SurgicalNews

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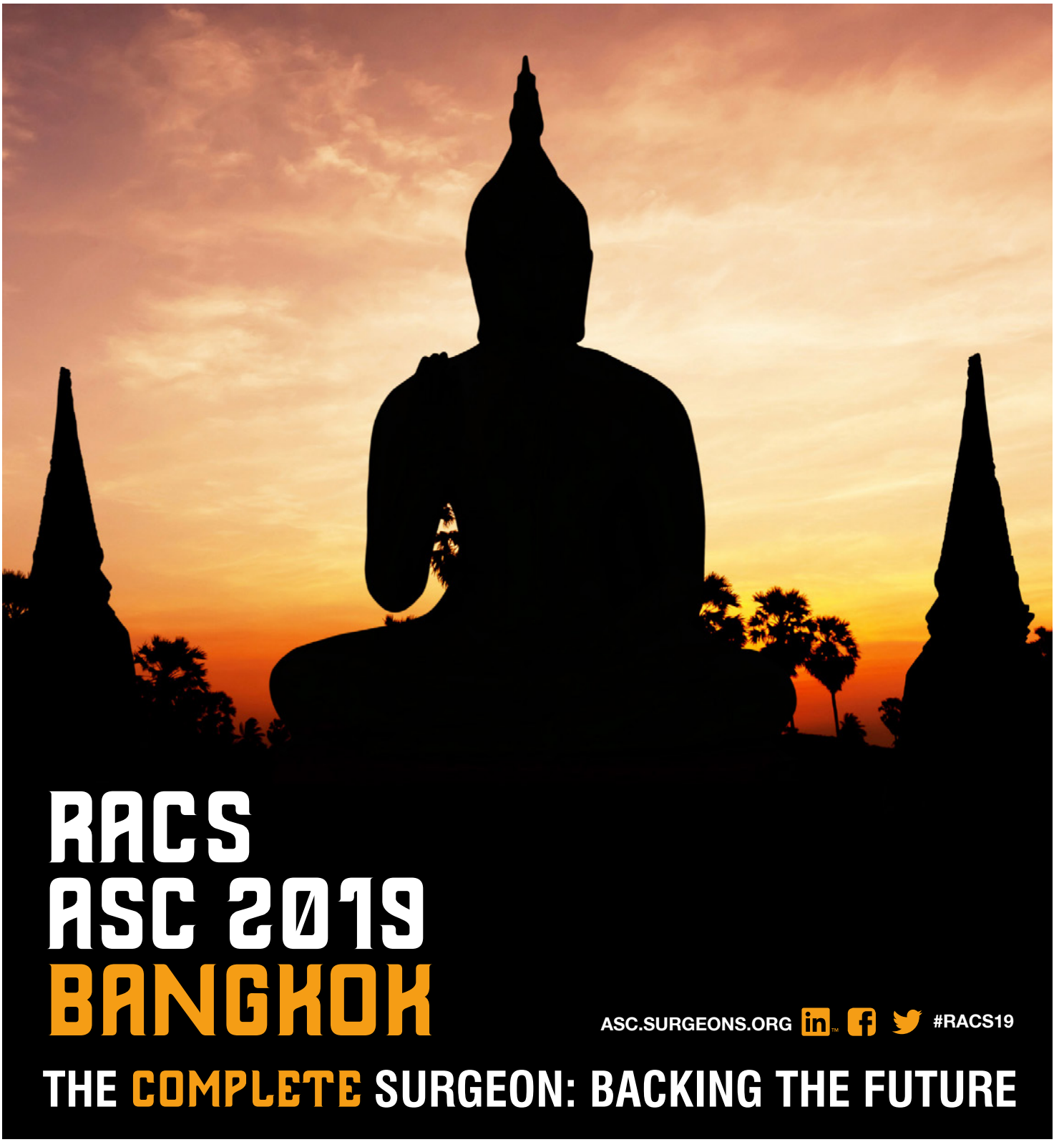
ROYAL AUSTRALASIAN COLLEGE OF SURGEONS



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

Sodexo 2017 Global Workplace Trends

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Above: Conjoined twins after six hour operation to seperate them at Royal Children's Hospital Melbourne.

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Looking to the year ahead

The year started on a high note with the New Year's Honours in New Zealand recognising our surgeons for their contribution to health.

We had four surgeons receiving New Zealand New Year Honours with one receiving a Companion of the New Zealand Order of Merit (CNZM); two receiving an Officer of the New Zealand Order of Merit (ONZM) and one receiving a Member of the New Zealand Order of Merit (MNZM).

The Australia Day Honours also saw 15 surgeons receiving awards, with nine receiving a Member in the General Division of the Order of Australia (AM) and six receiving a Medal (OAM) in the General Division.

I would like to congratulate these surgeons for their outstanding achievement. It is a distinction which they, their families and the College can be proud of as they represent sustained contributions to patients, the health services and hospitals in which they work, and to the wider community.

We are fortunate as a profession to have a strong focus on excellence and I commend all our surgeons for maintaining their professional standards and performance, and for demonstrating to RACS and any regulatory body that they comply with Continuing Professional Development (CPD) requirements.

I would like to take this opportunity to thank the many surgeons who take an active role in teaching other surgeons, Trainees, junior doctors, and other healthcare professionals including International Medical Graduates (IMGs) on a pathway to Fellowship of the College.

It is important that we, as surgeons, Trainees and IMGs, are aware of and understand new developments in our respective fields of expertise, so I encourage you to take advantage of the many courses, training opportunities and scholarships that RACS has on offer. We have a range of useful and practical courses ranging from learning how to give constructive feedback to expanding your knowledge and skills in surgical teaching and education.

