SurgicalNews

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Royal Australasian College of Surgeons

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Correspondence and letters to the editor for Surgical News should be sent to: surgical.news@surgeons.org
Editor: Abderazzaq Noor
T: +61 3 9249 1200 | F: +61 3 9249 1219
Contributing writers: Rochel Corkery, Fleur Morrison, Saleha Singh.
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Cover image: Dr Sally Langley, RACS President
Photo credit: Les O'Rourke

The College welcomes its 49th president – Dr Sally Langley

Surgical News spoke with the new Royal Australasian College of Surgeons (RACS) President, Dr Sally Langley, to find out more about her and her ambitions for the College. Dr Langley's term as president commenced on 13 May 2021.

Dr Sally Langley is the College's 49th president. She is the second female president, after Mrs Anne Kolbe (2003-2005), in the organisation's 94 years of existence.

The Christchurch-born president didn't think she would be a surgeon. Her first ambition was to be a violinist and she still plays unaccompanied Bach partitas and sonatas – no mean feat, as the famous musician's superlative works for violin are considered the pinnacle of achievement for any violinist.

Inspired by her father, who was a general practitioner in Christchurch, Dr Langley turned to medicine, an interest furthered by her childhood love of reading the anatomical section of a children's magazine called *Knowledge*.

After graduating from Otago University, she embarked on her medical career as a house officer for two years. This was followed by an additional two years as a registrar in Christchurch at Burwood and Christchurch hospitals. She then started a four-year training in Plastic Surgery, in Christchurch and Auckland. After gaining Fellowship, she did a six-month stint in Vascular Surgery, six months as a hand and microsurgery Fellow at Louisville, Kentucky, and one year at the Radcliffe Infirmary in Oxford, United Kingdom.

"I really enjoyed the time spent overseas," said Dr Langley. "It felt like a reward doing something special. I worked in head and neck surgery, cleft lip and palate, and hand and microsurgery."

Dr Sally Langley is a well-respected Aotearoa New Zealand plastic surgeon.

She has worked in both public and private surgery in Christchurch and Greymouth on the West Coast of the South Island for more than 30 years.

Her work covers the whole spectrum of Plastic Surgery, including craniofacial, cleft lip and palate, head and neck, paediatric, reconstructive including microsurgery, hand surgery, skin cancer and breast surgery as well as teaching and supervision.

"Now, with more staff than I had in earlier years, I concentrate on skin cancer, hand surgery, and breast surgery. My department has 10 plastic surgeons, four to five surgical education and training (SET) Trainees in Plastic Surgery, several pre-SET registrars, post-graduate year one and two junior doctors, and we have fourth year and sixth year medical students who spend time with us at clinics, operating lists and tutorials. I am also an intern supervisor for the Medical Council of New Zealand."

The unassuming surgeon didn't seek the position of president. "Having been a Councillor at the College for several years I knew the possibility of being elected to a higher position was there, but I didn't think I'd get to be president. I am also pleased, as a woman, to be leading this illustrious College. I hope that it will inspire other women to claim their place as leaders in surgery and medicine," said Dr Langley.

With more than 20 years in leadership roles, Dr Langley brings extensive experience to the role of president. She is a former president of the New Zealand Association of Plastic Surgeons and has been involved in surgical education and training throughout her career. She was elected to RACS Council seven years ago and served as the Chair of the College's Professional Development and Standards Board since 2019. Dr Langley was previously the Chair of Professional Development.

Dr Langley was also an examiner in Plastic and Reconstructive Surgery for nine years and spent two years as the New Zealand Deputy Chair of the Court of Examiners, the entity that conducts the RACS Fellowship exam.

Dr Langley generously pays tribute to the many people who helped her during her time at the College.

"When I started at the College, I knew I had a steep learning curve, but I have been lucky to work with a lovely group of people – my fellow surgeons, and the staff who kindly supported me along the way. That feeling of fellowship and coming together as a team has been a particularly enjoyable part of my journey. We, as surgeons, can get relatively isolated in our specialties and may not see other people in other specialties or other spheres of work, so connecting with others is great for broadening our perspective."

When asked what she would like to focus on during her presidency, Dr Langley said she had a range of issues to address. She stressed the importance of being proactive and looking to the future for what was most beneficial to patients and the surgical profession.

"The travel restrictions and the rapid adoption of virtual technology enabled one of my goals of achieving less domestic and international travel. We were able to hold many meetings and even the RACS Annual Scientific Congress as hybrid events, combining face-to-face and virtual modes. This is also great for the environment as we expend less resources.

"I am also passionate about environmental sustainability. The surgical workforce needs to do much more to minimise harm to the environment. I am particularly interested in supporting the work of our Sustainability in Health Care Working Group (SIHCWG), led by Chair Professor Mark Frydenberg, and the Environmental Sustainability in Surgical Practice Working Group (ESSPWG), led by Professor David Fletcher."

Equity is also an issue that Dr Langley rates as a key priority.

"We must continue to address equity in all its spheres. There are many aspects we need to work on such as gender, ethnicity and accessibility to surgical care. I am pleased that we have a strong focus on building respect in the surgical workforce and the great ongoing work on our rural health equity strategy will increase access to care, but there is so much more we need to do to ensure that surgical workplaces are equitable and surgical services are available to all."

Dr Langley also highlighted the importance of continuing advocacy work on issues such as road safety, protection of the title of surgeon, gun control and obesity as well as improving engagement with members and other stakeholders.

"We've also got to remain financially viable and, importantly, maintain a high level of education and the delivery of courses and examinations for our Fellows, Trainees and Specialist International Medical Graduates in these COVID-19 times and beyond."

When it came to opportunities for the College, Dr Langley said a continued focus on improving surgeons' wellbeing was paramount.

"As we extend surgical services, we need to train enough surgeons so that we can manage issues such as stress, burnout and flexible working hours better."

Family is important to Dr Langley who spends as much time as possible with her husband, Don, their four children and nine grandchildren.

In her downtime, Dr Langley enjoys exercising in the gym, biking, and listening to podcasts, audiobooks (she has more than 220 titles in her library) and webinars during her five to 10km runs. ■

Dr Langley's favourite podcasts and audiobooks

- *The Power of Introverts*, an audiobook by Susan Cain
- *Deep Medicine*, an audiobook by Eric Topol
- *This is Going to Hurt*, an audiobook by Adam Kay
- *Women and Leadership*, an audiobook by Julia Gillard and Ngozi Okonjo-Iweala
- *Elemental*, Radio New Zealand podcast on the periodic table

Image, over page:
Outgoing president Dr Tony Sparnon passes on the president's medal to incoming president Dr Sally Langley.

Meet our new vice president: Dr Lawrence Malisano

Dr Lawrence (Lawrie) Malisano, a former president of the Australian Orthopaedic Association (AOA) and Royal Australasian College of Surgeons (RACS) Councillor, is the College's new vice president.

Dr Malisano is a Senior Orthopaedic Consultant at the Royal Brisbane and Women's Hospital, Medical Director of the Brisbane Orthopaedic and Sports Medicine Centre and operates out of the Brisbane Private Hospital.

The son of Italian migrants, Dr Malisano always thought he would become a carpenter until his parents came back from a parent-teacher interview when he was in year 11 and asked him to consider going to university.

"I started to read about careers and I found myself gravitating towards anatomy, but I also liked engineering. I was accepted into both medicine and engineering and I remember sitting at the front steps of the J D Storey Administrative Building at the University of Queensland wondering which option to take. I had 10 minutes to make up my mind and medicine it was.

"I enjoyed medical school and chose intensive care and general medicine terms in my intern year before I applied to RACS for my primary examination and subsequently for the surgical training program. I was very well supported by surgeons who encouraged me to apply for the orthopaedic surgical training program."

After receiving his FRACS in 1988, Dr Malisano gained post-Fellowship training through an appointment in Hip and Knee Arthroplasty at the Royal National Orthopaedic Hospital, London; a Trauma Fellowship at the Ruhr-University of Bochum hospital, Germany; and a Reconstruction and Trauma Fellowship at the Sunnybrook Health Sciences Centre in Toronto, Canada.

Dr Malisano's career could have taken another very different path. When he was 13 and 14 years old, he held the Queensland and Australian Age Swimming records and was a state championship finalist in several other events. His best event was the 100 metres backstroke, followed by the 200 metres backstroke. He qualified to represent Australia in the 1972 Olympic Games in Munich but was unable to go due to lack of funding. His father was invited by the Italian government to relocate the family to Italy – they offered a house and employment on condition that young Lawrie represented Italy in the games. He didn't take up the offer.

Italy's loss remains Australia's gain, with Dr Malisano's three children also achieving success in their careers and education. His eldest son holds a PhD in materials engineering from Oxford University, his second son is about to finish his dentistry program in university, and the youngest, a daughter, is about to complete her master's in molecular biology.

Dr Malisano joined the College Council in 2012 and served until 2018, during which time he became Chair of the College's Professional Standards Committee. He rejoined the Council in 2019 as a Fellowship Elected Councillor.

When asked about his new role, Dr Malisano said that the College is an institution he had always been interested in serving.

"As a previous president of the AOA and its vice president for two years, I have a large knowledge base to draw upon. I understand what the role of vice president entails—predominantly to assist the president in achieving the RACS' strategic plan and working closely with College personnel."

When asked about his ambitions for the College, Dr Malisano said he would like to continue the ongoing work to cement relationships between the College and its specialty societies and improve digital outcomes.

"I strongly believe in the ongoing need for the College and surgical societies to continually strive to improve communication and cooperation, and build on the important work that has occurred in recent years.

Dr Lawrence Malisano

"As a College we managed our response to the COVID-19 pandemic remarkably well and our COVID response included a rapid transition to digital platforms, which coincided nicely with the One College Transformation program. This is an area that we need to continue growing as it will be critical in strengthening our links with each other."

Dr Malisano also has a keen interest in governance. He is a Fellow of the Australian Institute of Company Directors.

"I remember my first day at RACS Council. I went to all the meetings and was very impressed with the processes of the committees and how they were run," he recalled. "I left the meeting thinking I needed to learn more about governance, and I went on the company directors course. It stimulated a lot of interest in how companies and boards work and developing strategies. It also brought out the understanding that boards set the strategic direction and management implements it. More importantly, it really helped highlight that micromanagement isn't something a board should do.

"I really enjoy corporate governance and I think it is an area I will continue to work in as part of my own professional development." ■

Spotlight on

The RACS ASC 2021

Celebrating the art of surgery in a time of disruption

After postponing the Royal Australasian College of Surgeons (RACS) Annual Scientific Congress (ASC) in 2020, this year's RACS ASC took place in Melbourne and in hubs around the world, with a record 3706 delegates attending the meeting – the highest ever turnout in its history.

"To survive the changes 2020 presented us with, we have had to find creative ways to adapt our practices, support our patients, and provide care to our communities," said Professor Wendy Brown, RACS ASC 2021 Convener.

"We constantly needed to be agile and adapt – as the landscape changed, sometimes daily," said Associate Professor Sebastian King, RACS ASC 2021 Scientific Convener.

"Our surgeons had to rely on the art of what they do, not just the science of what they do. This creative element drives surgeons to continually improve and innovate, and this is what we wanted to showcase at RACS ASC 2021," he continued.

"In a practical way," added Professor Brown, "surgeons pursue various artistic interests that translate to their work with patients. We have used a virtual art gallery to present the talents our surgeons have not only with a scalpel but also in music, painting, sculpting and other creative pursuits."

The RACS ASC 2021 – one with many firsts

The Royal Australasian College of Surgeons (RACS) Annual Scientific Congress (ASC), which took place between 10–14 May 2021 ended on a high note. A record 3706 delegates attending the meeting – the highest turnout in its history.

Day one at the RACS ASC 2021 ended with an evening of celebration as 158 new Fellows received their Fellowship certificates during the convocation ceremony, which was held in multiple locations around Australia and Aotearoa New Zealand.

In a first for the Congress, we created hubs across Australia, Aotearoa New Zealand and beyond, enabling those who could not attend in person to congregate in a COVID-19 safe way to virtually enjoy the program in a collegiate setting.

COVID-19 derailed the 2020 Congress but served to inspire the theme for 2021, 'Celebrating the art of surgery - in a time of disruption'. Encouraging reflection on the changes to our lives over the last year, the congress aimed to illustrate how we've been creative and agile in our response to this disruptive force in surgical practice.

We were pleased to collaborate with the Royal College of Surgeons of Edinburgh (RCSEd) on the RACS ASC 2021 and enjoyed the President's Lecture delivered by the RCSEd President, Professor Michael Griffin OBE. We also welcomed other high-profile guests including Australian Treasurer, the Honourable Josh Frydenberg, Secretary of the Commonwealth Department of Health, Professor Brendan Murphy, who delivered the Syme Oration, and former Australian Deputy Chief Medical Officer, Dr Nick Coatsworth.

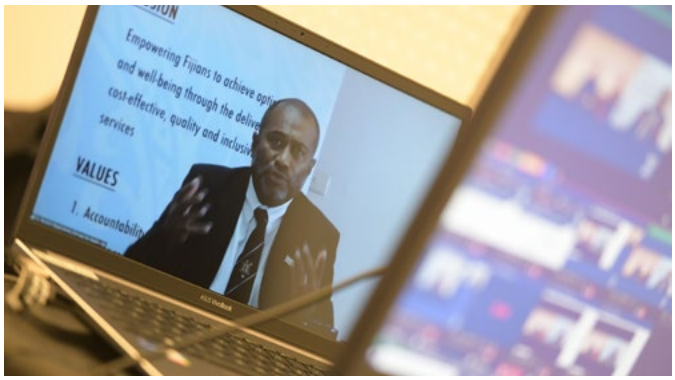
It was a week full of great presentations, fantastic speakers and engaged delegates from around the world. Here are some facts and figures we gathered on the Congress:

- 3706 registrants – the largest number ever at a RACS ASC, with 2860 attending virtually and 846 onsite around Australia, Aotearoa New Zealand, the United Kingdom and around the Pacific
- 285 sessions
- 986 posters and 1212 verbal presentations
- 1258 presenters
- 106 overseas presenters
- 153 new Fellows with 83 onsite across Australia and Aotearoa New Zealand and 70 attending virtually
- 3440 people watched the Plenary session on 13 May.

Thank you to all the delegates, speakers, sponsors and the many people behind the scenes who helped make the RACS ASC 2021 such a success. The generosity of spirit exhibited by everyone made the Congress possible and the unparalleled enthusiasm for the meeting far outweighed any technical hiccups.

We look forward to #RACS22. ▶

Seen at the RACS ASC (clockwise from top left):
The RACS booth; Dr Tony Sparnon with a convocee at the Melbourne convocation ceremony; Dr Amiria Lynch and Dr Amy Touzell at the Women in Surgery breakfast; attendees relax at the RACS booth.



Seen at the RACS ASC (clockwise from top left): *Participants at a DCAS session; convocees in Melbourne; Dr Julie Mundy with Colonel Brett Courtenay, presenter of the Sir Edward 'Weary' Dunlop Memorial Lecture; Dr Kate Fitzgerald, one of the newly graduated Fellows, with her family; Dr Brendan Murphy speaks at convocation; Mr Suraj Rathnayake and Dr Mahanama Dissanayake; Fijian Health Minister Dr Ifereimi Waqainabete gives the Rowan Nicks lecture.*

Seen at the RACS ASC (clockwise from top):
Attendees at the Women in Surgery Breakfast; Professor Elizabeth Molloy presenting as part of the Surgical Education program; Professor Mohamed Khadra with Dr Tony Sparnon at the opening plenary; the Indigenous Health breakfast; RACS ASC Convener Professor Wendy Brown with Dr Tony Sparnon and Dr Nick Coatsworth; Dr Amanda Foster, Dr Sally Butchers and Dr Christine Lai .

Reflections on an inclusive congress

In March of last year, we made the difficult decision to cancel the 2020 Royal Australasian College of Surgeons (RACS) Annual Scientific Meeting (ASC). However, amid COVID-19 restrictions, through the tremendous goodwill and hard work of a multitude of people, in 2021, we've had a very successful congress that has broken new ground in many ways. Thankfully, we had the unwavering support of Dr Tony Sparnon, our outgoing president, the College Council and RACS staff, led by our equally committed CEO, John Biviano. Lindy Moffat and her Conference and Events team, with leadership coming from Ally Chen, Binh Nguyen and Dr Liz McLeod, constantly amaze me with the incredible events they always deliver, and 2021 was on a scale like no other. Abderazzaq Noor and Tracey Volkmer rallied the communications team, who were enthusiastic, consistent supporters and tireless in disseminating information to members and other stakeholders using novel and innovative methods.

From the outset, RACS Council made a firm decision, and determined it was important to deliver our major continuing professional development RACS event of the year and convocate our Fellows. We must acknowledge the staunch support of the Aotearoa New Zealand and Australian state and territory offices. The managers and regional chairs, as well as society presidents, attended fortnightly working party meetings in the lead up for more than a year to develop the hubs concept.

Special recognition needs to go to Urological Society of Australia and New Zealand (USANZ) who joined the RACS ASC for the first time. Professor Henry Woo did a remarkable job to pull together a program after the congress planning had already commenced. Thanks for being there USANZ!

We also acknowledge the great collaboration from the Royal College of Surgeons Edinburgh (RCSEd). It was a wonderful addition to our international engagement, which also extended to the Asia-Pacific region.

Trying to second guess what the environment would be like 12 months after the declared pandemic was challenging. We understood that our members would be yearning for the socialisation that occurs at a face-to-face meeting. And yet, the digital platform provided opportunities for the dispersal of information that wouldn't otherwise have been possible, and members did manage to congregate and socialise in smaller gatherings across the world.

Professor Wendy Brown and Associate Professor Sebastian King (Convener and Scientific Convener) and their 2021 Melbourne Section Conveners were remarkable. The various Section Conveners were exemplary in being able to reformat their programs to accommodate the new normal. We also need to acknowledge and thank our Perth colleagues who had already started planning ASC 2021 but stood aside to allow the Melbourne program to be delivered.

Although we couldn't host our overseas faculty, we were able to have more international speakers than ever before. As usual, there was a feast of material and so much that I just couldn't get to, although the digital platform remains open for later viewing. But there's nothing like real time, and some of the highlights for me were the plenaries – the inspiring address by Mohamed Khadra, poet and playwright, and the amazing artistry of Chris Edwards, one of our surgeons turned sculptor. When the inevitable digital hiccup occurred, the show went on, and our President came to the stage and, right off the cuff, regaled the audience with his stories of cultivating his award-winning liliums. Another highlight was 'The Art of Communication in a Crisis' session with Dr Nick Coatsworth, the Federal Treasurer Josh Frydenberg and the RCSEd College President Professor Michael Griffin. Professor Brendan Murphy eloquently delivered the Syme oration at the convocation ceremony. We were honoured that he flew back from Canberra specifically to address our Fellowship in recognition of this special occasion.

Associate Professor Ramesh Nataraja organised an outstanding Global Health program that was inclusive and diverse. This was well demonstrated in the many combined sessions with the Directors section, surgical education, Paediatric Surgery, senior surgeons, Plastics and Reconstructive, younger Fellows, General Surgery, quality and safety in surgical practice and rural surgery.

The most confronting, gut wrenching, yet heartwarming moment was when Professor Zaw Wai Soe, a Myanmar orthopaedic surgeon, addressed the Global Health audience from a secret location. He spoke of the devastating situation during the military coup and the execution of young trainees and colleagues close to him, deemed dissidents by the military junta. Their unimaginable plight was made real for our audience in that session.

