SurgicalNews

Volume 21 | Issue 02 | **March-April 2020**

Page 24
COVID-19 | the impact on surgical training

Spotlight on | Page 8
Diversity and inclusion

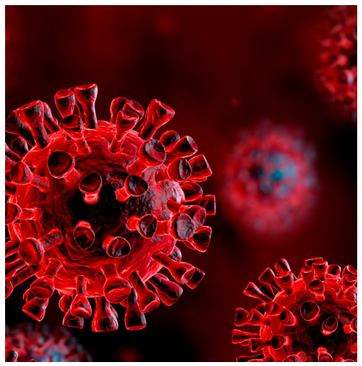
Royal Australasian College of Surgeons

SurgicalNews Volume 21 | Issue 02 | March-April 2020

RACS leadership

Spotlight on

Diversity and inclusion



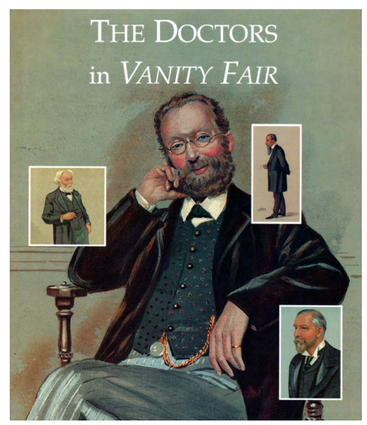
Articles of interest

Research

Historical

Education

Global Health



FSC www.fsc.org MIX Paper from responsible sources FSC® C007821

The Royal Australasian College of Surgeons supports green printing initiatives. Surgical News has been printed on FSC certified paper using vegetable based inks by Printgraphics Printgreen under ISO 14001 environmental certification. Surgical News is fully recyclable.

Correspondence and letters to the editor for Surgical News should be sent to: surgical.news@surgeons.org
Editor: Abderazzaq Noor
T: +61 3 9249 1200 | F: +61 3 9249 1219
Contributing writer: Sharon Lapkin
www.surgeons.org
ISSN 1443-9603 (Print)/ISSN 1443-9565 (Online).

Cover image: *Illustration by Ness Flett*

President’s perspective

The COVID-19 pandemic has changed life as we know it. I cannot recall spending an Easter break, when I have not been on call, anywhere other than camping on the banks of the River Murray. We are all part of a worldwide crisis and as surgeons who like to plan and consider the consequences of our actions, we are challenged by uncertainty, and conflicting advice and evidence that is presented to us. These unprecedented times have severely impacted our personal and professional lives.

We have had to quickly adapt to the many changes, but we have also learnt a lot in the process. The disruption it has caused to all aspects of our daily lives has been monumental –cancellation of day-to-day business and personal activities, the devastating health impacts, the economic meltdown that many governments, organisations and businesses are facing.

It quickly became apparent that we had to make some difficult decisions to protect the health and wellbeing of our Fellows, Trainees, International Medical Graduates, staff and the many other workers in the healthcare system. With this in mind, in early March we cancelled all RACS face-to-face events including courses, forums, and committee meetings for a period of one month.

As the situation escalated, we had to cancel other activities such as examinations and flagship events such as the Annual Scientific Congress, following the Australian and New Zealand governments’ advice banning large gatherings to limit the spread of the coronavirus. At that point we reiterated to our Trainees that we would provide all exam candidates with a minimum of three months’ notice when a decision to reinstate exams is made.

I empathize with our Trainees and I understand their concerns about their ability to achieve the requirements of the Surgical Education Training (SET) program for progression. I would like to reassure them that no Trainees will be penalised. We have allowed for extensions of training where necessary to allow mandatory requirements to be met. Should an extension of training be necessary, the maximum time to complete SET will also be extended. Trainees are obviously concerned about the uncertainty of their future and need to be reassured that surgical training and being a surgeon is not just about surgical knowledge and technical skill. This is a time when the other RACS competencies can be progressed including Collaboration and teamwork; Communication; Health advocacy; Judgement - decision making; Management and leadership; Professionalism and; Scholarship and teaching.

Equally, our Fellows have had their continuing professional development (CPD) disrupted. A commitment to lifelong learning and participation in CPD is an important way we demonstrate our professionalism to our peers, patients and the communities we serve. We understand that while COVID-19 will impact each surgeon differently, the restriction on participation and access to CPD events will affect us all. Considering these circumstances and the rapidly changing nature of the situation, we have approved the extension of the CPD period for 2020 to May 2021. Fellows will not be subjected to verification of CPD for this period. We will develop activities throughout the year to support Fellows to meet CPD requirements. The revised RACS CPD Framework is scheduled for launch in July 2021 and we look forward to communicating changes to you throughout the year.

While it is hard to find positives in the situation created by COVID-19, I am pleased to say that we have seen great collaboration among colleges, across our specialty societies and the medical workforce in general. We worked closely with the Australian and New Zealand College of Anaesthetists (ANZCA), the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and the Royal Australian and New Zealand College of Ophthalmologists (RANZCO) to call for a stop to all elective surgery, except urgent cases.

We were dismayed to see private hospitals standing down staff as the economic impact of COVID-19 escalated. We called on the federal and state governments in Australia to inject resources into the private sector to prevent job losses. This issue highlighted the importance of ensuring both the public and private sectors of our healthcare system are working optimally so that they are ready and able to help when the full impact of COVID-19 hits. We have to do absolutely everything to ensure that our health systems don’t get overstretched.

Australia and New Zealand are developed countries and we have many resources at our disposal, even though the challenges we face are many. I would urge you to spare a thought and extend support as best as you can to our neighbouring countries. The College, through its Foundation for Surgery, supports critical global health, Indigenous health and research to help ensure all children, families and communities have access to quality surgical care when they need it most. More than ever the Foundation needs your support to ensure that we support these communities. Please remember to donate to the Foundation for Surgery.

Another lesson for us has been the importance of communication. People everywhere wanted to know what was going on and our Fellows, Trainees, International Medical Graduates and staff were no different. Our management team at RACS set-up daily meetings to discuss what needed to happen on and we committed to communicating what we knew – general information, surgical guidelines and other relevant information. Thank you for your positive feedback regarding our communication efforts.

We anticipate that we may be living in these constrained conditions for possibly six months and measures such as social distancing to slow the spread of the virus are important to protect lives. At RACS, we have our staff working from home until further notice. This was a proactive measure to ensure that we are minimising the risk to all staff and ultimately minimising the risk to our surgical workforce. We remain available to offer support and take enquires from our Fellows, Trainees and International Medical Graduates.

We are operating in unchartered territory and we have had to adapt to the rapidly changing world around us. Our hope remains that we will come through this and repair the damage done to our lives, our health systems, our education and our economy. We will need to work together to do the best we can.

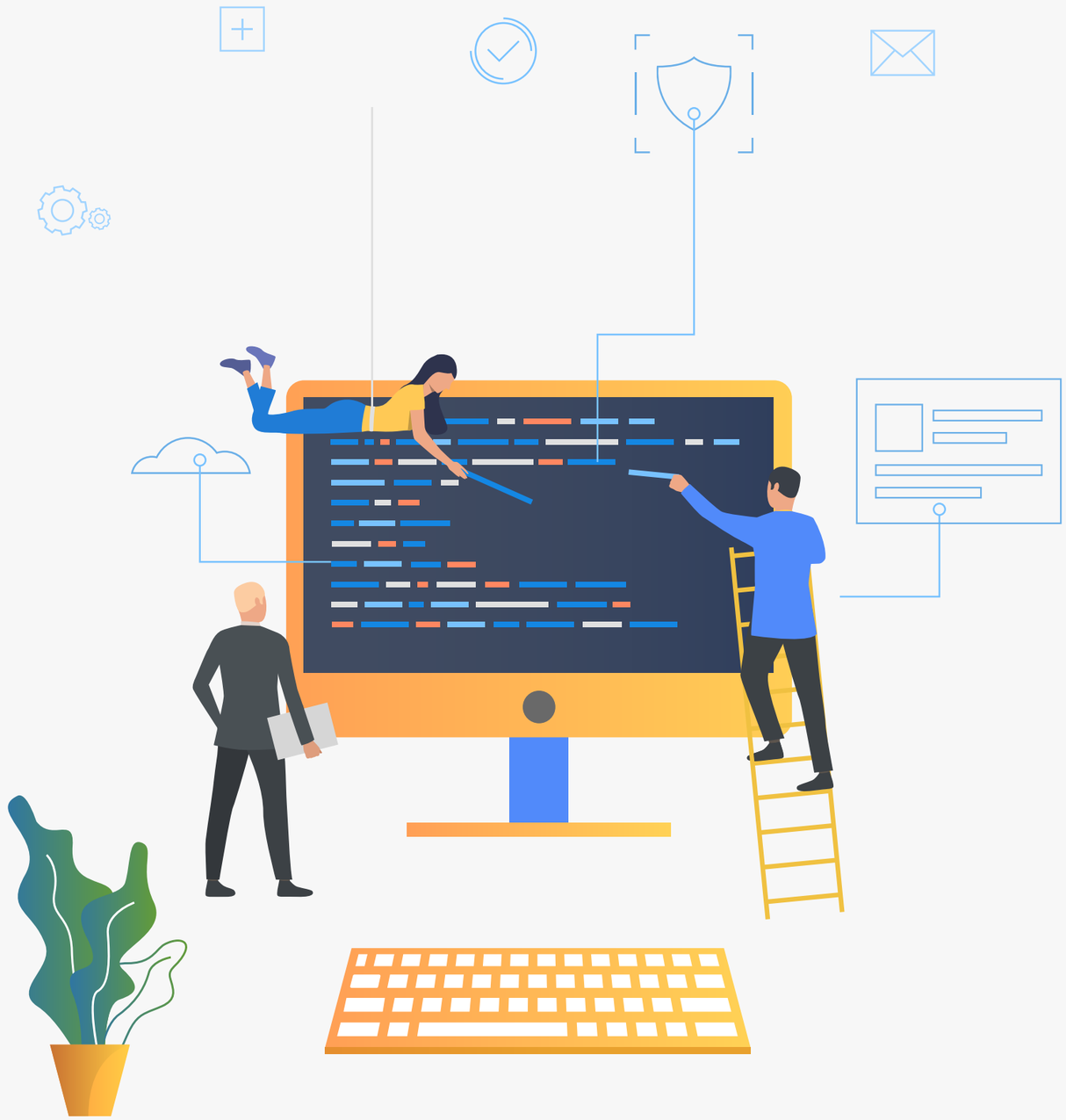
COVID-19 has reminded us how vulnerable we are as a society. It has also reminded us how dependent we are on each other and how important a fellowship organization can be in supporting those with different interest. We also need to more mindful of our personal wellbeing and behaviour, as that can affect our performance and that of others, as well as impact on patient safety. These have been good lessons and it is my sincere hope that we come out of this stronger and with a greater appreciation for values such as compassion and kindness.

While this period is very unfair to many, those who are lucky may lose a year of their lives, while those who are unlucky may lose their lives.

Stay safe. ■

Mr Tony Sparnon
President

The One College Transformation



The Royal Australasian College of Surgeons is an organisation of almost 7000 Fellows, 1800 trainees, 150 International Medical Graduates and 240 staff. It has capabilities across a range of activities such as education, training and research, professional standards and advocacy, global surgery and philanthropy. Harnessing our College's resources efficiently and effectively to support these activities is a challenge that increases as demands and expectations grow.

The Council, elected by the Fellows, is resolved to strengthen the governance of RACS to streamline its decision-making structures and processes, and improve engagement of Fellows. Work is advancing to achieve this. The Governance Committee's review of RACS governance is underway and minor changes have already been implemented.

One of the objectives is to reduce the number of committees (there are currently about 130). An important benefit of committees is that they provide an avenue for Fellows to be involved in College activities. A disadvantage is that the current structure is cumbersome, slows decision-making, can lead to frustration and is resource intensive. The requirement for committees that are primarily operational to report to Council through a chain constrains agility. These entities can function more effectively as organisational units: focused teams of Fellows, skilled staff and external advisors applying their expertise to shared objectives.

For example, the ASSET (Australia and New Zealand Surgical Skills Education and Training) Committee is charged with overseeing the delivery of fundamental surgical skills training to SET1 and prevocational Trainees. The committee comprises a team of Fellows, staff and educators who could manage that objective autonomously, provided they work within the agreed RACS strategic objectives and budget. This group should not have to seek permission through the Prevocational and Skills Education Committee, the Education Board and Council to update the course.

The One College Transformation is a College-wide infrastructure enhancement initiative. Although often perceived as an IT update, its scope also includes people and culture and governance changes to optimise decision-making and operational efficiency. The first two phases are complete, with a full review of RACS capabilities and organisational architecture, an update of aging IT hardware, and substantial security enhancements. Two key elements of the current phase involve review of the governance-management interface and rationalising the diverse software products currently in use to deliver a contemporary platform. As part of this project, RACS has become one of 1700 Microsoft partners worldwide, ensuring access to the latest enterprise resources. This partnership is expected to deliver significant benefits to Fellows, Trainees and International Medical Graduates over the next few years.

The One College Transformation Steering Group model will likely to be replicated in other domains of RACS activity. The steering group functions as a team, chaired by the Chief Executive Officer (CEO). The group also includes the Vice President, several Councillors and Fellows, the chief operating officer and external experts working in partnership, each contributing expertise and experience. The important difference between this and traditional RACS committees is that the Chair is not a Fellow; the CEO is fully empowered in his leadership role. Provided decisions fall within the prescribed budget, strategy and timeline, he does not need ratification. Recommendations exceeding the CEO's delegated authority must be approved by Council. Clarity of strategic objectives, budget, timelines, and performance metrics is fundamental to this model's success.

> Achieving this governance shift will require Council and committees of Council to dedicate their energy to strategic thinking and discussion, entrusting RACS management with the operational aspects.

This re-orientation does not come easily to surgeons, who are highly trained to focus on operational details. It is this intense focus that makes excellent clinicians, yet it can create challenges when we step out of the clinical arena and into governance. We are less adept at taking the big picture view and thinking strategically; we may struggle to delegate operational control to those we perceive as having received less rigorous training in technical detail. During my years on Council I have been in awe of the intellect and skill of external advisors, their ability to ask the right question in the right way at the right time, their maintainence of the appropriate overview, and not over-asserting a viewpoint or micro-managing. The needs of Fellows, Trainees and International Medical Graduates will be most effectively met if we bring people with those skills to work alongside us as equals in the governance and management of RACS.

The vision of the One College Transformation initiative is a robust, integrated RACS governance, management and infrastructure, which supports all Fellows and provides greater opportunities to be involved in, and feel part of, the capability the College offers the Fellowship, aspiring Fellows, and the surgical profession. ■

Mr Richard Perry
Vice President

Spotlight on

Diversity and inclusion

Our work to support diversity in the profession continues.

Diversity, in all its dimensions, will strengthen the profession of surgery and the College, and our profession will be strengthened by our ongoing efforts to ensure our surgical workforce reflects the diverse communities we serve.

Diversity and inclusion is part of the wider work we are undertaking in the College to build a culture of respect in surgery We are working towards:

- inclusive culture and leadership excellence
- gender equity
- inclusion of diversity groups
- diverse representation on Boards and in leadership roles, and
- benchmarking and reporting.

Read on to find out more about our broad range of Fellows, and some of the areas RACS is committed to supporting.

Faces of RACS

Dr Rhea Liang

Being a surgeon today means having the skills to manage healthcare in an increasingly complex environment. Patients are more complex, diseases are more complex, healthcare systems are more complex, society and societal expectations are more complex. It is no longer about being the boss or being able to operate but about a full range of skills, including flexible leadership and followership, a growth mindset and willingness to learn, and the understanding that very little nowadays is black and white.

The best part of my day is still the operating, when time seems to stand still and I am completely absorbed in what I am doing in order to help the patient. I think the desire to help others through one's surgical skills is the most important motivation for choosing to be a surgeon. There are, of course, rewards in remuneration and recognition that come from being a surgeon, but nothing to me is more rewarding than seeing that I have been able to help someone who was suffering.

Dr Jasamine Coles-Black

To be a surgeon today is to be a leader, an innovator, an academic, an educator, and an advocate for your patients as well as for what you believe in.

I love Vascular surgery as I enjoy working under pressure, the technically challenging and varied case mix and the complexity of patient pathology. However, if I have to narrow it down to my favourite aspect, it would be that the specialty has historically been at the forefront of new technologies.

Professor Deborah Bailey

Surgeons hold the trust of people in their most anxious times, we wield instruments that can harm and heal, and we have studied and worked for years so that this responsibility can be borne, despite our constant critical self-analysis. We must be a technician, compassionate physician, resource manager, technology buff, evidence-based expert and political punching bag.

As cool as it is to see the smiling faces of the children, the real best part of being a surgeon (Paediatic)is that special moment when you realise that you have received the trust of the caregivers (and hopefully the child as well): trust that you care what is going to happen and that you are going to do your best, even if you don't have all the answers. An operation completed as planned is a joy forever. And, ok, the smiling faces.

Mr Richard Lander

Today there is an urgent need to attract medical and postgraduate students to join the profession. Surgeons must create enthusiasm by being good role models and mentors. They must create a sense that young surgeons are recognised members of the community and that there are prospects for career development. Positive recognition by other colleagues, medical students, friends, family, nurses, other physicians and patients generates basic feelings of success and satisfaction.

The surgeon today is a surgeon and physician, a teacher, a leader, a manager and advocate, a family and community member. They must know their limits and recognise that they cannot do everything, and then manage the 85 per cent they can.

Dr Jennifer Chambers OAM

I wanted to be a missionary doctor and saw surgery as the most practical skill set to take with me. I loved the hands-on nature of surgery and the fine motor skills required. Enabling patients to actually get better and be healed is an amazing blessing.

The best part of working in my specialty has been the huge changes in Vascular Surgery that allow us to treat more elderly and unwell patients in less invasive ways, with better outcomes than ever before. The technology just continues to develop and it is wonderful to always be learning new skills.

Associate Professor Felix Behan

The information so readily available on internet today means that the patients are more informed, quite rightly, about their condition. They sometimes question the authority in surgical consultations, which may irritate. But this is the correct process and the value of a second opinion is sometimes mandatory. Any future operating will have a sound foundation.

I had the basic mental ability to pass university and college exams and was technically adept in many functions, from woodwork to mechanical repairs. This augured well for future surgical aptitude. It is also important to cultivate the characteristics of good observation. Any observational finding comes quickest to those attuned to the current research obligations.

Dr Mary Theophilus

A surgeon today is a multifaceted creature who understands and provides holistic patient care with shared decision making and empathy. Practising the art and science of operating is only one tiny part of our intense, complex and really quite fascinating lives.

I love the diversity that presents itself in Colorectal surgery, from the varying pathology, the size and complexity of the operations, and the patients themselves, whose lives we are privileged to be a part of. My Colorectal colleagues are by and large some of the most wonderful collegial characters on the planet. There is never a dull moment.

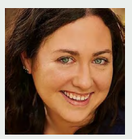
Operating is the best part of my day: the challenges, the rewards and the interactions with the whole team. Most of all I love the blissful bubble of pure concentration that blocks out all the other chaos when I'm in the zone. ▶

> A surgeon today is a multifaceted creature who understands and provides holistic patient care with shared decision making and empathy.
>
> Dr Mary Theophilus

Mr John Tharion

As a medical student I wanted to be a physician and was in awe of their clinical acumen and diagnostic skills. But when I became an intern I found that surgeons can make a diagnosis as well as offer definitive treatment, and what they did made a difference to the patient. I was convinced that I could offer more by being a surgeon.

Surgery is always evolving. The principles of treatment do not change but the way we do things will. The next challenges will be integrating artificial intelligence into surgery and adapting to developing technologies. While I think that robotics will become more common there will be technologies we have not even thought of today that will change the way surgeons work in the future.



Dr Jacinta Cover

The best part of General Surgery (and rural surgery) is the diverse case load and variety. It's great to be part of the community in rural surgery.

I see the future of surgery in technology advancements but also in patient engagement, looking to greater patient empowerment in modifiable outcomes.

Dr Jane Strang

Surgeons are not 'just' surgeons, we are leaders within the District Health Boards we work in.
Each of us has an obligation to progress patient care and be involved with clinical governance. We also have a huge responsibility to train the surgeons of the future, something I believe is not always well recognised by the system we work in.

There are core attributes that we need as surgeons and these attributes are not confined to one or two sectors of our population. Diversity brings so many benefits to our profession and our patients; I have enjoyed seeing the changes over the last twenty years as a result of an increasingly diverse workforce.

Dr Michael Ee

The best part of working as a paediatric surgeon is performing life-improving surgery on children and seeing them going home with a smile. Being a paediatric surgeon, I get to combine my two loves: Paediatrics and surgery from medical school, and as a houseman in the United Kingdom. I'm the current RACS Regional Trauma Chair (Tasmania) and am passionate about trauma prevention, including firearms safety.

I am also a keen educator/SET supervisor and very thankful for having been taught by my learned skilful teachers, mentors and even Trainees at times. My aim as an educator is to produce Trainees who are better Paediatric surgeons than I am and that is when I consider my job well done.

Dr James Churchill

The impact of the convergence of disruptive technology such as big data, blockchains and next-generation sequencing on medicine and surgery is difficult to predict, but the possibilities are enormous. Imagine if a patient could own and grant access to their transferable medical 'code', complete with big data-backed calculations of their likelihood for any given medical condition, complication and response to treatment, for use by their surgeon?

These tools already exist in other industries and their coming implementation in medicine will present significant technical, professional and ethical challenges. Future surgeons will need to be able to manage the massive burden of data (including research and new knowledge) and navigate difficult decision-making in the face of paradigm shifts in areas that we think that we know.

Dr Carina Chow

Colorectal surgery may not be the most glamorous but as a speciality it's fantastic. It has given me a broad range of skills – from massive open operations to minimally invasive and robotic surgery, all of which have taught me completely different skill sets. It has allowed me to pursue my varied interests, from the excitement of working on the frontline of technology, to working with essentially a knife, fork and spoon in remote areas of the Pacific Islands.

The best part is the colorectal surgeons. They are a very collegial, friendly and fascinating group. There is very little arrogance and great collaboration across the country. I enjoy the team and teaching aspect the most; working with a group of people who all have the same aim – to get the best outcome for the patient.

Dr Rajay Rampersad

I've had a long-term interest in anatomy and how things work and function. The attraction of being able to definitively fix most things with an operation combined with an interest in paediatrics made Paediatric surgery a natural choice.

> The surgeon today is a surgeon and physician, a teacher, a leader, a manager and advocate, a family and community member.
>
> Mr Richard Lander

The best part of Paediatric surgery is how quickly kids recover, even from the most traumatising surgeries. Their outlook on life is amazing – they haven't learnt the 'sick role' yet and as a result they get up and go much more quickly, which makes my job much easier.

Dr Lupe Taumoepeau

I was five when I started telling people I wanted to be a doctor. It never felt out of my reach, which is probably why there wasn't a plan B. I found it amazing you could change someone's life for the better with your hands. There's a strong service ethic in the Tongan community, to look after each other and put others first.

Dr Heidi Peverill

Being a surgeon today is a challenging but rewarding career. Patients, their families, hospitals and regulators all expect us to maintain a very high standard. We increasingly operate in highly co-ordinated teams, involving radiology, oncology and other specialities of medicine. This means we need to have exceptional communication skills to ensure the best outcomes for our patients.

My grandfather, Charlie Lomas, was a Thoracic surgeon. I spent a large amount of time with him as a child – he taught me to ride a horse, drive a car, peel a prawn. I saw the effect he had on patients' lives, as people would come up and thank him when we were out and about. It made me want to do something meaningful with my life too.

