceptional leaders of our College, and I am excited to see what RACS will achieve under their guidance.

I am looking forward to seeing many of you at the RACS ASC. ■

Images

Above:

Associate Professor Phillip Carson, Associate Professor Julie Mundy and Dr Tony Sparnon.

Over page:

Dr Sparnon with Councillors.

Front: Mr Adrian Anthony, Dr Sarah Coll, Associate Professor Julie Mundy.

Second row: Dr Pecky De Silva (Observer), Professor Deborah Bailey, Dr Tony Sparnon, Professor Henry Woo.

Third row: Professor Christopher Pyke, Dr John Quinn (Executive Director for Surgical Affairs Australia), Dr Lawrence Malisano, Associate Professor Phillip Carson, Professor David Fletcher, Professor Owen Ung, Dr Christine Lai.

Back corner: Dr Gregory Witherow.

Dr Tony Sparnon
President

RACS complaints process updated

Supportive, confidential, respectful, and non-judgmental – these are the words that best describe our new and enhanced 2021 complaints process.

As an organisation that furthers the interests of our members by supporting their ongoing development and maintenance of expertise, the College is in a unique position when it comes to dealing with enquiries regarding incidents and reports of poor conduct and inappropriate behaviour. We want to make sure that your concerns and complaints are heard and addressed.

Our position as a member organisation does not provide us with the powers that a hospital that employs surgeons has, or that a regulator such as the Medical Council of New Zealand (MCNZ) or the Australian Health Practitioner Regulation Agency (Ahpra) holds.

We simply do not have the legal powers, nor the resources, to effectively and efficiently investigate complaints, other than involving our own employees. We do not control the workplace of the complainant, respondent, or witnesses, and cannot conduct a sound, defensible, prompt fact-finding investigation. Our attempts to do so in the past have created legal challenges and have resulted in the complainants being confused and dissatisfied with the process and outcome. This inevitably led to some losing trust in the College.

We have taken steps to revise our approach. We learned from the way we used to address complaints and have developed a process that supports professionalism in surgery and ensures all complaints and concerns are handled by the agency best placed to manage them.

Our new complaints framework balances our:

- duty of care to our Trainees, Specialist International Medical Graduates (SIMGs) and surgeons to provide a safe environment
- responsibility to provide a procedurally fair and timely process
- professional commitment to build a culture of respect

- legal and ethical responsibilities as a College

While we must still work within the limitations that surround the way we can manage enquiries, reports and formal complaints, our new approach centres around offering our Fellows, Trainees and SIMGs support and guidance throughout our process. This applies to all types of reports we receive, whether they are out of our scope or better handled by an employer, a regulatory agency or a health complaints commission.

In 2020, we asked an external expert to review our updated complaints approach. Areas specifically reviewed were visibility, accessibility, responsiveness, restorative approach, independence, confidentiality, accountability, monitoring with a centralised, anonymous data collection with an analysis process, protection for those who make the complaint, and prevention of victimisation. You can read the full report and recommendations on our website.

While the findings were supportive of the changes we have made, several refinements and recommendations were suggested and are being addressed. You can read the full report and recommendations on our website at surgeons.org/about-racs/feedback-and-complaints.

How do we act when we receive a report?
Our new approach, which we have been trialling with success since late 2019, aims to build a culture of respect and trust between you and the College. Our process is informal and non-judgmental.

When you contact us, we discuss your options together and help you decide what to do next. We might refer you to another agency that has the necessary power to look into your concern or formal complaint. We will continue to keep in contact with you and provide support and guidance as you undergo that agency's process.

The details and outcome are always kept confidential. Even if you decide not to make a formal complaint, we urge you to raise any concerns you have with us, so we can look into the matter and help you resolve it.

If you prefer not to be identified, we will respect your wishes and will progress your report as long as we know who you are. Please be assured that we take each matter that comes to us seriously and treat each one with the utmost confidentiality and sensitivity.

What do we do to address a report?
We are committed to building a culture of respect in surgery and improving patient safety through identifying and addressing unacceptable behaviour. Unacceptable behaviour not only adversely affects co-workers, but also our patients. In instances where unacceptable behaviour is identified and a report is submitted to the College or information provided to us, we encourage a profession-led conversation to resolve the matter.

This approach is led by our surgical advisors, Dr Sarah Rennie and Professor Spencer Beasley in New Zealand, and in Australia, our Executive Director for Surgical Affairs, Dr John Quinn. We have found this approach, which is collegial and non-judgmental, encourages self-reflection and behavioural change.

Let me emphasise that this approach is not all-encompassing and will not be appropriate for all types of complaints or concerns. We assess each report based on information we receive and will progress each matter accordingly. We also work in tandem with healthcare services and employers of surgeons to support professionalism by collaborating for change.

As I mentioned above, sometimes the best approach is for us to refer the matter to the agency that will be able to act and carry out an investigation; with us helping you navigate these external complaints processes and staying in touch with you from start to finish.

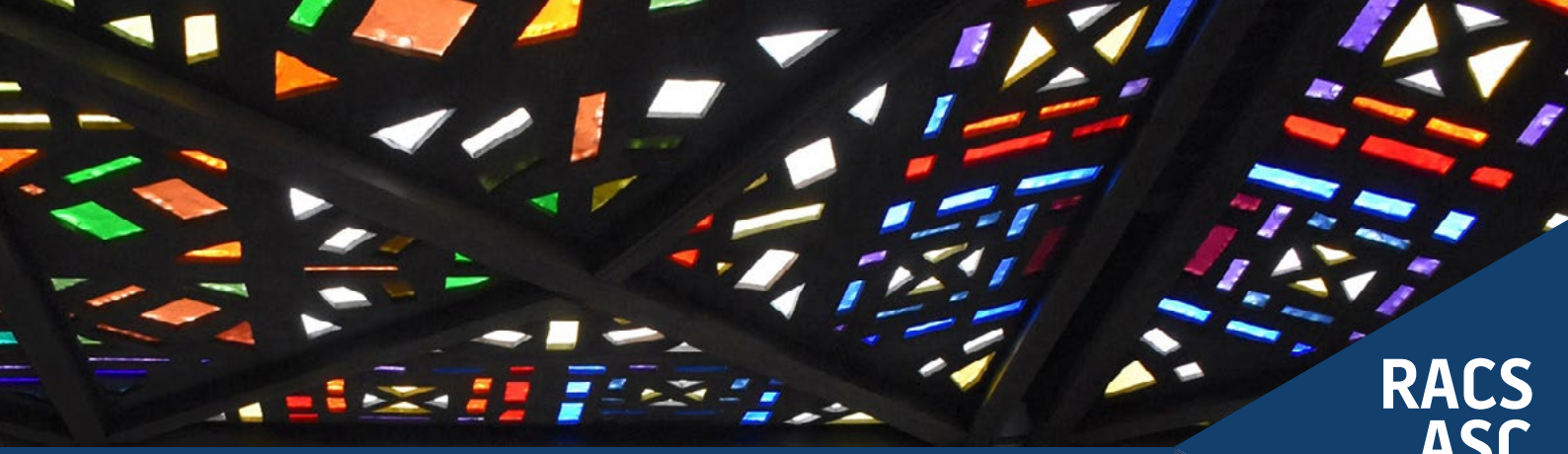
It is in all our interests to ensure our Fellows, Trainees and SIMGs are provided with a safe and respectful training and working environment. The core of our work is to provide caring, safe, and comprehensive surgical care for our patients, and the way we work and communicate with each other is a substantial part of that. We cannot provide satisfactory patient care if we feel unsafe or disrespected at work. It is important that all disrespectful behaviours are reported and not just accepted, and that we have a system that supports resolution and improves the workforce culture and respect.

I encourage you to access the RACS Support program. It is a free confidential service available to RACS Fellows, Trainees and SIMGs, and your immediate family. Visit our website to find out more: surgeons.org/about-racs/surgeons-wellbeing/racs-support-program ■

Find out more about our revised complaints approach and let us know how we can support you: surgeons.org/about-racs/feedback-and-complaints.

We recently published a short animated video to explain our new approach, which is also available on our website.

Dr Tony Sparnon
President



RACS ASC 2021

Full steam ahead for the RACS ASC

Good news (with fingers crossed) – we are now able to increase the number of in-person registrations for the Royal Australasian College of Surgeons Annual Scientific Congress (RACS ASC 2021) to 1000, and the allocation for each specialty for physical attendance has doubled. We hope the vaccine rollouts will increase our security in being able to deliver this component of the RACS ASC and will enable more of you to visit Melbourne in May. Several section dinners are being planned and may be able to proceed; the section conveners are working with venues to look at what is possible for our social functions. Details for these dinners will be made available on the RACS ASC 2021 website once confirmed.

On 4 March 2020, we had a meeting with the president and both vice presidents of the Royal College of Surgeons of Edinburgh (RCSEd). While there is great disappointment that their Fellowship cannot attend in person, all three were very excited about the hubs concept and seized on the idea to create hubs in their centres in Edinburgh and Birmingham. There was lively discussion around the available scientific programs for them to select, with content of general interest from the plenary, global health and surgical director's sections, as well as a mixture of specialty section content to create a stimulating virtual conference.

Our Edinburgh colleagues were also very excited about the possibility of using digital platforms to increase the level of collaboration between the two Colleges in the future.

The President of RCSEd, Professor Mike Griffin, will give the President's lecture, 'It's good to talk: talking to patients with cancer'. Having now met Professor Griffin and heard him speak, I'm sure this will be a standout finish to the Council Plenary on Thursday. We have also confirmed Dr Nick Coatsworth, former Deputy Chief Medical Officer for the Australian Government, who will speak on the topic 'Communicating public health messages to a general audience. What works and what doesn't?'.

Another standout will be the keynote address, 'Audacious goals 2.0: the global initiative for children's surgery', by Dr Diana Farmer, section visitor for RACS Global Health. As one of the co-founders of this growing collaboration, she will speak to the vision of safe, affordable and timely surgical care for all children. Dr Farmer will also be presenting to the Paediatric Surgery program, and I look forward to hearing her contributions.

The College Conference and Events and Communications teams have been working like trojans to prepare what is effectively two conferences, and my heartfelt thanks go to them. The final program is in the last stages of preparation and will be made available online in April. Registration is open and all Fellows are encouraged to register early for a spot to attend the RACS ASC physically at the Melbourne Convention and Exhibition Centre. Don't miss out on being part of a fantastic congress.

We would also like to thank our sponsors and exhibitors for their continued support of the Congress, in particular our Platinum Partners Ethicon and Medtronic, and our Silver Partner Device Technologies. ■

Dr Liz McLeod
RACS ASC Coordinator

Spotlight on

Embracing diversity

Diversity in all its dimensions strengthens the surgical profession.

Diversity and inclusion are part of the wider work we are undertaking in the College to build a culture of respect in surgery.

There is considerable advantage to having the Fellowship of our College reflect the diversity of the community that we are privileged to serve.

Read on to learn about the breadth of our surgeons working rurally and regionally across our two countries, Australia's first female paediatric surgeon, and how the College celebrated International Women's Day.

At the College we believe that celebrating our many parts makes us a greater whole.

International Women's Day at RACS

International Women's Day was commemorated on Monday 8 March, with various RACS events hosted around the country.

As part of our International Women's Day program, the 'President's Meeting Room' at the College will now be called the 'Anne Kolbe Room' in honour of our first female President, who was President of RACS 2003-2005.

In South Australia, Fellows and Trainees gathered at the new RACS office in Kent Town, Adelaide to celebrate the day. The ceremony was attended by the RACS Women in Surgery Chair, Dr Christine Lai, who took part in a panel interview with ABC journalist Wendy Harmer the day before, and former Queensland Premier Anna Bligh. Listen to their conversation here.

In Queensland, the local membership met at Customs House in Brisbane for a lunchtime gathering on Saturday 13 March.

A similar function was held in Western Australia, where guests gathered at Goodwood Restaurant at Optus Stadium on Saturday 20 March. ■

New South Wales International Women's Day

On Friday 12 March I was honoured to chair a discussion on 'Gender Parity in the Public Hospital Medical Workforce'. This event was co-hosted by the Royal Australasian College of Surgeons (RACS) New South Wales and the Honourable Bronwyn Taylor, New South Wales Minister for Mental Health, Regional Health and Women.

The purpose of the day was to focus on gender barriers in surgery, especially in the public hospital system. This was scheduled as part of New South Wales Women's Week, a week dedicated to celebrating achievements of women in the state.

During my time as a RACS New South Wales Committee member and now as Chair of the Committee, I have heard many female Fellows who have engaged with RACS New South Wales report frustration with current workplace practices. This was reflected in the discussions throughout the day, with many barriers to women's success identified.

These included:

- Difficulties accessing parental leave (both maternity and paternity)
- Female Fellows being discouraged from applying for advertised public positions and being told that the preferred candidate is a male
- Female Fellows working unpaid in non-clinical roles or being appointed but without operating privileges.

Elizabeth Koff, Secretary, New South Wales Health, and the Hon. Bronwyn Taylor, MLC, New South Wales Minister for Mental Health, Regional Youth and Women.

These issues compound the problems of the lack of visibility of women in surgery, which leads to barriers to attracting women Surgical Education and Training (SET) applicants, as well as a significant gender pay gap, which can be greater than 50 per cent in some specialties (based on RACS 2014 census data).

RACS has a diversity and inclusion policy and has been very proactive in increasing representation of women to boards and committees. Currently, 35 per cent of RACS committee and board members are women, even though only 14 per cent

of Fellows are female. Despite this, the proportion of female SET applicants has not increased beyond 30 per cent.

Many who attended the March 12 event felt a major contributor to this disparity is the lack of diversity in surgical departments in public hospitals. As more female Fellows complete training, if these gender barriers are not addressed, the problems will apply to a larger proportion of the workforce.

There is significant research that shows that diverse healthcare teams have better patient health outcomes, are more adoptive of innovation and change, and demonstrate better financial outcomes. RACS New South Wales believes that all Trainees completing the training program have demonstrated adequate capability to be registered as a practitioner in a relevant specialty. Furthermore, data reveals that outcomes achieved by female surgeons are not inferior; rather, these surgeons may be equal or superior to their male peers.

The theme of this year's International Women's Day, #choosetochallenge, was so appropriate. We should all choose to challenge the barriers and discriminatory behaviour in surgical departments, and question why they are so prevalent and systemic. Unless these barriers are changed, not only will there not be parity in the workforce, there will also be a continued absence of female surgical leaders in our health system.

Associate Professor Payal Mukherjee with RACS Councillors Professor Raymond Sacks, Dr Jennifer Chambers OAM and Miss Annette Holian.

Panellists for the discussion included: Minister Bronwyn Taylor; New South Wales Secretary of Health, Ms Elizabeth Koff; CEO of Sydney Local Health District, Dr Teresa Anderson AM; Head of Discipline of Surgery, University of Sydney and co-chair of the Institute of Academic Surgery at the Royal Prince Alfred Hospital, Professor Paul Bannon; RACS Councillor and Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS) Vice President, Professor Raymond Sacks.

Thank you to everyone who attended this event, including RACS committee members, Councillors, society and section representatives (especially those who travelled interstate), representatives from other colleges and the Australian Medical Association, as well as government representatives. I would particularly like to acknowledge those at the New South Wales Ministry of Health, who have championed this issue and expressed an ongoing commitment to address the barriers female surgeons face.

It was great to see the widespread support from all genders across several institutions, and the open forum, which allowed these vital discussions to take place. While we still have a long way to go, it is events like these that play a key role in setting the standards we should all abide by and uniting us in using these standards to deliver the best patient outcomes in health. ■

Associate Professor Payal Mukherjee FRACS

Left:
Dr Pecky De Silva, Deputy Chair of RACS Women in Surgery and Chair of Younger Fellows committees, with the Hon. Bronwyn Taylor.

Voices from the Pacific: International Women's Day event

On Monday 8 March 2021, in honour of International Women's Day, medical professionals from around the world gathered for the 'Voices from the Pacific' forum, a webinar focused on the challenges, opportunities and experiences of women working and training as surgeons, anaesthetists and perioperative nurses across the Asia-Pacific region.

The event was presented by Miss Annette Holian, Chair of the Royal Australasian College of Surgeons (RACS) Global Health Committee, and Dr Rachna Ram, a general surgeon from Fiji who specialises in Plastic and Reconstructive Surgery, currently undertaking her PhD in Melbourne.

They hosted a panel that included Dr Fane Lord, an ear, nose and throat (ENT) surgeon from Fiji, Dr Esther Apuahe, a neurosurgeon from Papua New Guinea (PNG), Nerrie Raddie a perioperative nurse from the Solomon Islands, and Dr Sepi Lopati, an ENT surgeon from Tonga.

The event began with an address from Dr Ifereimi Waqainabete, Minister for Health and Medical Services in Fiji, who is himself a general surgeon.

Dr Esther Apuahe, the first female surgeon in PNG and a mother of three, talked about her challenges in being accepted by her male colleagues and patients, especially in the provinces.

She hopes that her experiences made it easier for future generations of female surgeons, of whom there are now seven, and was especially proud that four of these women are now undertaking subspecialty training.

Dr Sepi Lopati is currently in Melbourne studying her Master of Surgery – Research degree on the prevalence of ear disease in primary school students in Tonga. As a mother to two young children while training, she found it difficult to find the appropriate training to suit her life. She found the lack of outside connections hard as she couldn't travel for training and wanted help finding a pathway. Dr Lopati explained that women entering the surgical field

"You must love what you choose. If you have the heart for the job and a good support system, you're able to cope and be up for the challenge."
—Dr Esther Apuahe

is a recent phenomenon in Tonga, and stressed the challenges faced by women wanting to upskill.

Ms Nerrie Raddie, a perioperative nurse in Honiara, Solomon Islands, has firsthand experience in educating and facilitating training. When she began perioperative nursing in 2006, she found it very different from her work on the wards, yet there were no practice guidelines in place. Ms Raddie learned from senior nurses and became passionate about the field. Ms Raddie joined the Pacific Islands Operating Room Nurses Association and is now interim secretary.

In 2015, practice guidelines were developed for 14 Pacific Island countries, and in 2016, Ms Raddie attended the Pacific Perioperative Standards Implementation workshop in Fiji. From there, she "teamed up with colleagues to do presentations at international conferences, co-authored articles for ACORN [the Australian College of Perioperative Nurses] journal, became involved in mentoring activities both in-country and in Fiji." She is excited to empower perioperative nursing practices and provide opportunities for women to excel in their profession.

Dr Fane Lord, a surgeon in Suva, Fiji, reflected on 16 years practising as a clinician with 13 years in the field of surgery. Dr Lord had always wanted to be a surgeon and applied for training every year, but when she was finally accepted she had a six-month-old baby. Luckily, she was offered a place again three years later and continued studying, specialising in ENT.