Meanwhile, our Pacific neighbours had access to our digital platform in their digital hubs and could be equally immersed in the interaction and involved throughout the program.

For the time, the hub concept has been the perfect solution and there will be learnings from this year that will no doubt carry through to future meetings. It's hoped that we will be able to have even greater engagement of a broader and larger number of members in years to come. ■

Professor Owen Ung
Outgoing Chair
ASC Conference and Events
Incoming Chair
Global Health

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A memorable RACS ASC for urologists

The 2021 RACS ASC will likely be one of the most memorable for Fellows for many reasons. The very fact that the RACS ASC even took place is thanks to the efforts of a large team of individuals who made extraordinary contributions. As a RACS Councillor, I was excited that this was the first time we would have program participation by all the nine RACS surgical specialties. This was a significant moment in RACS' history.

Our Urology program was held in lieu of our standalone Urological Society of Australia and New Zealand (USANZ) Annual Scientific Meeting, which had been cancelled for 2021. A packed four-day program ran from the opening day of the meeting and we were amongst the last out of the exhibition centre on the final day.

An outstanding feature of the Urology program was the diversity of presenters and session chairs. In particular, a high number of the female urologists invited were speaking or chairing sessions for the first time in their careers. It goes without saying that they were all outstanding (see table below).

On the opening day of the RACS ASC, USANZ established well attended hubs across Australia and New Zealand. These provided a much-missed opportunity for collegiate interaction. This model of USANZ sponsored hubs also provided an opportunity for urologists to interact with relevant industry partners. The concept of multiple local hubs has proven to be a formula worthy of continued development.

Our scientific program differed from our usual Annual Scientific Meeting (ASM) format. It provided more general Urology content as well as some content that would be of interest to those outside our specialty.

We delivered 20 sessions from national experts in Australia and New Zealand as well as five international visitors, including Professor Jelle Barentsz (the Netherlands), Professor Kurt McCammon (United States), Professor Caroline Moore (United Kingdom), Professor Margaret Pearle (United States) and Professor Stacey Loeb (United States). Professor Freddie Hamdy (United Kingdom) also joined us and delivered the 2021 *British Journal of Urology International* lecture.

An overwhelming number of 157 abstracts, the second highest number for a specialty in the 2021 RACS ASC, were submitted to Urology for consideration and 129 submissions were accepted as either verbal or poster presentations. Such a positive response from the Fellowship, and invited faculty and delegates was a true testament to the partnership RACS shares with the USANZ.

One highlight was a spirited debate with our general surgical colleagues over who should care for acute torsion of the testis. Although there may be conjecture over which team won the debate, the winners are the patients who can be reassured that whether cared for by a urologist or general surgeon, they can count on receiving first class surgical care.

An onsite session entitled 'Bread and Butter Urology' was dominated by general and paediatric surgeons and, in hindsight, the session could more aptly have been called 'Bread and Butter Surgery', given that multiple surgical specialties have a role to play.

A joint Urology and General Surgery session was devoted to the common problem of inguinal hernia management in the context of a diagnosis made prior to, during or following a radical prostatectomy.

Following this success, we hope to continue discussion with USANZ to ensure a urology program becomes a long-term feature of the RACS ASC. ■

Professor Henry Woo

Chair, Research and Academic Surgery

RACS ASC 2021

Gender Balance for Urology Program at RACS ASC 2021

	Women	Men	% Women
Invited International Guests	3	3	50%
Invited ANZ Speakers*	17	23	43%
Session Chairs	14	12	54%
Podium Abstract**	5	25	20%

* No manels
** Reviewers were blinded to abstract authors

Royal Australasian College of Surgeons

From the Aotearoa New Zealand hub

The Museum of New Zealand Te Papa Tongarewa was a superb and most fitting venue for the inaugural ASC Aotearoa New Zealand hub. The 33-year-old national museum is known to Kiwis as 'Our Place' and it certainly became our place for more than 150 RACS Fellows, Trainees and Specialist International Medical Graduates (SIMGs) who took part in the RACS ASC.

While many delegates watched the proceedings on big screens in one of four venues at Te Papa, others relaxed, with earphones donned and devices in hand at café tables or sofas overlooking Wellington's waterfront, to watch other sessions of their choosing.

Sharon Jay, RACS Trainee Association Aotearoa New Zealand's Representative, said, "There was so much to learn from all the various presentations and it was so easy to go between section talks online, but also from the Aotearoa exhibits and the history at Te Papa to enjoy. It was a fantastic hybrid conference experience."

Choosing the program for the hub was challenging, says Philippa Mercer, Chair of RACS' Aotearoa New Zealand National Committee. "We tried to cater to all tastes. Plenary and cross discipline sessions were well attended and people seemed very comfortable watching some specialty sessions on their own devices and Te Papa had many wonderful spaces where people could do that. As is always the case with the RACS ASC, many of the lectures and sessions were extremely inspiring and thought provoking. Equally importantly, the hub enabled people to catch up and enjoy each other's company face-to-face, which they clearly greatly appreciated."

A real highlight of the week for those fortunate enough to be able to attend was the local convocation ceremony at Te Marae, a contemporary, authentic and inclusive marae (meeting place), at Te Papa. Philippa Mercer said having a local ceremony made it easier for the families of the 11 new Fellows to attend. "We chose to hold our convocation and awards ceremony before linking up to Melbourne, which made the event more family friendly. Also, the audience seemed to really appreciate seeing all the New Zealanders being presented with their awards."

One of those convocating, Mr Victor Kong, a general surgeon based in Waikato, said he thoroughly enjoyed the ceremony. "Te Marae had a distinct and uniquely Aotearoa New Zealand ambience. This, along with a great atmosphere and a very well organised event, made the special occasion even more memorable."

Image above:
The convocation ceremony

From the Edinburgh hub

In May, the Royal College of Surgeons of Edinburgh (RCSEd) was delighted to collaborate with RACS for their 89th Annual Scientific Congress. Initially RCSEd representatives were planning to attend in person. However, COVID-19 required a change in plans and so an Edinburgh hub event was created, allowing the RCSEd College to host its first in-person event of 2021. We welcomed live speakers Professor Jason Leitch, National Clinical Director for Healthcare in Scotland, who covered the impact of COVID-19, safety in surgical practice, and David Sedgwick, Consultant Surgeon in Fort William, who discussed the provision of surgery in remote and rural environments. RCSEd President, Professor Michael Griffin

OBE, led the event and presented the President's Lecture on communication with cancer patients and their families. Attendees viewed the event as a great success with stimulating discussions and thought-provoking learnings highlighted. RCSEd hopes that by 2022 the College can attend in person and join our Australian and New Zealand colleagues for the 90th RACS ASC.

Above left:
Presenters at the Edinburgh hub

Above right:
Professor Michael Griffin OBE presents the President's Lecture.

From the Pacific hubs

This year the absence of our friends across the region, especially the countries working closely with RACS Global Health, was deeply felt. In response to the continued closure of the Australian international border, RACS Global Health was proud to create a set of Offshore Hubs, providing an opportunity for surgeons and other overseas health practitioners to join and participate in the RACS ASC online.

Participants in this year's Offshore Hub initiative included Angau Memorial Hospital in Lae, Papua New Guinea, and Guido Valadares National Hospital in Dili, Timor-Leste.

Dr Steven James, Head of Orthopaedic Services at ANGAU Hospital in PNG said, "There were a lot of very good presentations, and I would be humbled to have another [chance at] virtual access if and when the opportunity arises." ▶

Dr Mauricio da Silva Fraga and Dr Jose de Araujo join the RACS ASC remotely from Guido Valadares National Hospital in Dili, Timor-Leste.

From the Australian Capital Territory hub

RACS in the Australian Capital Territory (ACT) hosted a local convocation on Monday 10 May with six new Fellows convocating. A beautiful, intimate ceremony was held in the Enid Lyons Alcove in Parliament House.

The ACT hub live-streamed sessions across the rest of the week, with attendance from ACT Fellows in the office. The ACT hub held two sub-specialty hubs, one for breast surgery and one for Paediatric Surgery, as well as sponsored sessions by Sanofi.

Attendees watch a session at the ACT hub

From the Tasmanian hub

Meanwhile, Fellows from all over the north of Tasmania descended on the Launceston General Hospital Surgical Department for sessions. There were three rooms live-streaming sessions and great break out rooms.

All Fellows attending agreed the hybrid format was very appealing, as the operating theatre was only a short walk from the hub so they could come to sessions between cases.

The week closed with a dinner (pictured left) in honour of Di Cornish, Tasmania's outgoing RACS office manager, and her 39 years of service to the College.

The South Australian convocation ceremony

From the South Australian hub

The South Australian office was well supported, which helped to create an excellent atmosphere in the building. The office had the capacity to host up to 10 different sessions at any one time. The success of the event was a testament to the College's excellent new facilities at 24 King William Street, Kent Town.

From the Queensland hub

Queensland hosted a fabulous black-tie charity dinner on Friday 14 May, featuring entertainment from Opera Queensland. Proceeds from the night went to the Foundation for Surgery to fund the important work they undertake.

The Queensland convocation ceremony

From the New South Wales hub

Held at the world-renowned Sydney International Convention Centre on Monday 10 May, RACS past President Associate Professor Phil Truskett presided over the New South Wales (NSW) convocation with RACS NSW past chair Dr Ken Loi and RACS NSW Chair Associate Professor Payal Mukherjee in attendance.

It was the first time the ceremony was decentralised, and 17 convocees for NSW attended the evening.

Despite the challenges faced due to the pandemic, the personalised setting of a hybrid event was widely praised by new Fellows, their families and friends.

The remainder of the week consisted of specialty hubs held at the RACS NSW state office. This gave members of the College the opportunity to meet in person and network during the RACS ASC.

The New South Wales convocation ceremony

From the Western Australian hub

The recent 2021 RACS ASC convocations saw 12 new Fellows convocate at the State Reception Centre in Kings Park, Western Australia (WA). The formal convocation ceremony was followed by a celebration of this special achievement. A three-course dinner at the venue was enjoyed by the Fellows and their families, surrounded by glorious views of Perth city. As part of the WA hub arrangements of the ASC, WA state office meeting rooms were open to Fellows to view a range of sessions. ■

The Western Australian convocees

Talent on display in virtual art gallery

As part of the RACS ASC 2021 we displayed a virtual gallery with artwork by our talented members.

Mr David Freedman
General Surgery, Victoria

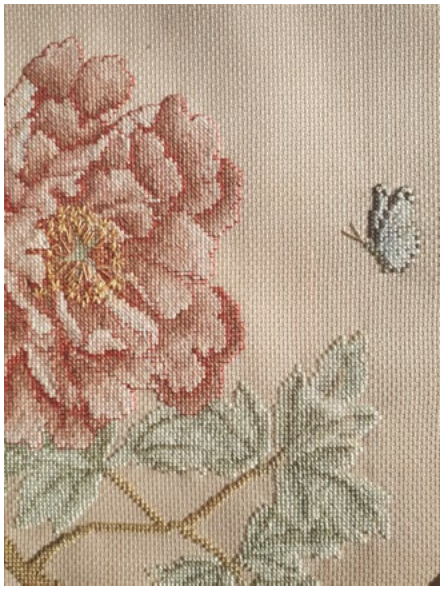
I worked as a rural general surgeon based in Swan Hill from 1978 until 2010 after gaining my Fellowship in 1974. General Surgery is at times a stressful occupation, especially when dealing with emergencies in a rural setting. I found painting very relaxing – it allowed an escape into another world.

For most of my professional life I have painted en plein air (outdoors) as a hobby. Retirement allowed more freedom and energy to pursue this, and two years ago I published a book entitled *Plein Air Painting: General Principles and Tips for Beginners*.

Last year, Richard Steele, Gavin Fry and I decided to collaborate to celebrate the beauty and diversity of Australia's birdlife, culminating in a book entitled *Australia's Birds*, for which I painted all 240 illustrations.

Painting requires a sharp eye and a deft hand, as does surgery. The best results require an adherence to and understanding of basic principles, and a stepwise approach for both disciplines. As you develop a deeper understanding with experience, you are able to refine your skills.

There is much in common but perhaps the biggest difference is the sense of freedom involved. In painting, failures do not matter. A painting can be wiped off, a piece of paper torn up and you are responsible to no one but yourself. This is a liberating feeling after a long surgical career.



Dr Rhea Liang
General Surgery, Queensland

My Chinese heritage was very important to me growing up in New Zealand in pre-internet days. From a young age, my sisters and I had an interest in creative arts, and indeed my two sisters are now famed for their creative output, which often has strong Asian themes (Renee Liang MNZM, poet, playwright, and paediatrician, and Roseanne Liang, director and screenwriter). I was more of a bowerbird, collecting traditional textiles and embroidery to document skills that have since vanished. These pieces inspire me to create works that bridge my Chinese heritage with the Western culture that I live in, using modern materials such as colourfast cotton and Western techniques such as cross stitch, but portraying Asian idioms such as the peony flower.

My needlework long predates my surgical training, so the needlework has always informed the surgery much more than the other way around. As a Trainee, there were times I would politely 'learn' a surgical technique while immediately recognising it as something already in existence in, say, lacemaking or garment-making. I like to respect that heritage by giving techniques back their original names. For example, the 'Aberdeen knot' is the same chain stitch that children learn when they start or finish their first piece of knitting or crochet. Its renaming as a surgical technique perhaps reflects the lack of diversity in the room to tell the 'inventors' that at the time!

Doing needlework (and my other creative love, crochet) is my safe space, where my breath slows and heart rate settles, where I can be mindful and think through issues methodically while my hands maintain a rhythm. There is actually a body of neurophysiological research linking repetitive movements and improved executive brain functions – one of the reasons we fidget, pen-tap, or doodle when trying to concentrate. I suppose my needlework and woolcraft simply fulfil that same function while also creating something beautiful in the process.

Mr Patrick Meffan
Urology, Aotearoa New Zealand

This work was inspired by Pine Taiapa (Ngati Porou), master carver and protégé of Sir Āpirana Ngata.

Sir Āpirana Ngata, the influential Māori statesman, was the first Māori to complete a degree at a New Zealand University and my grandmother was a teacher under him in the Ruatoria Native School in the 1930s. She became a great friend of his. When she left the school, he gave her a table with four heads on it, one to represent each of them and two others unknown. This table has been passed down in my family through my father to me and it is now the model for my carving.

In this time of inequity, it is a personal and precious link within our very Caucasian family to a very important person in history. As a child, my father was taught to carve by Pine Taiapa and this love of carving was passed on to me.

With wood there is the element of grain, which gives carving a certain complexity. Wood is an amazing natural product with a huge array of characteristics to achieve different finished appearances and functions.

With surgery, you start with perfection, when you consider the human anatomy, and then your job is to rectify a problem. By the time you've finished it's bloody and stitched back together and nowhere near the perfection it would have originally achieved in nature. Whereas with woodwork, you start with a rough piece of timber and from that comes an amazing piece of art or furniture, so in that respect it's the opposite process.

I personally get a huge amount from my creative pursuit and when I step into the workshop I can almost feel my blood pressure drop. There is no perfect carving and every project teaches me how I can improve the next time. This mindset of continually trying to improve, for me, is one of the most satisfying parts of surgery as well. ▶

Dr Sam Gue
General Surgery, South Australia

I have been practicing as a specialist surgeon in Adelaide for more than 40 years, mainly as a general surgeon with special interest in colorectal work. I am also involved in Surgical Education and Training (SET) selection, teaching and examining. I am a Fellow of the English, Australian, American and International Colleges of Surgeons.
I have exhibited my artwork in Adelaide, interstate and overseas. My last solo exhibition was held at the RACS building in Adelaide and was opened by His Excellency the Governor of South Australia. Some of the proceeds were donated to the Foundation for Surgery and a large painting was donated to the South Australian RACS office.

I operated on Jack Absalom, a famous Australian artist, many years ago and we became close friends. He introduced me to oil painting. Looking around Australia and at his work, I was fascinated with the colours of the earth, the blue bushes and gums, and wanted to recreate these in my paintings. I love using oil on stretched canvas with palette knife, creating layers to achieve a 3D effect. I have my studio upstairs at home and while I paint, I forget all my surgical worries. It is the best way to relax from the busy life and the challenging, 24-hour, arduous demands of surgery.

I feel surgery is an art and so is painting, which can help with your hand-eye coordination. Creating and caring go hand-in-hand and bring not only joy but fulfilment and happiness.

Dr Gillian Dunlop
Otolaryngology Head and Neck Surgery, New South Wales

At a very basic level there are similarities between surgery and art. Both involve thought, training and hand-eye coordination. Beyond this, surgery and art differ significantly.

Masterpieces of art evoke a spirit or mood using the language of emotion. As with other languages, there is a form of syntax and grammar. Consider edges within an artwork. Too much variety creates a fractured image but overall uniformity of edges does not excite or engage the viewer. A balance of soft and hard edges must be reached. The same applies to other parameters such as shape, colour and paint texture.

The focal point of a painted artwork has increased contrast, colour intensity and sharpened edges so as to garner attention and draw the viewer in. The periphery, as with peripheral vision, is more understated.

These concepts simply do not apply to surgery. I would argue the parallels are superficial and few.

Mr Chris Edwards
Plastic & Reconstructive Surgery, Tasmania

After a career in Plastic and Reconstructive Surgery I have an interest in human anatomy, proportion and the concept of beauty.

A sound knowledge of anatomy is of paramount importance to the surgeon and figurative sculptor alike. I believe the enhanced powers of observation and appreciation of form gained from sculpting in clay greatly aided my plastic surgery. Conversely, the knowledge of anatomy and human proportion learned from plastic surgery training has helped me with my sculpture.

My chosen medium of bronze appeals to me for its strength and durability. Having undergone the necessary transformation to embody the subject, it maintains its own distinctive character.

I believe we all have an innate need and ability to find joy in creation. It is hard to define, but it is generally agreed that art enhances a feeling of wellbeing both in the performer and the viewer (or listener). Art can be a great means of escape and relaxation. It allows for creative risk taking and the embracing of mistakes. (Something less desirable in surgery!)

In retirement from surgery, I believe my sculpture has helped me maintain a sense of self-worth and relevance, and acted as a buffer to the not uncommon ‘relevance deprivation syndrome’.

Dr David Kaufman
Opthalmology, Victoria

I started woodwork 20 years ago after encouragement from my mentor, Dick Galbraith. He explained that woodwork was similar to what I was used to as a microsurgeon dealing with tissue planes and specialised tools, only on a larger scale. Woodwork, like surgery, requires forward planning with strategies to deal with unexpected complications. Good visualisation and attention to detail, as well as using the correct tool, applies to both fields.

Surgery can be stressful, and I found that a hobby with expert tuition provides relaxation and interaction in a non-medical field, working with new colleagues, and at the same time having a lot of fun.

After the class, I find myself happy and enthusiastic. It doesn't get any better than that!

Mr Ian Jones
Orthopaedic Surgery, Victoria

I fell into sketching on a camping and walking holiday in Turkey about 10 years ago. The wives of two accompanying surgeons were keen and very proficient sketchers and, after I expressed some interest, the next morning I found a writing pad and HB pencil on the ground outside my tent.
I had not had any previous experience in painting or drawing but found sketching fun. I accompanied my wife on a gardening trip to China the following year, and early one morning sat in a park where peonies were in bloom. By the time I'd finished my sketch there was a crowd of about 20 people behind me each offering comments, which seemed to be complimentary.

