SurgicalNews

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Royal Australasian College of Surgeons

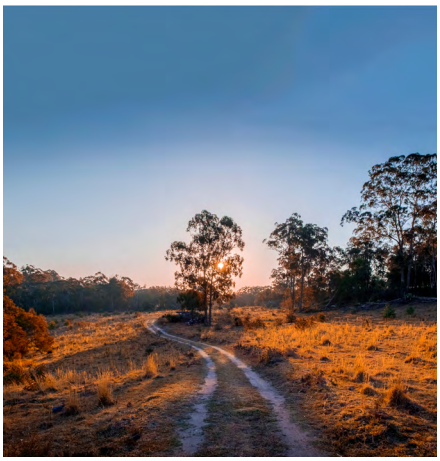
"Diversity: the art of thinking independently together."

Malcolm Stevenson Forbes

RACS leadership

Spotlight on

Global health



Scholarship

Historical

Research

Articles of interest

Correspondence and letters to the editor for Surgical News should be sent to: surgical.news@surgeons.org
Editor: Abderazzaq Noor
Coordinator: Fay Helfenbaum
Designer: Amy Tanner
T: +61 3 9249 1200 | F: +61 3 9249 1219
Contributing writers: Rachel Corkery, Shima Ibuki, Julia Medew, Fleur Morrison, Saleha Singh
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Colleges oppose removing independence in medical and nursing accreditation

The Council of Presidents of Medical Colleges, the Australian College of Nursing and the Council of Procedural Specialists have opposed the Australian Health Minister's directive to the Australian Health Practitioner Regulation Agency (Ahpra) to set up a new government committee to advise the National Boards on the standards of educating and training Australia's medical and nursing professions.

The organisations say there is no guarantee the medical and nursing professions will be adequately represented on this government committee.

The organisations also noted that the decision to create an independent accreditation committee does not adequately represent these professions, risks undermining the confidence of the public and health professions, and may endanger the safety of the Australian community.

Wellbeing charter for doctors

RACS has collaborated with the Australasian College of Emergency Medicine (ACEM), the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), the Australian and New Zealand College of Anaesthetists (ANZCA) and leading doctors' wellbeing experts to develop a Wellbeing Charter for Doctors. The Charter describes the shared responsibility for doctors' wellbeing in Australia and Aotearoa New Zealand. It demonstrates a unified approach to doctors' wellbeing and advocate with one voice to institutions, governments and policy makers.

We encourage Trainees, Specialist International Medical Graduates and Fellows to use the Charter as a resource to start conversations with colleagues, local teams and hospital management about how we can better support doctors' wellbeing. Read the charter at https://tinyurl.com/k2cmmnkz

ANZELA-QI two-year pilot outcomes article published

The ANZELA-QI Working Party are pleased to announce the publication of the article 'Two-year outcomes from the Australian and New Zealand Emergency Laparotomy Audit – Quality Improvement' in the *ANZ Journal of Surgery*. The article can be accessed online by searching 'ANZELA-QI' at surgeons.org

To enquire about participating in ANZELA-QI, please contact the team at Anzela-qi@surgeons.org

You can now chat online with library staff

Want to get more out of the RACS library? You can now find the chat icon on library pages of the website. Click on the icon to talk (via your keyboard) with our friendly and knowledgeable library staff Monday to Friday, 9am-5pm AEST.

Want to find out more? Contact the RACS Library team at college.library@surgeons.org

New chair for RACS Tasmania State Committee

Mr Peter Moore, an orthopaedic surgeon based in Launceston, has been appointed as the Chair of the RACS Tasmania State Committee.

Mr Moore hopes to focus on engagement and interaction across the state and increasing the number of local events.

Ahpra podcast: Women in surgery

The Australian Health Practitioner Regulation Agency (Ahpra) recently launched the *Taking care* podcast, which features a two-part series on women in surgery.

The series has interviews with Dr Victoria Atkinson, Dr Vera Sallen, Dr Pecky De Silva and Dr Christine Lai (pictured above, left to right).

Listen to the podcast at https://www.ahpra.gov.au/Publications/Podcasts.aspx

RACS Trauma group urges retention of New South Wales road safety enforcement measures

RACS has expressed support for the road safety enforcement measures currently in place in New South Wales.

Road safety expert and Chair of the Royal Australasian College of Surgeons' National Trauma Committee, Dr John Crozier, said that the measures are good for the community and good for the health care system.

"It is pleasing to see that the changes to the mobile speed camera program and other initiatives are contributing to a reduction in trauma-related death. We applaud any measures that promote public safety and reduce the burden on our health system.

"It would be a pity to wind back the benefits of the recently introduced road safety enforcement measures, which have both brought New South Wales into alignment with other jurisdictions on the one hand, but have also led the way with internationally leading road safety measures.

"We should regard it as a New South Wales legacy that we can all be proud of and one that will save lives."

Post Op podcast

The RACS Post Op Podcast is a medical podcast by the Royal Australasian College of Surgeons, brought to you with the generous support of the Bongiorno National Network.

Latest episodes

Eyes on the battle against Type 2 diabetes
Dr James Muecke is championing action to prevent Type 2 diabetes, a preventable disease and the leading cause of blindness in Australian adults.

Welcome to the new RACS Vice President – Dr Lawrie Malisano
New RACS Vice President, Dr Lawrie Malisano, discusses his role and the opportunities ahead.

Foundation for Surgery's support in the Pacific
Dr Trevor Cullwick, Head of Department of Surgery and Orthopaedic surgeon in Vanuatu, discusses his career and experiences working in a remote Pacific Island nation.

To listen to all these episodes and more go to
https://www.surgeons.org/en/media-centre/racs-post-op-podcasts

President's perspective

This is my first message to you in my capacity as president of the College. So far, I can tell you that it has been a busy and interesting time. There have been many useful meetings. While some have been face-to-face, the pandemic has curtailed travel so I've had many virtual meetings. Like many of you, I look forward to a time when we can move around more easily!

On a personal note, taking on the role of president has meant cutting back on my clinical work so that I can devote more time to Council matters. This is to be expected and is part and parcel of my new role.

I was fortunate to attend the 89th Royal Australasian College of Surgeons (RACS) Annual Scientific Congress held in Melbourne just before the lockdown restrictions were announced for Victoria. It was a wonderful event full of interesting sessions held onsite and virtually around Australia, Aotearoa New Zealand and many other parts of the world. One of the many highlights for me was seeing so many of my colleagues in person after such a long time. Congratulations to the RACS teams and conveners for making the event such a success.

In July, the Australian Commonwealth Government implemented significant changes to the Medicare Benefits Schedule (MBS). The changes relate to categories of Orthopaedic Surgery, General Surgery and Cardiothoracic Surgery and interventional cardiology.

It is pleasing to see the recommendations from the MBS Review Taskforce being acted upon, but it is important for patients and practitioners to have clarity about the changes, and how they will be reflected in private health insurance policies.

Our specialty societies impacted by these changes worked with the Australian Medical Association (AMA) to ensure that the fees list is clinically appropriate and supports high-quality patient care and informed consent.

In August, we launched our Indigenous Surgical Pathways Program (ISPP), an important initiative designed to increase the number of Aboriginal and Torres Strait Islander surgeons in the surgical workforce.

While there are more than 83,000 doctors registered to practise in Australia, fewer than 400 are Indigenous. This is despite more than 760,000 people in Australia identifying as Aboriginal or Torres Strait Islander. This demographic breakdown highlights the work we have to do for the Indigenous community to reach parity with non-Indigenous Australians.

In Australia and Aotearoa New Zealand we have a severe shortage of Indigenous surgeons. We need to do everything we can to change this disproportionate under-representation. The College is committed to addressing this health discrepancy and the ISPP will support this by encouraging and actively recruiting medical students and recent graduates into surgery.

I look forward to educating myself more on this subject and I recommend some of our excellent eLearning modules on Indigenous health. In Australia, the Aboriginal and Torres Strait Islander Health and Cultural Safety program is designed to support you with learning about what life was like before colonisation, and how colonisation, mistreatment through legislation, and removal of children has impacted so many. The program introduces the holistic health approach and highlights how to support and improve health outcomes. The MIHI course for Aotearoa New Zealand practitioners, developed by Otago University, promotes positive engagement, appropriate care and treatment and health advocacy for the Māori community.

You may have noticed that I am adding the name Aotearoa when I mention New Zealand. The RACS Board of Council recently approved the use of the term 'Aotearoa New Zealand' in our publications, digital content and correspondence. We did this because in the te Ao Māori, the Maori world, names are significant, and there is a growing acceptance that embracing the name Aotearoa is a tangible honouring of that obligation. We currently use the term for the Aotearoa New Zealand National Committee and for relevant staff roles. Extending the use of Aotearoa New Zealand in our publications, digital content and correspondence shows, particularly to the Māori community, that this commitment is serious and evident in our day-to-day work.

On other matters, I would like to congratulate the staff and Fellows at the College who were instrumental in preparing the organisation to achieve reaccreditation from the Australian Department of Foreign Affairs and Trade (DFAT). This is a significant step for us as it means that we can continue to receive funding under the Australian NGO Cooperation Program and other DFAT funding streams.

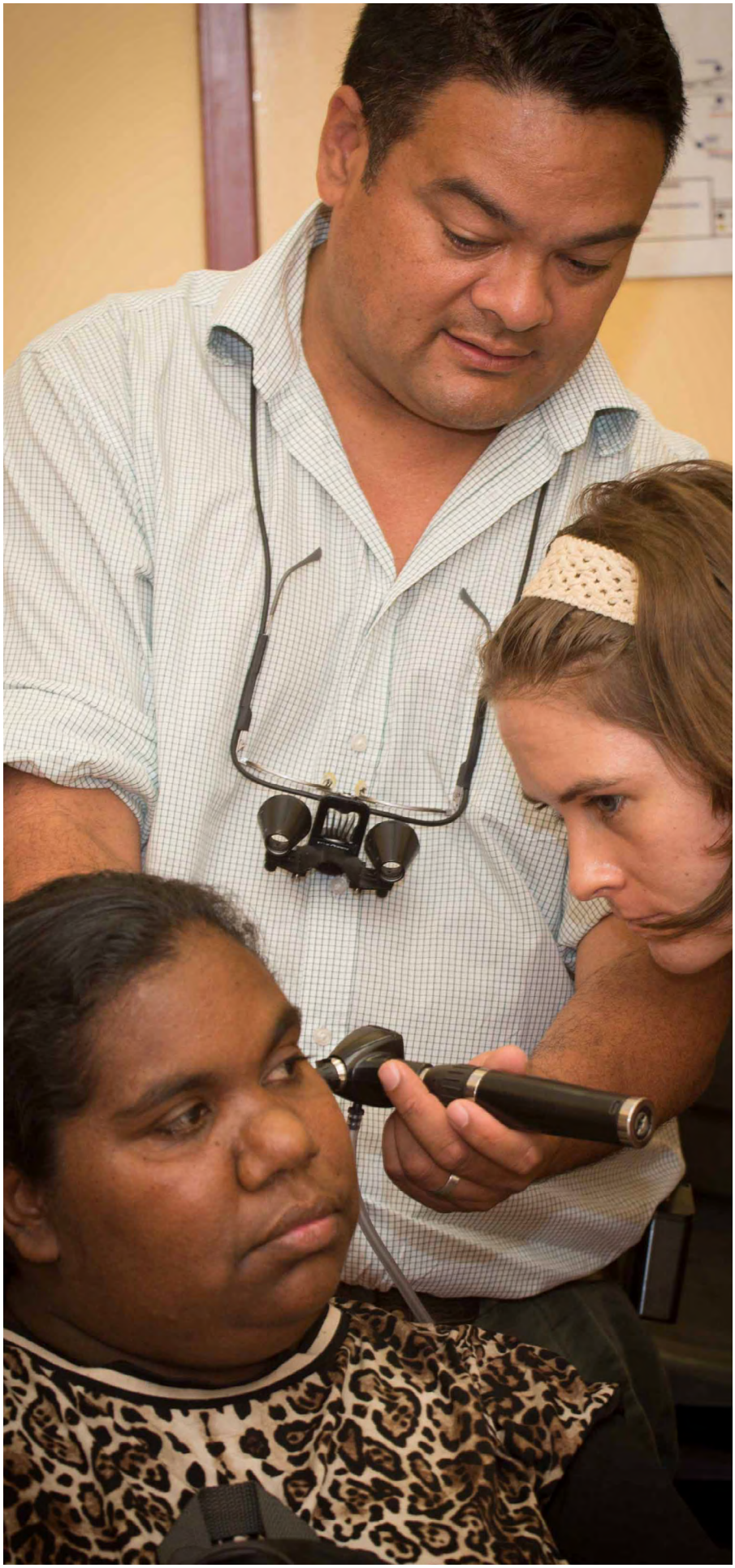
While the accreditation process was rigorous, I know that the process was a valuable capacity-building tool that enabled us to reflect, improve and grow. We received positive feedback from the Department, including recognition of our strong governance, risk management and finance systems. Our effective government partnerships and capacity to influence through effective advocacy was also noted. I have no doubt that the rigorous work done to achieve this standard will not only improve our processes and activities, but it will also help us maintain high standards in what we do to support healthcare in the Asia-Pacific region where we undertake our

global health programs. Well done to all involved.

On a final note, I would like to extend a warm welcome to our new Councillors: Associate Professor Andrew Cochrane (VIC), Cardiothoracic Surgeon and Specialty Elected Councillor; Dr Nicola Hill (AoNZ) Otolaryngology Head & Neck Surgery Surgeon and Fellowship Elected Councillor, and Dr Philip Morreau (AoNZ), Paediatric Surgeon and Specialty Elected Councillor. I know you will add immense value to the College and Council deliberations.

I look forward to having kōrero (conversations) with you all – the College staff, Council members, Fellows, Trainees, Specialist International Medical Graduates, our valued specialty societies and other stakeholders. ■

Dr Sally Langley
President



Professor Kelvin Kong, Chair of the Mina Advisory Group and part of the Indigenous Surgical Pathway Program Working Group, treats a patient in Fitzroy Crossing, Western Australia.

Vice president's perspective

I acknowledge that it is early days, however, I have a sense of areas I would like to focus on during my tenure as vice president of the College.

Those of you who know me are aware of my passion for building strong relationships. This is particularly important for membership organisations such as ours. Each Fellow, specialty and interest group within the Royal Australasian College of Surgeons (RACS) are part of an interwoven network where we must work together to enhance our collective problem-solving abilities and add value to the community. Collectively, we must strive to be the leaders in our field – in all aspects from board governance, professional development and standard setting, to assessment and professionalism.

By combining our efforts, efficiencies will be realised across several platforms, including delivery of world-class standards of training and assessment. This will directly translate to high quality care for the community. We also need to consider surgical sustainability to minimise the environmental impacts of surgery. Ongoing developments include processes to minimise duplications between the College and the specialty societies, for example, by developing common platforms that take into account the RACS and specialty society interactions.

A strategic workshop following the June Council session extensively analysed risks and opportunities and RACS' ability to manage them. To some extent, recent history has progressed to a devolved approach of many areas between RACS and specialty societies. Perhaps this principle could be extended for the advantage of all stakeholders.

There is an opportunity to continue improving advocacy and communication, which are inextricably interconnected. The College's ongoing communication and advocacy on road safety, the responsible consumption of alcohol, protection of specialist surgeon as a title, and many other issues has increased awareness, which certainly benefits from our collective voice. To this end, the more engaged our members are, the greater the impact we can have.

Reflecting on some of the lessons I learnt in my previous tenure as president at the Australian Orthopaedic Association, it is important to reach members at the coalface. With this in mind, I would like to hear more of the experiences and perspectives our teams at the Aotearoa New Zealand and Australian states and territories offices can bring to the table.

I am also passionate about contributing to a more respectful and inclusive environment for our members. I am proud that RACS is widely recognised as a leader in the healthcare sector for our efforts to increase professionalism in surgery. We have achieved international acclaim for recognising and managing areas for improvement of our culture and setting out a clear, evidence-based, and educationally sound plan to address them.

Measuring our progress is a key part of this effort. I would like to thank all those who responded to our request to complete the Building Respect Evaluation survey. The survey is one part of RACS' commitment and is designed to check that our work is on track and starting to make a difference. We are also grateful to those who participated in our key informant interviews. It is important that we take the views of our membership on board, as findings of the evaluation results will be used to forge a forward-looking Building Respect Improving Patient Safety plan for the coming five years.

The results of this important work will be used to continue focus on diversity and inclusion. Diversity, in all its dimensions, and our ongoing efforts to ensure our surgical workforce reflects the diverse communities we serve. This will strengthen the profession of surgery and the College.

The Foundation for Surgery is yet another area I will support as the vice president of our College. I am constantly inspired by the positive impacts achieved in our communities. But, most of all, I am proud to know that surgeons have not only achieved so much within their own careers but have also proven to be great philanthropists in supporting the Foundation for Surgery and its important work. This is needed more than ever to meet the increasing and changing health needs of communities around the world. I extend a special thank you to those of you who supported our colleagues in the Pacific and Timor-Leste by donating to the recent Pledge-a-Procedure campaign.

I would also like to take this opportunity to remind you that the Foundation for Surgery also gives back through scholarships and grants to aspiring surgeons, members and researchers. The Foundation is recognised as the second-largest funder of surgical education and research worldwide. I encourage you to visit our website and take advantage of the many opportunities the Foundation offers you.

My role also involves working with the *ANZ Journal of Surgery*, the leading publication for surgical research in Australia and Aotearoa New Zealand. The RACS Board of Council recently approved transitioning the journal to a digital only version by 2022. This means members will receive a digital copy of the journal. There are many reasons why we felt this was a sensible change. Other than the obvious environmental and sustainability issues associated with printing thousands of hard copies, readership of the online journal is already well-established. It is already the default reading mode for researchers and medical professionals, with over 360,000 article downloads per year. There is more information on the change in this issue of the magazine.

My final message to you is a reminder to look after yourselves. We've all experienced many trials, with the COVID-19 pandemic adding its own challenges and creating long-term effects on our wellbeing. So, please take the time to care for yourselves, your families, and your colleagues. ■

Dr Lawrence Malisano

Vice President

Spotlight on

RACS global health activities

The vision of RACS Global Health is that safe surgical and anaesthetic care is available and accessible to everyone.

The distinct international development contribution of our programs is that we work in direct partnership with national governments, regional organisations, hospitals, surgeons and patients to ensure we can support the strengthening of health systems, with a central focus on workforce capacity building. The overall aim is to enable sustainability of health services into the future.

Through work with our Asia-Pacific regional partners, RACS Global Health ensures that our programs are driven by the self-determined needs and priorities of the national governments we work with.

In response to the impacts of the COVID-19 pandemic, RACS Global Health has continued to provide international support to our partners through online training and clinician support. This has included facilitation of regular forums and peer support with the critical expertise of our pro bono specialist Fellows, allied health professionals and Australasian specialist colleges.

Significantly, the pandemic has provided opportunities for national partners to directly implement activities with remote support from RACS Global Health and Fellows. Our Timor-Leste Country Office operations have continued implementation with the support of in-country and expatriate staff during two national emergencies: floods and the COVID-19 pandemic. These events presented opportunities for significant logistics and equipment support to national hospital partners and programs.

Our work would not be possible without the pro bono expertise of our specialist visiting medical teams, which support vulnerable communities to address significant unmet demand for surgical healthcare. We look forward to the continued and growing involvement of the RACS Global Health pro bono specialists and commencing re-deployment as soon as possible.

This year also saw the establishment of a RACS Global Health Section. You can find out more about the section activities, including how to join, on page 22.

Call for Aotearoa New Zealand-based specialist volunteers

Through partnerships with our Asia-Pacific neighbours, the Royal Australasian College of Surgeons (RACS) Global Health programs provide specialist medical education, formal and on-the job training and mentoring, and direct clinical services to 13 countries in the Asia-Pacific region.

The Pacific Island Program (PIP) is one of RACS Global Health's largest programs and is supported by the Australian Government through the Department of Foreign Affairs and Trade (DFAT). It is delivered in partnership with the Fiji School of Medicine, the Pacific Community (SPC), Pacific Ministries of Health, local clinical teams, a range of specialist medical colleges and associations and, importantly, RACS specialist volunteers.

Since the World Health Organization (WHO) declared the COVID-19 outbreak a global pandemic in March 2020, RACS Global Health has pivoted most programming to remote clinical support.

Before the pandemic, RACS was deploying up to 70 visiting medical teams to 11 Pacific Island countries each year to provide clinical services, training and mentoring. During the current phase of PIP (2016–2021), RACS has supported 1709 vital surgeries, 1325 professional development opportunities, and 37 formal education and training activities.

While Australia has not yet established travel bubbles with Pacific countries, Aotearoa New Zealand has a quarantine-free travel bubble with the Cook Islands. We anticipate that Aotearoa New Zealand may establish similar arrangements with other Pacific Island countries. In anticipation of this opportunity, RACS would like to grow our cohort of Aotearoa New Zealand-based specialists, including surgeons, anaesthetists and nurses, so we can recommence the clinical support, training and mentoring that has been suspended, due to COVID-19.

We are seeking expressions of interest from Fellows and other specialists interested in participating in a visiting medical team with PIP. At this stage we are only asking for Aotearoa New Zealand-based specialists, as Australia has not yet opened its borders.

Our volunteers are invaluable. They continually tell us how much they gain from contributing to our global health programs. An anonymous PIP pro bono specialist said, "Being involved in PIP has enriched my life. The people I have met and the professional, personal knowledge and experiences I have gained on these trips have been more valuable than I can put into words."