In 2017, she was a recipient of the Rowan Nicks Pacific Islands Scholarship and as a result completed a placement at Royal Adelaide Hospital. "I didn't realise the depth or breadth of ENT until I went to the Royal Adelaide," she said. "I felt out of my depth and was willing to learn as much as I could." She continued mentorships on her return to Suva and believes that "now the onus is on me to impart whatever knowledge I've received – there's a real shortage of female mentors." Dr Lord also stressed the importance of family support. "You can't do this alone," she said.

Dr Pecky De Silva, a vascular surgeon and the Deputy Chair of RACS Women in Surgery and Chair of Younger Fellows committees, echoed the importance of female role models. "When you're a smaller proportion, our duty is to carry that torch, to make our junior colleagues feel empowered and allow them to follow in our footsteps," she said. Dr De Silva explained the four main themes of the strategic plan of the Women in Surgery Committee: leadership, role modelling, flexible training and advocacy.

In the lively discussion that followed, all participants stressed the importance of loving the work. "I love being a surgeon," said Dr De Silva. "I think it's a great career. I'm so happy where I am and I hope I show that to all my junior doctors and medical students."

Dr Apuahe agreed. "You must love what you choose," she said. "If you have the heart for the job and a good support system, you're able to cope and be up for the challenge."

The group discussed the challenges of balancing a family at any stage of your career and developments that could make life easier for families, such as dedicated rooms for mothers and children, childcare services, flexible training and parental leave.

Miss Holian invited all participants and viewers to join the new RACS Global Health Section, designed to foster connection and communication with like-minded people. She suggested it can be a forum for discussions such as the ones they were having, whether someone is interested in learning more about training pathways or a particular disease, or looking for resources and support. "I see it as a great constellation of surgical shining stars connected across PNG and the Pacific," she said.

All participants agreed there had been improvements over the years but there were still more changes to be made. As Ms Raddie said, "With challenge comes change. May we all choose to challenge." ■

RACS Global Health is committed to supporting and advocating for Pacific Island women clinicians through the Pacific Islands Program, an Australian aid initiative implemented by the Royal Australasian College of Surgeons on behalf of the Australian Government.

Australian Aid

Over page, clockwise from top left:
Dr Rachna Ram, Dr Fane Lord, Dr Esther Apuahe, Dr Sepi Lopati, Miss Annette Holian, Dr Pecky De Silva

It's a great life out there!

Surgeons share their experiences working in rural and regional areas of Australia and New Zealand

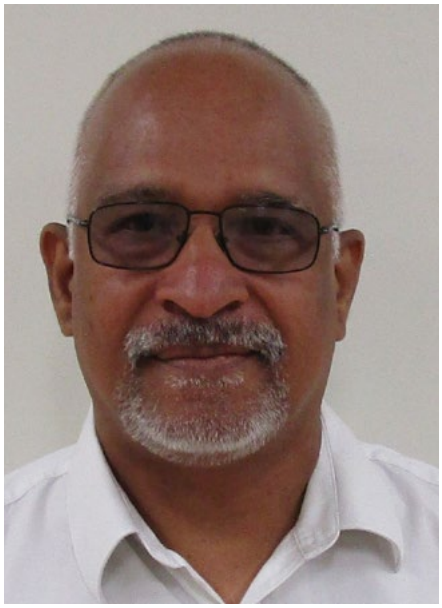
Mr Sabu Thomas, General Surgery, Kalgoorlie, Western Australia

I have always had wonderful and very collegiate general and subspecialty colleagues in the regional areas where I worked. In rural practice you have a close relationship with colleagues, including surgeons, anaesthetists, staff in clinics and theatre.

Urban surgeons and specialty boards need to value rural surgery and rural surgeons. Don't devalue their work – indirectly, or directly. Support rural surgeons by visiting them, and credential them to visit and work in needed subspecialty areas in big tertiary centres once in a while.

Rural surgeons need to be encouraged to do procedures that can be safely done in regional hospitals, rather than always sending patients to larger hospitals. Sending patients away does not build regional surgical capacity, nor attract a capable workforce to regional areas.

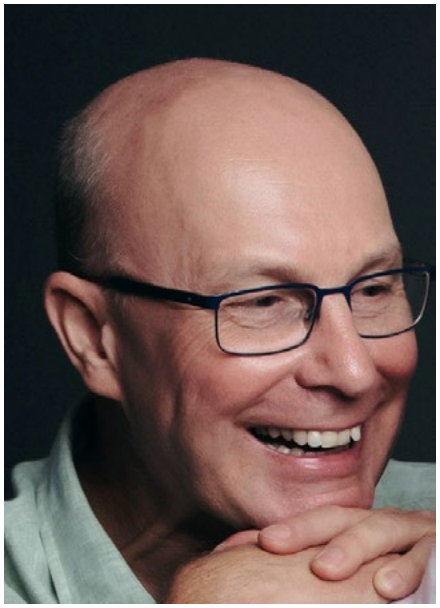
If you are a surgeon in a regional area, keep learning new procedures relevant to your practice. Travel nationally or internationally, if possible, and keep using your learning and skills to assist in different parts of the world. Think of surgery in terms of a vocation and calling.



Associate Professor Matthias Wichmann, General Surgery, Mount Gambier, South Australia

When we came to Australia from Munich we had to work in an 'area of need'. We chose Mount Gambier because it was halfway between Melbourne and Adelaide, had good schools for our children, and the hospital was closely connected with two universities.

Working in a rural environment always keeps you on the tips of your toes. Even after 15 years of working in rural surgery,



you need to come up with new ideas or find a friend to talk to about how best to approach a certain condition. In Mount Gambier I have always been lucky to have colleagues to work with and to rely on. This has made my life as a rural surgeon much easier and much less stressful.

Rural surgery is probably the only specialty where a surgeon can do an endoscopy and a hernia repair followed by a gallbladder and a bowel resection – all on patients they have met before surgery, will meet again after surgery and will most likely bump into at a friend's place not long after that. We get to care for our cancer patients throughout their cancer journey and I would not want it any other way.

Every Australasian surgeon should be exposed to rural surgery for at least six months of their training. I would be surprised if we do not see more young surgeons developing an interest in this fascinating specialty. Life in rural communities is very rewarding and welcoming. My advice would be, try it and keep an open mind about a non-metropolitan career. It's a great life out here!

Dr Roxanne Wu, Vascular Surgery, Cairns, Queensland

Living and working in a regional area has given me a balanced life and a richly rewarding career. I have brought subspecialty skills in Vascular Surgery to a region that did not know they needed a vascular surgeon. When I came to Cairns it became evident there was a huge need for dialysis and its attendant vascular problems; a need for a vascular surgeon to attend to the diabetic foot problems and of course the usual peripheral vascular disease and trauma.

It takes me 15 minutes to drive to the hospital, except for the days I do a rural outreach clinic which is usually an hour's drive away. Running a practice in a regional centre is easy. I have never had to look for work, it comes to find me. Most of the general practitioners know you personally and it is easy to get to know them. There is absolutely no shortage of work, rent is reasonable, and getting good

employees who stay for years is not a problem.

One of the best things is the ability to work in a community: patients and their families stay close and now that I have been practising here for over 30 years, I have had the privilege of operating on multiple generations of the same families. I have one of the best followed up cohort of EVAR (EndoVascular Aneurysm Repair) patients in the country. It is really special to follow up patients for decades and be able to really know what one's outcomes are for the procedures that you do.

Dr Shehnarz Salindera, General Surgery, Woolgoolga, New South Wales

I grew up in a rural area and studied medicine with the goal of one day practicing in my hometown. As I progressed through training, I requested rural rotations where I was able to meet wonderful mentors, such as Dr Sally Butchers in Lismore and Dr AJ Collins in Bega, who encouraged me and supported me through training. They showed me that you can be a generalist and practice subspecialty surgery in a rural setting.

Working in a rural setting has ensured I maintain my skills in General Surgery and further developed my leadership and management skills. In a smaller hospital you will be asked to step up and lead hospital committees, help establish clinical services or assist with managing the trainees or rosters.

I have been able to establish my practice relatively quickly and use all of the skills from my training immediately. I also had the opportunity to establish a breast reconstruction service from the ground up and design the model of care in line with best practice, instead of having to fit into an existing structure or way of doing things, which has been very exciting.

Don't be afraid to ask for the working conditions and flexibility you need to make the move to rural. Consider how you will maintain your collegiate networks and support structures once you make the move.

Specialty boards can help by developing more rural training positions at all stages in the training pipeline, including Fellowship posts. Having the opportunity to train rurally at any point in your pathway will help more Trainees explore the wonderful opportunities available in rural settings.

Dr Lincoln Nicholls, Orthopaedic Surgery, Whangārei, New Zealand

I'm currently a Māori SET 3 Orthopaedic Trainee working at Whangārei Hospital in New Zealand's most Northern District Health Board.

My wife is a Māori pharmacist and health research fellow and together we are proud and dedicated Māori health practitioners from small town Aotearoa New Zealand. We believe we are charged with the responsibility to work extremely hard and strive to improve outcomes for Māori as well as all patients under our care. This is a responsibility we are honoured to uphold. We believe that our clinical skills, soft skills, life experiences, our cultural expertise and command of Te Reo and Tikanga Māori can help achieve this.

Being from small towns in New Zealand, we feel we have a responsibility to return to the regions after completing our

training to work amongst regional and rural communities where our people are. As Māori there is a very strong internal drive to do this.

My training career thus far has seen me working in four regional hospitals and one tertiary hospital. Next year, for my final two years in training, I will be placed in a tertiary hospital, which is probably a necessity. However, on completion of training, my whānau and I would very much love to move to a region with high Māori need. Te Tai Tokerau, Rotorua, Waikato, Te Tairawhiti, Manawatu, and Whanganui are all regions we have iwi (tribal) connections to and regions where our people would like us to be. We look forward to opportunities that may arise from such communities.

A Māori whakatauki (proverb) explains the importance of training and remaining or returning home to their people. 'Tangata i akona ki te kāinga, tūngia ki te marae, tau ana. A person trained at home will stand on the marae with dignity.'

Mr Philip Gan, General Surgery, Warrnambool, Victoria

When I set up a practice in Warrnambool 19 years ago I wanted to maintain a broad skill-set and varied practice, but also to have a greater relative freedom to follow my areas of interest, to avoid the battle of Melbourne traffic, and to be close to the ocean, which I have always loved. ▶

My first 'bosses' as an accredited registrar were Mr Rodney Mitchell and Mr John Daniels in Bendigo, who inspired me to high levels of surgical care in a regional setting. I could see that skills and standards are something you develop and bring with you, wherever you practise. Importantly, my wife, who is a general practitioner, spent many of her formative years growing up on the Gold Coast and was very comfortable moving to another coastal region. We did investigate the local schools and were satisfied that we could provide our two children with a great education without resorting to boarding schools.

When I started, there were only three general surgeons in Warrnambool, with far fewer sub-specialties available locally. I was therefore doing superficial parotidectomies, thyroidectomies, fundoplications, Dupuytren's contractures, digital nerve and extensor tendon repairs, finger fractures, all manner of flaps and grafts, breast surgery, as well as a broad range of colorectal surgery on top of the usual gamut of cholecystectomies and hernia repairs.

As subspecialists started to set-up in Warrnambool, I progressively divested those areas of my practise, which allowed me to further focus on my particular passion of minimally invasive surgery. I have incorporated single and reduced-port, mini-laparoscopic and even hybrid trans-vaginal NOTES techniques across a very broad range of operations. My series of laparoscopic colorectal resections was the first to be presented from any Australian regional centre (RACS Annual Scientific Congress, Hong Kong 2008), and have evolved to intra-corporeal anastomoses. These patients go home as early as day one or two post op without opioids. My cholecystectomies are typically day procedures, also generally without requiring discharge opioid analgesia.

I became involved in medical device innovation and have three patents to my name, covering two medical devices, one of which (the LiVac Retractor) is already in market. I felt very supported during the journey of taking this from concept to registered medical device, particularly in conducting a First in Human Clinical Trial to International Standard ISO 14155 (2011). This was the first and only time that St John of God Australia and South West Healthcare Warrnambool had approved a First in Human medical device trial.

I don't know that I could have developed and maintained the same breadth of practice that I enjoy now in an urban setting. Being in a rural setting has not prevented me from advancing my surgical interests and skills.

Dr Sally Butchers, General Surgery, Lismore, New South Wales

Rural surgery has given me the opportunity to maintain an interesting and broad general surgical practice. I have not had to subspecialise, and I enjoy the wide variety of work that I am able to do. I also feel that the opportunity to be involved in the local community has provided me with a good work-life balance.

I live on a property that is 15 minutes from work with no traffic, and I do feel that the lack of commute has played an important part of being able to get the balance right!

I was honoured to convene the 2015 Provincial Surgeons of Australia Annual Scientific Conference (PSA ASC) in Lismore, which provided a great opportunity to showcase to junior doctors, registrars, and young Fellows some of the benefits of living and working in a non-metropolitan surgical environment.

I think it is important for everyone to recognise that maintaining generalism within any specialty training program is important. It allows us to provide a level of care to the same high standards for all Australians, regardless of where they live.

We need to support Trainees who have an interest in working in rural areas, and the establishment of more rural training hubs is one way to achieve this goal. We can also continue to promote rural Fellowship positions. An example of this is the collaboration between the many specialties in setting up the Post-Fellowship Education and Training (PFET) program in Rural Surgery, commencing in 2022. This program will allow Fellows to have additional training in two subspecialty areas in metropolitan centres, and establish vital peer support networks that they can call upon when they start working in their rural positions.

Dr Mark Romero, General Surgery, Port Macquarie, New South Wales

Working in a regional area means you have to be flexible in order to provide care to the community. Although all the general surgeons here have a subspecialty interest, we all also overlap in a lot of ways. This means we can often cover for each other and also that when more specialised care is required, we can refer to or consult each other. Your area of practice is broader than in big centres but not so broad that you become a 'jack of all trades'. It's certainly a nice balance. We are expected to deal with all emergency general surgery when on call, which can range from simple abscesses to trauma laparotomies. Elective operating lists are varied and it's not too uncommon to start the day with, for example, an ingrown toenail and finish with an ultra-low anterior resection.

The most surprising thing about rural surgery is the sense of community. You will fix a hernia on a patient one day and a few months later you will see them at Bunnings, or they will turn out to be your child's soccer coach. New patients will tell you how you operated on their neighbour or that their friend recommended you. Word of mouth is incredibly powerful and, given that there are only a few of us, the need to advertise or 'compete' with each other is non-existent. I feel this generates a very collegiate work environment and I have always felt very supported.

The advice I would give to aspiring rural surgeons is to voice your desires as soon as you know them. If you are in a rural term and you could see yourself working there, let the local surgeons know. They will often keep you in mind and let you know if a job is coming up, whether in that institution or somewhere else. I find the lifestyle fantastic and I thoroughly recommend it.

Dr Kesley Pedler, Urology, Port Macquarie, New South Wales

I grew up in Sydney and did not consider regional practice until I was seconded on rural rotations as a surgical registrar. I particularly enjoyed working in Port Macquarie. I liked the beautiful region and the staff who worked at the hospital. I came back to Port Macquarie two years later as a Urology Trainee and was inspired by the consultants, who had established a subspecialised unit offering almost all the same procedures available in a large city hospital, including major oncology operations.

My goal is to offer patients who live in a regional and rural Australia the same quality health care as is received by patients who live in the city. It can be challenging accessing new technology, such as robotic surgery, but I am fortunate to have a very supportive colleague in Sydney who mentored me for robotic cases, first in Sydney and now locally.

If you are interested in working in a regional area I would strongly recommend working in the area beforehand if possible, either as a Trainee or a locum. There is more than just location to consider when setting up practice and this will allow you to get to know the other surgeons and staff who work in the area. I am fortunate to work with three other urologists so I have supportive colleagues locally.

I also recommend establishing good relationships with colleagues in your close major centres who will be able to give you advice for complex cases and accept referrals for patients who cannot be managed locally. ■

The two of us

Meet twin surgeons Associate Professor Sanjay Warrier and Dr Satish Warrier

Associate Professor Sanjay Warrier and Dr Satish Warrier are twins – identical twins – with many shared interests including surgery, family, sports and music.

Associate Professor Sanjay is a breast oncology and oncoplastic surgeon. He is a current Council member for Breast Surgeons of Australia and New Zealand (BreastSurgANZ) and the immediate past president (May 2019-May 2020). Dr Satish Warrier is a colorectal and general surgeon at Peter MacCallum Cancer Centre, Alfred Health, and Epworth Healthcare.

Born in Albury and growing up in Nambucca Heads, New South Wales, Sanjay and Satish enjoyed an idyllic country life. As twins, who were mistaken for each other in primary school, they were content with each other's company, spending hours together studying, playing sports and spending time with their family.

"We are very close," Sanjay said. "It's an interesting phenomenon to be growing up with another person who is your best friend and spending every day together until you're outside of university. It's been a norm for us – someone being there all the time."

Associate Professor Sanjay Warrier

Associate Professor Sanjay Warrier and Dr Satish Warrier

Growing up in a family where their mother was a local general practitioner and their father a surgeon, gravitating towards a medical career from a young age was a given. "Dad said to us, 'Service is a part of our goal. Do your best, do your duty, and help others,' and it became ingrained in us and a driving force for us to do medicine," Satish said.

But at 17, Sanjay and Satish travelled to India for six months and lived in an ashram. They were the youngest at the ashram where they lived a simple life: they woke up early, prayed, sang bhajans (devotional songs), and learnt to play the tabla (Indian drums).

On their return they enrolled in the University of New South Wales medical school, completed an elective in Bangalore (India) – where they did a modelling stint – and travelled to Dublin for a year. Sanjay remembers their Dublin days with fondness. Along with excelling in their studies, both brothers were strong in the sporting field, playing cricket and tennis at inter-varsity levels.

Their paths split after they completed medical school. Satish completed his internship in Hobart to be with his future wife and later relocated to Melbourne. Initially he was interested in Plastic Surgery and as a pathway studied General Surgery. Around that time laparoscopy or keyhole bowel surgery was emerging, and he found the procedure technically very interesting. "Since this surgery was minimally invasive, I was attracted to it and the more I found out about the surgery the more I veered towards that pathway," Satish said.

In 2009, Satish got his Fellowship and in 2010 he spent a year at Epworth Cleveland as part of the Epworth's Cleveland fellowship program. That experience was an eye-opener, with world experts teaching him not only surgical skills but also how to balance

clinical life with academic and home life. That set the standard as he pursued his professional career.

Meanwhile, Sanjay undertook general surgical training at the Prince of Wales Hospital Network, where he had a broad exposure to oncology surgery. His post-Fellowship training was an extensive three and a half years in breast surgery. As part of this, Sanjay spent a year and a half at the Prince of Wales Hospital and Royal Hospital for Women within the Breast Surgical Oncology Unit. He was based at the Oncoplastic Breast Unit at Royal Prince Alfred Hospital for two years, consolidating surgical techniques in both an oncological and reconstructive setting.