On return home, my wife booked me in to a masterclass of botanical art with Jenny Phillips, whom she had known from her school days. I must say I felt a real goose on the first day, walking into a room of 15 experts in botanical art with white gloves on, numerous pencils and multiple brushes.

I've subsequently enjoyed two formal week-long courses since then, and one of my roses was included in a fundraising diary put out annually in the past by the botanical gardens.

Mr Richard Lander
Orthopaedic Surgery, Aotearoa New Zealand

I have been interested in photography since my secondary school years. My artistic interest was influenced by my parents who were both talented in drawing and craft work. My younger brother is a professional artist who has interests in watercolours, oils and ceramics, and now papermaking and film.

I started with a film camera and have more recently migrated to digital. I had a brief period of dabbling in a home darkroom, experimenting with chemicals and developing, but that was curtailed by university studies. Now the darkroom has been displaced by computer software programs such as Adobe Lightroom and Photoshop, allowing creative images to be developed digitally on the computer. The challenge is to create the best of an image 'in camera' and then tweak the result in post-production.

There is art and science in both surgery and in photography. In photography, pressing the shutter is the culmination of the compositional and artistic act, with the final image appreciated by both the photographer and the viewer. In surgery, the operation is the culmination of meticulous planning, careful and thoughtful skill, and the execution of processes, to give a satisfying result for both the surgeon and the recipient.

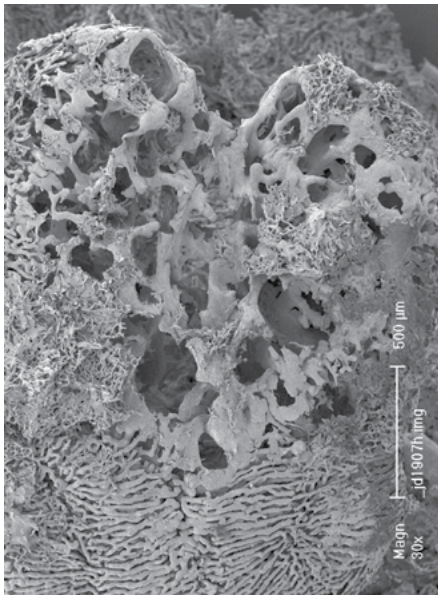
Every patient has a story to tell and so does every good photograph. Good photographs satisfy, stimulate and provoke. They are multilayered and fit a cultural context, as are patients who wait to tell their story. ▶

Mr Randall Sach AM
Plastic & Reconstructive Surgery, South Australia

I was introduced to working hot glass in 1993. What then began as a hobby interest, has since become a consuming passion. Glass complements and shares many similarities with my previous regular work as a plastic surgeon (with hand surgery as a major interest). Common themes include teamwork, planning and preparation, a technical and scientific basis, manual dexterity, attention to detail, lateral thinking and a creative flair.

My plastic surgery background has helped inform a deep interest in aesthetic human forms, of which replication in glass with sculpture techniques is both seductive and challenging. The technical and creative processes continue to inspire the ongoing development of my artistic sculptures, both anatomic and more abstracted.

Many of the skills needed for excellence in surgery are equally applicable to working in hot glass, and sculpture in particular. In addition to the common skills mentioned above, both these practices share careful planning in reverse, a strong sense of 3D proportion and technical precision. Both disciplines are based on scientific principles and share similar training and educational activities.



Dr Jurstine Daruwalla
General Surgery, Tasmania

I completed a combined MBBS and PhD at The University of Melbourne. My surgical training was through the Alfred and Austin Hospital, obtaining FRACS in General Surgery in 2019. I am currently working towards a specialisation in Hepatobiliary surgery.

This image, titled *At the Heart of It All*, is of a resin cast of the microvasculature of colorectal cancer liver metastases, which I prepared during my PhD. This image demonstrates the disorganised, tortuous and irregular tumour microvasculature formed during angiogenesis.

The tumour vasculature formed during angiogenesis is essentially the 'heart' of the tumour and without it, the tumour cannot establish. The tumour here ironically resembles the shape of a heart.

This image was taken with a Philips XL30 Field-emission scanning electron microscope (Eindhoven, Netherlands) at a voltage of 2kV and spot size 2. With acknowledgment to Dr Simon Crawford, Senior Microscopist, University of Melbourne.

Dr Nicola Fleming
Surgical resident, Victoria

After growing up in country New South Wales, I came to Melbourne to study and never left. I am now a PGY3 surgical resident hoping to pursue a career in Plastic & Reconstructive Surgery, with a keen interest in surgical education and multidisciplinary research.

Learning about the intricacies of the hand and its functions was one of the things I enjoyed most when studying medicine. It is something that I return to repeatedly when searching for a creative outlet. In this piece, I wanted to explore the structures of the palmar and dorsal surfaces of the thumb and the parallels and variations between the two.

What has always drawn me to surgery is the combination of creativity and technique combined to produce the best outcome for the patient. For me, drawing is a way to not only reinforce learning, but a way to appreciate the beauty and complexity of anatomy.

Dr Nagham Al-Mozany
General Surgery, Aotearoa New Zealand

I am of Middle Eastern heritage, and have been raised in France, the United Kingdom and the United Arab Emirates. I immigrated to New Zealand to attend university and completed my undergraduate studies in Pharmacology and Biological Sciences followed by Medicine at the universities of Auckland and Otago respectively. I am a painter. My artwork is constantly evolving. It began with portraits, landscapes and floral designs in my teens and continued throughout university and general surgical training.

Though I am Middle Eastern and the only female Colorectal and General Surgeon of this heritage in New Zealand, I am a polyglot, which reflects my childhood upbringing. I am grateful to be able to use this skill set to engage with the diversity of patient ethnicities and cultures within New Zealand.

In more recent times, I prefer to paint abstract. The medium that I use to paint has also changed over the years, from oil-based paints to acrylics. I am inspired by other artists, particularly Claude Monet, the French Impressionist. I was raised in Paris, which I think may have also influenced my artwork subconsciously.

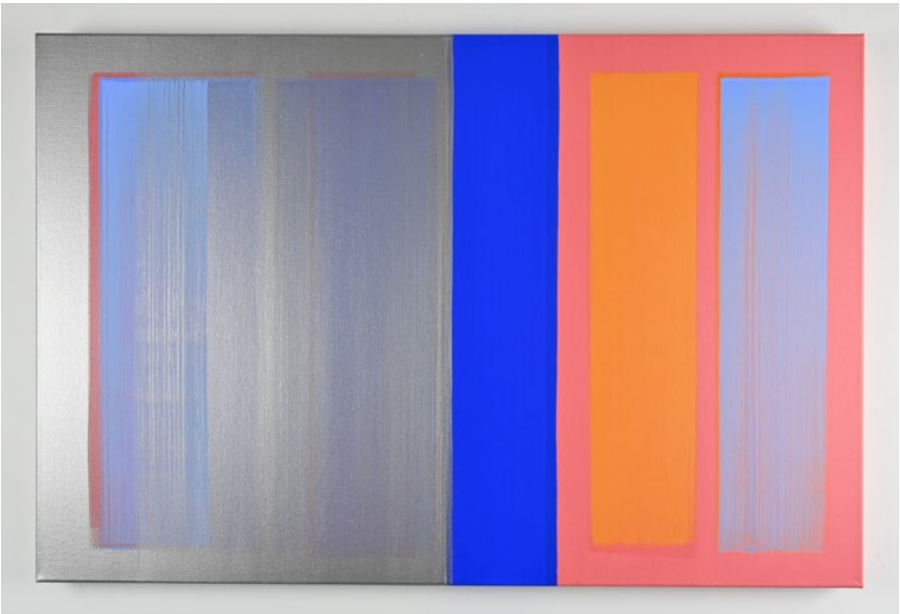
I am the mother of a 15-month-old baby boy and my husband is a Senior Associate Architect. Learning to juggle the tasks of being a surgeon, a mother and a wife can be challenging at times. However, I have my artwork that provides 'me time' when I have a few minutes to spare.

Art and surgery share the unique ability to reflect reflection, determination, devotion and patience – all attributes that have assisted me during my career. The ability to use paint as a medium to express my deepest thoughts and provide an outlet for my emotions on canvas has provided me with a channel to express sentiments encountered as a woman, a mother and a surgeon.

Dr Stefanie Schulte PhD
Australian Capital Territory

Surgery and Fine Art are two disciplines that may not seem to be related. However, being married to a surgeon, I have discovered the connections between these two worlds. In my opinion, a surgeon is an artist, the surgeon must be extremely creative.

In my artworks I like to explore interactions of colour shades and different partitions of the canvas. The colours themselves are my inspiration – the possibilities of combining and arranging them are endless. The effects the shades have on each other are fascinating; a colour can change its appearance depending on where it is placed.



The strongest parallel between my work and my husband's work as a surgeon is probably the subtlety of the layers. My paintings, too, are built up by a countless number of very thin layers of colours. Another parallel could be the science. My artistic research almost has a scientific character when I analyse shades of colour and the influence the layers of colour have on each other.

It is very invigorating when a painting is finished after many long sessions in the studio and when I am happy with the result. ■

Visit our virtual gallery at https://publish.exhibbit.com/gallery/381463704078055736/marble-gallery-58471/

The creative surgeon

The *British Journal of Surgery* Oration 2021, delivered by Professor Mohamed Khadra AO

Those who are not surgeons tend to think of surgery as a highly technical and physical specialty. The thought that surgeons could be creative causes cognitive dissonance. They box surgeons into occupational categories that include mechanics and carpenters, or in my case as a urologist, plumbers. When people talk of creativity, they often use one small subset of creativity as their measure: that is, artistic creativity. We know, for example, that Picasso or Bach or Monet were creative. We don't think of a surgeon doing a laparoscopic cholecystectomy as creative. When you ask people to define creativity, they often use the words like 'artistic' or 'create'.

Generally accepted definitions of creativity encompass more than art. The *Oxford English Dictionary* defines creativity as the use of imagination or original ideas to create something; Edward De Bono says creativity is the use of ideas and skills to create something that was not present before.

Perhaps the best definition of creativity was put forward by Robert E Franken, a Canadian psychologist and researcher living and working near Vancouver. He defines creativity as 'the tendency to generate or recognise ideas, alternatives, or possibilities that may be useful in solving problems, communicating with others, or entertaining ourselves and others.'

Using this definition, we as surgeons display creativity daily to make difficult diagnoses, approach challenging operations or deal with patients and their families. Creative surgeons devise new ways of doing operations, new clinical pathways and models of care, and push the boundaries of disease even further towards conquest. The story of surgery, even to our modern day, is rife with examples of invention and innovation.

Most of the time, as is evidenced by the data collected on our endeavours, we are successful in our clinical outcomes. Australia and New Zealand boast some of the best outcomes in surgery and are two of the safest places in the world to have an operation. The Royal Australasian College of Surgeons has, since its inception, had a central theme in training us for excellence.

Yet there are times when even our best skills, clearest thinking or our most innovative technologies do not yield a desired result. Patients die or are forced to live a lifetime with complications that we have caused. We, as human surgeons, are forced to rationalise these injuries. They are cumulative in their effect on our collective souls. Time does not ease the pain of the harm we cause. The years only condemn. Some of us turn to alcohol and other addictive drugs. The data tells us that 14 per cent of doctors in Australia have an alcohol problem and two per cent have narcotic dependence. Depression and anxiety are higher per capita in our profession than the general population. We suffer for our craft and our craft suffers as a result.

This collective post-traumatic stress disorder has to be resolved. I would contend that the solution is within us all. Using our innate creativity as surgeons and directing it towards artistic creativity is an unparalleled mental release. The artistic feeds the surgical creativity and the surgery feeds our art. They are a continuum of one and the other.

The desire to create beauty out of the ugliness of disease, to contribute something with our creative energy outside the sterility of the operating theatre, provides, for many of us, the counterbalance to insanity and allows us to gain an equanimity that physician Sir William Osler so often expressed as the foundational characteristic of an effective doctor.

Anton Chekhov, the Russian doctor and playwright wrote, 'Medicine is my lawful wife, and literature is my mistress. When I get fed up with one, I spend the night with the other.'

For me, writing and art have always been my haven and I have been lucky enough to have four novels published by Random House. My first book, *Making the Cut*, has become a best seller and has sold more than 30,000 copies. In some ways the book is also a historical text. It documents what it was like to be a resident and registrar in the late 1980s and early 1990s, long before safe working hours and 'woke' communication with our bosses.

My second book, *The Patient*, is about a middle-aged manager who wakes up one morning with blood in his urine. The book is not just a story about our health system. It is my attempt to examine the Biblical book of Job.

My third book came out of a presentation by our then Prime Minister Kevin Rudd, who came to Nepean Hospital to talk about the Health Reform Commission. The book was called, perhaps somewhat dramatically, *Terminal Decline: A Surgeon's View of the Australian Health System*.

My fourth book was a story of a surgeon who serves his country in the military. It is based on interviews with a number of our colleagues who have served in wars and disaster and who endanger their lives for the greater good. Their contribution is supreme and makes anything I do pale into insignificance. It is called *Honour, Duty and Courage*.

All my books are based on real stories and experiences that I turn into de-identified novels. Arthur Conan Doyle, who was a doctor as well as a writer, wrote, 'There's no need for fiction in medicine for the facts will always beat anything you fancy.' Taking that advice, I try to tell it like it is.

I have also written a play in conjunction with one of Australia's great playwrights, David Williamson. The play is called *At Any Cost?* and it was an examination of futile care. The story centred on an elderly woman in an intensive care unit and the decisions her family make about her care. It premiered at the Ensemble in Sydney and has played in a number of centres around Australia, including, most recently, a production that has just concluded in Western Australia. I have certainly been lucky with my writing.

Currently, when I am not working in my private practice, or being Clinical Director of Surgery, or teaching at the university, I paint. Watercolour, I find, is one of the most challenging things I have ever done. I also make wooden boxes and give them to friends and colleagues. I doubt if my watercolours will ever be hung or my boxes ever be sold. The point is the expression of beauty in whatever form it takes. John Keats, another one of our medical colleagues, wrote in his poem *Ode on a Grecian Urn*, 'Beauty is truth, truth beauty, – that is all Ye know on earth, and all ye need to know.'

Some ask, how do you have time to do these things? I think that giving expression to our artistic creativity is important enough to make time. Associate Professor Brian McCaughan, who was my mentor and guide, told me when I was his resident, "Khadra, there are 24 hours in every day, and then there's the night." I have lived by that adage since. Judging by the virtual gallery that is part of this conference, I am certain there are many surgeons in the audience who also share their lives with artistic creativity.

Creativity is not a commodity isolated to one craft or one mode of expression. It is an innate and limitless resource inherent to all of us. It is the great antidote to the emptiness of existence and we, as surgeons, are luckier than most, because creativity is practised and learned, honed and developed, sourced and expressed in the craft we ply throughout our working life. Ladies and gentlemen, in reality, we are all creative surgeons. ■

Professor Mohamed Khadra AO

Images:
Professor Khadra's watercolour paintings

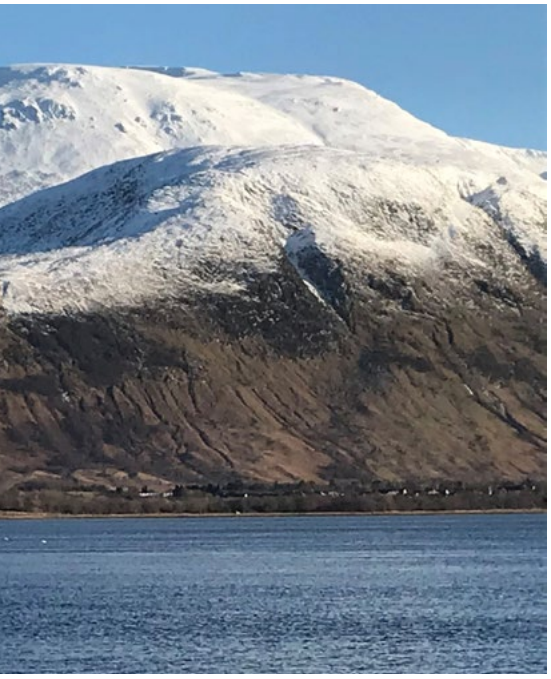
Rural General Surgery in Scotland

Perspectives from a general surgeon based in the United Kingdom

The rights of every individual in society to local and accessible health care provided by the state, regardless of ability to pay, were important recommendations of the Dewar Report to the Scottish Highlands and Islands Medical Services Committee in 1912. Shortly thereafter, well-organised medical services were established in rural Scotland and this report formed the blueprint for setting up the United Kingdom (UK) National Hospital Service, 36 years later.

Remote and rural surgery is delivered in six locations in Scotland: three on islands and three on the mainland. The Island Rural General hospitals (RGH) are situated in Lerwick on Shetland, Kirkwall on Orkney, and Stornoway on the Isle of Lewis; on the mainland they are in Wick, Fort William and Oban. Each hospital has strong links with a city centre hospital for those requiring more specialist care. Each hospital serves a base population of between 20,000 and 44,000 people. However, they are all based in popular tourist destinations. For example, each year, at least one million visitors pass through Fort William, where I have practised for 21 years.

With such small base populations, which are used to determine the hospital workforce, the provision of surgical and medical services is challenging. Here in Scotland, as in Australia and New Zealand, increasing super-specialisation in training and healthcare provision has led to centralisation of services, particularly in cancer care and, to a certain extent, the demise of the general surgeon. However, there has been a recognition that this shift has advanced too much or too far and that mechanisms are now needed to train more general surgeons.



Professor David Greenaway, in his report 'The Shape of Training Review' (2013), states that the four to six years of training after the two foundation years should be more general to provide surgeons who can practice independently in elective and emergency general surgery, or go forward for further specialist training or fellowships.

The provision of a Rural Surgical Fellowship funded by the Scottish government is an important development to enable surgeons to top up their training over six to18 months for broad-based clinical work.

Rural general surgery has provided a very fulfilling career for me, with special interests in colorectal, urology and trauma. It is possible to continue providing a safe and sustainable surgical service in the RGHs because of managed clinical networks and multidisciplinary teams, which includes joint operating and close collaboration with super-specialists in the city-centre hospitals. This has been outlined in the 2016 Royal College of Surgeons Edinburgh (RCSEd) report on 'Standards informing delivery of care in rural surgery'. Over the past 30 years, many reports have been produced that define the way to provide rural surgical services but many of the recommendations have not been instituted. This has to be rectified in some way or we envisage rural patients having to travel up to four hours to have their appendix removed, abscess drained or strangulated hernia repaired.

The variety of work seems attractive to students on placements in rural settings. However, during training for surgery, which inevitably is in city-centre units because of case numbers, this enthusiasm seems to wane and disappear. Furthermore, the imperative that each trainee selects a super-specialism in order to obtain a Certificate of Completion of Specialist Training (CCST) mitigates against certification of a rural general surgeon.