While on overseas deployment, all travel, accommodation, transport, pre-trip medical checks and meals are funded by RACS. We have also engaged International SOS, an organisation that provides health and security advice and support to our volunteers.

RACS Global Health specialist pro bono applicants must complete a two-stage interview selection process to assess clinical competency and suitability for overseas deployment. If selected, volunteers are asked to complete key compliance tasks, including undertaking a New Zealand Ministry of Justice Criminal Check and online training modules.

For further information on volunteering with RACS Global Health please refer to the RACS Global Health Deployment Guidebook. This resource provides comprehensive information about volunteering on a RACS Global Health program. ■

How to apply

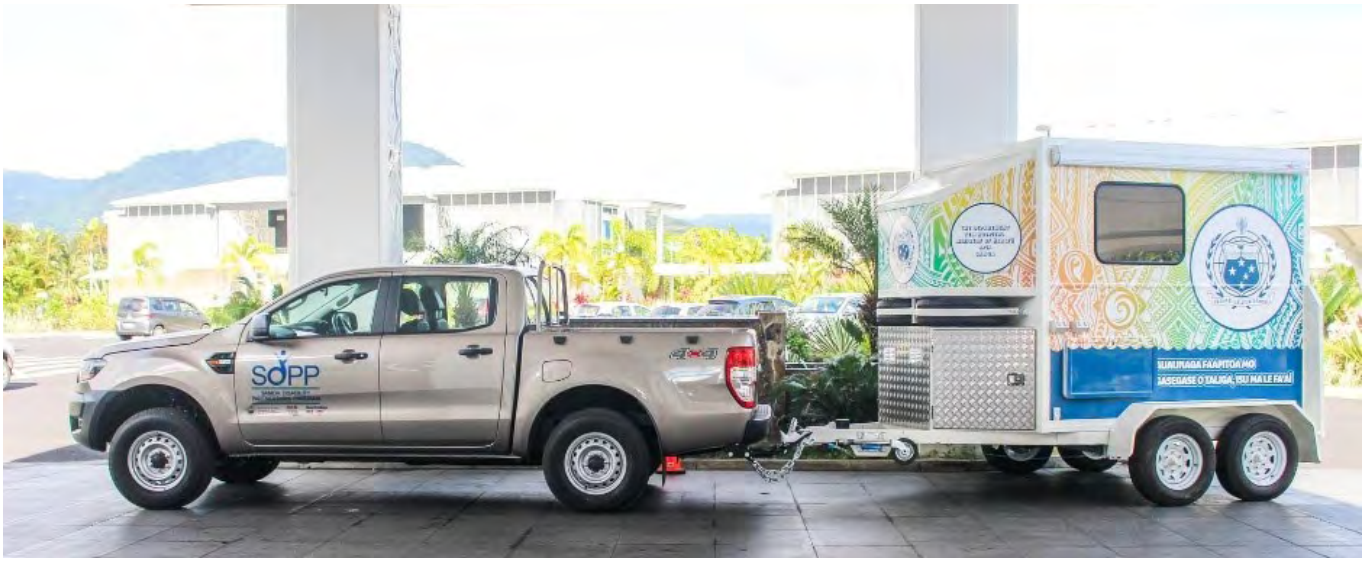
If you wish to apply to become a RACS Global Health specialist Aotearoa New Zealand volunteer, please email volunteer@surgeons.org and provide the following:

- Current CV
- Copy of qualifications
- Registration Certificate with the Medical Council of New Zealand

To find out more about RACS Global Health programs, please visit surgeons.org/about-racs/global-health

Australian Aid

Mobile audiology outreach trailer ready to hit the road in Samoa



Samoa Hearing program audiology trailer and truck. Photo credit: MWSCD

Access to hearing screening and specialist medical treatment for people living with disability in rural communities in Samoa has just been given a major boost. The Ministry of Health and the Ear Nose and Throat (ENT) Unit at Tapua Tamasese Meaole (TTM) Hospital in Apia, Samoa have received a mobile audiology trailer as part of the RACS Global Health, Department of Foreign Affairs and Trade (DFAT) funded Samoa Hearing Program. This project falls under the broader Australian Government investment in the Samoan Disability Partnership Project, implemented by the Samoan Ministry of Women, Social and Community Development (MWSCD) in collaboration with a range of local community-based organisations, including those for people with disabilities.

As part of their commitment to supporting the hearing services component of the project, led by the head of the TTM ENT unit Dr Sione Pifeleti and RACS Global Health, the MWSCD donated a new Ford Ranger truck. The truck will tow the audiology trailer as part of the hearing services outreach program to rural areas of Samoa.

The handover took place in the first week of June 2021 to coincide with the launch of the community sector development plan and policies, including the national policies for persons with disabilities. The celebrations and presentations by the MWSCD and Ministry of Health reaffirmed the importance of providing early intervention for people with hearing impairments, improving their chances at participating in education and work opportunities.

Caretaker Minister and retired Cabinet Minister Dr Leao Talalelei Tuitama said the new truck and trailer will enable specialist medical services to offer ENT and audiology checks in rural communities. This was highlighted in a review of the current MWSCD community sector plan, after receiving feedback from stakeholders like Nuanua o le Alofa (NOLA) on the need to promote and support people living with a disability.

Ministry of Health Director-General, Leauasa Dr Take Naseri complimented the audiology trailer. He said people living with disabilities will be offered the services by TTM Hospital's medical specialists, local community organisations, and schools. "We have lots of people with ear problems and it links to sore throat and also to rheumatic fever," he said. "The purpose of this truck and trailer is to provide services to assist and support people with disabilities in rural areas, but we also offer support to anyone here in town or anywhere else in Samoa."

RACS Global Health and the Samoa Hearing Program will continue to support the development of hearing services over the next few years. A full audiology suite will be installed at TTM Hospital when travel restrictions ease. The Primary Ear Health Care training and hearing aid fitting will be rolled out to doctors, nurses, and community workers in the next six months. ■

Samoan dancers celebrating the handover of the trailer and vehicle and launch of the new community sector plan. Photo credit: MWSCD

Royal Australasian College of Surgeons
Foundation for Surgery

Did you know RACS is now the second largest funder of surgical education and research worldwide?

Come and join the change

Apply for a Learning and Development Grant today at **surgeons.org/scholarships**

Research Scholarship applications open online in March 2022.

Through the Foundation for Surgery, you can also establish a scholarship or grant in your name today, or establish your legacy through a gift in your will.
Contact **foundation@surgeons.org** for information on how to give today.

A surgical future in Vanuatu

Dr Trevor Cullwick discusses the challenges and future directions of surgery in Vanuatu.

Dr Trevor Cullwick

Dr Trevor Cullwick is the senior general surgeon at Vila Central Hospital, the main referral hospital in Vanuatu.

Born and raised in Vanuatu, he completed the majority of his surgical training at Fiji National University and took to the surgical aspect right from his undergraduate degree. "I thoroughly enjoyed the structure and the thought process that went into it, and the challenge," Dr Cullwick said. "I realised that in a rural setting I wanted the surgical skill set or at least to be able to help people. So that drove my passion further," he continued.

A desire for further training and experience brought Dr Cullwick to Australia and Aotearoa New Zealand. He undertook an attachment for two years in Christchurch in Orthopaedics and has just returned from his Rowan Nicks Scholarship at Melbourne's Northern Hospital, under the supervision of Ms Wanda Stelmach. This occurred during the COVID-19 pandemic, which meant Dr Cullwick was juggling his surgery and COVID-19 restrictions at the same time.

The COVID-19 pandemic has created difficulties in Vanuatu as well. Although there have been no community outbreaks, Vanuatu has been unable to host visiting medical teams. These visiting teams usually advise and discuss patients with surgeons in Vanuatu, and they bring in much needed medical supplies. Another issue is that Dr Cullwick and his colleagues are unable to refer difficult cases to be seen in Australia and Aotearoa New Zealand. "This has impacted our services greatly," he said, "because we've cut down on electives, we're only doing emergencies and electives in some situations. That has affected us."

Other than COVID-19, Dr Cullwick sees the main challenges in Vanuatu falling under the category of human resources. "We don't have enough surgeons to actually carry out the surgery. There are currently four of us serving a population of 300,000," he said. This is also an issue for anaesthetists and other support staff. Dr Cullwick thinks it's important to consider building service capacity in a broader team sense. Another challenge is the financial support necessary to develop services and standards of healthcare. Dr Cullwick sees this as a long-term issue that needs commitment, a rigorous process and vision from the Ministry of Health.

Vila Central Hospital is the main referral hospital in Vanuatu and provides health services to over 78,000 people. It is the only hospital able to perform a high standard of surgery. Dr Cullwick worries that 60 per cent of the population don't have access to simple surgeries, such as hernia repair or lipoma, so they have to fly to Vila Central Hospital, which is costly. Dr Cullwick would like to see funds and staff made available to provide outreach and surgical services in remote communities.

Dr Cullwick spoke highly of the Foundation for Surgery and the College. He expressed appreciation for the College's programs, such as the Pacific Island program, that provide training, and for the College's facilitation of examinations. He also appreciates the worth of scholarship and fellowship programs funded by the Foundation. He personally found it valuable to be able to "go and see what it's like in these developed centres, where we can say, 'Look, we're not far off, and here are little tweaks we can do to bring about changes'."

Dr Cullwick is clear that his future lies in surgery in Vanuatu. "I love what I do. I love general surgery. I love how I can help people and at the same time be able to teach and be an example for the young guys that are coming up," he said. Developing the next generation of surgeons is key for him. "With the facilitation of RACS we can get our young surgeons attached to existing teams to groom them, to learn the process, to inspire their passion. These are the surgeons who will eventually be taking over from us."

Dr Cullwick is focused on the service he can provide to his patients. "When you get into surgery you can work anywhere but it's about your capacity and where you want to see surgical services. For me, that is Vanuatu." ■

We've revved up your member benefits!

If you're looking to buy, lease, rent or insure a car – or just save on petrol or car accessories – your first stop should be your College benefits program. As a member of the program you get:

- Up to 20% discount on novated leasing through Private Fleet and Vehicle Solutions
- Discounts on MotorBuys Car Buying Service
- Discounts and exclusive benefits on Tesla vehicles and energy products
- Up to 10% off car rental through Hertz and Europcar
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- Discounted car insurance through Bingle, Vero, Avis and Budget
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Royal Australasian College of Surgeons | Member Advantage

New chair for RACS Global Health

The Royal Australasian College of Surgeons (RACS) , an accredited non-governmental organisation (NGO), strives to ensure that safe surgical and anaesthetic care is accessible to everyone in the Asia-Pacific region. RACS, through its Global Health department, currently supports local healthcare systems in 13 Asia-Pacific countries, by providing specialist medical education, training and medical aid. This supports those health care systems to provide quality medical services for themselves into the future.

Professor Owen Ung is the new Chair of RACS Global Health. He joins the team and will guide it through some transitions, while keeping Fellows connected and engaged with meaningful international aid work. He plans for Global Health to hit the ground running next year as the pandemic eases.

Professor Ung is a breast and endocrine surgeon based in Brisbane. Among his many roles, he is Director of the Metro North Comprehensive Breast Cancer Institute, a visiting specialist surgeon for the Breast and Endocrine Surgery Unit at the Royal Brisbane and Women's Hospital, and a Professor of Surgery at the University of Queensland.

Professor Ung has given back to his profession through many voluntary contributions to RACS. He was on the Court of Examiners for 10 years, and has been a member of RACS New South Wales and Chair of Queensland State committees. Professor Ung represents surgeons at a Federal level as a Councillor for the Australian Medical Association (AMA).

"For me, there's much more to the surgical profession than earning a living," he said. "It's about what you do in terms of community engagement, academia, and contributions to the betterment of your profession and fellow human beings."

"Global health is a bit left field for me," Professor Ung continued. "But I'd like to learn more about it and make a contribution in that area, even if it's not actually being on the ground." Professor Ung was responsible for supporting Thai surgeons through the Weary Dunlop Boon Pong Exchange Fellowship, a collaboration between the Royal Australasian College of Surgeons and the Royal College of Surgeons of Thailand. Through this program, he helped surgeons gain specialist medical experience and grow valuable networks with international colleagues. He hopes to bring this experience to Global Health.

Professor Ung is determined that adjustments to how the department functions will be "positive changes with purpose". It is important for him to streamline the programs and engage Fellows in rewarding global aid work, while achieving sector and Department of Foreign Affairs and Trade (DFAT) accreditation. "Change is not always easy and adaptation takes time. We are adapting and RACS will continue to deliver excellent global health programs."

As someone who has volunteered much of his own time for the betterment of health, Professor Ung knows only too well how vital participation from dedicated Fellows is for the success of Global Health programs. "Regardless of what regulations are in place, if the Fellowship becomes disconnected because our Fellows don't have an adequate vision, you don't have a program," Professor Ung said. "We have to keep the vision, maintain flexibility and ensure our Fellows stay engaged in the process, because they do fantastic, important work and we don't want to lose that vital enthusiasm."

Earlier in his career, Professor Ung had a brief opportunity to make a difference at ground level to the health of a community in Tanzania. He feels that short experience was enough to ignite a desire to share his medical knowledge with global communities less well resourced than ours. "If every surgeon had even a small experience working in a developing environment, I think it would open their eyes to the plight of vulnerable communities, and what Australia and New Zealand can do as privileged countries."

"Global health is an important part of what RACS does," says Professor Ung. "It should be about opening up and bringing together that wonderful fraternity of surgeons, healers and healthcare providers."

Professor Ung is excited about working with his team to steer global health programs back into vulnerable communities as the COVID-19 pandemic subsides. "There'll be many productive and meaningful roles RACS can fulfill at a time of great need. There's no better time to jump on board and unite with other committed health professionals to make a difference to the health of people everywhere, particularly our regional neighbours." ■

Professor Owen Ung

Not just about surgery

An interview with Mr Kiki Maoate, a surgeon and trusted advisor to ministers and governments in Aotearoa New Zealand and the Pacific.

When Kiki Maoate was a boy, Saturday mornings were an adventure. As well as completing their chores or weeding plantations near his Cook Islands home, Mr Maoate and his brothers would accompany their father on his medical rounds.

Riding in a jeep through local villages, the family would look for flags outside people's homes to alert them to sick people. The boys acted as runners for their dad, fetching equipment for him. Sometimes they went home with mangoes and other fruits for their efforts.

Mr Maoate remembers his father, Sir Terepai Maoate, working like a true generalist. There were times when his father sailed between islands in rough seas to help women give birth. He could perform caesarean sections with ether and resuscitate babies at the same time.

"They had to run the gauntlet at the time, but I think they did a pretty good job," Mr Maoate says.

Sir Terepai was a public health practitioner long before the profession became revered due to the COVID-19 pandemic. Instead of just treating patients with parasitic diseases like filariasis, Sir Terepai and his colleagues found ways to prevent them. Their methods were later acknowledged by the World Health Organization (WHO) as a key component of successful eradication programs.

"They would have been running all the epidemic work if they were here today for COVID," says Mr Maoate.

These examples were not lost on Mr Maoate. When, as a young man, he decided to become a surgeon, he never imagined working in an operating theatre alone. After completing his paediatric urological and general surgical post-Fellowship training at Melbourne's Royal Children's Hospital, he attended WHO conventions to learn more about public health systems.

Mr Maoate was interested in models of care for people living in countries like 'the Cooks' (Cook Islands) – a disparate archipelago where many people cannot easily access a tertiary hospital. At the time, WHO was taking an increasing interest in surgery so Mr Maoate set up a recurring conference to discuss, debate and improve health care in the region. He has since helped develop Paediatric outreach clinical services in Aotearoa New Zealand and throughout the Pacific region. "I realised my role was not just about surgery, it was about health leadership," he says, reflecting on the early days of his medical career.

The Christchurch based surgeon went on to lead in many ways in various domains. As well as teaching and mentoring Trainees and junior colleagues, Mr Maoate is a trusted advisor to ministers and governments in Aotearoa New Zealand and the Pacific. In 2014, he became an Associate Pacific Dean, Christchurch School of Medicine, Otago University. In the same year, Mr Maoate received a Aotearoa New Zealand Order of Merit for his commitment and dedication to Pacific health.

Mr Maoate is now president of the Pasifika Medical Association (PMA) , an organisation that supports Pacific health professionals in Aotearoa New Zealand, Australia and the Pacific region. The PMA commissions social and health providers to improve the prosperity of Pacific families and deploys medical assistance teams to Pacific countries and within Aotearoa New Zealand. It assists with natural disasters and medical emergencies, performs diverse public health work, and teaches cultural awareness to health professionals.

In 2019, Mr Maoate helped lead the PMA's response to a catastrophic measles outbreak in Samoa that claimed the lives of 83 children. The disaster occurred in a community where vaccination rates had dropped significantly as a consequence of the low level of confidence in the nation's vaccination program over the previous years. In addition to the success of the vaccination and health programs, the work of psychosocial teams providing mental health support for the families and health workers was noted by the Samoan Ministry of Health as a highlight of the PMA's response.

Mr Maoate also chairs the Aotearoa New Zealand Pasifika Futures Board (an entity of the PMA Group). The Board aims to lift the socio-economic status of Pasifika people who experience worse health and social outcomes than those living in Aotearoa New Zealand.

In the past five years, the Board has helped more than 100,000 people with health, housing, education, training and economic development. Among other projects, it helped young people interested in trades boost their job prospects, and created opportunities for enterprising families to commercialise their businesses. A social return on investment analysis predicts that every dollar spent on these projects will deliver a return of $43.

Mr Maoate says this work will help address some of the root causes of health inequity among Pasifika people who experience more barriers to accessing health care and delayed diagnoses for diseases including breast, colorectal and lung cancers.

Mr Kiki Maoate

"If you ask Pacific families throughout Aotearoa New Zealand if health is their main concern, they'll say, 'No, our main concern is that we don't have enough money to pay the bills or buy bread or pay the rent'," he says. "There is no point giving a family a prescription if they will not fill it."

"Equity is about providing the opportunity to do these things, whether it's helping with transport, employment or getting a driver's licence – all these things matter. If we can get that equation right in Australia and Aotearoa New Zealand, the burden on the two countries will be reduced."

Mr Maoate has a long history of leadership and involvement with the Australian Government funded Pacific Island Program (PIP) led by the Royal Australasian College of Surgeons (RACS) Global Health, a program that works across 11 Pacific Island countries to build surgical work-force capacity building and strengthen health systems.

Mr Maoate has always seen public health advocacy as part of a surgeon's job. He says surgeons should recognise their power and use it to help the community. "People listen to surgeons, anaesthetists and other specialists who speak out. A lot of specialists will say, 'I counsel my patients when they come into my rooms', and that's right, they do that, but they're flawed if they think that's having an impact on the population."

Despite living a privileged life in many respects, Mr Maoate has felt the impact of premature death among his own family and friends. His baby sister died from tetanus when she was one, his grandfather died of a heart attack in his 60s, and family friends have lost their lives prematurely.

More recently, his uncle Dr Joe Williams died from COVID-19. The well-known physician and former prime minister of the Cook Islands was the 24th person to die from the disease in Aotearoa New Zealand. Dr Williams worked closely with Mr Maoate's father on the eradication of filariasis in the Cook Islands and was still working as a doctor in Auckland two days before he fell seriously ill with COVID-19 last year. He was 85.

This work ethic was also displayed by Mr Maoate's father until his death from prostate cancer in 2012. He was 79. After starting his working life as a doctor, Sir Terepai entered politics in the Cook Islands and served as prime minister between 1999 and 2002. He was known for working 90-hour long weeks and continued fishing and planting crops while working as a politician. A favourite saying of Sir Terepai's was, "We would be all better off if we just shared".

One of his legacies was ensuring the Cook Islands had reserve funds for crises like the current pandemic, which has slashed tourism income. While the Cook Islands have largely kept COVID-19 out, Mr Maoate says the government now faces the difficult task of re-opening in a way that is sustainable for the people and their environment.

The most significant enabler and core of his family is his wife, Ali, and their children. He is forever grateful to his mentors and colleagues past and present in the Pacific region, Australia and Aotearoa New Zealand for their guidance and patience. As for the students, "they are all amazing kids," Mr Maoate says.

Mr Maoate says he, too, may become a politician one day. But not in Aotearoa New Zealand. He wants to return to the Cook Islands, his beloved home territory, to ensure its prosperity. "I do think about it now and again... but I'm parking it for the moment," he says. "There are certainly other people who think it should have happened yesterday but it's all about timing." ■

Q&A with Jenni Lillingston

Surgical News talks with the RACS Global Health Timor-Leste Country Office Manager

Jenni Lillingston (right) with Dr Celestina (left), one of the recipients of the RACS scholarship for Masters in Medicine (Surgery)

Can you describe your professional background?

I am an experience development leader with over 20 years of experience in relationship, governance and program management in senior positions both in Australia and internationally. I originally led policy and management reforms and program delivery in the Commonwealth and Victorian Departments of Finance, Treasury, Premier and Cabinet, Human Services and Auditor General. After a Christmas holiday epiphany, I made the move across to international development sector where I could combine my programming experience in community and health development, with my love of travel and experiencing different countries and cultures.

While completing my Masters In International Development I undertook a number of assignments including with UN Country Office (Timor-Leste), a local health non-governmental organisation in Calcutta, and a number of short consultancies in the Solomon Islands.

Since then I have worked in Cambodia for SNV Netherlands Development Organisation, in Dili for the Department of Foreign Affairs and Trade (DFAT) funded WASH program with Australian Red Cross (ARC). I began my current role at RACS at the end of 2020.

What do you enjoy most about international development work?