Although the twins work in two different branches of surgery, both are involved in cancer treatments and have been pioneers in their respective fields. As a colorectal and general surgeon, Satish does minimally invasive work and evaluates newer technologies, including advanced applications of robotics, which he has helped introduce in Australia. He also does a lot of advanced cancer treatments, which have good outcomes with complex cancer patients. He says this is extraordinarily rewarding.

Sanjay has had his share of using innovative technology. He is currently using ICG (indocyanine green – a fusion tool for assessing blood flow after breast reconstruction), which reduces skin death at the time of reconstruction, and has led the country in this area. Sanjay and his team are currently trialling radar technology in the form of a probe, a small antenna placed in the breast.

Outside of surgery, both brothers are dedicated to teaching. Sanjay is an Associate Professor at the University of Sydney with the Royal Prince Alfred Academic Institute. He is the lead researcher at the institute and hopes to develop and create a culture of academia in the Breast Department. Satish is the Chair of the Training Board for General Surgery in Victoria and has a keen interest in teaching the next generation of surgeons.

Despite their busy schedules, Satish and Sanjay talk to each other every day. They discuss sport, still a big part of their lives, and keep abreast of each other's work and discuss commonalities – the way they evaluate a patient, radiology and whether alternate treatments are a good idea. Both appreciate having a broader perspective outside their own fields, as the principles of surgery remain the same. While cancer is a daunting experience for most of their patients, treating them with compassion and achieving positive outcomes has been rewarding .

Dr Satish Warrier

When asked what they think of each other, Sanjay said, "Satish has been blessed with natural talents, whether in studies or sports. While I've had to study harder and longer, Satish would finish his three-hour exam in 45 minutes, maximum an hour, whereas I would wait until the final three hours revising my papers. Same with sports, be it tennis, cricket or golf. He just has sheer natural talent."

Meanwhile, Satish says that "Sanjay is unafraid to meet new challenges and extremely hard working and goal-focused. He plays competitive tennis and is quite good at music, playing the piano, guitar and tabla – all of which are self-taught."

Both also share a passion for travel – which they still do together whenever they get the opportunity – and their young families. Family has been a key component for them since they were young and now provides a foundation for a successful career and life.

"Along with our parents, our older brother – an ophthalmologist in Brisbane and a naturally gifted person – has been a great influence in our lives," Sanjay said. "This has translated into how we treat our families."

Outside of work, Sanjay spends his time with his doctor wife and son. "My son is a kind and gentle person. He enjoys playing basketball and we go for runs together. Taking care of our bodies is very important and I instil that in our son," he said.

Satish has an equally supportive family. His wife, who has just completed her paediatric training, specialising in ICU, has been his biggest support. Of his children, Satish says, "My daughter talks about being a doctor but at the moment enjoys her tennis and may represent Australia one day. My son is extremely bright, he may become a businessman and start his own tech firm. But it's early days yet."

In the end, both believe their children should follow their dreams. They will be happy as long as their children turn out to be good human beings and contribute to the good of the society and community, as they were taught to do. ■

Pioneer, inventor, educator: Australia's first female paediatric surgeon

Helen Rae Noblett was a pioneering and innovative paediatric surgeon. Born in Terowie, South Australia, but brought up in Queensland, Helen made an impression at her school as a sporty, bright and hard-working scholar who won prizes and a scholarship to medical school in Brisbane.

She qualified in 1957 and proceeded to training in General Surgery and then Paediatric Surgery in Brisbane Children's Hospital under the late Des McGuckin in 1962. She was McGuckin's first Trainee.

In 1963, Helen moved to the Royal Children's Hospital, Melbourne and continued her training as a registrar under Frank Douglas Stephens AO, Edward Durham Smith AO and others. She was awarded her FRACS in 1964, becoming the first female paediatric surgeon in Australia.

During Helen's time in Melbourne, she pursued research in gastrointestinal diseases in parallel with her clinical work, working with Ruth Bishop's team (which later went on to first describe Rotavirus in 1973). It was during this research that she invented a device for sampling ganglion cells in rats, which she later developed into the instrument for use in babies and children. It bears her name to this day.

In the United States, Helen worked as a research fellow with Bill Clatworthy and Jim O'Neill at Columbus Children's hospital from 1967-1968 and made a strong impression. Her colleagues noted that she was 'delightful, collaborative, charming, very scholarly,' 'we learned an enormous amount from her' and that 'she was the real thing'. Other Americans mention her enthusiasm, skill and kindness.

Back in Melbourne, Helen was part of the thoracic surgery unit headed by Russell Howard, which also included Nate Myers and Max Kent. Helen developed her own method for managing babies with oesophageal atresia post-operatively: at the time of repair she fashioned a gastrostomy with a trans-pyloric feeding tube to enable immediate enteral feeding without the complications of gastro-oesophageal reflux. She continued to use this technique throughout her career. For cases with a long gap she used the reversed gastric tube, though later she was open to discussion of alternatives.

In 1969, Helen published two landmark papers. The first was a method for the non-operative treatment of meconium ileus by Gastrografin enema. Until that time, most babies were treated surgically. The second described the rectal suction biopsy device of her own invention used in the diagnosis of Hirschsprung disease. Both of these are in regular use worldwide today and associated with the name of Noblett.

In 1976, Helen left Melbourne to become the first paediatric surgeon at the Bristol Royal Hospital for Children in the United Kingdom. Bristol was one of the last major centres in the UK to recognise the need for paediatric surgery and there was opposition to the role in the entrenched views of some senior surgeons and paediatricians. However, Helen was a very strong and resilient character and within a short time she had demonstrated that her outcomes were as good as those at any centre in the country.

The next battle was to appoint a colleague but it was not until 1982 that David Frank was appointed to share the large workload and develop paediatric urology in Bristol. It is difficult to understand how one person managed the workload generated by a

population of four million people for six years, but she did, and to an extremely high standard.

Helen was a scholarly and cerebral surgeon. From 1976, she published 22 papers on a variety of topics and was always innovative and up to date. She served as examiner for the newly introduced Fellowship of the Royal College of Surgeons (Paediatrics). She had little taste for managerial or administrative duties and concentrated on her patients, who were the driving force behind her extraordinary energy and stamina. Her patients and their families appreciated how fortunate they were to be under her care and spoke of her with affection and respect.

Helen had exceptional technical expertise and clinical judgement. She cherished the concept of a strong team and glowed in the company of her favourite colleagues and Trainees. She took her responsibility as a trainer very seriously and many distinguished surgeons from a variety of countries regard her as the formative figure in their careers.

There was a steely side to Helen which was apparent whenever anything threatened to interfere with patient care. Trainees described her variously as 'tough but fair', and 'a hard taskmaster' who 'did not take any nonsense', but all emphasise how supportive she was to those she assessed as sensible, competent, and hard-working. She was uncompromising and a shrewd judge of Trainees. If a Trainee did not come up to her high standards, she made sure they went into a different branch of medicine.

Away from work, Helen was cultured and sociable, warm and humorous. She could discuss art, literature and music, with Mozart a particular favourite. Her annual Christmas parties were eagerly anticipated; the food and drink were lavish, and we gathered round the piano (with Helen playing) to sing carols. Her relaxation often centred round her canal narrow-boat, 'Katkin', and she had many amusing anecdotes concerning boating mishaps to tell in the theatre coffee room between operations.

Helen Noblett deserves to be remembered as a great character and a paediatric surgeon of the highest calibre. Her legacies are her innovations in her field, the many departments around the world which she inspired, the large number of children who owe their lives to her exceptional abilities, and the large and thriving department of Paediatric Surgery in Bristol today. ■

Mr Richard Spicer FRCS

Adjunct Professor Deborah Bailey FRACS

A career of research, innovation and surgery

Almost 20 years after the Bali bombings, Professor Fiona Wood talks about her life's work.

In 1985, Professor Fiona Wood was jolted by a realisation that defined her medical career for the next 35 years.

A young child was brought into the hospital where she was working in the south of England. He'd had a cup of hot coffee spilled down the front of his chest. The burns healed, but he was badly scarred and in need of plastic surgery.

"It hit me straight between the eyes that this boy would never move properly again and the scars would be with him for life," she said. "I became increasingly focused on how to make sure that the quality of outcome must be worth the pain of survival."

This led to a decision that her surgical career would be a combination of research, innovation and surgery. Has she achieved this goal? "It's been a long journey," she said, "and it's still a work in progress."

Director of the Burns Service of Western Australia since 1991, consultant plastic surgeon at Fiona Stanley Hospital and Perth Children's Hospital, and Winthrop Professor at the School of Surgery at the University of Western Australia's Faculty of Medicine, Professor Wood packs a lot into her days. But this isn't surprising, considering that she once said, "There's absolutely no mileage at all in getting up in the morning to be average."

"For whatever reason, I've been driven and motivation is contagious but illusive. I feel I'm very fortunate. I found something I'm passionate about, and to work with an amazing multidisciplinary clinical and research team is exciting, exhilarating, exhausting and, at times, overwhelming," she said. "I absolutely get all that, but for me it's a privilege."

The Bali bombings

In October 2002, Professor Wood faced one of the most challenging incidents in her surgical career. One, it turns out, that resulted in her being made a Member of the Order of Australia, being awarded the Australian Medical Association's Contribution to Medicine Award, and being recognised as an Australian Living Treasure. She was also awarded the 2003 and 2004 West Australian of the Year, and was Australian of the Year in 2005.

The Bali bombings left 202 people dead and hundreds injured. Twenty-eight of the seriously injured were airlifted

from Denpasar to Royal Perth Hospital under the care of Professor Wood. She coordinated four operating theatres that ran concurrently for five days, as well as 19 surgeons and 60 nurses, and was able to provide surgery and post-operative care to 28 badly burned bomb victims.

Looking back, Professor Wood said she was grateful that her team had participated in significant disaster planning exercises as a result of the 2000 Sydney Olympics. The plans were then expanded in collaboration with and with the support of Woodside Petroleum, the Royal Flying Doctor Service and the Department of Health. The resulting recommendations were signed off by the Health Minister's Advisory Council two months prior to the bombings. "We had a level of understanding about how to respond and the philosophy 'We do best what we do every day, but we have to work out how to escalate to maintain the quality of care as the number of patients increase'," she said.

The Bali bombing patients received a standard of care that Professor Wood and scientist Marie Stoner had developed over the previous decade. "We started using cell-based therapies in 1993, and by 1995 we were spraying skin cells onto the wounds. By 2000, we were using a point-of-care device, and by 2002 we had invented, developed and built a medical device for the point-of-care harvesting of cells. The autologous cells were used on the prepared wounds in isolation and with traditional skin grafting techniques."

Caring for your team and yourself

On teamwork, Professor Wood said that the time invested in training a team is important because "when push comes to shove, the reliance on each other is extraordinary". The team expands as well, she said, and "because we have such a cohesive team, the hand of friendship goes out to all those in our buddy systems to collaborate".

Beyond teamwork, it's essential to look after your own health, as well as your education, and it's those things that can be uninteresting that are important, such as adequate rest, eating well and sensibly, and staying fit, Professor Wood said. "I was in the ocean this morning in the dark because if I don't go in the dark, at this time of year, then I'll miss that start to the day with exercise," she said. Every day she does some form of exercise because "by looking after yourself, you have the capacity to look after others."

A broader education

Professor Wood is an advocate for students studying dual degrees, such as science and commerce. "It enables you to look at a single problem through multiple lenses and provides a diversity of solutions that are more likely to have a positive outcome," she explained.

"We live in a complex world with extraordinary technology and knowledge. Translating information to knowledge to experience facilitates innovative solutions," Professor Wood said. "We need to push forward and collaborate and link with people who have a broader view, or a different view to us."

The Fiona Wood Foundation

Since 1995, when Professor Wood began spraying skin cells onto burns patients, she has been working towards scarless healing. Understanding the triggers to regeneration as opposed to scar repair is an ongoing journey, but one she works on continuously.

Along with Stoner, she established the McComb Foundation in 1999. It was named in honour of Dr Harold McComb, and renamed the Fiona Wood Foundation in 2012. The Fiona Wood Foundation is the primary support organisation for the Burns Service of Western Australia, and is affiliated to and collaborates with a range of prominent institutes and organisations. It includes a research hub dedicated to all facets of burn care along the patient journey, including cell-based therapies to rehabilitation. The Fiona Wood Foundation relies on philanthropic support from a generous community to facilitate research, education and innovation.

Collaborating to develop 3D skin

In June 2020, the Medical Research Future Fund awarded a grant to a team of researchers to develop a treatment for acute and chronic skin wounds. Led by Associate Professor Pritinder Kaur, they advance the work on 3D printing of skin by the Burn Injury Research Unit of UWA and Inventure to the next phase – developing a clinical prototype, a 3D bio-printing platform using stem cells to improve the treatment and healing of wounds and scars.

The burn surgery research expertise of Professor Wood and Dr Mark Fear, two of seven key investigators on the project, is integral to the team's goal of 'in situ tissue-guided regeneration to regenerate skin'. The current method for deep burns is to put a scaffold on, wait a few weeks for it to repair the deeper elements of the skin, and then repair the superficial area with skin grafts or skin cell spray. What the team hopes to do is spray on the dermis, as well as the epidermal cells.

"We're trying to print the whole of the skin – not just the skin cells, but the chemistry of the skin framework. So instead of putting the scaffold at the base of the wound, we want to spray the scaffold onto the wound with the cells," she explained. In a single process they'll be able to tailor the repair to exactly how much is missing.

"It's a collaboration that's built on work already in play and it allows us to do better," Professor Wood said. "We've started the preliminary work, but have a long way to go."

Future plans

"We get to know our patients really well," Professor Wood said. Some have gone on to do remarkable things, and she takes an active interest in their endeavours. Unsurprisingly, when asked about her dream for the future she explains what she'd like for her patients.

"My dream is that we can print in the basic elements within a wound that not only have the raw materials to facilitate regeneration of the tissue, but with analgesic properties and anti-microbial properties, so that we can sort out the pain and infection issues and link that with a visualisation program so that we use the power of the brain to drive a neurologically intact repair. Then I wake up because that's my dream. I often say to the guys – 'One day we'll all be able to think ourselves whole.'" ■

Over page:
Main: Professor Fiona Wood
Inset: A recent book on Professor Fiona Wood for 10 to 13-year-olds from Wild Dingo Press ISBN 9781925893281

College Name Change Working Group

The Aotearoa New Zealand National Committee recently requested that RACS Council consider updating the College name to better reflect the binational nature of the College, and where its members come from – Australia and New Zealand. Councillor Andrew Hill has assembled a working group to discuss options, which will then be put to Council for consideration and potentially a vote by the Fellowship in the future. The group represents a wide cross-section of the College from both nations, including senior surgeons, Councillors from both countries, a Younger Fellow, a Trainee, and both New Zealand and Australian Indigenous representatives.

The College of Surgeons of Australasia was founded in 1927, and the Exordium specifically refers to 'Australasia, which includes New Zealand'. In 1930, King George V granted permission for the prefix 'Royal' to be used, and the name was changed to the Royal Australasian College of Surgeons in 1931. At this time, the 'Journal of the College of Surgeons of Australasia, which includes New Zealand', changed its name to the *Australian and New Zealand Journal of Surgery*, suggesting the term 'Australasia' was not clear to all even then.

Over time, the term 'Australasia' has become less prevalent. Its meaning is not clearly defined, and some definitions include Melanesia and wider Oceania. The word 'Australasia' is not well understood, particularly by those outside New Zealand and Australia, but even amongst our own Fellows and Trainees. It is often mistakenly written or spoken as 'Australian', even in our own College documents. A web search brings up an Australian Government Department of Health document with the heading 'Royal Australian College of Surgeons'; references to several surgeons with an 'Australian Fellowship of the College of Surgeons'; and to the 'Royal Australian College of Surgeons training program'. Meanwhile, surgeons and surgical organisations from other countries often interpret Australasia to include Asia.

This means that the strength and unity of the binational nature of our College is not always recognised. New Zealanders have always been active participants in our College's activities from formation. While there is generally open internal recognition of this and of the College's binational status, externally this is often not apparent. A number of other medical colleges and surgical specialist associations use 'Australia and New Zealand', for example, the Australian and New Zealand College of Anaesthetists.

There have been a number of occasions when the issue of changing the College name has been raised, in particular by the New Zealand Fellowship. A referendum of all Fellows on the College name was held in 2007, with 57 per cent of respondents voting to change the College name to the 'Royal Australian and New Zealand College of Surgeons'. This fell short of the 75 per cent required at the time to change the Articles of Association (no longer applicable; since replaced by the Constitution). In contemporary process, the Australian *Corporations Act* requires a special resolution passed by members, with the support of at least 75 per cent of votes cast, to change a company name.

The Aotearoa New Zealand National Committee believes it is time to revisit this matter and to propose to all Fellows a change in name. ■

Dr Nicola Hill FRACS
Dr Rachelle Love FRACS
College Name Change Working Group

Use of name Aotearoa in New Zealand

The Aotearoa New Zealand National Committee has requested that the working group incorporate 'Aotearoa' into any proposed new name for the College.

The name Aotearoa can be traced back 700 years to our great navigating ancestor, Kupe. After a long voyage, Kupe observed a cloud bank and surmised that it must be gathered above a land mass. It is not clear whether he was applying this term to Great Barrier Island or Te Ika-a-Māui (the North Island) and whether it included Te Waipounamu (the South Island).

In the signing of our foundation document, Te Tiriti o Waitangi, the name Aotearoa was not used. The term Niu Tireni was. This is likely to be a transliteration of New Zealand. The origin of the name New Zealand is less familiar to most of us. Abel Tasman, the Dutch explorer, first named it Staten Land, thinking it was part of the vast southern land mass. It was subsequently renamed Nieuw Zeeland by an unknown Dutch cartographer after a province in Holland. It's not clear whether this cartographer ever set foot on this land, but it certainly seems that our country took its official name from a group who were just passing through.

After being on the periphery for many years, the name Aotearoa has organically worked its way into common parlance.