Academic and professional support for rural general surgeons in Scotland and other countries in the North Atlantic comes from the Viking Surgeons Association (VSA). The VSA has held annual meetings in the locations of each of the hospitals for updating by super-specialists and enabling these city-centre consultants to experience the challenges of rural surgery. In response to the present pandemic, the VSA teamed up with the Faculty of Remote, Rural and Humanitarian Healthcare at RCSEd (FRRHH) to provide a series of webinars on rural surgery which have attracted more than 500 surgeons from more than 50 countries. This has been a valuable collaboration for our rural surgeons and is in keeping with the primary objective of FRRHH 'to improve the health outcomes of individuals living and working in remote, rural, austere and life threatening areas of the world'. This is one positive outcome of the global pandemic for rural surgery in Scotland. ■

Mr David Sedgwick
FRCSEd

Top image:
Nevis Range across Loch Linnhe, Fort William, a beautiful place to live and work

Image over page:
Viking Rural Surgeons (l-r) Mr Gordon McFarlane, Mr David Sedgwick and Mr Stuart Fergusson at the annual conference at the Royal College of Physicians and Surgeons, Glasgow 2017

The state of robotic surgery

Robotic surgery began in Australia in 2003, having commenced in the United States in 2002. Urology was the first surgical discipline to take up robotic surgery, mainly robotic radical prostatectomy. Since its introduction, there have been significant barriers to its adoption. These can be summarised in three points.

First, scepticism about the perceived benefits of robotic surgery compared to traditional open and laparoscopic surgery; robotic enthusiasm was once described as 'gizmo idolatary'.

Second, the capital cost of the robot being around $4 million prevented installation of these machines in the financially constrained public hospital system, where registrar surgical training occurs. This meant that graduate Fellows of the College of Surgeons (FRACS) have to do a second expensive Fellowship to learn robotic surgery after graduation.

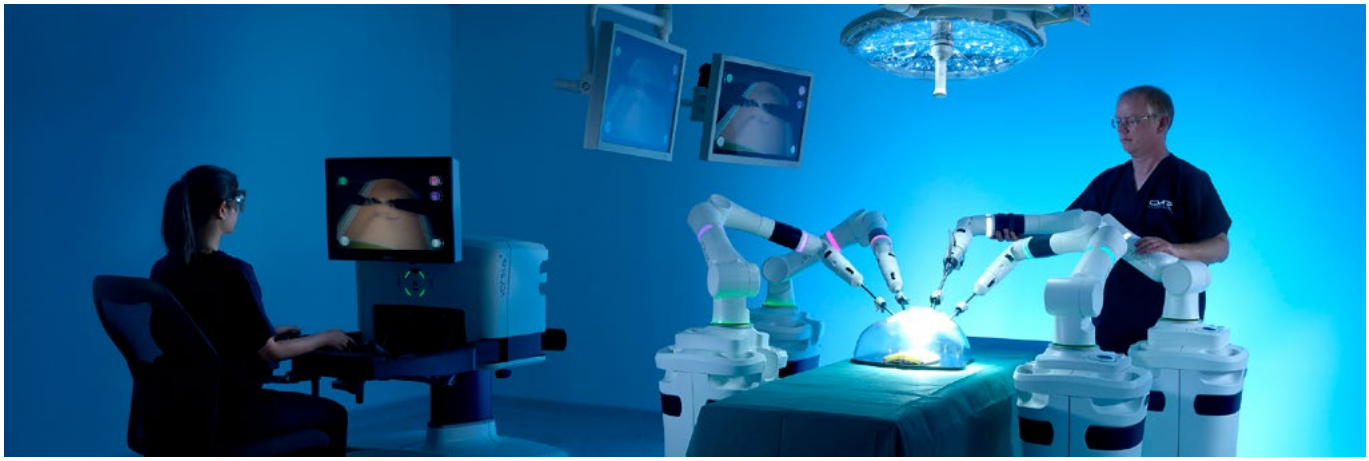
Third, there is no validated curriculum for credentialing to proficiency in robotic surgery. Vendors have thus far provided the education and credentialing for robotic surgery. In Australia this means a brief online instructional video on how to drive the robot, called 'buttonology'.Then a single porcine live animal surgery, followed by mentorship by another colleague in one or two early cases. As has often been the case in the digital age, the introduction of fancy new technology outstripped the ingenuity and ability of those destined to use it. Nowhere has this been more obvious than the introduction of telerobotic surgery. The manufacturers of the robot, mainly engineers not surgeons, developed a brilliant new technology.

We have recognised the true benefits of minimally invasive surgery since the introduction in the 1990s of laparoscopic surgery, which disseminated through many surgical disciplines. Minimally invasive surgery provides small incisions, reduced blood loss, reduced length of hospital stay and earlier return to normal activities. Robots added a third and fourth dimension to laparoscopy being three-dimensional 10 times magnified view for the surgeon, and digitised telestrated intuitive hand movements, rather than the counterintuitive movements used in laparoscopy.

We have just witnessed the end of the first generation of robotic surgery led by the Intuitive Surgical Company with the da Vinci machine from 2000-2021. In 2022, there will be at least three new robotic surgical machines available in Australia from three different providers: Medtronic, Cambridge Medical Robotics and Medicaroid Corporation (developer of the Japanese Kawasaki Hinotori machine). Intuitive Surgical Company's da Vinci machine has proven to be the Rolls Royce in robotic surgical technology. It remains to be seen whether the new machines will be equivalent or at least good enough to challenge the existing monopoly. These machines will come with lower costs and enable provision of machines in the public system where Surgical Education and Training (SET) occurs. This second generation of robotic surgery will also embrace application of artificial intelligence in surgical procedures, and certain parts of operations such as suturing and wound closure may be automated. The cost of robotic machines is likely to reduce by about one third when competitive technologies are introduced. Robotic procedures will be undertaken in many more disciplines, including General Surgery with cholecystectomy, appendicectomy and hernia repair. Other disciplines to embrace robotics include bariatric, Colorectal, Ear Nose and Throat (ENT), gynaecology and Cardiothoracic Surgery.

Based on sales of $5.3 billion in 2019, Goldman Sachs has predicted that the worldwide robotic market will increase incrementally after the emergence of new competitors. The prediction is the market will be worth $14.1 billion in 2025, and $24 billion in 2030.

In 2018, an independent commission, established by the Royal College of Surgeons of England, published a report on the 'Future of Surgery'. This report describes how the surgeon's role will change in the next 10 years. The surgeon of the future will have multiple skills. They will have to understand the language



CMR Versius robotic system

Left: William Halsted, who inspired the traditional training model, taught at the Johns Hopkins Hospital in 1902. Right: The da Vinci surgical system

of medicine, genomics, robotic surgery, engineering, bio- engineering and molecular biology. Surgeons will need improved leadership, managerial and entrepreneurial skills.

Previous training systems involved seven years of training with a seven-day working week and no vacation. This is clearly not suitable for the modern Trainee and nor should it be. How do we overcome the barriers to modern registrar surgical training in robotics? We need to consider safe working hours, the limited number of operations to train on human patients, and the reasonable desire for modern surgeons to have their training time reduced. The present six year training path seems too long. There are already simulation metrics, which can test the aptitude of a potential trainee surgeon, which objectively assess hand-eye coordination and visual- spatial orientation. The simulation metrics can also identify rapid adapters for whom training can be expedited.

The issue of robotic education, training and credentialing is the most vexed. Most of our surgical trainers trained in open and laparoscopic surgery and have then had to learn on the job to use the robot without access to a structured training pathway. There is a dearth of expert robotic surgical trainers in Australia. The year 2022 will see a significant change in surgical delivery in Australia.

Robotic training could allow surgeons to learn more quickly through the application of modern educational methods. An ideal scenario would involve online learning with quizzes before moving on to a simulation-based training.

The Australian Medical Robotics Academy has developed a fully validated approach to surgical training so that surgeons can learn more quickly and adapt by application of modern educational methods. Following scored proficiency in simulation, the surgeon can operate on simple procedural models in a dedicated robot laboratory, away from the high pressure operating room.

In 2022, there will be high-quality, high-fidelity, synthetic 3D computer generated human organ model systems for surgical training. These models will replace reliance on cadavers and live animals for training. The models will allow repetitive surgical procedures for surgical Trainees to work towards scored proficiency before finally going to the operating room.

The eventual outcome of a formal structured robotic surgical training pathway for our SET Trainees will be enhanced training. Hopefully by shorter and better training we could eventually reduce surgical complications for patients, a most worthwhile societal objective. ■

Professor Anthony J Costello AM MD FRACS, FRCSI

Mimic simulator

Professor Anthony J Costello

A rare breed of rural surgeon

Mr Kyngdon with his award.

Rural Surgeons Award winner, Mr Richard John Kyngdon, known to the RACS community as John, is one of the very few rural or provincial surgeons who has worked in both Aotearoa New Zealand and Australia.

John was presented with the Royal Australasian College of Surgeons (RACS) Rural Surgeons Award at the Aotearoa New Zealand National Committee meeting last December. The Rural Surgeons Award acknowledges significant contributions to surgery in rural settings in Aotearoa New Zealand and in Australia. These include conspicuous and continued involvement of at least 10 years to the development of a high standard of surgery, a commitment to quality assurance, and the ongoing education and training of individual doctors and other healthcare staff.

John holds medical registration in General Surgery in both Aotearoa New Zealand and Australia. He is also registered as a vascular surgeon in Aotearoa New Zealand. In 2014, he became a general surgeon in Kalgoorlie and held a position with the Flying Surgical Service in south-west Queensland.

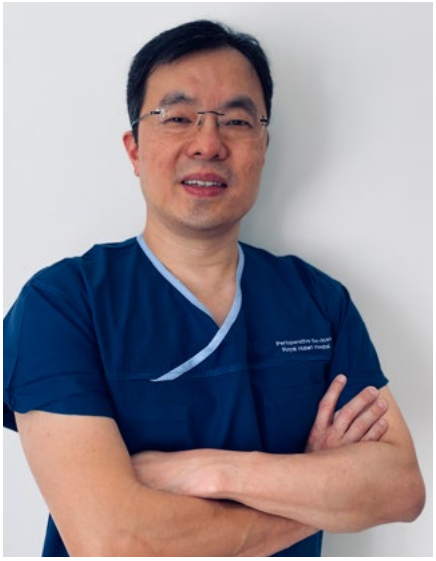
From 2005 to 2014, John was Chief Medical Advisor and Medical Director for the Bay of Plenty District Health Board (DHB). He worked as a general surgeon in Tauranga Hospital where he was involved in General Surgery training. During his nine years with Bay of Plenty DHB, he had significant involvement in community health and health promotion activities, including general practitioner liaison and medical support to the New Zealand Red Cross. His hospital roles included chairing both the Ethics and the Clinical Governance Committees of the District Health Board.

From 1986 to 2005 John was a general and vascular surgeon in Gisborne, working in the public hospital and also in private. During this time he was Clinical Director of Surgery and also Hospital Supervisor for Basic Surgical Training.

In addition to his clinical and hospital governance activities, John served as an elected member of the New Zealand National Board for nine years, ending his time on that Board as its Chair. He was Convener for the Rural Surgery Section of the RACS ASC in Auckland in 2013, in Brisbane in 2016 and again in Bangkok in 2019.

John epitomises the criteria for this award through his continued involvement of more than 30 years in the development of a high standard of surgery in rural or provincial settings. He has demonstrated his commitment to his own quality assurance activities, as well as that of his department and hospital. Throughout those 30 years he has also dedicated himself to the education and training of surgical and other healthcare staff in the rural sector. ■

Gendered titles: a badge of honour or time for a change?



Mr and Miss or just Dr? Are gendered titles confusing and discriminatory?

As the only profession left still using gendered titles, it is worth considering why this practice began in the first place centuries ago. Back in the 16th century, barber surgeons (Mister) were performing surgeries under the directions of university medical degree physicians (Doctor), and these different titles were used to differentiate the two groups of individuals. Interestingly, surgeons in 1730 had no right to be called 'Doctor'.[1] We certainly don't have physicians directing surgeons how to operate anymore but we still work closely together to look after our vulnerable patients, all as doctors. So do we need distinguishing gendered titles anymore?

An article published in the *Australia and New Zealand Journal of Surgery* in 2017 on this topic by Associate Professor Susan Neuhaus caught my attention straightaway. This was the trigger for a decision I made as the convener of the 2018 RACS Combined Tasmanian Annual Scientific Meeting and Trauma Symposium to use the title 'Dr' for all surgeons attending the meeting (except for individuals with academic titles). No surgeons that I know of came back to protest or request a change. I was certainly proud of the contribution made, especially as I was practising in Tasmania, a place that, along with Victoria, has the highest use of gendered titles in the country among Fellows.[2]

Since returning to Adelaide in 2020, I was delighted to participate in the Women's and Children's Hospital social media campaign together with my colleague, Dr Amy Jeeves (plastic surgeon) to change gendered titles for all surgeons from 'Misters' to 'Doctors'. Being the first hospital in the country to do so was a reflection of the strong leadership displayed on this issue. I have also been inundated with many congratulatory messages for this and I hope to do my part to keep this momentum going and a change amongst surgeons around the country and across the Tasman.

As a paediatric surgeon, I would say the use of any titles can be a barrier to communication with young people and children. Introducing myself as 'Michael' without the 'Dr' to patients and other health workers has become routine. It is certainly not that I am uncomfortable with the title, but to most children, teenagers and other health workers this is a barrier that can be overcome easily. Often, being less formal (and authoritative) is effective. As I frequently remind myself, I don't need others to show me respect just by addressing me as 'Mr' or 'Dr'. We have all worked so hard for so many years that I know when I have gained the trust of others and confidence in my skills and ability to look after them or their children.

This opinion piece is most certainly not an attempt to instruct other Fellows not to use gendered titles but to highlight a change that is coming. As we all know, change is inevitable, and nothing is permanent (traditions included) in life and as surgeons. We don't need to hold on to gendered titles just because this is how it has been for centuries, and especially taking into consideration the reason behind it in the first place. ■

Dr Michael Ee FRACS

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QASM Connects webinar series

The Queensland Audit of Surgical Mortality (QASM) is hosting a new series of free webinars under the banner QASM Connects from 2021 onwards. QASM Connects will be held three or four times a year and will be presented by surgeons.

Surgeons can contact QASM to discuss topics they would like to share with their peers or are interested in learning about. The QASM Connects webinar series is open to all surgeons, registrars and Trainees. Surgeons are encouraged to register and learn what their peers feel is important for patient care.

QASM Connects – 2021 webinar series program

- Webinar one (completed)
  Thursday 15 April 5 pm
  Dr David Grosser – Popliteal vein compression syndrome

  Dr Grosser presented on the importance of altering the perception that the main cause of DVT and PE is idiopathic.
- Webinar two
  Thursday 29th July 5 pm (AEST)
  Dr Stephen Allison – Continuity of care

  Dr Allison will present on the importance of hand-over and the continuity of care for admitted patients.
- Webinar three
  Thursday 7th October 5 pm (AEST)
  Dr Joanne Dale – Big bowel big problem

  Dr Dale will present on the early diagnosis and timely treatment of bowel obstructions.

Visit the QASM workshops and seminars webpage to find out more at https://tinyurl.com/ybjsccpe

If you have any questions please contact the QASM team: QASM@surgeons.org

QASM Connects – 2022 webinar series program

- Webinar one
  Thursday 17 February 2022
  Dr Leong Tan – Cervical collars in elderly patients

  Dr Leong Tan will be presenting on the management of elderly patients being treated with cervical collars.
- Webinar two
  Dates and speakers to be confirmed
- Webinar three
  Dates and speakers to be confirmed

Strengthening the foundation of surgical education to improve patient care

The College is developing a Professional Skills Curriculum aligned with and highlighting the importance of the Surgical Competence and Performance Framework.

The framework, available in the Royal Australasian College of Surgeons' (RACS) Surgical Competence and Performance Guide, reflects the standards we hold as a profession and our commitment to the community to deliver high quality patient centred surgical care. Comprising 10 competencies, the framework forms the foundation of the development, practice and assessment of surgeons at all stages of their career across all areas of surgical practice.

The new RACS Professional Skills Curriculum will be aligned with eight out of the 10 competencies.

- Communication
- Collaboration and teamwork
- Cultural competence and cultural safety
- Health advocacy
- Judgement and clinical decision making
- Leadership and management
- Professionalism
- Scholarship and teaching

Medical and technical expertise are specific to each surgical specialty. This curriculum is planned to complement the existing curricula offered by our Specialty Training Boards.

This was a key requirement of the accreditation review of surgical training by the Australian Medical Council and Medical Council of New Zealand, and is aligned with other Australasian colleges such as the Royal Australasian College of Physicians.

The curriculum is being created to provide surgical Trainees, Specialist International Medical Graduates (SIMGs) and supervisors with consistent and standardised expectations of the required knowledge, skills and behaviours in surgical practice.

We are developing this curriculum because 'multiple studies have demonstrated that improvements in nontechnical [professional] skills such as communication and surgical teamwork can improve patient care, patient safety, operating room efficiency, and patient outcomes.'[1]

The curriculum aims to develop surgeons of the future. Future-thinking anticipates the healthcare system will shift from a 'model of physician self-governance, autonomy and paternalism to a model of co-creation, partnership with patients, based on mutual respect and trust, transparency, shared decision making, shared learning and accountability.'[2]

Dr Rebecca Garland, Chair of the Professional Skills Curriculum Working Party, and Otolaryngology Head and Neck surgeon, explains how the curriculum is being formulated. "A working group comprising Fellows from all specialities meet regularly to work with the College to develop the curriculum," she said. "Because the curriculum will be broad enough to reflect all our specialities, we need input from a wide range of Fellows."

Making surgical education better for the future

The new curriculum will support Trainees and SIMGs as they learn and demonstrate professional skills deemed essential by the College. The curriculum will give Trainees and SIMGs clarity on how they develop their professional identity while highlighting what they are assessed on and the standards of performance they need to achieve within each competency.

"Skills such as communication, professionalism, collaboration and teamwork are considered to be foundational skills," said Mr Philip Morreau, Paediatric Surgery Fellow. "It doesn't matter how strong your medical and technical expertise is, if you have not developed all the professional skills outlined in the curriculum, your potential will not be reached."

According to Margaret Bearman et al., 'Trainees may also find themselves working in an environment that requires practice without supervision even though they are still in training.'[3] To sufficiently equip Trainees and SIMGs, Bearman and her colleagues suggest empowering them to negotiate environments where there is limited feedback. They must be equipped appropriately to manage their own learning.

"One of our goals in developing this curriculum is to help Trainees and SIMGs become self-directed learners, and to enable them to plan their own learning pathway," said Mr Adrian Anthony, Censor in Chief and General Surgery Fellow.

Having a curriculum to refer to will increase the graduates' confidence when they become Fellows and supervisors themselves and operate within the clinical setting.

We intend for the curriculum to provide Fellows, as surgical supervisors, with a guide that will help them to efficiently and effectively supervise and assess Trainees and SIMGs in their clinical activities. Supervisors will have clear statements of learning outcomes that must be demonstrated by Trainees and SIMGs at identified stages of their development.

"There is a common myth that suggest you can't teach someone how to be a teacher, but that is absolutely untrue," said Associate Professor Philip Truskett, General Surgery Fellow. "You can teach someone how to be an effective teacher, a compassionate leader and to be part of a team. These so-called 'soft skills' can be learned."

"This curriculum will be a powerful tool to assist in surgical teaching and learning," said Dr Garland. "It will provide supervising Fellows with a framework to use when they work with a Trainee or ▶

(continued on p37)

Dr Steven Craig on a life-changing Canadian Fellowship

It was 33C degrees when we flew out of Sydney, and -26C when we arrived in Calgary. We stepped out of the airport's heavy double doors and our two-year-old daughter, shocked by the cold, screamed, "Bad Canada!" We ran back inside, tore open our bags and put on almost every item of clothing we had.