As is always our concern, the beginning of the year also takes a serious look at the road toll. While the Australian Federal Deputy Prime Minister, the Hon. Michael McCormack MP, announced a reduction in the nation's road toll from 1,224 in 2017 to 1,146 in 2018, a total of 78 fewer fatalities, the fatalities are still too high. I commend my colleague, Dr John Crozier and his team of passionate Fellows and staff who support RACS' efforts to call out road safety issues and reiterate our position, that serious and immediate action is critical to achieve zero death and zero injury from road crashes.

The New Zealand Trauma Committee has also been active in promoting road safety messages with the chair, Dr Li Hsee calling for prompt implementation of effective controls to prevent deaths and serious injuries from quad bike crashes.

We have much work to do in 2019, including sharing the new 2019 – 2022 strategy which presents an opportunity to build on the past while preparing the profession of surgery for a dynamic future.

I look forward to providing you with updates as the year progresses.

Mr John Batten
President

Acknowledging the vital contribution of surgeons

As I write this, the Australia Day Honours have just been announced, and four weeks ago the New Zealand New Year's Honours list was published. Among the recipients were a large number of health professionals, including surgeons, and I would like to extend my sincere congratulations to you all.

This leads me to reflect on all the great work that is done by many Fellows across both countries — particularly their pro bono contributions to RACS and their voluntary work in the community.

At RACS, we remain very dependent on the goodwill and pro bono work of a large number of Fellows - our unsung heroes. Not only do many of us devote hours to mentoring and teaching our Trainees during the week, but there is a huge amount of time spent collectively teaching the various skills courses run by Specialty Societies and by RACS, not to mention the hours that go into course and curriculum development, instructor training courses, examination preparation and the like.

Many of you will have served on RACS' regional committees or Boards, as well as in the governance structure of your Specialty Societies. Among the many RACS committees, the tremendous and unwavering advocacy work done by the members of the Trauma Committee and the Global Health Committee in particular is worth drawing to your attention.

Then of course there are the countless hours spent on teleconferences and in meetings, all with the best interests of the community and our colleagues in mind.

I have written before about the tremendous work done around Australia and New Zealand by the Foundation for Surgery, and the overseas teaching and aid work done by our Fellows never fails to fill me with admiration.

Other surgeons are heroes of a different kind — choosing to devote their voluntary efforts to local communities, schools, churches, sports and volunteer organisations to name a few. Often it is not until we read an obituary that we appreciate what full and selfless lives these remarkable individuals have lived.

So, as 2019 gets underway, follow the example set by your peers and give some thought to how you can increase your contribution to those around you.

As we salute those surgeons and other health professionals who have been honoured this year, we also pay tribute to all our selfless colleagues who give of their time and skills so freely.

Thank you all.

Ms Cathy Ferguson
Vice President

Introducing the new RACS executive leadership team and portfolios

RACS has moved its leadership to a structure of four portfolios under the Chief Executive Officer: Fellowship, Education, Partnerships and Operations, each managed by an executive leader.

The new structure aims to better meet stakeholder expectations and evolving strategic priorities. It brings together key functions and expertise to create greater collaboration, increase operational efficiency and effectiveness, and simplify the engagement with Fellows, Trainees and IMGs, as well as Council and Committees.

Chief Executive Officer


Mary Harney

Mary Harney was appointed Chief Executive Officer of the RACS in October 2017, having previously worked as Chief Executive of the Gardiner Dairy Foundation. She has more than 30 years' experience in senior leadership roles inside and outside the health sector, including as Chief Operating Officer of Research, and Director of the Office for Cancer Research, at the Peter MacCallum Cancer Centre. In the last 15 years, Mary has held executive positions in the public health, commercial, biotechnology, pharmaceutical, and agricultural sectors.

Ms Harney has a Bachelor of Science (Monash University) and a Bachelor of Arts (University of Melbourne). She completed her MBA at INSEAD International Business School, is a Member of the Australian Institute of Company Directors and in 2016 was the recipient of the Monash University Science Faculty Alumni of the Year Award.

Fellowship and Standards

Incorporating the Australian states, territories and New Zealand offices, the Fellowship portfolio is also responsible for the processes and procedures related to surgical standards and quality care, policy development and the recertification of Fellows and a range of other fellowship services including a library.


John Biviano

This portfolio is headed by John Biviano, Deputy Chief Executive Officer. John Biviano was appointed Deputy Chief Executive Officer of RACS in 2015. He has over 30 years' experience working in the health sector, including working in medical colleges, hospitals and in government. For the past 12 years he has worked in senior executive roles in two of the largest specialist medical colleges in Australasia, with expertise in leadership, strategic policy development, professional standards, and government relations.

While at RACS he has had major involvement in the development and implementation of various sustainability in healthcare initiatives, the indigenous health strategy, and the Building Respect, Improving Patient Safety Action Plan. He holds a Bachelor of Applied Science, a Masters in Management, and is a Fellow of the Institute of Managers and Leaders and a Graduate of the Australian Institute of Company Directors (AICD).

Operations


Emily Wooden

The Operations function ensures the efficient management of the internal operations of the College. The portfolio contains the business resources of the organisation including Governance and Risk (which includes General Counsel and Complaints Resolution), the Building Respect, Improving Patient Safety initiative, Human Resources, Research, Audit and Academic Surgery (RAAS), IT, Finance, Facilities, Archives and Records Management and College Collections.

Emily Wooden was appointed Chief Operating Officer (COO) of RACS in 2018. Emily's most recent employer was Catholic Super, where she was initially Executive Officer, Business Transformation and then subsequently, COO.

Prior to this, Emily had an extensive career across several specialty areas, sectors and organisations including executive positions with The Royal Australian College of General Practitioners, Complete Childcare Solutions, International Development Support Services (a commercial subsidiary of Oxfam Australia) and World Vision. A CPA by profession and Chartered Secretary, Emily has experience across many of the COO remits including Finance and Audit, Governance, Legal and Complaints, IT, People and Business Transformation.