I enjoy working with a range of partners to build positive change. I appreciate working in environments where I can build on my experience in a different way from what I would be engaged with in Australia. The diversity of issues and exposure to new contexts and ways of seeing the world constantly help me reconsider approaches to my work.

What have been some of the key challenges in Timor-Leste so far?

The journey to Dili included an unplanned three-week stop in Darwin due to the Timor-Leste border closing (which included two hotel evacuations due to fire alarms in the middle of the night). This was followed by a further two-week quarantine. After finally making it to the office, Timor-Leste extended the COVID-19 State of Emergency, meaning we needed to suspend training and community outreach activities. After rapidly moving our post graduate courses online, Dili and parts of Timor were hit by the worst floods in 40 years. In addition to substantial damage to many houses (including those of our staff, clinical educators and trainee doctors) there were significant ongoing power and internet outages.

There was a rapid escalation of positive COVID-19 cases in Dili, leading to continued extensions of the State of Emergency order. Our key partners, Hospital Nacional Guido Valadares (HNGV) and the Ministry of Health, are fully engaged in mitigation and response actions.

Despite these challenges we continued to keep the RACS office operational, delivering RACS education programs , developing clinical educator capacity at HNGV, supporting other COVID-19 related response training, establishing district eye clinics and securing essential supplies and equipment. I am particularly proud that we managed to complete the Family Medicine Post Graduate program online and conduct the required exams. This took incredible commitment and hard work from the RACS teams and the clinical education team from HNGV and Maluk Timor, as well as from the trainees themselves.

Now that staff and our clinical partners are fully vaccinated, we have been able to resume face-to-face activities in Dili and continue travel to the districts. We are moving quickly to restart training and clinics.

Timor-Leste family medicine graduates

Tell us about the RACS Timor-Leste team and projects.

RACS Timor-Leste programs focus on medical health workforce development and health systems strengthening. We work in partnership with the Ministry of Health, HNGV and the National University of Timor-Leste (UNTL). Our office is based in HNGV. We manage the training building used for postgraduates, undergraduates and other HNGV training and meetings. Our programs include:

- The Australia Timor-Leste Program of Assistance for Secondary Services-Phase II (ATLASS II) was established in 2012 to strengthen the medical workforce through in-country postgraduate medical education to develop junior medical doctors' clinical skills, knowledge and professionalism while developing a senior medical faculty that is capable of taking on clinical leadership and teaching roles
- The East Timor Eye Program (ETEP) provides training and mentoring in ophthalmology, optometry, eye care nursing and allied eye health specialties. RACS is currently working with the district hospitals to establish screening and surgical eye care clinics.

We also deliver projects with the National Eye Centre, and work closely with a number of HNGV departments including surgery and emergency.

The RACS Timor-Leste office currently has a largely non-clinical team, with a national staff of three who support project logistics and office management, as well as an international long-term Ophthalmologist.

General practitioners from community and district health posts at a recent session on identifying and responding to gender-based violence

One of our project staff, Sarmento, has been with the office since 2002 so has seen considerable change in that time. Januario re-joined RACS in 2020 after finishing his Master's in Education in Aotearoa New Zealand, and Joaquin joined in 2018 after completing Bachelor's in English Literature.

What does your day-to-day work involve?

Regular parts of my day include working with the HNGV medical teams and other partners to plan, coordinate and extend delivery of training and services that improve health and other development outcomes for the people of Timor-Leste. My focus is to ensure that programs are effective and sustainable and that they integrate themes around equity and inclusion. Our HNGV partners, including the surgery department, clinical educators and the National Eye Centre team have been incredibly welcoming, and our collaboration is a key part of what I enjoy in the role.

I also enjoy working with the RACS Fellows, including President of Royal Australian and New Zealand Collage of Ophthalmologists (RANZCO) Dr Nitin Verma. I am very appreciative of the history of long-term support by Fellows, including Dr Glenn Guest.

What does the future hold for the RACS Global Health programs in Timor-Leste?

Our immediate focus is restarting district-based activities, including eye health screening and surgical outreach and training. One of our programs, the Australia Timor-Leste Program of Assistance for Secondary Services-Phase II (ATLASSII) finished at the end of this year so we are also looking to programming from 2022. We have been developing funding submissions for new activities and are in the process of developing a Country Strategy plan that will identify priority areas for the next phase of operations. ■

A tribute to Tonga's first ENT specialist

Dr Leiukamea Saafi

A paediatric surgeon and Associate Dr Leiukamea Saafi was a person of many talents and Tonga's first consultant specialist for ear nose and throat (ENT). Dr Saafi founded the ENT clinic at the Vaiola Hospital in Tonga in 1987. His surgical Otolaryngology, Head and Neck specialty service to the people of Tonga for more than 30 years was exceptional.

Over the years, the ENT service in Tonga improved through Dr Saafi's leadership and his team's collaboration with specialists from Australia. His clinical team participated in the Department of Foreign Affairs and Trade (DFAT) funded Pacific Island Program (PIP), managed by the Royal Australasian College of Surgeons (RACS). This program contributed by providing surgical services and equipment and the training of in-country ENT personnel for many years.

RACS Global Health pays its respects to the late Dr Saafi and his family and thanks him for his continual encouragement and work to support the RACS Global Health visiting medical teams. His humble nature and good sense of humour will be remembered by many of the RACS Global Health volunteers who visited Tonga. ■

A heartfelt thank you to Dr Berlin Kafoa

Dr Berlin Kafoa

The Royal Australasian College of Surgeons (RACS) Global Health team would like to express its congratulations and heartfelt thanks to Dr Berlin Kafoa, who will be taking on a new role at Pacific Community (SPC) as Director of the Public Health Division.

RACS Global Health Pacific Islands Program (PIP) partners with SPC and has been working with Dr Kafoa and his experienced clinical services team for many years to support the delivery of clinical activities and education across the region.

SPC is an international development organisation that supports the wellbeing of the Pacific community through the effective and innovative application of science and knowledge, guided by a deep understanding of Pacific Island contexts and cultures across a range of key areas such as health, education and climate change.

Dr Kafoa's support to RACS Global Health PIP has been invaluable in guiding the focus of RACS' assistance and facilitating linkages and relationships with Pacific Island clinicians, Ministry of Health partners and Pacific clinical networks.

Dr Kafoa, reflecting on his work with RACS Global Health PIP, said, "PIP has made a huge difference in the training and delivery of clinical services over the past 20 years, and will continue to do so in the next 20 years through its unique approach of building long term relationships and mentoring of clinicians, nurses and biomedical teams. PIP is, by far, the best health program (delivered by an Australian Institution) in the Pacific Islands that the Australian Department of Foreign Affairs and Trade has supported."

RACS Global Health welcomes the appointment of Dr Salina Motofaga as the interim Clinical Services Program Leader at SPC. ■

Royal Australasian
College of Surgeons

AUGUST 2021–MAY 2022

RACS Global Health Section events

Event	Description	Date	Location
Introduction to the Work of Global Health and the Global Health Section	Introduction to the Global Health team, including Chair Owen Ung, on the status of Global Health programs and plans for post-COVID-19, 2021 and beyond. Presentations from National Clinicians and former Program Directors on in-country implementation and work of the Visiting Medical Teams including: - The Pacific Island Program (featuring guest speaker and a National Practitioner) - The East Timor Eye Program (featuring guest speaker and a National Practitioner) - Papua New Guinea Australia NGO Corporation Program (featuring guest speaker and a National Practitioner).	23 August 2021 23 September 25 October	Online
All Colleges, Societies and Organisations Forum	All Colleges, Societies and Organisations Global Health Forum. *Collaboration and Leveraging Gains in International Development and Global Health Across Our Region*	10 September 2021	Online and in-person at RACS offices
	Distribution of the All Colleges, Societies and Organisations Global Health Forum report.	TBC September 2021	
Global Health Section Member Presentations	Face-to-face and virtual presentations from Global Health Section members on topics relating to Global Health (call for expressions of interest in presenting).	1 October 2021 1 December 2021 1 March 2022 1 June 2022	Online / College Campus, Melbourne
	Special session with RACS Aotearoa New Zealand and Aotearoa New Zealand Fellows to extend engagement with Aotearoa New Zealand.	16 September 2021	Online
Global Health event to thank volunteers / program directors / current chairs	An in-person event (lunch or dinner) to thank Global Health volunteers for their contributions to the program and the work of our partners.	2 May 2022	College Campus, Melbourne (possibly RACS ASC)

All sessions in Australian Eastern Standard Time (AEST).

Please share with your colleagues. All are welcome to join to share experience and expertise.

For information on how to join the Global Health Section, please contact Global Health Engagement Coordinator James O'Keefe on james.okeefe@surgeons.org

RACS welcomes new councillors

Introducing new councillors Associate Professor Andrew Cochrane, Dr Philip Morreau and Dr Nicola Hill

Giving life and providing opportunities to others are two main themes in Associate Professor Andrew Cochrane's professional and personal life. He has been heavily involved in teaching for the College and has travelled regularly overseas for over 20 years with cardiac surgery teams. In addition to being an active philanthropist volunteering with medical organisations, Associate Professor Cochrane also supports academic and music students through scholarships and prizes.

His father, the late Professor Donald Cochrane, was Dean of the Faculty of Economics and Politics at Monash University from 1961–1981, and his mother, the late Margaret Schofield, was an eminent pianist who taught at the University of Melbourne's Faculty of Music.

They encouraged Associate Professor Cochrane towards the study of medicine after secondary school, but it was his mother who inspired Associate Professor Cochrane and his sister, Dr Fiona Cochrane, to develop a passion for providing opportunities for others. After their parents' deaths, the siblings established the Cochrane-Schofield Charitable Fund, which awards academic scholarships to secondary school and university students (through Monash University) and provides funds for musical events and prestigious musical performance competitions.

Cardiothoracic Surgery appealed to Associate Professor Cochrane as a student and young doctor because he felt that he could do more for patients as a surgeon.

Associate Professor Cochrane has donated many surgical hours and his expertise as a medical teacher and Board member, starting, over 20 years ago, with Open Heart International. He has made many overseas medical trips to the Pacific Islands, East Timor and more recently to countries in South America such as Peru and Ecuador. Under the Rotary Oceania Medical Aid for Children Program (ROMAC), Associate Professor Cochrane has helped to bring patients, mostly children and young adults, to Australia for surgery. He notes that this has been difficult over the last few years, due to hospital financial restrictions and now COVID-19 restrictions.

More recently, Associate Professor Cochrane has been involved as a Board member with Maluk Timor, a not-for-profit organisation providing medical training and healthcare in tuberculosis, HIV, malnutrition, rheumatic heart disease and other fields. He has been a Board member of East Timor Hearts.

"It gives me great satisfaction to do a lot of good in these developing countries," Associate Professor Cochrane said. "And it's equally important to teach and train their local surgeons."

This year, Associate Professor Cochrane felt it was an appropriate time for him to join the Royal Australasian College of Surgeons (RACS) Council.

"After focussing on performing surgery over many years, then spending time in education and training, I now feel I am more interested in, and would like to contribute to, the direction of the College," he said. Associate Professor Cochrane has taught the ASSET, CCrISP and CLEAR courses for the College and he ran the annual Cardiothoracic Trainees Course 2011–2018.

He said that, while he has no major reforms or agendas to bring to Council, he would like to explore how the College could better recognise its teachers, particularly those surgeons who give much of their own time and weekends delivering courses and training.

Another area he would like review is the College's engagement with Trainees and Younger Fellows. "Sometimes the messaging of what the College does to support these members could be improved," he said. "But I'm also a gradual change person. I think overall the College is in a good place and doing a good job."

It is difficult to imagine Associate Professor Cochrane has any spare time but when he does, he enjoys distance running and kayaking. He has been involved more than 10 times in the Murray Marathon canoe race relay. Has he inherited any musical talents from his mother? "I used to play the flute and I keep meaning to pick it up again," he said. "Maybe one day!" ■

Associate Professor Andrew Cochrane enjoys kayaking.

Dr Nicola Hill was first attracted to the idea of medicine through a combination of humanities and science. Dr Hill's final year subject selection in high school combined both – she completed a mixture of languages, history and sciences.

"The longer I progress in my medical career, the more important I realise the humanities are, in terms of communication and understanding people," Dr Hill said. She continued her appreciation for literature, completing a Bachelor of Arts degree in Classical Studies five years ago. More recently she completed a Master of Science in Evidence-Based Health Care through the University of Oxford, which she was awarded with distinction.

Other positive experiences and observations shaped Dr Hill's journey towards surgery. A family general practitioner was very supportive, she was mentored during her student placement in the Wellington hospital orthopaedic department, and then she found she liked the teamwork and the anatomy and technical challenges associated with ear, nose and throat surgery. Dr Hill was also impressed by how much the otolaryngologists she worked with enjoyed their careers. "I could see these senior doctors coming to work and really enjoying their jobs, even while they were close to retirement. I thought there must be something in this!" she said.

Now Dr Hill works as an Otolaryngology surgeon in Nelson, a regional city at the top of the South Island in Aotearoa New Zealand.

As a generalist surgeon working at a regional hospital, Dr Hill performs a wider range of surgeries than she might in a city hospital, including facial plastic surgery for skin cancer. While this can be a challenge, she enjoys the breadth of her work.

Dr Hill's appreciation for a generalist approach to surgery is one of the reasons she stood for election as a Fellowship elected councillor on the Royal Australasian College of Surgeons (RACS) Council in 2020.

> "I think it's important to respect and value generalism because I can see that focus becoming increasingly necessary for future surgical provision in both Australia and New Zealand," Dr Hill said.

"I have joined the Rural Health Equity Steering Group as the Aotearoa New Zealand representative, which I am really excited about," she continued.

"The Rural Surgery Section has put together a comprehensive strategy to address health inequity in rural, regional, and remote locations." Another issue important to Dr Hill is surgical generalism.

Dr Hill is an experienced committee member. She joined the Aotearoa New Zealand National Committee in 2012 and held several office-bearing positions, most recently as Chair from 2018–2020.

Dr Hill was also the New Zealand Society of Otolaryngology Head and Neck Surgery representative to the Professional Development and Standards Board.

This gave her exposure to the RACS Council. "I've always admired the leadership and governance skills of our RACS councillors."

Dr Hill believes that the bi-national nature of the College gives it strength and history, but at the same time adds a layer of complexity. She is looking forward to being a strong voice for Aotearoa New Zealand on Council, while contributing to the activities of the College as a whole.

Working and living in Nelson has helped Dr Hill find work-life balance. The regional setting creates challenges in the scope of her work, including more frequent on-call periods and less junior support, but it also offers many lifestyle advantages. She enjoys spending family time with her husband and three young

Dr Nicola Hill with her family.

children, paddle boarding, skiing, and hiking in the beautiful countryside around Nelson. She reads a lot, particularly science fiction, Antarctic and medical history, and philosophy.

"I definitely appreciate the lifestyle that living and working in a regional centre offers," Dr Hill concluded.

Paediatric surgeon Philip Morreau has been elected to the Royal Australasian College of Surgeons Council (RACS) as a representative of the surgical specialty.

Dr Morreau is a consultant at the Starship Children's Hospital in Auckland and works in all areas of paediatric surgery and urology, including minimally invasive surgery and endoscopy in children.

After training in adult surgery in Christchurch, Dr Morreau decided to pursue a career in Paediatric Surgery, as he enjoys the creativity involved in working with children. He believes building relationships with patients and their families is key to the success of his role.

"In Paediatric Surgery there is an element of creativity necessary to ensure that we get things right for 70 years, not just the final five years of people's lives," Dr Morreau said. "While the conversations, management and decision-making can be challenging, I find it really rewarding. You couldn't be involved in this kind of surgery without embracing both the challenges and the rewards."

The promotion of the importance of non-technical skills will be one of his priorities as a new RACS councillor, along with improving professional standards and advancing social concerns.

Dr Morreau considers 'soft skills' such as effective communication, teamwork and leaderships to be central to the clinical work of surgeons. He aims to promote their importance in his position on RACS Council, and as Chair of the Training and Professional Skills Committee.

"In the past, these skills have been seen as add-ons, but I believe they are foundational skills upon which good technical skills are built. These skills are fundamental to the clinical encounters of surgeons."

Dr Philip Morreau enjoys cycling in his free time.

"In addition, I look forward to addressing issues of social concern, like racial and gender inequality, and environmental sustainability in healthcare," Dr Morreau said.

Another priority for Dr Morreau will be the maintenance and improvement of professional standards. In his work as senior examiner for Paediatric Surgery and as a postgraduate educator, he has come to understand the importance of training and mentoring in maintaining the standards of graduating Fellows.

"It is crucial for the College, the community and the candidate that we maintain professional standards through our training, education and assessment programs," he said.

As past president of the Australian and New Zealand Association of Paediatric Surgeons, Dr Morreau is aware of the need to represent the broad base of surgeons on each side of the Tasman.

A challenge he sees as being common to surgeons living in both countries is the importance of access to surgical expertise, irrespective of location and socio-economic status. He would like to see access to surgical care improved for children living in remote areas, while maintaining high clinical standards.

"The provision of care without social disruption is an evolving challenge," Dr Morreau said. "While we don't have the same tyranny of distance as in Australia, we have remote parts of New Zealand where socio-economic disadvantage has the same impact on access to care. There needs to be strong services close to children's homes to ensure they receive the care they need, in a supportive environment."

Dr Morreau's work took him around the world to Perth, Melbourne and the United Kingdom, before he returned to Aotearoa New Zealand.

Dr Morreau considers his parents to have been influential in his decision to pursue a medical career. His father was a clergyman and his mother was a teacher, and they instilled in him an interest in the caring professions. His passion for surgery is one that he has passed down to three of his children, who have followed him into surgical training. The fourth works in investment banking.

Outside his work, Dr Morreau unwinds by competing in triathlon events. Earlier in the year he won the New Zealand Ironman for his age group. Dr Morreau attributes his ability to commit to the RACS Council while undertaking a demanding surgical role to the support of his wife and family. ■

How AI will enhance the work of surgeons

Three surgeons talk about how they are investigating artificial intelligence (AI) to personalise treatment, streamline preoperative decision-making, and achieve optimal outcomes for their patients.

What does artificial intelligence (AI) mean for surgery in 2021? Will robots take over the theatre, rendering surgeons obsolete? For the time being, that's the stuff of science fiction. The highly complex, finely-tuned movements and acuity of a surgeon would be extremely difficult for algorithms to mimic. But well-designed AI can help the surgeon improve decision-making and make faster, more accurate diagnoses. It all feels new now but it's predicted that in 20 years' time all surgeons will be assisted by AI in their jobs.

Three surgeons talked to *Surgical News* about how they are investigating AI in different ways to enhance their work and meaningfully shift the future for surgery.

Associate Professor Narinder Singh

Associate Professor Narinder Singh, an ear nose and throat (ENT) surgeon and Head of Department at Westmead Hospital in Sydney, thinks using advanced AI is inevitable in health care and that within the next three to five years AI will be assisting doctors with the predictable, time-consuming parts of their jobs.

Associate Professor Singh and his team are writing AI software to accurately diagnose ear disease in Aboriginal and Torres Strait Islander children in rural and remote areas. They've partnered with Microsoft to build an algorithm from their database of over 15,000 images collected from over 10 years of telehealth consultations. "We'll create a smartphone app so the untrained health worker in the community can use an otoscope in a child's ear as an instant, accurate diagnostic aid," Associate Professor Singh explained. It will use a traffic light system, for example, green, everything's fine; orange, review again in a few months; red, see the specialist straight away. He hopes the same technology can be used in the future to triage ear disease in general practice and emergency departments.

Associate Professor Singh is also investigating using AI to interpret CT scans and prepare reports. "Surgeons want reports that give a detailed and structured review of the anatomy to guide them in surgery," he said. "We want to design an automated system for generating comprehensive, standardised reports that don't try and diagnose tumours, but talk about variables we expect to see in every scan. For example, the degree of internal carotid artery dehiscence in the sphenoid on a sinus CT."

AI is ideal for automating the time-consuming job of writing reports. Associate Professor Singh explained that an AI algorithm can be trained to recognise a straightforward process, like audiograms (hearing tests), where existing reports with validated results can be scanned. It doesn't need the numbers, just the audiogram images. "If the AI could generate the report, the surgeon would read through it and just tick a box if they agree, or if there's a problem, address it," he said. "This saves the surgeon's time for more detailed analysis; it doesn't mean we replace anyone."

Driven by his interest in technology, Associate Professor Singh convened the first Australian congress of the Society for Artificial Intelligence in Medicine, Surgery and Healthcare (AMSAH) in 2019 (www.amsah.org). He hopes there will be many more conferences to come where healthcare professionals and tech specialists can gather to network, share ideas, and discuss future possibilities for the health industry.

Professor Antonio Di Ieva is a neurosurgeon, neuroanatomist, neuroscientist, and Head of the Computational NeuroSurgery (CNS) Lab at Macquarie University. He's training AI to recognise patterns in MRIs and find diagnostic, prognostic and therapeutic biomarkers. The AI can distinguish a tumour from the normal brain, detect where it is, and extract it from the images.

Professor Di Ieva said these outcomes are only preliminary. He's training the machine to recognise types of tumours and give a probability of disease. In this instance, the technology is being used for brain tumours and cerebrovascular pathologies, but it can be applied to many other diseases.

Professor Di Ieva knows that decisions made based on MRIs can be wrong. Lesions caused by other diseases can mimic brain tumours, and not be picked up until surgery is underway. Human fallibility is a factor. "There's always the potential for lack of objective decision-making," he said. "Having a different mix of people in the same team could result in different decisions about a surgery. AI can help customise decision-making and remove human bias."