In 2018 I elected to take time away from my visiting medical officer (VMO) positions in New South Wales to undertake further education in two areas of particular interest, namely endocrine surgery and surgical education. These are also specialty 'areas of need' in the districts that I am employed. To further my education in these areas, I developed a comprehensive educational program in North America.

I was accepted to commence an American Association of Endocrine Surgeons (AAES) Fellowship at the University of Calgary under world-renowned endocrine surgeon Dr Janice Pasieka. The AAES Fellowship is merit-based and highly competitive, with only 25 Fellows selected for high-volume sites across the entire United States and Canada. This fellowship met the clinical component of my educational goals, and it further developed important academic skills in teaching and research.

After our first night in Canada, we scurried from the empty outdoor car park to the mall to buy clothes. (Only later did we realise that the 'parkade' signs we kept seeing were directing us to the underground heated carpark, where everyone else had parked.) That afternoon, in our 'proper' Canadian winter clothes, we had a snowball fight in the park opposite our apartment, and Canada was no longer 'bad'.

A few days later, I was issued the regulation white lab coat with my name emblazoned on it, and I set off to start my American Association of Endocrine Surgeons Fellowship. Once I'd figured out that there was no 'tea room' ("Oooh the tea room?! Is the Queen coming or something?!") and to look instead for the 'doctors' lounge', things went smoothly, despite the lack of tea – and the terrible coffee.

My experiences – clinically, and in terms of research and teaching – were varied and valuable. The case volume was broad and covered the full spectrum of endocrine surgery, with consistently challenging and complex cases, befitting a major university hospital. There were regular clinics for general endocrine surgery, genetic endocrine conditions, and neuro-endocrine tumours, and I

Dr Steven Craig with Professor Janice Pasieka

The family enjoying the Canadian winter.

was fortunate to complete ancillary rotations through endocrine medicine, radiology and pathology. I gained valuable experience in retro-peritoneal adrenalectomy, the application of intraoperative PTH in primary and tertiary hyperparathyroidism, sternotomy for the management of goitres, and the surgical management of gastro-intestinal neuro-endocrine tumours.

My preceptors, Dr Janice Pasieka and Dr Adrian Harvey, were meticulous. Their interest in the intricacies and nuances of current endocrine surgery, and how it might be applied to practice, was impressive. It also appealed very much to my academic bent and to my love of the exquisiteness of endocrine surgery.

Fellows' meetings were held every Monday at 7am, come snow or shine, often based around a current controversy in endocrine surgery that I would need to research, present, and defend. I was also immersed in the history of endocrine surgery (a favourite topic of Dr Pasieka), including founding figures and contributors, and how the specialty has evolved over the years.

Complementing my clinical experiences were some great research opportunities,

Dr Steven Craig receives the Selwyn Taylor award from Professor Gerard Doherty of Harvard University.

mostly centred around my interest in thyroid cancer. Most valuable was my work in the lab of Dr Oliver Bathe, a translational surgical oncology researcher. Together, we developed a prognostic gene assay for thyroid cancer, which is currently being moved towards commercialisation. I was fortunate to present this work at the recent International Association of Endocrine Surgeons meeting in Krakow, Poland, winning the Dr Selwyn Taylor Award for best scientific presentation. I was also given opportunities to lead a number of scientific papers and book chapters and was supported by the Fellowship to attend conferences across North America.

Like Australia, Canada's population is aging, multicultural, yet largely Anglo-Saxon, with similar first-world health issues, such as obesity. There are pockets of significant disadvantage, including among Indigenous people. Canada is both heavily urbanised (concentrated along the southern border) and dispersed, and many patients have to travel long distances for tertiary appointments.

Of course, in Australia, those patients usually show up. In Calgary, when there's 80 centimetres of snow, and your condition isn't life-threatening, you just stay home and skip your clinic appointment (if you haven't already travelled south to Arizona for the winter). We were also often unable to discharge patients because of the snow, particularly if they lived in the Rockies.

It was interesting to work in an entirely public system. While the Canadian public health system is well-resourced, I felt perhaps the lack of a private comparison made it less efficient. Things are generally well-organised, but perhaps a little slower, and there seemed to be a lot of red-tape in the system: bureaucrats would decide, for example, who your secretary would be, not you.

Overall, our time in Calgary was life-changing. The Fellowship delivered on its promise to build my clinical expertise, and allow for and support higher-level academic work.

As with most travel, our understanding of the world and how people live expanded too. Our girls are now among the most intrepid four- and six-year-olds we know. They've skied Canadian black runs, hiked through the woods carrying 'bear spray' and cut down our own real Christmas tree. My wife was just as adventurous and even more tenacious, completing a marathon while also carrying bear spray, and triumphing over wild kids on snowed-in days, as well as on long summer days when the sun sets after 10pm and nobody could sleep.

We trick-or-treated, had a magical white Christmas and ate our body weight in ribs at the annual Calgary stampede. We left Calgary with heavy hearts, but with perhaps the best possible souvenir: our six-week-old baby with a Canadian passport. ■

Dr Steven Craig FRACS

Strengthening the foundation of surgical education (continued from page 35)

◀an SIMG experiencing difficulty in their journey, particularly in areas such as communication, judgement and decision making, and the newest addition of cultural competency and safety.

"Many surgical trainers and Fellows recognise when these skills need to be developed in training and the curriculum gives us a way of articulating those skills with a common language.

"In my time as chair of training in the Training and Education Committee, a division of the New Zealand Society of Otolaryngology, Head & Neck Surgery, I noticed that many boards were facing similar challenges with these competencies. It makes a lot of sense to come together to develop an over-arching framework we can reference."

We envisage the curriculum as being part of an ongoing cycle of quality improvement in surgical education and training and professional development. It will be integrated with existing skills courses and will complement the medical and technical curricula components offered by our Specialty Training Boards in partnership with specialty societies and associations.

The curriculum presents a program of increasing complexity from early to late Surgical and Education Training (SET), providing both supervisors and Trainees a clear pathway to track areas for development during the SET program. The College will actively engage Fellows to develop the curriculum, by meeting regularly with Specialty Training Boards (both Fellows and training managers). We will collect feedback and instructions on how well the competencies have been addressed.

We look forward to sharing more about the curriculum with you soon. ■

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Surgeon develops liquid biopsy to improve outcomes for paediatric oncology patients

Associate Professor Jonathan Karpelowsky

Associate Professor Jonathan Karpelowsky, recipient of a John Loewenthal Project Grant, has developed a multi-modal liquid biopsy approach for the molecular monitoring of sarcomas. The method is less invasive than traditional tissue biopsies and offers the opportunity for the oncology team to monitor treatments and their impact on cancer cells in the bloodstream more closely.

A paediatric surgeon and Associate Professor at the University of Sydney, Associate Professor Karpelowsky is dedicated to improving the outcomes of children and adolescents with solid tumours. His main position is at The Children's Hospital at Westmead, with appointments at Royal Prince Alfred Hospital and Westmead Private Hospital.

He and his team at the Advanced Molecular Diagnostics Laboratory within the Children's Cancer Research Unit have used the grant to develop the liquid biopsy approach using similar technology to that used in the non-invasive prenatal genetic testing in pregnant women.

While a traditional biopsy would require an incision with the accompanying risks and side effects, Associate Professor Karpelowsky's process means that the procedure is less invasive for children and testing can occur more often. The opportunity for repeated non-invasive testing offered by the liquid biopsy means that more accurate information is available to clinicians. This has the potential for the use of more adaptive, personalised treatments, and ultimately, a better outcome for patients.

The liquid biopsy allows researchers to study the DNA of cancer cells retrieved from the bloodstream to identify any changes that have occurred and determine the success of cancer treatments, such as chemotherapy and targeted therapy.

Associate Professor Karpelowsky said the grant had made it possible to progress this research, attract additional funding and to form international collaborations.

While further research into liquid biopsies for paediatric oncology patients is needed, the results to date have been extremely promising.

"I'm very grateful to the College for the wonderful opportunity the grant has given me," Associate Professor Karpelowsky said. "It certainly has borne fruit and enabled me to move forward with this research in a really important way."

Associate Professor Karpelowsky's history in medicine spans continents. The beginnings of his interest in the field can be traced to his childhood in South Africa, when he lost an 11-year-old friend to bone cancer.

He originally started training in thoracic surgery before undertaking both his adult and paediatric specialist surgical training, which he completed in 2006. He then achieved his PhD at the University of Cape Town.

He is passionate about educating the surgeons of the future and is the current immediate past chair of the Board of Paediatric Surgery, which supervises paediatric surgical training across Australia and Aotearoa New Zealand. As Associate Professor at the University of Sydney, he regularly tutors undergraduate and postgraduate students towards higher degrees.

Associate Professor Karpelowsky has served and currently serves on a number of committees, including the Sydney Children's Network Human Research Ethics Committee and the Australasian Association of Paediatric Surgery Executive Committee. He has led working parties for the Section of Academic Surgery into research requirements for the Royal Australasian College of Surgeons. He is currently on the section of Academic Surgery Executive Committee and the convener of the annual Developing a Career in Academic Surgery (DCAS) course.

Alongside his interest in the use of liquid biopsies in the molecular monitoring of sarcomas, Associate Professor Karpelowsky's areas of research include long term follow-up in thoracic conditions of childhood, augmented intraoperative reality for cancer surgery navigation and randomised trials in childhood surgical conditions.

His paediatric surgical clinical interests focus on paediatric surgical oncology and minimally invasive surgery for thoracic conditions of childhood.

Associate Professor Karpelowsky said that since arriving in Australia, he has been impressed by the care and training available through its health service.

"Australia has an enormous amount to be proud of with its freely available clinical care and training opportunities. I thoroughly enjoying working as a surgeon here."

However, the ability of surgeons to access protected time to pursue research can be more challenging due to the paucity of paid academic positions. He sees the College as having a crucial role to play in ensuring that surgeons are able to carry out vital, lifesaving research and to collaborate with international researchers by awarding grants like the one he received. ■

Creating safety and respect in healthcare cultures

The Royal Australasian College of Surgeons (RACS) is widely recognised for its sustained commitment to fostering a safety culture and promoting respect in health care. In April, the College collaborated to organise the Creating Healthcare Cultures of Safety & Respect Conference, to help progress cultural change and explore the role of different healthcare agencies in meeting this enduring challenge.

More than 250 people now working in Australia and Aotearoa New Zealand to effect cultural change in health care registered to join in our first combined virtual summit, which recognised RACS' leadership and sustained commitment to building a culture of respect through surgical education, cultural change and complaints management.

Collectively, speakers called time on describing the problems in healthcare culture and called for evaluations of interventions and actions to implement that support behavioural change.

In keynote addresses, Professor Johanna Westbrook, of Macquarie University, and Professor Russell Mannion, of the University of Birmingham, spoke about the idea of incivility contagion, which compromises team performance and therefore patient safety.

Professor Westbrook discussed research findings about the poor performance of teams exposed to rudeness. She said some groups (often younger staff, nurses and non-clinical staff) were more at risk of incivility and unprofessional behaviour, which was prevalent across the sector. Other research found skills in 'speaking up' were associated with lower odds of experiencing frequent bullying and reduced the impact of bullying. She explored how rudeness increased individuals' cognitive load by stealing resources away from the task at hand.

Professor Mannion spoke of the importance of a 'speaking up' culture, as well as the complexities inherent in creating it. This included the need to differentiate bullying from under-performance, lack of staff clarity about what issues should be raised, questions about the motivations of whistle-blowers and "organisational resistance to bad news", when "people in positions of power are vested in narratives of success". The invisibility of actions taken in response to issues raised was also a deterrent to speaking up. Professor Mannion discussed the National Freedom to Speak Up Guardians in the United Kingdom, a National Health Service mandated program recognising the role of speaking up in safe and respectful healthcare cultures. He spoke about the frequent gap between organisational intention and resourcing, and of the systemic barriers to effecting change.

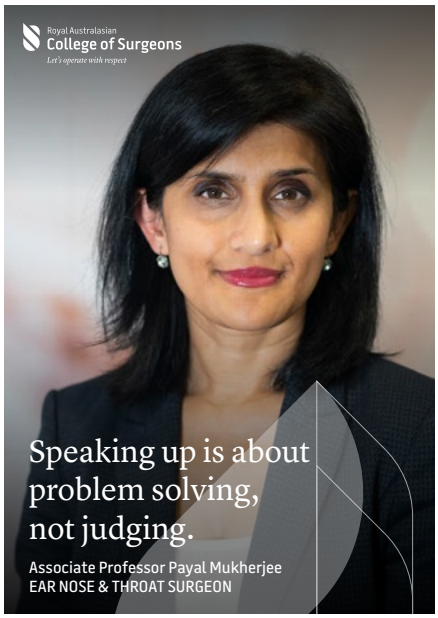
Conference speakers advocated for collaborations to support cultural change in health care that foster safety and respect, arguing that a shared endeavour from employers, educators and professional associations was essential. Both individual and systemic change is needed, given that good people in bad systems lead to bad outcomes.

Long-time adviser to RACS and keynote speaker Dr Gerry Hickson shared research indicating how the failure to address disrespectful behaviour leads to more lawsuits and more poor patient outcomes, has a negative impact on culture and performance, and causes organisational reputation damage. Dr Hickson was adamant that "you don't have safety without respect," and he said that "teaching our people to talk to each other in the moment" was a feature of the Vanderbilt University system, which has shaped RACS' approach to cultural change. He described professionalism as "the body of knowledge owned by the profession, distinguished from mere skill", and of the obligation for self-regulation in medicine.

In the context of speaking up about unacceptable behaviour, presenters brought together by the Royal Australasian College of Medical Administrators (RACMA) spoke of the value of pre-rehearsed responses in the face of racism, sexism or other prejudice. One such example that gave was, 'I was having a great day until you made that casually racist/sexist remark.' They also asserted that people don't have to be in a leadership role to make such statements, the most senior person in the room holds the responsibility to call it out.

Dr Christine Lai showcased RACS' Building Respect program and shared her insights into what we have learned. It is pleasing that conference delegates have since followed up with their interest in our work, given multi-party collaborations are key to building a culture of respect.

RACS is proud to have collaborated in the organisation of the April 2021 Creating Healthcare Cultures of Safety & Respect Conference, with Macquarie University, St Vincent's Health Australia and RACMA. ■



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Fellow profile: Dr Alpesh Patel

What would you do if you had a hard day of surgery? Run, of course, to reduce stress.

Dr Alpesh Patel is passionate about orthopaedics and running. He advocates following one's passion to his family and colleagues.

Dr Patel grew up in South Auckland. He was born in Middlemore Hospital, where he is now an Orthopaedic Surgeon and Clinical Lead for the Supra Regional Spinal Cord Injury service. As a Governance Group member of the New Zealand Spinal Cord Injury Registry (NZSCIR), he is involved in collaborative research of Spinal Cord Impairment in New Zealand and Canada. He operates on spinal injuries along with adult degenerative conditions, infections, primary and secondary tumours of the spine, and tetraplegic upper limb surgery. However, he noticed a lack of people of colour and women in his chosen speciality – something he feels is "slowly changing, and I was on the cusp of it." Alpesh is the first doctor in his family.

A sports lover, Dr Patel played hockey growing up. "I gravitated towards Orthopaedics when I saw the injuries on the field. Physically helping people and the hands-on approach of the speciality intrigued me and sparked my interest."

After completing his medical training, Dr Patel spent six months as Spine Fellow in Middlemore hospital – the first in the hospital. Since he was also interested in hand surgery, he undertook a year's Fellowship at Sydney's Royal Northshore Hospital. He then went to Vancouver General Hospital for a year at a Quaternary Spine Referral Centre, which served 4.5 million people. "It was here that I was introduced to the O-Arm, which takes X-rays in a 360-degree arc that connects to a navigation system to allow us to place instrumentation into the spine accurately," he said.

When Dr Patel returned to Aotearoa New Zealand, there was only one O-Arm at Christchurch "and I was keen to acquire one in our area and helped raise funds for it," he said. "It has been a great tool, both for patients, and registrars as it gives them confidence placing screws around the spine." With more than 700 spine surgeries being performed annually at Middlemore Hospital (Dr Patel performs about 200) the O-Arm has been a boon.

For Dr Patel it is the intricacies of spinal surgery – the challenges, the advent of robots, and the ever-evolving field of technological advances – that makes his profession exciting. Earlier in his career he was offered a lucrative job at another hospital but specialising in a different sub-speciality. "I told the surgeon I was working under about the offer and he gave me the best advice, which I share with my colleagues, house officers and registrars. He said, 'You will be an orthopaedic surgeon for the next 30 years, and you want to go to work every day enjoying what you do. Base your decision on your passion.'"

"In New Zealand it's tough to get positions, so some young doctors take up the first offer. But if your heart isn't in your chosen field, it's best to wait – even if it takes time to understand what this is. It's a small price to pay for the remainder of your career," Dr Patel advised.

Dr Patel's second passion is running, and in May he completed the Hawkes Bay Marathon. "I'll put my shoes on anywhere I can," he said, "whether before work, in between work, or after work".

This love for the outdoors is shared by his doctor wife and three young children. Next month they are going bushwalking with Dr Patel's mother. They are looking forward to skiing and snowboarding this winter, and come summer the beaches beckon them. The perfect wellbeing antidote for all the family. ■

What are you:

- Reading?
  The Happy Runner by David Roche and Megan Roche, MD
- Watching?
  Seaspiracy
- Listening to?
  Running podcasts on the way to work, and pop or hip hop at the operating theatre.

Aotearoa New Zealand restructures its health services

For a number of years, the health sector and the public have been concerned about the apparent inadequacies and shortcomings of some of the services provided by Aotearoa New Zealand's health services, including ongoing inequities of access and quality that particularly affect disadvantaged and vulnerable groups. This concern led to the instigation of a Health and Disability Review, commissioned by the government in 2018.

In April 2021, the government released its response to the review with its plan to strengthen the health system to ensure every Aotearoa New Zealander can access the right care at the right time. It observed that the health system is supported by a dedicated workforce, but that the system has become overly complex and fragmented. It committed to a single nationwide health service with structures that ensure government is both closer to communities and more nationally connected.

What will the reform look like?
The Ministry of Health will refocus to become the lead advisor to government on matters of health. A new organisation will be created, Health NZ, to take responsibility for the day-to-day running of health services, meaning the 21 District Health Boards (DHBs) will become obsolete. A new Māori Health Authority will be created with the aim of improving outcomes for Māori, and to provide tailored health services for Māori where Māori models of care can flourish. It will work in partnership with Health NZ to commission care across the country. Finally, it will establish a new Public Health Agency within the Ministry of Health to respond to threats to public health, such as pandemics.

What does it mean for hospital and specialist care?
The review identified a need for greater consistency of care across the country. Care should be offered where it is accessible and practical, and the costs need to be better managed. The review proposed wider regional networks, coordinated services, and improved access for those in rural areas. The new service aims to provide greater certainty where more specialist or complex care is required, less fragmentation of services, and less competition between districts for staff and resources.

What will these reforms mean for surgeons?
At present there is little detail of how the plan will be implemented, but there are some likely consequences for surgical services.