Education


Julian Archer

The Education portfolio is responsible for supporting, shaping and directing the development of world-class curricula to select, train and sustain surgeons to provide the best patient care. Grounded in the clinical education literature, the portfolio supports the delivery of high impact learning outcomes, built on current best practice in, for example, simulation, assessment and evaluative learning cycles.

This is realised through partnerships with stakeholders, Training Boards, hospitals and global technology providers, to ensure the highest standard of safe, respectful and comprehensive surgical care through excellence in training and professional development and continuous education.

Professor Julian Archer was appointed Executive General Manager, Education in late 2018. Prior to this, Julian was a senior clinical academic leader in the UK. He worked as a consultant paediatrician in the National Health Service (NHS) and founded the Collaboration for the Advancement of Medical Education Research and Assessment (CAMERA), within the Faculty of Medicine and Dentistry, University of Plymouth where he retains an honorary Chair. He was personally funded by the National Institute for Health Research (NIHR) for nearly 10 years.

Julian has substantial experience leading clinical education research, designing postgraduate medical curricula and has held numerous senior advocacy roles in healthcare education and regulation.

Partnerships


Susan Wardle

This portfolio develops and strengthens partnerships within the surgical community and the broader community it serves to increase the impact and reach of the profession of surgery and the College. Functions within the portfolio are Global Health, Conferences and Events, Communications and Advocacy and the Foundation of Surgery. Priorities include working with the Specialty Societies, to identify and progress their unique and collective priorities and building opportunities to collaborate with other health related organisations.

Susan Wardle was appointed Executive General Manager, Partnerships of RACS in 2018. Susan has most recently provided consulting services in areas of strategy, communication and issues management, stakeholder relations, government grants and advocacy with international bodies, sponsorship and philanthropic organisations.

Prior to this, Susan spent 10 years at Epworth HealthCare in the role of Executive Director, Strategy, Marketing and Business Development. Her earlier career includes experience across sectors such as health, technology, energy and education. Susan has held Board and advisory roles in organisations including Deakin University, Open Family Australia, HomeGround Services and the Royal Children's Hospital School.

Nima and Dawa with their mother Bhumchu

Melbourne surgical team gives conjoined twins their independence

With the eyes of the nation upon them and the hopes of a mother resting in their hands, paediatric surgeons from the Royal Children's Hospital (RCH) in Melbourne successfully separated conjoined twins Nima and Dawa last year.

The girls, from Bhutan and named after the sun and the moon, were joined at the sternum and shared a liver.

Despite scans and tests, the team was still relieved to be met with no surprises after the six-hour separation surgery got underway, according to team leader, Paediatric Surgeon Dr Joe Crameri.

Dr Crameri said that while surgeons were confident they could successfully separate the small girls, doubts remained as to whether they may find joined or deficient anatomy too small to see on scans.

He said it had also been impossible to determine if the girls had separate bowels or how they would react to anaesthesia before the surgery began.

Six paediatric surgeons from RCH conducted the surgery in early November last year, with the team divided to treat the girls once the separation had been completed.

The team comprised Paediatric Surgeons Dr Crameri, Dr Tom Clarnette, Dr Michael Nightingale, Dr Liz McLeod and Paediatric Plastic Surgeon Dr Jonathan Burge. Anaesthetic support was provided by Dr Ian McKenzie, Director of the Department of Anaesthesia and Pain Management, and Dr Geoff Frawley, Senior Paediatric Anaesthetist.

Dr Crameri, the Head of the Department of Paediatric Surgery at the RCH, said they had been pleased to find that the bowel was not connected at all and that the liver could be safely separated.

"We knew very little about the girls when they first came here and only had a rudimentary CT scan taken in Bhutan to go by, but we knew from what we saw that they could be successfully separated," he said.

"We knew their sternum and lower ribs were connected and that they shared a liver but we didn't know about the bowel because it was impossible to determine on the images.

"However, we thought that if the proximal bowel was separate, we could work with that and we were very pleased to find that the blood vessels and bile ducts of the liver weren't connected which was very important.

"As soon as we saw that, we knew that separating the liver would be quite safe.

"We were also concerned that they might share some anatomy too small to see on scans or that the pericardium might be deficient but that did not eventuate fortunately."

Dr Crameri said the team worked in the largest OR available at the RCH, having decided to treat the girls in the same theatre after separation to minimise their movement for the anaesthetic team and so that Dr Burge could assist with both girls during abdominal reconstruction and closure.

Over six hours, the team divided the twins' lower ribs and sternum, then conducted a liver resection followed by the reconstruction of the abdominal wall and the repair of an anterior diaphragm defect in one twin.

The smaller of the twins, Dawa, also required synthetic tissue and a mesh at the upper incision site.

The surgery went like clockwork, with the 16-month old girls dealing well with the anaesthesia and the surgery, in part due to the painstaking care taken to make sure they were strong enough pre-operatively.

"The twins were malnourished, anaemic, developmentally delayed and had weak respiratory systems when they arrived which presented a challenge," Dr Crameri said.

"They had not met the targets we set by the time we had originally planned to conduct the surgery so we delayed it for a month so they could gain strength and their excellent recovery following the surgery shows that to be a very wise decision.

"That delay also gave us further time to walk ourselves through all the procedures involved in the separation surgery.

"We planned how best to place the girls on the bed so we could get optimum access, we planned what and when equipment would come in, we made sure that each girl had her own set of instruments and that they were all accounted for, we worked out how best to move them following separation and who was in charge of each procedure."

And throughout the delay and the surgery, having taken the two little Bhutanese girls into its collective heart, the public watched and waited.