Mr Jitoko Cama

Paediatric surgeons are fortunate because we can still be regarded as general surgeons looking after young people, namely from the newborns to adolescents. Therefore, with some exceptions, we surgically manage the younger population from head to toe. We are a small, close knit and supportive group of professionals who are always keen to give advice and assist each other with complex surgeries. Seeing the smiles on these kids' faces and the relief and gratitude of the parents is always satisfying. The best part is getting a fist bump, high five or a hug from the kids when they recover from their surgery.

Dr Mohammad Amer

General Surgery has the perfect mix of bedside diagnostic workup and management, diverse subspecialties and operative aspects. The most enjoyable part of my work is being part of the patient's perioperative journey and recovery, which is humbling and rewarding in equal measure.

I think a lot of factors contributed to my ending up in surgery. My father was a general surgeon before he retired into teaching, so I grew up hearing a lot about it. I had a number of great surgical mentors and role models throughout medical school and in my pre-training years who encouraged and supported me. Ultimately though, I was attracted to the practical, problem-solving nature of surgery.

Associate Professor Susan Neuhaus

Being a Surgical Oncologist requires close relationships with patients and colleagues from multiple different disciplines. Despite the fact that I write a lot of condolence cards to families, it is a huge privilege to travel with them through a cancer diagnosis, surgery, and often (but not always) for decades of follow-up. I am always struck by how much a cancer diagnosis, no matter how tragic and difficult at the time, often contains a gift of changing priorities, reassessment of lives and healing of relationships that otherwise might never have occurred.

Dr Sally Meade

As surgeons we are held to increasingly high standards, with the expectation of incisionless, non-invasive, error-free curative surgery. In my opinion, our role as surgeons is to maintain quality of life first and foremost. This is particularly important as I think the principle challenge of our time is to consider how we use our precious resources, and how we can deliver surgery sustainably.

In the future I expect to see increased utilisation of telehealth: teleconsulting, tele-mentoring, tele-proctoring, telesurgery, tele-trials – using technology to improve access, education and support for patients, surgeons and Trainees in regional, rural, and remote areas. Seeing the value in the application of this technology may be an unexpected 'benefit' of the current COVID-19 pandemic. ■

Indigenous health

RACS acknowledges Aboriginal and Torres Strait Islanders as the land owners of Australia and Māori as tangata whenua (people of the land) of New Zealand. RACS is committed to Indigenous health and places emphasis on the most appropriate and effective ways to achieve the vision of health equity, as well as increasing Indigenous representation in surgery and creating a surgical enviroment that is culturally safe and more relatable to Aboriginal, Torres Strait Islanders and Māori.

The Indigenous Health Committee (IHC) and Māori Health Advisory Group are instrumental in ensuring these priorities are met. The IHC, supported by RACS Indigenous Health Project Officers, also has a wider role in helping apply an Indigenous lens to other College projects. Two documents that guide the Indigenous Health portfolio are the Reconciliation Action Plan and Te Rautaki Māori.

Above and over page: Participants spent the first day of the LIME conferenece at Ōnuku Marae, near Akaroa Christchurch

Health equity

World Health Organisation defines equity as: "the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification. 'Health equity' or 'equity in health' implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential."

The United Nations Declaration on the Rights of Indigenous People also addresses health equity and the health rights of Indigenous people. Article 23 states that Indigenous peoples "have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them…" and Article 24 (2) states "Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health."

Reconciliation Action Plan 2020-2022

When it comes to Indigenous health, several tools are used in our effort to address Aboriginal and Torres Strait Islander health inequities. One such tool is our Reconciliation Action Plan (RAP). A RAP is a strategic document developed to support an organisation's business plan. The purpose of a RAP is to contribute to reconciliation both internally and in the communities in which the business operates within. Our current RAP is part of a series of RAP frameworks created by Reconciliation Australia. There are four frameworks in total: Reflect, Innovate, Stretch and Elevate. Each stage is a progression from the last and each is designed to assist an organisation on its Reconciliation journey. Our current Reflect RAP is in the process of being superseded by RACS Innovate RAP, which is currently in development. We are aiming to launch the new RACS Innovate RAP in late May 2020.

Te Rautaki Māori, Māori Health Strategy and Action Plan 2020-2023

Te Rautaki Māori (meaning Māori Strategy) presents an opportunity to build upon some of the work implemented through the previous Action Plan 2016-2018. It maps a path toward achieving the vision of Māori health equity and a culturally safe and competent surgical workforce. Te Rautaki Māori includes six kaupapa (priority areas):

1. *Pae Ora* (Healthy futures) is the New Zealand Government's vision for Māori health, which provides a platform for Māori to live well and healthily in an environment that supports a good quality of life;
2. *Mātauranga Māori* (Māori knowledge and capability) provides a foundation for building a capable surgical workforce and increasing the Māori knowledge of RACS governance groups and staff to make informed decisions on issues relating to Māori;
3. *Whakatipu* (Workforce development) focuses on increasing and maintaining the Māori surgical workforce and creating an environment that is safe for Māori;
4. *Rangahau Māori* (Research and development) is using kaupapa Māori methodology to undertake research that is beneficial for Māori and increases understanding of te ao Māori and mātauranga Māori;
5. *Kaupapa Here* (Stronger policy and development). Policies that are reviewed and/or developed will produce better results for Māori and better reflect the needs and aspirations of Māori;
6. *Ngā Hononga* (Partnerships) will be developed and maintained to support the progression of Te Rautaki Māori.

The strategic framework includes the Treaty of Waitangi principles as the foundation for policy review and development, planning and building partnerships. These are:

- Tino rangatiratanga: the guarantee of self-determination
- Partnership: good faith, mutual respect, be able to express tino rangatiratanga
- Active protection: Mana motuhake, manage affairs according to own tikanga and also tikanga present in mainstream health services
- Options: right to choose social and cultural path and exercise authority
- Equity: specifically target disparities, expected benefits of citizenship

The full version of Te Rautaki Māori 2020 – 2023 was endorsed by Council in February and will be available on the RACS website by April.

Indigenous Health Meetings

The Indigenous Health Committee meets three times a year, with one face-to-face meeting. The IHC's next meeting is 26 May.

The Māori Health Advisory Group also meets three times a year with one face-to-face meeting. Its next meeting is 23 April.

If you would like to raise an issue with either group please make contact with Damien Loizou or Chelsea Jacobs-Prescott via indigenoushealth@surgeons.org.

Leaders in Indigenous Medical Education Conference

The Leaders in Indigenous Medical Education (LIME) Conference hosted by Otago University Medical School took place in November 2019 in Christchurch, with RACS Fellows and staff from Melbourne and New Zealand in attendance. One of the highlights was the first day spent at Ōnuku Marae, near Akaroa Christchurch, where participants were treated to a traditional powhiri (Māori welcome) and learned about the Māori history of the area.

The next three days of the conference saw some amazing presentations about Indigenous people in medicine, cultural safety versus cultural competence, personalised and institutional racism, medical students' experiences in community health centres and more.

Indigenous Health Committee Members
Maxine Ronald (Chair)
David Murray (Deputy Chair)
Michael Wilson
John Mutu-Grigg
Ben Wheeler
Ben Cribb
Andrew Martin
Stephen O'Leary
Stephanie Weidlich
Secretariat – Damien Loizou

Māori Health Advisory Group Members
Patrick Alley (Chair)
Maxine Ronald
Jonathan Koea
John Mutu-Grigg
Ben Wheeler
Ben Cribb
Rachelle Love
Jaclyn Aramoana-Alridge (Trainee)
Secretariat – Chelsea Jacobs-Prescott

The IHC oversees the work of the Māori Health Advisory Group

Tēnā koutou katoa (Greetings to you all)

Te Reo Māori (the Māori language) is an official language of New Zealand under the Māori Language Act 1987. Before the 1800s Māori was the only language spoken in New Zealand. Due to colonisation processes and deliberate language domination, by 1960 only 25 per cent of Māori were speaking the language. Today there is an increase in Te Reo Māori speakers driven by the community and the more recent initiatives implemented across the education sector by the New Zealand government.

The use of Te Reo Māori within RACS documentation enhances the integration of Māori knowledge, supports a te ao Māori (Māori world view) environment and creates a sense of belonging to which Māori can connect.

Try incorporating Te Reo Māori into your day:

- Greet someone with *Kia ora* (Hello or G'day).
- Farewell someone with *Ka kite* (goodbye).
- Begin emails with *Kia ora* (informal greeting) or *Tēnā Koe* (formal greeting for one person), *Tēnā Kōrua* (for two people) or *Tēnā koutou* (three or more people).
- Sign your emails with *Ngā mihi* (Kind regards).

If you're nervous about pronunciation there's no need to worry, you can visit www.maoridictionary.co.nz. Search for the word you would like to hear pronounced and then click on the speaker icon. Even if you're not sure, it is always good to give it a go!

Dr Rachelle Love, Dr Maxine Ronald and Dr Kelvin Kong at the LIME Conference

Language nations

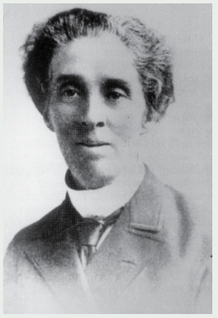
Aboriginal people over the past 65,000 years dispersed and settled into different groups and areas. Over this time more than 250 separate language nations were formed. Each Aboriginal language nation has its own geographical region, language, cultural beliefs, laws and political systems. In some regions, sophisticated hand-sign languages were also developed.

Like other cultures (such as Vikings) that relied on the oral transmission of history and culture, Aboriginal people's history and cultural practices were transmitted through Songs and ceremonies.

Language nations were separated by geographical boundaries but connected by trade, culture and exchange of information. Songs were sung during journeys that captured details of the trade routes connecting neighbouring Nations, including information on landmarks and directions, backgrounds to ceremonies, and details on the locations of water and food sources. These are known as Songlines.

The IHC Team is working on assisting RACS regional offices with a reference tool to assist with the pronunciation of the language nationin which RACS state offices are situated. If you would like more information don't hesitate to contact the IHC team at indigenoushealth@surgeons.org.

RACS milestones



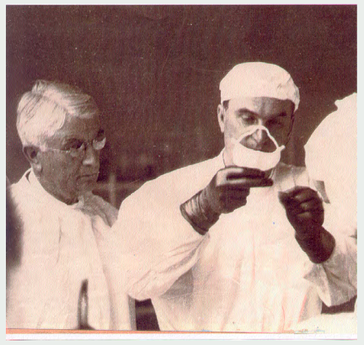
RACS was formed on 5 February 1927 and its first President was Sir George Syme. Its remit was to raise and uphold surgical standards. Initially, Fellows were elected but later it was felt that there was a need to train aspiring surgeons. Prominent among the Founders was Sir Hugh Devine who is also recorded as our first Fellow.

Sir Hugh Devine
Devine was a charismatic Melbourne surgeon (pictured below with US surgeon William Mayo) who played a pivotal role in the development and formation of the College. He was a councillor for many years and President, 1939-1941. Most of his working life was spent at St Vincent's Hospital, Melbourne where he and his colleagues facilitated the hospital's growth and affiliation with the University of Melbourne as a clinical school.

Devine's surgical interest was gastro-intestinal surgery and his publications include the classic Surgery of the Alimentary Tract, 1940.

Lilian Cooper
Lilian Cooper (pictured above) became a Foundation Fellow in 1927, our first female FRACS. Born in Chatham, England, she migrated to Queensland and was the first female medical practitioner to be registered there. In 1896 she was appointed as an Honorary Medical Officer at the Hospital for Sick Children in London.

Cooper was determined to offer her medical services to the war effort: in 1916 she joined the Scottish Women's Hospitals and was sent to the Serbian front. Conditions were horrific but she did incredible service at Ostrovo and the makeshift Doraveni Dressing Station.



THE 1930s: THE SPECIALTIES EMERGE
During RACS's early history, most surgeons practised general surgery but many, such as Hugh Trumble, were also interested in other disciplines, such as Orthopaedics. Trumble had many strings to his bow and by 1934 he had established a Neurosurgery unit at the Alfred. In 1940, he was one of the founders of the Neurosurgical Society of Australasia.

In the early 1930s, the College's specialties consisted of Ophthalmology and Laryngo-Otology (Otolaryngology). The first Fellow in Laryngo-Otology was Sir Arthur Amies in February 1934. However, Amies' primary focus was dentistry and he had a distinguished career as a Professor of Dental Science.

Jean Littlejohn
In 1935 Littlejohn became the sixth female Fellow of the College. After graduation from the University of Melbourne, she became interested in the fledgling specialty of Laryngo-Otology and was its third Fellow. Appointed Assistant Surgeon at the Royal Victorian Eye and Ear Hospital in 1929, she was the first person to be awarded a Diploma in Laryngology & Otology from University of Melbourne, 1933.

In 1947 she was appointed Clinical Dean of the Eye and Ear Hospital and after retirement , in 1957, established the Jean Littlejohn Deafness Investigation and Research Unit there.

AFTER WORLD WAR 2: THE RAPID GROWTH OF SPECIALTIES
The number of specialties at RACS grew rapidly after the war and the College also introduced its own examinations for Primary (1950) and Final (1947) Fellowship. Prior to these dates, examinations had been held under the auspices of the English College. The number of women surgeons also began to increase but most women chose to specialise in general surgery, obstetrics and gynaecology, ophthalmology or paediatrics.

Sir Benjamin Rank
Rank (pictured below with Sister Tissie) became interested in Plastic and Reconstructive surgery in the 1930s. During the war, he commanded the plastic surgery unit at El-Qantara in Egypt, then returned to Australia to work at the Heidelberg Military Hospital. After the war, he was instrumental in furthering the cause of plastic surgery and became the first honorary plastic surgeon at the Royal Melbourne Hospital. He was President of the College from 1966-1968.

Pearl MacLeod
Scottish surgeon Pearl MacLeod became interested in Orthopaedics after the war. In 1949 she worked with the head of Orthopaedics at the Glasgow Royal Infirmary and then became the Orthopaedic Registrar at the Darlington Memorial Hospital in England.

In 1952, Macleod moved to New Zealand and became Senior and Assistant Orthopaedic Registrar at the Dunedin Public Hospital. She was mostly involved with Orthopaedic out-patients and fracture clinics. In July 1954 Macleod, who was then living in Dunedin, became our first female Fellow in Orthopaedics. ■

The two of us

Dr John Mutu-Grigg and Dr Lincoln Nicholls share a tuakana—teina relationship

Dr John Mutu-Grigg BHB, MBChB, FRACS

I first met Lincoln about six years ago at a Māori doctors' conference. He wasn't in Orthopaedics at the time; he was a general practitioner. Lincoln had done other things before medicine; he'd been a school teacher and served in the Army. He really liked the look of Orthopaedics, so we sat and had a bit of a chat. I told him, "If you ever need any tips or pointers, or anything like that, let me know." It wasn't until years later that we caught up again.

Lincoln has something that Orthopaedics is really lacking. As an Indigenous doctor, he has the language skills and cultural understanding – he's very strong on that.

> For years he's gone around the community, encouraging Māori and talking to young doctors and students in schools.

He does the IronMāori, which is like Ironman, and he's a great role model to young Māori.

When I was coming through as a junior, Orthopaedics was often a hostile place for Māori. I downplayed my Māori roots and minimised my Māori background. This was quite difficult to do because my mother is a Professor of Māori Studies at Auckland University; she is high profile and often in the news. So, everyone knew who she was. I regularly got snide comments from consultants about her. I would always stay quiet. Although most Ccnsultants supported me, there were many who made it clear to me, usually those I did not work for directly, that I was different – and not in a good way.

I'm on the Indigenous Health Committee, where a lot of us have hidden our culture to fit in. We understood that we needed to do that and it's a problem because when you're hiding Māori culture from everyone it's not a healthy place for other Māori to be.

When Lincoln came into Orthopaedics we caught up again. He was applying for the Orthopaedics Training Scheme, and I went through his application. Currently, in New Zealand, Māori have significantly worse outcomes than non-Māori, and the massive and continually growing data set shows that we, as doctors, play a significant part in that. I got angry when I looked at his application. The things that would make him a good Māori surgeon, and a better candidate than others to deal with a significantly neglected area of New Zealand, were not valued under the current admission criteria.

I, and a number of other Māori doctors, had a meeting with the New Zealand Orthopaedic Association (NZOA) about what we saw as discrimination and neglect on their part. At first the NZOA was quite hostile to making any changes, but with time the NZOA has made some concrete first steps, and currently it leads the other surgical specialties in this area. There is still a long way to go to remove the inherent bias ingrained into the current system.

It was Lincoln who helped me find my own voice. Before I knew Lincoln, I had been a member of NZOA, quietly doing the things surgeons do. But when I saw what he was going through, I realised that we need to change the way we do things.

I think Lincoln has the potential to be one of the greats – a surgeon who will change the way things are done, and whose name will grace the annals of surgery. He has a massive future and I want to do everything I can, as a friend, to support him. Orthopaedics is a very small world and we'll run into each other forever on.

Dr Lincoln Nicholls MBChB, FRNZCGP

The first time I met John was at a Te ORA (Māori Medical Practitioners Association) Reo Wānanga at Te Manukanuka o Hoturoa Marae in Auckland. He'd just returned from his Fellowship in Canada and I was in General Practice. I'd always been interested in Orthopaedics and we ended up chatting about it.

I didn't see him for a while, then we reconnected in 2016. I had applied for the Orthopaedic Training Scheme. I picked his brain about the Surgical Education and Training (SET) interview and how I should tackle it. I was unsuccessful the first time, and when I applied again the second year we got together a few times for preparation and practice. He flew to Wellington to catch up and to practise interview scenarios. Then we did Skype interviews where he would pose a question and I'd answer it. He really helped out in my preparation. He was a tuakana, a big brother, and his help and advice were invaluable.

> We Māori doctors have a responsibility to help and mentor each other. It's an integral part of Māori culture.

We call it 'tuakana–teina'. An older or more experienced tuakana mentors a younger or less-experienced teina. That's the relationship that John and I have, and I take it on my shoulders to do the same for my teina. It filters down. I have a formal role where I mentor a couple of medical students and junior doctors. You're paying back what's been put into you by helping people on our waka (canoe). John's my mentor, I'm a mentee for him, and then I'm a mentor for others.

In New Zealand, the number of Indigenous doctors is too low and we're significantly underrepresented. The system isn't geared for Māori, but at the moment we have to work with that system. I have a phrase I like to use: 'Windows, Doors and Mirrors.' I believe that we, as Māori, need windows to look through to see opportunity. We need to have mirrors – and this is the important thing about mentorship – we need people like John who look like us and are like us, so we can see ourselves reflected in them in aspirational positions. And we need doors so we can access the training to get where we need to go for our people. The Treaty of Waitangi would call this 'participation'. So, with regards to John, he provides a window for me to see opportunity and he's a mirror for me. I can be inspired by him and say, "Hey, he's done it, so maybe I can do it." It's important that we see leaders in our culture, so we know we can achieve it. The last part is access. We need the Royal Australasian College of Surgeons (RACS) to open the door and give Māori opportunities to train as surgeons.

Next weekend I'm running a Wānanga (learning opportunity) for Māori non-training Registrars, who are trying to get onto training positions with RACS. Two colleagues are helping and we'll be preparing them for the upcoming SET interviews. We'll go through interview scenarios and help them interview confidently. It's a supportive weekend focusing on helping the next generation of Māori doctors.

For me, being Māori, speaking the language and understanding the culture makes me a better doctor. I can comfortably walk in two worlds for my patients – a Māori world and a western world.

John is an Orthopaedic consultant and I'm training at the moment. I appreciate the commitment it takes to reach that level. He's a great father, husband, successful surgeon and a well-rounded person. For him to spend time helping me is awesome, humbling, motivating and inspiring. It demonstrates to me what kind of a leader I want to be. ■

RACS celebrates International Women's Day

International Women's Day, 8 March, is a global day celebrating the social, economic, cultural and political achievements of women. The day also marks a call to action for accelerating women's equality. Find out how RACS commemorated this important day.

Victoria

On Tuesday 3 March, Surgeons, Trainees, Junior Doctors and RACS staff gathered at the College in Melbourne to mark International Women's Day with a lecture and cocktail function.

The event, a collaboration between the Victorian State Office, the Academy of Surgical Educators and the Women in Surgery Section, attracted almost 50 attendees to hear Dr Sanziana Roman speak on 'Diversity and Belonging in Medicine: Practical Approaches to Moving the Needle'. Following the talk, attendees enjoyed discussion and networking at a cocktail function.

South Australia

Guests gathered at the Macquarie Group offices to celebrate the day and to watch Dr Roman's presentation via video link. Attendees included RACS President Dr Tony Sparnon, Chair of the RACS Women in Surgery Section and RACS Councillor Dr Christine Lai, and Dr Sonja Latzel, who was the state's first female Chair from 2014-2016.

Thank you to everyone for making the event so successful, and to the Macquarie Group for hosting the gathering. It was a thought-provoking presentation and we look forward to hosting similar events in future years.

Meanwhile staff at the Research, Audit and Academic Surgery (RAAS) and the South Australia Regional Office marked the occasion by gathering in the RAAS boardroom for morning tea, where all staff received a delicious International Women's Day cupcake.

Western Australia

Inspiring women, male change champions and mentors, delicious canapes and refreshing beverages filled the Crystal Club Lounge at Crown Towers Perth for the Women in Surgery Cocktail Evening as RACS Western Australia celebrated International Women's Day on Friday 6 March.

Keynote speakers Dr Helen Ballal and Professor Richard Carey-Smith shared personal anecdotes about female role models in the industry, their experiences and future plans for supporting diversity and change.

Paediatric orthopaedic surgeon Dr Kate Stannage was awarded with a RACS Certificate of Community Service in recognition of the outstanding service provided to the community.

A beautiful door prize was won by the very lucky Dr Alice Waldron, a stunning pendant generously donated by Paspaley Pearls. The event, sponsored by Avant Mutual, was thoroughly enjoyed by all.

Above: Mr Greg Janes and Dr Kate Stannage

New South Wales

On Sunday 8 March, a group of Fellows, Registrars and medical students gathered at the Tank Stream Bar in Sydney for a scrumptious networking lunch. It was well attended by Fellows from all specialties. RACS also sponsored the attendance of four medical students who are keen aspiring surgeons. There was much laughter and some great stories about being a woman in surgical training, especially from our more senior fellows! We are all looking forward to our next gathering.

Australian Capital Territory

The ACT RACS Office, in conjunction with ACT Women in Surgery, hosted a breakfast on the morning of Friday 6 March to celebrate International Women's Day. Dr Hari Band, ACT Women in Surgery representative and neurosurgeon, opened the event to medical students, Trainees and Fellows. Ms Meegan Fitzharris was the guest speaker and gave an insightful presentation on her career, and how to go about career progression, including taking up different opportunities when they are presented to you, even if they are sometimes surprising and accidental. She also spoke on women in leadership roles and how to navigate being in such positions. Ms Fitzharris finished her presentation with a great motto to build your career: "Do what you are good at, do what you can get paid for, do what you love, and do something the world needs".

NSW morning tea

Queensland

Brisbane, Gold Coast and Cairns all held International Women's Day celebrations to create a community of women in surgery. Across Queensland, women Fellows, Younger Fellows, IMGs, Trainees and medical students collaborated together, creating a space to talk about their own personal experiences in surgery and surgical training.

Brisbane and the Gold Coast were electronically connected to hear renowned professional Jenny Stevens, CEO of Attune Hearing, speak on the topic 'Power in Personal Leadership'. Professor Deborah Bailey chaired the Gold Coast event held at Bond University. Doctor Heidi Peverill chaired the Brisbane event held at Customs House.

Jenny spoke about the practical need for women to take on the key leadership role of mentoring. Her advice was, "Whoever you are mentoring, you need to help them embrace fear of failure." This is something women are often taught to shy away from. Jenny also highlighted the many obstacles that women face when reaching out for leadership positions. She said the key to success is "knowing what outcome you want, and relentlessly pursuing it."