Firstly, the impediments caused by the current DHB structure for those surgical specialties providing a regional service (i.e. across DHB boundaries) should be diminished, allowing for the creation of better national and integrated specialty networks. This will particularly affect the smaller specialties such as Neurosurgery, Cardiothoracic, Vascular and Paediatric Surgery. Currently, service development is very ad hoc, often done in isolation, and is typically short-term. Hopefully, having a single Health NZ will enable improved long-term planning.

Secondly, our College has already applauded the recognition of inequalities in the system and has indicated it will do everything it can to support the initiatives to correct these. Exactly how the commissioning of Māori services will affect surgery is not yet known, but RACS will be actively working to ensure it succeeds.

Thirdly, the plan makes no mention of significant increases in funding, so it is likely that there will be ongoing pressure around resourcing of services, especially surgical services. It behoves us to continue to use our limited resources wisely without compromising the quality of care we provide. ■

Spencer Beasley and Sarah Rennie
Aotearoa New Zealand Surgical Advisors

For more information see: https://dpmc.govt.nz/our-business-units/transition-unit/response-health-and-disability-system-review/information

The Pacific Island Program – how are we doing?

Since 1995, the Royal Australasian College of Surgeons (RACS) has been working with health partners in Pacific island countries to improve access to surgical care through the Australian aid-funded Pacific Islands Program (PIP). PIP, now in Phase-V (2016-2021), aims to increase access to surgical care across 11 Pacific island countries by providing education and training to Pacific surgeons, nurses and other health workers and by supporting surgical teams to deliver surgeries locally. In May 2020, RACS Global Health commissioned a mid-term review of PIP (2016-2021) to identify opportunities to strengthen its ongoing implementation and impact.

Over a million people in Pacific island countries do not have access to essential surgery when they need it. RACS recognises that investing in people is essential to increasing access to health care in these countries and meeting the ongoing needs of Pacific communities.

To understand PIP's performance and identify opportunities to ensure its success into the future, RACS commissioned a mid-term review of the program. The review included 35 interviews, and 79 online surveys with Australia- and Aotearoa New Zealand-based specialist medical volunteers, and Pacific stakeholders and healthcare workers.

The review found that PIP has delivered well against its mandate to support service delivery which would not otherwise have been available and to provide in-country training through on-the-job experience and the delivery of courses.

Between 2016 and 2019, RACS deployed 178 specialist medical volunteers (including surgeons, anaesthetists, specialist nurses and other healthcare workers) to provide training and mentoring to Pacific surgical and other healthcare workers via PIP. Accumulatively, through PIP, RACS specialist medical volunteers, in partnership with in-country clinical teams supported the delivery of more than 1700 surgical procedures. These occurred across eight Pacific island countries and 11 specialties. It also provided more than 1300 professional development opportunities for Pacific surgical healthcare workers.

Pacific surgeons were interviewed about their experiences participating in PIP. Many reported that they valued PIP highly for the clinical opportunities it provides. Almost 90 per cent of surgeons and other healthcare workers surveyed felt that their participation in PIP was 'very' or 'extremely' beneficial to their professional development. Many highlighted the importance of the professional support provided through PIP, which had increased their confidence and exposed them to development opportunities across a range of clinical and surgical specialities they would not otherwise have had.

"My confidence and courage to perform urgent life-saving operations have significantly increased from my involvement in PIP. It is important to have PIP volunteers continue to mentor, engage, enable, evaluate and audit the work that I do to support ENT in Samoa and the Pacific," said Dr Sione Pifeleti, a Pacific Island Program participant and Otolaryngology Ear Nose and Throat (ENT) registrar in Samoa.

Dr Sione Pifeleti, a Pacific Island Program participant and ENT registrar in Samoa

However, among the Pacific surgeons interviewed, there were also calls for PIP to support stronger reporting against competency frameworks, including formalised workforce development plans and Continued Professional Development (CPD). Other Pacific interview respondents felt there was work still to be done to improve PIP's strategic alignment to Pacific surgical priorities.

Going forward, opportunities to ensure PIP's ongoing impact, including those identified in the review, will be considered in consultation with Pacific and implementing partners as part of the design of the next phase of PIP.

RACS Global Health is committed to increasing the sustainability and relevance of PIP and supporting regional efforts to increase access to safe surgical care for Pacific communities. ■

The Pacific Islands Program is an Australian aid initiative implemented by the Royal Australasian College of Surgeons on behalf of the Australian government and delivered in partnership with the Pacific community, Ministries of Health, specialist colleges and associations, and partners.

If you are a health professional and interested in volunteering or supporting RACS Global Health please contact volunteer@surgeons.org

Australian Aid

Tour de Cure SA Discovery Tour 2021: persistence rewarded with satisfaction

Squeezing every last drop out of whatever life serves up to you

What does one do when life deals you a seemingly never-ending supply of lemons? To quote Elbert Hubbard, "You start a lemonade stand!"

I have a feeling that 2020 may well be remembered as the Year of Lemonade. Many people had to pivot, re-imagine or just postpone their plans for 2020 when, like an uninvited, distant relative, COVID-19 came to stay. Unfortunately, I was gifted the opportunity to become an expert lemonade producer throughout 2020.

I have been involved with Tour de Cure (TDC) – an organisation that exists to 'Cure Cancer and Change Lives' – for the last five years. They raise funds, through large group bike tours, for researchers in the field of cancer, organisations that support people along their cancer journey, and cancer education and prevention programs. TDC is a significant supporter of the RACS Foundation for Surgery. Over the last 15 years, TDC has raised more than $66 million, supported over 550 cancer research projects, helped fund 45 cancer research breakthroughs, and has spread their prevention message to over 160,000 school children around Australia.

My support crew

Each year since 2007, TDC have run a Signature Tour. This is a nine-day challenge, held in different parts of Australia, for riders who have raised funds throughout the year. When I first heard of the organisation in 2015, I had a relatively embryonic interest in bike riding. I wondered if I would ever be able to get to the level where I could ride 150km a day, for nine days straight, and climb approximately 15,000 metres of vertical ascent during those days on the bike.

As is the case for too many, I have had many unwanted brushes with 'the Spanish Dancer' and have managed many patients through the effects of this terrible affliction. I saw TDC as an opportunity to both improve myself and, by suffering a small amount on my bike, help lessen the suffering of others due to cancer.

The first South Australian (SA) Discovery Tour was in 2016 and I initially trained and fundraised to participate in these annual Tours. I found them extremely worthwhile adventures, and after completing a few I began to wonder, could I take on the Signature Tour?

All the planets seemed to align as 2019 was progressing. I had saved up annual and long service leave and I thought it was now or never to commit to the training I knew would be required for such

On the road between Clare and Tanunda

an arduous task. I set out my training program, some 10 months in advance, and set about building up my stamina and losing as much weight as possible to make climbing the endless hills more achievable.

My plan was to complete both the Signature Tour (March-April 2020) and the SA Discovery Tour (May 2020) and then enjoy a bike riding holiday through Tuscany and The Dolomites. The latter would be the prelude to spending three months in Italy with my wife, enjoying my long-awaited long service leave.

My training progressed really well. As those who ride bikes will attest, it never gets easier, you just get a bit faster. By mid-March 2020, I had arranged a locum for my private practice, raised more than $30,000 and was possibly in the best physical shape I'd been in since my teenage years. I was ready. Bring it on!

Well, it was certainly on, but not in the way I had been anticipating. In short, the COVID-19 pandemic led to the cancellation of all my planned activities for 2020. To say this was a devastating blow would be a massive understatement.

Instead of challenging my body, mind and spirit to complete the TDC and Italian bike tours, I was suddenly thrown into helping to navigate the medico-political turmoil that was elective surgery cancellations, the management of the surgical response to COVID-19 in SA and trying to survive my private practice closure. I couldn't even continue my bike riding due to lockdown directions. All I knew was that my plans lay in tatters. However, I quickly realised that I was fortunate to be able to self-isolate in the beautiful Adelaide Hills.

The loan of an indoor trainer from a friend and the discovery of amazingly life-like cycling video apps enabled me to keep up with my riding. I lost count of the number of hours I spent on that trainer, first completing both 'virtual' Signature and SA Discovery Tours, to acknowledge all my financial supporters, then riding 'virtually' around Italy.

Looking back, I believe that the unending support of my family, coupled with planning, commitment, persistence, dedication and resilience, all of which have enabled me to navigate my surgical career so far, helped me to survive this potentially dark period of time. I was determined to make the best darned lemonade that I could!

Eighteen months of training later, I finally participated in the SA Discovery Tour 2021. One hundred and ten riders and 40 support crew set off from Clare on 9 April 2021 and, over the next three days, we battled head and side winds, mixed with rain and sunshine, to travel a very circuitous route through Tanunda and Hahndorf ending in McLaren Vale after 350kms. The relief of actually getting out on the road was palpable. The physical and emotional challenges were hard but the rewards of new friendships, goals achieved and a real sense of being part of something outweighed any hardships experienced.

During what was a difficult year for all, I kept telling myself that missing out on travel was not a matter of life or death, but the alternative of having uncontrolled COVID-19 infection in the community, potentially overwhelming our health system, certainly was. I count myself fortunate that I had something so worthwhile to focus my energies on and that I was able to turn the sourest of lemons into sweet lemonade. ■

Mr Philip Worley FRACS

Inspiring students and junior doctors to incorporate research into their daily practice

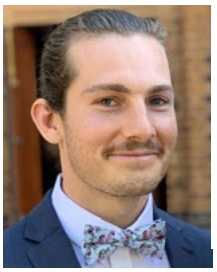
The Surgical Trainee Organisation for Research Central Coast Collaborative (STORCC) was founded in Gosford on the Central Coast of New South Wales in 2016. Within two years it participated in its first international collaborative trial: Ileus Management International (IMAGINE), protocol for a multicentre, observational study of ileus after colorectal surgery. In 2020 STORCC was the largest Australasian site in the CovidSurg week study, the largest ever surgical trial with more than 140,000 patients from 116 countries.

Trainee-led regional networks in General Surgery have changed the paradigm for a collaborative approach to research and have proven to be very effective globally in delivering large multicentre clinical trials. The West Midlands Research Collaborative, founded in 2007, was the earliest surgical trainee-led collaborative trials network in the United Kingdom. By 2016, there were 33 documented surgical trainee research organisations and this number continues to increase. The research collaboratives use a corporate authorship model that recognises the work of individuals who contribute to the project as a PubMed citable co-author. STORCC now has more than 150 team members who each have at least one peer-reviewed publication.

Dr Sharon Laura, Breast and General surgeon
"Ongoing research is so important in medicine. We are constantly gaining new knowledge through research and using this to improve patient care. As a clinician, it is a pleasure and a privilege to be a part of that. I feel proud to be part of such an important large research project and enjoyed working with my mini team on the Covid SurgWeek project."

STORCC is unique as the chair of the research group is a prevocational junior doctor. As a regional site, surgical registrars rotate on a six- or 12-month placement. However, junior doctors and students have at least a two-year placement. Medical students at the University of Newcastle Central Coast Clinical School in Gosford can complete their five-year program locally, and historically over half return as interns for a two year placement. This is due to the Clinical School's research project program that encourages medical student involvement in assisting junior doctors, surgical trainees and consultants. By working together in mini teams, a strong sense of camaraderie and teamwork is created, which adds to the positive experience for medical students participating in clinical studies. This program provides long-term stability for their involvement and sustainability for the organisation. As a regional hub, the Central Coast has reduced access to research support and funding. The trainee-led research collaboratives are independent of traditional research funding and therefore work particularly well in hospitals where resources are limited.

Trainee research networks require the support of a mentor, who provides arm's length guidance. As the Surgical Specialty Lead Prevocational Doctor and Central Coast general surgery clinical academic, I facilitated STORCC's development by focusing on its importance to the entrepreneurial and experiential pedagogy of medical student and junior doctor academic education. As past chair of the Critical Literature Evaluation and Research Committee, I identified the importance of providing students and trainees the opportunity to apply their epidemiological knowledge and to develop proficiency in large scale clinical trial research participation, capacity to effectively manage a local research site, and national leadership capability in project management.



Dr Benji Julien, JMO
"Being involved in the CovidSurg study provided me with a great insight into large multinational studies. It was a pleasure to be able to work with colleagues from home and around the world to contribute to a study with genuine benefit for patient care worldwide".

The Royal Australasian College of Surgeons, through the Section of Academic Surgery, recognised the importance of supporting the development of scientifically literate trainees, and in 2017 established the Clinical Trials Network of Australia and New Zealand (CTANZ). Trainee-led collaboratives have a dual purpose, as they both promote a culture of trial design, and conduct governance at a formative stage of surgical training. This ultimately produce surgeons who are both efficient consumers of research and actively involved in it.

As one of the earliest Australasian trainee led surgical trials networks, STORCC was actively involved in the foundation of CTANZ. STORCC is proud to report that its members contributed to the Australian arm of the randomised controlled trial SUNRRISE in 2020, which was supported by a successful Medical Research Future Fund grant of more than $780,000.

STORCC also contributed to the international medical student led trials by the GlobalSurgCollaborative (Global Surg3 – Quality and outcomes after global cancer surgery: A prospective, international cohort study).

Key research projects for STORCC in 2020 and 2021 include being part of a series

Dr Upuli Pahalawatta, Radiology Registrar
"Participating large multicentre research projects has introduced me to protocol development and increased my understanding of clinical surgery. Being involved in the ethics process has allowed me to efficiently apply for increasingly complicated individual research projects. STORCC has provided multiple opportunities for learning and teaching. The collaborative model, increases the scope of resident initiated research projects and allows for more ambitious projects."

Tanishq Khandelwal year 3 medical student
"I was lucky enough to be involved with the COVIDSurg team at Gosford Hospital. I thoroughly enjoyed the experience of being part of an international multi centre trial of this magnitude, and it gave me a great perspective of how research is conducted at such a grand scale. I think the coordinators at Gosford were amazing at keeping us informed of what we needed to do and making us aware of all the developments in the project ever since we signed up. Definitely would be interested in getting involved with STORCC again and I will keep a look out for any other opportunities that might pop up in the future!"

of international COVIDSurg studies that reported on the optimal timing of surgery following SARS-CoV-2 infection and the importance of SARS-CoV-2 prophylactic vaccination prior to elective surgery.

STORCC also contributed to a *Lancet* publication highlighting the expected increase in global demand for cancer surgery from 9.1 million to 13.8 million procedures over the next 20 years. It warned of the need to meet a significant increase in the clinical workforce of nearly 200,000 additional surgeons and 87,000 anaesthetists globally. This study demonstrated global inequity, with cancer patients in low- and lower middle-income countries up to six times more likely to die from complications within 30 days of surgery, compared to those in high-income countries.

In 2021, STORCC is proud to participate in the CTANZ supported POSTVenTT (POST operative Variability in anaemia Treatment and Transfusion) audit, which aims to increase our understanding of variability in adherence to anaemia management guidelines and to assess the impact of anaemia management in clinical care following major surgery.

It is vital to keep the collaborative conversation going as we want to support a healthy and vibrant surgical academic community. We would love to support your participation in collaborative research – let's chat. ■

Associate Professor
Amanda Dawson FRACS

Above:
The STORCC team includes (l–r): Amrita Nair, Ashe DeBaisio, Amanda Dawson, Log Tung La and Colby Stevenson.

STORCC MEMBERS

Elizabeth Lun (current Chair)

Andrew Drane (immediate past Chair)

Colby Stevenson (founding Chair)

Amanda Dawson (Surgical Specialty Lead)

Consultants

S Laura, S Clark, S Bengeri, P Stewart, B Munro, P Hamer, A Tchen, K Kwok, E Latif, K Wong, P Chen, R Poon, Z Hou, I Gunawardena, R McGee, D Wong, B Short, LH Le, A Dawson.

JMO and registrars

A Drane, E Lun, K Tree, U Pahalawatta, J Ma, H Narroway, T Ewington, K Chew, C Zhang, A DeBiasio, I Liang, V Lee, TY Ngan, J Kane, S Khanijaun, H Luo, P Ghosal, D Steiner, E Taylor, A Chong, B Buckland, S Van Ruyven, M Kaufman, C Parkin, H Cheah, S Miles, S Somasundran, W Ziaziaris, B Julien, D Jolly, B Mortimer, A Noor, T Cordingley, M Zhang, YS Lee, D Abulafia, EJ Loh, K Tran, K Muir, C Stevenson.

Medical students

E Devan, L Buith-Snoad, R Kaul, S Thong, V Yu, C Leung, C Saab, P Lin, M Park, S Fitt, V Ly, B Zhu, S Sebastion, R Simpson, S Holmes, T Khandelwal, R Amoils, N Bahtigur, A Gojnich, B Macnab, A Fatima, A Middleton, L Vance, J Gaul, P Ireland, N Taylor, LT Lai, A A Nair, V Thirugnanasundralingam, J Wong, HJS Jun, R Hengpoonthana, XM Woon Shoo Tong, B Blackman, G Dennis, L Charman, C Chu Wen Lo, A Mozes, H Han Tan, E Wall, A Au, I Deng, J Myooran, B Lim, J Phan, A Yeoh.

Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS) Annual Scientific Meeting

17–19 September 2021, Melbourne, Victoria, Australia

The Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS) Annual Scientific Meeting (ASM) is the premier education and networking event for the Otolaryngology Head and Neck Surgery community in Australia. This year marks the 71st anniversary of the Society's Annual Scientific Meeting.

With the restrictions of COVID-19 felt locally, nationally and internationally, ASOHNS intends to hold a physical meeting in Melbourne, welcoming most delegates in person, and providing a strong virtual connection to their overseas colleagues. Their rapid pivot to a fully online meeting in March 2020 provided the expertise and wisdom to administer a high-quality virtual attendance option.

The attendance of two keynote sponsors is made possible by the support of the Royal Australasian College of Surgeons (RACS): Dr Sujana Chandrasekhar, an otologist/neurotologist from the United States, and Dr Kate Heathcote, a consultant laryngologist from the United Kingdom (UK). Both speakers will present on a range of topics including updates in neurotology, changes to guidelines and pathways to leadership in otolaryngology as well as updates in laryngology.

Dr Chandrasekhar practises in New York City and Wayne, New Jersey, and has a passion for ear and balance patient care as well as teaching, humanitarian work, and developing leadership skills and the empowerment of others.

Elected by their 12,000 members in August 2014, Dr Chandrasekhar is the president-elect of the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) and the third woman and the first person of Indian descent to hold that office. She previously served as chair of the AAO-HNS Board of Governors and is secretary-treasurer of the American Otological Society.

Dr Kate Heathcote

Dr Chandrasekhar attended medical school at Mount Sinai School of Medicine in New York City, graduated at the age of 22, and completed her residency in Otolaryngology-Head and Neck Surgery at New York University Medical Center in New York. She then completed her Fellowship in Otology and Neurotology at the House Ear Clinic and Institute in Los Angeles, California.

Dr Chandrasekhar served on the full-time academic faculty of both the University of Medicine and Dentistry of New Jersey Medical School and Mount Sinai School of Medicine, before entering private practice in New York City in October 2004. She is currently Director of Neurotology at the James J. Peters Veterans Administration Medical Center, Otologist/Neurotologist at the New York Head and Neck Institute, Clinical Professor at Hofstra-Northwell SOM, Clinical Associate Professor at Icahn SOM, and holds staff privileges at several New York and New Jersey hospitals.

The second speaker, sponsored by RACS, is Dr Kate Heathcote, a consultant laryngologist at the Robert White Centre for Voice, Airway and Swallowing in Poole Hospital National Health Service (NHS) Foundation Trust in the UK.