Dr Crameri said that through several media appearances he had tried to explain that the complexity of the surgery lay not so much in the procedures themselves as making sure the twins could cope with the surgery.

"This was not the 32-hour marathon surgery that was conducted at RCH to separate conjoined twins Trishna and Krishna in 2009 which really was incredibly complex," he said.

"As surgeons, we do more complex work than this quite often but it was rewarding to know we were making such a profound difference to the lives of these little girls.

"We knew at the outset that the twins were quite independent little people who just happened to be stuck together so we did our best to give them their independence."

Dr Crameri said that while it had been planned to place the girls in separate beds following surgery, they became upset and tachycardic when they could not see or touch each other.

"From the moment they'd been born they'd been looking at each other and in the first days following surgery they needed to be touching and in sight of each other to be calm," he said.

"Then, over the next days and weeks they each gradually gained the confidence to be apart and to move freely for the first time in their lives."

Karen Murphy
Surgical News journalist

Twins Nima and Dawa

The importance of RACS scholarships

Professional bonds forged by Bhutanese surgeon Dr Karma Sherub during a year in Australia funded through a RACS scholarship helped pave the way for the successful separation of conjoined twins Nima and Dawa at the Royal Children's Hospital in Melbourne last year.

Dr Sherub came to Australia in 2016 through the Rowan Nicks International Scholarship to undertake an intensive training program at the Monash Children's Hospital which enabled him to become the only qualified paediatric surgeon in Bhutan.

He first met the girls the day after they'd been delivered by caesarean section in July 2017 at a district hospital. While twins had been expected, medical staff were surprised to find them joined at the sternum and sharing a liver. They are believed to be the first conjoined twins born in the tiny Himalayan nation.

Speaking to *Surgical News*, Dr Sherub said he first approached Paediatric Surgeon Dr Chris Kimber at Monash Children's Hospital for assistance in managing the care of the twins.

He said that initial support was then followed by an offer to bring the girls to Melbourne for surgery by the Children's First Foundation and the subsequent decision to conduct the surgery at the Royal Children's Hospital (RCH) under the leadership of Paediatric Surgeon Dr Joe Crameri.

That surgery took place in early November and Dr Sherub was flown from Bhutan to Melbourne to observe and participate.

He said that while he did not have the necessary authorisation to operate in Australia, he participated in pre-operative meetings and discussions between consultants and was in the operating theatre during the procedure.

"Getting the twins to Australia for surgery was made possible through the good relationships and links I had with Australian surgeons that were formed during my Scholarship year," Dr Sherub said.

"The first time I met Dr Crameri was after the twins arrived in Melbourne.

"It was a great pleasure to meet such a lovely man and I thank him for including me when the surgery was going on. It would have been great to be operating with the team but I was happy just to observe the whole procedure."

Dr Sherub said the highlight of the surgery was after the twins' joined liver had been completely divided.

"Back home in Bhutan, that was the aspect that most worried me," he said.

"We have limited resources, but at the RCH they had everything they needed to ensure this aspect of the surgery was successful."

Dr Sherub said he felt confident of their on-going health and wellbeing.

"I think they will need a lot of physiotherapy to build up the muscles of their lower abdomen and lower limbs, and their wounds at the separation site may need close attention upon their return home," he said.

"However, on the whole the picture looks good and I think they will now grow up like any other girls of their age."

Karen Murphy
Surgical News journalist

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

Monday 6 May 2019, 7:15am - 4:00pm

Centara Grand & Bangkok Convention Centre, Bangkok

Provisional Program

6:15am	Registrations open	
7:15am - 7:30am	**Welcome and introduction** John Batten, Marc Gladman and Amir Ghaferi	
7:30am - 9:30am	**Session 1: A career in academic surgery**	
7:30am - 7:50am	What is an academic surgeon	Mark Smithers
7:50am - 8:10am	How to get research started	Deborah Wright
8:10am - 8:30am	Research pathways: Outcomes, translational, educational, basic science – which one is right for you?	John Windsor
8:30am - 8:50am	Tech options for data collection	Karl Bilimoria
8:50am - 9:10am	How to keep academic balance – clinical work, research, teaching, and leadership	Marc Gladman
9:10am - 9:30am	Discussion	
9:30am - 10:00am	Morning tea	
10:00am - 10:30am	**Hot topic in academic surgery: Big data** Amir Ghaferi	
10:30am - 12:30pm	**Session 2: Ensuring academic output**	
10:30am - 10:50am	Writing an abstract	Drew Shirley
10:50am - 11:10am	Writing and submitting a manuscript	Colin Martin
11:10am - 11:30am	Presenting at a scientific meeting	Mary Hawn
11:30am - 11:40am	Discussion	
11:40am - 12:30pm	**Keynote Presentation**	
11:40am - 11:45am	Introduction	
11:45am - 12:30pm	Transforming health outcomes – how a surgeon can do it	Christobel Saunders
12:30pm - 1:30pm	Lunch	
1:30pm - 2:40pm	**Session 3: Concurrent academic workshops**	
	Concurrent workshop 1: Early career development "What can I do to enhance my academic career?"	
	Student	Jane Cross
	Junior doctor	James Lee
	Registrar	Christine Lai
	Finding a mentor and being a mentee	Michelle Locke
	Supporting yourself through fulltime research	Sarah Aitken
1:30pm - 2:40pm	**Concurrent workshop 2: Tools to help with research**	
	Data storage	Fabian Johnston
	Understanding statistics for clinical research and trials	Caroline Reinke
	Navigating the ethics framework – human, ethics, animal and tissue banks	Tarik Sammour
	Building teams and collaborations	Owen Ung
1:30pm - 2:40pm	**Concurrent workshop 3: Getting funded**	
	Tips for successful grants	Julian Smith
	Beyond NHMRC - seeking support from non-Government sources	Guy Maddern
	NHMRC and MRFF – impact of a rapidly changing funding landscape	David Watson
	Industry funding / partnerships benefits and pitfalls	Greg O'Grady
2:40pm - 3:00pm	Afternoon Tea	
3:00pm - 4:00pm	**Session 4: Thriving in academic surgery**	
	Leadership, mentorship and sponsorship	Andrew Hill
	Work life balance	Julie Howle
	Where are the gaps – future trends in research	James Toh
	Closing remarks	

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

Proudly sponsored by:
Johnson & Johnson MEDICAL DEVICES COMPANIES

NOTE: New RACS Fellows presenting for convocation in 2019 will be required to marshal at 4:15pm for the Convocation Ceremony.