A substantial barrier to developing practical AI for healthcare is a lack of well-integrated design teams, in which health professionals are needed to play a vital role. "If the computer scientists work in a silo, they'll just produce a very nice algorithm," said Professor Di Ieva. "But in my CNS lab, at the moment, there are 10 people who are clinicians, computer scientists and engineers. We talk together every day in order to try and find middle ground. That's the only way to progress AI and make it pragmatic and useful in the clinical scenario."

Dr Ben Dixon, an Otolaryngology Head and Neck surgeon at St Vincent's Hospital and Epworth Hospital in Melbourne, is exploring the possibilities of AI through his research on surgeon–computer interface

Professor Antonio Di Ieva

design. He's interested in how AI can assist surgeons as they operate. Dr Dixon argues we should find out where AI is most needed during surgery, rather than developing technology first and finding somewhere to apply it later.

Dr Dixon says that lack of data on how surgeons operate is the biggest barrier to moving forward with technology. "Useful AI requires massive amounts of good data and there's currently no system for unified data collection in Australian hospitals. If the data's not there, the computer isn't going to come up with a solution."

Through his research, Dr Dixon is collecting data on how surgeons perceive and respond to challenges during surgery. Surgeons complete pre- and post-operation questionnaires, and their heart rate and stress responses are monitored during the operation. "We're using the data to work out the right questions to ask surgeons. What do they find difficult? Where should we be injecting technology to reduce workload and improve outcomes?"

Dr Lorwai Tan, the Academic Surgery Manager at RACS, has a background in clinical medical research and is fascinated by the rapidly growing area of data science. She believes the current shortage of data scientists is a big barrier to developing functional AI in the health sector. Data scientists are well paid and in great demand. "It's hard to compete in areas like health, to have a group of data scientists write the code and understand how to approach a multifaceted problem, which should be a collaboration between surgeons, research scientists, data scientists, patients and consumer representatives," she explained.

Her team at RACS is looking for solutions to the scarcity of good data scientists. They've joined forces with DataRobot Inc. to investigate how 'citizen data scientists' – scientists who don't have a PhD in data science, but have a relevant PhD and research background – can be trained on the DataRobot automated platform.

Dr Tan considers investment in AI vital to the future efficiency and productivity of the health industry. "With AI, creating machine learning models from large sets of patient records, with hundreds of thousands of data points, can be completed in days. The same task would take an army of five or six people a couple of weeks.

"The goal is to work in concert with surgeons, who catch the vision," she continued. "That then builds momentum to get more people on board with the possibilities of using AI technology to advance patient care," said Dr Tan.

All three surgeons agree that a healthy dose of scepticism is important in the early stages of AI technology for the health industry. Large volumes of good quality data is key to gaining trust. "I want to have the data to show that things can be done in a safe and ethical way. I'm one of the first to be sceptical, but I'm always trying to fight it by means of hard data," said Professor Di Ieva.

Will AI take over the surgical theatre in 50 years' time? Professor Di Ieva describes this as "overenthusiastic science". The surgeon's unique skill set will be very challenging for software to replicate. However, well-designed AI, backed by vast quantities of relevant data, is ideal for quickly compiling personalised, accurate health information and assisting surgeons in their life-saving work. ■

Dr Ben Dixon

Tackling rural health inequity head on

In Australia and Aotearoa New Zealand, people living in rural, regional and remote areas often have worse health outcomes compared with people living in cities. A lack of rural specialist surgical services and maldistribution of services are significant factors. We need sustainable long-term solutions to this shortage of health services, which is an unfair disadvantage to a substantial portion of our population, many of them vulnerable communities.

The Royal Australasian College of Surgeons (RACS) advocates for all communities to have equitable access to quality healthcare, irrespective of geography. The Rural Health Equity Steering Committee has been formed to tackle this pressing problem. Its aim is to deliver the Rural Health Equity Strategy to increase the surgical workforce and build sustainable surgical services so that everyone can have equitable access to healthcare.

Council approved the Rural Health Equity Strategy in October 2020. COVID-19 has put a damper on any fast-paced action, but it's an exciting time and an empowering step in the right direction.

Associate Professor Kerin Fielding is Chair of the Steering Committee, a member of the Rural Surgery Section, and a RACS Councillor. She's an orthopaedic surgeon and a teacher at Notre Dame University in Wagga Wagga, New South Wales. Associate Professor Fielding's family came off the land in central New South Wales and she was drawn back to it for the quality of life and the diverse professional opportunities.

Dr Bridget Clancy is Vice Chair of the Steering Committee and Chair of the Rural Surgery Section. An ear, nose and throat surgeon based in Warrnambool, Victoria, Dr Clancy spent half her childhood in the country and has a deep connection to rural living.

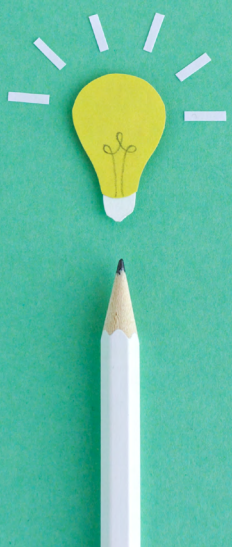
Both surgeons find it unacceptable that rural communities like their own, regardless of particular circumstances, are not protected from poor health outcomes in the same way as city communities. They have stepped up to advocate strongly for change, which starts with more specialist training happening on home turf. "At the moment, specialist training is about 90 per cent in the city, 10 per cent rural," Associate Professor Fielding explained. "I want to flip that, for students to do 70 per cent in a rural area and 30 per cent in the city, so their base is here and this is home," she said.

"People who have connections to rural, or have spent a lot of time training in rural, are the sort of people we want to attract. To take an urban person and expect them to thrive in a rural area without social supports is not a recipe for success. We've got to start selecting the right people early and give them opportunities and experience," says Dr Clancy.

Australia and Aotearoa New Zealand have very different rural challenges. Dr Nicola Hill from Aotearoa New Zealand, a RACS Councillor and member of the Rural Surgery Section Committee, will be convening a workshop in Queenstown in September 2021 to discuss how the strategy can be tailored to meet rural Aotearoa New Zealand needs.

A big part of the current strategy is to support remote central and northern parts of Australia. Implementation will assist Indigenous medical students who may be reluctant to leave Country to undertake training closer to home, thereby contributing to improved health outcomes for Indigenous communities.

The Rural Health Equity Strategy is built around four pillars: Select for Rural, Train for Rural, Retain for Rural, and Collaborate for Rural. The strategy is designed to be tailored to context, flexible on process, and focused on outcomes. Visit the RACS website to read the full plan.



Definitions of rural and remote areas

Australian definition

The Federal Department of Health is moving to use the Modified Monash Model for medical workforce, rather than the Australian Statistical Geography Standard. For now, both models are used.

Rural area, defined by the Australian Statistical Geography Standard – Remoteness Areas (ASGS-RA) 2 to 5

https://www.health.gov.au/health-topics/health-workforce/health-workforce-classifications/rural-remote-and-metropolitan-area

Modified Monash Model, where MM1 is urban and MM7 is remote

https://www.health.gov.au/health-topics/health-workforce/health-workforce-classifications/modified-monash-model

Aotearoa New Zealand definition

The Urban Rural Profile Classification (rural areas with high, moderate, or low urban influence and highly rural/remote areas)

https://www.stats.govt.nz/assets/Uploads/Methods/Urban-accessibility-methodology-and-classification/Download-document/Urban-accessibility-methodology-and-classification.pdf

Dr Bridget Clancy

The **Select for Rural** pillar focuses on ensuring that specialist training does not hinder selection of applicants from rural origin, which has unintended consequences for rural people. Rural work experience is highly valued in the selection criteria and selection interviews can be accessible online.

The **Train for Rural** pillar requires that all Trainees have rural work exposure and that Surgical Education and Training (SET) posts are distributed according to community need for surgical care. This pillar suggests a separate accreditation criteria to reflect the unique nature of rural training posts, and rural-facing curricula to demonstrate the need for a broad surgical skill set. The establishment of a Global, Remote/Rural/Regional and Deployable (GRiD) Surgery faculty would allow for dual Fellowship concurrently with another specialty. See the RACS website for a full list of Train for Rural actions.

The **Retain for Rural** pillar oversees ongoing educational, professional and personal support for rural surgeons, ensuring that individuals and surgical teams want to stay in their rural posts. Actions include advocacy for financially sustainable salary models, support for Specialist International Medical Graduates (SIMGs), and advocacy for infrastructure and funding for rural surgical services.

The **Collaborate for Rural** pillar focuses on providing access to safe surgery as close to home as possible. Actions include development of a RACS National Surgical Systems framework, a Remote Central and Northern Australia Surgical Services Strategy, and an Aotearoa New Zealand Provincial and Rural Surgical System Strategy.

For the Rural Health Equity Strategy, the immediate challenges will be keeping momentum, engaging more stakeholders, and harnessing the full attention of the Federal government and its funding.

The biggest achievement at this early stage has been gaining Council approval and agreement that rural health equity is a top priority flagship initiative. Another crucial achievement has been securing support from specialty training boards and valuable stakeholders. There have already been very productive, collaborative workshops and meetings. Importantly, health professionals who are well-connected at the Australian Federal level have joined the Committee, which will help ensure our strategy is aligned with Federal initiatives. Professor Ruth Stewart, the Australian National Rural Health Commissioner, and Professor Alan Sandford AM, President of the Royal Australasian College of Medical Administrators, are both on board.

The next 12 months will be a steep climb. The Steering Committee will tackle accreditation, which must be tweaked to fit the differing needs of rural training sites. Accreditation standards must be reviewed and then implemented, a process that can take up to 18 months.

What does success of the Rural Health Equity Strategy look like? Full implementation would take 10 years. The ultimate goal would be rural training sites in Orthopaedics and General Surgery in cities of 30,000 people or more, like Darwin, Townsville, Alice Springs and Cairns.

Rural training hubs would train other specialties (such as Otolaryngology (ear nose and throat), Plastic and Reconstructive, Urology and Vascular). In future, it's hoped that analysis of specific case loads will determine how many Trainees a site can have (rather than the number of Fellows). Rural orthopaedic and general surgeons would have close connections to

Associate Professor Kerin Fielding

18% of urban specialists provide intermittent rural outreach services

specialists in the city when needed (for example, Cardiothoracic, Paediatrics or Neurosurgical), and as many other specialties as possible would be trained rurally.

Interactive hybrid models of online training and remote supervision would allow Trainees to learn from rural sites. In 10 years' time, remote operative supervision may even be conceivable. A rural surgeon and a robot could be helped by a specialist in the city.

Sustainable solutions to rural health inequity are long overdue in well-resourced countries such as Australia and Aotearoa New Zealand. "We may not be able to achieve everything in the strategy, but it's time to get serious and talk about the health of our Australian and New Zealand populations," said Associate Professor Fielding.

"The Australian Medical Council gives us approval to train surgeons for excellence and community need, but there can be no excellence if 30 per cent of the population aren't getting access to surgical care or are getting delayed access and poor outcomes. There's no excellence unless we're focused on community need," said Dr Clancy.

The RACS Rural Health Equity Strategy has been approved for action and is well underway, setting up solid foundations for a training pathway that will keep surgeons in rural areas, connect rural and urban surgeons, enable junior doctors to specialise from their rural sites, and result in enough rural specialists to meet the healthcare needs of their local communities.

To learn more about the Rural Health Equity Strategy go to surgeons.org/News/News/Rural-Health-Equity-Strategic-Action-Plan. If you'd like to get involved please email rural@surgeons.org ■

RACS ASC 2022

RACS 90TH ANNUAL SCIENTIFIC CONGRESS

Sustainability in the Dispersed Workplace

Monday 2 May to Friday 6 May 2022

Brisbane Convention & Exhibition Centre
Brisbane, Queensland, Australia

Royal Australasian College of Surgeons

asc.surgeons.org #RACS22

RACS ASC 2022 – Sustainability in the Dispersed Workplace

I am pleased to announce that plans for the Royal Australasian College of Surgeons (RACS) Annual Scientific Congress (ASC) 2022 in Brisbane are progressing well. The theme is 'Sustainability in the Dispersed Workplace', which provides a broad platform of many great areas to explore. You'll hear more in the coming months from the Executive, led by Professor Chris Pyke as Convener, ably assisted by Professor Deborah Bailey, Scientific Convener, Dr Heidi Peverill, Dr Jennifer Ah Toy and Dr Chris Allan.

With half of all Australians currently locked down, the reality of COVID-19 is front of mind once more, and with the pace of our vaccine rollout it is very likely that we are looking at a hybrid congress for next May. International borders are unlikely to be open, although hopefully our bubble with Aotearoa New Zealand will be active once again. We all know there were some technical challenges with RACS ASC 2021, and we are working hard to improve the digital platform for 2022. The content however, was excellent, and the opportunity to engage a wide range of international speakers to present virtually is being taken by our section conveners for Brisbane. We are, of course, also looking at the range of outstanding local talent within the state, and within Australia and Aotearoa New Zealand.

The program is shaping up well, and we are on track to have the provisional program to you by October. We have an outline of the plenary sessions, and while we are still waiting for some speakers to confirm, we have Dr Bridget Clancy delivering the *Australia and New Zealand Journal of Surgery* lecture. Bridget is spearheading the RACS regional and rural initiative and will join Friday's plenary, entitled 'The Dispersed Workplace – Lessons from the Extremes'. Also speaking will be Dr McLee Matthew, known to many in Melbourne from his time training at the Royal Children's Hospital Melbourne. We are very pleased to welcome McLee as the visitor for Paediatric Surgery, and look forward to hearing about his experience in Papua New Guinea, among other topics.

It seems like I'm working backwards, so Thursday's plenary is titled 'Sustainable Cultural Safety' and will give us the opportunity to contemplate the new RACS 10th competency. Wednesday's plenary is around 'Sustainability as an Everyday Event' and Heidi will update us on this soon.

We very much hope our president, Dr Sally Langley will join us to open RACS ASC 2022 on Tuesday morning. Her address will be followed by the plenary on 'Sustainability in Education'. We have confirmed presentations by Graham Beaumont , who will speak on the topic of 'Sustaining proficiency: the journey' and Professor Johannes Fagan of the Colleges of Medicine of South Africa, who will speak on the topic 'Delivering and modernising specialist examinations through COVID-19'. As we know, the Fellowship Exam process was challenging for the last 18 months; hopefully Professor Fagan will provide us with some insights.

Keep an eye out on the website, and don't forget to check the socials, as our Communications team, led by Abderazzaq Noor, will be updating us regularly.

I'm looking forward to seeing as many of you as possible in Brisbane. ■

Dr Liz McLeod FRACS

RACS ASC Coordinator

Advocacy at RACS

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

We regularly advocate for these positions across a number of different mediums, including the media, public campaigns, or by direct negotiating or the provision of written submissions to both Government and non-Government agencies.

Over the last few months some of the advocacy work the College has undertaken included:

Smokefree Aotearoa 2025 Action Plan
RACS Aotearoa New Zealand National Committee (AoNZNC) recently made a submission to the New Zealand Ministry of Health's Proposals for a Smokefree Aotearoa 2025 Action Plan. Smoking is a leading cause of preventable disease and death in Aotearoa New Zealand and it continues to have a significant impact on Māori and Pasifika health inequities. The AoNZNC generally supports the proposals put forward, which are designed to eliminate the smoking of tobacco products in Aotearoa New Zealand within the next five years.

ACCC consultation on Honeysuckle and nib
Honeysuckle Health Pty Ltd (HH) and nib Health Funds Ltd have sought authorisation from the Australian Competition and Consumer Commission (ACCC) for HH and nib to form and operate a buying group. The intent is that the buying group will collectively negotiate and administer contracts with healthcare providers (including hospitals, medical specialists, general practitioners and allied health professionals) on behalf of participants for a period of 10 years. The College sent in an initial submission to the ACCC on 11 March 2011.

Following the initial consultation process, the ACCC issued a draft determination proposing to grant authorisation, with a condition, for five years. Interested parties were invited to make a submission on the draft determination, to which RACS responded on 14 June 2021. The College also published a media release on 28 June highlighting our concerns with the draft determination.

A pre-decision conference was held on 8 July 2021. At this conference, RACS expressed concerns for managed care and the dominance of the private health insurer buying group seizing a sizable market share with the potential for anti-competitive cartel behaviour. A third submission is currently being prepared to further emphasise these points.

Australian MBS Review Taskforce Report and the 21 recommendations
In previous issues of *Surgical News* we have provided updates on the work of Medicate Benefits Schedule Review Taskforce. At the end of 2020 the Taskforce provided a final report, which detailed 21 recommendations.

RACS broadly supports the recommendations. A submission has been completed and sent. Some key points include advocating for out-of-pocket transparency, more funding for health registries, establishment of a continuous review mechanism, and urging caution in response to the proposed establishment of a Medical Fee Complaints Tribunal.

First meeting of the Health Policy and Advocacy Committee
On 7 July, RACS' new Health Policy and Advocacy Committee (HPAC) held their inaugural meeting.

In addition to the HPAC members, the first meeting was attended by RACS President, Dr Sally Langley. Attendees discussed the role of HPAC, and it was agreed that the committee will help determine advocacy priorities for the College and oversee the development of strategies in relation to these priorities.

HPAC will assist with day-to-day policy activities, such as the development of submissions, preparations for hearings, and responses to policy queries. HPAC will make recommendations to the Professional Standards & Advocacy Committee (PSAC), the Vice President, the President and Council.

The Committee is chaired by Professor Mark Frydenberg and the remaining members will be finalised in the coming weeks. We will continue to keep you updated on the composition and activities of HPAC in future issues of *Surgical News*. ■

Want to know more about RACS Advocacy?
Every four to six weeks RACS distributes an *Advocacy in Brief* newsletter, which includes detailed updates on recent RACS submissions from Australia and Aotearoa New Zealand, active consultations and engagement opportunities, and various other items of interest.

If you would like to be added to the distribution list for future issues, please email the RACS Policy and Advocacy Team at RACS.Advocacy@surgeons.org

All submissions are available to read in the Advocacy section of the RACS website.

Changing energy mix vital for the health sector

The environmental impacts of one doctor at work is far greater than the impact we have in our home lives. The average 300-bed hospital, for example, uses the equivalent of 5000 households' worth of gas and electricity, not to mention all the waste we create from the resources that we use.

About one-quarter of the healthcare industry's emissions stem from direct energy use, while the carbon emissions generated per kilowatt hour vary across our two countries. In New Zealand, Tasmania and the Australian Capital Territory (ACT) carbon emissions tends to be very low (between 0.1 and 0.2 kg of carbon dioxide emitted per kilowatt hour). This is because the energy grids in these jurisdictions have a higher concentration of renewable sources such as wind, hydro and solar power.

At the other end of the scale, the emissions generated in Victoria are highly reliant on brown coal. Although the energy mix is slowly changing, at present each kilowatt hour emits approximately one kilogram of carbon.

I am often asked whether single-use or reusable instruments are better for the environment. This can be difficult to answer as it really does depend on where you are, and what item you plan to use. What I can say for certain, though, is that there are some things that are always more efficient to reuse regardless of your location. Cotton textiles, such as disposable theatre gowns, are one such example.

To provide a simple analogy, every time you wear a disposable gown in the ACT, New Zealand or Tasmania, it is the equivalent of burning the same amount of fuel as if you drove an extra 30 kilometres on your next car trip. Even with Victoria's energy mix, you are still driving an additional 10 kilometres every time you put on a gown. It might not seem like much, but over the course of a week this could equate to the equivalent of driving hundreds or even thousands of extra kilometres. As for other reusable items, if you are in the ACT, Tasmania or New Zealand, you should almost always look to reuse items. This is also largely the case in South Australia, which is not far behind in its emission of carbon dioxide.

The biggest development in this area is Victoria's commitment to source 100 per cent renewable electricity for all government operations, including all Victorian public hospitals, from 2025. This is a national first and promises to be a game-changer. The sooner private hospitals and other jurisdictions adopt this model, particularly other larger emitters like New South Wales and Queensland, the sooner we can achieve zero emissions in our sector.

In the meantime, there are practical things that surgeons can do to be more sustainable, which are largely guided by the five Rs: Reduce, Reuse, Recycle, Rethink, Research.

- Look for simple changes. In my own hospital we found that the steam sterilisers in operating theatres used just as much energy when they were being used as they did when they were idle. By using them more efficiently we achieved a large cost saving, and we were able to save the equivalent of 10 houses' worth of electricity and water use for every single day across the course of five years.
- Support and engage in research and collaboration. This is particularly relevant in the areas of procurement and life cycle assessments of the various resources that we use.
- Advocacy and policy are incredibly important. Clinicians can not only make a difference in their own hospitals by championing green initiatives, but collectively they can influence Government policy. For example, the ACT and South Australian Governments have announced that their newest hospital builds will be entirely electric rather than relying on gas infrastructure.
- Choose wisely. Low value and unnecessary surgeries can be futile, and they add to our carbon footprint. Conversely, delaying necessary elective surgery, which then leads to emergency surgery, is not only a terrible outcome for the patient, but the increased resources required significantly adds to the carbon footprint of their care.
- Recycle. It really does make a difference.

A surgeon has agency. They can activate, animate, energise, inspire, instigate, launch and move. Remember, renewables make reusables better so stop using single use (i.e. having renewable electricity shifts the environmental benefits of reusable equipment, gowns, etc. dramatically). We all create a lot of waste but if we get behind the principles of the five Rs, together we can do better. ■

Associate Professor Forbes McGain

Anaesthetist and Intensive Care Physician, Western Health, Melbourne

NAIDOC Week 2021

On behalf of the members of the Royal Australasian College of Surgeons (RACS) Indigenous Health Committee and Mina (Aboriginal and Torres Strait Islander Advisory Group), the Indigenous Health Committee extends a warm acknowledgment to all traditional owners and custodians of the lands in which we reside and pays deep respect to elders, past, present and emerging, and celebrates their continuous connection to land, water, culture, community and family.