Dr Sujana Chandrasekhar

Having completed her ear, nose and throat (ENT) training, she undertook a six-month Fellowship with Professor Jean Paul Marie in Rouen, France where she trained in pioneering techniques of laryngeal reinnervation. She went on to complete a further Fellowship at the Royal National Throat Nose and Ear Hospital in London before taking up her consultant post in Poole.

Dr Heathcote established the Centre for Airway Voice and Swallowing in 2013 and has worked to develop it as a cutting-edge centre offering advanced techniques to NHS patients. As well as multidisciplinary voice clinics, the centre runs treatment clinics using transnasal techniques and diagnostic clinics in conjunction with gastroenterology.

Since returning from France, she has worked at introducing techniques of reinnervation to the UK and disseminating the techniques globally via courses and conferences. Working with colleagues at Southampton Children's Hospital, Dr Heathcote has established a national centre for paediatric laryngeal reinnervation. Dr Heathcote is on the council of the British Laryngological Association and the scientific committee of the European Laryngological Society. ■

Status quo remains in Tasmania

The Gutwin Government has been re-elected in Tasmania and will govern in majority after winning 13 of the state's 25 House of Assembly seats.

The remaining 12 seats will be held by the Labor Party (nine seats), the Greens (two seats) and newly elected Independent MP Kristie Johnson.

Before the 1 May poll, the Royal Australasian College of Surgeons (RACS) Tasmanian Committee sent an election statement to the major parties. The statement identified six key focus areas relevant to surgery. These issues were:

- Compliance management and research at the Tasmanian Health Service
- Elective surgery waiting lists
- Rural health
- Tasmanian 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. To view RACS' Tasmanian election statement, as well as responses from the Liberal and Labor parties, please visit the RACS website.

Following the election, it was announced that the state's new Health Minister will be the Deputy Premier, the Honourable Jeremy Rockliff. RACS congratulates Minister Rockliff on this appointment. The Labor Party Shadow Minister for Health is Bastian Seidel.

Over the next four years, the committee will continue to meet and work with the government and the opposition to progress issues of public health, particularly those raised in the election statement.

The Tasmanian election was the third state election to be held this year, with governments also being easily re-elected in Queensland and in Western Australia. There are no more state or territory elections scheduled for 2021. However, it is anticipated that an Australian Federal election will be held either late this year or early next year.

Once a federal election is called, RACS will once again send a national election statement to all major parties contesting the election. If you would like to find out more, or to suggest key topics that you would like the College to raise prior to the election, please contact the RACS Policy and Advocacy team at racs.advocacy@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	Brisbane, Queensland
	Wednesday 18 August	Melbourne, Victoria
Conflict and You	Thursday 5 August	Brisbane, Queensland
Foundation Skills for Surgical Educators	Thursday 15 July	Melbourne, Victoria
	Saturday 31 July	Perth, Western Australia
Non-Technical Skills for Surgeons (NOTSS)	Friday 30 July	Auckland, Aotearoa New Zealand
Operating with Respect	Thursday 1 July	Adelaide, South Australia
	Thursday 8 July	Christchurch, Aotearoa New Zealand
	Friday 16 July	Canberra, Australian Capital Territory
	Thursday 12 August	Melbourne, Victoria
	Friday 20 August	Sydney, New South Wales
Process Communication Model: Seminar 1	Friday 25 June	Auckland, Aotearoa New Zealand
Process Communication Model: Seminar 2	Friday 6 August-Sunday 8 August	Brisbane, Queensland
Promoting Advanced Surgical Education	Friday 30-Saturday 31 July	Sydney, New South Wales
Surgeons as Leaders	Friday 6 August-Saturday 7 August	Sydney, New South Wales
	Wednesday 25 August-Thursday 26 August	Broome, Western Australia
Writing Medico Legal Reports	Wednesday 21 July	Sydney, New South Wales
	Tuesday 24 August	Melbourne, Victoria

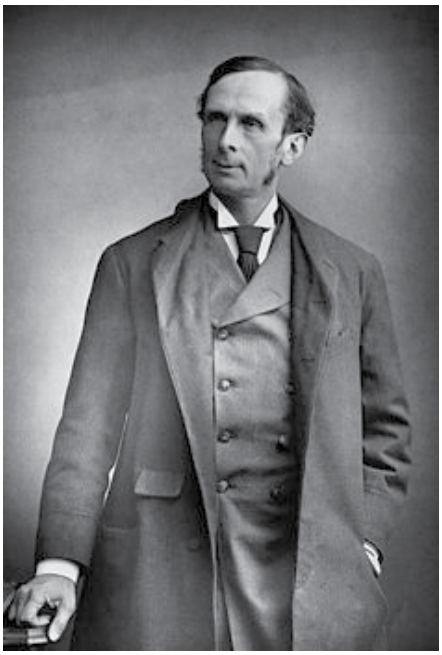
Online courses

Course	Date
Leading Out of Drama	Tuesday 15-Thursday 24 June
Educator Studio Session featuring Dr Bryan Ashman on 'Old dogs, new tricks: what motivates experienced surgeons to learn new surgical techniques'	Wednesday 23 June
Conflict and You	Thursday 29 July
Educator Studio Session featuring Dr Bryan Ashman on 'Narcissism or empathy: should personality traits be assessed prior to selection for surgical training?'	Wednesday 4 August

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

Sir Morell MacKenzie: Disease of the throat (7 July 1837-3 February 1892)

Kt. MRCS LSA (MRCP)



Sir Morell MacKenzie

Sir Morell MacKenzie was *Vanity Fair*'s 'Man of the Day', No. 387: his caricature, entitled *Disease of the Throat*, the work of Carlo Pellegrini, 'Ape', appeared on 15 October 1887.

Vanity Fair noted that he, 'took to looking down people's throats for guineas. His success in private practice was great and immediate, and in a few years after setting up, he could give to physicians who had been established a lifetime, a score of patients and a beating. He became a specialist. Sir Morell has long been the physician and friend of all singers and actors.'

Morell descended from the Highlands Scottish family of MacKenzie in Ross-shire: his father was Dr Stephen McKenzie, a general practitioner in Leytonstone, Essex, then a country village on the edge of London.

Born on 7 July 1837, the eldest of eight children, Morell proved to be a delicate child. He was earnest and reflective, and his early education was interrupted by illness. At 14, Morrell was called out of school and taken home to find his father dead: his father had been thrown from his gig while visiting patients, never regaining consciousness.

At 16, Morrell MacKenzie became a clerk in the City of London, still dreaming of entering the medical profession and attending evening classes in natural history and chemistry at King's College. His maternal aunt lent him money for his fees, and he enrolled as a medical student at the London Hospital where subsequently he was described as one of its most distinguished pupils, winning the Senior Gold Medals for Surgery and Clinical Medicine.

In 1858, MacKenzie took the then usual examinations for 'College and Hall' diplomas, Membership of the Royal College of Surgeons (MRCS) and Licentiate of the Society of Apothecaries (LSA). On qualifying, he was appointed House Surgeon at the London Hospital.

Again, assisted by his aunt, he spent a year in Paris followed by a year in Vienna and Budapest. In 1859, fate intervened when he encountered Professor Johann Czermak, and the laryngoscope, invented by Manuel Garcia in 1855.

The Laryngoscope.
Woodcut from Morell Mackenzie's "The Use of the Laryngoscope," 1865.

From that time MacKenzie specialised, proposing a hospital for Diseases of the Throat. Sir James Paget declared that he might as well found a Hospital for Diseases of the Great Toe. The laryngoscope was ridiculed as a toy, declared to be useless, and The Lancet observed, 'without its use, throat diseases were perfectly well treated by every general hospital in London'.

Singing and public speaking interested MacKenzie, who said, "without an artistic enunciation sound loses one of its greatest charms". He published his lectures to doctors in the form of pamphlets, such as the 1863, *On the Treatment of Hoarseness and Loss of Voice*.

The correct practice then, as now, was for a consultant to see only such patients as were referred to him by another doctor and not to retain them as his own patients. MacKenzie, however, had no qualms in accepting and treating the numerous patients who came to him directly, in addition to accepting medical referrals, which explains some of the British medical profession's antipathy towards him.

In 1862, he founded the free dispensary for 'Diseases of the Throat and Loss of Voice', which in 1865 moved to larger premises in Golden Square, previously the London Homeopathic Hospital. MacKenzie renamed it 'The Hospital for Diseases of the Throat'. In 10 years, it treated almost 38,000 outpatients and 949 inpatients. It also achieved a reputation for postgraduate teaching unsurpassed in Europe, involving more than 2300 medical graduates.

In 1863, he married Miss Margaret Bouch, who was to become the mother of two sons and three daughters. In 1864, he passed the examination for Membership of the Royal College of Physicians (MRCP).

Morell MacKenzie's first book, *The Use of the Laryngoscope in Diseases of the Throat*,

was published in 1865. This was later followed by the two volumes of *Diseases of the Throat and Nose*. The first volume was published in 1880 and the second in 1884.

In 1870, aged 33, MacKenzie moved to 19 Harley Street, where on the ground floor there were consulting rooms, a laboratory and dispensary, and a huge waiting room. On the first floor, drawing rooms stretched right across the house; MacKenzie said to his wife, "My dear, now you have a new duty in life, fill these rooms!" The couple soon became known for dinner parties attended by the most famous actors and opera singers of the day, although MacKenzie was seldom present.

MacKenzie's medical practice in the 70s and 80s was said to be the largest in the world. By the 1880s, he was earning upwards of £15,000 a year. His usual fee was two guineas, operations were infrequent and on a minor scale.

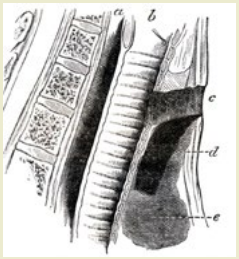
MacKenzie dictated all his correspondence to his amanuensis, and although he purchased one of the first typewriters to cross the Atlantic, this was soon abandoned, due to patients' complaints regarding the 'impersonal appearance' of typescript.

At the 1884 International Congress of Medicine in Copenhagen, MacKenzie was elected President of the Inaugural Section of Laryngology.

On 18 May 1887, MacKenzie received a message requesting that he proceed to Berlin urgently, to see His Imperial Highness Frederick, the Crown Prince of Germany, reason unspecified. On his arrival, the German medical staff, none of whom were laryngologists, submitted that the Prince had throat cancer and required an immediate laryngectomy.

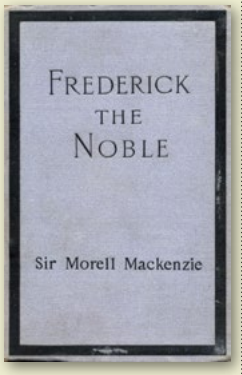
MacKenzie's laryngoscope next confirmed a tumour involving the left vocal cord. However, in an early example of evidence-based medicine, he insisted on confirmatory histopathology. On three occasions MacKenzie resected as much of the tumour as he could, however, each time the eminent pathologist, Professor Rudolf Virchow, opined that the tissue obtained contained no neoplastic element.

A month later, Frederick attended the London celebrations for the Golden Jubilee of his mother-in-law, Queen Victoria: MacKenzie was knighted in September of that year by the Queen for his services to medicine and Frederick.



However, the tumour continued to grow, and either a tuberculous or syphilitic aetiology was also queried, the latter favoured.

In February 1888, Frederick almost died of asphyxia and an urgent tracheostomy was undertaken by an inexperienced German surgeon. Subsequently there were many problems with management of the cannula, culminating with the digital formation of a false passage resulting in a pre-tracheal abscess.



The unfortunate Frederick died on 15 June 1888, with MacKenzie observing, 'thus passed away the noblest specimen of humanity it has ever been my privilege to know'. The autopsy confirmed cancer.

Over this period there had been great antagonism between MacKenzie and his German 'colleagues': MacKenzie recorded his account of the case in 1880 with *The Fatal Illness of Frederick the Noble*, which not only created a sensation but was condemned by MacKenzie's many British critics and earned him the censure of the Royal College of Physicians.

Between 1888 and 1892, MacKenzie fell easy prey to various illnesses, including influenza and his old enemy, asthma. He passed his nights dozing in a sitting posture and his sleep was always broken: his former exuberant energy disappeared.

He died suddenly at just 54 years of age on 3 February 1892, and was buried near the country home he loved, in the churchyard of St Mary's Church, Wargrave, close to the river Thames. ■

Mr Peter F Burke
FRCS FRACS DHMSA

This page:
(L-r) The Crown Prince Frederick; Frederick the Noble *Fig. 21, c) tracheostomy d) false passage e) pre-sternal abscess;* Frederick the Noble*, bookcase; Ape caricature* Disease of the Throat*, 15 October 1887.*

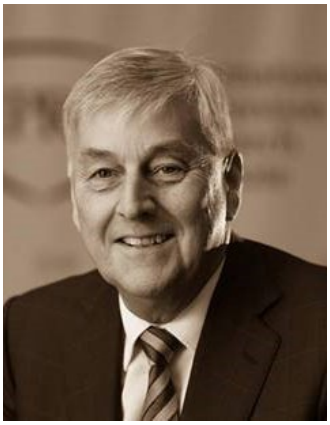
The value of surgical mentors – academics

OPUS LXIX

Part II

"We make a living by what we get, but we make a life by what we give." –Winston Churchill

Bill Manchester



Bob Thomas

Gordon Clunie

Bob Marshall

In those post-Madrid days in 1972 after Professor Bill Manchester of Auckland University had acknowledged my Angiotome concept, my wife Mariette and I entertained Bill and his wife over Dover Sole and Chablis at a restaurant in Piccadilly, London. There I gleaned information about his surgical style and his perfectionist traits. Bill was really the Benny Rank of New Zealand and a recently published biography by Earle Brown and Michael Klaassen is titled *Perfection*. The basic mantra of the Buddhist philosophy is a repeated chant seeking perfection – Bill's mantra.

Our mentors selected us as protégés, really as a mirror of their own personalities, to become plastic surgeons. If they liked us, they invited us into the fold, as we do likewise for the next generation of surgeons. The axiom that knowledge, when based on experience, creates wisdom is implied. However, with the newer generation's selection process involving submitting numerous papers and presentations to increase their point score, their clinical perspectives are harder to assess. And who gives a bad reference to anyone?

My London experience over a three-year period stands out remarkably from a mentoring viewpoint. Leaving the London scene on Benny's suggestion created a mental quandary at a crossroad in my career. Benny was right when he suggested I was being used there, which led to my return to Melbourne and to marriage. The Antipodes has been very kind to me ever since. And now I can look back askance at Samuel Johnson's words of 1777: 'when a man is tired of London, he is tired of life'.

One of the first surgical minds was Professor Gerald 'Charlie' Westbury from the Westminster Surgical Head and Neck Unit. A protégé of Sir Stanford Cade, who escaped the Bolsheviks in 1917 without a word of English and became Vice President of the Royal College of Surgeons (RCS). Charlie reflected a survivalist style of Sir Stanford's that no problem was too big and no incident too insignificant to ignore, as noted before.

Ian Wilson is the next branch of the mentoring tree, a product of the Scottish surgical fraternity from Edinburgh University, having worked under five surgical knights there. He moved onto the London scene as the Head and Neck Surgeon between Westminster, the Royal Marsden and St George's hospitals. In his house in Chelsea, where I used sometimes to be his security tenant while he was on overseas lecture tours, his home was the focus of lavish entertainment with many international personalities. Even John Hueston was a guest there before I arrived. Ian regarded me as a type of inexperienced sommelier to select the French wines for his black-tie dinner exploits entertaining hospital CEOs to international surgeons – a trend I continued on my return to Melbourne but with my wife's French cuisine.

In an earlier article of *Surgical News,* titled Canons of Plastic Surgery, I reflected on my plastic surgical mentors. Now I will focus on the influence of my academic associates in my career.

Professor Emeritus Gordon Clunie had a background in the academic world in the Department of Transplant Surgery at the University of Queensland, having emigrated from Edinburgh in 1968. Sam Mellick recalled to me how this Scottish family left Edinburgh at -4C to arrive in Brisbane to 34C. Gordon achieved his Edinburgh Fellowship in 1963 and his academic style in teaching and research reflecting the Scottish surgical tradition – they call Edinburgh 'the Athens of the North'. Gordon became Director of Surgery at the Royal Melbourne Hospital (RMH) after Professor Maurice Ewing, who arrived from London's Hammersmith Hospital. Prince Henry

Hospital in 1937 was to become the Hammersmith in the Antipodes, according to the late Don Marshall's recollections. But the war said no.

During those early years in reconstructive surgery, I would see Gordon regularly to discuss ideas for the *Australia and New Zealand Journal of Surgery* (*ANZ Journal*), of which he was editor at the time. He would assiduously read every article that came across his desk. As a primary mentoring source, his advice was always crisp and synoptic: "Felix, if you have got something new to say get off your derriere and get it into print." His other major observation to me was in relation to integrity in publishing: "If you publish locally, you will own it." This must have reflected his experience overseas as an editor, referring indirectly to plagiarism or scientific poaching (a future publication).

Professor Bob Thomas was another academic associate and was Professor of Surgery at the Western Hospital before becoming Director of Surgical Oncology at the Peter MacCallum Cancer Institute (my alma maters). Fortuitously, he was also another Editor of the *ANZ Journal*. He advised me, when discussing my initial keystone publication in 2003 saying, "This new concept will have far-reaching implications and you should be the single author." Thank you Bob for your editorial input (at present the National Library of Medicine, Maryland, United States of America lists 187 keystone publications).

Professor Dick Bennett came from the Department of Surgery at St Vincent's to the Peter MacCallum Cancer Institute and was also another *ANZ Journal* Editor.

My own career at Peter MacCallum began 40 years ago in the field of head and neck surgery under Brian Fleming, while my Plastic Surgery career focussed on melanoma. It was intriguing to hear Brian's comments over morning tea (which I made), quoting from RMH Board meetings about Gordon Clunie, who was held in awe because 'what Gordon wanted Gordon got'. Gordon even allocated research funds to Brian to publish his series of parotidectomies.

At Peter MacCallum I was instrumental in establishing the first multidisciplinary combined consultative melanoma clinic with radiotherapist Jill Ainsley and chemotherapist Michael Millwood. When the clinical significance of this arrangement emerged, Dick Bennett, as the Director of Surgical Oncology, wanted it under his domain and not a subspeciality in keeping with world trends. I agreed wholeheartedly, relinquishing any Head of Unit terminology. Subsequently David Speakman, Michael Henderson and the chemotherapist Grant McArthur have created an International Centre for Melanoma Treatment, at Peter Mac.

My earlier clinical experience in melanoma began as a student in Brisbane under Neville Davis and Professor Les Hughes. Their rule of thumb was simple: 'level I melanoma, one centimetre clearance; level II, two centimetres; level III, three centimetres'. Umpteen papers keep surfacing regarding such excisional dimensions, including fascia, but Neville Davis introduced me to the importance of excising fascia as a trilaminate factor in management. Additionally, closing a large defect aesthetically with the keystone flap fulfils the requirements of oncological management and artistic closure.

I now conclude with some recollections on Professor Bob Marshall, who taught me politics and wisdom. David Scott recently reminded us that each of the Marshall clan - Bob, Vernon and Don – were Heads of Department individually at the former Prince Henry's Hospital. Just as Hammersmith was severely damaged in a World War II air raid, similarly Prince Henry's would also succumb, but to the wreckers ball in 1994. Grey Turner, the President of the RCS, gave the College his oak table, as he had no children to pass it down to.