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

General Surgery Trainees who attend the RACS Developing a Career and skills in Academic Surgery course during their SET Training may, upon proof of attendance submitted to board@generalsurgeons.com.au, count this course towards one of the four compulsory GSA Trainees' Days.

Information correct at time of printing, subject to change without notice.

Hot topic speaker:
Amir Ghaferi

Keynote speaker:
Christobel Saunders

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

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

2018 comments:

"Fantastic event that has reaffirmed my passion for academia in surgery. I can't wait to be back next year"

"Outstanding course in every regard"

"Usual high standard maintained. Excellent faculty"

"This is a life changing course. It gives me new tools and goals as a medical student and for my future career"

Association for Academic Surgery invited speakers:
Karl Bilimoria - Illinois, USA
Amir Ghaferi - Michigan, USA
Mary Hawn - California, USA
Fabian Johnston - Maryland, USA
Colin Martin - Alabama, USA
Caroline Reinke - North Carolina, USA
Drew Shirley - Ohio, USA

Australasian Faculty:
Sarah Aitken - New South Wales
John Batten - Tasmania
Jane Cross - New South Wales
Marc Gladman - South Australia
Andrew Hill - Auckland
Julie Howle - New South Wales
Jonathan Karpelowsky - New South Wales
Christine Lai - South Australia
James Lee - Victoria
Michelle Locke - Auckland
Guy Maddern - South Australia
Greg O'Grady - Auckland
Tarik Sammour - South Australia
Christobel Saunders - Western Australia
Julian Smith - Victoria
Mark Smithers - Queensland
James Toh - New South Wales
Owen Ung - Queensland
David Watson - South Australia
John Windsor - Auckland
Deborah Wright - Birmingham, England

DCAS course participation
Cost: $220.00 per person GST not applicable
Register online: www.tinyurl.com/DCAS2019
There are fifteen complimentary spaces available for interested medical students. Medical students should register their interest to attend by emailing dcas@surgeons.org

Further information:
Conferences and Events Management
Royal Australasian College of Surgeons
T: +61 3 9249 1260
F: +61 3 9276 7431
E: dcas@surgeons.org

Trainee gains invaluable Ethiopian experience

By the time Victorian SET3 Trainee Carolyn Chew took time out of the training program to work in Ethiopia last year, she was already familiar with life in Africa.

The daughter of committed Christian missionaries who have dedicated their lives to the teaching of surgery and medicine in resource poor countries, this was her sixth trip to Africa.

Her father, Mr Andrew Chew FRACS, is currently serving a five-year posting as Chief of Surgery and Ethiopian Program Director for the Pan African Academy of Christian Surgeons (PAACS) hospital in Soddo, a rural town in Ethiopia with an urban population of around 200,000.

With a life-long commitment to help increase the number of desperately needed surgeons in Africa, Andrew Chew is also a member and examiner of the College of Surgeons of Eastern, Central and Southern Africa (COSECSA), the internationally-recognised body responsible for surgical training in the region.

Since 2015, Mr Chew has trained and mentored seven surgeons through to the successful completion of their Fellowship and will stay to complete his term and support other Trainees before returning home to Adelaide in 2020.

Carolyn's mother, Dr Sok Hui Goh, is the Medical Director of the same hospital. Known as the Soddo Christian Hospital (SCH), it is one of ten PAACS surgical training centres dotted across the vast continent. A trained physician and palliative care specialist, Dr Goh also works as an internist, supervising the Emergency Department and Intensive Care Unit as well as providing consultation services to the surgical, obstetric and orthopaedic services.

Speaking to *Surgical News*, Dr Carolyn Chew said she took up the opportunity to work at the SCH for six months because she had a strong interest in global health, wanted to expand her medical experience and spend time with her parents.

Currently working as one of the surgical registrars at SCH, she said the main difference in the surgical services provided in Soddo compared with her experience in Australia was the significant breadth and complexity of cases.

In the months since her arrival, she has assisted with procedures rarely treated in Australia, and witnessed the great ingenuity required of surgeons working in resource poor countries.

She said that even though Soddo was served by another government hospital, the SCH saw most of the trauma patients because it had the only working CT scan in the region.

"The majority of our admissions are trauma related, with injuries caused either through road traffic accidents or interpersonal violence," Dr Chew said.

"These are very challenging patients but the PAACS program includes visiting specialists who come for a time to teach the registrars. These include maxillofacial surgeons, urologists and plastic surgeons.

"We also see the normal general surgical issues like small bowel obstructions, and thyroid masses and we treat paediatric patients presenting with hernias, intussusception, infantile hypertrophic pyloric stenosis and Hirschsprung's disease.

"During my time here we have also had a visiting urologist from the USA training us in urological procedures such as cystoscopies and urethroplasties."

Dr Chew said that with a core commitment to training surgeons to work in regional areas of Africa, rather than the bustling urban centres, PAACS focused on providing practical training adapted to the regional environment.