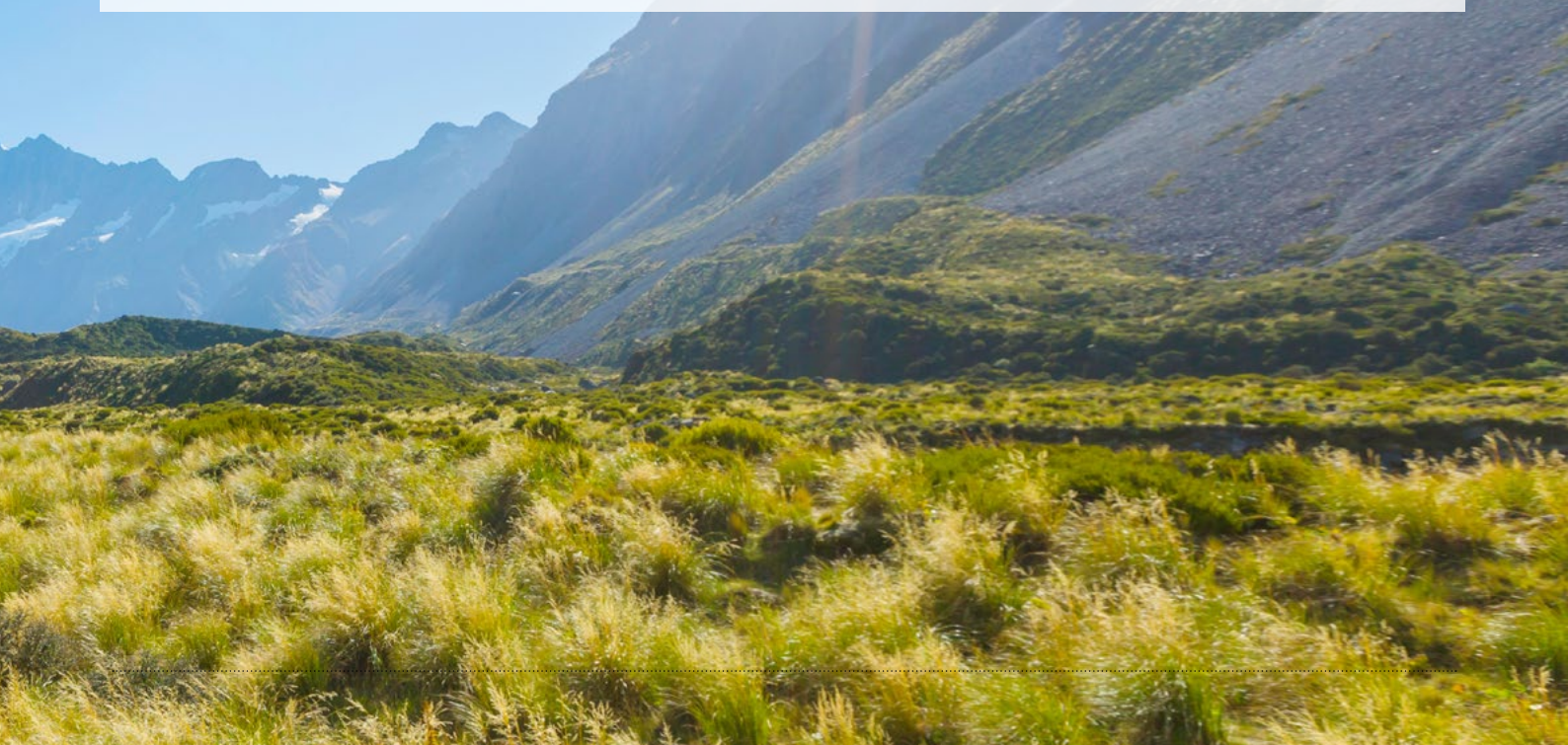
A senior colleague tells us that while she was in her 20s, Aotearoa was the first Te Reo Māori word she learned to spell. Aotearoa is now ubiquitous. It appears on official government documents, in business names, popular songs, sporting events and many other places. The words 'Aotearoa' and 'New Zealand' are paired on the cover of the New Zealand passport and banknotes. Although some struggle to pronounce the name fluently, almost all recognise it as an alternative name for New Zealand.

In a Māori world, names are significant. There is mana (honour, status and authority in this context) and obligations that come from the naming process. The obligations of our joint cultures coming together in nationhood were recognised in Te Tiriti O Waitangi. Te Tiriti is a broad statement of principles on which the British and Māori made a political compact to found a nation state and build a new government in New Zealand. There is a growing acceptance that embracing the name Aotearoa is a tangible honouring of that obligation.

However, there is an attachment to names. For example, our forebears fought for this country, New Zealand, and stood under the same flag that we acknowledge today. Many of us feel proud to be part of RACS, or to have our FRACS, and wonder what any new combination of letters might sound and look like. We worry that others won't be able to say the name or maybe that we ourselves won't really get our tongues around it. We have no issues with ordering a pinot or a cappuccino. As with surgical skills, repetition will likely sort that out. We note that, within our lifetimes, Yugoslavia is now six separate countries, Rhodesia is now Zimbabwe, and Holland is now the Netherlands. There is no doubt that there were (and perhaps still are) challenges for these countries, but the rest of the world seemed to manage, and respect, the name change without great difficulty.

In wrestling with our identity, resisting change is a default setting. We have a unique opportunity to determine how we wish to be identified as surgeons and as inhabitants of New Zealand. The proposal to change our name to include Aotearoa doesn't mean that we remove a part of our history, it incorporates another story. The first story. The story of tangata whenua, the Treaty partners. Moving forward in partnership means telling that story and it also means being an active part of that story. ■

Dr Nicola Hill FRACS
Dr Rachelle Love FRACS
College Name Change Working Group



End-Of-Financial-Year Benefits for RACS Fellows

Coming into EOFY season, your College benefits program includes exclusive offers to help you save. Visit your benefits website to find all your offers.

Member Advantage

Royal Australasian College of Surgeons

www.surgeons.org/memberbenfits

College Financial & Insurance Offers

Rediscover credit card and charge card offers with a welcome bonus for new cards. Plus an exclusive reduced annual fee for all cards taken out through Member Advantage.

Save on international money transfers with fee-free transfers over $200 AUD at OFX. Pay international invoices, send money to overseas family all with the convenience of 24/7 online access.

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Introducing our New Zealand surgical advisors

Introducing Dr Sarah Rennie and Professor Spencer Beasley, the Royal Australasian College of Surgeons (RACS) New Zealand's two new surgical advisors.

Dr Rennie and Professor Beasley replace Mr Richard Lander, former New Zealand Executive Director of Surgical Affairs. The new part-time positions are designed to make the workload more manageable for active Fellows and enable a wide range of experience to be brought to the roles.

As Surgical Advisors, Dr Rennie and Professor Beasley support Fellows, Trainees and Specialist International Medical Graduates (SIMGs) on the pathway to Fellowship who are experiencing difficulties, advocate for them through a range of forums, and provide advice to RACS Aotearoa New Zealand National Committee.

"Ultimately our role is to embody the RACS values: service, integrity, respect, compassion and collaboration," says Dr Rennie, a general surgeon. "I hope that we can provide a safe space for people to contact us, raise concerns, ideas to improve the College, ways we can advocate for our diverse population in Aotearoa New Zealand and work towards health equity.

"Some surgeons feel removed from our College and uncertain about its relevance to them. Many have had bruising experiences as Trainees," continued Dr Rennie. "However, being involved with the professional development wing of the College over the last seven years has enabled me to appreciate how passionate some Fellows and staff are about ensuring quality continuing surgical education across a wide spectrum of the College competencies."

Professor Beasley, a paediatric surgeon, says since taking up their new roles late last year, he and Dr Rennie "have been very quickly acquiring an understanding of some aspects of College function, things of which we had little knowledge previously. It has opened up new insights into how our College works. The most enjoyable part so far has been re-establishing connections and relationships with friends and colleagues and getting to know a whole lot more.

"Although we remain Fellows of the College, we are now College staff and as such our relationship with other Fellows is altered. So is our role on the various boards and committees. We are there to support Fellows of our College and provide advice as required."

Professor Beasley has carried out many roles both within his specialty society and at the College for the last 30 years, including being a RACS Councillor, Chairman of the Court of Examiners and Deputy Censor-in-Chief. "During my long association with our College I have come to deeply respect what it does for surgeons and for surgical training," he said. "It has been highly effective in representing our specialties at multiple levels, and the quality of its specialty training programs has been a major reason that surgery is of such a high standard in both countries. But challenges remain, as do opportunities to improve what we do." ■

Dr Sarah Rennie and Professor Spencer Beasley.

Developing a Career and skills in Academic Surgery (DCAS) course

Monday 10 May 2021, 7:15am – 4:30pm
Melbourne Convention and Exhibition Centre, Melbourne

6:15 am	**Registrations and light breakfast**
7:15am - 7:30am	**Welcome and Introduction - Tony Sparnon, Colin Martin and Jonathan Karpelowsky**
7:30am - 9:30am	**Session 1: A Career in Academic Surgery**
	Why every surgeon can and should be an academic surgeon - **Marc Gladman** Finding your research question - **Carrie Lubitz** Finding the time – clinical work vs research, an ongoing conundrum - **Christobel Saunders** Burnout and wellbeing, a constant challenge - **Brenessa Lindeman** Academic engagement and navigation in a new virtual world - **Eugene Kim** Panel discussion
9:30am - 10:00am	**Morning Tea**
10:00am - 11:00am	**Session 2: Inclusion and Diversity in Surgical Academia**
	Inclusion and diversity in surgical academia - How can we improve? - **Lesly Dossett** BLM an Australian Indigenous perspective - Where to in surgery? - **Kelvin Kong** BLM a U.S perspective - Where to in surgery? - **Colin Martin**
11:00am - 11:30am	**Hot topic in Academic Surgery: First in Human Trials - Michael Vallely**
11:30am -12:20pm	**Session 3: Tools for Academic Output**
	Preparing a conference abstract and presenting at a scientific meeting - **Amir Ghaferi** Writing and submitting a manuscript - **Zara Cooper**
12:20pm - 1:00pm	**Keynote Presentation: Disruption and Innovation in Academic Surgery - Peter Choong**
1:00pm - 2:00pm	**Lunch**
2:00pm - 3:10pm	**Session 4: Concurrent Academic Workshops**
	Concurrent Workshop 1: Finding My Niche / Fit / Tools of the Trade
	Basic science translational research – bedside to bench to bedside - **Michelle Locke** Clinical research and randomised control trials - **Michael Solomon** Being part of international collaborative studies - developing and engagement in international RCT - **David Gyorki** Beyond medicine - Interdisciplinary collaboration - **Payal Mukherjee** Panel discussion
	Concurrent Workshop 2: Trainee Led Collaborative Trials
	ACTA (Australian Clinical Trials Alliance) and the clinical trials landscape in Australia - **Christopher Reid** Engaging surgical trainees in collaborative research - **Sean Stevens** Starting early – Engaging medical students and their surgical societies in collaborative research - **William Ridley** Mentoring a trainee network – How I do it - **Sarah Aitken** Panel discussion
3:10pm- 3:30pm	Closing Remarks
3:30pm - 4:30pm	**Networking Function**

DCAS Course Participation:

Physical registration: $250.00 per person incl. GST (includes virtual platform access)

Virtual registration: $100.00 per person incl. GST (provides access to sessions **prior to lunch only)**

Register online:

www.tinyurl.com/DCAS2021

There are fifteen complimentary spaces available for interested medical students. Medical students who would like to register their interest, please visit www.tinyurl.com/DCAS2021 for further information.

Proudly sponsored by:

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MEDICAL DEVICES COMPANIES

Presented by:

Association for Academic Surgery in partnership with the RACS Section of Academic Surgery.

AAS Association for Academic Surgery

Royal Australasian College of Surgeons

Hot topic speaker:

Michael Vallely - Ohio, USA

Keynote speaker:

Peter Choong - Victoria

Who should attend?

Surgical Trainees, research Fellows, early career academics and any surgeon who has ever considered involvement with publication or presentation of any academic work.

If you have been to a DCAS course before, the program is designed to provide previous attendees with something new and of interest each year.

2019 comments:

"A transformational day"

"Wonderful course, as a first-time delegate this was very inspirational. All of the speakers were highly knowledgeable"

"Really informative sessions... As a prevocational doctor
I felt that the course was perfectly targeted to me"

"A truly inspirational course"

Association for Academic Surgery and International Invited Speakers:

Zara Cooper - Massachusetts, USA
Lesly Dossett - Michigan, USA
Amir Ghaferi - Michigan, USA
Eugene Kim - California, USA
Brenessa Lindeman - Birmingham, USA
Carrie Lubitz - Massachusetts, USA
Colin Martin - Alabama, USA

Australasian Faculty includes:

Sarah Aitken - New South Wales
Marc Gladman - South Australia
David Gyorki - Victoria
Richard Hanney - New South Wales
Julie Howle - New South Wales
Jonathan Karpelowsky - New South Wales
Kelvin Kong - New South Wales
Michelle Locke - New Zealand
Payal Mukherjee - New South Wales
Christopher Reid - Victoria
William Ridley - New South Wales
Christobel Saunders - Western Australia
Michael Solomon - New South Wales
Tony Sparnon - South Australia
Sean Stevens - Victoria

Notes:

New RACS Fellows presenting for convocation in 2021 will be required to marshal at 4:15pm for the Convocation Ceremony.

CPD Points will be awarded for attendance at the course with point allocation to be advised at a later date.

General Surgery Trainees who attend the RACS Developing a Career and skills in Academic Surgery course during their SET Training may, upon proof of attendance submitted to board@generalsurgeons.com.au, count this course towards one of the four compulsory GSA Trainees' Days. Information correct at time of printing, subject to change without notice.

Further Information:

Conferences and Events Management
Royal Australasian College of Surgeons
T: +61 3 9249 1117
E: dcas@surgeons.org

Embracing diversity through POSTVenTT

Surgical trainee participation in multi-centred trials has been shown to contribute significantly to advances in clinical practice, which in turn improves patient management and outcomes.

The Royal Australasian College of Surgeons, through the Clinical Trials Network Australia and New Zealand (CTANZ), is preparing a future surgical workforce of scientifically literate trainees who will develop the necessary leadership, training, organisational and analytical skills vital to successfully helping with large-scale clinical trials and studies, and also to understanding clinical research and how data can impact surgical care.

Over the last 12 months, CTANZ-associated studies have confirmed that trainee collaboratives can deliver unique and informative practice-changing research. In the SUNRRiSE International Collaborative Clinical Trial, trainees successfully recruited 300 patients at eight centres in Australia and New Zealand.

Building on this highly successful Clinical Trials Network (CTN)-UK collaborative model, CTANZ reached out to SET Trainees who, together with junior doctors and medical student societies, have created the critical mass that ensures patient recruitment numbers were met in a series of ongoing global COVIDSurg studies: several thousand patients were recruited by many hundreds of researchers. The collaborative framework within CTANZ has now facilitated more 'homegrown' multi-centred studies that will harness the energy and enthusiasm exhibited by junior doctors and medical students.

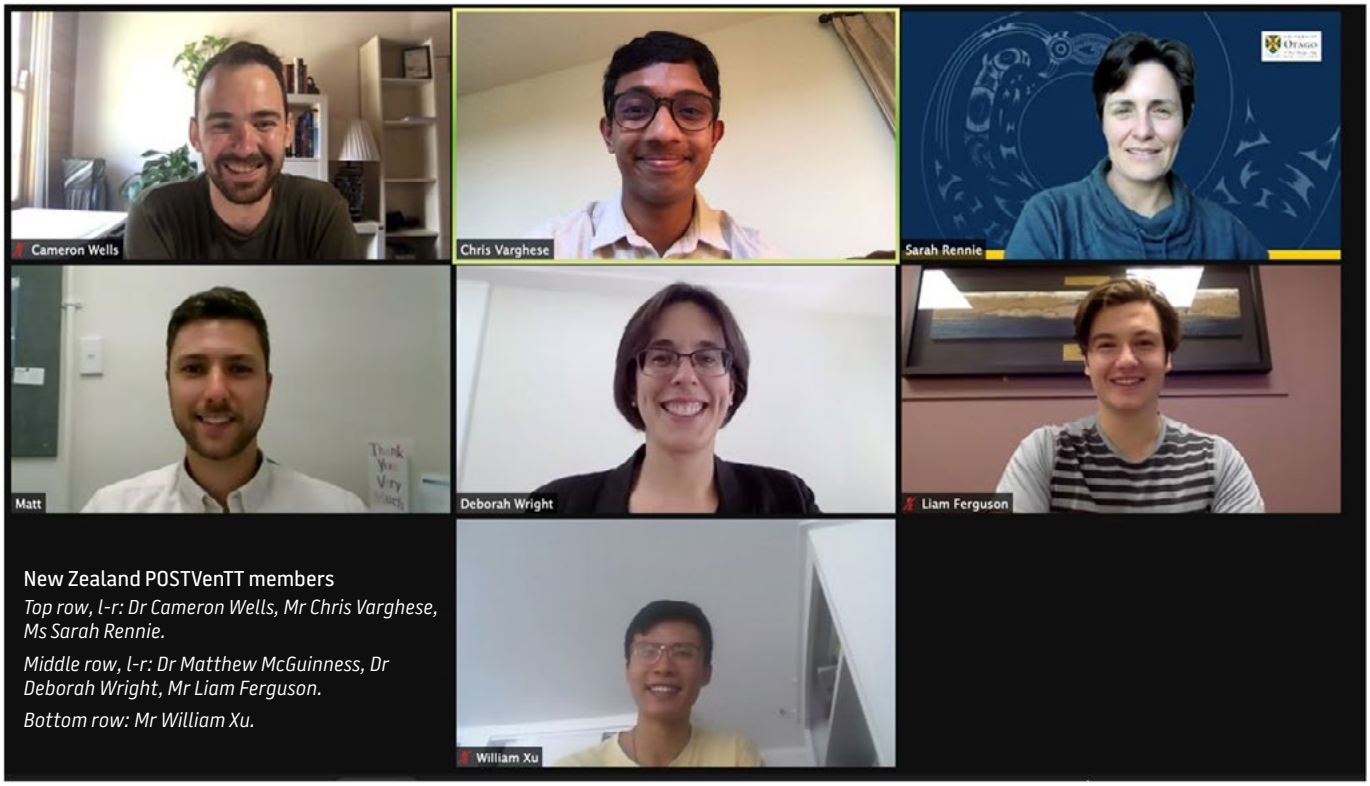
The rewarding experience provided by involvement in large-scale audits has whetted the appetite of this younger cohort of surgeons-in-training to assume greater organisational responsibility in conducting future multi-centred studies. Impeccable timing has played a part in presenting this group of juniors with an opportunity to lead and launch a new 2021 study in post-operative variability in anaemia treatment and transfusion, called POSTVenTT.

The POSTVenTT study, led by Professor Toby Richards, builds on a large multi-centre, randomised controlled trial, PREVENTT, and aims to increase our understanding of variability in adherence to anaemia management guidelines. It also aims to assess the impact on patient outcomes and readmission to hospital of anaemia management in clinical care following major surgery.

It is evident that a sustainable workforce can only be created and maintained by welcoming a diverse group of collaborators that includes junior doctors and medical students into the CTANZ program. ■

Professor David Watson FRACS

Professor Toby Richards FRACS



New Zealand POSTVenTT members

Top row, l-r: Dr Cameron Wells, Mr Chris Varghese, Ms Sarah Rennie.

Middle row, l-r: Dr Matthew McGuinness, Dr Deborah Wright, Mr Liam Ferguson.

Bottom row: Mr William Xu.

Hearing care for all: World Hearing Week in Samoa

On 3 March 2021, the Royal Australasian College of Surgeons (RACS) Global Health department celebrated World Hearing Day, established by the World Health Organization (WHO) to raise awareness of how to prevent deafness and hearing loss and promote ear and hearing care across the world.