RACS also hosted a second International Women's Day session in collaboration with Queensland Women's Medical Society. Doctor Sarah Coll travelled from Cairns to chair this motivational session. Doctor Zelle Hodge AM, a former president of Australian Medical Association Queensland, spoke about 'Leadership as a Medical Woman'. She gave great insight into the many obstacles women in medicine face but also the amazing opportunity women have to influence the future of modern medical institutions.

All together we had a combined group of 81 women coming together to celebrate collaboration, achievement, and the future of women in surgery.

Cairns held an independent event on the evening of 6 March. Approximately 80 attendees came to support 'Life of Women Surgeons in Cairns'. Doctor Roxanne Wu chaired and organised this session, which was a comprehensive celebration of women. The Cairns audience was privileged to get a glimpse into the trials and triumphs of four local woman surgeons: Doctor Isolde Hertess (Plastic and Reconstructive), Doctor Angela Robson (General Surgery), Doctor Marcia Mickelburgh (Plastic and Reconstructive) and Doctor Deb Lees (Orthopaedics).

Doctor Wu said, "It was eye-opening and inspiring to hear each speaker outline the scope of their professional achievements (while maintaining their) gracious acknowledgement of the support from family and mentors that everyone needs to be successful (in surgical training)."

The Cairns group also learned about the practicalities of being pregnant and maintaining family life while striving to continue in surgical training. They heard a truly inspiring story from a woman who has lived and trained in three countries, experienced violent confrontations at work, and actively chose to stay in regional Queensland to raise her family and build a flourishing career.

Following the presentations at all locations, attendees gathered for food and drinks together, giving an opportunity for questions, further discussion and celebration. After such successful International Women's Day celebrations, RACS Queensland looks forward to hosting an equality in medicine event later in the year. ■

Gold Coast, QLD morning tea

What diversity looks like

Diversity is for everyone, writes Dr Deanne S Soares

Diversity is beneficial for all industries and has specifically been flagged as a matter of importance by RACS, with the publication of its Diversity and Inclusion plan in 2016.[1] The Ottawa consensus says specialist training groups should aim for a workforce that is representative of the population it is serving.[2] This not only includes the obvious categories such as gender and ethnicity but also sexual orientation, age, disability and religion. As a woman of colour in a predominately male surgical specialty, I am well aware of the reaction to discussions about diversity and inclusion and the incorrect assumption that this means exclusion or silencing of the Caucasian male. On the contrary, diversity means many things.

Yes, it means increasing the number of female surgical Trainees by reducing barriers not only to applying and being selected, but also to completing training. A qualitative study published in *The Lancet* last year interviewed 12 women who had chosen to leave surgical training in Australia and New Zealand.[3] They confirmed well-known factors that contributed to female Trainees leaving training:

- Long working hours
- Fatigue and sleep deprivation
- Unpredictable lifestyle
- Impact on relationships
- Sexual harassment and assault

Interestingly, they also found six new factors:

- Unavailability of leave
- Distinction between valid and invalid reasons for leave
- Poor mental health
- Absence of interactions with the Women in Surgery section of their professional body and other supports
- Fear of repercussion
- Lack of pathways for independent and specific support

Diversity can also mean variation in the 'standard' training pathway, including part-time training and the ability to take leave to be the primary caregiver to children. A friend and fellow urology Trainee has decided to interrupt their training for a year to spend more time looking after their adorable baby boy, Harvey, who is now six months old. Their partner is also a medical professional who is close to completion of a busy training program. This time off has helped their family out immensely, as it allows both parents to spend time with each other as well as care for Harvey.

I interviewed this Trainee and asked what the feedback has been to interrupting their Urology training in what would have been their Fellowship Exam year. The overall response has been positive, with most consultants, Trainees and other colleagues being supportive of this decision. The Trainee had some concern about regressing in training and losing clinical and surgical skills, but these have been very much mitigated by the joy of being able to spend time with their baby.

They described the transition to being a primary caregiver as natural, rewarding and "less exhausting than surgical training". The first few months of Harvey's life were particularly challenging when they were in a busy hospital doing long hours, which left little time with their partner and missing precious moments with their son. Both parents love training and working, but this time spent with baby Harvey is beautiful and rare and special.

Image:
David Wetherill, the Trainee who interrupted training, with his family.

Interrupting surgical training for paternity leave is a rarity. It should be encouraged as it allows for a broader view of what it means to be a surgical Trainee in a contemporary world. When surgery is filled with individuals with different backgrounds and different needs, it means there is no 'standard' expectation of what Trainees or training looks like outside of the clinical context. This is diversity and inclusion.

Diversity is many different things.

Diversity is for everyone. ■

Dr Deanne S Soares
Urology Representative, RACSTA

REFERENCES

1.Royal Australasian College of Surgeons. Diversity and Inclusion Plan. Melbourne: RACS; 2016 Nov. 16p. Available from: https://umbraco.surgeons.org/media/1232/2016_12_20_diversity_and_inclusion_plan.pdf
2. Prideaux D, Roberts C, Eva K et al. Assessment for selection for the health care professions and specialty training: consensus statement and recommendations from the Ottawa 2010 Conference. Med Teach. 2011; 33: 215-223
3. Liang R, Dornan T, Nestel D. Why do women leave surgical training? A qualitative and feminist study. Lancet. 2019; 393:541-549

Breaking Barriers Report

A key element of the RACS Diversity and Inclusion Plan is to increase the numbers of female surgeons. To inform this work, a survey was conducted aimed at identifying perceptions and experiences when considering a surgical career in Australia and New Zealand.

The Breaking Barriers survey asked questions about demographics, perceived barriers and drivers in various medical specialties, in medical school, in lifestyle considerations, in profession considerations and about Surgical Education and Training.

In comparison to other medical specialties, surgery was perceived as having the highest barriers for women. The top driver that emerged from this survey related to delivering the surgical needs of patients. Additional key drivers highlighted were the professional ambition of respondents, the remuneration potential of a surgical career, the intellectual challenge of surgery and the interest in experiencing available and emerging technologies in surgery. A lack of time for dependents, hobbies and leave (travel) were also raised, as well as a perception of inflexibility within the Surgical Education and Training Program.

The survey, which targeted medical students and non-vocational junior doctors who are female, received almost 1700 responses. ■

For more information see our 2019 progress update: *https://bit.ly/2VmVHTa*

Did you know RACS is working on the following exciting initiatives to increase diversity and inclusion across the College?

- RACS has and continues to advocate and work toward a target of 40 per cent representation of women on boards and committees.
- Together with the Royal Australasian College of Physicians, the Australian and New Zealand College of Anaesthetists, the Royal College of Physicians and Surgeons of Canada, the Australian and New Zealand College of Psychiatrists, RACS has signed and committed to the United Nations Women's Empowerment Principles Statement.
- RACS is advancing the availability and take-up of flexible training, including actions to minimise barriers for all Trainees, recognising the impact flexibility can have on surgeon wellbeing and a diverse workforce.
- To improve the participation, leadership and treatment outcomes for women across all of RACS's Global Health programs and processes, Global Health is undertaking a gender analysis across its programs.
- To break down some of the barriers to becoming a surgeon, RACS offers scholarships for aspiring Aboriginal, Torres Strait Islander and Māori surgeons as well as IMGs who are asylum seekers or who have previously been refugees.
- All research scholarship applications now include a question on gender desegregation to ensure research outcomes are appropriate for all people.
- The Foundation for Surgery Board is hosting an Unconscious Bias in Philanthropy workshop to ensure unconscious bias is minimised in all philanthropic decision making.
- To ensure the accessibility of philanthropic funding and scholarships is maximised, an unconscious bias review of key scholarship communications and processes will be conducted this year.
- RACS is working to establish national ear and hearing care services that are accessible and inclusive to the Samoan population, alongside local disability groups and the Ministry of Women, Community and Social Services. RACS aims to ensure services provided both at primary and tertiary level are targeting those with the greatest barriers to treatment and ongoing care.■

Image:
Women in Surgery breakfast, ASC 2019

COVID-19 and the impact on surgical training

Unprecedented times call for unprecedented measures. Such are the times we are living in, amid the global pandemic known as COVID-19.

Since its discovery in November 2019, in the city of Wuhan in the Hubei province in China, the virus has exponentially infected people across the globe and was declared a pandemic by the World Health Organisation in early March.

At the time of writing the Australian number of COVID-19 cases exceeded 6500, with the majority in New South Wales, Victoria and Queensland. Meanwhile there have been more than 1600 cases in New Zealand.

The Australian Government is scrambling for best up-to-date advice from its health experts; understandably a moving target due to the nature of this unprecedented pandemic. Nation-wide, grocery store shelves are empty of the essentials, including the infamous 'toilet paper gate', and families are stockpiling like never before.

The impact of a variety of restrictions is permeating through all industries and the final effects will be seen in the upcoming months to years.

The peak body for surgical governance and training in Australia, The Royal Australasian College of Surgeons (RACS) has been working overtime to try to mitigate the effects COVID-19 and the associated restrictions have had on surgeons and Trainees. The swift RACS response to this unfolding crisis has been made on the back of the overarching principle that patients and communities come first. Even though we are surgeons, we are doctors first and foremost who took the Hippocratic oath to protect and serve the community.

Impact on RACS related events

The first six months of the year is a very busy time for RACS and its various surgical specialty societies. Due to the rapid escalation of COVID-19 and fears for mass transmission, the college's largest event, the Annual Scientific Congress scheduled for May this year, was cancelled. The cancellation was necessary despite alternative methods being considered, such as a virtual conference. The organisational effort to plan and coordinate such a large event that can attract up to several thousand people is tremendous and the decision to wasn't made lightly.

The specialty societies also conduct training conferences for Surgical Education and Training (SET) Trainees and, on a personal level, the Plastic Surgery SET conference to be held in Melbourne was cancelled 10 days out from the event considering the current circumstances of trying to minimise mass gatherings. Specialty societies' face-to-face board meetings have now also been converted to virtual.

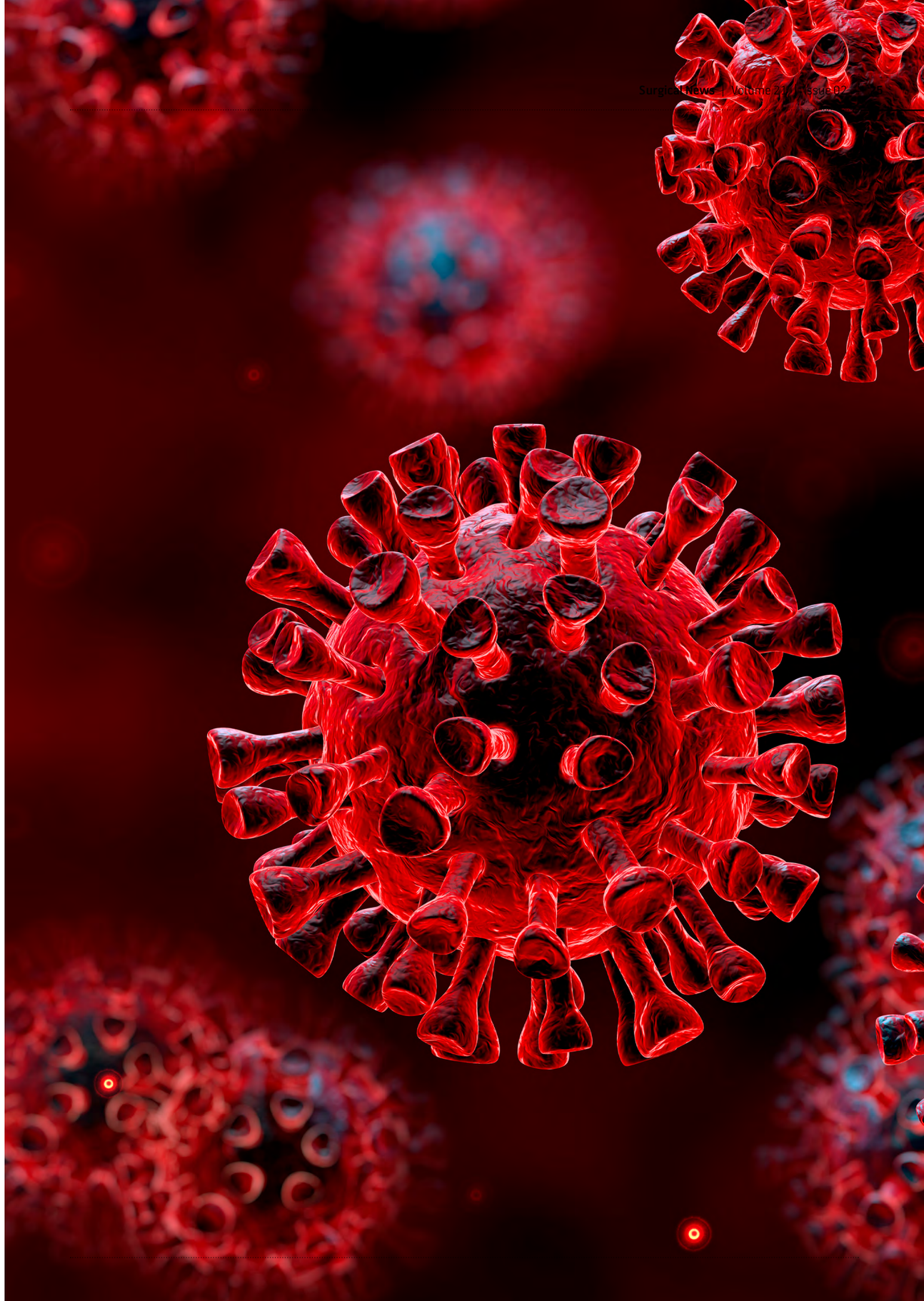
Impact on surgical Trainees

The impact on surgical Trainees, particularly those sitting exams, has been devastating to say the least. The RACS Fellowship Examination scheduled for April/May has been postponed for the foreseeable future. The surgical Fellowship Exam is the culmination of years of hard work and study into one final test before becoming qualified as a specialist surgeon. The preparation is never-ending, the missed family time is copious and a social life during this period is non-existent. One can then imagine the heartbreak for Trainees and their families when such a defining event in their life is postponed indefinitely. The knock-on effect of then not being able to definitively plan for fellowships locally, regionally or internationally can be challenging for the individual involved but also the potential accepting institution. Other exams too have been postponed such as the Generic Surgical Sciences Exam (GSSE), Clinical Examination (CE) and Specialty Specific Examination (SSE) – all of which have ramifications. RACS have stipulated that for all exams and mandatory courses, candidates will be given a 'minimum of three months' notice when a decision to reinstate exams has been made'.

Surgical supervisors have now begun to advise that with the reduction in elective surgeries, Trainee logbooks will be affected in terms of number and breadth of surgeries. Where issues affect Trainee experience, the 'specialty training boards will consider their circumstances on a case-by-case basis'. Ward round reviews and scrubbing in for cases is on a 'need to only' basis. The experience that will be lost will clearly have an impact on surgical training. Journal club meetings have been postponed indefinitely and even regional group teaching sessions are at risk. However, RACS has agreed that surgical training can be extended if it needs to be to allow trainees to achieve the experience and competencies as required.

Impact on potential surgical candidates

The fallout from this pandemic is also affecting the unaccredited or service registrars or often known as the 'forgotten group' of doctors. The aspiring surgical trainees caught up in the process of fulfilling their applications for surgical training that includes successfully completing the GSSE and, soon to be compulsory, the CE. Each passing year that service registrars are unsuccessful with entry into training is another year that requires a tremendous amount of effort and commitment in the form of more research, undertaking RACS-approved courses and acquiring referees for the application. Such a scenario is faced by every unsuccessful candidate across Australia each year and thus ▶



spurring the beginning of another sprint in the ‘rat race’.

Fortunately, the GSSE and CE were just held in February but the second round sitting in June has now been indefinitely postponed pending further developments. Those who have successfully completed those two exams in February are at least now eligible to apply for training, albeit depending on when the applications will be. For those who were either unsuccessful or yet to sit exams, it will be another agonising wait and ever-building anxiety for applications for 2021.

The Trainee selection process in 2020 for 2021 is also on hold until alternative non-face-to-face delivery mechanisms can be configured. This further adds to the anxiety and uncertainty not only for surgical registrars but also in terms of workforce planning for next year for administration.

The impact across the surgical body financially also cannot be understated. The financial loss through non-refundable or non-transferable flight bookings, accommodation bookings, venue hire bookings, catering, organisational and exam preparation fees would be significantly into the hundreds of thousands of dollars. The phone call to the insurance companies (for those who pre-emptively took out insurance) can become several hours long before even being able to speak to a customer officer often ending with the too-familiar response of, “you can submit your claim but it will take up to 28 days to be processed”.

What can we give?

While all these challenges are being faced by the surgical community, there are tremendous efforts into research and development being undertaken around the world and locally into finding a potential cure and vaccine against COVID-19. Researchers from Melbourne’s Doherty Institute have been able to map out the immune response to COVID-19 and in Queensland two medications already in use have been found to effectively kill the virus in vitro.

Meanwhile, government advisory experts have called upon the general public to practise social distancing and stay at home. Thorough hand hygiene should be practised along with self-isolation for those recently returned from international travel. For all the latest government updates visit covid19.govt.nz/ or australia.gov.au/.

As surgeons, leadership is of the essence. Cold steel (metaphorically) is not necessarily what is required to combat this pandemic, but empathy and collegiality certainly is. Times ahead are going to be tough for many of our colleagues across all specialties and thus support for them is paramount. Lend a helping hand in whatever capacity you can and ask, “Are you okay?” As individuals we won’t be able to control this pandemic but as an army of one we can defeat this invisible disease. ■

Dr Shahriar Raj Zaman

Plastic Surgery SET 3 Trainee

Mr Jeremy Rawlins

Consultant Plastic, Reconstructive, Aesthetic and Burns Surgeon

President of Australia and New Zealand Burns Association

COVID-19 information hub

RACS has been monitoring the outbreak of COVID-19 and complying with advice and instruction from our governments. We set up a COVID-19 information hub on our website to provide a place for our Fellows, Trainees, International Medical Graduates and staff to find out the latest updates.

You can access the hub via the banner on our homepage or at: surgeons.org/media-centre/covid-19-information-hub

Printing and mailing of *Surgical News*

The printing industry, like many other industries, is experiencing disruption. In many countries, distribution of print materials is suspended, making it impossible to ensure copies reach intended destinations. Fewer passenger flights and the need to prioritise medical supplies has also reduced the availability of air freight.

Given these obstacles and concerns, as well as the desire to reduce pressure on supply-chain vendors to send their employees to work and increase their risk of exposure to the virus, we have suspended all printing and distribution of the ANZ Journal of Surgery and Surgical News until further notice.

The ANZ Journal of Surgery can be accessed via Wiley Online Library here https://onlinelibrary.wiley.com/journal/14452197 and Surgical News is also available online here https://www.surgeons.org/media-centre/surgical-news.

FRACS in Dublin, Ireland

Dr Tony Sparnon, President of the Royal Australasian College of Surgeons, recently visited Ireland to speak at the Royal College of Surgeons in Ireland’s Charter Day Meetings, the annual surgical conference exploring medical innovation and healthcare challenges.

The conference’s theme was Choosing Wisely. Other speakers included Laura Magahy, Executive Director of Sláintecare and Professor Stephen Wigmore, Regius Professor of Clinical Surgery, University of Edinburgh.

Here is Dr Sparnon catching up with Dr Sinead Hassett FRACS and Professor Raymond Fitzgerald FRACS, both of whom currently live in Ireland.

Educator Studio Sessions –Webinars

Each month, the Academy of Surgical Educators presents a comprehensive schedule of education events curated to support surgical educators. They provide insight, a platform for discussions and an opportunity to learn from experts.

Register for the webinar here: www.surgeons.org/studiosessions

Course	Start Date	Speaker
Five myths about unacceptable behaviour in surgical education	Wednesday 6 May 2020	Dr Rhea Liang
Cultural safety, racism and unconscious bias in medical education	Wednesday 27 May 2020	Prof Gregory Phillips

COVERT-20: PLAGUES

COVID-19 and pandemics through the ages

OPUS LX111

The genesis to this story is a little intriguing. We are in a state of social isolation due to the coronavirus and any contact is measured in metres and with grandparents protected by glass separations. I was enjoying a black coffee with Bernard on a recent Saturday before the lock-down. Bernard reviews books and literary works at Readings, and he likes the light tone of my surgical dissertations, he calls them "somewhat conversational". During this coffee interlude he suggested I write something on the coronavirus, or even the Black Death. Nothing was further from my mind – then.

The word 'covert' subsequently surfaced in my awareness, meaning something hidden or disguised – a perfect descriptor of the virus, COVID-19. This title, is a mixture of the year of discovery, 2019, and CoV, the name of the family of virus, hence my title above. The virus discovery was made by an Australian academic, Professor Edward Holmes of the University of Sydney in 2019.

And when one sees the blatant disregard for social gathering, as revealed in the photograph taken at Bondi Beach in mid-March, this sparked awareness to write that we need to be more vigilant in our social isolation. As Ernest Hemingway said, "When people talk, listen completely. Most people never listen." How relevant currently.

My conversation with Bernard then reverted back to the Black Plague of the 1660s. My only fleeting recollections of this disease was the time frame of the 17th century and the Great Fire of London.

Its clinical manifestations have been synopsised in the children's nursery rhyme we all sang: Ring a Ring o' Roses. This rhyme was first published in 1880s and put to an earlier tunes handed down over the centuries.

During my clinical years as a reconstructive surgeon, my regular anaesthetist was Peter Courtney. It was he who brought this to my attention – the Black Death explanation:

Ring a Ring o' Roses: inflammatory nodes in groin

A pocketful of posies: the same lumps could be felt in the groin when covered with clothing, or this could refer to posies of herbs or flowers to protect the bearer and add fragrance to the distraught surroundings.

Atishoo atishoo: the sneezing that resulted from the pneumonitis

We all fall down: the obvious final common pathway when millions died. One of my colleagues could also remind me that, originating from the time of the Plague, when one sneezed the social expression 'bless you' was commonly practiced. It was suggested by Pope Gregory I, or Saint Gregory the Great, during an earlier plague as a means of warding off illness and avoiding the 'wrath of God', and therefore possibly surviving.

It was during the same week of potential quarantine that I was in regular communication with my neighbour in Parkville, Peter Doherty, the Nobel Laureate of the Doherty Institute.
I remarked how cool and contained he had presented on television during a recent ABC interview about the coronavirus.
I admired his crisp response to one of the penetrating interviewer's varied questions about statistics, or people, or degree of exposure, to which he simply replied: "That relates to government policy, let's stick to immunology."

In a subsequent ABC Radio interview, a few days later, he talked about the disadvantages and lethal outcome for coronavirus victims, particularly smokers. He taught me a new acronym: ACE, denoting Angiotensin Converting Enzyme. When the ACE inhibitors are used in the treatment of lung disease, function improves. When experiments were done using hydroxychloroquine with the SARS virus changes were observed in the human cell receptors due to the acidity produced by the enzymes. Smoking has an effect on the ACE mechanism so the COVID-19 virus can enter the human cell because of the suppression of the receptor function. Bypassing the protective function of the receptors allows the virus to invade. Besides smokers, this may explain the general need for ICU admissions and the world demand for ventilators, because of the pneumonitis.

Now back to the Black Death. The bubonic plague was one of the most devasting pandemics in human history, caused by the bacterium yersinia pestis. Archaeological finds in ancient Sweden and other European areas show the yersinia pestis has been around since time immemorial. It initialy peaked in Europe in the 1350s, killing hundreds of millions of people (facts unbeknown to me). Authorities say it probably originated in Asia and travelled down the Silk Road, eventually reaching Istanbul and then the world. It was carried by rats who initially had a free ride on the back of the camel trains and it ultimately killed almost 200 million people.