We also acknowledge all the Ngangkari of Australia and the continuing and important role they perform in cultural healing and medical practices.

As we are all aware, the health inequalities between First Australians and the broader community are stark. It is RACS' position that no difference between the life expectancy of First Australians and non-Indigenous Australians should exist. It is poignant then that the theme for NAIDOC week 2021 is 'Heal Country, heal our nation'.

The NAIDOC Committee has said of the 2021 theme, "Healing Country means embracing First Nations' cultural knowledge and understanding of Country as part of Australia's national heritage. That the culture and values of Aboriginal peoples and Torres Strait Islanders are respected equally to the cultures and values of all Australians".

For several years RACS has been working towards turning its commitment to Indigenous health into action. In recent years we have seen the ratification of the Cultural Competency and Cultural Safety (10th competency) in the Surgical Competence and Performance standards; the introduction of the Aboriginal and Torres Strait Islander cultural eLearning course and the consolidation of recruitment initiatives into the Aboriginal and Torres Strait Islander – Indigenous Surgical Pathway Program (ISPP).

Adding to this body of work, the RACS Reconciliation Working Group has put together a NAIDOC 2021 virtual program designed to assist Fellows and RACS administration staff develop a deeper knowledge and appreciation of First Australians' connection to country, and the important role acknowledgment of culture and values has in contributing to the health and wellbeing of the nation.

We invite you to walk with us on this journey. ■

Dr Maxine Ronald FRACS

Chair, RACS Indigenous Health Committee

RACS launches program to increase number of Indigenous surgeons

The Royal Australasian College of Surgeons (RACS) is proud to launch its Indigenous Surgical Pathway Program Australia to try and increase the number of Aboriginal and Torres Strait Islander surgeons in the medical workforce.

The program aims to reduce the professional health workforce inequity faced by Aboriginal and Torres Strait Islander people in Australia.

While there are more than 83,000 doctors registered to practice in Australia, fewer than 400 are Indigenous. This is despite more than 760,000 people in Australia identifying as Aboriginal or Torres Strait Islander.

"In Australia and New Zealand we have a severe shortage of Indigenous surgeons and we need to do everything we can to change this disproportionate under-representation," said Dr Sally Langley, RACS President.

"The College is committed to addressing this health discrepancy. The program will support this by encouraging and actively recruiting medical students and recent graduates into surgery."

The program will facilitate a comprehensive strategy to prepare and engage Indigenous doctors into specialist training. An increase in the number of Indigenous entrants to the Surgical Education and Training (SET) program would be a great indicator of success.

Professor Kelvin Kong, first Indigenous surgeon in Australia, was encouraged to become a tradie by a careers counsellor at secondary school.

"But everything changed for me when I heard two Aboriginal medical students speak at careers day," said Professor Kong. "I knew I wanted to pursue medicine and serve my community."

With the ISPP in place, there is a firm structure for continuous investigation of support strategies for Aboriginal and Torres Strait Islander surgical Trainees.

"When it comes to ensuring access to surgical care for Aboriginal and Torres Strait Islander people, we must consider that Indigenous people are much more likely to get and follow medical advice and treatment if there are more Indigenous people represented in the medical workforce," said Professor Kong.

"When I treated my first Aboriginal patient who was an Elder, the woman started to cry after I had taken an extensive history. I will always remember what she said, 'I never thought I would live to be treated by an Aboriginal doctor'.

"That cemented in my mind the professional inequity that is rampant in medicine. To have someone understand the trauma she'd been through in her life was huge."

The program is ongoing and will seek to target students at early stages of their education to highlight to them that medicine and surgery are viable career options for them. To learn more about the ISPP contact the team at indigenoushealth@surgeons.org ■

Reaching parity

There are currently more than **8000** active RACS Fellows, Trainees and Specialist International Medical Graduates (SIMG). This translates to roughly **3500** patients per surgeon in Australia.

If applying the same 'population per surgeon' formula to Indigenous people, we should have **219** Indigenous surgeons. Currently, we have **three**.

This demographic breakdown highlights the work we have do for the Indigenous community to reach parity with non-Indigenous Australians.

Royal Australasian College of Surgeons

RP Jepson Medal & Justin Miller Prize

Friday 22 October 2021

from 2pm

All welcome

Complimentary event

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Royal Australasian College of Surgeons

RACS travel scholarship opens door for South Australian surgeon

Dr Yu Chao Lee decided to move from Malaysia to Adelaide to pursue a degree in medicine based on his good secondary school results and because "as South-East Asians there are only three careers our parents dream of for us – doctors, lawyers, and engineers."

Dr Lee graduated from the University of Adelaide and obtained his specialist qualification in Orthopaedic Surgery from the Royal Australasian College of Surgeons (RACS). He specialises in minimally invasive spinal surgery and uses muscle sparing techniques for treating adult degenerative spinal disease and spinal deformity.

It was in his fourth year of medical school, during orthopaedic and trauma rotation that Dr Lee decided Orthopaedics was his calling. "I was fortunate to have registrars and consultants who were great teachers and allowed me to insert screws and perform ankle and hip fixations," Dr Lee said. Seeing patients gain a meaningful life post-surgery stimulated his interest in Orthopaedics. His early research was on posterior hip anatomy, and the prevention of hip dislocation following total hip replacement. His research added to perspectives on how to guide rehabilitation.

After his surgical training, Dr Lee completed a sub-specialist Fellowship training in the area of adult and paediatric spine in Adelaide.

In late 2018, Dr Lee won a spinal scholarship to the Royal National Orthopaedic Hospital in London. "I explored various funding options to supplement my Fellowship remuneration as they are not as well funded as Australian fellowships," Dr Lee said. "I came across the RACS Margorie Hooper Travel Scholarship, which I am so grateful for. It is specifically for South Australians looking at post-graduate training, which will benefit the local community."

The scholarship gave Dr Lee the opportunity to work at the largest spinal deformity unit in Europe. The Royal National Orthopaedic Hospital is recognised globally for its quality of service to patients suffering from spinal deformity and tumours. The hospital has 10 consultants, supported by three Fellows, registrars, specialist radiologists, nurses and pathologists. It has an annual operative volume of 1200 cases – many times more than any centre in Australia.

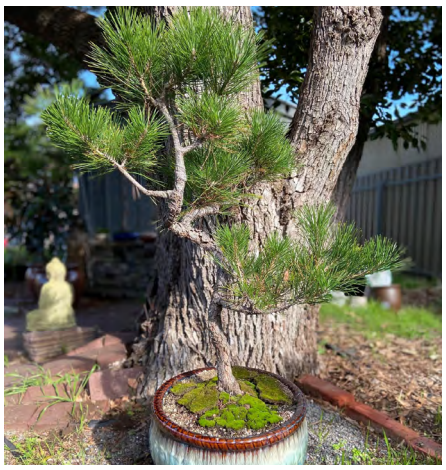
"As a Fellow, I operated on adult patients who had degenerative deformity, complex revision cases, paediatric scoliosis, primary sarcoma of the spine and metastatic cord compression," Dr Lee said.

> "Working in a high-volume hospital with a mix of cases helped my surgical skills and improved my decision-making during operations."

" More importantly, I learnt when not to operate, and improved my skill set when dealing with complex spinal surgeries," Dr Lee said.

In London, Dr Lee used the intraoperative cone-beam CT, which "allows you to navigate instrumentation and implants on a patient. This provides better understanding of anatomy and improves screw accuracy during surgery, compared to free-hand technique."

As well as spinal navigation, Dr Lee learnt the anterior reconstructive spine approach using minimally invasive techniques. This allows him to better address spinal deformities in the sagittal plane, improve fusion rates and prevent adjacent segment



degeneration, reducing chances of further surgery in the future. "Due to my high-volume practice in London, I am very comfortable using these technologies in Australia, including trouble shooting," Dr Lee said.

Adult spinal deformity and spinal tumours affect a significant proportion of the elderly population. "My fellowship at the Royal National Orthopaedic Hospital has provided me with invaluable lifelong experience that I have now incorporated into my clinical practice. I offer my patients minimally invasive surgeries for degenerative cases, adult deformity cases, tumours, and spinal trauma."

Dr Lee is a consultant at the Royal Adelaide Hospital where he shares his knowledge with registrars and Fellows, equipping the next generation of surgeons with the latest surgical techniques.

When not operating, Dr Lee spends time with his young family and grows bonsai (pictured above and below) – a hobby he cultivated when he returned from London. "I love being able to shape any tree, big or small, into a bonsai and see them thrive." ■

Making flexible surgical training accessible for everyone

Dr Marnique Basto, a Urology Trainee, is a firm believer in making flexible surgical training an option for all Trainees. To better understand how more Trainees can be encouraged and empowered to take up flexible training, Dr Basto analysed models of past and present flexible positions. Dr Basto presented her findings at the Royal Australasian College of Surgeons Annual Scientific Congress 2021 and shares highlights of her findings and her personal experience with flexible training.

Flexible training is essential to prevent surgical Trainees from leaving their positions and to encourage diversity in the surgical workforce.

Having personally benefited from flexible training, I was keen to understand why more than 30 per cent of Trainees have expressed interest in flexible training, yet less than one per cent are currently in flexible training roles. If we don't bridge this gap, we risk losing talented surgeons, including a disproportionate number of women.

I analysed the number of flexible training positions over a seven-year period by specialty. General Surgery Trainees made up 62 per cent of all flexible positions. Pleasingly, there was an almost 50 per cent increase in flexible positions from 2018 to 2019, so we are heading in the right direction. Unfortunately, in this timeframe there were several specialties yet to offer part-time (job share or stand-alone) positions to their Trainees, for example, Cardiothoracic Surgery, Neurosurgery and Vascular Surgery.

I spoke to 17 Trainees with experience in flexible training positions and found that many of them agreed that having a flexible training position allowed them to manage other life commitments and helped them from remain in the profession.

If flexible training had not been an option, almost one-quarter of Trainees I surveyed would have withdrawn their training, and another quarter interrupted their training. I suspect some of the Trainees who interrupted or returned in a full-time capacity may not have continued, so this may be an underestimate.

Dr Caroline Dowling (left) and Dr Marnique Basto (seated) in theatre.

Coming into surgical training at the age of 30, I was aware that I was going to devote my child-rearing years to my surgical training. During a period of extended maternity leave I had two children, supported my husband's overseas surgical Fellowship and completed my research doctorate. While living in New York during my husband's Paediatric Cardiac Surgery Fellowship, my son was born with a life-threatening congenital heart condition and required open heart surgery at birth.

With the barriers to return to training mounting, I was very fortunate to have the support of the Urology training board. Dr Robert Forsyth, a Urologist in Ballarat, was the Victorian Chair of Training and Education at the time. I vividly recall standing on my balcony in New York and Dr Forsyth saying, "We haven't formally done part-time training before, but there's no reason you can't be the first person". There was a part of me that felt I needed to prove I could come back in a full-time capacity but, in all honesty, I would have been setting myself up to fail.

As I understand it, the Urology training board reached out to all the hospitals with accredited Trainees to assess units that could accommodate a flexible Trainee.

I suspect this was the opportunity Dr Caroline Dowling had been waiting for to progress the conversation of flexible training. As just the second female Director of Urology in Australia, Dr Dowling knew this struggle all too well. Dr Dowling had her first of four children during her own Urology training when flexibility was much less accepted.

I was fortunate that Dr Dowling set up the first stand-alone part-time training position in Urology for me. I worked three consecutive days a week and was an additional role to the unit. I was allocated to three operating lists, two outpatient clinics and an administration morning, as well as a multidisciplinary cancer meeting, radiology meeting and teaching time. This certainly gave me the breadth of exposure I needed. The on-call was one-in-four and assessments were performed quarterly, the same as for other registrars.

This position at Eastern Health allowed me to successfully transition back into the workforce from maternity leave and find the balance between surgery and family. The following year I undertook another flexible position at Royal North Shore Hospital. The New South Wales Training and Education Chair and urologist at Royal North Shore Hospital, Dr Michael Wines, was pivotal in setting up this second Urology flexible training position.

Dr Marnique Basto and Dr Matthew Liava'a with their children

This was a job-sharing position between two Trainees of a similar level where the week was split. One trainee worked three days (Monday to Thursday midday, no weekends) and the other worked two days (Thursday to Friday, alternative weekends). This roster rotated every three months. We had Thursday morning as an overlap where we would do the ward rounds together to hand over, and the team benefited from having an additional person in the clinic. The unit was extremely satisfied with our continuity of care.

I feel these two years in flexible training positions have given me a greater breadth of surgical exposure than one full-time year in training. Unfortunately, there are still some old-fashioned views out there that this is a 'lesser' form of training. In my research, more than half the Trainees with experience in flexible training positions faced negative perceptions from colleagues and superiors, including bullying and discrimination. This is on par with a study in the United Kingdom that showed 52 per cent of respondents experienced negative encounters.[1]

Interestingly, negative comments came from consultants, fellow registrars and administrative staff. One Trainee, returning from a period of serious illness, was faced with their Fellow saying, "Part-time surgical registrars, is that a thing now?" There is still a huge lack of awareness about the benefits of flexible training and we have a lot of work to do. It is important these flexible positions are well mentored within a supportive unit to ensure their success.

Of the Trainees surveyed, more than 90 per cent were female and raising children was their main reason for requesting flexible training. As the number of female Trainees in surgical training approaches 30 per cent, flexibility is now essential to prevent our Trainees from leaving the profession. However, it is important that flexibility is provided for a variety of reasons, including for men in our surgical workforce who care for children and family, and for individual health and mental health reasons. All reasons for requesting flexible training should be considered valid and equal.

Of the Trainees surveyed, over three-quarters felt satisfied with their progress in operative skills and knowledge. Flexible training allowed Trainees to successfully manage their other life commitments. You can raise a family, pursue wider interests and expand your life experience while you do your training. This allows us to bring a myriad of skills and experiences to our role and further strengthens patient care.

Life does not have to stop for surgical training. I'm proud of the Royal Australasian College of Surgeons and the work they have done to start the conversation about flexible training.

We now need more heads of unit to champion these roles at the hospital level, and administrators willing to see the benefits and share in the conversation. Research in other fields shows that there are advantages in terms of team morale, productivity, and staff wellbeing. We have now shown that these benefits extend into surgical training. ■

Dr Marnique Basto BBMSc MBBS DMSc
Urology Trainee

Acknowledgements: Thank you to co-authors Dr Christine Lai FRACS, Dr Carolyn Vasey FRACS, Professor Shomik Sengupta FRACS, Professor Debra Nestel PhD FSSH, Dr Caroline Dowling FRACS. Also, thank you to the Royal Australasian College of Surgeons for assisting with collating the data on the numbers of flexible training positions by specialty.

For resources about how to set up a flexible training position at your hospital: surgeons.org/Trainees/the-set-program/flexible-training

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Reflection on Australia's Plastic Surgery community

Keith Bryant has been the CEO of the Australian Society of Plastic Surgeons since November 2015, managing a small team that supports the 500 plastic and reconstructive surgeons working in Australia. Keith has worked in non-profit management and governance for more than 20 years. His previous career was in investment banking.

At points of change in our professional lives it is always useful to reflect. Not just on our personal journeys but on the journeys of the institutions that make up our working lives. As the Australian Society of Plastic Surgeons (ASPS) passes its 50th year, I consider myself fortunate to have been its CEO for the past six years.

To my mind, the most significant change in that six-year period has been the way the Society engages with the College. I recall a time when frustrations abounded in this relationship and opportunities for improvement seemed wildly naive.

Today I can report a significant change. We respect one another, we listen to one another, we have come to appreciate the power of collaborating with one another.

The secretariats of the specialty societies have played an important role in this change. Though they are often small offices with small staff numbers, professional management has taken root. Our governing bodies have seen the value in this professional management, recognising that it is different and yet complementary to the experience of surgeons.

I have been fortunate in having Councillors at ASPS who have been open to new ways of doing things. As you might expect, through various iterations and check-ins on our strategic plan we have consistently addressed the need to deliver better member services.

We have also recognised the important role the ASPS plays in maintaining and enhancing the identity of our specialty in the community. The Society has been honest enough to recognise that plastic surgeons, as a craft group, are easily misunderstood. The Society recognised that we had to address what we stood for, how we saw ourselves, and how we wanted to present ourselves to the communities that we worked in.

The foundation for this work has been articulating and implementing an ethical framework of principles and values that define and drive us both as a specialty organisation and as individual surgeons. Over the past five years we have carefully implemented this framework and been delighted with how our members have supported and engaged with it. Always reverting to the ethical 'high ground' has been a phrase that has resonated with the ASPS Council and our membership.

The work on identity and ethics has led to other important changes in the Society's activities. We have reinvigorated our commitment to research, where Australian and New Zealand plastic surgery has historically had an outstanding international reputation. And we have reviewed how we approach public advocacy – not only on behalf of individual members but with a keen eye to what is in the best interests of the health system and how to best deliver patient care and safety.

The success of our advocacy efforts based on this mantra has surprised us. It has shown us how much the system wants to reach out to thoughtful agencies that start from that truly professional vision of working for a better health system.

There is still much to do. It is clear to us that the RACS family working as a surgical community can be much more effective in its advocacy for a better health system. The ASPS hopes to play its part in contributing and collaborating to achieve that. Most importantly, surgeons need to resist the temptation to fragment their efforts and identify only their differences. This makes us all poorer and less influential.

My experience with Australia's Plastic Surgery community underlines how intelligent and committed surgeons are and what an important contribution their representative agencies (the specialty societies and RACS) can make to leveraging that considerable intelligence and hard work for the greater good. ■

Keith Bryant
Outgoing CEO, Australian Society of Plastic Surgeons

Surgeons mark CrazySocks4Docs Day

Surgeons marked CrazySocks4Doc Day in June by wearing their loudest, zaniest socks, sharing photos on social media with the hashtag #CrazySocks4Docs, and starting important conversations about doctors' wellbeing with colleagues. In preparation for the day, RACS had a crazy sock giveaway at the recent Annual Scientific Congress in Melbourne and in hubs across Australia and Aotearoa New Zealand.

CrazySocks4Docs Day was founded by Dr Geoff Toogood, a Melbourne cardiologist with experience of both depression and anxiety who has faced discrimination at many levels. He was determined that, once recovered, he would create an awareness movement to break down the stigma faced by health professionals and to reduce doctors' suicide around the world.

CrazySocks4Docs Day has grown significantly over the past few years and is celebrated internationally.

Surgeons shared their colourful socks and messages on social media. Dr Mary Langcake, Trauma surgeon, thanked a colleague for her coffee themed socks, tweeting "We are all vulnerable at times in life. It's hard to reach out but please know if you are falling, we will catch you."

Dr Sharon Jay, a General Surgery Trainee from Aotearoa New Zealand, posted "Happy CrazySocks4Docs Day everyone! Let's start the conversation about doctors' mental health. Thanks @RACSSurgeons for the super cool socks!"

Mr Jason Chuen, a Vascular Surgeon from Victoria, showcased a week of crazy socks on his Twitter account.

Meanwhile Dr Rhea Liang tweeted, "A big vote of thanks to @gdtoogood for founding #CrazySocks4Docs Day and his immense effort every year to keep the spotlight on #mental health for doctors – and not just on the day."

The 2021 CrazySocks4Docs Day was launched with a virtual panel, opened by the Hon. Julia Gillard AC, Chair of Beyond Blue. Panellists included Indrani Tharmanason and Graeme Port, parents of junior doctor Tasha Port, who died of depression in June 2020.

Indrani Tharmanason shared that Tasha had suffered from depression for many years while still continuing to achieve high results. "With her smile and laughter, very few people realised the challenge she faced," Indrani said. "Medicine was her love, but the work demands of the job, the isolation interstate, the stigma associated with mental health within the medical profession leading her to keep silent, all contributed to a deepening of her depression and loss of self-worth. Tasha's suicide came as a complete shock to us, our family and to those she was working with."

We all have a role in supporting doctors' wellbeing as colleagues, leaders and decision makers.

The RACS Wellbeing Working Group is currently undertaking a review of initiatives that support the wellbeing of Trainees, Specialist International Medical Graduates and Fellows. ■

Need to talk?

The **RACS Support Program** delivered by Converge International offers confidential counselling to you and your immediate family. The service offers up to four free sessions a year and provides confidential support and counselling for any work or personal issues. Call 24/7 (AU) 1300 687 327 or (AoNZ) 0800 666 367.

Other options include the Australasian Doctors Health Network, Drs4Drs at drs4drs.com.au/, or calling Lifeline (AU) 13 11 14 (AoNZ) 0800 54 33 54, 24 hours a day, seven days a week.

Visit the CrazySocks4Docs and RACS Surgeons Wellbeing webpages for more information.

Surgical snips

Some highlights from recent *ANZ Journal of Surgery* articles

Hepato-pancreato-biliary and transplant surgery experience among Aotearoa New Zealand General Surgery Trainees
Subspecialty surgery experience during general surgery training in Australasia is influenced by many factors, including duration of training, training location and the introduction of post-Fellowship training programs.

Experience in hepato-pancreato-biliary and transplant surgery is part of the General Surgery curriculum, although Trainee experience in these subspecialties has not been quantified in Aotearoa New Zealand.

Read more here: https://bit.ly/2UFAAOp

Narrative review of the epidemiology/biology of basal cell carcinoma: a need for public health consensus
Basal cell carcinoma is the most common skin malignancy afflicting modern Australian society.