The RACS Global Health Samoa Hearing Program supports the Samoan Government's strategy on disability and inclusion and the broader Australian Aid-funded Samoan Disability Partnership Program. This program aims to support the Samoan Government's implementation of disability-inclusive policies, plans and programs that assist in decreasing barriers for people with

disabilities to access services.

Pacific Island countries have among the highest rates of ear disease and hearing loss in the world.[1] In Samoa, approximately 40,000 children will reach school age in the next decade and, based on current service estimates, fewer than 20 per cent of these children will receive a routine hearing test. Fewer than five per cent of those with a hearing impairment will receive any hearing intervention or support. The impacts of unaddressed hearing loss or impairment on the inclusion and productive potential of Samoa's population are profound. Yet screening and hearing interventions, such as hearing aids, are a relatively cost-effective intervention to implement at scale.

RACS Global Health is responding to this critical issue under the direction of Dr Sione Pifeleti, with the Tupua Tamasese Meaole (TTM) Hospital ear nose and throat (ENT) team. The Samoa Hearing Program supports the further development of a cohesive national hearing service across Samoa to help bridge the gap between mainstream and disability services. Recent activities include the delivery of a mobile hearing trailer, and success in securing accreditation through the Samoan Qualifying Authority for the WHO Primary Ear Health training course. This course will be offered to healthcare professionals and community service providers later in the year.

For World Hearing Day, Global Health supported events such as free hearing screening clinics, talks on ear and hearing health, and promotion of ear and hearing health training for health workers in Samoa. The activities took place across a full week, with official presentations by the Minister for Health and outreach visits to rural areas such as Savai'i and Vaovai.

RACS Global Health, with the support of the Department of Foreign Affairs and Trade (DFAT) Humanitarian Corridor, has been able to deliver 32 boxes of equipment to Samoa. This included a large shipment of hearing aids and batteries, audiometers and tympanometers, as well as training materials and instruments to facilitate the delivery of the WHO Primary Ear and Hearing Care Training Program. The timely arrival of this equipment aided RACS' local partners to advocate for and raise awareness of ear and hearing health throughout World Hearing Day celebrations.

Government partners include the Ministry of Health and the Ministry of Women, Community and Social Development. Local civil society partners include SENSE, a special education organisation supporting the inclusion of those with hearing loss and impairment, to participate in education and the community, while providing other vital support to hearing impaired individuals and their families. RACS Global Health also works with local Disabled People's Organisations, Nuanua O Le Alofa (NOLA), the umbrella organisation for disability advocacy in Samoa, and SASLI, the Samoa Association of Sign Language Interpreters, who work closely with the hearing impaired community. ■

Hearing loss: facts and figures

- 400 million people, including 34 million children, are estimated to be living with hearing loss globally, and approximately 80 per cent of people with hearing loss are living in developing countries.
- Major causes of hearing loss include congenital or early-onset childhood hearing loss, chronic middle ear infections, noise-induced hearing loss and age-related hearing loss.
- Children with hearing loss and deafness in developing countries often experience greater barriers in access to education, impacting their ability to participate when navigating future employment and social contexts.
- WHO estimates that unaddressed hearing loss costs the global economy US$980 billion annually due to health sector costs (excluding the cost of hearing devices), costs of educational support, loss of productivity and societal costs.

REFERENCES

1. Kaspar A, Pifeleti S, Driscoll C. The role of health promotion in the development of ear and hearing health services in the Pacific Islands: A literature review. SAGE Open Med. 2021 Feb 10; 9:2050312121993287. doi: 10.1177/2050312121993287. PMID: 33623701; PMCID: PMC7878995.
2. Samoa Bureau of Statistics, Ministry of Women, Community and Social Development, Pacific Community and UNICEF Pacific, 2018 Samoa Disability Report: An analysis of 2016 Census of Population and Housing. UNICEF, Suva, 2018.

Over page:

Top: Dr Sione Pifeleti examines a patient.

Bottom: The SENSE team at World Hearing Day events providing information and advice on hearing devices and educational support.

Left:

Australian High Commissioner Sara Moriarty presenting Dr Sione with a certificate for completing the RACS Global Health Child Safeguarding training.

All photo credits: Ministry of Women, Social and Community Development.

PREPARATIONFORPRACTICE MELBOURNEWORKSHOP

21-22 AUGUST 2021

BUILDING BLOCKS FOR STARTING OUT IN PRIVATE PRACTICE

This two day workshop will provide surgeons, final year trainees and practice managers with information and practical skills to set up and manage private practice.

LEARN ABOUT:

- Issues involved in setting up private practice.
- Practical strategies and tools for practice operations.
- How to develop a practice framework and improve practice performance
- Managing practice staff, staff contracts and employment relations

CPD FOR FELLOWS

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

VENUE

RACS - Melbourne
250-290 Spring Street
Melbourne East, 3002

Contact:
Victorian State Office
P:9249 1254
E: College.vic@surgeons.org

https://www.surgeons.org/about-racs/racs-offices/victoria

Bringing progressive microsurgery to Australian hospitals

Dr Bishoy Soliman

Dr Bish Soliman, a Sydney-based plastic and reconstructive surgeon, used the Morgan Travelling Fellowship to advance his knowledge of microsurgery in Canada.

Dr Soliman chose the Morgan Travelling Fellowship because it fitted his needs professionally and, from a personal standpoint, his young family wanted to explore Canada. He came back with new surgical skills and refined techniques to share with colleagues and Trainees, so they can benefit from advanced, efficient microsurgical practices.

He spent the first six months of his fellowship involved in state-of-the-art microsurgery at the University of Manitoba in Winnipeg. He participated in more than 150 cases of microsurgical reconstruction, mostly of the breast, head and neck, and lower limb.

During his time in Manitoba, Dr Soliman learned advanced surgical and flap techniques that aren't yet widely used in Australia but, more importantly, he discovered how to be highly efficient in microsurgery. Now, he shares these skills with his surgical units at home, where patients can benefit from a broader range of reconstructive options.

Dr Soliman also learned new techniques in free flap planning with 3D printing. This is invaluable in head and neck reconstruction and facial trauma, as surgeons can plan their reconstruction before surgery. This takes the stress out of the procedure and reduces operating time.

He also noted that using the same well-trained team, set up and equipment for all flap cases reduces variability and helps with efficiency.

Dr Soliman saw how useful Enhanced Recovery After Surgery (ERAS) protocols can be. These multimodal perioperative care pathways are designed to solve problems that may delay recovery and, ultimately, discharge (for example, pre-op nutritional support, post-op early mobility, pain management and bowel function). ERAS protocols lead to improved outcomes and greater patient satisfaction.

Dr Soliman spent his second six months in Kelowna, British Colombia, where he enhanced his skills in aesthetic reconstructive surgery. Participating in 250 cases, he learned new techniques in the art of breast shaping and pre-operative planning for aesthetic and reconstructive breast surgery.

Dr Soliman also realised the true value of teamwork and the importance of good communication. Grateful for his experiences, Dr Soliman gave back to the system by getting involved in the resident training program. He gave talks on burns management and ran pre-exam slide sessions.

Since returning to Australia, Dr Soliman has begun two consultant microsurgery positions in Sydney tertiary referral centres. He's implementing the knowledge he learned abroad and hopes to bring more efficiency to free flap planning and execution. He also plans to set up a free flap database for research and teaching purposes, and would like to teach his microsurgical techniques to registrars.

Dr Soliman feels very grateful to have worked alongside world-class surgeons through his fellowship. He hopes more surgeons will seek out a scholarship to go abroad and return with enhanced skills, so New Zealand and Australian surgeons can share knowledge and strengthen the future of surgery in our corner of the world. ■

JDocs: five years of preparing aspiring surgeons and proceduralists

JDocs program participant Dr Sarah Page

Surgery is often characterised as a rewarding and challenging career, and the challenges start before training even begins.

Junior doctors need to have a great knowledge of the body, its systems and what can harm it. They also require an excellent knowledge of anatomy, physiology and pathology. They also need strong interpersonal, professional, cultural awareness and safety skills that allow them to listen, lead, learn, communicate effectively, make appropriate decisions, empathise and understand. But how can junior doctors and aspiring surgeons navigate their way through all of this?

The Royal Australasian College of Surgeons (RACS) established the JDocs Framework because it recognised a need to provide educational resources and guidance to junior doctors seeking to explore a proceduralist career, so they can make informed career decisions prior to committing to a specialist pathway.

The JDocs Framework and ePortfolio was launched in February 2016. It is supported by a range of learning and assessment resources and is available to any junior doctor registered in Australia and New Zealand.

The development of JDocs has been guided by the following aims:

- identify the skills, knowledge and behaviours expected of junior doctors and aspiring procedural specialists so they can be a safe and competent clinician during the early postgraduate years
- provide a range of work-based assessment strategies and tools to identify the clinical situations in which a junior doctor can demonstrate the achieved learning outcomes and professional standards
- provide junior doctors with tools and resources to support the development of their professional profile by documenting evidence of work-based assessment, achievements and experiences through the ePortfolio

The JDocs Framework is aligned to the RACS Core Competencies, with learning outcomes or activities grouped into Key Clinical Tasks (KCTs). The KCTs represent the daily professional activities undertaken by a junior doctor, where the level of performance can be observed and feedback provided. The KCT documents include options for a supervisor or mentor to provide feedback.

Cardiovascular Surgery Trainee Dr Sarah Page completed a Bachelor of Science degree, majoring in anatomy and pathology – subjects she found so interesting that she applied for a postgraduate degree in medicine. Her passion was haematology "but in my first clinical year I did some hands-on work in orthopaedics and that changed everything. The fast-paced atmosphere, technical aspects, and the teamwork in the theatre made me want to take it up," Dr Page said.

While working as an unaccredited cardiothoracic registrar in Townsville, North Queensland, a colleague suggested she contact a surgeon in Melbourne to discuss future opportunities. He provided instrumental career advice, including recommending JDocs.

Subscription to the JDocs ePortfolio (at a cost of AU$350 in 2021) enables the progressive assembly of evidence of achievements, work-based assessments and experiences, which can help support application to proceduralist specialty training.

In addition, JDocs subscribers also have access to a range of resources including:

- Generic Surgical Science Examination resources and a multiple-choice question bank
- select RACS library resources
- eLearning resources (currently 23

Dr Jennifer Chambers, RACS Chair of the Prevocational & Skills Education Committee

online modules and resources including the Aboriginal and Torres Strait Islander Cultural Safety: Course 1 and 2)

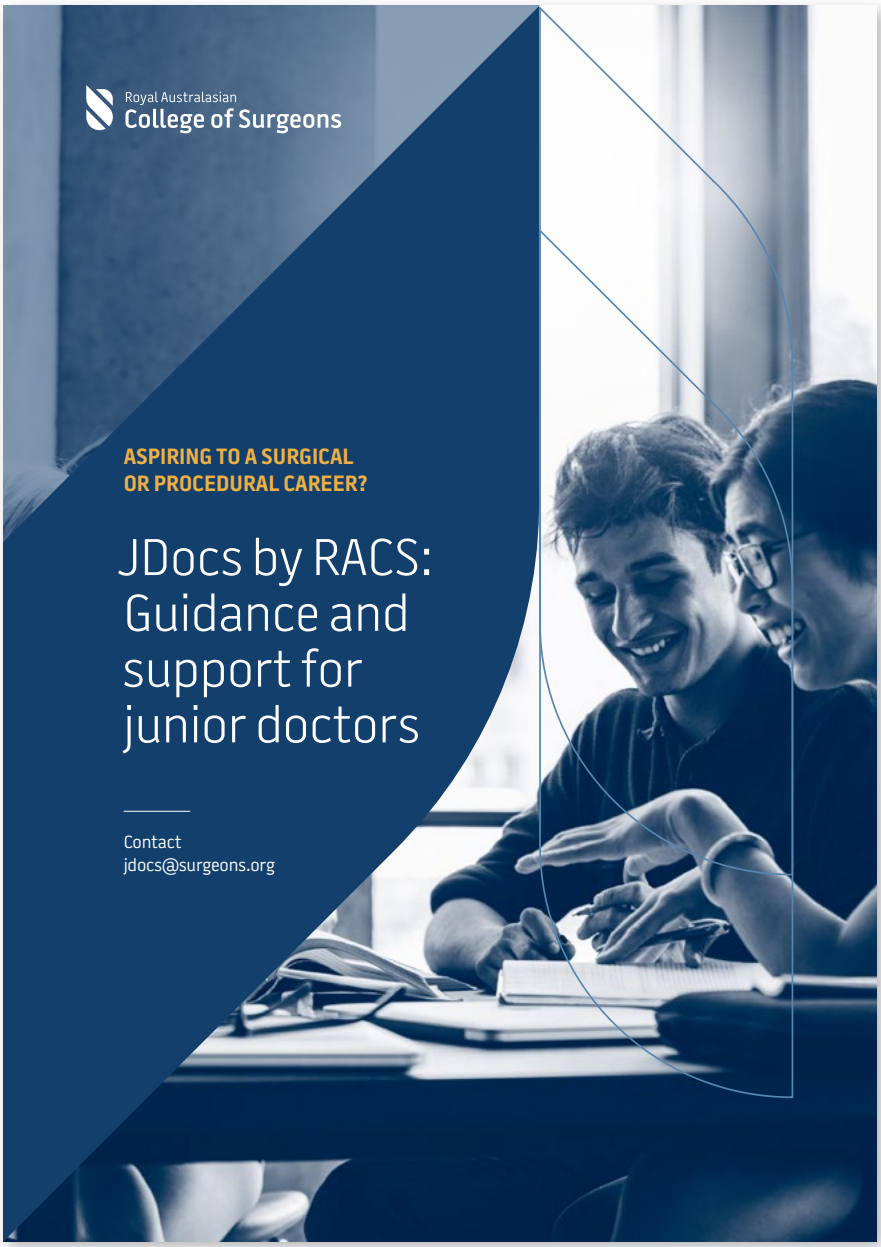
- Morbidity Audit Logbook Tool (MALT) for junior doctors

JDocs does not guarantee selection into any procedural specialty training program. However, by engaging with the JDocs Framework and ePortfolio, junior doctors can ensure their skills, knowledge and behaviours are at the level expected for entry to procedural specialist training.

Dr Page said the JDocs framework and ePortfolio have been beneficial, especially the MALT logbook, which contains a record of all the procedures and assisting she had done during her unaccredited years. This was helpful for Surgical Education and Training (SET) selection and job interviews, and when starting a new job – giving surgeons an idea of her experience. The JDocs framework proved useful when preparing for the SET interviews and the ePortfolio, RACS modules and resources came in handy. "I liked having a logbook, so I can monitor my own progress and performance, and patient outcomes. I've discovered the clinical tasks section, which will be helpful for the communication stations in the clinical exam. I would encourage junior doctors to use JDocs to track their progress and assist with their SET applications."

Dr Page's experiences with JDocs have been shared by current junior doctors who have found JDocs very helpful in covering many educational and clinical aspects of medicine and surgery. Along with being technical, JDocs elaborates on the importance of communication and decision-making – managing critical patients and assessing the risks. Dr Natasha Bertschi said that "there are many resources for planning exams and having the information in one place helps keep track of your progress. You learn what is required of you and keep to a plan, and the wide range of resources cover all the RACS competencies."

Throughout 2020, RACS increased engagement with the JDocs subscriber cohort through the newly established JDocs eNews. The newsletter provides JDocs subscribers with useful information on relevant RACS activities and has seen subscription renewals increase from 46 per cent in 2019 to nearly 60 per cent in 2020.



Dr Jennifer Chambers, Chair of the Prevocational and Skills Education Committee and JDocs champion, is meeting with the Specialty Training Boards (STBs) to increase awareness of JDocs in preparing SET applicants for the selection process. She is also seeking feedback on STB-specific requirements that can enhance the Framework. This year the Morbidity Audit and Logbook Tool (MALT) Committee membership includes a current JDocs subscriber to provide insight on the experiences of this fundamental user group.

Through the RACS portfolio, all RACS members have access to JDocs View. This allows supervisors or mentors to explore the ePortfolio resources and access and support junior doctor development on their KCTs.

There are also many free resources available on the JDocs website that can be accessed by medical students considering a career in surgery. ■

For further information on JDocs see surgeons.org/jdocs or contact jdocs@surgeons.org with any questions.

Western Australian election ends in landslide

The McGowan Government has been emphatically re-elected in Western Australia.

In the recent election in Western Australia, the Labor party won 53 of the state's 59 legislative assembly seats. The National Party now holds four seats, leaving the Liberal Party holding only two seats.

Before the 13 March poll, the Royal Australasian College of Surgeons (RACS) Western Australia Committee sent an election statement to the major parties. The statement identified six key focus areas relevant to surgery:

- Data sharing legislation
- Elective surgery waiting lists
- Ongoing COVID-19 response
- Public and private hospital re-admission rates
- Western Australian Audit of Surgical Mortality
- Use of the title surgeon

The statement provided background information on each of these issues and then posed a series of questions.

There have been many examples where RACS has been able to secure firm commitments from political parties before an election. In response to this election statement, the Labor Party reaffirmed its commitment to update the state's data sharing legislation.

With a depleted opposition lacking in resources, the role of the College and other like-minded organisations in holding the government to account will become increasingly important.

Over the next four years, the Western Australian Committee will endeavor to work with the Government and the opposition to ensure that issues of public health, particularly those relating to the delivery of surgical services, remain a priority.

To view RACS' Western Australian election statement, as well as the Labor Party response, please visit our website. ■

Potential game changer in the management of high-risk prostate cancer

Dr Renu Eapen

Dr Renu Eapen, a Melbourne-based urologist, has used the Royal Australasian College of Surgeons (RACS) Paul Mackay Bolton Scholarship to explore treatment options for men diagnosed with prostate cancer.

Dr Eapen's research has the potential to change the management of high-risk prostate cancer. It focuses on the clinical and immune landscape response to Lutetium PSMA therapy in advanced disease.

High-risk localised prostate cancer is usually treated by radical prostatectomy or radiotherapy. A significant number of these patients will progress to have local recurrence or metastatic disease. Clinical trials of neoadjuvant therapies including chemotherapy have not shown survival advantages.

Dr Eapen is looking at the clinical effects of the novel treatment Lutetium PSMA given upfront before prostate cancer surgery, through the LuTectomy trial. She wants to see how this impacts disease recurrence and long-term survival.

Excitingly, her team can interrogate tissue in the lab and understand the impact of Lutetium PSMA on the tumour microenvironment, including changes in tumour immune context and cell types. Dr Eapen hopes to identify tissue and serum biomarkers that may be associated with clinical outcomes and the factors that lead to the progression of low-risk to advanced disease.

After her urology training, Dr Eapen embarked on fellowships in the US and Canada where she spent four years training in uro-oncology and robotics, as well as functional urology. She was exposed to a great deal of prostate cancer research in highly academic centres, such as the University of California in San Francisco, which sparked her interest in the management of low-risk and high-risk disease.