It was the Swiss bacteriologist Alexandre Yersin after whom the pathogen was named, and Paul Louis Simond confirmed the transmission by flea bites in 1898. Then Francis Gasquet implicated rats and fleas in his publication on the epidemiology of the Black Death.

Clinical manifestations are noteworthy and similar to some present-day COVID developments. A digital clinical manifestation of the plague illustrating digital necrosis is not dissimilar to what one has experienced in modern times with meningococcal illness and terminal phalangeal necrosis. Malignant groin nodes are sometimes called 'buboes' and can hit any of the regional drain sites from groin to armpit to neck. In the Black Death, these lumps the size of eggs would rupture through their black necrotic spots and spread infected material throughout. On the Dutch scene a monk by the name of Lodewijk Heyligen remarked that a distinct form of the disease affected the lungs, and this is the basis of the classification of the pneumonic plague with its 10 per cent survival rate. How similar is the current Italian experience with multiple deaths, numbering in the thousands.

The importance of hygiene only received major prominence in 19th century, following the work by Ignaz Semmelweis and Louis Pasteur, with the former using lime solution to sterilise wounds and the latter creating sterilisation or 'pasteurisation'. In the labour wards in Vienna in 1850s (where medical students, in their street gear, would walk up from mortuary lab and confine women without appropriate cleansing) the death rate beforehand was so high in the wards the expectant mothers preferred to be confined elsewhere, even in the street. Now the Parisian fashion establishments are making masks and sterile hand solutions. Meanwhile in Western Australia some enterprising vineyard is converting its smoke-tainted grapes from the recent bushfires into alcoholic hand lubricant.

My 10 Per Cent Rule may have some relevance here (it usually works). If you are lost for a percentage calculation about a statistical outcome or likelihood in a clinical development or complication, a little above or a little below 10 per cent gets you out of a tight corner in an exam. The mortality rate of the Bubonic Plague after the introduction of antibiotics is 11 per cent. For untreated cases the majority die within a week, and the mortality rate of over 90 per cent is associated with pneumonic plague – not dissimilar to the COVID-19 epidemic in Italy. Is there a serendipitous link between these clinical manifestations and statistics with of the Plague and coronavirus? Recently *The Lancet* published the mortality rate of less than 10 per cent.

Let me conclude by quoting Lord Acton, famous for the words with a little metaphorical play: "Power tends to corrupt, and absolute power corrupts absolutely." I am sure Acton did not have the flea in mind when he penned this adage; he was no doubt referring to international personalities. Yet his words could similarly be applied to the flea in the Black Death or the coronavirus currently in prominence. Even the Chinese Doctor Li Wenliang, in Wuhan Province in China, the source of the current coronavirus, tried to warn the world of its lethal potential. Regretfully, he died in the wake of those pronouncements, reprimanded but subsequently exonerated by the Chinese authorities for his apparent intransigence.

An afterthought: as someone observed, who would have thought a submicroscopic particle (10^{-9} – a billionth the size of a human hair) could clear the streets of the world's capitals, London, Paris, New York, and the international airways and the channels of the seven seas of humankind and our pollutants in such a short space of time. Finally in these commercially derelict and taxing times those that work in the public domain warrant our meritorious praise. ■

Associate Professor
Felix Behan

Image:
Painting of Marseille during the outbreak of a pandemic in 1720 by Michel Serre

Musculoskeletal disorders in surgeons – can physical training help?

A number of publications show a significantly high incidence of musculoskeletal disorders and symptoms in surgeons. What can we do to prevent it?

Surgery is a physical activity requiring stamina, endurance and muscular control, especially during long procedures and working on long operating lists. It is often necessary to stand in twisted or cramped positions holding awkward instruments for long periods of time.

A number of publications based on surveys of surgeons of various specialties show a significantly high incidence of musculoskeletal disorders and symptoms. A meta-analysis of 21 articles by Epstein et al including nearly 6000 surgeons and interventionalists found overall career musculoskeletal disorder (MSD) prevalence to be: degenerative cervical spine disorders (17 per cent), rotator cuff pathology (18 per cent), degenerative lumbar spine disease (19 per cent), and carpal tunnel syndrome (9 per cent). Between 1997 and 2015 the prevalence of degenerative cervical spine disease and degenerative lumbar spine disease increased by 18.3 per cent and 27 per cent respectively. The overall 12-month prevalence of pain was: neck 65 per cent, shoulder 52 per cent, back 49 per cent, and upper extremity 39 per cent.

According to Epstein et al, numerous other cross-sectional studies report that more than 80 per cent of surgeons experience significant pain when performing procedures, and in one study 35 per cent of 103 injured surgeons performed fewer operations due to the injury.

The physical limitations caused by pain and other musculoskeletal symptoms may reduce surgical efficiency, prolong procedures, lead to early cessation of the performance of certain procedures and early retirement, and adversely affect patient outcomes.

For all but the tiniest portion of the hundreds of thousands of years that humans have existed, much of each day was spent in physical activity. Today we spend most of our time seated and rarely lift our arms above our shoulders. The devotion to study required to be accepted for medicine and then to obtain good academic results may well lead to the neglect of physical sports and body-strengthening activities.

The young human body is strong and resilient. Hence most surgical trainees are unlikely to be troubled by musculoskeletal symptoms or notice limits to physical strength or endurance early in their careers. Physically inactive people lose 3-5 per cent of muscle mass each decade after the age of 30, a percentage that increases in later years, with the associated loss of strength and mobility. Baby boomer surgeons are now at the age of 58 to 73 years when MSD might be expected to occur as a result of age, arthritis and muscle loss.

Surgeons, of course, are not alone. Work-related MSDs are commonplace in many forms of industry and employment.

So what can be done to combat the onset of symptoms? In publications on MSD in surgeons, unfavourable ergonomics are referred to as contributing factors that require attention. However physical training for surgery does not appear to have been discussed.

Skamagki et al performed a literature review of 12 recent studies that investigated strength exercise programs instituted by health professionals to treat work-related MSDs. They found evidence to suggest that high-intensity strength exercises may decrease pain and symptoms for employees who experience chronic MSDs. Exercise interventions reported in this review included specific muscle strengthening, kettlebell training, stretching, and "all-round exercises". They pointed out that current research on the subject is limited.

It is the contention of the author, based on his own surgical career, experience of injuries and many years of resistance training, that the importance of strength and physical fitness has not been adequately recognised by the surgical community. To fit a strength-building exercise program into a busy week is not easy, but it is suggested that this would benefit all surgeons, and that Trainees should be encouraged to do so from the beginning of their careers. ■

Dr David Close FRACS (OL-HNS)

Should surgical performance be assessed?

MEASURING PERFORMANCE WILL PRODUCE BETTER PATIENT OUTCOMES

Measuring allows us to compare a subject of interest with a certain baseline; we measure performance in surgeons to be able to objectify the quality of care delivered. Performance of a surgeon could be measured in the wards, operating theatres, or in the outpatient departments, each representing a different process in a patient's treatment.

In general, measures could be classified into 'process' measures and 'outcome' measures.[1] Measures such as mortality, adverse event rates, and survival are outcome-based. Process measures encompass markers such as technical efficiency, like the time for procedure or lymph node clearance. Newer approaches that involve machine learning or automated algorithms are currently being developed to aid in measuring performance indices[2]; this will be a subject to consider in the future.

At any time, 50 per cent of surgeons will have below average performance and 50 per cent will have an above average performance. By comparing a surgeon's performance to baseline, we will be able to analyse why the surgeons are in a particular percentile of performance and identify the strengths and/or weaknesses of the particular surgeon. We should not use these measures to discriminate against surgeons but rather to implement strategies to improve on weakness while encouraging the development of positive characteristics, with a hope of raising the baseline of average quality of care. This process should create a cycle of defining the best, comparing with the best, and learning from the best – benchmarking.[3] This method will hopefully allow us to provide to patients the highest possible care.

Outcomes measures, which should be the easier measure to obtain, can be used as a screening to identify potential issues during the delivery of care, where process measures will allow identification of issues in a specific portion during the delivery of care, thus enabling specific targeting of quality improvement procedures. It would be unfair to say that the responsibility for a patient rests solely upon the shoulders of a surgeon; individual performance that is measured across sites could also allow us to identify systemic flaws[4] that could be targeted for growth and to refine healthcare delivery to produce better patient outcomes.

Medical staffs have an additional role in educating the next generations. Measuring surgeons' performance in the role of training and teaching juniors would mainly be constituted via feedback from the Trainees. Objective measures would be rather more difficult to obtain in this scenario. However, if we are able to ensure that high quality education and training is constantly being delivered, we would expect the development of better surgeons.

We must use great caution in what we measure and how we interpret the measure. For example, a surgeon who takes on higher risk cases could be criticised for a higher than average mortality rate despite providing benefit for as many patients as a surgeon with a lower mortality rate. This highlights the importance of risk adjustment; patients who are at a higher baseline risk will run the higher risk of morbidity or mortality regardless of the expertise of the surgeon.[5] Conversely, a low mortality rate may mean that surgeons are only selecting the fittest (low-risk) patients on which to operate.

Surgeons are rarely assessed after obtaining Fellowship. Surgical coaching directed at qualified surgeons is a new approach that is slowly getting acceptance.[6] This becomes even more important if the studies that demonstrated deterioration in 'non-technical skills' are accepted.[7]

Measurements of performance should be tailored specifically towards different scenarios. Ideal measures of performance should be easily recorded, reliable, readily amenable to quality improvement activities, and improving on them should make significant impact towards patient outcomes.

Professor Guy Maddern

RP Jepson Professor of Surgery, University of Adelaide

References

1. Hyder JA, Roy N, Wakeam E, Hernandez R, Kim SP, Bader AM, et al. Performance measurement in surgery through the National Quality Forum. J Am Coll Surg. 2014;219(5):1037-46.
2. Hung AJ, Chen J, Gill IS. Automated Performance Metrics and Machine Learning Algorithms to Measure Surgeon Performance and Anticipate Clinical Outcomes in Robotic Surgery. JAMA Surg. 2018;153(8):770-1.
3. Clavien PA, Puhan MA. Measuring and achieving the best possible outcomes in surgery. Br J Surg. 2017;104(9):1121-2.
4. Kiernan F, Rahman F. Measuring surgical performance: A risky game? Surgeon. 2015;13(4):213-7.
5. Treasure T, Valencia O, Sherlaw-Johnson C, Gallivan S. Surgical Performance Measurement. Health Care Management Science. 2002;5(4):243-8.
6. Min H, Morales DR, Orgill D, Smink DS, Yule S. Systematic review of coaching to enhance surgeons' operative performance. Surgery. 2015;158(5):1168-91.
7. Gostlow H, Marlow N, Thomas MJ, Hewett PJ, Kiermeier A, Babidge W, et al. Non-technical skills of surgical trainees and experienced surgeons. Br J Surg. 2017;104(6):777-85.

DELIVERING THE BEST SURGICAL OUTCOMES FOR OUR PATIENTS

Being a master surgeon was once assessed against decisiveness, speed and flair. Challenged character traits and poor behaviours were tolerated, even admired, by timid junior staff working in a highly hierarchical system. Of all the competencies, technical expertise was the one most admired and desired, with lip service paid to the unarticulated other nine. Progression through training was achieved by the ability to assist during the day, operate on public emergencies after hours, and ensure the boss was firmly tucked up in bed. There was no tolerance of fatigue or mental health problems. Surgeons were supposed to appear strong and invincible - of course this was not always so! Those who fell by the wayside were cast out.

Those days are past now and in the past they must remain, despite being etched into the memories of the third of the current RACS fellowship who are aged over 55. Being a competent and proficient surgeon today means achieving the best outcomes for patients, utilising knowledge, skills and behaviours across a wide range of overlapping competencies. The RACS set of nine competencies, with a tenth about to be added, include high professional standards[1,2], good, timely decision making, embracing diversity, acknowledging the values and beliefs of other cultures; collaboration within teams and across disciplines; effective and respectful communication; leadership that brings out the best from followers and team members; willingness to teach and support one's colleagues; technical and medical expertise, and advocating for the health of the community, patient, one's team and oneself.

Almost twenty years ago, RACS developed its competency-based framework, naming the nine. The first RACS guide to assessment of competence and performance was produced in 2009.[3] It introduced three patterns of behaviour with good and poor behavioural markers for each competency. A second edition updated these and introduced a multisource feedback assessment tool to rate, but not calculate (ie not to measure by numbers), a surgeon's performance.[4] Competency is what we have been trained to do and can do. Performance is what we actually do in practice. Recently a third edition approved by Council has added cultural competency to the RACS competency framework. Progression through training standards for assessment were developed in 2012.[5]

RACS Fellowship in a specialty represents certification and enables initial Specialist registration. In addition to certification, fitness to practice requires ongoing CME, performance assessment, and audit of outcomes, each matched to scope of practice.[6] Recognising these requirements, the RACS CPD program has four categories. It mandates participation in the audit of surgical mortality with peer review of surgical practice and its outcomes[7] (Category 1). It promotes reflective practice (Category 3), including assessment of performance in practice by one or more of: multisource feedback using a structured framework, professional development review, a structured learning plan, practice visits, training in cultural competency and the Operate with Respect course. There is, and always will be a requirement to maintain knowledge and skills (CME - Category 4), and to engage in clinical governance (Category 2). Today's regulators expect surgeons to be more than just technicians (although, of course, technical expertise is definitely required) and to perform well across the whole competency spectrum.[8] Each CPD activity is therefore matched to one or more competencies. Multi-competency cannot be assumed, it needs to be re-assessed at intervals, based on observable behaviours and outcomes in the workplace. RACS was ahead of the game 10 years ago in developing assessment tools for the Fellowship to use.

For senior surgeons, trained under the system described in the first paragraph, multi-competency performance assessment is all the more important to reassure patients, credentialing committees and regulators that, despite seniority, one is still fit to practice in the third decade of the third millennia. While promoting audit of outcomes for complex procedures, or measuring technical performance under simulated conditions may be useful, my belief is that actual surgical outcomes are team-dependent. In the more complex procedures the best outcomes certainly represent multidisciplinary skill sets and performance. ■

David A Watters
AM OBE FRCSEd FRACS

Alfred Deakin Professor of Surgery, Deakin University and Barwon Health

Chair, Victorian Perioperative Consultative Council

References

1 RACS (2016).The RACS Pledge. RACS Code of Conduct, page 5
2 RACS (2016).The RACS Code of Conduct. https://umbraco.surgeons.org/media/1599/2016-04-29_mnl_racs_code_of_conduct.pdf
3 Dickinson I, Watters D, Graham I, Montgomery P, Collins J. Guide tothe assessment of competence and performance in practising surgeons. ANZ J. Surg. 2009; 79: 198–204.
4 Royal Australasian College of Surgeons. Guide to Surgical Competence and Performance, 2nd edn. Melbourne: Royal Australasian College of Surgeons, 2011.
5 RACS (2012). Becoming a competent and proficient surgeon. Training standards for the nine surgical competencies. https://umbraco.surgeons.org/media/1047/mnl_2012-02-24_training_standards_final_1.pdf
6 Klass D. N Engl J Med. 2007 Jan 25;356(4):414-5. Assessing doctors at work--progress and challenges.
7 RACS (2014). Surgical Audit and Peer Review Guide. https://umbraco.surgeons.org/media/1350/surgical_audit_and_peer_review_guide_2014.pdf
8 Watters DA, Smith JA. Being a better surgeon: a multi-competency challenge. ANZ J Surg 2019;89:461-3.

The ninth dimension

Emergency General Surgery and teaching technical skills in regional Australia

The current surgical curriculum has been with us since 2007 and is now embedded in the practice of our surgical community. It is broken up into competencies: there are eight non-technical skills, with many courses provided by RACS that can be successfully mapped onto them. Having done many of these courses myself I can attest to the powerful impact they can have on personal values, perception, advocacy and performance.

What about the ninth competency, technical skills? Mentorship and repetition are crucial: muscle memory is as important to the surgeon as the concert pianist and the aviator. So in General Surgery, the answer should be straightforward. That is what five years of the training program should achieve! However, open surgery, particularly open emergency surgery, remains a problem.

In regional Australia there is a continuing need for the provision of emergency general surgery (EGS), much of it being open surgery. It takes a special Trainee with a lot of special training to prepare for this role. Figure 1 outlines the procedures associated with the majority of costs, complications and deaths in EGS. Although the data is from the US, it will be immediately recognizable to surgeons in Cairns or other regions.

However, this list does not include trauma or complex soft tissue infections, important contributors in our regions.

Meanwhile Figure 2, again from the US but similar to its local counterpart, suggests the enormity of the impact of EGS in the overall context of health service provision.

The regional general surgeon in Australia deals with a large volume of emergency surgery; much of this will be performed as open surgery. It makes sense that the training is provided regionally. All our surgical institutions understand that EGS goes to the heart of the contract between surgeons and communities. But how do we provide the necessary repetition, the volume, the muscle memory, in a regional setting?

We have good evidence in Australia that our Trainees progress through their five-year program acquiring operative experience in an appropriate fashion. It does appear that most of them gravitate to the metropolis doing Fellowships, and eventually into increasingly narrow specialist practice.

I joined James Cook University in 2011. I was already involved with some Anatomy teaching when I was challenged by Roxanne Wu (who specialises in Vascular surgery in Cairns) to show that we could teach the entire curriculum of operative General Surgery by cadaveric simulation.

Together with Andrew Hattam, then a medical student and now a vascular SET, we formed a study group, worked out a program, acquired instruments and, backed by our Dean Richard Murray, launched our first Anatomy of Surgical Exposure (ASE) course in 2013. Almost without exception we were supported by the Cairns surgical community.

The course has grown in complexity, but not in length or duration. We have maintained our commitment to teach an overall curriculum in operative General Surgery, highlighting emergency procedures and trauma. We teach the major vascular exposures, emphasizing Arnold K Henry's 'extensile' approach. Our tutor faculty now comes from around Australia, many of them regulars who have become experts, and also excellent surgeons from the National University of Singapore and universities in Colombo. We run the program as operating theatre simulations where every table has a full set of good instruments, and a registered nurse (RN). Our RN consultants run the Operating Room Nurse programs with RNs attending from around Australia. Our volunteers, mainly medical students but also interns and residents, help to run the programs and learn a lot of anatomy on the way. Many go on to pass the GSSE.

Figure 1:
Use of National Burden to Define Operative Emergency General Surgery. Scott et al
JAMA Surg. 2016;151(6):e160480. doi:10.1001/jamasurg.2016.0480

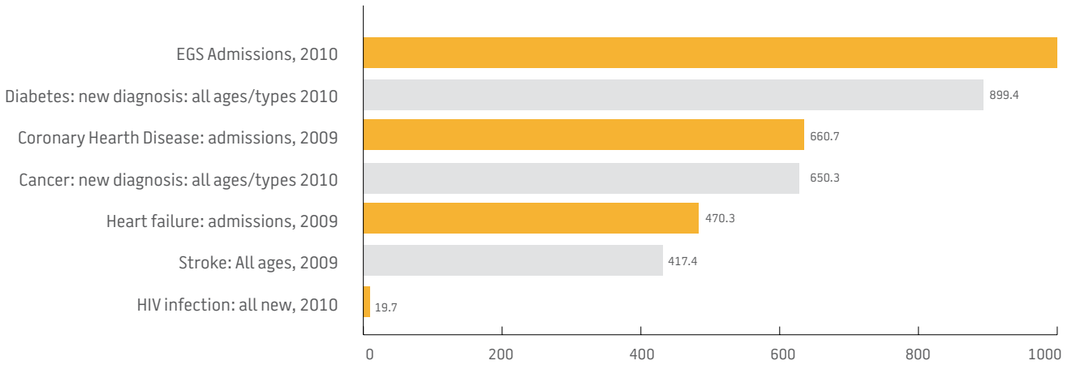
Published online April 27, 2016

	Account for
Partial Colectomy	80% procedures
Small bowel resection	80% costs
Cholecysectomy	80% deaths
Operative management of peptuc ulcer disease	80% complications
Lysis of peritoneal adhesions	
Appendicectomy	
Laparotomy	

3 million EGS admissions yearly

More than the sum of all new cancer diagnoses

Figure 2: EGS Admissions vs Other Public Health Concerns
Incidence per 100,000 US population
Gale et al. J Trauma Acute Care Surg. Volume 77, Number 2



Our cadavers are formalin preserved and are stiff, if variable. Remarkably, we are able to complete all the exposures required as practice has provided us with the correct sequence, which is the key to getting them done. Our laboratory is brilliantly ventilated, and no one complains about formalin irritation.

We recognize that the ASE course is potentially a franchise that can be set up anywhere with a good laboratory and cadavers. We are open to suggestions from RACS, General Surgeons Australia, and other Universities as to where and how the courses may evolve. We are fortunate to have generous support from industry, which has helped us to get over the line every year. But it remains hard work.

The evidence we see is that Technical Skills in Open General Surgery can be taught and practiced by cadaveric simulation. The model we have developed works well.

Those of us in regional Australia, sustained as we are by many excellent overseas trained surgeons, are sensitive to evolving trends and see a danger to the role of General Surgeon. If regional surgery positions are expected to contract to fit the current zeitgeist, we may see failure of "rescue", inappropriate transfers, demarcation disputes and fragmented care, with enormous financial and other costs to our regions. The American approach to this crisis in evolution has been the development of the Acute Care Surgeon, with extra training and remuneration. This may be something to consider for regional Australia.

There is a role for government and health departments here to respond to this evolution. General Surgeons need to be carefully selected at a specialist level, with remuneration that reflects their training and responsibility. Our institutions and regulatory agencies must support this. Our General Surgeons need to be trained to the very high standard required: they need to maintain their skillset with regular access to simulation courses and formal short Fellowships in Specialist units like ASE. Good General Surgery should be developed not diminished. ■

Associate Professor
Alan DeCosta

For more information about the ASE course visit ase.training/

We now have a dedicated administrative staff and excellent anatomy staff in Smithfield, Cairns. We have developed Operation Manuals for all the courses we run, and a set of course videos to match the programs.

We take the simulation aspects of the course seriously. We primarily cater to SET Trainees but we are open to residents as well as younger consultants. We tailor the course to each participant's ability and interest and ensure that they have the manuals and videos for the course for preparation. A detailed debrief is carried out, based on an extended Pendleton Method and using numerical Objective Structured Assessment of Technical Skills (OSATS) data. We invite feedback on the course and send out questionnaires. The tutors have a separate manual and access to all the other course materials.

There have been some unexpected outcomes of this program. Similar programs have now been appearing elsewhere in Australia and overseas. Our tutor surgeons are among the greatest beneficiaries of the program. In Cairns, we no longer approach thoracotomies or craniotomies with dread as we have had continuous practice on cadavers every year; we are a much better team of surgeons for it. Our SET Trainees who have done the course have now returned as tutors post-Fellowship.

The surgeons of *Vanity Fair* magazine

The term 'Vanity Fair' originally meant 'a place or scene of ostentation or empty idle amusement and frivolity', a reference to the decadent fair in John Bunyan's 1678 book, *The Pilgrim's Progress*.

By the 19th century, author William Makepeace Thackeray made *Vanity Fair* his own, borrowing the term for the name for his 1848 satirical novel.

The same title has since been used over the past 200 years for various magazines, including one currently published by Condé Nast from 1983 with an emphasis on popular culture, and from 1991 as an international edition, introducing articles on national and world affairs.

The *Vanity Fair* magazine referred to in this series of articles, however, refers to the most successful Society magazine in the history of English journalism, published over almost 50 years from 1868 to 1914.

The success, indeed the very essence of *Vanity Fair* hinged upon the personality and background of Thomas Gibson Bowles: journalist, parliamentarian, and founder, owner and editor of the original magazine.