The most influential response has been through public health primary prevention campaigns which have persevered since the 1980s. These campaigns are widely heralded a success but clinical data quantifying these benefits are limited.

Read more here: https://bit.ly/3zU1odH

Leadership and surgical training part 1: preparing to lead the way?
Leadership skills are increasingly important for surgeons, who need knowledge of organisational structure and policy, management strategy and team dynamics to deliver and improve health care in resource-constrained environments.

Learn more here: https://bit.ly/3y4Sp7Z

ANZ Journal of Surgery: Making the shift from print to digital publishing in 2022

The Council of the Royal Australasian College of Surgeons recently made the decision to move the *ANZ Journal of Surgery* to a digital-only publication format from 2022. This is consistent with the College's long-term environmental sustainability strategy. The Journal is published 10 times a year, with an extra supplement in May, which contains all the abstracts of research presentations delivered at the Annual Scientific Congress. Going digital will save the printing of 16 million pages and the shipping of 85,000 copies, each wrapped in a plastic bag, from the printers in Singapore.

Most readers already access the Journal's content online. Only four copies of the Journal are printed for readers other than College Fellows, Trainees and Specialist International Medical Graduates (SIMGs). With over 360,000 article downloads annually, readership of the online publication is already well established and the online Journal, both in HTML and PDF formats, is undergoing constant refinement and improvement on the Wiley Online Library platform. Multiple sharing options make it easy for Fellows, Trainees and SIMGs to share articles with colleagues and researchers, even if they do not have subscription access. Simple access and electronically delivered table of contents (eTOC) alerts ensure that updates will not be missed.

A wholly digital publication will mean the Journal becomes more agile. Article publication will become more efficient such that surgical research will be published more quickly, read faster on any device and have a potential impact on practice sooner. Video clips, photo galleries and sound bites, previously impossible in the print version, can easily be included. The overall cost of publishing and distributing each issue will be significantly reduced and the number of actual pages will increase. A digital Journal will allow more streamlined submission, proofing and publication systems, a process of continuous rather than per issue publication, integration with pre-print services and authoring tools and many other future improvements.

Further details regarding the logistics of the digital transition will continue to be communicated to all College stakeholders and well in advance of the 2022 commencement. ■

Professor Julian A. Smith, MBMS, MSurgEd, FRACS
Editor-in-Chief
Department of Surgery, Monash University, Victoria, Australia

Dr Lawrence P. Malisano, MBBS, FAOrthA, FRACS, FAICD
Vice-President
Royal Australasian College of Surgeons

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.

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.

Surgeons can contact QASM to discuss topics they would like to share with their peers or are interested in learning about.

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.

  This webinar can be viewed at: https://www.youtube.com/watch?v=HKtBDyRkuro

- Webinar two (completed)
  Thursday 29th July 5 pm (AEST)
  Dr Stephen Allison – Continuity of care

  Dr Allison presented on the importance of hand-over and the continuity of care for admitted patients.

  This webinar can be viewed at: https://www.youtube.com/watch?v=1nrA4J1dZxw

- 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 seminar Eventbrite link to register your interest in attending this webinar: https://tinyurl.com/4tcjt8fw

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

If you have any questions about these events 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 ■

Fellow profile: Dr Matthew Seeley

A third generation ENT surgeon based in Wellington, Aotearoa New Zealand

A career in medicine was not initially on the cards for Aotearoa New Zealand otolaryngologist Matthew Seeley. In his final years of school, Dr Seeley originally considered pursuing journalism before changing his mind and selecting science-based subjects.

The move ultimately led him to follow in his parents' and grandfather's footsteps into medicine. Later, he became the third generation of his family to become an ear, nose and throat (ENT) surgeon, after his father and grandfather.

Dr Seeley has often been reminded of the family connection to the specialty in his work, particularly when he was based in Hamilton, where he grew up. His new patients remembered seeing his grandfather decades ago.

"It was amazing how many patients told me they'd had grommets done by my grandfather, and the nursing staff also remembered him well," Dr Seeley said.

Dr Seeley chose the specialty due to the variety involved with ENT surgery – he liked the mix of surgical and non-surgical work and the range of ages and severity of conditions he encountered in the specialty.

His family both inspired him to pursue his career pathway and provided him with a realistic understanding of the challenges involved. "My parents are both doctors and so I think I had a fairly pragmatic insight into what life as a doctor would be like," he said.

Dr Seeley has worked across Aotearoa New Zealand, although he completed most of his training in Wellington and Waikato. He currently works as at the Wellington Regional Hospital and has a small private practice in Wellington.

One of the great challenges of the specialty is in communicating adequately with patients and colleagues and managing the time and resource constrained environment of healthcare provision with the best interests of each patient in mind.

Communication and relationship building are central to Dr Seeley's role, and he enjoys the opportunity to work closely with patients, sometimes over many years. One of the most satisfying parts of his job is problem-solving to deal with unusual conditions and achieve positive outcomes for patients.

Dr Seeley continues to draw on advice he received from a mentor that surgeons could be unintentionally intimidating, and he tries to be as approachable as possible by inviting patients and staff to ask questions or raise any concerns they might have.

Throughout his training and career, Dr Seeley has valued the support of colleagues, whether during his training or through his professional relationships with specialists, including anaesthetists, neurosurgeons and immunologists.

Dr Seeley sees one great challenge of his role as giving his patients the time they need, despite the constraints of the health sector.

His advice to Trainee surgeons or medical students interested in pursuing surgery is to try to get as much surgical exposure (with instruments in hand) as possible, as it is a speciality in which opportunities to operate can be limited during training.

While the career remains a challenging one, life becomes easier at a consultant level. "ENT surgery isn't always easy but it's never boring!" he said.

Outside his job, Dr Seeley is a Francophile and loves to cycle – two interests that sit together comfortably, along with his enjoyment of craft beer and eating out . Once international borders reopen, he is looking forward to travelling to Europe. ■

What are you:

- Reading?
  The Economist, Super Pumped - The Battle for Uber by Mike Isaac, and *Mastery* by Robert Greene
- Watching?
  Occupied
- Listening to?
  The National, Ben Howard and various down tempo electronic playlists while operating

Sir John Bland-Sutton: 'A Great Surgeon'

21 April 1855-20 December 1936

Bt. KB. FRCS LSA FACS LL.D

Sir John Bland-Sutton was *Vanity Fair*'s Man of the Day number 1214; his portrait, rather than a caricature, was captioned 'A Great Surgeon'. *Vanity Fair* noted *inter alia*, 'He is the scientific mind incarnate, a born enemy of ambiguity and indecision, dangerously fond of facts and an accurate observer'.

Born at Enfield Highway, on 21 April 1855, John Bland-Sutton was the eldest son and second of the nine children of Charles William Sutton, a farmer, market gardener and naturalist, a self-taught taxidermist whom young John watched at work for hours: school played a less prominent part in his education than his own sharp eyes and sceptical curiosity.

He attended the local school of St James the Great, soon proving to be the best pupil: aged 15 he trained as a teacher, completing studies in London, and working as a schoolmaster. His studies required that he should repeat 50 lines of poetry from a selected author; he memorised Scott's Lady of the Lake and subsequently always committed his lectures and addresses to memory, easily and quickly.

He then resolved to proceed with medical studies and commenced saving for the requisite fees: Mr Thomas Cooke, one of the surgeons at the Westminster Hospital, conducted an anatomy school for students requiring extra tuition; here John worked, earning the fees required for medical school. Bland-Sutton offered to dissect the 'parts' in return for free participation at the anatomy lectures: he was thus able to dissect the whole body twice before he joined a hospital.

On April 25, 1878, he went to the Dean of the Middlesex Medical School and paid the 100 sovereigns he had saved, enrolling as a 'perpetual student'. Within a year he was appointed an Anatomy Prosector, and in 1880, Junior Anatomy Demonstrator: he subsequently worked for 17 years in that Anatomy Department. Always interested in animals, their habits and diseases, in 1881 Bland-Sutton became a prosector at the Regent's Park Zoological Gardens, where he methodically dissected the bodies of animals for nine years.

He lived frugally and worked intensely, and although not taking part in any of the student leisure activities, won the respect of his fellow students with his zeal and ability to assist them. In those days, the road to the surgical staff was through the dissecting room: perhaps the most striking aspect of his personality was that he was never one of the crowd, he always took the part of the master, not the pupil: although his attendance at lectures was erratic, he was always keen to learn.

Having gained his FRCS in 1884, two years later, he was elected Assistant Surgeon to the Middlesex Hospital, with the proviso that he should remain in London during the months of August and September, when the senior surgeons were accustomed to take their annual holidays. It was not until 1905 that he became Surgeon to the Middlesex Hospital, filling the post until 1920, when he resigned and was made Consulting Surgeon, spending in all, 42 years there.

In 1886 he married Agnes Hobbs, who tragically died at 39 years of age, only 12 years later.

In 1896, Bland-Sutton was appointed Surgeon to the Chelsea Hospital for Women, and although practising as a general surgeon, it was with gynaecological surgery, that he made his name. The 'couch-invalid', formerly seen in so many families, generally a woman with fibroids or the sequelae of pelvic inflammation, now became the province of Bland-Sutton where he rapidly created one of the largest surgical practices in Britain. His operating afternoons at that hospital attracted surgeons from all over the world. As an operator he was rapid and safe, his results were excellent.

In 1899, as there was another 'J B Sutton' in practice in London, John changed his name by deed poll, adding that hyphen. In the same year he married Edith Bigg on his 44th birthday: ultimately, she survived him, however, as there were no children by either wife his 1925 Baronetcy lapsed on his death.

The couple lived in a house in Brook Street, on the site where the ballroom of Claridge's Hotel now stands. In 1905, he constructed 'Sutton's Folly', a replica of an Assyrian Hall, twelve feet high with a glass roof supported on 32 columns, surmounted by two-headed bulls, as in the edifice built by Darius, at Persepolis in Persia, 521-485 BC.

In all seasons, the hall decorated with turquoise glazed bricks, showing Susian archers, provided an extraordinary setting for the Bland-Suttons to offer generous hospitality: their sterling silver dining service inspired by Archaemenid designs, was gifted to the Royal College of Surgeons (RCS) by Lady Bland-Sutton in 1943 , who also established the Bland-Sutton Research Scholarship

The first Bland-Sutton scholar in 1946 was Raymond Jack Last FRCS, born in Adelaide and author of *Anatomy Regional and Applied*, a book which would be familiar to most readers.

At the RCS, he was awarded the Jacksonian Prize in 1892 for his essay, *Diseases of the ovaries and uterine appendages, their pathology, diagnosis and treatment*. Elected

to Council in 1910, he was Vice-President in 1918, 1919, and 1920, and President in 1923, 1924 and 1925, being succeeded by Lord Moynihan. A great achievement was his provision of a Supplementary Charter, providing female Fellows with the same privileges as male Fellows of the College.

John considered that his 1887 book, *Ligaments, their nature and morphology*, was his finest work and he was especially proud of the expensive wood-cut illustrations. He once remarked to a colleague, in reference to a large textbook, 'it is very easy to write a big book and very difficult to write a small one'.

Of slight physique and with small bright eyes, he was a fluent writer: His letters were always brief and pointed, written in a clear and unhurried hand: he never employed a secretary.

He was an entertaining after-dinner speaker, retaining and perhaps cultivating his Cockney accent: Rudyard Kipling was an old and intimate friend. *Vanity Fair* noted, 'He has more friends than most people who speak the truth have, but his strongest virtues are not social ones'.

One observer noted 'something Napoleonic' in his profile, revealed by his intense industry, his coolness in crisis, and his quick grasp of the essentials of the problem, and the rapid translation of decision into action, and, in a certain aloofness of personality.

In a speech at Glasgow in April 1927 celebrating the centenary of Lister's birth, Bland-Sutton observed, "I was trained in the old school and lived to revel in the wonders of the new. But this is not the end: the legitimate function of surgery is the repair of physical injuries.

"We must strive to cure morbid growths with drugs prepared by biochemists. We may believe that chemotherapy and physics, which have furnished surgeons with powerful and reliable remedies, will help to deliver mankind from some of the most distressing and uncompromising operations of modern surgery. There are clear signs of the dawn of such an era."

Sir John Bland-Sutton died after a short illness on 20 December 1936 and his body was cremated as he requested,

'Put me on the kitchen fire, and then pull out the damper;
All that's left of my poor bones, will up the chimney scamper.'

'*Nulla dies sine linea*', (Pliny the Elder) was one of his favourite quotations.

His ashes were placed in the Museum of the Middlesex Hospital, which he had generously endowed.

Memorial services were held at the Middlesex Hospital and Westminster Abbey. ■

Mr Peter F Burke
FRCS FRACS DHMSA

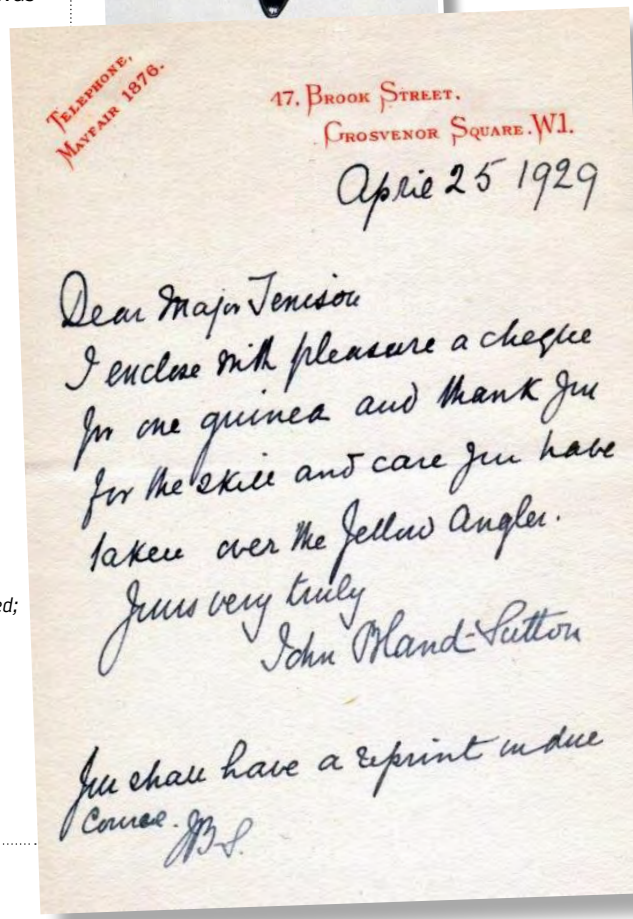

Image over page:
Bland-Sutton's 1909 caricature by B. Moloch, French illustrator and caricaturist

Images above, clockwise from top left:
Section of wall of Assyrian Hall, now demolished; and inset, original two-headed bull, British Museum; Rudyard Kipling and Bland-Sutton, Middlesex Hospital, 1908, for medical student prize-giving; John Bland-Sutton in Vanity Fair, *3 February 1910, 'A Great Surgeon'; portion of silver dinner service, willed to RCS collection, London; Handwritten note found interposed in the autobiography of John Bland-Sutton.*

The Developing a Career and skills in Academic Surgery (DCAS) Course 2021

Left to right: Dr Marc Gladman, Georgina Ryan, Mr Richard Hanney, Davina Daudu and Associate Professor Jonathan Karpelowsky

The 12th Developing a Career and skills in Academic Surgery (DCAS) Course was held in Melbourne and via virtual sessions on 10 May 2021. The one-day course offered attendees motivation and advice in developing a career that involves both research and medicine. We welcomed seven international guests from the Association for Academic Surgery and a further 15 from Australia and Aotearoa New Zealand.

Session one explored why research was important for surgeons, and the importance of finding the right topic and time for research. Associate Professor Carrie Lubitz gave an interesting talk on how to find your research question. One of the highlights of the session was a talk by Dr Brenessa Lindeman on how to navigate the balance between burnout and wellbeing. The session finished with advice from Professor Eugene Kim on the benefits of participating in virtual conferences.

The second session explored inclusion and diversity in surgical academia, providing perspectives on the Black Lives Matter movement from the United States and Australian perspectives. Assistant Professor Lesly Dossett gave a talk on the importance of diversity in academic surgery, followed by Associate Professor Colin Martin, who spoke on the Black Lives Matter movement in the United States and the many initiatives that have been established there. Professor Kelvin Kong's presentation provided insight into some of the issues faced by Indigenous Australians. He shared with the audience his journey to becoming a surgeon, and insights on how the lack of awareness of Indigenous culture adversely impacts the health journeys of Indigenous Australians. Professor Kong advocated for altering the status quo through changing bias, making a genuine effort to listen and support Indigenous Australians, and calling out racism.

The 'Hot Topic' First in Human Trials was presented by Professor Michael Vallely. Professor Vallely described his journey and experience in suggesting new procedures, gaining permission and undertaking these first in human trials. His guidance included ensuring patients are at the forefront of decision-making and that the suggested treatment is an acceptable option for them. He describe the importance of having a sound knowledge of the different devices available, gaining institutional approval, building a multidisciplinary team, planning the procedure, completing the procedure and then publishing about the outcome.

Professor Peter Choong (left) and Professor Julian Smith (right)

Session three focused on tools for academic surgery. Associate Professor Amir Ghaferi began the session on conference abstracts by recommending that writers ensure their stories are centred on data, and the value of presenting at scientific meetings. Some useful tips for virtual presentations included recording presentations from a standing position, avoiding animation, practising, focusing on a positive audience member and, most importantly, keeping to time. Associate Professor Zara Cooper then provided pearls of wisdom on writing and submitting manuscripts, with a focus on telling an interesting, original story while paying attention to the targeted audience and journal formatting requirements.

The keynote address , Disruption and Innovation in Academic Surgery, was delivered by Professor Peter Choong from the University of Melbourne. His thoughtful presentation encouraged disruption by surgeons in relation to problems where innovation could progress and drive new contemporary treatments and outcomes for patients. Through continuing to disrupt and innovate, current surgeons can provide guidance for younger generations in developing new technology and improving evidence-based medicine.

The first concurrent session focused on finding your niche and tools of the trade, with presentations covering basic science, translation research, clinical research and randomised controlled trials, international collaborative studies and interdisciplinary collaboration. The second concurrent session focused on trainee-led collaborative trials, covering topics on the clinical trial landscape in Australia, engaging medical students and surgical trainees, and advice on mentoring trainee networks.

For in-person attendees, the course finished with a networking opportunity with faculty members.

Feedback from attendees indicated that presentations were well received, with most rated highly. ■

Associate Professor Jonathan Karpelowsky FRACS
Co-Chair of DCAS Course

Associate Professor Colin Martin FACS
Co-Chair DCAS Course

Mr Richard Hanney FRACS
Convenor

DCAS Course Award recipients share experiences of training

Annual Academic Surgery Conference participants and winners of the DCAS Course Award, Dr Gillian Lim and Dr Georgina Riddiough, share their experiences of attending the course.

DCAS Award Winner 2019

Earlier this year I attended the Developing a Career and skills in Academic Surgery (DCAS) Course in Melbourne as a first-time delegate, an invitation I received after being presented the DCAS Award at the Royal Australasian College of Surgeons (RACS) November Annual Academic Surgery Conference in 2019. The DCAS Course is an invaluable opportunity for aspiring academic surgeons to familiarise themselves with the surgical research landscape both in Australia and internationally.

The event was preceded by an intimate dinner with the core of the robust Australian research community; experienced, established surgeons who are passionate about the future of surgical academia. This dinner was a unique opportunity to foster and develop relationships with these academics I hope to one day work with as colleagues and mentors.

The course itself covered a variety of thought-provoking and highly topical subjects presented by eminent and engaging speakers, all of which I found particularly relevant as a prevocational doctor. Presenters emphasised the fundamental role research plays in surgery and the benefits research provides for all stakeholders – clinicians, patients, and the wider population. The day focussed on the practical tools required for research: constructing a team with a varied skill set; writing abstracts and manuscripts; and strategies to avoid burnout in a high pressure, rigorous environment.

A particularly resonant concept I took from the day was the importance of disruption. Disruption is what fosters innovation and compels others to view the world through a new lens. This progressive thinking is what shapes the future of academic surgery into one that is diverse, unique, and unafraid to challenge the status quo. The intermissions between sessions proved equally valuable, as these allowed me to meet and exchange experiences with other delegates at every stage of career progression.

The DCAS Course was an enriching and inspiring event, and I look forward to attending future events and using the lessons learned to further my journey in academic surgery.

Dr Gillian Lim

DCAS Award Winner 2020

It was an honour to attend this year's DCAS Course in Melbourne at the 2021 RACS Annual Scientific Congress. For many, the opportunity to simply attend a major scientific meeting in-person brought real joy.

The satisfaction of catching up with old friends and making new contacts was wonderful. In the past, surgeons may have cowered from the spotlight or avoided unnecessary small talk, but this year's conference enjoyed a renewed energy for interaction and communication. And that is probably the essence of the DCAS course, to inspire, through meaningful interactions and thoughtful communication, the next generation of surgeon scientists.

One of the main take-home messages from the course, which was rich in speakers from diverse backgrounds, is that the modern-day surgeon scientist can take many forms. For some it can mean working in a laboratory, for others it can mean interpreting big data sets; working in multi-disciplinary teams with engineers, immunologists, statisticians, oncologists; designing novel devices to solve a clinical problem; educational and wellbeing research and working with international collaborators.

The theme of one of this year's concurrent sessions, 'Finding my niche', emphasised the importance of using the literature to establish knowledge gaps, while drawing on clinical experience to harness research questions that will provide the most impactful findings.