After returning to Melbourne, through her work at the Peter MacCallum Cancer Centre and Austin Health, Dr Eapen found herself working with teams who were on the cutting edge of incredible research. The collaboration of urologists, nuclear medicine physicians, and medical and radiation oncologists in developing world-class trials led her to enrol in a PhD with the University of Melbourne.

The Paul Mackay Bolton Scholarship is supporting her prostate cancer research based on the LuTectomy trial and her PhD. Dr Eapen and her team will recruit 20 patients for the trial. Seven have been recruited so far.

The outcomes of the trial could potentially be game-changing in the management of high-risk prostate cancer. PSMA technology has changed the landscape in the management of prostate cancer, with significant implications in diagnosis, staging and theranostics. This use of theranostics in high-risk localised prostate cancer is pushing the boundaries even further.

Dr Eapen says the Paul Mackay Bolton Scholarship has been instrumental in backing this important work in prostate cancer.

"Research is exciting if you can imagine the implications of your findings and how they can impact on the day-to-day management of patients," she said. This potential 'bench to bedside' transition is what inspires Dr Eapen and makes her efforts worthwhile. She encourages young surgeons not to accept clinical limitations and to always think about how the situation can be made better for the patient. "This inspires ideas and the RACS scholarships are instrumental at making those ideas a reality." ■

Global Health at the RACS ASC

The past year has been especially challenging for the Royal Australasian College of Surgeons (RACS) Global Health, our partners and the communities we work with. As our programs rely largely on freedom of movement and international travel, many of our efforts in delivering safe, accessible and affordable surgical care to some of the most vulnerable and isolated communities in our region are either on hiatus or have undergone a significant operational transformation.

Our participation in the 2021 RACS Annual Scientific Congress (ASC) is no different. The ASC, to be held from the 10-14 May 2021, is a unique opportunity for RACS Global Health to connect and engage with our peers in Australia and New Zealand, as well as internationally. However, given the obvious impacts of COVID-19 on international travel, many of our overseas-based partners, who would usually travel to Australia to participate, will be unable to attend in person this year.

To overcome this unfortunate situation, RACS Global Heath has created an innovative registration option for international surgeons and other health professionals to participate virtually in the RACS ASC via offshore hubs. These hubs will allow overseas participants to dial in from surgical centres free of charge from many of RACS Global Health's partner countries across the Indo-Pacific region. This will allow us to broaden the contributions and discussion amongst participants, and share more widely the lessons and networking opportunities this important event provides.

For this year's event, RACS Global Health is proud to have confirmed a stellar cast of speakers to present on a variety of topics critical to our work. On the first day of the RACS ASC, Monday 10 May, RACS Global Health will share a welcome and introduction of the upcoming Global Health Section, presented by RACS Chair of Global Health, Miss Annette Holian, an overview of Global Health Programs by Head of Global Health Philippa Nicholson, and impacts of the East Timor Eye Program by RACS Global Health's International Advisor, ophthalmologist Dr Manoj Sharma.

Our session will also include a discussion around the preparation of a regional strategy on National Surgical, Obstetric and Anaesthesia Plans (NSOAPs) delivered by Dr Liz McLeod, a presentation on RACS Global Health Volunteering by former RACS President and Visiting Medical Team leader Mr John Batten, and a conversation about the changing face of international development with Philippa Nicholson and the CEO of Interplast, Mr Cameron Glover. Participants at this session will also be able to engage more closely with the RACS Global Health panel during a 30-minute question and answer session with the speakers at the conclusion of the presentations.

Throughout the week, participants will also have the opportunity to join a range of Global Health presentations on topics including regional health security, sustainability in health services and the prize session for Global Health abstracts.

For more information on the RACS Global Health sessions please contact Global Health Engagement Coordinator Mr James O'Keefe, at james.okeefe@surgeons.org. ■

Education activities

The Professional Development Program aims to support surgeons in aspects of their professional life, encouraging professional growth and workplace performance. Life-long learning through professional development can improve our capabilities and help us to realise our full potential as surgeons as well as individuals.

Face-to-face courses

Course	Date	Region
Clinical Decision Making	Wednesday 14 July 2021	Brisbane, Queensland
Foundation Skills for Surgical Educators	Saturday 5 June 2021	Auckland, New Zealand
	Saturday 19 June 2021	Adelaide, South Australia
	Thursday 15 July 2021	Melbourne, Victoria
Non-Technical Skills for Surgeons (NOTSS)	Friday 30 July 2021	Auckland, New Zealand
Operating with Respect	Saturday 22 May 2021	Sydney, New South Wales
	Saturday 19 June 2021	Melbourne , Victoria
	Thursday 1 July 2021	Adelaide, South Australia
	Thursday 8 July 2021	Christchurch, New Zealand
	Friday 16 July 2021	Canberra, Australian Capital Territory
Operating with Respect (Trainees)	Friday 18 June 2021	Melbourne, Victoria
Process Communication Model: Seminar 1	Friday 25-Sunday 27 June 2021	Auckland, New Zealand
Promoting Advanced Surgical Education	Friday 30-Saturday 31 July 2021	Sydney, New South Wales
Writing Medico Legal Reports	Wednesday 21 July 2021	Sydney, New South Wales

Online courses

Course	Date
Conflict and You	Wednesday 26 May 2021
	Thursday 29 July 2021
Leading out of Drama	Tuesday 15-Thursday 24 June 2021

For more information email PDactivities@surgeons.org or visit our website surgeons.org/education/professional-development

Seeking examiners

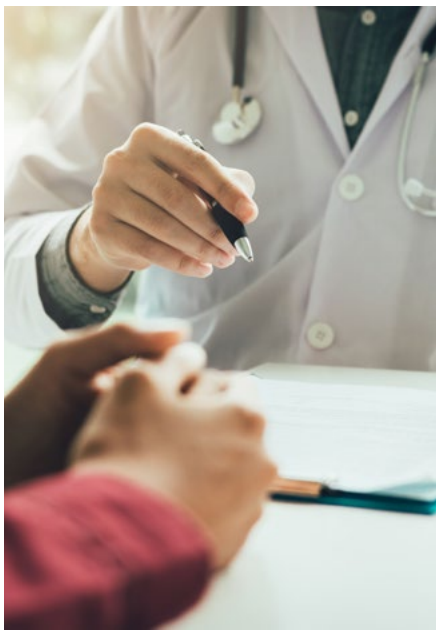
The Clinical Committee is seeking examiners for our upcoming June 2021 Clinical Examination.

The Clinical Examination will take place on Saturday 26-Sunday 27 June 2021 at the Royal Children's Hospital in Melbourne, Victoria.

The Royal Australasian College of Surgeons Clinical Examiners are involved in the assessment of Surgical Education and Training (SET) Trainees, gain valuable Continuing Professional Development (CPD) points (four points per examination) and have an opportunity to meet and build rapport with colleagues.

Please note you may be required to complete Clinical Examiner training if you have not examined before. The training will require 1-2 hours of your time and will be held a week or two before the exam. Further information will be sent in the coming weeks.

If you have any questions, please contact examinations@surgeons.org ■



Operating on the cutting edge

Virtual planning and 3D modelling technology is helping surgeons at Chris O'Brien Lifehouse perform intricate operations with tremendous results.

When 46-year-old mother-of-two Tara Flannery first noticed a lesion on her upper gum, she never could have imagined the road that lay ahead. "I received a call saying I needed to meet with the surgical team at the Lifehouse Centre because my lesion was something more sinister – cancer," she said.

After months of uncertainty and multiple biopsies, Tara was diagnosed with a squamous cell cancer. It was already surrounding her teeth and her medical team recommended the complete removal of her upper jaw. Surgically, it was far from the easiest option but it would give her the best chance of a cure.

On its own, the removal of Tara's cancer would leave significant cosmetic deformities and make it difficult, if not impossible, for her to chew and swallow. But the surgical team at Chris O'Brien Lifehouse utilised the collective expertise of head and neck ablative and reconstructive surgeons, maxillofacial surgeons, and prosthodontists from Westmead Oral Restorative Sciences to map out the removal and complete reconstruction of Tara's jaw.

Associate Professor Carsten Palme, Director of Head and Neck Surgery at Lifehouse, was one of Tara's surgeons. He said that while medical teams are good at getting cancers out, historically they have not measured up when it comes to rehabilitation.

"Dental rehabilitation is crucial to restoring a patient's appearance and function and allowing them to successfully integrate back into work and society," Associate Professor Palme said.

Lifehouse surgeons have expertise in virtual surgical planning, allowing them to comprehensively map out a patient's

Professor Jonathan Clark AM

surgery. This groundbreaking approach enables them to plan the surgery digitally, and use 3D printed models and guides with custom-made titanium plates to hold the transplanted bone in place.

"We can plan where cuts should be made, what part of the body we are going to borrow bone from, what precise part of the fibula to take, where the dental implants and bridge should be positioned, and where teeth will be in the future," Associate Professor Palme said.

Professor Jonathan Clark AM, Director of Head and Neck Research, said past procedures of this kind have relied solely on the surgeon's experience and judgement about where the bone should be located. Now virtual modelling leads to a much higher success rate. "It means the patient can walk in and out of hospital looking almost the same," he said.

In the months before her surgery Tara

Associate Professor Carsten Palme

was aware of the meticulous planning going on behind the scenes, but admits she was apprehensive given the invasive nature of the surgery. As a primary school teacher, she envisioned having to stand with a disfigured face in front of a class of 30 children.The 'what ifs' took a toll on her mental health, but Tara said going to work became a coping mechanism.

"I wanted to model resilience for the kids," she said. "There was a little girl at school who also had jaw cancer. We said we were 'jaw buddies' and would high five every time we passed. I thought, if this little girl can come to school, then I can too."

Six weeks before Tara's surgery, surgeons placed implants and a new gum lining in Tara's fibula. Dental implants are placed in the patient's leg bone and then a denture is fitted to the implants when the cancer is removed, so that the patient leaves hospital with a full set of teeth.

Above:
Tara Flannery, before her cancer diagnosis (left) and after her successful reconstructive surgery (right).

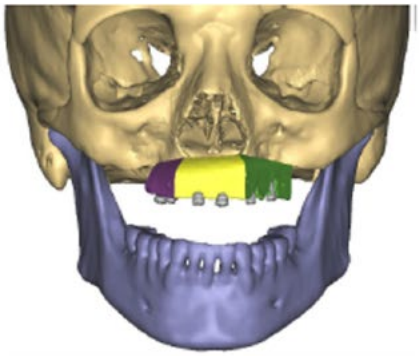
Before going into theatre on the day of her second surgery, Tara recalls being astounded at the number of surgeons and nurses lined up ready for the marathon procedure. "The surgery took 12 hours but proved a success," Tara said. "I will be eternally grateful for medical science and the skill of my surgeons."

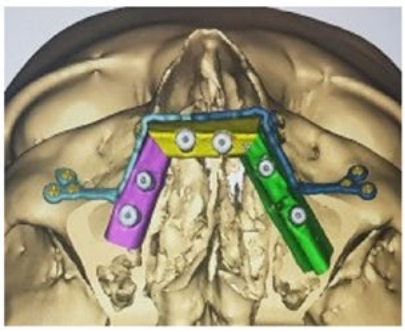
Tara's recovery has been a long process, and the pain associated with the bone removed from her fibula took two years to subside. But she is now in remission and, other than a scar on her leg from the transplant, there are no visible signs of the invasive surgery she has endured. "My daughters tell me my nose is a little bit wider, but when I'm meeting new people they have no idea," she said.

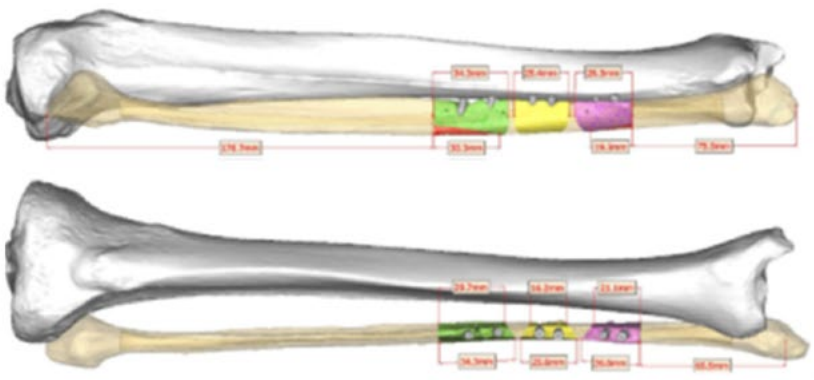
According to Associate Professor Palme, tongue and lower jaw cancers have historically occurred in male smokers and drinkers, but now a lot more young people are presenting with mouth cancers. "We are seeing the numbers increase by about five per cent every year, especially in young non-smoking women," he said. "I recently saw a 15-year-old kid who had bone cancer of the upper jaw. He will be one of the beneficiaries of this work."

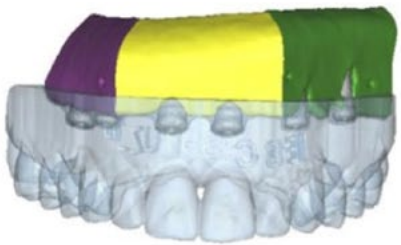
The Lifehouse team, backed by a $4 million multi-institutional grant, is currently attempting to grow bone and cartilage in laboratories, in the hope they can be used in future reconstructive operations. They expect the project will take years but are excited by what lies ahead. ■

Below:
Images from the planning stages of the operation.









Oscar Clayton: surgeon and socialite (1816-1892)

Knight Bachelor. C.B. C.M.G. LSA FRCS M.D.(Erlangen)

Oscar Clayton was featured in *Vanity Fair* on 12 September 1874 and caricatured by Carlo Pellegrini 'Ape' with the caption, 'Fashionable Surgery'. The National Portrait Gallery, London holds the original Pellegrini watercolour and the published lithograph created from it.

Vanity Fair noted, 'the son of a surgeon, Oscar Clayton was from his youth up destined to be a Doctor. By dint of hard labour made himself master of all that was known and of even more than was practised in his profession'.

Clayton qualified via University College London and the Middlesex Hospital and first practised from his father's address until in 1853 he was elected a Fellow of the Royal College of Surgeons. He spent his later years in practice at Number 5 Harley Street: Clayton was essentially a fashionable general practitioner.

From 1841, Clayton was 'surgeon' to the St Pancras Charity School for Female Children, aged between nine and 14, where children were 'treated with the strictness so difficult to accomplish, except within the walls of a public institution', he said in a later address. In 1842, Clayton had been elected a Fellow of the Royal Medical and Chirurgical Society of London, and the following year read a paper before that Society, an account of several cases of a hysterical affection of the vocal apparatus. This was to be his only recorded publication.

In 1841 and 1842, a considerable number of the institute children were afflicted with, as he told the Society, 'a short almost hacking constant cough altered to shrill screaming expiration followed by a quick catching inspiratory effort.' Following the failure of treatment with expectorants and sedatives and with 'the uproar in the building becoming alarming to the neighbourhood', Clayton assembled the children and informed them, 'I must apply a red-hot iron to the throats of all who were not quite well on the following morning.'

Any failures were to be treated by a spatula covered with a silk handkerchief and heated in boiling water. Treatment was successful with no remissions!

Vanity Fair observed, 'He was early made Surgeon to the London Police and acquired such experience that he has now grown to be the favourite medical authority consulted by young men of fashion.'

On 10 February 1840, the cousins Queen Victoria and Prince Albert were married in London: they had no less than nine children, five daughters and four sons. Their eldest son, Albert Edward, known as 'Bertie' to his family, was Prince of Wales, and heir to the throne.

Tragically, Albert, the Prince Consort, died at Windsor Castle on 14 December 1861, following chronic and debilitating medical episodes, and finally typhoid fever. At this time there were 120,000 cases of typhoid each year in England, and of these, one in six died.

In 1868, Clayton was appointed as Extra Surgeon-in-Ordinary to the Prince of Wales, later King Edward VII, and as Surgeon-in-Ordinary to his brother, Prince Alfred, Duke of Edinburgh.

In November 1871 'Bertie', the Prince of Wales, became gravely ill: at the time he was at Sandringham, where he was seen by Dr John Lowe MD FLS, a physician and naturalist medical attendant to the Royal Family at Sandringham. Dr Lowe diagnosed typhoid and sent for Clayton, who agreed with Lowe's opinion.

There was grave concern that the Prince of Wales would succumb to typhoid, just as his father had, on the 10th anniversary of his father's death. The Archbishop of Canterbury issued a form of prayer to invoke his recovery and a slightly altered version was used in Catholic churches and synagogues.

The bellringers were summoned to St Paul's Cathedral to prepare to toll out the Prince's death: miraculously, over a weekend he began to improve and thereafter made slow and continuous progress towards recovery.

With his recovery came the granting of honours. Oscar Clayton in due course collected the CB (Companion of the Order of the Bath), CMG (Companion of the Order of St Michael and St George) and a knighthood. It was usually said that Clayton had diagnosed the Prince with typhoid, whereas Dr Lowe, who had actually made the diagnosis, and attended the Prince most assiduously, received nothing! Lewis Harcourt, who was knighted at Windsor with Clayton,

wrote, 'Oscar Clayton, who is nominally doctor, but really "pimp" to the Prince of Wales'.

James Tissot's portrait, *HRH The Prince of Wales* in the *Vanity Fair* of 8 November 1873, confirms a complete recovery: *Vanity Fair* commented, 'this day he completes his 32nd year, and it is to be hoped that he will see many more before he comes to his inheritance'.

Likenesses of Clayton are rare: in 1890 his portrait was painted by Frederick Goodall and is now in the Hunterian Art Gallery in Glasgow. The art journal *The Academy* described it as the first important portrait of Sir Oscar Clayton, continuing, 'the eminent medical practitioner and *homme du monde* is represented sitting, and leaning, after his wont, somewhat heavily upon his walking stick; and while certainly observing all the time with nothing less than his accustomed shrewdness whatever persons may be in his company'.

In 1880, the magazine *Time: A Monthly Miscellany* published a sketch of a society doctor entitled 'Mr Osric Claypole', which began with, 'gold rimmed spectacles; hair carefully distributed by the brush… A rosy, healthy face… When Osric Claypole dines out, which he does on every night that he does not entertain at home, he shuffles off the last remnant of the doctoral coil and is the heartiest and merriest of companions'.

Some weeks later another review noted, 'surely Mr Osric Claypole, with his *Louis Seize* furniture, his Sèvres, and his 'younger Court' was Mr Oscar Clayton of Harley Street?'

Royal patronage was showered upon him. *Vanity Fair* stated, 'He is a favourite with all, he gives dinners where all may meet, he is always afoot, and when he retires, both he and his greys will be missed from London'.

In 1885 the *Midland Medical Miscellany* recorded, 'The career of Sir Oscar Clayton is an interesting one. He shone suddenly as a star in the medical firmament. To do him justice, he is one of the first medical men of the day, in spite of his exquisitely varnished boots and his aspiration to the juvenility that is not his'.