Current PAACS trainees at Soddo Christian Hospital, Wolaita Ethiopia from L to R - Dr Tsegaye Woldegiorgis, Dr Mehret Desalegn, Dr Chala Regassa, Dr Carolyn Chew and Dr Temesgen Zelalem.

Soddo Hospital, Ethiopia.

She said that meant teaching surgeons to use resources that were available, such as using dental wires to fix maxillofacial fractures, rather than procedures that relied on technology and advanced equipment.

"The main difference I have found here in respect to operative procedures is the exposure to open surgery," Dr Chew said.

"Laparoscopy at our institution is rarely utilised due to equipment issues and because patients often present with such advanced pathology they are difficult to treat laparoscopically.

"I've also been exposed to a range of sub-specialties that I would normally never see or be involved with in Australia. For example, we regularly do craniotomies and craniectomies for intracranial bleeds - a procedure I'd never seen before I started working in Ethiopia.

"I've also had the opportunity to scrub for several obstetric and gynaecological procedures including Caesarean sections, hysterectomies and myomectomies."

Dr Chew said that while her work in Soddo would not count towards her Australian training at the Western Health Network in Melbourne, she had found it an invaluable experience both in terms of clinical exposure and broadening her surgical skills.

"The surgical registrars here impress me every day," she said.

"They work incredibly hard and the variety and complexity of cases that they see and manage every day is astonishing.

"In addition to this, operating here is very difficult. We have blackouts multiple times a day and working with limited resources and old equipment is a daily challenge that makes me appreciate how lucky we are in Australia.

"This has been a unique experience and while I hope to continue this work in the future, I also want to make sure I have the appropriate training and breadth of experience so that I am useful and adequately skilled if I return to work in a resource poor setting."

Mr Andrew Chew's guide to the surgical need in Africa:

- World Health Organisation estimates that 5 billion people around the world lack access to safe and affordable surgical and anaesthetic care when needed.
- 143 million additional surgical procedures are needed each year to save lives and prevent disability.
- Eastern sub-Saharan Africa requires 17.5 million additional surgical procedures per year.
- Sub-Saharan Africa (which excludes North Africa) requires 41 million procedures each year.
- The 880 million people in sub-Saharan Africa have 0.968 surgeons per 100,000 people compared to 24.9 surgeons to 100,000 people in Australia.
- Ethiopia has only 0.36 surgeons across all sub-specialties (except obstetrics) per 100,000 people – the equivalent of 3.6 surgeons per million people.
- Ethiopia currently faces the equivalent of having only 18 surgeons across surgical specialties to serve the comparable population of either Sydney or Melbourne.
- More than 80 per cent of surgeons live in Addis Ababa, where less than 10 per cent of the population reside.
- The Pan African Academy of Christian Surgeons (PAACS) is a rural-based training program directed by board-certified surgeons from Surgical Colleges around the world designed to train and retain surgeons in regional settings.

If Fellows are interested in providing support or training, please visit www.paacs.net or contact Mr Chew at andrew.chew@flinders.edu.au

Karen Murphy
Surgical News journalist

Pearl Anna Inglis MacLeod

A pioneer in orthopaedic surgery, 1916-2010

Born in Airdrie, Lanarkshire, Scotland, Pearl MacLeod completed a Bachelor of Science at the University of Glasgow in 1937 then graduated with a MB ChB in 1941. She became a Fellow of the Royal Faculty of Physicians and Surgeons of Glasgow (FRFPS) in 1948[1].

Pearl graduated in wartime and her early practice was quite eclectic – she worked as a General Practitioner in England and Scotland, as a House Surgeon at the Emergency Medical Services (probably the Lady Margaret Hospital) Hospital in Millport, Scotland and as a Physician at the Glasgow Fever Hospital.

In March 1945, she began her war service with the Royal Army Medical Corps (RAMC) and in the closing months of the war, was posted to the British Medical Hospital at Poona in India where she performed general surgical duties. She was then sent to the Middle East and worked at the RADOC Base Depot in Tell-El Kebir and later, as Medical Officer in charge of the Moascar Garrison No. 9 Reception Station in Egypt.

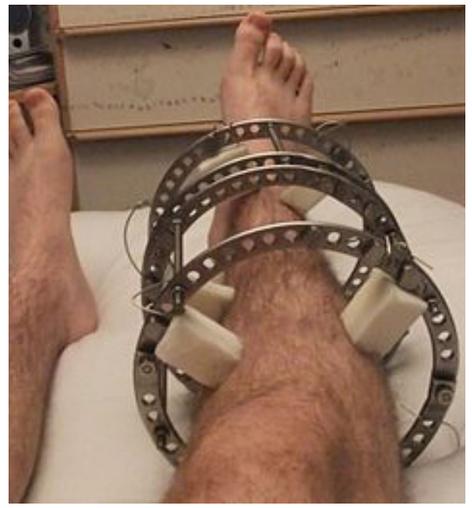
It is likely that her experience with the RAMC inspired her to practice Orthopaedic Surgery and in September 1949 she was employed as a Registrar at the Glasgow Royal Infirmary, working with the Professor of Surgery, J. Burton and the Head of Orthopaedics, James Patrick. From 1949-1952, she was Orthopaedic Registrar at the Darlington Memorial Hospital in England. She noted that her work included Out-Patient's and Fracture Clinics, wards, operating and general emergencies. When the two Orthopaedic surgeons were absent or unavailable, she was in sole charge of the Orthopaedic department.

Pearl MacLeod began her surgical career in Orthopaedics at a time of change and technological advance. By the early 1950s, several developments led to major advances in Orthopaedic surgery. In the late 1930s, German surgeon, Gehard Küntscher invented the Küntscher nail. Designed for femur and tibia shaft fractures, this was '… an internal fixation device used to maintain the position of fracture during healing.' As Küntscher's invention coincided with the commencement of World War 2, his

Dunedin Public Hospital 1950s ('Scattered Seeds' Home Page. Dunedin Public Libraries. 2015)

device was used to care for German soldiers, but was not embraced by the wider surgical community until after the war.