An excellent biography of Bowles by Leonard E Naylor entitled, appropriately, *The Irrepressible Victorian*, was published in 1965. Bowles was 19 when his father, as President of the Board of Trade, nominated him to a clerkship in the Legacy and Succession Duty Office at Somerset House, London, also providing him with an annual stipend.

Bowles 'worked' there for eight years, however, his early diaries reveal how little time he spent there: he had a hectic social life and there are stories of daily bouts of gymnastics, foot racing, games of rackets, fencing, riding, skating, endless parties and trips to the theatre, where he knew all the stage celebrities of the day.

He was never in bed before four in the morning and obviously had astonishing stamina: to supplement his income he commenced writing newspaper articles and from age 25 devoted himself entirely to journalism.

In later life Bowles told his sons that he started Vanity Fair with a capital of £200: in its first issue dated 14 November 1868, *Vanity Fair* introduced itself thus:

In this show it is proposed to display the vanities of the week ignoring or disguising the fact that they are vanities, but keeping always in mind that in the buying and selling of them there is to be made a profit of Truth.

There will be no long faces pulled, and no solemn praises sung, over any of the wares, neither will magnifying or diminishing glasses be used to them; but they will be spread out upon their own sole merits, ticketed with plain words.

Those who think that that the Truth is to be found in the Show will probably buy it; those who do not will pass on their way to another, and both will be equally right.

Of the first issue only 619 copies were sold: in the following week it was a mere 408.

Written by and for the Victorian and Edwardian establishment, *Vanity Fair* was the magazine for those 'in the know': for them it summarised the important events of their world each week.

Caricatures were not included in the early numbers but only from issue 13, on 30 January 1869, when Benjamin Disraeli (pictured right) was the first subject. The caricatures were an instant success and the circulation, which had been falling, increased dramatically. The combination of portrait caricature and colour lithography had never previously been attempted in England.

There was criticism that the caricatures were grim and grotesque but Bowles denied this, saying:
There are grim faces made more grim, grotesque figures made more grotesque, and dull people made duller by the genius of our talented collaborator Ape, but there is nothing that has been treated with a set purpose to make it something that it was not already originally in a lesser degree.

Many artists over the years contributed the caricatures but certainly the two best-known were Carlo Pellegrini, with the 'nom de crayon', 'Ape', and Leslie Ward, with the signature 'Spy'.

The Neapolitan Pellegrini was witty, volatile and gregarious, and produced ▶

Image over page:
Cover of In 'Vanity Fair' *by Roy T. Matthews and Peter Mellini, designed by Alan Bartram.*

the first caricature of Benjamin Disraeli: he featured prominently in the earlier issues, once delivering a weekly cartoon without a break for 107 weeks in 1874-5.

Eton-educated Ward was droll, reserved and something of a snob: however, his work output was enormous. He produced 1325 portraits over four decades, his watercolour portraits were transformed into chromolithographs for publication in *Vanity Fair*.

Leslie Ward had his first caricature published in *Vanity Fair* in 1873 when he was just 21 years of age. His autobiography, *Forty Years of "Spy"*, noted: *I venture to prophesy that, when the history of the Victorian era comes to be written in true perspective, the most faithful mirror and record of representative men and the spirit of their times will be sought and found in* Vanity Fair.

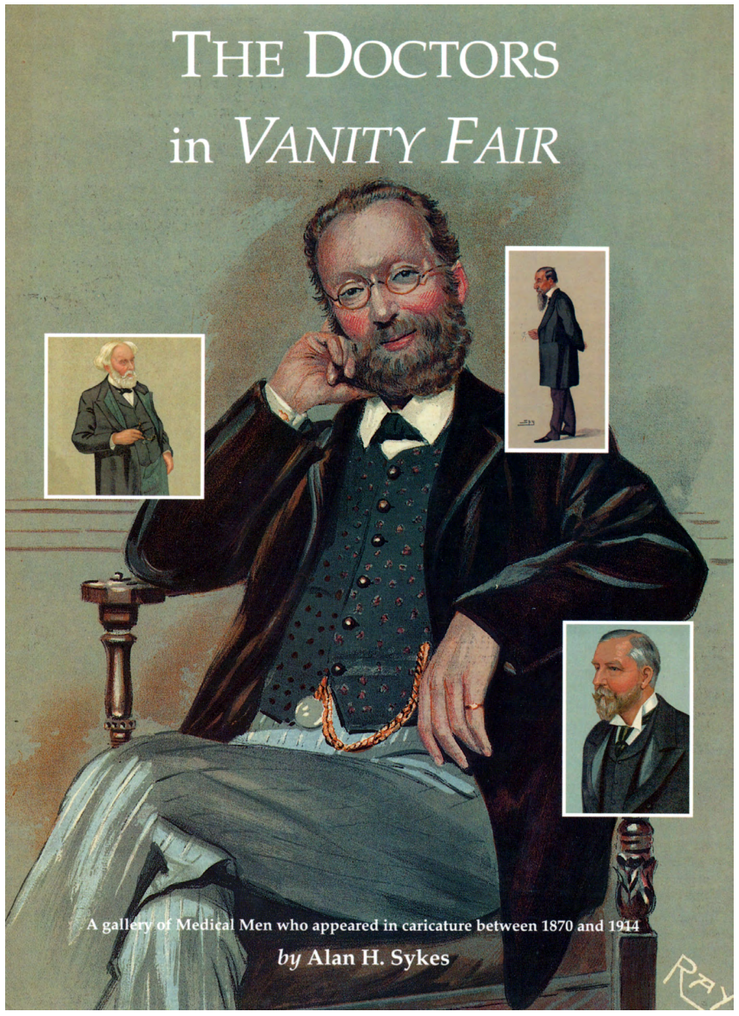
Such was his influence that some refer to any *Vanity Fair* caricature as a 'Spy Cartoon', irrespective of whether Ward was the artist!

In total over 2300 separate prints were produced in the weekly issues of the magazine and several more in a series of special numbers: an excellent reference volume, *In "Vanity Fair"*, written by Roy T. Matthews and Peter Mellini, was published in 1982, simultaneously in London and by the University of California Press.

The subjects caricatured came from a wide range of fields such as sport, music, literature and law, as well as from the mainstay of contemporary politics. They were of people known to the London world of government and society as either members of this establishment or elite members of organisations that served its many interests.

Every week for half a century *Vanity Fair* treated the world of wit and fashion to a clever, amusing and sometimes libellous burlesque on its political and social 'vanities'.

Few English caricatures have ever been so well and attractively produced in such numbers, nor enjoyed such a long and popular life. Virtually every person of importance was a 'victim', and the fashionable world an amused audience. They introduced the distinctive, highly sophisticated form of satirical portraiture, known in France as *'portrait chargé'*.



From time to time, probably unconsciously, we observe in pubs, sporting clubs, offices and even in recognised portrait galleries these somewhat unusual portraits, of persons, generally unknown to us.

In 1978 your author gained by examination the Diploma of the History of Medicine of the Worshipful Society of Apothecaries of London: a fellow graduate and friend was Alan Sykes from Ambleside, Cumbria.

In 1995 Alan wrote *The Doctors in* Vanity Fair*: A gallery of medical men who appeared in caricature between 1870 and 1914*: the two of us had a marvellous and memorable reunion at my home in 1997, sharing our Vanity Fair reminiscences, as I had then been collecting the caricatures myself for almost 20 years!

Closer examination reveals that no less than 53 doctors were thus illustrated over the life of the magazine and, of these, surgeons comprised a significant proportion.

This introduction leads into a proposed series of articles in *Surgical News* discussing some of the surgeons featured in *Vanity Fair* over the years, outlining not only their lives, but also in an attempt to formulate the reasons for their selection, be it professional, or non-medical, such as their role in literature, politics or the arts. ■

Mr Peter F. Burke, FRACS

Image:
Cover image from The Doctors in *Vanity Fair by Alan H Sykes, designed by Sophia Flynn.*

POPs, PFAS and organic fluorines

Oakley in Queensland, Katherine in the Northern Territory, and Williamtown in New South Wales, though geographically remote, all have one thing in common: they recently settled out of court a class action with the Department of Defence for $212 million over toxic firefighting foam containing PFAS, and the resulting contamination of their land and water systems.

PFAS are per- and polyfluoroalkyl substances. For anyone without a degree in chemistry they are confusing in nomenclature with over 4000 compounds. PFAS do not naturally degrade due to the strength of their carbon fluorine bonds: they persist in the environment, contaminating drinking water, wildlife, marine animals and the food chain. They may lie in the soil for decades before finding a route through the ground to contaminate drinking water and/or flow down rivers to the sea. PFAS precursors that are volatile can travel long distances before degrading to PFAS and being deposited in the soil of places remote from the source.

Products containing PFAS became popular in our daily lives in the 1950s because of their non-stick properties and low surface tension. They were first manufactured for cookware before their use in the 1960s extended to aqueous film-forming foams (AFFF) to fight fires at airports and military bases (the contaminating cause of the above class actions). In the 1970s their waterproof properties led to their use in disposable food packaging, outdoor gear, furniture and carpets. PFAS are in our household dust, drinking water, diet and serum.

In the early 2000s, PFAS were found in the blood of polar bears, sounding international alarm bells, and they were later detected in most human blood samples as well. By then they were ubiquitous but the alarm prompted concerted global action. This resulted in the major producer, 3M, discontinuing manufacture of the major chemical then used to produce PFOS, which was later added to the Stockholm Convention's list of globally restricted persistent organic pollutants (POPs) in 2009. Since then, Australians' and others' serum levels of PFAS have steadily reduced over time.

At a time where we are considering how to better dispose of or recycle waste, we need to consider some of our legacy and current practices with landfills. Landfills contain our dumps of municipal waste, though others include construction and demolition waste. Landfill leachates in Australia all contain PFAS, with perfluorohexanoate (PFHxA) predominating. Those that contain construction and demolition waste tend to leach the highest concentrations of PFAS.

Food Standards Australia and New Zealand recommended levels are shown in Table 1.

Most health research has focused on the sulfonate and carboxylate PFAS. The likely effects are immunotoxic and metabolic, endocrine system disruptive, possibly reproductive, carcinogenic and neurodevelopmental.

Probable health risks for PFOA exposure in the C8 Health Project in West Virginia and other studies include high cholesterol, thyroid disease, pregnancy induced hypertension, ulcerative colitis, immunotoxicity, and carcinogenesis, particularly renal and testicular cancers.

The industry producing PFAS has reported that newer shorter chain PFAS with shorter half-lives are less likely to affect human and animal health. However, these may in fact have a greater propensity to interact with body biomolecules, including the microbiome. PFAS not previously detected in earlier studies were found in recent Australian serum samples and will need to be further studied. Official advice is available by State or Territory here: https://www.pfas.gov.au/advice.

Lawyers are following up with similar class action claims across New South Wales, Western Australia and South Australia.Serum levels have been dropping, standards are improving and may now be safe, but for those who built on a legacy landfill, or whose farm is next to an airfield or military base, the jury is still out! ■

Dr BB G-loved

Table1: Recommended PFAS levels by Food Standards Australia and New Zealand

Toxicity reference value	PFOS/ PFHxS	PFOA
Tolerable Daily Intake (µg/kg/d)	0.02	0.16
Drinking Water Quality Guideline (µg/L)	0.07	0.56
Recreational Water Quality Guideline (µg/L)	0.7	5.6

https://www.health.nsw.gov.au/environment/factsheets/Pages/pfos.aspx

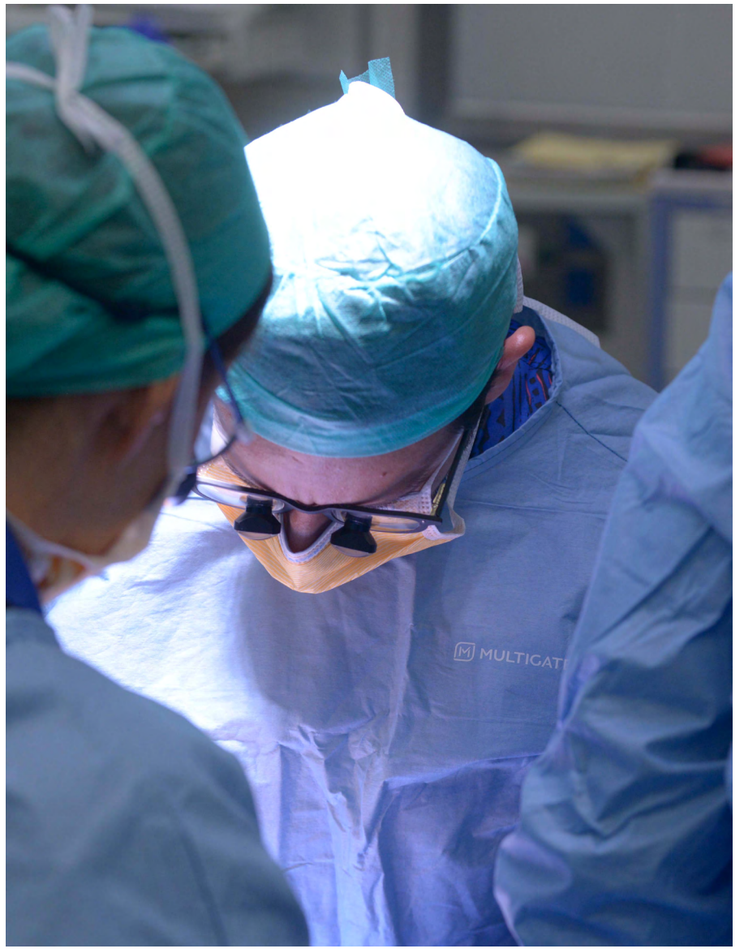
Pilot STP funded fellow placements in Darwin and Cairns

Two Fellows will complete a rural General Surgery pilot program at Royal Darwin Hospital and Cairns Hospital, respectively. These placements are the first of their kind, an initiative of the RACS Specialist Training Program (STP) approved by the Commonwealth Department of Health (The Department).

Fellows will complete 12 months of surgical practice in northern Australia where they will experience a comprehensive, high quality experience in a rural location. This will help to consolidate their skills and encourage them to consider working in a rural setting long-term.

Each hospital will receive government funding of $200,000, along with their agreed co-contributions, to provide their Fellow with support for salary, professional development and relocation needs.

In December 2019 the RACS STP Team received 17 Expressions of Interest from hospitals interested in the program in New South Wales, Queensland, Victoria, Tasmania, Western Australia and the Northern Territory. Royal Darwin Hospital and Cairns Hospital were successful.



Cairns Hospital has a strong Tropical and Public Health Division which supports research and management of the unusual and challenging surgical problems particular to the region. These challenges include mycobacterium ulcerans, meliodosis and tuberculosis.

The medical community in Cairns has a track record of constantly improving the quality of health care for their community and fosters a culture of striving for best quality surgery and medicine. A key priority of the Cairns-based position will be working towards 'closing the gap' for Aboriginal and Torres Strait Islander peoples who make up a large part of the community.

The Northern Territory has an Indigenous population of 30 per cent, and Royal Darwin Hospital typically has an inpatient load comprising 60 per cent Indigenous patients. Therefore, the capacity to assist with Aboriginal and Torres Strait Islander health needs is high.

The Fellow at Royal Darwin Hospital will also have an opportunity to participate in the outreach program which covers Katherine and Gove Hospitals, and to present at the Top End Surgical Prize in December 2020.

The Federal Department of Health would like to acknowledge Dr Bridget Clancy, Chair of RACS's Rural Surgery Section. Dr Clancy proposed this idea at a consultation meeting earlier last year in Mt Gambier for the National Medical Workforce Strategy. Mr Adrian Anthony, Chair to the Board of Surgical Education and Training (BSET) endorses the pilot saying, 'it is a significant step forward'.

As this is a one-year pilot, the placement will be fully evaluated by the Department of Health to see what the future will be for this initiative.

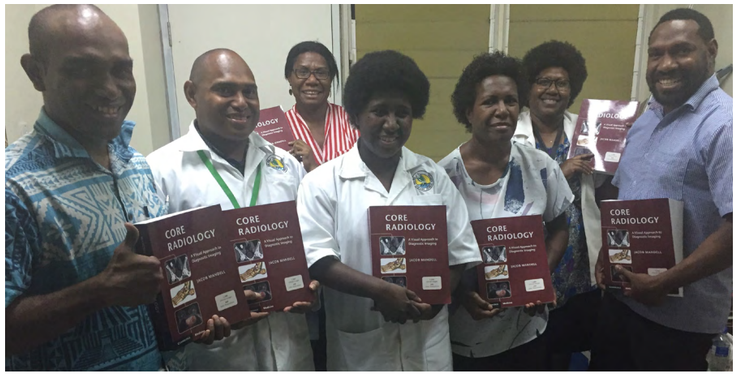
The Department commented that "the team have done a fantastic job getting the pilot up and running". ■

Papua New Guinea book donation

In November 2019 RACS provided teaching materials to seven radiology registrars in Papua New Guinea (PNG) to support their training. Professor Peter Scally, a Consultant Radiologist at Royal Brisbane and Women's Hospital and a mentor to the registrars, facilitated the donation. He said that the new textbooks were very well received and will be a great help to the registrars and a great improvement on existing materials. Professor David Watters AM OBE was glad to be present at the PNG examiners' meeting where the support that RACS provided was acknowledged. ■

Images:

Above, left-right: Dr Lisandra Wapi, 5th year, PNG; Dr Monica Clement, radiologist, Port Moresby General Hosspital; Dr Dora Lenturut, radiologist, Director of Training PNG; Dr Caroline Feka, 6th year, PNG;Dr Evelyn Gima, 2nd year, PNG; Dr Matilda Linge, 5th year graduate; Dr Mary Mamba, 4th year, PNG; Dr Owen Botty, 4th year, PNG; Dr Joseph Pa'ahu, 4th year, Solomon Islands; Dr Simon Wale, 4th year Trainee from the Solomon Islands; A/Prof Peter Scally, external examiner, RBWH, Brisbane.



Left, left-right: In the radiology seminar room at Port Moresby General Hospital with Dr Simon Wale, 4th year trainee from the Solomon Islands; Dr Joseph Pa'ahu, 4th year, Solomon Islands; Dr Lisandra Wapi, 5th year, PNG; Dr Evelyn Gima, 2nd year, PNG; Dr Mary Mamba, 4th year, PNG; Dr Caroline Feka, 6th year, PNG; Dr Owen Botty, 4th year, PNG.

Opinion: Paul Anderson and Jordan Anderson

Specialist Review Clinics – a novel solution to ever-lengthening waiting lists?

Surgeon Paul Anderson offers a specialist review clinic, located in a General Practice, that could be a model for making a real difference to waiting list woes through early diagnosis and prioritisation of treatment.

We first successfully trialled a Specialist Review Clinic in a local general practice (GP) in Whakatane New Zealand offering free half-hour appointments to patients as part of a six-week pilot study. The primary objective was for a specialist (an Upper Gastrointestinal Hepatobiliary and Bariatric surgeon) to offer the local community access to a review assessment when a patient, or their GP, was concerned about a medical or surgical problem and wanted to ensure urgency of investigating it and the patient's subsequent access to treatment.

The six-week trial was with a Specialist (the senior author) interfacing with patients in a General Surgical practice for half-hour appointments half a day per week, which we first successfully trialled and published on two years ago.[1]

The results exceeded expectations: not only was there significant early identity of a number of cancers but in a number of cases, where there was a need for urgent investigation or semi-urgent treatment, this resulted in referral to the specialty unit at the local hospital, improving the efficacy and efficiency of assessment and treatment. In addition, the post-trial survey of those patients treated in the Specialist Clinic returned a 100 per cent satisfaction rating with this kind of specialist care. Some of these patients and members of the community subsequently created The Emergency Assessment Fund, a not-for-profit charity to ensure the concept survived. Since that time over 400 patients have been reviewed in a GP Practice set in a low socio-economic community.

There are a number of issues that could potentially be improved through Specialist Review Clinics. A lack of efficiency of specialist assessment, as well as limited specialist numbers, impacts timely patient review, and treatment; this is then complicated at the public hospital level where there is a lack of people power for investigations such as CT scans and angiograms etc. The long waiting list is also the result of rapid primary practice assessment, due to heavy demand, with reduced clinical information impacting on assessment and prioritisation of investigations. Another contributory issue is assessment of electronic referrals at the tertiary care District Health Board (DHB) level, which is carried out in some cases by junior or administrative staff.

This means is it is currently very difficult in New Zealand to meet the government mandate of treating all patients with an urgent health problem within four months of referral. Adding to this growing problem is an attempt at primary care level to decrease a patient's waiting time by listing patients as 'urgent', which just adds to the urgent waiting list burden. In a small country with limited public resources, the reality is that patients wait many months to even be investigated; an estimated 170,000 patients in New Zealand are not even on waiting lists, with an average wait of 304 days for specialist review.

Political responsibility is being side-stepped; the issue being portrayed as the medical profession is deemed to be the only ones who can determine urgency. Specialist Review Clinics located in General Practice may be a part of a medical/surgical solution to determining what is truly urgent. Patients can then be effectively prioritised into the public system, reducing waiting times and identifying serious medical and surgical problems, such as cancer, thus improving treatment and patient outcomes.

Pilot study a success.

During the trial 25 patients were seen with four follow-up appointments. The age range was from 21 to 84 years and the ratio of male to female patients was 15:10.

Eight patients had pathology discovered following specialist-recommended diagnostic investigations, resulting in an urgent referral directly to the public system. One example was a woman who had experienced low-grade abdominal pain for over 12 months, which didn't meet the GP referral criteria for a public ultrasound. Examination revealed lower abdominal tenderness and pain and, on specialist recommendation, the patient paid for a private ultrasound, which revealed metastatic ovarian cancer. Public chemotherapy was arranged and instituted within two weeks.

Four other patients were identified with pathology deemed urgent and referred for specialist review. The remaining 13 patients were deemed non-urgent and not investigated privately, but a full referral was submitted electronically into the public system and to their GP.

An evaluation questionnaire indicated all 25 patients found the atmosphere with the specialist relaxing, the information easy to understand, and all patients were extremely satisfied that their queries had been dealt with. Additionally, they reported that they had a much better understanding of their health problems. All 25 patients stated that they would not hesitate to recommend such a clinic to their friends. As a result, the Specialist Review Clinic was established permanently in Kawerau, an area of social and economic need. After 18 months, 400 patients have been reviewed, 30 undiscovered pathologies identified, and 60 patients have had their health problems upgraded to urgent. During this 12-month period, numerous personal consultations were carried out with GPs within the practice and they have found the Specialist Review Clinic an excellent resource.

Review clinics: a model that could make a real difference?

A Specialist Review Clinic can clearly improve patient assessment and treatment when located in a primary health setting. The question, therefore, is whether it can be more widely adopted and what the impediments to this would be, practical, political and medical. Most consultants have public appointments; they could do half a day in a GP clinic in lieu of seeing outpatients, thereby not increasing their work loads, and potentially increasing enjoyment as well as efficiency of assessment and care. Having electronic access to the local DHB referral system, through GP clinic computers, would make assessments easier to review. There would be no significant extra cost as consultants are DHB funded.

To overcome any GP concerns about favouritism, Specialist Review Clinics could be part of a local or national program incorporating many specialties allocated to practices after discussions with local GPs and practice managers. To prevent this becoming an elite service as compared to hospital outpatient programs, GPs have suggested specialists see urgent cases only. In a Specialist Review Clinic in General Practice, a half hour consultation with a motivated specialist has the added potential to contribute to better-informed and less anxious patients. This is not insignificant, as several studies have shown a positive correlation between effective communication and improved outcomes. The other positive non-measurable benefit is the support of staff in a primary health care setting, something the senior author found quite revealing and enjoyable vis a vis a larger tertiary system.