The former actress, Lady Bancroft, wrote in her memoirs published in 1909, that Oscar Clayton was well-known as a Court Surgeon; 'his dinners at the corner

of Harley Street sparkled with good company but were of the old fashion; a separate choice wine being served with every course, of which there were, also, far too many'.

Towards the end of his life Clayton was noted to remark, 'I should have been far more successful if I had sometimes been able to write cheques instead of prescriptions for my patients… worry kills most people, and, want of money is often the root of bodily evil'.

Plarr's Lives of the Fellows of the Royal College of Surgeons of England concluded Clayton's entry thus: 'The successful career of Sir Oscar may have aroused some jealous comment amongst his contemporaries, but he was a staunch friend, a good colleague, and a supporter of the medical profession'.

Sir Oscar Clayton died aged 76 on 27 January 1892 and his will was proved at upwards of £150,000, a very substantial fortune. No reference to partnerships, marriage or descendants is recorded. ■

Mr Peter F Burke
FRCS FRACS DHMSA

Images

Over page:

Top left: Mr Oscar Clayton. Fashionable Surgery 'Ape' 1874.

Bottom right: Prince Alfred and Prince Albert, September 1867.

This page:

Top left: Harley Street, London. Typical Georgian facade.

Bottom left: His Royal Highness The Prince of Wales, Vanity Fair, *8 November 1873.*

Top right: Oscar Clayton. Portrait by Frederick Goodall, 1890.

Pearls of wisdom from my surgical mentors

OPUS LXVIII

Part I

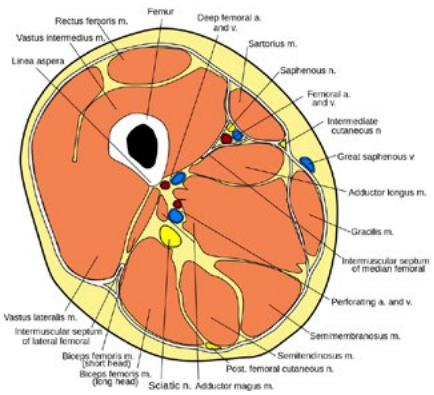
The term 'pearls of wisdom' dates back to Biblical times. In the Old Testament Book of Job it says, 'No mention shall be made of corals or pearls but the price of wisdom is above rubies'. The pearls of wisdom I have gained from my surgical mentors is the basis of this article. These range in variety like the colours of the rainbow and, at the completion of our careers, Churchill's words ring true: 'We make a living by what we get, but we make a life by what we give'.

Recently in my consulting rooms I repeated Newton's experience. He originally observed morning light's reflection off a mirror painting the colours of the rainbow. I saw the same effect in my consulting suite bathroom.

Newton's scientific eminence ranged from gravitational constants to telescopic investigations of the universe, but he always acknowledged his forebears in this scientific journey. There is a French saying, *debout sur les épaules de géants* – 'standing on the shoulders of giants' – and this mentoring article is an acknowledgement of some of my predecessors' contributions.

The late Max Hickey was my original mentor in the basic science of Anatomy at the University of Queensland. His philosophical and academic style stood him in good stead and, thanks to my father, who was on the senate, his academic appointment was approved by the University Senate in the late 1950s, contrary to the wishes of the Professorial Board.

Max had us focus on transverse anatomical sections, the bane of our lives. Little did we know in the late 1970s when CT investigations were established our background was atuned to the use of this investigative tool in the diagnosis and management of tumours and malignancies.



Transverse section of the mid-thigh showing the relationship of muscles and other vital structures.

The late Sam Mellick was the next rung in this ladder. He was a vascular surgeon from Brisbane and achieved eminence in the Royal Australasian College of Surgeons (RACS) hierarchy, holding positions from censor-in-chief to senior vice president. When visiting him at Ascot we would lunch on seafood and champagne while sitting on his veranda, his favourite distraction. His embracing lecture style imparted wisdom based on experience, something we all have tried to emulate. What a mentor he was. His style was in stark contrast to another eminent lecturer on the Oxford set – W H Auden, the composer of the poem for Rodin's Thinker. He once lectured in that post-prandial phase after lunch when he said it was like lecturing sleepwalkers.

Another figure in this mentoring saga is the late Brian Courtis, who topped the 1944 English Primary Fellowship exam, winning the Hallett Prize. He was tutored by Raymond Last of *Last's Anatomy* fame. We all used this famous textbook for our Primary FRACS but some of us had to re-read it. Brian's philosophical advice for me in surgery was simply, "if you cannot make a diagnosis, just open up and have a look".

Original French version of the dermatome pattern defined on a leather doll of the 1930s.

The late Bob Shannon, trained by Michael DeBakey in Texas, introduced me to vascular surgery for repairing large and small vessels while using the DeBakey forceps. Their gentle apposition in pincer activity was non-traumatic (suitable for coronary vessels), whereas the toothed variety of Adson and Gillies forceps could cause adventitial or paratenon damage in any reconstruction.

I joined Benny Rank at the Victorian Plastic Surgery Unit (VPSU) in 1970 to commence my transition in Plastic and Reconstructive Surgery. This was the beginning of my journey into surgical refinement in the fields of head and neck, hand and general reconstructive surgery.

London was the next phase in my maturation process. I worked at three major teaching hospitals doing head and neck surgery and established hand units at each. I am grateful to the late David Conroy for suggesting I go to London to do the College course and stay at Nuffield for six weeks – I ended up staying three years. Over lunch at the PANCH (Preston and Northcote Community Hospital) in the Doctors dining hall David suggested I do the English Fellowship, including the College course to become acquainted with surgery on the London scene.

William Cheselden by Jonathan Richardson the elder.

This English Fellowship course had some light moments and I recall an incident with one of the other surgical personalities on my first bus trip to St Thomas'. He greeted me with a handshake and was obviously from the Oxbridge fraternity. My maroon and navy club tie caught his eye. "Kings College, Cambridge, I presume?" he said. I could not resist giving my reply, "No, I'm sorry, Fosseys of Footscray in Melbourne".

The accommodation at Nuffield, next to the Royal College of Surgeons (RCS) in Lincoln's Inn Fields, became my surgical focus. In the corridor linking Nuffield to the College, this portrait of William Cheselden I passed many times. He was also Isaac Newton's physician.

My English Fellowship exam with Felix Eastcott, who did the first carotid endarterectomy at Middlesex Hospital in London, was no more than a social interchange. We spent the whole time discussing Maurice Ewing from the Middlesex and his transition to the Antipodes as the inaugural James Stewart Chair of Surgery at the University of Melbourne.

Tompsett's image of stillborn child of the vascular patterns of the head and neck in the Huntarian Museum at the RCS.

At Nuffield I became deputy warden before becoming a Research Fellow at the RCS, assisting DH Tomsett with his vascular anatomy resin studies.

Royal College of Surgeons, London adjacent to Nuffield College.

This research led to the establishment of the 'angiotome', a term describing the neuro dermatomal background of island flaps with a fascial base and random perforator blood supply. Simply, if there is a nerve supply, there must be a blood supply. Historically, the focus of vascular investigation of the perferator architecture has not highlighted any aspects of somatic, autonomic and lymphatic input. Let us not forget, nature gave us all these modalities. The development of the keystone has been my tool to documenting these essential clinical contributions all based on clinical observations with an embryological basis.

Now back to dermatomes. Sir Henry Head, a neurologist at Trinity College, Cambridge, established the pattern of the dermatomes in 1929. Russell Brain from Queen Square, London, said of Henry Head, "Some men find teaching difficult: others are born exponents".

Benny and I became mutual friends. He was not one for familiarity but we respected each other's personalities. Every time he came to London over those three years, I was his *aide-de-champ*.

Sir Henry Head, neurologist at Trinity College Cambridge, established the pattern of the dermatomes in 1929.

On the evening following the Queen's bestowal of his Knighthood at Buckingham Palace in October 1973, he invited me to return to Melbourne – yes, the wine must have been talking!

His stern teaching style reflected his wartime aptitude but in all surgical procedures he always had the patient's interests at heart. Even on ward rounds we learnt this one simple principle from him: "What is best for the patient?"

Benny subsequently offered some critiques about some of my reconstructive procedures of doing island flaps in lower limb repairs, a little contrary to his own dogmas. But the keystone island flap worked successfully, reflecting the Helen Keller dictum of heresy and orthodoxy, which I have quoted in the past: "the heresy of one age becomes the orthodoxy of the next".

Incidentally, Don Marshall totally supported my island flap reconstruction ideas and used my cases with acknowledgement at one of the plenary sessions of the RACS meetings in the 90s.

Finally, I must mention the late Bill Manchester from New Zealand, my next mentor. We met at the fifth international Plastic Surgical Congress in Melbourne in 1971 before meeting again at the Madrid Congress in 1972, where I gave my first 'Angiotome Concept' presentation. Afterwards, he said, "Felix, traditionally I don't know where you are coming from, but keep it up." What a mentoring gesture during my phase of exploring new avenues of reconstruction! ■

End of part I

Associate Professor
Felix Behan

RACS welcomes new draft road safety strategy

Every year, around 1200 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. This does not even take into consideration the countless other lives shattered in the process.

As we enter a new decade, we must draw a line and recalibrate.

In February, the Australian Government released its draft National Road Safety Strategy 2021-2030. The draft strategy outlined a series of targets to reduce deaths and serious injuries on our roads, setting us on the path to achieve Vision Zero (zero deaths and serious injuries) by 2050.

The draft strategy has three key themes: Safe Roads, Safe Vehicles and Safe Road Use.

Safe speeds, which was considered as a fourth theme in the previous strategy, has been highlighted as an overarching message and is integrated into all of the other areas.

In response, the Royal Australasian College of Surgeons (RACS) commended the extensive consultation that has occurred in developing the draft strategy. The College is satisfied that the vast majority of our recommendations, made in prior consultations, have been considered and implemented.

Our response is available on the RACS website by searching for '2020-2031 Road Safety Strategy' and highlights a number of initiatives that the College is supportive of. One of these is the central role that the Government's Office of Road Safety will play in the strategy.

The establishment of this office was a key recommendation of the 2018 Inquiry into the effectiveness of the previous road safety strategy, and it will play an important role in providing national oversight of and ensuring ongoing accountability in the new strategy.

While RACS welcomes the draft strategy, it is important to reiterate that the hard work has yet to begin. Australia failed to meet the conservative targets identified in the National Road Safety Strategy 2011-2020. We cannot allow this to happen again.

It is therefore imperative that the Government remains committed to delivering the objectives of the new strategy throughout its tenure. This includes updating the strategy when necessary and dedicating the appropriate resources to allow this to happen.

RACS recognises that it is incumbent upon us all to work towards these objectives, and we remain committed, throughout the duration of the strategy, to advocating for and supporting sensible policies that aim to eliminate death and serious injury on our roads. ■

The American College of Surgeons in Australia and New Zealand

Calling all RACS Fellows and Trainees: the Australia New Zealand (ANZ) Chapter of the American College of Surgeons (ACS) invites you to apply to become a member and enjoy the benefits.

The ACS ANZ Chapter promotes the objectives of ACS, including elevating the standards of surgery, establishing a standard of competency and character for practitioners of surgery and educating the public and profession regarding training in surgery.

The Chapter facilitates communication among its members and works towards building new and stronger links between the ACS and RACS, to enable a united effort in improving the care of surgical patients.

Founded 36 years ago, the ANZ Chapter welcomes all RACS Fellows and Trainees. Those holding FRACS for more than three years can immediately apply to become members. Those holding FRACS for less than three years can apply to become associate members and Trainees can apply to be guests.

Professor Andrew Hill, a general surgeon based in Auckland, is the current President of the ANZ Chapter Council. "The benefits of being a member of the Chapter include meeting and networking with other members of the ACS across Australia and New Zealand," he said.

"However, the main benefits come from being FACS, which requires an interview process and involves having your surgical education and training, qualifications, competence and ethical conduct rigorously evaluated and being found consistent with the high standards established and demanded by the College.

"FACS also gives you heavily discounted registration, including an online option, to the annual ACS clinical congress, the largest surgery conference in the world, attracting members and presenters from all over the world," he continued.

"It also gives you access to a wealth of educational resources to support life-long learning."

The ANZ Chapter meets once a year at the Annual Scientific Congress (ASC) and it funds and runs a number of scholarship programs. These include the Hugh Johnston ANZ Chapter ACS Travelling Fellowship and the John Buckingham Travelling Scholarship, which provide for a young Fellow and Trainee to travel to the United States and attend the Annual Clinical Congress of the ACS.

RACS has provided administrative support to the ANZ Chapter of the ACS for many years. This support is currently provided by the Fellowship Services Department and the Finance Department. ■

For more information visit: surgeons.org/en/Resources/interest-groups-sections/anz-chapter-of-the-american-college-of-surgeons.

Who should use the title 'surgeon' in Australia?

As many members know, while the use of the title 'specialist surgeon' is restricted in Australia, the use of 'surgeon' itself is not protected or restricted. Last year, the Australian Health Practitioner Regulation Agency (Ahpra) wrote to the Royal Australasian College of Surgeons (RACS) expressing the following view.

Enforcement of use of the title 'surgeon' is complex as the term 'surgeon', with other descriptors, is used commonly to describe medical practitioners who, as part of their usual practice, perform surgical procedures of varying invasiveness. This reflects the common definition of surgery, as well as the fact that the basic medical qualification is generally a 'bachelor or doctor of medicine and surgery'.

This means there is little to prevent any medical practitioner from referring to themselves as a 'cosmetic surgeon', or other similar titles. Meanwhile, using 'surgeon' in combination with other words that imply a person is registered in a particular surgical field of specialty practice (i.e. one of the nine RACS specialties), is prohibited when the person using the term is not registered in that specialty.

However, there is some movement on this issue happening at a government level. Not long before their focus turned to the COVID-19 pandemic, Australian health ministers announced they would undertake 'consultation on which medical practitioners should be able to use the title "surgeon"'. With this process in mind, RACS decided to reconsider the issue, and in February endorsed a new position on who should be able to use 'surgeon' in their title in Australia.

It must be recognised that Australian governments do not seek to protect medical titles in order to protect the interests or prestige of practitioners; they do so with the aim of ensuring Australians have access to a safe and competent registered health workforce.

The RACS position is that those who are not specialist surgeons should be restricted from using 'surgeon' in their titles, except if they are a member of a medical profession which has a significant surgical training component in its curricula. (Such professions include specialist medical practitioners in obstetrics and gynaecology and ophthalmology.) According to the RACS position, these medical practitioners would be able to use 'surgeon' in combination with relevant 'qualifier' or 'descriptor' words that accurately describe their scope of practice. This would allow titles such as 'ophthalmic surgeon'.

General practitioners in areas of need, where other medical specialists are less accessible, and when they have attained their qualifications via Australian Medical College accredited courses including a surgical component, would also be able to use 'surgeon' in their title. This would only be in combination with the words 'GP' or 'general practitioner', allowing the titles 'GP surgeon' or 'general practitioner surgeon'.

This position is one that cannot be construed as RACS restricting the title to RACS Fellows. Its focus on surgical training means the position is primarily about patient safety. Allowing GPs with relevant training in underserved areas to use the term acknowledges the need to ensure equitable access.

With this new position confirmed, RACS will be engaging with Australian governments as their focus widens beyond COVID-19. ■

The detail of RACS' position can be found on the RACS website at surgeons.org/about-racs/position-papers.

Academic gown donation

RACS would like to thank Mrs Sue Armstrong for the generous donation of Mr W. L. H. Armstrong's academic gown to the College, and Mr Kenneth MacGowan FRACS for the generous donation of his academic gown to the College.

RACS preserves academic gowns for use by Convocating Fellows and at graduation ceremonies at the College. If you no longer have use for your gown, RACS would be grateful to add to our reserve. We can acknowledge your donation and place your name on the gown if you approve.

To donate your gown, please contact the Conference and Events Department +61 3 9249 1248. Alternatively you could mail the gown to Ms Ally Chen c/o Conferences and Events Department, Royal Australasian College of Surgeons, 250-290 Spring St, EAST MELBOURNE, VIC 3002.

Case note review

Introduction of the audit of surgical mortality in Tasmania

Tasmania has Australia's oldest (median age 42) and most regionally dispersed population. A relatively high proportion of its population of around 534,000 (as of June 2019) lives in areas of disadvantage, as compared with other states. More than 33 per cent of Tasmanians are living within geographic areas in the lowest quintiles of disadvantage, as classified by the Australian Bureau of Statistics' socio-economic indexes for areas. Along with age and socio-economic disadvantage, reduced education rates, reduced employment rates and other environmental factors combine with the result that Tasmanians have the highest burden of chronic disease, the highest prevalence of risk factors (e.g. smoking prevalence and high blood pressure) and generally the poorest health outcomes of any state in Australia.

Tasmania was the second jurisdiction in Australia to introduce an audit of surgical mortality in 2004. This was based on the successful introduction of the Western Australian Audit of Surgical Mortality (WAASM), which commenced on 1 June 2001 as a pilot project under the management of the University of Western Australia (based on the then Scottish Surgical Mortality Audit).

Mr Rob Bohmer and I were appointed by the Tasmanian Audit of Surgical Mortality (TASM) Management Committee as the inaugural chairman and program manager, respectively. Together we have now completed 16 annual reports. While working under the aegis of the RACS TASM Management Committee my salary has been paid by the Tasmanian Department of Health (DoH) under a contracted arrangement. As a result, I actively participate in the Clinical Quality, Regulation and Accreditation unit within DoH, Tasmania.

Due to Tasmania's relatively small number of public hospitals (Royal Hobart Hospital, Launceston General Hospital, North West Regional Hospital and Mersey Community Hospital), Tasmania quickly arrived at a position where every surgeon in public practice in the state was enrolled in the audit. From the outset, all public hospitals referred all eligible deaths fitting the audit criteria to TASM.

Tasmanian private hospitals were also engaged from 2004. Calvary Health Care operates two hospitals in Hobart, Calvary Lenah Valley and St John's Hospital, and two in Launceston, St Luke's Hospital and St Vincent's Hospital. In addition, Healthscope operates the Hobart Private Hospital, and Healthcare Australia Pty Ltd operates the North West Private Hospital in Burnie.

Tasmania became the first state in Australia to include all anaesthetists in the audit, starting from 2004. This initiative has since been picked up by other jurisdictions, including New Zealand.

Over the past 16 years, 2300 deaths have been reported to TASM. These have all been recorded and reviewed, giving TASM a rich dataset of surgical mortality.

Recruitment of both surgeon and anaesthetist first-line assessors has been very strong since the inception of TASM, however an issue in a small jurisdiction such as Tasmania, is the ability to appoint second-line assessors. TASM welcomes and encourages recruitment of second-line assessors.

Not only does this activity provide continuing professional development (CPD) points to the assessor, but it provides deeper learning into the patient journey and identification of where there may have been system or process errors. The feedback provided to the treating surgeon and anaesthetist helps inform and educate them about valuable lessons learned and helps facilitate change for best practice.