Another session discussed the impressive strides made by Trainee-led collaboratives recently. The SARS-CoV-2 pandemic has wreaked havoc on surgical services worldwide and through this experience, the COVIDSurg Collaboratives were born. These collaboratives combine data from centres worldwide in order to carry out high-powered surgical research. Large, multicentre observational studies orchestrated by the COVIDSurg Collaborative have influenced surgical practice by informing when and how to operate on patients, and what complications to expect.[1,2,3]

Recently, surgical collaboratives in Australia have made excellent progress and tackled important questions such as the timing of chemoprophylaxis administration for elective general surgery.[4,5,6]

The DCAS Course was inclusive, and while it attracts senior surgeon scientists, it is an excellent introduction into surgical research for medical students, junior doctors and registrars all considering an academic pathway. ■

Dr Georgina Riddiough
SET Trainee

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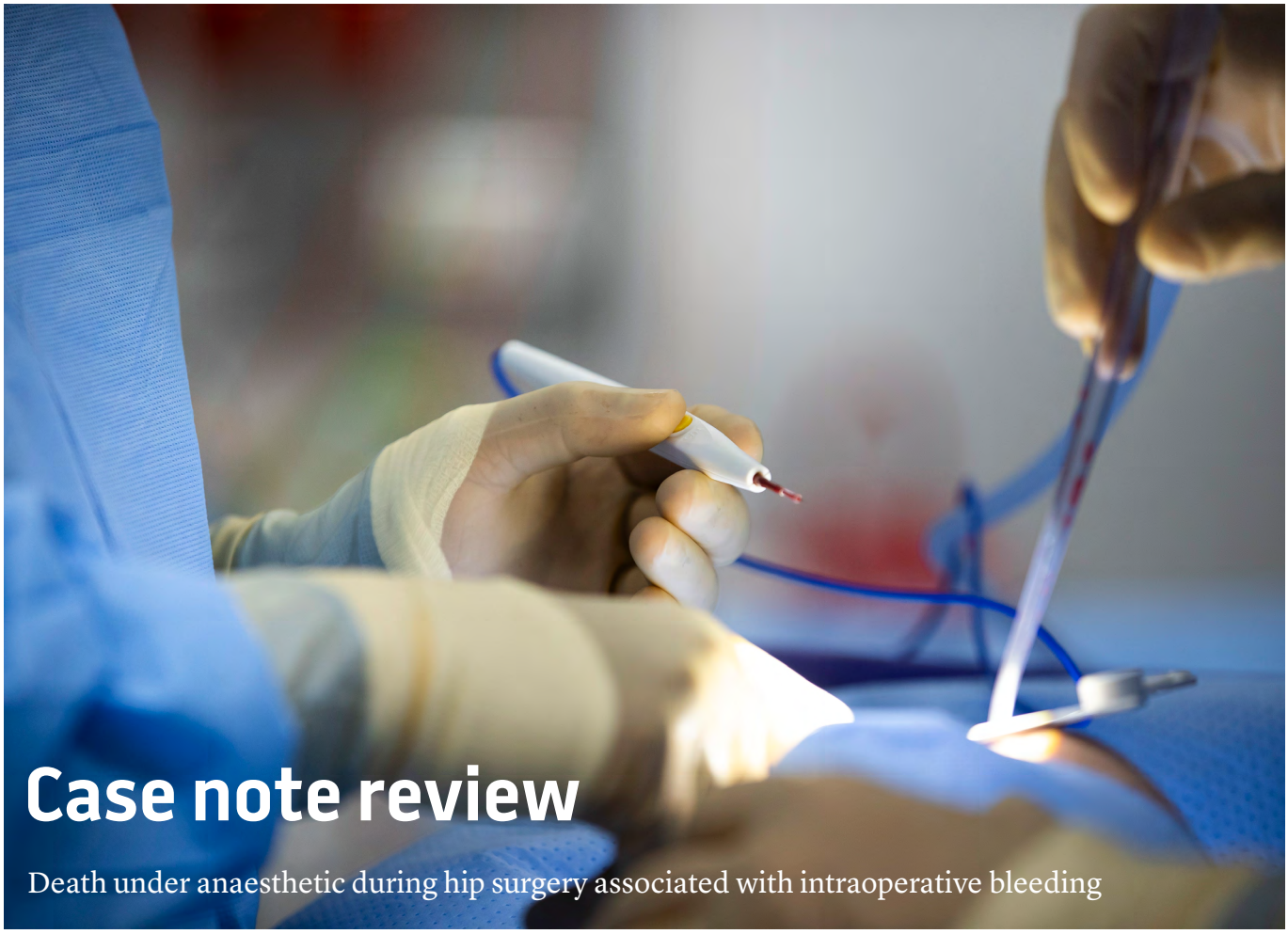


Case note review

Death under anaesthetic during hip surgery associated with intraoperative bleeding

Case summary

A patient in her mid-80s was admitted to hospital with active shingles, a urinary tract infection, general deconditioning and mobility issues. Six weeks after transfer to the rehabilitation ward she suffered a fall, resulting in a Vancouver C periprosthetic fracture between a previously revised hip replacement and a knee replacement.

The patient had an extensive medical history. She suffered from osteoarthritis, hypertension, chronic obstructive pulmonary disease (COPD), recurrent urinary tract infections and gout. She had had an internal iliac artery aneurysm five years previously and more recently had undergone aortic valvuloplasty, after which she was suspected to have had a cerebrovascular accident (CVA). A history of deep vein thrombosis (DVT) had been without incident for the past 35 years. She had previously been diagnosed with disseminated breast cancer, which resulted in a mastectomy, three cycles of poorly tolerated chemotherapy followed by radiotherapy, and continuing treatment with anastrozole. She was in remission for a splenic marginal zone lymphoma, for which she had received chemotherapy four years earlier. She was on multiple medications, including clopidogrel, ferrous sulphate, enoxaparin and strong analgesia.

The day after her fall, the patient was admitted to the orthopaedic unit (following communication between the medical officer and Orthopaedic registrar). Her previous CVA (three months before admission) was noted, as were her current medications, although the plan regarding DVT prophylaxis was hard to determine given the poor legibility of the notes. Drug chart review indicated that enoxaparin (40mg) was administered the day after the fall.

Two days after her fall, the patient went into atrial fibrillation. A coagulation profile performed the same evening was within normal limits regarding prothrombin, INR (international normalised ratio) and APTT (activated partial thromboplastin time). None of these measures indicate the effectiveness of enoxaparin, which requires an anti-Xa assay, which is not routinely done.

The patient's haemoglobin level was noted to be 67g/L when reviewed by the after-hours resident medical officer two days after the fall. A haematology review was advised for the following morning but there is no record of this consultation in the case notes.

The patient was not seen by an Orthopaedic resident until two days after her transfer to the Orthopaedic unit. She had been catheterised, and it was noted in the early hours that her urinary output decreased then increased after a bolus of 200ml of fluid. It was noted at that time that the patient also suffered from congestive cardiac failure. Her fracture was un-displaced, and it was not until two days after the fall that gentle traction was prescribed.

At surgery (three days after the fall), the exposure was uncomplicated; all bleeding points would have been controlled. The attempted reduction of the fracture was difficult. The intent, from the preoperative plan, was to use a plate, screws and cables, plus an allogenic cortical strut graft. The case notes

reveal that there was a spontaneous bleed from a perforating artery, which could not be controlled – presumably the artery would have been divided and controlled during the exposure, but would then have retracted past the posterior midline, becoming inaccessible for clamping. The record shows that there was 300ml of rapid blood loss. Under normal circumstances, one would expect that this bleeding could be controlled by packing the wound and this amount of blood loss would not be life-threatening. In this case, it was associated with a cardiac arrest. Despite calling for emergency assistance, the patient could not be resuscitated; the procedure was terminated without completion of the fixation.

Comments

From the records, it seems clear that this patient with multiple comorbidities was approaching the end of her life. The fall and the comminuted fracture of the distal shaft of her femur was the final straw. The very high risk of the procedure had been noted and this had been appropriately discussed with the patient and with her daughter, but the nature of the fracture meant that surgery was nevertheless required.

The surgery for this condition proved difficult. The bone would have been very osteopenic and achieving a stable reduction was always going to be a challenge. Perforating arteries are often encountered but one assumes that bleeding can be controlled during the exposure. In dividing perforating arteries, the proximal end is very prone to retract medial to the posterior midline of the shaft of the femur, making it extremely difficult to find and control should further bleeding occur. In this situation, it is a particular surgical challenge to try to control such bleeding – packing the wound is often the best, and virtually only, appropriate step. It seems likely, however, that the effects of enoxaparin and clopidogrel contributed to the uncontrolled bleeding and the difficulty achieving control by packing the wound.

Clinical lessons

Despite multiple doctors seeing the patient with a view to optimising her preoperative risks, it seems that the complexity of her comorbidities may have meant that the enoxaparin and clopidogrel may not have been withheld for long enough preoperatively to maximise safety. The opinion of the haematologist would be enlightening in this regard, but unfortunately a record of a haematology consultation with the patient cannot be found. It remains unknown whether the haematologist was aware that the patient was on these medications.

Taking all things into consideration, the risk of the procedure was so high that mortality was a possibility that was actively considered preoperatively. Even if everything had gone as planned, the outcome may not have been any different. ■

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

The influence of Jonathon Hutchinson

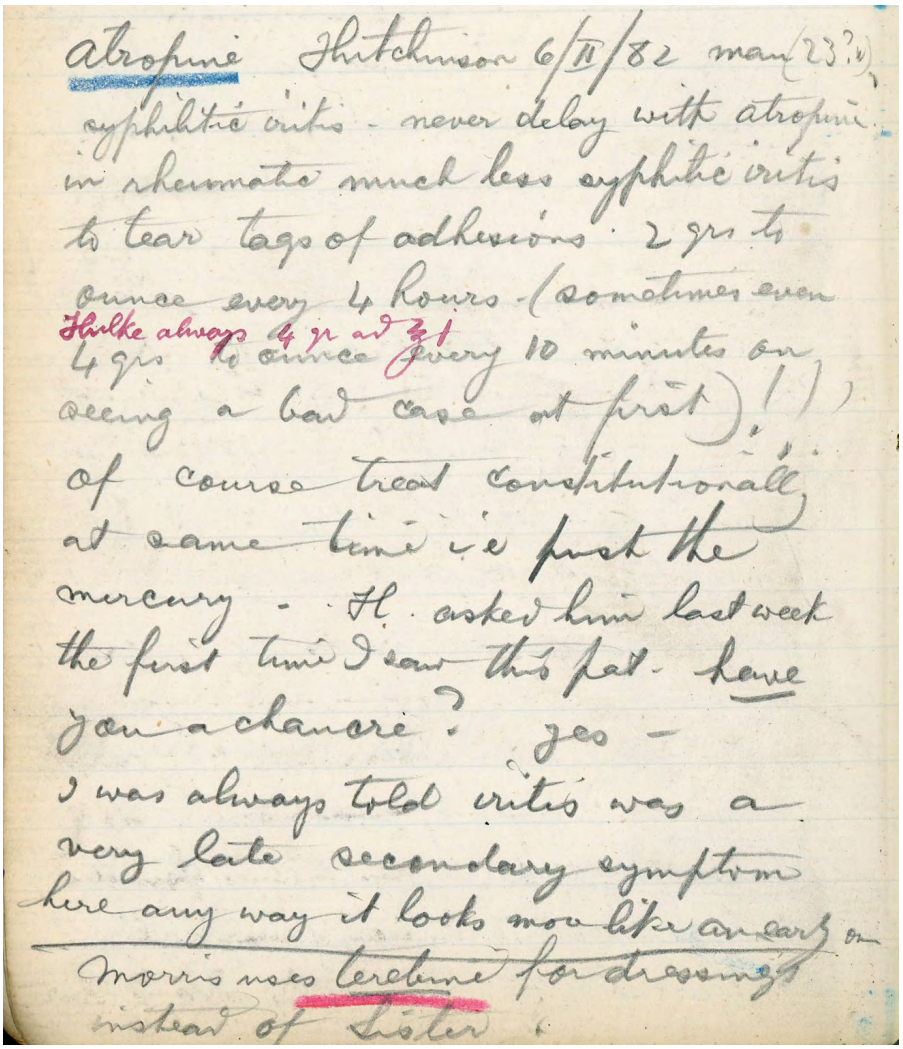
From Archibald Watson's surgical diary 1882–1883

Archibald Watson began his post-graduate training in London at a time when English surgeon Sir Jonathon Hutchinson (1828–1913) was coming to the end of his career.

Hutchinson, described in *Plarr's Lives of the Fellows* as "one of the great medical geniuses of his time", was Hunterian Professor of Surgery and Pathology at the Royal College of Surgeons from 1879 to 1882.[1] Mentored by Sir James Paget, he trained as an Ophthalmologist at Moorfields Hospital but his interests were very broad and included skin diseases, gout, haemorrhages, leprosy and syphilis. In 1876, his seminal work on syphilis described a triad of signs that indicated congenital syphilis.

In the early 1880s, syphilis was treated by arsenic or mercury used either in its elemental form or in a compound such as mercurous chloride (calomel). From 1884, bismuth salts, which were less toxic than mercury, were also used to treat syphilis. Jonathon Hutchinson disliked arsenic, which he felt was carcinogenic, and for early syphilis he advocated two to three years administration of metallic mercury by mouth. In 1882, Archibald Watson observed several of Hutchinson's cases of syphilis.

"Syphilitic iritis? – never delay with atrophine in rheumatic much less syphilitic iritis to tear tags of adhesions – 2grms to ounce every 4 hours (sometimes 4 grs to ounce every 10 minutes on seeing a bad case at first)!!! (Hulke always 4gr and 1oz) – of course treat constitutionally at same time ie push the mercury – H asked him last week the first time I saw this pat – have you a chance? Yes –)


atrophine Hutchinson 6/II/82 man (23?W)
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I was always told iritis was a
very late secondary symptom
here any way it looks more like an early on
Morris uses terebene for dressings
instead of Lister.

6/2/82 (page 35) Man (23? W) Atrophine

"I was always told iritis was a very late symptom – here any way it looks like an early one"

English physician William Heberden first described Nodi Digitorum in the late 1700s. Consisting of bony outgrowths at the distal interphalangeal joints, Heberden noted that the disease process was distinct from gout. In June 1883, Watson records that Jonathon Hutchinson dealt with a possible case of the disease. However, given the patient's age and history, the diagnosis was not straightforward.

"Haberdeen's [sic] nodi digitorum extremely rare in young people – this boy's knees and elbows are also enlarged

"Diagnosis (nothing else one can think of - tendency to rheumatic gout in subject having had rickets)

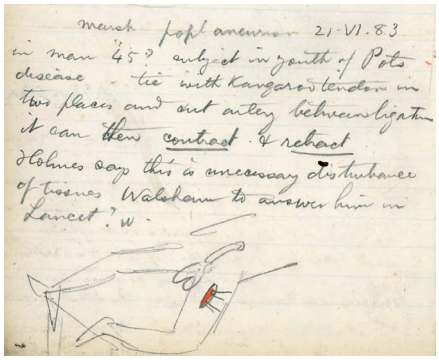
"The ends of the fingers were not curved downwards (as in grande cucheron) but if anything backwards – at the same time this boy has severe flat foot on left side"

In the 1870s, Lister's student H.O. Macy of Boston introduced kangaroo tendons for suturing and by the 1880s they were used by Hutchinson and many of his contemporaries.[2] There are several references to the use of kangaroo tendons in Watson's diaries. They include Frederick Marsh's operation in 1883:

"Subject in youth of Pots[sic] disease – tie with kangaroo tendon in two places and cut artery between ligation – it can then contract & retract"

In 1913, Hutchinson wrote a glowing endorsement of kangaroo sutures:

"On the whole my experience with kangaroo tendon has been so satisfactory that I do not wish to find any better material. It is very strong, less slippery and easier to tie securely than catgut, the

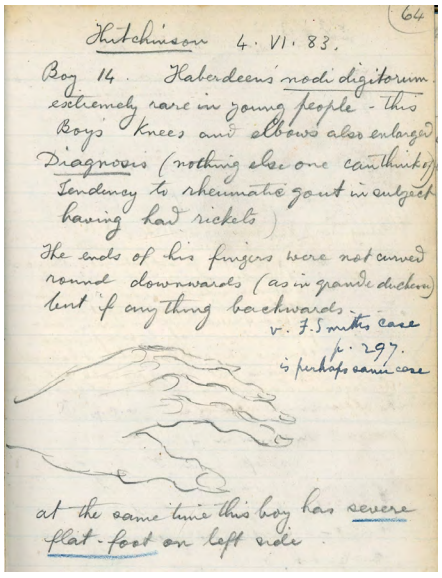


4.VI.83 (page 64) Boy 14

strands can be readily made of the required size (I think the tendency is to use it too thick), it can be preserved an indefinite time in a strong antiseptic solution, it is well tolerated by the tissues, in fact it becomes a living fibrous structure."

Jonathon Hutchinson was an exceptional surgeon whose varied interests matched the inveterate curiosity of his student, Archibald Watson. ■

Elizabeth Milford, RACS Archivist



Marsh popl. Aneurism (page 83) 21.VI.83 in man 45

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2. Kangaroo tendons from Watson's archive are on display in the College Museum.

Further commentaries on surgical fees

– with a touch of criticism

OPUS LXX

In my March 2016 story in *Surgical News* discussing fees, it was titled 'Milking the System'. In it I recalled historical references to this topic dating back to the time of Louis XIV and his Superintendent of Finances, Nicolas Fouquet. What did he do? He decked out his own *chateau lèse-majesté*, with splendiferous adornments, richer in appearance than that of the king's. As the royal artistic director and regal advisor, he merely followed the king's instructions, but when the artisans just happened to make two *objet d'art* for the price of one (which the king paid for), he picked the better one. 'Things did not add up' when the king visited Fouquet's chateau (an example of 2+2 ≠ 5) and Fouquet subsequently went to prison.

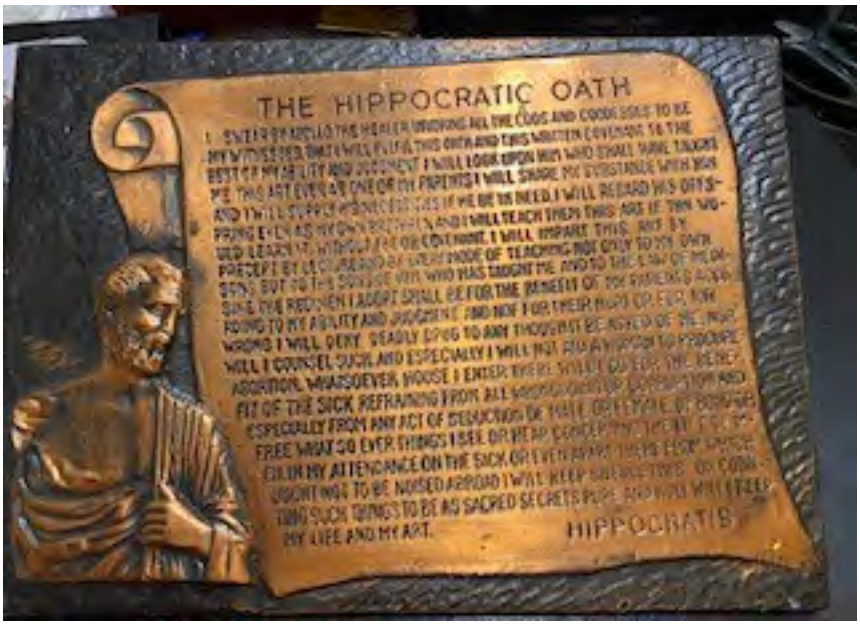
In the 2016 article I referenced current examples of exorbitant surgical fees, from $10,000s for hips and $2000s for carpal tunnel procedures done by the consultants' former registrars who lacked the experience of the master. I recalled David Scott's comments at the time when he was Surgical Director at the Royal Australasian College of Surgeons (RACS) that an open-heart transplant was cheaper then – only $4000 in the Medicare Benefits Schedule. However, not all are guilty, perhaps the 10 per cent rule emerges again. But in the public's view, the value of private health insurance becomes contentious, and with the public health system overburdened, what is the future? The noose of financial largesse may tighten, or, as the French say, *l'étau se resserre*.

The College has a way of processing such exorbitant fee trends, as confirmed recently by Professor Julian Smith. But quoting Ross Gittins, columnist for *The Age*, the most effective corporate solution for financial mismanagement under the Australian Securities and Investments Commission (ASIC) umbrella is collegial rejection. At our FRACS level, collegiate rejection can also apply.

Now, antiques and historical items are forever on my mind and that is why I write these stories. I recently bought a plaster cast model of Hippocrates for $100 (I could not afford the 4th Century BCE stone carving priced in the six-figure range). He taught students the ethics of medical practice, to do no harm. The Oath, as illustrated, encourages all medicos to help patients to the best of their abilities while pursuing scientific gains and avoiding the traps of over-treatment and 'therapeutic nihilism' (an Oliver Wendell Holmes expression).

I recently had a clinical episode which spurred me into activity regarding overcharging. The brother of a nursing associate of mine recently had a shaved biopsy for an in situ melanoma of the cheek. He was referred to a plastic surgeon for removal of this lesion, which was no bigger than one's little fingernail. The patient was quoted an upfront fee of $3000 and his anaesthetic support team, playing the same game and painting with the same brush, wanted a prepayment of almost $400 above the rebate. This is totally divorced from any altruistic Hippocratic principles. The patient was a farmer from country Victoria who had recently survived fires, droughts, floods and financial hardship. Incidentally, he already had a parotidectomy done by a senior Head and Neck surgeon I knew. I phoned his general practitioner (GP) to get the referral to that surgical practice and the problem was solved without any financial stress, thanks to his private health insurance.