The Specialist Review Clinic has now been accepted as an innovative approach to improving patient care by many GPs in the Eastern Bay of Plenty area and will be presented at the next New Zealand National GP meeting.

The development of Specialist Review Clinics in primary practice locally or nationally needs further discussion and ongoing proof-of-concept. One challenge not to be understated is convincing some primary health care providers that this is about better patient outcomes, and is not usurping their authority but augmenting it. On a personal level, the Specialist Review Clinic has provided great mental stimulation, social interaction and a genuine feeling of meeting a community need. ■

Paul Anderson, MBChB FRACS/FRCS (Edin) MA, PhD Dip Tch is an Upper Gastrointestinal Hepatobiliary and Bariatric surgeon. He is also a lecturer in anatomy and physiology at Te Whare Wānanga o Awanuiārangi's indigenous nursing school, offers a free Specialist Review Clinic to the Eastern Bay of Plenty (www.aeFund.org.nz) and is the founding Chairman of Specialists without Borders (www.specialistswithoutborders.org.au). Jordan Anderson MBChB is a Resident at Flinders Medical Centre, Adelaide, South Australia.

1. Specialist Review Clinic: A Novel Pathway to Improved Patient Care? Paul G Anderson and Jordan Anderson. Cutting Edge magazine. Issue 66 March 2018

Case note review

The dilemma of decisions regarding venous thromboembolism (VTE) prophylaxis in a high-risk patient delicately balanced between wound and infection management and thrombosis risk

Case details: A 72-year-old man with previous total hip replacement (THR) surgery on both sides had ongoing problems of instability. Three years ago, he required a relatively early revision for stability by extending the offset of the left hip prosthesis. This may have been the turning point in future events for this patient.

This first revision surgery occurred in a private hospital. The patient progressed well until three years later, when he suffered a prosthesis fracture of the left hip. The patient's body weight loading on the high offset stem could have led to this mechanical stress pattern on the prosthesis that failed, requiring a second revision in a private hospital. The patient was transferred three days postoperatively to another private hospital for recovery and rehabilitation and placed on thromboprophylaxis. In the third week postoperatively, the patient's wound staples were removed, and wound dehiscence was noticed. The patient was then transferred to a tertiary hospital for care of this problem. Patient history included chronic pain syndromes, previous spinal fusion surgery, previous elbow arthroplasty, bilateral THR, fatty liver, gastro-oesophageal reflux disease (GORD) and nephrolithiasis. The most important history of note was that the patient had suffered pulmonary embolus (PE) during the primary left THR surgery while on Clexane (according to the admission notes).

The patient received multiple wound washouts, component exchange and the first stage of the two-stage revision protocol treatment for what was—by then—an established prosthetic joint infection of the left hip. The decision for surgery, the technical procedures, and the seniority of people making the decisions and involved in the actual surgical procedures all align with the current accepted standards of practice.

One week after the first wound washout, a decision was taken on ward rounds to suspend the patient's chemoprophylaxis in consideration of the persistent wound discharge. The patient was placed on mechanical prophylaxis including thromboembolism-deterrent (TED) stockings and passive mobility devices. It was also noticed in repeated unrelated notes that the patient suffered significant peripheral neuropathy bilaterally below the knees. The patient died almost two months later secondary to pulmonary embolism causing a cardiac arrest.

Clinical lessons: The cause of death raises suspicion about the compliance and efficacy of mechanical prophylaxis devices. These are often questionable, especially for a patient with a history of previous PE, multiple revision hip surgeries and liver disease, who remains at significantly high risk of thromboembolism. This case highlights the importance and difficulty of decision-making about thromboprophylaxis, which is a familiar dilemma in current orthopaedic practice where the risks and benefits of available VTE prophylaxis strategies are hard to balance and there is no particular direct evidence to strongly steer decision-making. When a patient at significantly high risk of VTE cannot receive chemoprophylaxis due to wound discharge and infection, and the mechanical prophylaxis may be questionable, perhaps other measures like an inferior vena cava (IVC) filter could be considered. However, the use of an IVC filter itself is a difficult decision carrying its own significant risk in such difficult patients. ■

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

Please note: these cases are edited from ANZASM first- or second-line assessments that have been generated by expert surgeons in the field.

Working to improve IMG assessment processes

In 1992, Dr Kerin Fielding (pictured below) became the first female Orthopaedic Surgeon in NSW, and the third in Australia. It was an uncommon profession for women three decades ago, and Dr Fielding came up against a lot of opposition. "There were bosses who weren't keen on having a woman," she said. And the challenges didn't end there. "Patients in those early days would say 'Thank you very much doctor, that's all very nice but who's going to do the operation?'" she explained.

Fast forward 28 years, and Dr Fielding is running her own successful Orthopaedic Practice in Wagga Wagga, working as an Associate Professor at the University of Notre Dame, and is Chair of the Clinical Surgical Training Council at the NSW Government's Health, Education and Training Institute. She is also a member of the RACS Council and Chair of IMG (International Medical Graduate) Assessment Committee.

The struggle young doctors experience when negotiating their way from medical school through to advanced training is something Dr Fielding cares deeply about. "They get out of medical school and are really passionate about wanting to be surgeons, but then they find all these blocks to progression," she said. This can affect women in particular because they're graduating at an age when they may want to have children. Dr Fielding mentors, tutors and, most importantly, serves as a visible role model for female surgeons who are exposed to negative stereotyping and who fear they may not be able to have both a surgical career and a family.

Dr Fielding is also a passionate advocate for rural medicine and achieving equity of access for rural and remote patients. There is frequently a shortage of surgeons in rural and regional areas and IMGs often fill these roles, Dr Fielding said. They can experience difficulties if they come from different cultural backgrounds or have undergone overseas training programs. In addition, if they're in a remote location they might be remotely supervised and have no access to mentors on the ground.

The IMG Assessment Committee has been around for two years and, as Chair, Dr Fielding emphasises the importance of transparency and fairness. "The process needs to be carefully executed so that it's fair for all IMGs," she said. With this in mind, the committee is reviewing training and assessment processes.

Supervisor training

A new workshop has been established to assist supervisors in understanding the professional needs of IMGs. Meanwhile, reviews of all the sub-specialty training programs are underway to identify where IMGs could be slotted in to complement their study and preparation for the Fellowship exam.

Orientation

The orientation process has been updated with more extensive instructions on what IMGs need to do and how to access professional education.

Reviewing the IMG process

The IMG Committee is currently reviewing the validity of the Fellowship exam for IMGs who have been out of training in their own countries for more than five years. While the Fellowship exam is well validated in the training space, it is not validated in the space of people who have been working as consultants, Dr Fielding said. The IMG Committee is midway through a pilot project that uses work-based assessments to test these consultant-level IMGs.

The signs are encouraging that it will prove to be an alternative method for testing IMGs, and Dr Fielding is impressed with the results to date. While it isn't an exam, she said, it thoroughly tests competence and knowledge and provides a sound insight "into how these people are working".

The IMG Committee is passionate about helping IMGs in their preparation for the Fellowship exam, Dr Fielding said, and "when you look back over the last two years, we've made a lot of progress." ■

Get to know the Educator of Merit 2019 awardees

Every year, the Academy of Surgical Educators (ASE) presents the Educator of Merit award to recognise the exceptional contribution by our surgical educators. This is the second and final part of the series. Let's hear from our awardees.

Educator of Merit – SET Supervisor/IMG Supervisor of the Year (Australian Capital Territory):
Associate Professor Sivakumar Gananadha, Fellow since 2007 in General Surgery

What inspired you to pursue surgical education?

During my surgical training I was inspired by surgeons who were amazing teachers, with their ability to teach and explain with such clarity and deep understanding of the surgical techniques. These surgeons have had a lasting impact on my training and my surgical career. Surgical education provides the opportunity to give back and help the next generation of surgeons. Teaching also allows me to reflect on my practice, which helps me to improve as a surgeon.

What do you hope to see in the RACS surgical education scene moving forward?

The future for education, especially surgical education, is exciting. E-learning is increasingly becoming part of surgical education but we have lagged behind in the uptake of technology. I hope to see utilisation of the technology including surgical simulation and virtual reality technology in surgical education, and for this to be widely available to Trainees.

I would also like to see increased importance placed on teaching in the selection of candidates to Surgical Training Program and to encourage Trainees to pursue teaching during their training. It is not surprising that teaching does not feature highly on a busy surgeon's schedule, especially if the surgeon is poorly equipped, trained and paid for teaching.

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

Students, residents and Trainees always appreciate the teaching they have received, and it is satisfying to know you are helping educate the next generation of surgeons.

Educator of Merit – SET Supervisor/IMG Supervisor of the Year (New Zealand):
Mr Dilhan Cabraal, Fellow since 1994 in Otolaryngology Head and Neck

What inspired you to pursue surgical education?

I have always enjoyed teaching and have been involved in teaching from the time of being a junior doctor. As a junior doctor I always had very dedicated consultants taking time to teach me, which inspired me to become a teacher after I became a consultant. As a teacher and a supervisor of registrars I have recognised that each registrar has different needs and the teaching and mentoring have to be tailored according to the needs of each registrar. Being able to recognise these different needs and the satisfaction I get from helping them to overcome their difficulties has been a main factor that has inspired me to take up surgical education.

What do you hope to see in the RACS education scene moving forward?

I believe all surgeons are teachers and I hope to see RACS involved in developing more programs and courses for surgeons to be teachers. I also believe RACS should be involved in developing a program to provide feedback to the surgeons on how they are performing as teachers. This should involve getting formal feedback from registrars and passing their comments on to the surgeon so that they can improve their teaching practices.

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

I find teaching and supervising registrars a highly rewarding experience. Recognising the different needs of registrars and helping them to overcome these is a very satisfying experience. Having a well-established teaching program in a surgical department not only helps the registrars it is also very beneficial for the consultants to keep up with the latest information and surgical techniques. It is a very satisfying experience to see the registrars whom you have taught becoming highly recognised surgeons in their respective fields. ■

Prepared by Professor David Fletcher, Chair of ASE with Grace Chan, Academy Program Coordinator

Images:

Above, top-bottom: Associate Professor Sivakumar Ganandha, Mr Dilhan Cabraal with Professor David Fletcher (left).

Oslo on the brink of history

In 2019 the Norwegian capital of Oslo achieved the remarkable feat of zero fatalities for cyclists, pedestrians or children under the age of 16. In fact, across the entire city, there was only one death of a road user, a motorist who was sadly killed when he crashed his car into a fence.

This amazing achievement did not occur overnight. The 2019 figure follows years of continual decline of road fatalities in Oslo, particularly since they implemented the 'Vision Zero' strategy almost two decades ago.

At its core Vision Zero starts with the ethical belief that everyone has the right to move safely in their communities, and that system designers and policy makers share the responsibility to ensure safe systems for travel. Importantly, it recognises that people will sometimes make mistakes, so the road system and related policies should be designed to ensure those inevitable mistakes do not result in severe injuries or fatalities.

In Oslo's case, the city implemented a range of measures to improve safety. These included lowering speeds, significant investment in infrastructure, and a mix of policies that specifically targeted separating different road groups as much as possible. This was backed by a national policy that demanded significantly improved vehicle standards. Norwegian officials particularly highlighted that the success was largely due to a consistent and intense focus on road safety by successive governments regardless of their political persuasion.

In addition to Oslo's success, fellow Nordic capital Helsinki also recorded zero fatalities among cyclists, pedestrians and children, and just three fatalities of motorists. This was achieved by employing similar road safety and traffic reduction strategies.

While road fatalities in Australian and New Zealand cities have also declined significantly over the last several decades, unfortunately in recent years we have stalled in our progress.

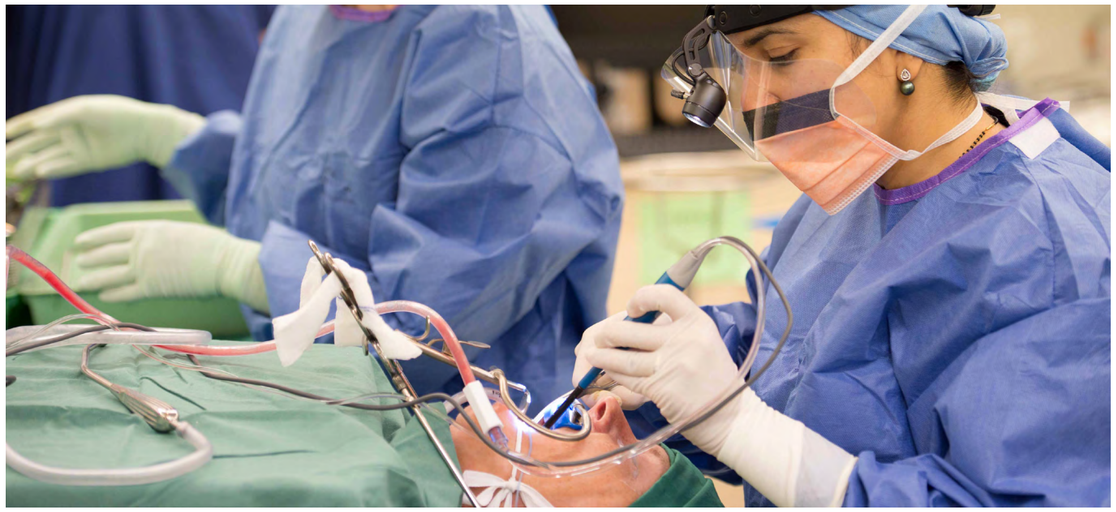
In Australia, according to figures from the Department of Infrastructure, Transport, Cities and Regional Development, there was a 2.5 per cent increase in road fatalities in 2019 compared to 2018. This includes a noticeable spike in deaths on Victorian roads in that time, while South Australia experienced its worst year on the roads in almost a decade. Similarly, in New Zealand, road crash death and serious injury rates have dramatically risen over the last three years.

Both Australia and New Zealand have their own unique differences compared to the Nordic countries. The dominance of vehicle traffic in our central business district areas presents a clear challenge, and most notably, in Australia at a national level, our significantly larger road network comes with its own cost pressures to maintain.

In Australia there is also a growing sense of frustration at the delays taken to mandate new technologies in vehicles. The Inquiry into the National Road Safety Strategy 2011-2020 that I co-Chaired described the lag in time taken for safety technologies entering the market before they became compulsory design requirements as 'unacceptable'. The Inquiry recommended that Australia rapidly introduces and mandates proven life-saving technologies in all new vehicles, including for heavy vehicles.

It is clear we require a much more targeted approach to city planning and investment in infrastructure. Additionally, we require an adaptive regulatory system that is agile enough to keep pace with the rapidly changing technological landscape. This will be particularly important moving forward as technologies, such as autonomous vehicles, continue to become much more viable in the Australasian market.

Oslo and Helsinki are living proof of the reduced likelihood of serious crashes between motorists and vulnerable road users when governments set ambitious targets and dedicate the appropriate resources to support them. I am hopeful that the success of these Nordic capitals will inspire city planners and policy officials across Australia and New Zealand, and that we will begin to seriously ask ourselves: if they can do it, why can't we? ■



Spotlight on our surgical societies

Otolaryngology Head and Neck Surgery in Australia and New Zealand

Mr Zahoor Ahmad New Zealand Society of Otolaryngology Head & Neck Surgery President

Legend has it that in 1903 Dr James Hardie Neil persuaded the Auckland Hospital that it needed to appoint an ear, nose and throat (ENT) surgeon to its honorary staff. Forty-four years later, in 1947, in another first, Dr Neil was elected president of the newly founded Otolaryngological Society of New Zealand.

Today, Associate Professor Zahoor Ahmad is President of the New Zealand Society of Otolaryngology, Head & Neck Surgery (NZSOHNS), with two ENT Surgeons, Dr Kevin Smith and Dr Campbell Baguley, serving as Secretary and Treasurer, respectively.

There is another milestone on the horizon for NZSOHNS, and it's a welcome one: NZSOHNS will soon have its own permanent office at the RACS office in Wellington. It's been functioning at a high level without paid staff for a long time, and "the volunteers have been wonderful," Mr Ahmad said. But, in a development that will ease the pressure on NZSOHNS' Members, a provision has been made for the society to have paid office support.

Mr Ahmad arrived in New Zealand in 1995 as an International Medical Graduate (IMG). He'd trained in Kashmir, worked in the Middle East and completed Fellowships in the US and UK. He had to retrain in New Zealand for his vocational registration and completed his FRACS in 2002. For him, NZSOHNS is like a family.

"We're a close-knit society and we all know each other," he said, admitting that he knew all the New Zealand ENT Surgeons and Trainees by name.

With 153 Members – made up of 117 active Members, 23 Trainees and a few Life Members and affiliate Members – it's clear that collegiality is an important component.

Mr Ahmad said the society actively promotes ENT as a career option for women. "We encourage women to apply," he said. "Historically, there has been a male dominance, but over time it's changing, and we encourage them to participate as speakers and to represent the society."

ENT is a popular career choice for Trainees, with only two or three being accepted each year from a cohort of 15 short-listed applicants. Recently, NZSOHNS conducted a survey of ENT Surgeons across New Zealand, which found that more than 50 per cent of them were aged 55 years and older. Over the next 10 years, some will be dropping sessions or retiring, Mr Ahmad said. "There are already shortages in some places," he added, indicating that it could become a workforce crisis if action isn't taken – perhaps by increasing training places or by bringing more IMGs to New Zealand.

There are currently around 8-15 IMGs working in New Zealand. They're generally able to take jobs where Fellowship-trained supervisors are working. "They're closely monitored and supervised, and their supervisors often act as referees," Mr Ahmad said. "This makes a difference when they're interviewed for the vocational registration for the College because they've been here and seen the standards."

Something Mr Ahmad is very pleased about is the change over the last 20–30 years in how IMGs from India and Pakistan are regarded. It was often more difficult for IMGs who came to New Zealand in the 1990s from countries other than the UK or the US, he said. These days, there's a better pathway, and the majority are evaluated as very good doctors.

NZSOHNS and ASOHNS [Australian Society of Otolaryngology Head & Neck Surgery] share a close association, Mr Ahmad said. "We know each other well, and when we hold our Annual Scientific Meetings the President from the other country is invited as an honorary guest."

Mr Ahmad teaches at Auckland University and it's a role he loves. Research is a keen interest, too, and he does a lot of research on salivary glands with colleague Professor Randall Morton. Along with Dr Malcom Giles, the two were co-authors of the three-volume set Symptom Oriented Otorhinolaryngology – Head & Neck Surgery.

Mr Philip Fisher Australian Society of Otolaryngology Head & Neck Surgery, Immediate Past President

The Australian Society of Otolaryngology Head & Neck Surgery (ASOHNS) is celebrating its 70th birthday this year. Founded in 1950, it has a prestigious history that includes 37 past presidents and 14 Life Members – with half of the Life Members appointed Members of the Order of Australia in acknowledgement of their outstanding achievement and service to their country.

Outgoing President Mr Phil Fisher says a constant value within the society has been its collegiality. With a current membership of 486, and an expectation this will reach 500 in the near future, Mr Fisher views the camaraderie between Otolaryngology Head & Neck (ENT) Surgeons as an intrinsic part of the ENT culture. "We're still small enough to be very collegial," he said.

If striving for gender equality and family friendly policies for all Trainees is any indication, it's clear that ASOHNS includes trailblazers on its committee. Currently, 31 per cent of Trainees are women; however, only 14 per cent of Fellows are women. "For a couple of years, we had an intake of 50 per cent," Mr Fisher said, adding that a recently appointed Diversity and Inclusion Adviser is working to maintain and increase diversity.

"In every state we've arranged part-time positions that are available to both males and females and we encourage our male members to take parental leave, if they wish to," Mr Fisher said. "We're also seeing quite a few babies arriving throughout our training program."

ASOHNS is the third largest specialty and, by all accounts, a popular one. "We have far more applicants than we can fit in the training scheme," Mr Fisher said. "It's a fantastic profession with a broad group of sub-specialties. Any skilled surgeon can find their niche and succeed."

The Fellowship exam is "a tough exam," Mr Fisher said. Most ENT Trainees pass on their first or second attempt, but there are a few candidates who go on to further attempts. Overall, the pass rate is very high, he added.

Fellowship exam pass rates for International Medical Graduates (IMGs) are mixed. For those who are practising in teaching hospitals there is access to the same training as Registrars. They "have equally high pass rates," Mr Fisher said. However, for those IMGs working in rural and remote areas without access to the same training and resources, the story isn't always as favourable. "We have difficulty with the jurisdictions – providing support, leave cover, financial assistance or whatever they need to get to training events."

Mr Fisher was vice-president of ASOHNS from 2016–2018, and President from 2018–2020. He now serves a further two years as Immediate Past President. Living in Perth, he won't miss the frequent flights across the Great Australian Bight to the eastern seaboard.

There have been many challenges over the past two years and, as a society, ASOHNS has been very much involved and supportive of the way the College of Surgeons is embracing change. On his achievements as president, Mr Fisher said that purchasing a new head office in Sydney (with room to grow) and employing three dynamic staff, "who are moving our society forward", were at the top of his list.

The ASOHNS' CEO has recruited a Membership Manager and SET (Surgical Education and Training) Program Manager, which has expanded the society's ability to "help members and look after Trainees", Mr Fisher said. The new location also provides space for member events and Trainee meetings. His involvement in the development and oversight of the new head office, he explained, was one of his "greatest long-term achievements as President".

Mr Fisher is grateful to the members who volunteered their time over the past two years to supervise and mentor Trainees, and to advocate and support ASOHNS through workshops, conferences and outreach work. ■

Images:
Above, left–right: Mr Zahoor Ahmad, Mr Philip Fisher.

Electronic Prescribing implementation underway

In October 2019 the Commonwealth Department of Health and the Australian Digital Health Agency established the regulatory and technical frameworks that will support electronic prescribing for Australia. Electronic prescribing provides an option for prescribers and their patients to have a digital prescription as an alternative to a paper prescription.

The Department and Agency are now working with clinical software vendors, state and territory health departments and peak bodies like the Royal Australasian College of Surgeons to implement electronic prescribing.

What is electronic prescribing?

Electronic prescribing is the process by which a prescription is electronically generated by a prescriber using software which conforms to stringent requirements as published by the Australian Digital Health Agency. The Department of Health have made changes to Commonwealth PBS regulations to recognise an electronic prescription as an alternative to a paper prescription and has worked with states and territories to ensure amendments are aligned across Commonwealth, state and territory legislation.

Patients and prescribers will be able to choose an electronic or a paper version of their prescription.

Electronic prescribing is not mandatory, and patients and prescribers will be able to choose either an electronic or paper prescription. Over time, the convenience of an electronic prescription will likely see patients transition to using electronic prescriptions as their preferred option.

What will it look like?

The technical framework for electronic prescribing published by the Agency provides guidance to clinical software vendors to update their prescribing and pharmacy dispensing software to support electronic prescribing. The technical requirements outline two options for patients to access their electronic prescription: by using either a 'token' model or an 'Active Script List (ASL)' model.

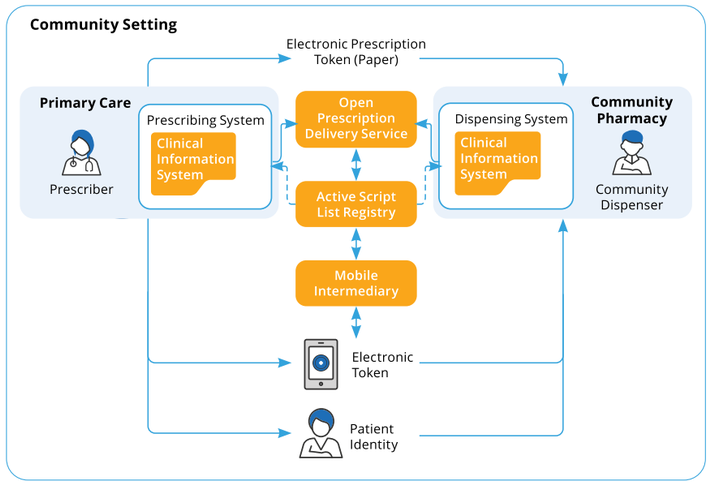
Token:

A token is received as a QR code on a patient's mobile phone by SMS (or by email). When scanned, the token unlocks the electronic prescription from a secure, encrypted, cloud-based prescription delivery service.