The RACS TASM Management Committee

meets twice a year, with the membership consisting of RACS members, a member of the Australian and New Zealand College of Anaesthetists, a member from the Tasmanian DoH, and a member from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. The Chair, Mr Rob Bohmer, specialises in upper gastrointestinal and hepatobiliary surgery across both the public and private sectors.

In conjunction with the Tasmanian DoH, TASM presents individual hospital reports to each public and private hospital in Tasmania every year. The state TASM report is tabled with the Tasmanian Minister for Health and the Secretary of Health at the end of each calendar year.

There are ongoing professional development activities either run by TASM or undertaken in conjunction with RACS and the Tasmanian DoH Clinical Quality, Regulation and Accreditation unit. These sessions have been well supported and provide opportunities for ongoing discussion about quality improvement in areas such as unexpected death, improving patient outcomes, patient safety and culture. ■

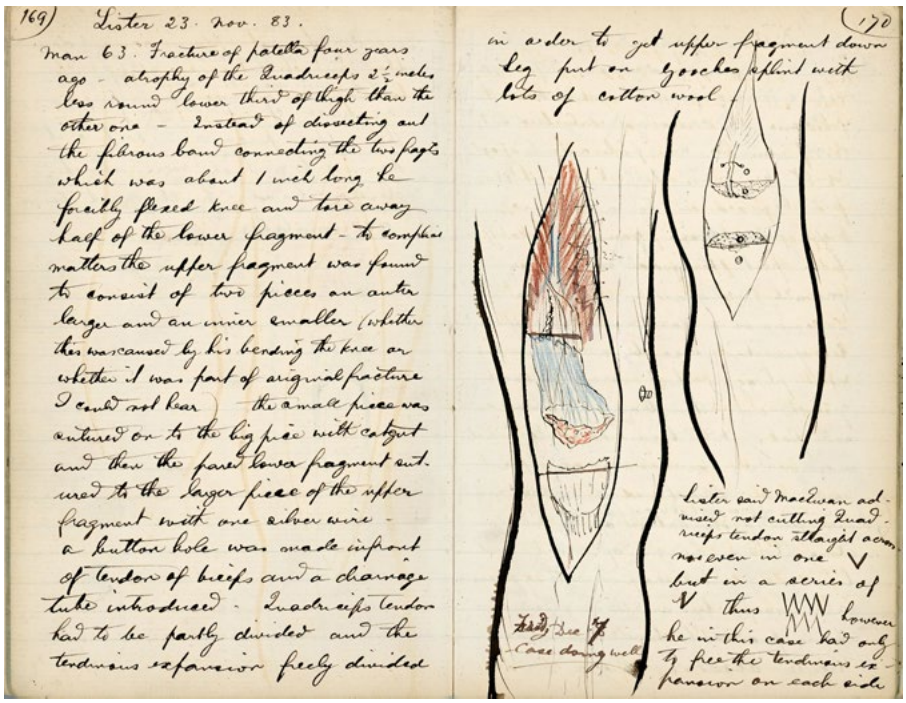
Ms Lisa Lynch (with Mr Rob Bohmer FRACS)

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

Vala Afshar

A glance at Archibald Watson's surgical diary

London, January 1882-April 1884


169) Lister 23 Nov. 83.
Man 63. Fracture of patella four years ago - atrophy of the Quadriceps 2½ inches less round lower third of thigh than the other one - Instead of dissecting out the fibrous band connecting the two fragts which was about 1 inch long he forcibly flexed knee and tore away half of the lower fragment - to complicate matters the upper fragment was found to consist of two pieces an outer larger and an inner smaller (whether this was caused by his bending the knee or whether it was part of original fracture I could not hear) the small piece was sutured on to the big piece with catgut and then the pared lower fragment to the lower piece of the upper fragment with one silver wire - a button hole was made in front of tendon of biceps and a drainage tube introduced - Quadriceps tendon had to be partly divided and the tendinous expansion freely divided
170
in order to get upper fragment down leg put on Gooches splint with bits of cotton wool
Lister said Macewan advised not cutting Quadriceps tendon straight across nor even in one V but in a series of V thus WW however he in this case had only to free the tendinous expansion on each side
Case doing well

Images from Watson's surgical diary. Patella operation- Lister page 169-170.

Born in Tarcutta, New South Wales in 1849, Archibald Watson had a chequered early life and in 1872 he was aboard the notorious brig *Carl* when she was involved in 'blackbirding' activities in the Pacific.[1]

In 1873, Watson travelled to Europe and studied medicine at the Georg-August Universität Göttingen (MD 1878) and the Université de Paris (MD 1880). By 1880, he was in London working as an assistant demonstrator in anatomy at the Charing Cross Hospital Medical School and studying surgery under Joseph Lister. He was already a member of the Royal College of Surgeons (RCS) and was working towards his Fellowship, which he obtained in 1884.

Watson's densely written 384-page diary, filled with illustrations and addenda, meticulously records operations performed by some of the most notable surgeons of the period. Prominent among them are Joseph Lister, Jonathon Hutchinson, Christopher Heath, John Whitaker Hulke, John Wood, James Cantlie, Henry Morris, William Savory and Waren Tay.

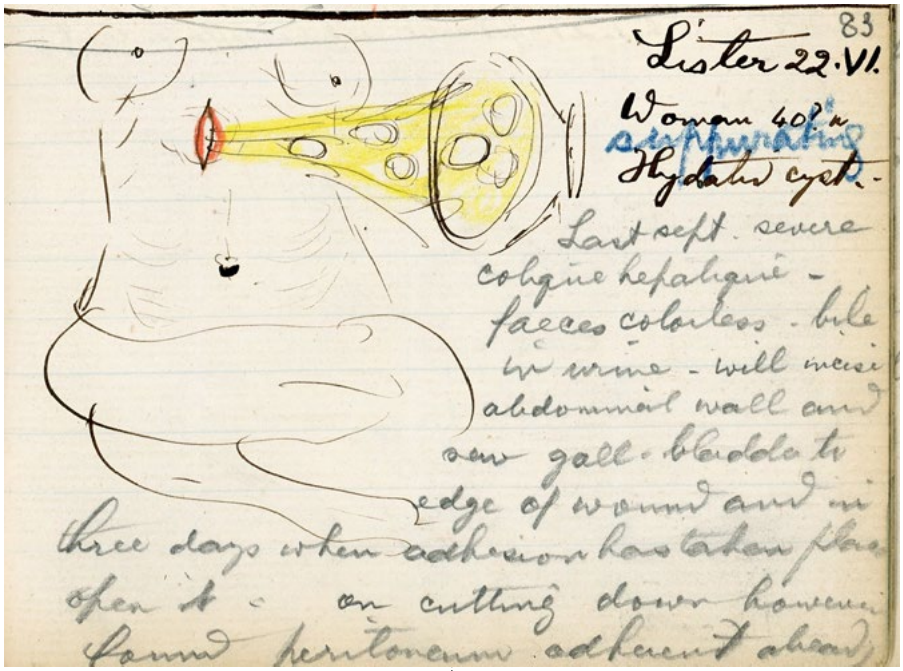
Lister is a pervasive influence in Watson's diary. His role as a pioneer of antiseptic surgery is undisputed and by 1867, he was using carbolic acid as an antiseptic in the operating theatres, as well as for dressings and sterilising instruments.

In 1877, Lister left Edinburgh to replace Sir William Fergusson at the King's College Hospital in London. While Watson records only about 15 of Lister's operations, he clearly thought highly of him. On 7 December 1883, Watson noted, 'Lister came to the hospital a Baronet today'.

There are numerous references to Lister throughout the diary. On the 18 January 1884, for example, John Hulke operated on a boy for phimosis and Watson noted that Hulke 'likes Lister's dressing forceps only with longer blades'. Similarly, in notes made in August 1884 about multiple cystic epithelioma, Watson mentions that 'Wood likes Lister's method of elevation thereby emptying the veins by gravitation and the capillaries and arteries by reflex action'. Other references include Lister's plates and Lister's verband. It is apparent that many of the surgeons that Watson observed embraced Lister's innovations and his theories of antisepsis.

Lister's innovations included a method of repairing kneecaps with a metal wire, the use of catgut sutures and rubber drains. Watson described these methods in an operation on 23 November 1883.

Fracture of patella four years ago – atrophy of quadriceps 21/2 inches less round lower third of thigh than other one – instead of dissecting out the fibrous band connecting the two fragts [sic] which was about 1 inch long he forcibly flexed knee and tore away half of lower fragment – to complicate matters the upper fragment was found to consist of two pieces an outer layer and an inner smaller (whether this was caused by his bending the knee or whether it was part of the original fracture I could not hear) – the small piece was sutured on to the big piece with catgut and then the pared lower fragment to the lower piece of the upper fragment with silver wire – a button hole was made in front of the tendon of the biceps and a drainage tube introduced – quadriceps tendon had to be partly divided and the tendinous expansion freely divided



Left:
Hydatids 1, Lister page 84.

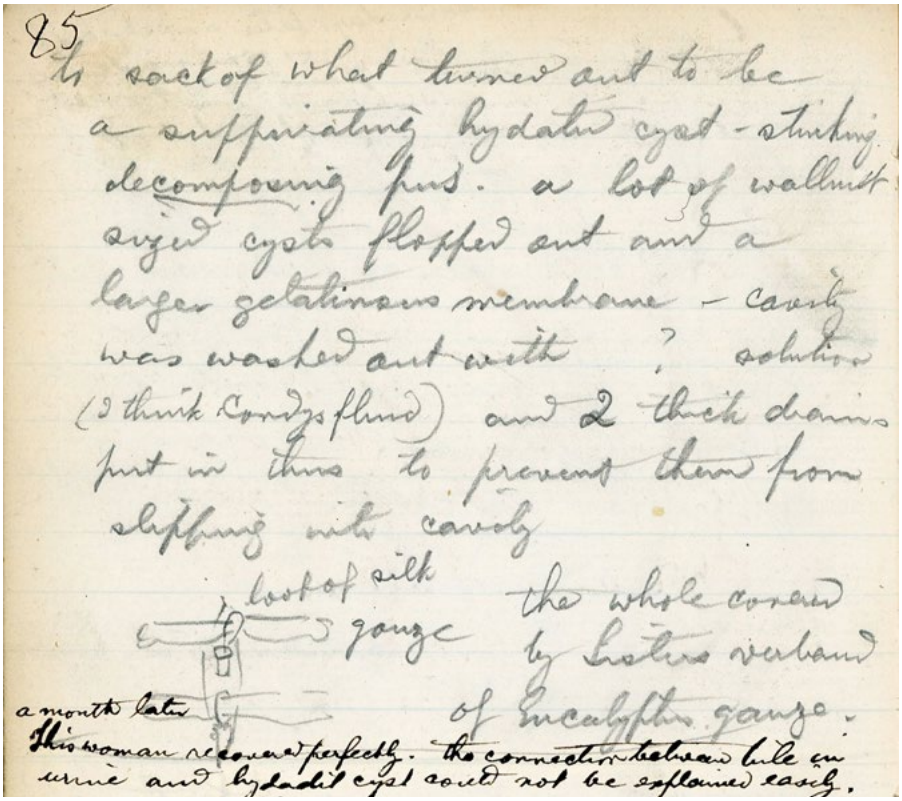
Below:
Hydatids 2, Lister page 85.

in order to get upper fragment down leg – put on Gooches splint with lots of cotton wool

The procedures observed in the diary were diverse and ranged across every specialty. On the 26 June 1883, Watson watched another of Lister's operations on a woman with hydatid cysts.

Last sept severe colique hepatique – faeces colorless [sic] – bile in urine – will incise abdominal wall and sew gall bladder to edge of wound and in three days when adhesion has taken place open it – on cutting down however found peritoneum adjacent ahead to sack of what turned out to be a suppurating hydatid cyst – stinking decomposing pus – a lot of wallnut[sic] sized cysts flopped out and a larger gelatinous membrane – cavity was washed out with ? [sic] solution (I think Condy's fluid) and 2 thick drains put in thus to prevent them from slipping with cavity

The whole covered by Listers verband [sic] of eucalyptus gauze



Watson's first surgical diary is significant because it provides insights into late 19th century surgery, and to the great surgical names of the period. ■

Elizabeth Milford, RACS Archivist

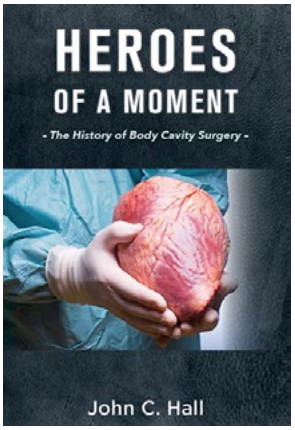
REFERENCES

1. See Carter, J, *Painting the Islands Vermillion*, Melbourne University Press, 1995 and https://adb.anu.edu.au/biography/watson-archibald-8997

Good reads

Heroes of a Moment: The History of Body Cavity Surgery

John Hall



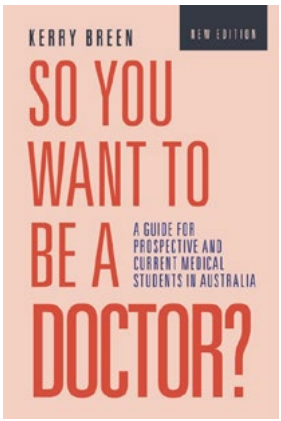
Heroes of a Moment details the most productive period in the history of surgery. Anaesthesia and antisepsis made it possible to explore the contents of the abdomen, chest and skull. However, even in the early part of the 20th century, these main cavities of the body were only invaded by the most adventurous surgeons.

Once the mechanics of operating had advanced, science and technology became the drivers for change. These changes were reflected in the equipment used by surgeons, the architecture of hospitals, and the nature of being a surgeon. The expansion in manufacturing that occurred after World War II fuelled a new era of open body cavity surgery.

Another big advance occurred in the 1990s when the rapid uptake of laparoscopic cholecystectomy generated the 'escape velocity' needed to progress minimal access surgery. At the end of the 19th century, surgeons used cutlery; by the 21st century, they were looking at digital images and flirting with robots.

So You Want To Be a Doctor?

Kerry J Breen



This book is an Australian first. It is designed to help young people who are thinking about applying to study medicine and become doctors to become as fully informed as possible in regard to what is required to be successful in their application, and more importantly what is really involved in a career in medicine.

The book describes the attributes that the Australian community desires in its doctors, the prerequisites for entry into medical school, the nature of the educational programs offered by Australia's nineteen medical schools and the expectations placed upon medical students. It includes advice about study methods, financial support and balancing study with part-time work and a social life.

In memoriam

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

Our condolences to the family, friends and colleagues of the following Fellows whose deaths have been recently notified.

William David Proudman (SA)

Keith McDowell Ewen (NZ)

Helen Rae Noblett (NZ)

Informing RACS

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

ACT: college.act@surgeons.org

NSW: college.nsw@surgeons.org

NZ: college.nz@surgeons.org

QLD: college.qld@surgeons.org

SA: college.sa@surgeons.org

TAS: college.tas@surgeons.org

VIC: college.vic@surgeons.org

WA: college.wa@surgeons.org

NT: college.nt@surgeons.org

William David (Bill) Proudman AO MBBS FRCS FRACS

General surgeon

20 January 1928-16 February 2021

Born in Adelaide in 1928, Bill was foremost among surgeons in South Australia and a highly valued mentor to many students and surgeons throughout his career. He was truly a general surgeon, able to operate in many areas that are now separated into sub-specialties. He contributed greatly to his profession, the Royal Australasian College of Surgeons and the community.

After attending Glenelg Primary School and St Peter's College, Bill graduated from medicine at the University of Adelaide in 1951. Shortly afterwards, he travelled to the United Kingdom where, after several years, he became a Fellow of the Royal College of Surgeons of England. He returned to Adelaide in 1958 where he became a Fellow of the Royal Australasian College of Surgeons after further training.

When The Queen Elizabeth Hospital (TQEH) opened in 1959, he was appointed the first senior registrar in the Department of Surgery. He subsequently joined the ranks of the honorary consultant staff, where he became one of the specialists who provided clinical services and graduate and undergraduate teaching on a voluntary basis. This practice continued for another ten years until the excessive demands on clinicians were recognised and payment was introduced.

In 1965, together with Dr Peter Knight, Bill performed the first successful live donor renal transplant procedure in Australia. It was performed at TQEH with Bill removing the kidney from the donor. The actual procedure proved hazardous with the discovery of a vascular anomaly, but ultimately resulted in the delivery of a viable donor kidney.

The use of a live donor was highly controversial at the time and Bill played a leading role in gaining the approval of the Ethics Committee to perform the procedure.

In the early 1960s, the surgical transplant team spent many sessions in the Animal House at TQEH developing and honing their skills in renal transplant surgery. Immunosuppressive medication was in its infancy and Bill was closely involved in the planning and establishment of protocols for every aspect of the renal transplant process. He continued to play a leadership role in obtaining renal transplants from many live and deceased donors over many years.

Bill was a highly skilled surgeon and one of the key innovators in the development of parathyroid surgery in Adelaide in the 1970s. He authored scientific papers on thyroid and parathyroid surgery. He performed the first insertion of an Austin-Moore prosthesis in a patient with a fractured hip at TQEH, illustrating his ability to operate in a broad range of areas.

Bill remained in South Australia, providing a lifetime of surgical service and education to aspiring young surgeons. His extraordinary knowledge, clinical skills and judgement were highly sought after and valued by generations of students and colleagues. 'Proudman's Rules of Surgery' are still quoted.

In addition to surgical matters, he had an outstanding knowledge of the basic surgical sciences (histopathology, anatomy and physiology) and rare medical conditions, which he eagerly debated with his colleagues in their own fields of expertise. Such was his passion for knowledge and education.

This obituary was provided by Mr Tim Proudman FRACS

Royal Australasian College of Surgeons
Foundation for Surgery

Thank you for your extraordinary support to the Foundation for Surgery from January to March.

Every donation makes an incredible difference to help ensure children, families and communities can access safe and quality surgical care when they need it most.

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Ms Karlene & Ms Waratah Bell
Mr Mark Hehir
Ms Joanna Jensen
Mr Konfir Kabo
Mr Henry Lumley
Mr Peter Lumley

Silver

Mr Adrian Anthony
Mr Ronald Baker
Anonymous donor
Mr Wei Chang
Dr David Choy
Dr Stephanie Demkiw
Anonymous donor
Mr Philip Gan
Mr Roger Hargraves
Anonymous donor
Dr Sanjay Kalgutkar
Mr Srisongham (Sam) Khamhing
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Mr John MacCormick
Mr Murray Melville
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Mr Rudolph Ngai
Mr Martin Rees
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Dr Luke Mooney
Mr Andrew Moot
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Assoc Prof Matthew Morgan
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Assoc Prof Gary Morgan
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Anonymous donor
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