Bob's textbook, *Living Anatomy*, is merely a conversational piece, painting a picture of living anatomy not unlike Last's publication. Gray's tome now has become volumetrically a doorstop. Bob puts applications into *Living Anatomy* and his subtitle, 'structure as the mirror of function', harkens back to Wolff's Law of 1892.

Geoff Kenny, the anatomist from Brisbane and subsequently Melbourne, introduced me to this concept of structure and function, where historic principles keep resurfacing.

Bob personally delivered his book to my rooms one Friday afternoon and noted that the way I thought anatomically gave some clinical perspective to his text. My Angiotome concept, where if there is a nerve supply there must be a blood supply. This has an embryonic basis, which he acknowledged. I think I recall him saying, "Felix, we are on the right tram." My initial meeting with Bob was at the College course for the Primary in 1967, where he was stylishly groomed in a beige linen suit, straight out of Hardy Amies in Saville Row. Yes, he took his coat off in the 35C heat and gave off the cuff the best description of the muscles of the back I can recall.

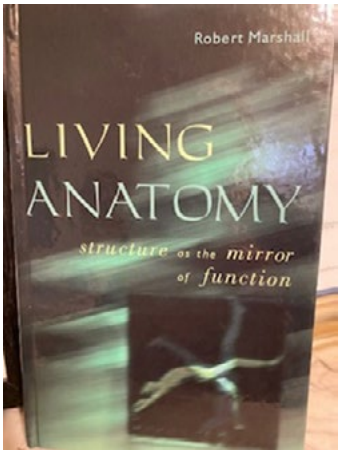
Finally, as a gourmet king I always remember his concertinaed style of organising mussel shells. (Guess who now does this now every time he eats mussels?) This technique reflects his organisational mind and is a mirror of his surgical skills.

Finally, on planning retirement, his decision was simple: "Felix, it doesn't take a clever mind to pay $15,000 indemnity insurance while your income is $12,000." Amen Bob, I loved your mind.

Let's not forget what Mozart did in composing his string quartets after leaving Haydn at the Estherházy estate: he dedicated his compositions accordingly – I do likewise to my surgical mentors. ■

Associate Professor Felix Behan

A correction, with thanks to Irwin Faris: Maurice Ewing came from the Hammersmith and Felix Eastcott came from St Mary's, having graduated at the Middlesex University. Again, this correction elucidated the fact that DeBakey did the first endarterectomy – unpublished.



Living Anatomy *by Professor Robert Marshall*

PREPARATION FOR PRACTICE MELBOURNE WORKSHOP

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.

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- 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

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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

QASM Annual Seminar 2021 Surgery – Timing is Everything

The Queensland Audit of Surgical Mortality (QASM) 2021 annual seminar will be held on Thursday 18th November 2021 at the Sunshine Coast Health Institute (SCHI), located at the Sunshine Coast University Hospital (SCUH), 6 Doherty Street, Birtinya, Queensland 4575.

A live webinar is also available for those unable to attend in person. For those attending at the venue, there will be limited tickets to two live sessions in the SCHI's Simulation Rooms (12.30pm during the lunch break and 3.30pm after the seminar closes). The Live Simulation Sessions will be streamed into the auditorium and via the webinar.

Confirmed speakers include

- Dr Manimaran Sinnathamby (Northern Territory, General Surgeon)
- Graham Reeks and Melissa Fox (consumer representatives)
- Dr Jill O'Donnell (Queensland, Vascular Surgeon)
- Mr Neil Wetzig (Queensland, General Surgeon)
- Prof Marianne Vonau (Queensland, Neurosurgeon)
- Mr David Stoney (Queensland, General Surgeon)
- Mr Sanjeev Naidu (Queensland General Surgeon, Queensland State Committee)

Parking will be available on the SCUH campus with approximately 3,500 car parking spaces (P1 and P2) designed with sufficient capacity to accommodate the parking requirements of all staff, students and visitors. The daily fee is $15.60 (accurate at the time of publishing). ■

Visit the QASM seminar Eventbrite link to register your interest in attending: https://www.eventbrite.com.au/e/qasm-seminar-surgery-timing-is-everything-tickets-154504592395

If you have any questions about this event, please contact the QASM team at QASM@surgeons.org

Case note review

Tragic outcome from prosthetic joint infection

A patient in her early 70s had an elective right total knee replacement (TKR) for severe osteoarthritis at an outer city hospital (hospital A). There were comorbidities of obesity (BMI 40) and hypertension. On postoperative day five she was transferred to hospital B for rehabilitation. She remained afebrile but some ongoing wound ooze, thought to be cellulitis, was noted and treated with dressings followed by cephalosporins.

Eleven days later she was transferred back to hospital A due to persistent bleeding and possible septic arthritis. She underwent washout and poly exchange, although the wound was unable to be closed, with ongoing intravenous infusion of cephazolin. Wound cultures resulted in no bacterial growth.

Two days later there was a repeat washout and vacuum-assisted wound closure (VAC) dressing change. Further wound cultures still resulted in no bacterial growth. Another washout and VAC dressing change occurred two days later, with no wound cultures undertaken. Five days later there was a further washout and VAC dressing change. This time, *Corynebacterium tuberculostearicum*, *Staphylococcus haemolyticus* and *Staphylococcus epidermidis* were grown, resulting in intravenous vancomycin being added to intravenous cephazolin.

The patient was transferred to hospital C for further assistance from their Orthopaedic unit and for an opinion from Plastic Surgery about possible wound coverage. This transfer was delayed for three days due to a bed shortage. After another three days, the patient was transferred back to hospital A, as the hospital C Orthopaedic team were not happy to treat an infected TKR. No procedure was undertaken at hospital C.

Staphylococcus epidermidis was grown after a further repeat washout and poly exchange at hospital A. Two days later, *Clostridium difficile* was grown from faecal samples and three days after that Candida species were grown from urine samples. The patient was treated with vancomycin and metronidazole.

The following day the patient was transferred to hospital D through the registrar, with no consultant communication taking place. On arrival at hospital D, the patient was noted to be malnourished with low albumin. The next day, she underwent removal of all implants, extensive debridement and insertion of a static antibiotic cement spacer due to extensive infection and a large soft tissue defect down to necrotic bone. She had three further washouts, debridements and VAC dressing changes every three or four days. There was growth of ESBL enterobacter (extended-spectrum ß-lactamase producing *Enterobacteriaceae*) and *Pseudomonas*.

Despite optimal antibiotics (as per infectious diseases advice and debridement cultures) the patient continued to deteriorate. General medicine and dietitian reviews were ongoing. Difficulties with oral intake and malnutrition resulted in nasoenteric tube feeding and later a post-pyloric tube was placed via endoscope. The patient required intensive care unit admission.

There was consensus between orthopaedic and plastic consultant surgeons to proceed to above knee amputation at a little over two months following the original TKR. There were a further five washouts and revision amputations, with a delayed primary closure at three weeks following the patient's initial amputation. Two weeks later, she suffered a pulmonary embolus and commenced therapeutic heparin. Two days after that, she had severe abdominal pain. The patient was reviewed and was thought to have a duodenal or colonic perforation but was not considered an operative candidate. Palliative care was started, and she died four days later.

Comment

This case demonstrates the difficulties in diagnosis and management of a prosthetic joint infection, and the problems with accessing detailed information from case notes that are a

mixture of paper and electronic records from four different hospitals. The records from hospitals A, B and C contained few consultant notations. In a case like this, where a serious and prolonged complication of sepsis has occurred following an elective procedure, there would have been numerous consultant-to-consultant conversations about the patient. It would help if more attention was paid to notation of such discussions.

There was a delay in the diagnosis of a prosthetic joint infection. Poor communication by the Orthopaedic team at hospital A led to the unnecessary transfer to hospital C and therefore further delay in treatment. At hospital D, there appeared to be better documentation and more consultant input, although ongoing sepsis remained despite multidisciplinary efforts to manage this.

It is unclear whether the patient's abdominal pain (said to be due to bowel perforation) was related to insertion of a post-pyloric tube under endoscopy. There was no record of any difficulty or otherwise with insertion. There was no record of an autopsy.

ANZASM Clinical Directors' comment

In situations where infection of a joint prosthesis is suspected, antibiotic therapy without concomitant early aggressive surgical treatment greatly impairs the likelihood of successful treatment. Protocols should be in place that facilitate communication between transferring institutions for effective management of suspected joint infections to ensure early transfer of patients back to their treating surgical doctor (or Centre of Expertise) for provision of appropriate surgical care. Consultant-to-consultant communication is imperative throughout. ■

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

Scholarships and Grants Program

Learning and Development grant opportunities open in August 2021 for 2022 activity.

Outcomes advised in November 2021.

Are you interested in pursuing professional development, training or a short-term research activity with the support of a RACS Learning and Development grant?

The Scholarships and Grants Program 2022 Learning and Development round will open for application in August 2021.

RACS, through the Foundation for Surgery, is one of the largest funders of surgical research and education worldwide. The Scholarships and Grants Program supports surgeons and other health professionals to learn, facilitate change and improve the quality of surgical care and practice in Australia, Aotearoa New Zealand and the Asia-Pacific region.

Learning and Development activity is usually undertaken over weeks or some months within the grant calendar year, with funds paid directly to the recipient at the beginning of the year.

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

- removing barriers to the participation of women in surgery
- continuing and enhancing initiatives designed to increase the participation of Aboriginal and Torres Strait Islander and Māori doctors in the practice of surgery.

Please visit surgeons.org/scholarships to read the Scholarships and Grants Program conditions and further information on each of the opportunities listed.

For further information, please contact the Scholarships and Grants Team:

Ph: +61 03 9249 1216

Email: scholarships@surgeons.org

www.surgeons.org/scholarships

For Fellows

Morgan Travel Fellowship

$11,000

Supports travel to gain clinical experience or conduct research.

Who can apply? Early-career – RACS Younger Fellows

Bongiorno National Network Younger Fellows Travel Grant

$10,000

Supports post-Fellowship studies and furthering surgical experience overseas.

Who can apply? Early-career – RACS Younger Fellows

Rural Surgery Fellowship for Provincial Surgeons

$10,000 each (up to three Fellowships given)

Supports regional and rural surgeons to travel and develop existing skills or acquire new skills.

Who can apply? RACS Fellows – non-metropolitan

Medtronic Younger Fellows Travel Grant

$7500 each (up to two grants given)

Supports post-Fellowship studies and furthering surgical experience overseas.

Who can apply? Early-career – RACS Younger Fellows

Queensland Younger Fellows Grant

$2500

Supports travel to obtain post Fellowship training, and/or supports return to practice in Queensland.

Who can apply? Early-career – RACS Younger Fellows (Queenslanders only)

For SET Trainees

Indigenous Program – SET Trainee One Year Scholarship

$20,000 each (up to three scholarships given)

May fund SET registration fees, SET course fees, SET examination fees, research projects, mentoring programs, travel to attend conferences and/or relevant professional development activities.

Who can apply? Aboriginal, Torres Strait Islander and Māori SET Trainees

Poate Family Plastic & Reconstructive Surgery Travel Grant

$1500

Supports travel to obtain further training and experience in plastic and reconstructive surgery

Who can apply? Plastic and Reconstructive SET Trainees

COVID-19 impact on scholarships and grants

Given the continued challenges of COVID-19 and its impact on travel, Learning and Development grants for 2022 that allow for 'overseas' activity will include travel from Australia to Aotearoa New Zealand and vice versa, with preference given to activities that can be undertaken in either country.

Applicants who wish to travel internationally will need to substantiate why the activity cannot be undertaken in Australia or Aotearoa New Zealand and that their reason to travel has been confirmed (for example a conference is proceeding).

Applications to Global Health scholarships and grants have been paused for 2022 activity.

If you are a recipient of a 2020 scholarship or grant who elected to defer completion of your activity to December 2021, and you are unsure that you can now complete your activity by December this year, please contact scholarships@surgeons.org. We are keen to work with you and discuss the options available for your specific circumstance.

For Fellows and SET Trainees

Pickard Robotic Training Grant

$100,000 – divided amongst recipients

Supports training and/or research opportunities to expand expertise in innovative robotic techniques.

Who can apply? RACS Fellows, SET Trainees, non-RACS surgeons and health professionals (South Australians only)

Stuart Morson Neurosurgery Grant

$30,000

Funds travel to support early-career neurosurgeons who wish to advance their experience and skills in neurosurgery by undertaking further training or research.

Who can apply? RACS Younger Fellows, SET Trainees and non-RACS neurosurgeons

Hugh Johnston Travel Grant

$10,000

Supports travel for RACS Fellows and Trainees to take time away from clinical positions to gain specialist knowledge and expertise.

Who can apply? RACS Fellows and SET Trainees

Murray & Unity Pheils Colorectal Travel Grant

$10,000

Supports travel to obtain further training and experience in the field of colorectal surgery.

Who can apply? RACS Fellows and SET Trainees

Aziz Hamza Rural Surgery Grant

$1500

Assists in delivering quality surgical care to people in remote and regional Australia and Aotearoa New Zealand.

Who can apply? Early-career – RACS Younger Fellows and SET Trainees

For non-RACS members

Pickard Robotic Training Grant

$100,000 – divided amongst recipients

Supports training and/or research opportunities to expand expertise in innovative robotic techniques.

Who can apply? Non-RACS surgeons and health professionals, RACS Fellows and SET Trainees (South Australians only)

Anwar and Myrtha Girgis SIMG Grant

$10,000

Supports migrant, refugee and asylum seeker doctors experiencing financial hardship to gain the professional development required to practice surgery in Australia or Aotearoa New Zealand.

Who can apply? Doctors who are recent migrants or of refugee or asylum seeker background

Skills Training Faculty Grant

$10,000

Provides a professional development opportunity to senior Skills Training Faculty in recognition of their significant pro-bono work.

Who can apply? Senior instructors or directors (including RACS members) in a RACS skills training program

Indigenous Program – Career Enhancement Grant (junior doctors)

$5000 each (up to six grants given)

Supports junior doctors to acquire knowledge and skills that will strengthen their surgical career pathway.

Who can apply? Aboriginal, Torres Strait Islander and Māori junior doctors

Indigenous Program – ASC Award

Up to $5000 each (up to six awards given)

Supports final year medical students and doctors interested in surgery to attend RACS 2022 Annual Scientific Congress.

Who can apply? Aboriginal, Torres Strait Islander and Māori doctors and final year medical students

Indigenous Program – ASC Peer Support Award

Up to $5000 each (up to two awards given)

Supports final year medical students and doctors interested in surgery, to attend RACS 2022 Annual Scientific Congress.

Who can apply? Aboriginal, Torres Strait Islander and Māori doctors and final year medical students who have previously attended an Annual Scientific Congress

Indigenous Program – Davison Family Grant

$2500

Supports doctors who have the potential to inspire and attract young people to the field of surgery and who, without financial assistance, may be unable to contemplate a career in surgery.

Who can apply? Aboriginal and Torres Strait Islander doctors wishing to undertake postgraduate surgical training

Indigenous Program – Career Enhancement Grant (medical students)

$2000 each (up to six grants given)

Supports final year medical students who are interested in pursuing a surgical career.

Who can apply? Aboriginal, Torres Strait Islander and Māori final year medical students

Rural Junior Doctors Surgical Skills Course Grant

$1500

Supports rural or regional junior doctors to undertake a surgical skills course in a rural or regional location.

Who can apply? Rural or regional junior doctors – registered with JDOCs and members of the Rural Surgery Section. ■

Advertised opportunities are an initial guide only. Please consult the RACS Scholarships and Grants Program webpages surgeons.org/scholarships for detailed information. The values of these opportunities are in Australian dollars and are for a tenure of one year unless otherwise stated. Early-career surgeons are Trainees or Younger Fellows (within ten years of obtaining Fellowship). FRACS applicants may apply where eligible for all opportunities listed for Fellows, providing they can provide evidence of completing all Fellowship requirements by 1 November 2021. SET applicants may apply where eligible, providing they can provide evidence of acceptance into the SET Program by 10 December 2021. In addition, Specialist International Medical Graduates (SIMGs) who meet the eligibility requirements outlined at surgeons.org/scholarships may apply to opportunities open to SET Trainees.

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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.

Mr Adrian Vorbach (SA)

Dr Belinda Mary Scott (ANZ)

Mr Timothy McGahan (QLD)

Emeritus Professor James May (NSW)

Mr Colin George Davis (NSW)

Mr Fredy Jacob Daniel (VIC)

Mr Peter Crowe (NSW)

Informing RACS

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Fredy Jacob Daniel MBBS MS FRACS

Cardiothoracic Surgeon

25 May 1939–22 February 2021

Fredy was the surprise second twin born at home in a small town in southern India in 1939. In spite of his medically challenging start to life, Fredy thrived at school, completing his education in a boarding school some 80 kilometres from his hometown. This was the same school his older brother, Willy John Daniel, had attended. After secondary school the two brothers' academic paths diverged with John coming to Melbourne to study medicine and later completing his surgical training, while Fredy went to medical school at Manipal Medical College in Udupi, Southern India, and then on to the Kanpur Medical College to undertake a Masters in Surgery. Having completed his basic surgical training, Fredy worked at the Calicut Medical College Hospital in northern Kerala, India. It was there that Fredy, a surgical registrar, met Dr Valsa Thomas, an intern doing her surgical rotation. They decided to marry in 1969.

From there, Fredy applied for and was successful in achieving a position in thoracic surgery at the Royal Melbourne Hospital in the early 70s. This was the beginning of a new life in Australia for him, his wife Valsa and 10-month-old son, Dennis.

In his early years in Australia, Fredy completed cardiac surgical training at St Vincent's Hospital in Melbourne, under Mr George Westlake and Mr John Clareborough, cardiothoracic surgical training at Royal Melbourne Hospital, working closely Mr Ian McConchie, and spent two years training in paediatric cardiac surgery at the Royal Children's Hospital.

This tribute was written by colleagues: Hamish Ewing, Siven Seevanayagam, Simon Knight and Fredy's wife Valsa and daughter Deepa.

James May AC MD MS FRACS FACS

Vascular Surgeon

1934–2021

Professor May was an outstanding academic surgeon, teacher, and trainer of generations of surgeons in this country.

Professor May provided a remarkable service to both the University of Sydney and Royal Prince Alfred Hospital (RPAH) over many years. As well as being the Bosch Professor of Surgery, Professor May was Head of the Division of Surgery at the RPAH from 1979 to 1995, and Head of the Department of General Surgery at that hospital from 1979 to 1988. Professor May was seen by his surgical colleagues as the 'father of vascular surgery' in Australia, and he held an outstanding international profile in this discipline.

Professor May was responsible for the introduction of endovascular surgery in Australia and has served on many national and international endovascular societies. This included Member of the Board of Directors of both the International Society for Endovascular Surgery, and the International Society of Endovascular Specialists. Indeed, he was elected President of the latter Society from 2005 to 2007. Professor May also served as the President of the Australian and New Zealand chapter of the International Society for cardiovascular surgery, and from 2001-2004 he was President of the International Society for cardiovascular surgery.

Professor May's academic contribution to endovascular surgery was outstanding. He served on the editorial boards of most of the major national and international journals of surgery.

This obituary was provided by Dr Raffi Qasabian FRACS.

Royal Australasian College of Surgeons
Foundation for Surgery

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