Active Script List (ASL):

An ASL displays a list of a patient's active prescriptions available to be dispensed, to those health professionals who the patient has consented to view their ASL. Scanning a token is not required, and patients can manage and view their own prescriptions via an App.

Figure 1: Technical framework for electronic prescribing - Token and Active Script List models.



Electronic prescribing as part of COVID-19 National Health Plan

On 11 March 2020, the Commonwealth Government announced plans to fast-track the implementation of electronic prescribing to help protect people most at-risk in our community from exposure to COVID-19. This measure is designed to support the new telehealth measure and will allow a doctor to generate an electronic prescription that the patient will then be able to electronically share with their pharmacy, where the pharmacy is able to support the home delivery of medicines.

More information about electronic prescribing is available at digitalhealth.gov.au

More information about electronic prescribing as part of the COVID-19 National Health Plan is available at health.gov.au

STRIVE WA

How medical students are taking the initiative and making their mark in collaborative research and audit

Clinical trials require leadership, collaboration and teamwork. The Australian Clinical Trials Alliance and RACS through Clinical Trials Network Australia New Zealand (CTANZ) have actively promoted networks of researchers. In Western Australia, medical students are leading the way in this important area.

Medical student and junior doctor collaboratives have recruited over 100,000 patients across 450 surgical units globally in the last decade. The project was initiated in the UK in 2007 and now has a global reach with established large collaborations. The Right Iliac Fossa Treatment (RIFT)[1] Study in the British Journal of Surgery in 2019 ranks highly on the Altmetric Attention Score (a weighted count of the online attention found for a piece of research). The Reinforcement of Closure of Stoma Site (ROCSS)[2] clinical trial was published in The Lancet in February 2020 and presents some potentially practice-changing results. The impact of research collaboratives on evidence-based surgical practice is only beginning to be realised.

Surgical research collaborations enable a specific clinically relevant question to be asked in a well-designed protocol with high quality and power, reducing research waste.[3] Through the very nature of collaboration, detailed protocols and stepwise mentorship they provide and enable opportunities for novice surgical Trainees to be exposed to quality audit and research while training in teamwork and collaboration.

In Western Australia (WA), all three medical school student societies came together to form the Student Research Initiative Western Australia (STRIVE WA) under the guidance of Professor Toby Richards. This is part of a WA Health Translation Network initiative to harmonise and promote clinical research in WA. Based on the framework of Student Audit and Research in Surgery (STARSurg) an equitable committee was set up to develop this homegrown collaborative research framework.

In 2019, STRIVE WA conducted the Respiratory Complications after major Abdominal Surgery (RECON) audit to assess adherence to guidelines designed to reduce postoperative pulmonary complications at a tertiary centre in WA. Twenty-five medical students supervised by nine junior doctors recruited 130 patients to the RECON audit. Internationally, the RECON audit recruited 11,692 patients from 586 centres across Australia and the UK. A manuscript encompassing the global study is being prepared for publication and STRIVE WA has taken the opportunity to disseminate our results locally and nationally. These included poster presentations at the local South Metropolitan Health Service Board meeting, the University of Western Australia research presentation meeting, and the International Surgical Students' Conference in 2019 where we won the Best Poster prize. This was the first time in Australia that a student-led collaboration had facilitated such an audit. Since then, we have sought to increase our reach.

STRIVE WA now has critical mass and momentum, enabling it to provide education to students and prevocational doctors about audit and research, exposure to REDCap and other IT tools of the trade, opportunities for practical experience in collaborative audits, and continued participation in national and international collaboratives, including the Australasian TASMAN Collaborative (trials and audit in surgery by medical students in Australia and New Zealand) , STARSurg, and Europe's EuroSurg. Our vision is to arm students with the necessary skills to perform collaborative audits and research. This will empower them to hit the ground running as Trainees, and ultimately produce research that benefits the primary stakeholder in all medical ambitions: our future patients. ■

Mr Kyle Raubenheimer
STRIVE WA Steering Committee Member
Vice-President Internal - Australasian Student's Surgical Association (ASSA)

Professor Toby Richards
Lead Facilitator - Trials and Audit in Surgery by Medical students in Australia and New Zealand (TASMAN) Collaborative

Pre-vocational doctors and students presenting their results for the RECON audit at the South Metropolitan Health Service meeting, left-right: Dr Archana Shrivathsa, Dr Robert Swart, Marcel Nejatian, Andre Sincari, Salar Sobhi, Kyle Raubenheimer, Joseph Hanna, Aksh Handa and Emily Anderson.

References

1. Nepogodiev, D., Matthews, J. H., Morley, G. L., Bhanderi, S., Jain, S., Mohamed, W., ... & Bhangu, A. (2018). Right Iliac Fossa Pain Treatment (RIFT) Study: protocol for an international, multicentre, prospective observational study.
2. Bhangu, A., Nepogodiev, D., Ives, N., Magill, L., Glasbey, J., Forde, C., ... & Pinkney, T. (2020). Prophylactic biological mesh reinforcement versus standard closure of stoma site (ROCSS): a multicentre, randomised controlled trial. The Lancet, 395(10222), 417-426.
3. Ahmed, W. U., Mills, E., Khaw, R. A., McLean, K. A., & Glasbey, J. C. (2019). Collaborative student research efforts provide a solution to research wastage. Bmj, 364, l795.

New South Wales Chair update

My time as Chair is coming to an end and, as happens in these situations, it's natural to reflect on changes, achievements and the future.

Before going further, I feel that the College Council, the State and Territory Committees and the New Zealand Board have a responsibility to advise our Fellows, Trainees and IMGs on taking safe appropriate measures regarding the Coronavirus that protect not only ourselves but also the patients we care for.

We must be led by good practice and I feel it appropriate to include recommendations from New South Wales (NSW) Health. For information for health professionals: https://www.health.nsw.gov.au/Infectious/diseases/Pages/coronavirus-professionals.aspx

I am fortunate to have been involved with an active Committee that believes they can make a difference in NSW and I am excited to share that Dr Payal Mukherjee is taking over from me as Chair with Michelle Atkinson as the Deputy Chair. With their support the RACS NSW Committee can go on to even greater things.

The College has been going through a period of change, with the aim of better representing you and promoting patient care and better outcomes. The NSW Committee and I are fortunate to be part of this evolution. I am confident that we are moving forward as an organisation and that there are a lot of Fellows and staff working hard to achieve our goals. Inevitably there are areas that need work, but I encourage you all to ask, "How can I help make the College a better place?" This change does not mean we just resort to what we have done previously; rather we should take the best from the past and work out how to use it in an ever-changing world, take the best from the present and mould it to our needs, and plan for opportunities in the future.

I feel that the NSW State Committee, and the other State and Territory Committees and the New Zealand Board are in a strong position. We have seen change coming for some time and we have adapted. I'm not totally sure where we will end up but we will always strive to represent you.

The NSW Committee continues to advocate on important issues. One area that has been on our agenda is the protection of the term "surgeon". We have addressed this for many years in NSW and it continues to cause frustration as it has been a slow battle, potentially putting public safety and health at risk. This has been a fight that other stakeholders have been involved in and can relate to, particularly ASPS, ASAPS from a cosmetic surgery perspective and the AOA from a podiatry one. We support each other towards positive health outcomes and it has been a pleasure to co-sign, represent to the Minister, and present to Senate enquires with other Specialist colleagues.

Further to this, we have supported the Trauma community and Emergency Departments with issues associated with alcohol and violence. I would like to especially commend John Crozier for his tireless work in this area.

Surgeons' Month has now been running for six years and we continue to develop the model to offer better engagement with our members.

Another issue that has been raised recently is leave entitlements of Trainees crossing State and Territory borders to continue their training. We were able to advocate with the NSW Health Minister to help address this ongoing issue. The Minister is supportive in recognising leave entitlements of Trainees coming into NSW, with similar advocacy happening in several other States and Territories.

I have thoroughly enjoyed my time as Chair and am looking forward to being part of the RACS NSW State Committee for another year. I am proud of what we have done and I believe that there are even greater times ahead for the NSW Committee. ■

Mr Ken Loi

Outgoing Chair,
RACS NSW State Committee

The importance of a consistent surgical assistant in the rural and regional areas

Providing the best possible outcomes from major surgical operations for patients can be largely dependent on a high level of cooperation from all members of a surgical multidisciplinary team. The surgical assistant is a valued member of these teams, whose skills and experience maximise safety and efficiency during an operation. Surgical assistants support the primary surgeon as a skilled second pair of hands providing continuous, competent and dedicated assistance under the direct supervision of the primary surgeon.

A surgical assistant can be either a qualified surgeon, a SET Trainee, a medical practitioner (such as a general practitioner or junior doctor), a qualified specialist nurse, or a medical or nursing student in certain circumstances, such as in rural and regional areas.

We support the use of surgical assistants who are appropriately credentialled, working within their scope of practice, and supervised, monitored and appraised. It should be up to the primary surgeon to decide if they wish to use a particular surgical assistant. There should be flexibility that allows the primary surgeon to choose who they would like to assist depending on skill and availability.

Between metropolitan and rural centres there is a large maldistribution in the medical workforce. The shortage of doctors in rural areas means that they are usually too busy or not interested in assisting in operating theatre. SET trainees, if they are present, are obligated to the public hospitals. Qualified nurses, such as perioperative nurse surgical assistants (PNSA) or registered nurse first surgical assistants (RNFSA), are increasingly being used in settings where medical surgical assistants may otherwise be unavailable. We would emphasise that in providing this support it is expected that the minimum entry requirements are maintained and that non-medical surgical assistants:

1. must obtain appropriate qualifications (i.e. PNSA course offered by La Trobe University or RNFSA at Auckland University), credentialing, and indemnity insurance,
2. have access to a surgeon mentor,
3. have formalised oversight and participation in ongoing competency based CPD within the appropriate scope of practice (RACS can review and provide advice on the proposed CPD framework).

When providing care to areas of need where there is a shortage of medical assistants, non-medical or nursing surgical assistants can play a role to ensure a consistent and stable surgical team. Where a medical surgical assistant is remunerated by Medicare Benefits Schedule (MBS), the cost of the service provided by a qualified nursing surgical assistant or other non-medical practitioners generates an out-of-pocket expense to be paid by the patient or their surgeon. This places a disproportionate financial burden on the rural, regional and remote patients and their surgeons as Medicare, Department of Veteran Affairs and the private health funds will not provide rebates.

Given the workforce constraints in rural, regional and remote areas, patients would benefit from being able to receive MBS surgical assisting services from the best available practitioner. A flexible system that allows the primary surgeon to enlist a medical, nurse practitioner or PNSA depending on skill and availability would be ideal, with all three groups having access to assistance fees in the MBS. WorkCover Queensland already recognise that PNSA fill a gap where there is a shortage of medical assistances. As a result, a 15 per cent assistant's fee is payable based on the above rules for 'Assistance at Operations' for PNSA who are members of the Australian Association of Nurse Surgical Assistants. (1)

The introduction of an MBS item number for Assisting at Operation based on geographical remoteness could benefit rural, regional and remote patients by reducing the health and financial inequality with the potential to save costs within the healthcare system. ■

References

1. WorkCover Queensland. Medical Items Table of Costs 1 December 2019 to 30 November 2020 [Internet]. Brisbane: WorkCover Queensland, 2019 [cited 2020 Mar. 10]. Available from: https://www.worksafe.qld.gov.au/service-providers/medical-fees

Updated RACS position paper on domestic violence

Domestic violence is one of the most urgent social and public health issues of our time. Surgeons of all specialties are likely to interface with survivors of domestic violence in outpatient clinics, emergency wards and at hospitals.

In the interest of decreasing the rate of a weekly death from domestic violence in Australia and New Zealand, not to mention the many who continue to be assaulted, it is imperative that surgeons understand their role and step up.

With this in mind, at the end of 2019 the College updated our pre-existing position on domestic violence to provide greater guidance to Fellows, IMGs and Trainees. The updated position paper intends to raise awareness amongst surgeons about ways to assess risk and triage patients appropriately.

The primary goal of this paper is to assure surgeons that, while we cannot solve the entire problem by ourselves, we can play a much greater role in identifying cases and referring to our colleagues for advice and support. The key is to work as a team to address domestic violence, just like we would with any other disease or condition we are presented with.

The updated position paper also highlights the prevalence of people working while dealing with domestic violence in their own lives.

Domestic violence can affect anyone irrespective of social and economic status, or education or racial background. This includes doctors.

It is so important that we are aware of this possibility, not just for the safety of our colleagues but also for the safety of our patients. When someone is in distress and worried about their own safety or that of their child, their capacity to perform to the best of their abilities is compromised. We need to be able to provide compassion and support to anyone going through this situation and establish procedures within our hospital system to help them.

I urge everyone to take the time to read the paper and to consider the role they can play in helping to end the scourge on our society that is domestic violence. I also recently recorded a podcast on this topic which is available on the RACS website.

The updated Domestic Violence position paper is available at https://umbraco.surgeons.org/media/1636/2019-09-10_pos_rel-gov-036-domestic-violence.pdf.

The podcast featuring A/Prof Mukherjee is available to listen to at https://podcasts.apple.com/us/podcast/opening-up-opportunities-for-women-in-surgery/id1125227899?i=1000468621703 or wherever you find your podcasts.

RACS is committed to providing support to surgeons to assist them appropriately through difficult situations. More information can be found here https://www.surgeons.org/about-racs/surgeons-wellbeing/racs-surgeons-support-program. ■

Associate Professor Payal Mukherjee

Chair, RACS NSW State Committee

bongiornonationalnetwork

vic bongiorno group nsw bongiorno & partners qld walshs sa bartons wa smith coffey

RACS Post Op podcasts

Check out the interviews with some of the most inspiring and forward-thinking industry professionals.

Developed by RACS, the Post Op Podcasts feature extended interviews on the latest research across the medical industry as well as practical advice that surgeons can implement in their practices, such as insights on financial management, wealth creation, legal and tax advice and economic forecasts.

You can subscribe to the fortnightly RACS Post Op Podcasts on Apple's iTunes or, for those with other smartphone models, on Stitcher.

Listen on iTunes

Search 'RACS Post Op' in the Podcast app on iPhone or in iTunes on desktop

Listen on Stitcher

Search 'RACS Post Op Podcast' on stitcher.com

Diversity and inclusion

SELECTED REFERENCES

E-Book

Martin ML, Heron S, Moreno-Walton L, Strickland M. Diversity and Inclusion in Quality Patient Care: Your Story/Our Story – A Case-Based Compendium. 2nd ed. 2019. ed.: Springer International Publishing; 2019.

E-Journal

Equality, diversity and inclusion: an international journal

E-Journal Articles

DeMartine JC, Maffe T Saddam A. Developing Diversity and Inclusion Within Organizations. Leadership Excellence Essentials 2016;33(11):12.

Moves to increase diversity and inclusion in the workplace: Fairness and camaraderie as building blocks. Human Resource Management International Digest 2018;26(2):41-43.

Köllen T, Kakkuri-Knuuttila M, Bendl R. An indisputable “holy trinity”? On the moral value of equality, diversity, and inclusion. Equality, Diversity and Inclusion: An International Journal 2018;37(5):438-449.

Quinn GP, Quinn GP, Gwede CK, Gwede CK, Meade CD, Meade CD. Diversity Beyond Race and Ethnicity: Enhancing Inclusion With an Expanded Definition of Diversity. The American Journal of Bioethics 2018;18(4):47-48.

Morley T. Making the business case for diversity and inclusion: Short case studies and research papers that demonstrate best practice in HR. Strategic HR Review 2018;17(1):58-60.

Sposato M, Feeke S, Anderson-Walsh P, Spencer L. Diversity, inclusion and the workplace-equality index: the ingredients for organizational success. Human Resource Management International Digest 2015;23(5):16-17.

Hackett AN, Kramer JE, Leonard SR, Scotellaro MA, Voigt BL, Silvestri JM, et al. Development of an Innovative Diversity and Inclusion (D&I) Educational Program. Academic Pediatrics 2018;18(5):e1.

Brottman MR, Char DM, Hattori RA, Heeb R, Taff SD. Toward Cultural Competency in Health Care: A Scoping Review of the Diversity and Inclusion Education Literature. Academic Medicine 2019 09/:1.

Nivet MA, Castillo-Page L, Schoolcraft Conrad S. A Diversity and Inclusion Framework for Medical Education. Academic Medicine 2016;91(7):1031.

Chandrasekhar SS. Strengthening Our Societies with Diversity and Inclusion. Otology & Neurotology 2019;40(1):1-5.

Sanyal C, Wilson D, Sweeney C, Smith Rachele J, Kaur S, Yates C. Diversity and inclusion depend on effective engagement: It is everyone’s business to ensure that progress is maintained. Human Resource Management International Digest 2015;23(5):21-24.

Obeid S, Fanning A, Hultman CS. Diversity and Inclusion in Plastic Surgery Education: A National Survey by the American Council of Academic Plastic Surgeons. Plastic and Reconstructive Surgery - Global Open 2017 09/;5(9):e1469.

McGregor AD. Gender and the surgical profession. New Zealand medical journal 2019;132(1504):77-83.

Siotos C, Payne RM, Stone JP, Cui D, Siotou K, Broderick KP, et al. Evolution of Workforce Diversity in Surgery. Journal of Surgical Education 2019;76(4):1015-1021.

Backhus LM, Fann BE, Hui DS, Cooke DT, Berfield KS, Moffatt-Bruce SD. Culture of Safety and Gender Inclusion in Cardiothoracic Surgery. The Annals of Thoracic Surgery 2018;106(4):951-958.

Kuo LE, Parangi S, Cho NL. Diversity and inclusion in a surgical society: A longitudinal investigation. Surgery 2019;165(4):808-813. West MA, Hwang S, Maier RV, Ahuja N, Angelos P, Bass BL, et al.

Ensuring Equity, Diversity, and Inclusion in Academic Surgery: An American Surgical Association White Paper. Annals of Surgery 2018;268(3):403-407. ■

Good reads

Textbook of Surgery

Edited by Julian A. Smith FRACS, Andrew H. Kaye FRACS, Christopher Christophi FRACS and Wendy A. Brown FRACS with contributions from a range of other RACS Fellows.

The book focuses on the principles and techniques of surgical management of common diseases. Great emphasis is placed on problem solving to guide students and junior doctors through their surgical training.

Medical students and Trainees must possess an understanding of basic surgical principles, a knowledge of specific surgical conditions, be able to perform a few basic procedures and be part of a multidisciplinary team that manages the patient in totality. All students of surgery must also be aware of the rapid developments in basic sciences and technology and understand where these developments impinge on surgical practice.

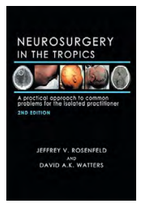
Each topic is written by an expert in the field from his or her own wisdom and experience. All contributors have been carefully chosen from the Australasian region for their authoritative expertise and personal involvement in undergraduate teaching and postgraduate training.

Including new or extensively revised chapters on a number of topics.

Available online at: https://bit.ly/2TJhFPN

Neurosurgery in the Tropics: A practical approach to common problems for the isolated practitioner

Jeffrey V Rosenfeld FRACS and David AK Watters FRACS



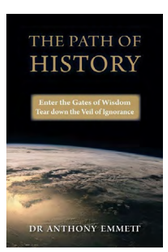
We live in a world where the global burden of unmet but treatable neurosurgical conditions approximates to 5m per year. Patients with head injuries, large heads, deformities, tumours, spinal problems and back pain then present to the nearest general surgeon, who must determine what is treatable and what is not, and who must also manage emergencies that cannot be referred. This book is written for surgeons working in tropical and/or low- and middle-income countries and there is no trained neurosurgeon. It is a practical guide to neurosurgical assessment, diagnosis and treatment, written around presentations and conditions.

It describes the common conditions and how to perform the common operations required, and recognises that the general surgeon often needs to perform life-saving surgery soon after the patient reaches hospital. The book is well illustrated with clinical pictures of the conditions, imaging, and figures. This is a book for surgeons to have in the operating room and to review when assessing challenging patients who present with probable neurosurgical conditions..

This book was donated to the RACS library by the authors.

The Path of History: Enter the Gates of Wisdom Tear down the Veil of Ignorance

Dr Anthony Emmett FRACS



This book gives a historical overview of our development to the way we are in this time. Learning from our past helps guide our actions into the future and grow our understanding of this world. In this set of stories, we are following timeline paths through history, seeing connections over hundreds and thousands of years.

These are changing times. History is a series of connected events we all take part in and behind it all we find the influence of the human unconscious mind, the subconscious and superconscious in deeper levels.

There are many diseases of rulers that influenced the way they led and governed, and this world has been shaped by their actions. This is covered in the Chapter 2, which covers a range of people from Hitler and other Nazis to Stalin, Napoleon, Tony Blair and George W. Bush. Meanwhile Chapter 42 delves into: World Population Epidemic, Climate Change, the Forest Ratio, this Habitable Planet.

It is observed that history books written at different times will vary in their account. Look into our history and see the little-known stories of why it happened as it did.

This book was donated to the RACS library by the author.

In memoriam

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

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

Peter Cant

Informing RACS

If you wish to notify the College of the death of a Fellow, please contact the manager in your regional office:

ACT: college.act@surgeons.org

NSW: college.nsw@surgeons.org

NZ: college.nz@surgeons.org

QLD: college.qld@surgeons.org

SA: college.sa@surgeons.org

TAS: college.tas@surgeons.org

VIC: college.vic@surgeons.org

WA: college.wa@surgeons.org

NT: college.nt@surgeons.org

Warren Neil Cranston Fraser FRCS(Eng) FRACS

Orthopaedic Surgeon

12 December 1928 – 10 July 2019

Warren Fraser passed away in his 91st year after a short illness.

Warren grew up in Auckland, the elder child of Robert Fraser, an engineer, and Clara Thomas. He had a younger sister, Jean. After attending Kohimaramara Primary school, Warren moved on to Auckland Grammar School where he became Class Captain and was regarded as an accomplished pianist. During this time, he was introduced to skiing and this became a life-long passion. Very capable academically, he topped his class and gained a university scholarship. As Robert had continued in the large and successful engineering company established by his father, Warren was strongly encouraged to continue in the family business. However, from a relatively early age he had determined he wished to follow a medical pathway.

After completing two years at Auckland University, Warren gained entry to Otago Medical School and moved to Dunedin. During his fifth year, while completing his obstetrics attachment at Queen Mary Hospital, Warren met Valarie Batts, a budding Karitane nurse, and a friendship was soon established. Completing his MB ChB in 1954, he worked as a house surgeon in Auckland and Hawera and then spent two years as a surgical registrar at Middlemore Hospital in Auckland. Warren and Valarie married in 1956. Advised there would be a consultant position in orthopaedic surgery on his return, Warren was strongly encouraged to travel to the UK to obtain his fellowship and training. Consequently, in 1958 with Valarie and six week old Louise, he sailed to England serving as ship's doctor. He obtained work at the Marsden Hospital in Chelsea, Barnet General Hospital and then the Royal National Orthopaedic Hospital at Great Ormond Street in London. Completing the Primary Examination in Edinburgh he gained his FRCSEng in 1962. After four and a half years in the UK, Warren was offered a position as a fulltime consultant at Middlemore Hospital and the family, now with two additional children Timothy and Kathryn, returned to New Zealand. The family was subsequently completed with the birth of Amanda.

Mr Peter Robertson FRACS, Valarie and Tim Fraser assisted in the preparation of this obituary.