Gavril Ilizarov of the USSR was sent to Siberia to look after wounded soldiers in the late 1940s. Concerned by misaligned fractures and poor healing, in 1951-2, he designed the Illizarov Apparatus which was first used successfully in 1954. This device, which improved



Ilizarov Apparatus (Wikimedia Commons)

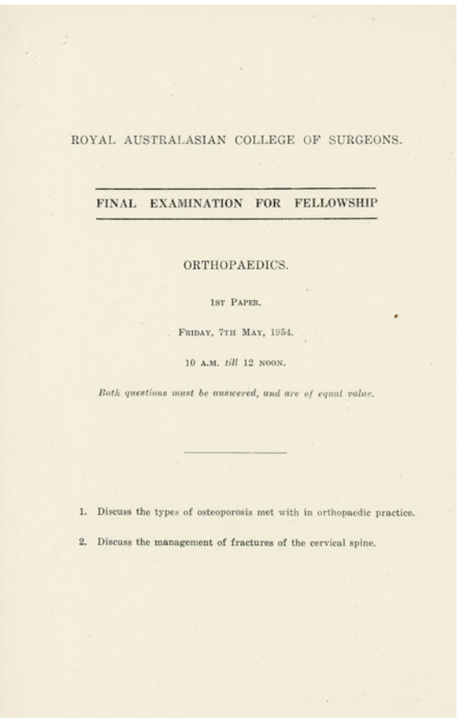
'healing, realignment and lengthening' was '…a ring with external fixators tensioned like the spokes of a bicycle'.

In 1940, Austin T. Moore completed the first partial metallic hip replacement in Columbia, South Carolina. But, it was not until the early 1960s that the British surgeon, John Charnley perfected his *Low Friction Arthroplasty Concept* and performed the first total hip replacement.

In this post-war climate of change and innovation, Pearl MacLeod made an interesting decision in 1952. She moved to New Zealand and became Senior and Assistant Orthopaedic Registrar at the Dunedin Public Hospital. Working under N.W. Nisbet and one of the Founders of the New Zealand Orthopaedic Association, H.W. Fitzgerald, she was mostly involved with Orthopaedic Out-Patients and fracture clinics. In the late 1940s, there was a perception that Orthopaedics required a degree of physical strength, so it was unusual for a woman to specialise in Orthopaedics. However, it is likely that Pearl was able to perform most of the required surgical tasks.

Pearl also worked as an assistant lecturer in Orthopaedics at the Otago Medical School and in 1952, applied to sit the FRACS final exam in Orthopaedics. Pearl who was then living in Dunedin, became a Fellow in Orthopaedics in July 1954. Thus, Pearl MacLeod (FRACS#1038) was our first female Fellow in Orthopaedics.

It is unclear why Pearl decided to leave Dunedin, but according to the Medical Council of New Zealand register, she returned to Scotland in February 1955. In a British medical directory of 1958, she is listed as an Assistant Orthopaedic Surgeon at the Royal Bath Hospital in Harrogate, Yorkshire. The Royal Bath Hospital had a



ROYAL AUSTRALASIAN COLLEGE OF SURGEONS.

FINAL EXAMINATION FOR FELLOWSHIP

ORTHOPAEDICS.

1ST PAPER.

FRIDAY, 7TH MAY, 1954.

10 A.M. *till* 12 NOON.

Both questions must be answered, and are of equal value.

1. Discuss the types of osteoporosis met with in orthopaedic practice.

2. Discuss the management of fractures of the cervical spine.

Final exams in Orthopaedics, May 1954 (RACS Archive)

reputation for the treatment of rheumatoid diseases and hydropathic treatments. However, apart from the fact that she died in North Yorkshire in 2010, we have no knowledge of Pearl's later career.

The final FRACS exam in Orthopaedics was only introduced in 1947 so Pearl was one of the College's first examinees in Orthopaedics. At a time when Orthopaedic Surgery was advancing at an exponential rate, the singular career of Pearl MacLeod, our first female FRACS in Orthopaedics, is certainly worthy of our attention.

[1]. In 1962 the Faculty became the Royal College of Physicians and Surgeons of Glasgow.

Elizabeth Milford
RACS Archivist

Professor Wendy Brown conducts world-first research

The first woman to be awarded the prestigious John Mitchell Crouch Fellowship is using the funding to conduct world-first research into the economic benefits of bariatric surgery as a first-line treatment for severely obese high-resource patients.

Professor Wendy Brown became the first woman to be appointed Chair of the Monash University Department of Surgery in 2015 and is the Director of the Centre for Obesity Research and Education (CORE) and Clinical Lead for the National Bariatric Surgery Registry and the Victorian Upper GI Cancer Registry.

She is President of the Australia and New Zealand Gastro Oesophageal Surgery Association (ANZGOSA), a past President of the Obesity Surgery Society of Australia and New Zealand (OSSANZ) and is the Scientific Chair of the International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO).

Professor Brown received the John Mitchell Crouch Fellowship at last year's Annual Scientific Congress.

Professor Brown said it had allowed her to expand her work investigating the benefits of fast-tracked, intensive obesity interventions in high-resource patients to determine if bariatric surgery reduced hospital interactions and total health care costs while improving health and quality of life.

She said having this information was vital in an era in which obesity now affects 28 per cent of Australians and 33 per cent of New Zealanders, making it the most prevalent disease in both countries.

Professor Brown is currently analysing the cost benefits of the reduction in hospital interactions and medications following the surgical treatment of high resource obese patients along with any broader productivity gains made through returning patients to better health.