This episode led me to phone one of my colleagues in the College hierarchy, a former President, and he recounted his experience in worker's compensation absurdities where quotes for proposed operations merely reflect the habit of inventive item numbering. I also have experienced cases in the medico-legal network, including fingertip reconstructions where the operation lists up to eight item numbers. Let us hope the surgical assistant, who usually does the paperwork, does not think this is the norm. A little belatedly, Don Marshall, in his heyday, asked me to write an article along these lines when he observed, "Felix, any fingertip injury should warrant a fee of no more than $500."



The Hippocratic Oath, with thanks to Kathy Bourke who found this in an op shop

Cromwell House, 139 Collins Street was a two storey establishment initially and the third floor was subsequently added.

Hamilton Russell with Percy Grainger.

Locally, WorkSafe is under financial stress and recently received a $1.5 billion government bailout. Is this sustainable? Our clinical experiences of worker's compensation and Transport Accident Commission (TAC) payments have been our lifeline when working mainly in the public system. But changes are emerging. A United Stated insurance company in Michigan, taken over by a private equity fund, adopted the 9–5 business hour syndrome. An emergency case arriving at 5.05 pm and following triaging was advised to phone back the following day at 9 am for insurance approval. I hope this is not a sign of things to come in Australia.

Let us have an intermission in this cinematic exposé. Overcharging can have many perspectives – this one with a touch of humour relating to the first Lord Moynihan (thanks to a Don Marshall recollection). Having graduated from the University of London in 1887, Moynihan became Professor of Surgery at Leeds and eventually President of the English College of Surgeons from 1926–1932. This career prominently reflected his surgical talent. He had a lilting Irish accent, with a touch of Tipperary, and a long list of admirers, surgical and others. His prowess reflected his surgical intuition, with his saying, "The perfect surgeon must have the heart of a lion and the hands of a lady, not the claws of a lion and the heart of a sheep."

On one occasion he caught the train from Paddington Station to the country to see a patient with an abdominal complaint, which he subsequently solved. The following day his anaesthetist Dr Kinsey asked him what such a visit would cost. He responded, "Twenty-one pounds, fourteen shillings and six and a half pence."

Kinsey asked, "Isn't that an unusual fee?" Moynihan's response, raising his arms with a touch of nonchalance, said, "Well, that was all they had".

A more modern experience was revealed at one of our D'Extinguished Surgeons luncheons some years back. Here Brian Collopy discussed the Beaney Scholarship in Surgery for final year graduates at the University of Melbourne (still available). Brian was encouraged to complete his book on Dr James Beaney, which I helped him launch in April 2018 at Readings Bookstore and is now available. Beaney was a politician, a philanthropist and an honorary surgeon at the Royal Melbourne Hospital from the mid-1860s into the 1890s. His flamboyant personality matched the jewellery that adorned his hands even during operating, which earned him the eponym 'Diamond Jim'. The champagne was never too far away, even offered to guests invited to watch him operate and to enjoy again later in the tearoom. 'Diamond Jim' had a big surgical income, earning approximately £12,000 annually in the 1890s, when Melbourne was one of the wealthiest cities in the world.

He built his consulting rooms suite at 139 Collins Street, Melbourne, an address that recently sold for over $60 million. The current tenant is Louis Vuitton, the haute couture fashion house.

Barry Elliott, recently deceased and to whom I dedicate this article, presented this Cromwell House story at one of our luncheon lectures focussing mainly on Hamilton Russell. He recounted that musical concerts also took place at Cromwell House regularly and here Hamilton Russell and Percy Grainger performed. Hamilton Russell was a musical mentor to the young Grainger, little realising his mentee would become an international musical figure. H*andel in the Strand* and *Country Gardens* are just two of Grainger's umpteen compositions that are regularly heard on ABC FM. On the 14th July they played Grainger's rearrangement of Aaron Copland's *The Cat and the Mouse* composition – ecstasy with my morning coffee.

As Barry recounted, Hamilton Russell was GP to the Grainger family before becoming a consultant orthopaedic surgeon at the Alfred Hospital. Everyone knows the Hamilton-Russell traction now superseded by modern ORIF procedures for fractured femurs.

To conclude this surgical fee story, I must touch on some aspects of the microsurgical 'Mecca' in Melbourne. The late Bernie O'Brien established the cost basis for such procedures, reflecting the long hours and dedicated labour they entail. However, absurdity raises its head again when people are quoted $30,000 for a breast reconstruction, or an alternative venous flowthrough thumb pulp reconstruction in the thousands. A Littler neurovascular island flap would have worked with minimal cost and minimal operating time and a functional digit with almost intact sensation for tripod and pincer grip activity and a successful return to work.

A medico-legal practice is a great source of information. When the dollar becomes the determinant factor, this invites an updated version of the Hippocratic oath. In this modern world of commercial extravagance, one must avoid 'doing financial harm' to dissuade soaring fees, or *flambé des prix*.

Let us not forget in any critique, the people that matter don't mind but the people that do mind, don't matter! ■

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	Tuesday 12 October	Perth, Western Australia
Conflict and You	Friday 29 October	Sydney, New South Wales
Difficult Conversations with Underperforming Trainees	Friday 29 October	Brisbane, Queensland
Foundation Skills for Surgical Educators	Saturday 16 October	Adelaide, South Australia
Leading Out of Drama	Saturday 30 October	Sydney, New South Wales
Non-Technical Skills for Surgeons (NOTSS)	Friday 10 September	Adelaide, South Australia
Operating with Respect (Fellows)	Thursday 16 September	Brisbane, Queensland
	Thursday 16 September	Melbourne, Victoria
	Friday 8 October	Hobart, Tasmania
	Friday 15 October	Wellington, Aotearoa New Zealand
Operating with Respect (SET Trainees)	Thursday 14 October	Wellington, Aotearoa New Zealand
Process Communication Model: Seminar 1	Friday 3–Sunday 5 September	Adelaide, South Australia
	Friday 8–Sunday 10 October	Melbourne, Victoria
Promoting Advanced Surgical Education	Friday 24–Saturday 25 September	Melbourne, Victoria

Online courses

Course	Date
Writing Medico Legal Reports	Tuesday 24 August
Leading Out of Drama	Wednesday 1–Monday 13 September
Educator Studio Session featuring Dr Claudia Villanueva and Mr Marc Seifman	Thursday 19 August
Educator Studio Session featuring Dr Hercules Kollias	Wednesday 13 October

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

Changes to RACS alcohol policy

Many Fellows who generously perform pro bono work for our College will already be aware of the recently introduced RACS 'Responsible Approach to Alcohol' policy. For most, it will have come as no surprise; however, for others, the purpose and consequences of it may have been less clear. Here we explore why it has been introduced, and how it might affect you.

For decades RACS has been a strong public advocate highlighting the harm caused by alcohol in the community, including to our patients – whether it be from road trauma, domestic violence, or alcohol-related disease. On the other hand, alcohol has been consumed by us and reimbursed during our pro bono work for the College; yet we are also aware of our responsibilities to uphold the highest standards of behaviour when performing any RACS-related activity. RACS is committed to providing a respectful, safe, and inclusive working and learning environment.

The new policy acknowledges that alcohol can contribute to a successful event or occasion but places some caveats around its responsible use. It provides some guidance as to when and how alcohol can be included at College events, and when it should not be consumed e.g. during business meetings, and in settings where a power imbalance may exist between Fellows and employees, Trainees, specialist international medical graduates, junior doctors or medical students. It still allows for alcohol consumption at specific RACS social events and defines the circumstances and process around these.

How will it affect Fellows who provide pro bono work for the College?

RACS no longer reimburses alcohol that is consumed outside of formal RACS dinner events. A RACS dinner event is defined as an organised event involving food and alcohol that has been predefined and approved in advance by a member of the executive leadership team. An event that is formally approved in advance has a Fellow or staff member nominated to take responsibility for the alcohol served and charged to RACS. The policy denotes the Fellow or staff member in this instance as the 'nominated responsible Service of Alcohol representative'. The College no longer reimburses alcohol served external to these situations such as with an evening meal after work. The policy also advises against providing alcohol products as private gifts or as part of charity donations such as raffles.

This does not mean the value of pro bono work is diminished in any way, and as a membership organisation all Fellows are appreciative of the voluntary work done by those who contribute to the various College courses, exams, committees and other RACS activities.

The successful organisation is one that is sensitive – and can adapt – to the prevailing trends of society, particularly as they may interface with the organisation's values. ■

Spencer Beasley and Sarah Rennie
Aotearoa New Zealand Surgical Advisors

The Alfred Hospital Intensive Course in General Surgery 2021

29–30 October 2021, Pullman Melbourne on the Park

The Department of General Surgery at The Alfred Hospital Melbourne is once again holding its biennial meeting. The Alfred Hospital Intensive Course in General Surgery is scheduled to take place at Pullman Melbourne on the Park from Friday 29 October to Saturday 30 October 2021.

The course targets all general surgeons and Trainees with a wide range of surgical interests. Course highlights include new perspectives on challenging problems, major intra-operative abdominal bleeding, improving outcomes by thinking laterally and a colorectal operative surgery symposium.

While the current climate means we are unable to have overseas speakers join us this time, we are delighted to bring you an array of excellent national keynote speakers including:

- Professor Andrew Stevenson, a colorectal surgeon from Brisbane. Professor Stevenson is Head of the Colorectal Surgery department at Royal Brisbane Hospital, and Associate Professor of Colorectal Surgery at the University of Queensland.
- Professor Peter Stanton, an endocrine surgeon from Hobart. Professor Stanton has extensive experience in all areas of thyroid and parathyroid surgery, but especially in the areas of surgery for MEN1 and re-operative surgery.
- Associate Professor David Cavallucci, a hepato-pancreato-biliary (HPB) surgical oncologist from Brisbane. Dr Cavallucci is a graduate of the two-year ANZHPBA post-Fellowship program in HPB surgery and of the surgical oncology and abdominal transplantation Fellowship at the University of Toronto.
- Ms Jane Fox from Melbourne. Ms Fox is the current Director of Breast Services at Monash Health encompassing breast surgery and Monash BreastScreen. Ms Fox also has a senior role in the multidisciplinary team which includes medical imaging, medical oncology and radiation oncology at the Monash Cancer Centre.
- Dr David Martin, a laparoscopic and upper GI surgeon from Sydney. Dr Martin is a consultant surgeon at both the Concord and Royal Prince Alfred University Hospitals in Sydney. Dr Martin is involved in the provision and initiation of cutting-edge, evidence-based health care and the development of world class tertiary upper gastrointestinal, laparoscopic and obesity surgical units.
- Dr Leigh Rutherford, a general surgeon from the Gold Coast. Dr Rutherford specialises in laparoscopic gastrointestinal, endocrine and melanoma surgery.

As always, in addition to our invited keynote speakers, an extensive list of the outstanding faculty of The Alfred Hospital will join us to provide further perspectives and presentations.

The course has been scheduled to enable delegates to go on to enjoy the long weekend in Melbourne.

There are five sessions on Friday and three on Saturday morning, including breakfast sessions on both mornings. The breakfast sessions include a Thyroid Surgery Masterclass on Friday morning and a session on Key Manoeuvres in Trauma Surgery on Saturday morning, which is proudly supported by our platinum sponsor, Medtronic. For the first time, we will also have a Saturday afternoon session, a Colorectal Operative Surgery Symposium with presentations including 'Time for a helping hand – when to use a hand port for the general surgeon' and 'Quality care in colorectal practice' delivered by keynote speaker Professor Andrew Stevenson, and a selection of other informative talks and case scenarios not to be missed.

Session one relates to new perspectives on challenging problems and includes when and how to perform a bile duct exploration, updates on surgery for inflammatory bowel disease, evolving melanoma surgical indications enabled by novel systemic therapies, managing enteric fistulas in the open abdomen and breast localisation – the future is wireless.

The second session focuses on meeting current and future standards of care in relation to what we have learnt from Covid-19, measuring outcomes in emergency surgery, tips and tricks for surgery administration, expectations and supervisory requirements around surgical Trainees and defining and managing surgical risk.

The first session after lunch focuses on major intra-operative abdominal bleeding as it relates to laparoscopic upper GI surgery, liver and pancreas, gall bladder and colorectal surgery and vascular control for general surgeons.

The final session on Friday is about thinking laterally and how we can improve outcomes by doing so. It focuses on operative approaches to large hiatus hernias, DVT prophylaxis guidelines, parathyroidectomy, muscularity in gastro-intestinal cancer as an outcome predictor, and improving outcomes with randomised controlled trials. On Friday evening at the conclusion of this session,

a welcome reception will follow in the exhibition area.

On Saturday morning, the first session after breakfast is on dilemmas and difficult problems and deals with topics relating to re-operations in bariatric surgery, de-escalation of adjuvant therapies for breast cancer, complex ventral hernias and their standard of care, avoiding functional issues following GI surgery and updates on treatment and surgical options for pilonidal disease.

The scientific program concludes with a session focused on the nitty-gritty of surgical techniques, including presentations around GIST tumours, colorectal liver metastasis, oncoplastic breast surgery, gastric bypass and laparoscopic distal pancreatectomy and splenectomy, followed by the Colorectal Operative Surgery Symposium.

The Alfred Hospital Intensive Course in General Surgery should appeal to general surgeons in all areas and all subspecialties.

We look forward to your attendance at the course and once again being able to come together with our colleagues. ■

Professor Jonathan Serpell AM FRACS
Convener, The Alfred Hospital Intensive Course in General Surgery 2021

Early bird registration closes on 19 September 2021. Register online now: www.alfredgeneralsurgerymeeting.com

For more information, contact:

RACS Conferences & Events Management

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QASM Annual Seminar 2021 Surgery – Timing is Everything

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

The QASM seminar is conveniently held the day before the Directors of Surgery and Queensland Health State Wide Services Forum on Friday 19 November followed by the Queensland State Conference held on Saturday 20 and Sunday 21 November on the Sunshine Coast at Peppers Resort, Noosa.

A live webinar is 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 (12.30 pm during the lunch break and 3.30 pm 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)
- Professor Marianne Vonau (Queensland, Neurosurgeon)
- Mr Sanjeev Naidu (Queensland General Surgeon, Queensland State Committee)

Parking will be available on the SCUH campus with approximately 3500 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

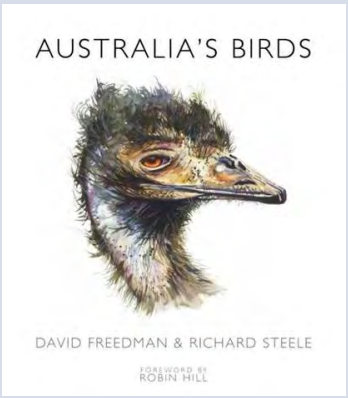
If you have any questions about this event, please contact the QASM team at QASM@surgeons.org

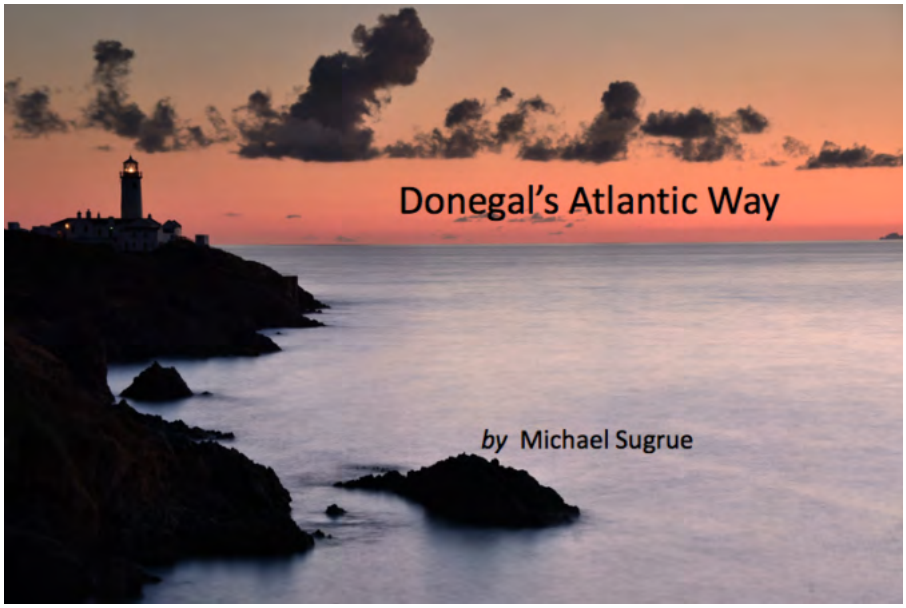
Good reads

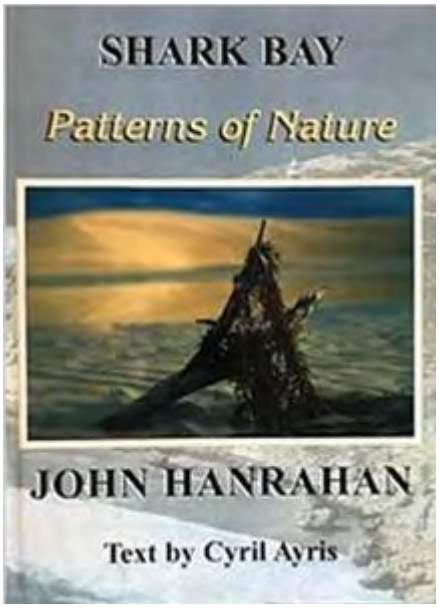
Australia's Birds
David Freedman & Richard Steele
Foreword by Robin Hill

Australia's Birds is a beautiful coffee table book of 292 pages including text and some 240 watercolour paintings of Australia's most common and interesting birds. David Freedman's illustrations depict the personality of each bird species. Richard Steele's informative and often humorous text make it a publication in which you will find something new every time you open it. The foreword has been graciously penned by renowned Australian ornithologist, author, illustrator and naturalist Robin Hill.

This book sets out to be quite different from other books on birds. Its simple and elegant design by expert Gavin Fry is aimed directly at celebrating the beauty and diversity of our Australian birds. The quality, unique format, modern design and state-of-the-art printing ensure this publication will become an instant favourite with all age groups and a future collector's item. Each illustration has been individually calibrated with the printed image by Adams Printers of Melbourne.







If you have published a pictorial or coffee table book and would like to donate a copy to the Library, we would love to add it to our collection.

In memoriam

RACS publishes abridged obituaries in *Surgical News*. Full versions can be found on the RACS website.

Informing RACS

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

ACT: college.act@surgeons.org

NSW: college.nsw@surgeons.org

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John Kendall Francis FRACS

General surgeon

15 February 1927–19 November 2020

John Kendall Francis will be remembered for three things: his skill as a surgeon; his enthusiasm as a teacher; and his compassion for those less fortunate than himself.

His initial schooling was at the East Kew State School and then at Ballarat High School. He earned his pocket money doing an early morning paper round. He started medicine at the University of Melbourne in 1944, graduating with honours in all subjects in 1949. He obtained his Master of Surgery degree in 1953, and went to Korea and Japan with the Australian Army Medical Corps.

Following this he sailed to England and obtained his FRCS in 1954. On his return to Melbourne he gained his FRACS and was appointed as a consultant to Footscray Hospital, which had only just opened, and to Prince Henry's. He continued as a member of the senior medical staff of both Hospitals until 1991.

In 1967, he led a Prince Henry's Hospital civilian surgical aid team to Vietnam. The team worked at Bien Hoa, a local provincial hospital 20 km out of Saigon. There was no political motive in Kendall's service in Vietnam. He regarded it as part of his calling as a doctor to serve those less fortunate. In Vietnam, he demonstrated his surgical skill, his organisational skills as a leader and motivator and his compassion for the Vietnamese civilians. He subsequently showed those same skills during a secondment to Timor-Leste.

At Prince Henry's Hospital, he and his close friend Bob Marshall, with the support of Vernon Marshall set up a surgical unit of the highest standard.

Felix Behan, David Scott, John Royle, Trevor Jones and Graham Thompson

Robert Lyons Pearce AM CStJ RFD OM(Fr.) FRACS

Plastic & reconstructive surgeon

20 April 1940–17 November 2020

Robert Pearce died suddenly and unexpectedly, the result of a pulmonary embolus, on 17 November 2020. Always interested in working with his hands, at the time of his death he was working at the local Men's Shed with his fellow weekend carpenters, making a table for the museum in Mandurah, Western Australia.

Robert Lyons Pearce was born on 20 April 1940, the son of Edward 'Ted' Pearce, the Chief Stipendiary Magistrate in Queensland, and his wife Jean, née Lawson Lyons. Robert completed his high school education at Gympie in December 1957 and enrolled with the Faculty of Medicine at the University of Queensland the following year.

He graduated MBBS Qld in 1965 and served as a Resident Medical Officer at the Princess Alexandra Hospital, Brisbane, 1966–1967. Following his desire to pursue a surgical career, he worked as a surgical registrar at the Toowoomba General Hospital in 1968 and then as a research assistant in the Lyons Renal Research Laboratory at the Princess Alexandra Hospital in 1969, subsequently winning the National Heart Foundation Essay Prize for his work on maintenance of normal blood pressure.

In 1970 he was appointed as a teaching registrar/surgical registrar at the Royal Children's Hospital in Brisbane, 'backfilling' the service of physicians and surgeons who had volunteered to serve in the Vietnam war.

Mr Peter F. Burke FRACS

For the full obituaries please visit our website.

Royal Australasian College of Surgeons
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