Platinum and Gold

The late Sheila Ann Carter | **Kevin Vandeleur Medical Pty Ltd** | **Ian and Ruth Gough**

Silver

Mr Wei Chang
Anonymous donor
Mr Bill Glasson
Mr Nigel Henderson
Dr Sanjay Kalgutkar
Dr Johannis Kilian
Mr Ross Littlewood
Assoc Prof Paul McCartney
Mr Gregory Mitchell
Mr Rudolph Ngai
Mr John Taylor
Assoc Prof Nitin Verma

Bronze

Dr Renata Abraszko
Mr Thomas Aczel
Mr Christopher Adams
Dr Christopher Allan
Dr Jacqueline Allen
Mr Robert Allison
Anonymous donor
Dr Taraneh Amir-Nezami
Mr Michael Anderson
Mr Benjamin Anderson
Dr David Anderson
Mr David Angus
Dr David Ardern
Anonymous donor
Dr Muhammad Ashraf
Dr Francis Asomah
Dr Arul Bala
Mr Simon Banting
Miss Ginny Barro
Mr Robert Bartlett
Mr Richard Barton
Dr Renata Bazina
Dr Margaret Beevors
Assoc Prof Felix Behan
Prof Ian Bennett
Prof Michael Besser
Dr Maria Bews-Hair
Mr Ratnakar Bhattacharyya
Dr Aziz Bhimani
Mr Lewis Blennerhassett
Mr Laszlo Borbely
Mr John Boulas
Dr Bernard Bourke
Mr Thomas Bowles
Dr Richard Boyle
Dr Luke Bradshaw
Anonymous donor
Miss Ingra Bringmann
Dr Adrian Brooks
Mr Peter Brown
Mr Colin Brown
Mr Michael Bruce
Mr Christopher Byrne
Mr Miles Callahan
Canterbury Eyecare
Mr Robert Carey
Mr Lawrence Carroll
Mr William Castleden
Mr Stanley Chang
Dr Abdul Chaudhry
Dr Ajay Chauhan
Dr Qiuye Cheng
Mr David Chew
Dr Kelvin Choo
Mr Chun-Hung Chow
Dr Sharon Chu
Dr Juliet Clayton
Mr Harvey Coates
Dr Neil Cochrane
Dr Jonathan Cohen
Mr Leon Cohen
Anonymous donor
Mr Trevor Collinson
Dr Daron Cope
Mr Robert Coren
Mr David Cottier
Assoc Prof Brendon Coventry
Dr John Crozier
Mr Ian Curley
Dr Richard Curran
Mr Geoffrey Curtin
Dr Jonathan Curtis
Dr Amitabha Das
Dr Paromita Das Gupta
Mr James Davidson
Mr Christopher Dawe
Mr Neelika Dayananda
Mr Michael Delaney
Mr Sham Deshpande
Assoc Prof Peter Deutschmann
Dr Michael Devadas
Dr Ian Dickinson
Mr Anthony Dunin
Dr Ertugrul Durmush
Dr Johnny Efendy
Anonymous donor
Mr James Emmett
Mr Erik Eriksen
Mr Max Esser
Mr Alan Evans
Mr Ian Farey
Mr Eric Farmer
Dr William Farrington
Prof Kingsley Faulkner
Anonymous donor
Mr Richard Ferguson
Mr Scott Ferris
Mr Patrick Finn
Dr Michael Fish
Mr John Fleischl
Prof David Fletcher
Dr Stephanie Fong
Mr Martin Forer
Dr Amanda Foster
Ms Jane Fox
Mr James French
Prof Peter Friedland
Mr Nicholas Frost
Mr John Gan
Dr Marek Garbowski
Mr Robert Gates
Dr Sam George
Dr Rohan Gett
Dr Katherine Gibson
Prof David Gillatt
Prof Peter Gilling
Mr Lawrence Giutronich
Dr Anthony Glover
Mr Jeremy Goad
Mr Jacob Goldstein
Mr Keith Gomes
Mr Anthony Goodman
Mr Paul Goodman
Dr Ahmed Goolam
Dr Alexandra Gordon
Anonymous donor
Mr Angus Gray
Mr John Gribbin
Mr Philip Griffin
Prof Ronald Gristwood
Mr Garry Grossbard
Dr Bina Gurung
Dr Alison Hallett
Mr George Halliday
Dr Auerilius Erastus Hamilton
Dr Marguerite Harding
Ms Ruth Hardstaff
Dr Craig Harris
Anonymous donor
Dr Merwe Hartslief
Mr Craig Hendry
Mr Michael Henningsen
Dr Hayley Herbert
Prof Alexander Heriot
Mr Tze Ho
Mr Damien Holdaway
Dr Annette Holian
Anonymous donor
Mr Robin Hooper
Mr David Huber
Mr Desmond Hughes
Mr Martin Hunn
Dr Anthony Hutton
Mr David Innes
Dr Mark Jackson
Dr Anthony Jacobson
Dr Carolyn Jameson
Mr Timothy Jansen
Mr Narayanan Jayachandran
Mr Bevan Jenkins
Mr Michael Johnson
Dr John Jorgensen
Dr Prashant Joshi
Mr Craig Jurisevic
Dr Richard Kahler
Dr Irene Kaiboni
Dr Larry Kalish
Mr John Kearney
Dr Michael Kern
Dr Jasmina Kevric
Dr Nina Marie King
Mr James King
Dr Leon Kitipornchai
Mr Jonathan Koea
Dr Saeed Kohan
Assoc Prof Tomasz Kozak
Dr Jai Kumar
Mr Thomas Kuruvilla
Prof Markus Kuster
Mr Min Lai
Assoc Prof John Laidlaw
Dr Julian Lane
Dr Marc Langbart
Mr Mikko Larsen
Mr Graeme Last
Dr Pui Yau Lau
Dr Hui Lau
Mr Matthew Lawrence
Mr Gabriel Lee
Mr Richard Levy
Dr Elizabeth Lewis
Mr Tao Shan Lim
Dr Alexander Lim
Dr Jocelyn Lippey
Mr David Liu
Prof Chung-Mau Lo
Dr Eu Jhin Loh
Mr Simione Lolohea
Dr Aldenb Lorenzo
Mr William Lynch
Mr Nicholas Maartens
Dr Patricia MacFarlane
Dr Frank Machart
Prof Stuart Mackay
Mr Alastair MacKendrick
Mr Craig MacKinnon
Dr Alexander Malone
Dr Aylwyn Mannell
Mr Simon Matthews
Mr Mervyn McCallum
Mr Peter McCombe
Mr Christopher McDonald
Dr Catherine Jane McDougall
Dr Samuel McGinness
Mr Nicholas McIvor
Mr Matthew McNamara
Mr Patrick Medlicott
Mr Mark Medownick
Anonymous donor
Dr Tulsi Menon
Mr Ian Michell
Dr Sameer Mihrshahi
Dr Justine Millar
Dr George Miller
Dr Geoffrey Miller
Mr John Miller
Mr Dragomir Mladenovic
Mr Ralph Mobbs
Assoc Prof Irwin Mohan
Mr Anthony Moore
Anonymous donor
Dr Joanna Morgan
Assoc Prof Matthew Morgan
Dr Mark Moroney
Dr Cara Morris
Mr Hayden Morris
Dr Edwin Morrison
Mr Peter Mortensen
Mrs Terri Mulhearn
Dr Juanita Muller
Mr Donald Murphy
Mr Peter Mutch
Mr Jeffrey Myers
Mr Ananthaswamy Nagesh
Dr Uvarasen Naidoo
Mr Ahmed Naqeeb
Dr Mischel Neill
Mr Nicholas Newman
Mr George Ngaei
Mr Thang Nguyen
Mr Ian Nicholson
Dr David Nicholson
Dr Gregory John Nolan
Dr Benjamin Norris
Mr Barnaby Nye
Prof Paul O'Brien
Mr John O'Brien
Dr Alfin Okullo
Prof Stephen O'Leary
Mr Barry O'Loughlin
Mr Robert Orec
Dr Bushra Othman
Prof Richard Page
Mr Anthony Parker
Dr Sandeep Patel
Mr Richard Pemberton
Assoc Prof Marcos Perini
Mr Mark Perko
Assoc Prof Christopher Perry
Anonymous donor
Mr Vivek Phakey
Dr Santosh Poonnoose
Dr Josephine Alexa Potter
Mr Vaughan Poutawera
Dr Chandrasiri Premaratne
Dr Kimberley Prince
Dr Pieter Prinsloo
Mr Per Prisell
Mr Michael Pullar
Mr Joseph Ragg
Prof Gunesh Rajan
Mr Siraj Rajaratnam
Mr Angamuthu Rajoo
Mr Quentin Ralph
Dr Anand Ramakrishnan
Dr Andrew Ramsay
Dr Prashanth Rao
Dr Siva Ravindran
Dr Sunil Reddy
Mr Kundam Reddy
Emeritus P Thomas Reeve
Dr Arash Riazi
Mr Denis Robinson
Dr Maxine Ronald
Mr Robert Rowan
Dr Daniel Rowe
Mr Craig Rubinstein
Dr Boris Ruggiero
Mr Grant Russell
Dr Alex Rutherford
Dr Yasser Salama
Dr Hardeep Salaria
Dr Lucia Saliba
Mr James Sanders
Mr Franko Sardelic
Mr Richard Sarre
Dr Rohit Sarvepalli
Mr Alan Saunder
Mr Philip Scarlett
Dr Heinrich Schwalb
Anonymous donor
Mr William Sears
Dr Mathew Sebastian
Dr Emma Secomb
Dr Negin Sedaghat
Dr Anil Sharma
Dr David Sharp
Dr Philip Sharp
Dr Ashvini Shekhar
Dr Andrew Sherrah
Mr Kush Shrestha
Mr Rodney Simm
Mr John Skelley
Mr Stewart Skinner
Kristie Solar
Mr George Somjen
Mr Samiul Sorrenti
Assoc Prof Phillip Spratt
Mr Juggrich Srisurakrai
Mr Gregory Stackpool
Mr Leslie Stagg
Mr Hans Stegehuis
Assoc Prof Graham Stewart
Mr Richard Street
Dr Kate Stringer
Assoc Prof Douglas Stupart
Mr Michael Sugrue
Mr Unis Suliman
Dr Saifulla Syed
Mr Konstantinos Syrrakos
Mr Robert Tam
Mr Alwin Tan
Dr Viliami Tangi
Dr Richard Tapper
Dr Kourosh Tavakoli
Mr Gregory Taylor
Assoc Prof Susan Taylor
Mr Stephen Tham
Mr James Thomas
Mr Robert Thomas
Dr Chantel Thornton
Mr Craig Timms
Dr Daniel Timperley
Dr Albert Tiu
Dr Elizabeth Tompsett
Mr Anthony Tonks
Dr Patrik Tosenovsky
Mr David Townend
Mr Simon Tratt
Anonymous donor
Mr Adrian Trivett
Dr Khrisna Tumali
Prof Richard Turner
Dr Daniel Vagg
Mr Neil Vallance
Prof Michael Vallely
Mr Jon Van Dalen
Dr Leendert Van Schoor
Anonymous donor
Dr Ashish Vaska
Mr John Vidovich
Mr Subramaniam Vigna-Rajah
Dr Danielle Wadley
Mr Timothy Wagner
Mr David Wallace
Mr Henry Walsh
Ms Susan Wardle
Mr Michael Warner
Dr Ross Warner
Mr Michael Weymouth
Dr Jennifer Wheatley
Mr Denis Whittle
Mr Mark Whitty
Mr Gerard Wilkinson
Mr Brian Wilson
Mr Gavin Wilton
Mr David Winkle
Mr Indrajith Withanage
Dr Hugh Wolfenden
Dr King-Sang Wong
Prof Henry Woo
Prof Fiona Wood
Mr John Woodfield
Mr Mark Wright
Mr Michael Wyatt
Mr Philip Yeung
Dr David Ying
Mr Michael Young
Mr Ian Young
Dr Ali Zarrouk
Mr Xiao-bo Zhang

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

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

100% of your donation assists in addressing critical surgical need

REGISTERED CHARITY

"A psychologically healthy workplace fosters employee health and wellbeing while enhancing organizational performance and productivity,"

Sodexo 2017 Global Workplace Trends

Flexible workplaces are happy workplaces

Speak in total confidence to a Converge International consultant.
Australia 1300 our eap (1300 687 327) **New Zealand** 0800 666 367
International +613 8620 5300 or **visit** convergeinternational.com.au

Converge international

Will you walk together, alongside aspiring young Aboriginal and Torres Strait Islander surgeons who are looking to make powerful, positive changes in their communities?

Please act now and let's actively walk alongside the aspiring young Aboriginal and Torres Strait Islander surgeons who are working to make powerful changes and shape a shared positive future.

Support them and Pledge-a-Procedure by making a tax deductible donation today. Donate online at **www.surgeons.org/donations/** to receive an instant tax receipt, or complete and return this form before 30 June 2020.

Alternatively, to make a more personal contribution, please contact Jessica Redwood, Manager, Foundation for Surgery, on +61 3 9249 1110 or at foundation@surgeons.org.

Please act now and support aspiring young Aboriginal and Torres Strait Islander surgeons to reach their potential, make powerful changes to health equity and shape a shared positive future.

At no other time has health equality been so important.

1 Please accept my donation of: $ ..... ◯ One-off ◯ Monthly*

2 My contact details are:

RACS ID (if applicable): .....

First name: ..... Surname: .....

Address: .....

Phone: ..... Email: .....

3 I would like to donate by:

◯ **Cheque or money order**
Please find enclosed my cheque/money order made payable to the Foundation for Surgery.

◯ **Credit card**

◉ Visa ◯ MasterCard ◯ American Express

Card number: ..... Expiry date: .....

Name on the card: ..... Signature: .....

◯ I do not give permission for my donation to be acknowledged in Foundation for Surgery publications.

◯ Please send me information about leaving a gift for the Foundation for Surgery in my Will.

Royal Australasian College of Surgeons
Foundation for Surgery

Thank you

www.surgeons.org/foundation/

*Monthly donations are deducted on or after the 15th of each month

Please return your completed form to the
Foundation for Surgery
Royal Australasian College of Surgeons
250-290 Spring Street
East Melbourne, VIC, 3002
Australia

Australia's most trusted hospital and private practice transcription provider

WEB-BASED
Dictate and receive reports from anywhere at any time

ACCURATE
Sub-specialty typists with over 99.5% accuracy

SECURE
Data securely stored at an accredited and endorsed State Government Data Centre

QUICK
24-hour turnaround time

GUARANTEED
cost savings and process efficiencies

FREE APP
Apple IOS/ Android App
Securely upload to our server

IMPROVE
patient care and reduce secretarial overload

ISO 9001:2015 Registered AUS/QMS/JAS-C0045/1117

JAS-ANZ www.jas-anz.org/register

An ISO 9001:2015 Quality Certified Company

Download our app now for your free no obligation trial OR Call our friendly staff anytime

1300 768 476 (Australia)
0800 884 323 (New Zealand)

Professional Transcription Solutions www.etranscriptions.com.au • info@etranscriptions.com.au

TEGO

Our strength. Your security.

Has your practice been impacted by COVID-19?

Find out about our flexible pricing model on **page 5**

It's time for a change

Tailored Medical Indemnity Insurance for specialists

- Competitive premiums to suit your specialty
- New to Private Practice Discounts
- 24/7 medico-legal support

Read our COVID-19 Insurance FAQ

Obtain a quick quote

Who is Tego?

Tego offers competitive premiums, unparalleled quality of cover and 24/7 support backed by Australia's top medico-legal advisers.

Our deep understanding of the medical profession has enabled us to provide tailored cover with more choice and greater flexibility, so you can practice with confidence.

We aim to better your current medical indemnity insurance, not just on price but on cover as well.

Who we cover

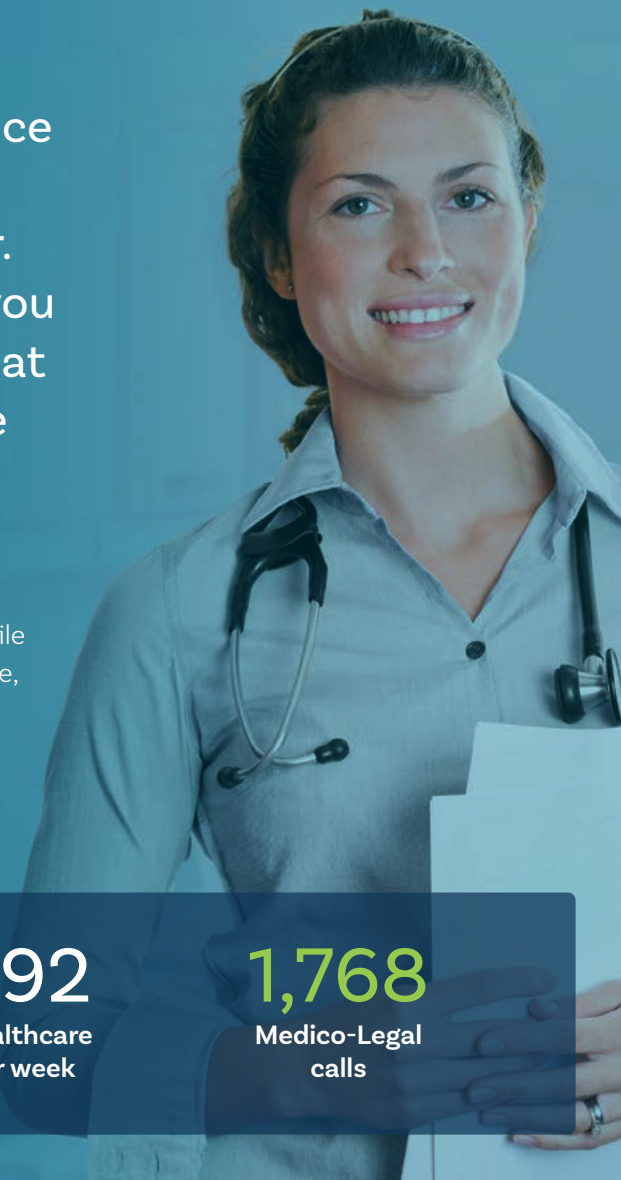
- Medical Practitioners
- Newly qualified Fellows
- Medical practices, clinics and day surgeries

Obtain a quick quote

Why Tego?

Medical indemnity insurance is a vital component of a long and successful career. Things can go wrong and you need the peace of mind that you have the best possible cover in place when you need it.

We tailor our pricing to your individual risk profile to ensure you have the right protection in place, and you're paying a fair premium.



73
Medico-Legal lawyers on our panel

83,792
Hours of healthcare insured per week

1,768
Medico-Legal calls

The trusted choice by specialists

Our medical indemnity insurance comes with built-in features that offer more security and value. From Medicare and tax audits to privacy breaches and patient complaints – we have you covered.

New to private practice

You can save with our discounted premium plan during your first four years.

Public patient cover

We cover claims where your hospital or area health service does not indemnify you.

Telehealth services

Automatic cover for telehealth consultations including MBS and non-MBS services.

The Tego Advantage

- **Two months free** introductory offer.
- **No excesses** anywhere on the policy.
- **'Like for like' policy match** to cover the terms of your previous year's policy should there be any differences in cover.
- **Unlimited retroactive cover** ('tail risk') for prior practice.
- **Tailored pricing.** Your premium is customised to reflect your individual risk profile and the proportion of your work in different sub-specialty areas.

To find out more about our market leading cover visit **www.tego.com.au**

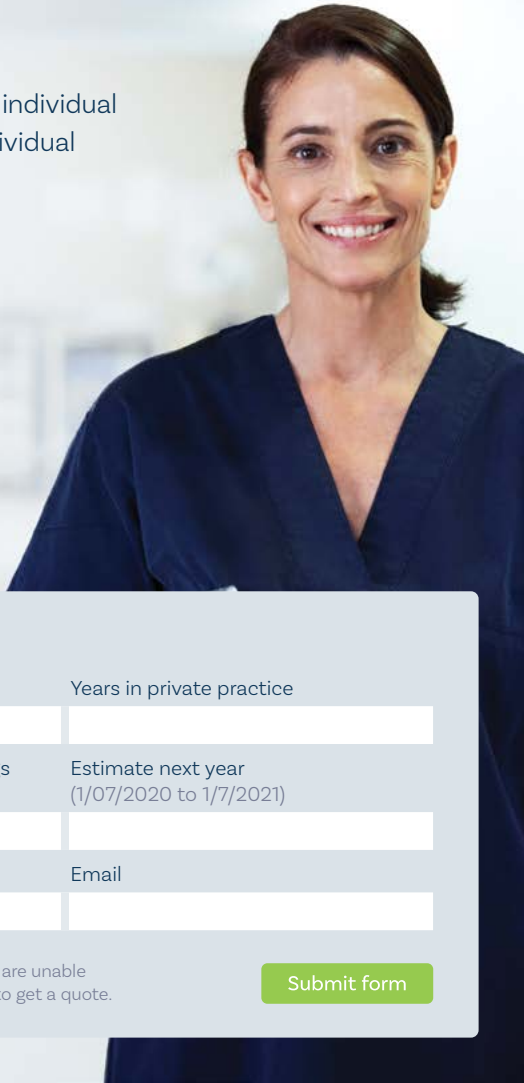
Has your practice been impacted by COVID-19?

A fair approach to pricing

With Tego, your premium is customised to reflect your individual practice as it changes over time. One factor is your individual private billings, which includes:

- Your estimated gross private billings for the next twelve months
- Your actual billings for the past two years

If your practice has been impacted by COVID-19, any reduction to your billings will be favourably factored into your premium calculations now and into the future as your practice begins to build again.



Request your Tego quote*

Specialty

Years in private practice

Prior year gross private billings (1/07/2018 to 01/07/2019)

Current year gross private billings (1/07/2019 to 1/07/2020)

Estimate next year (1/07/2020 to 1/7/2021)

Name

Mobile

Email

* Not all PDF readers support interactive functionality within PDF documents. If you are unable to add data to this form please call **1300 834 683**, visit **tego.com.au** or click **here** to get a quote.

Submit form

What our customers say

"After considerable time spent researching Tego and comparing it against other insurers, I found that Tego had actually listened to what doctors had been saying for years. The coverage was fantastic. Everyone is cautious, and so was I. I spent time reviewing the policy and talking to other doctors and the feedback was consistently positive and reassuring. And when I realised that the pricing was extremely competitive, I was even happier. Quality first, price second. But why not have both? Thanks Tego, very happy with the time spent alleviating my concerns."

Dr Chien-Wen Liew, Orthopaedic Surgeon

Real life savings examples:

General Surgeon
Female, $500k gross private billings

WAS PAYING **$32,172 p.a.** → SWITCHED TO TEGO, NOW PAYING **$16,947 p.a.** → **SAVED $14,225 BY SWITCHING**

General & Colorectal Surgeon
Male, $150k gross private billings, 3rd year in private practice

WAS PAYING **$7,473 p.a.** → SWITCHED TO TEGO, NOW PAYING **$4,609 p.a.** → **SAVED $2,864 BY SWITCHING**

Comparisons are real, made for the most recent renewal period, each for one genuine competitor product only, and current as at January 2020.

3 easy options to request a quote in minutes

Call us, visit our website, or complete the quick quote request form below.

Call **1300 834 683**

Visit **tego.com.au**

SMS your details or the quote request below to **0499 038 346**

Quick quote request*

Please complete and submit below or SMS a picture of this form to **0499 038 346** or email to **clientsupport@tego.com.au**

Specialty

Years in private practice

Estimated gross private billings

Name

Mobile

Email

* Not all PDF readers support interactive functionality within PDF documents. If you are unable to add data to this form please call **1300 834 683,** visit **tego.com.au** or click **here** to get a quote.

Submit form

TEGO