"We have patients who attend the heart clinic, the diabetes clinic and the arthritis clinic, with some obese patients requiring up to ten contacts with the public hospital system each year," she said.

Professor Wendy Brown

"Through the Monash University Department of Surgery and with the John Mitchell Crouch Fellowship funds, I've employed a research assistant to gather data looking at the effects of bariatric surgery to determine the reduction, post-surgery, in hospital contacts, medication and interventions.

"We already know through earlier research that assessed the outcomes of more than 1,400 bariatric procedures, that these complex patients lost an average of 20 kilograms in the first year after surgery with weight loss continuing over the six years of follow up analysis and that high-volume services are safe, cost-efficient and effective.

"We are now working to quantify those benefits in economic terms so that everyone working in the field of obesity – from health practitioners to hospital administrators to parliamentarians – will have that information when they are making decisions.

"We know through research and experience that bariatric surgery offers better and more durable benefits than more conservative approaches designed around diet and exercise.

"We see our patients become healthier, happier and more active, so while it might seem a no-brainer for us, we still need the data to prove broader economic benefits."

Professor Brown said she would use the initial data collected to design randomised control trials aimed at helping surgeons identify those high-resource patients who would gain the most from bariatric surgery.

She said the trial would compare the outcomes of complex obese patients who had bariatric surgery against those who were managed through diet, exercise and medication to determine which treatment regime proved the most cost-efficient and effective over time.

She said the information would help surgeons triage high-resource patients.

"The Alfred Hospital in Melbourne has one of the highest-volume bariatric services in Australia. Between 250 – 300 procedures are performed per annum yet we can't keep up with demand," Professor Brown said.

"This situation is replicated all around Australia in the public health setting so I hope this research allows surgeons to better triage and prioritise those patients who will benefit the most from surgery.

"We work with limited funding in the public health setting. We need to know who to choose, what to select and how to best manage the resources we have available to us.

> "This work will also be important to governments and other funders because if we can quantify savings across the public health system and even out the broader economy, it will make it harder for Governments or insurers to reject surgery as an effective, first-line treatment for obesity."

Professor Brown said receiving the John Mitchell Crouch Fellowship represents a significant change in medical attitudes towards bariatric surgery.

She said even in recent years, surgical treatment for obesity was still seen by some in the community as an 'easy way out' or a form of cheating and that all obese patients needed was the determination to take responsibility for their own health.

"Receiving such a prestigious Fellowship represents a change in attitudes toward obesity along with a greater understanding of the physiology that drives the disease state and the important role that surgery plays in treating seriously obese and complex patients," Professor Brown said.

"We now have a far better understanding of the metabolic and physiological disorders that drive the disease state which is helping to erode the prejudice and judgemental attitudes that have long impacted the care of obese patients."

Professor Brown said becoming the first woman to receive the John Mitchell Crouch Fellowship was both a great honour and humbling, given the calibre of past recipients.

"I feel very privileged to have been chosen to join such esteemed company as those academic surgeons who have received the John Mitchell Crouch Fellowship in the past," she said.

"It was an honour to be the first woman to receive the Fellowship but I have worked with some amazing women surgeon and scientists in recent years so I'm confident that it won't be long before another woman is selected to receive it.

"I also thank RACS and its Fellows for the generous support provided for surgical research. I feel very proud to be part of an organisation that both understands the importance of research and supports it through significant grants and scholarships."

The John Mitchell Crouch Fellowship was established by Elisabeth Unsworth in honour of her son, John Mitchell Crouch, a promising neurosurgeon who died in 1977 at the age of 36. It is managed by RACS and designed to support the aspirations of academic surgeons in the early years of their promising research careers.

Applications for RACS' most prestigious award the John Mitchell Crouch Scholarship open 1 March 2019. Please go to www.surgeons.org/scholarships to see this and other 2020 scholarships.

Karen Murphy
Surgical News journalist

Personalised surgical variance reports

Hernia procedures

Since 2016, Medibank has been collaborating with the Royal Australasian College of Surgeons (RACS) to identify and address variations in surgical procedures to improve clinical outcomes.

Working with RACS, it was determined that the next step in using the surgical variance data was to provide personalised reports to surgeons to enable them to gain an understanding of their own, proceedural data relative to their peers.

In 2018, RACS invited 50 surgeons to securely receive personalised reports as a pilot that offered opt-in personalised surgical variance reports. Of the 50 surgeons contacted, 24 opted-in to receive their personalised reports.

These reports showed each surgeon's data, relative to their anonymous peers', for hernia procedures with indicators for patients of median age, median length of stay and percentage of patients readmitted within 30 days.

Participating surgeons were asked for feedback on the report provided and 10 of the 24 participating surgeons responded. Of the 10 surgeons who responded:

- 90 per cent indicated they wanted to continue receiving their reports;
- 80 per cent found the indicators were relevant to their practice;
- 60 per cent agreed the reports would help them reflect and improve their practice; and
- 40 per cent found the case studies provided relevant insights.

The positive response from those involved has led to Medibank and RACS continuing to work together with General Surgeons Australia (GSA), to offer individualised variance reports to eligible surgeons who were not included in the pilot.

A further benefit of the personalised surgical variance reports is that it is consistent with the current aims of the RACS Continuing Professional Development (CPD) program, in that it promotes reflective practice.

RACS is working with Medibank to extend invitations to all remaining eligible surgeons (who weren't included in the pilot) to receive and review their personalised surgical variance reports for hernia procedures. These reports will will include data from FY2017 – FY2018.

Both RACS and Medibank are working together to achieve better outcomes for patients, improve clinical indicators. The collaboration will look for opportunities to improve and enhance the personalised surgical variance reports so to be as useful as possible to surgeons.

*Eligible surgeons must have conducted 10 or more hernia surgeries.

Achieving FRACS

Dr Rachel Care

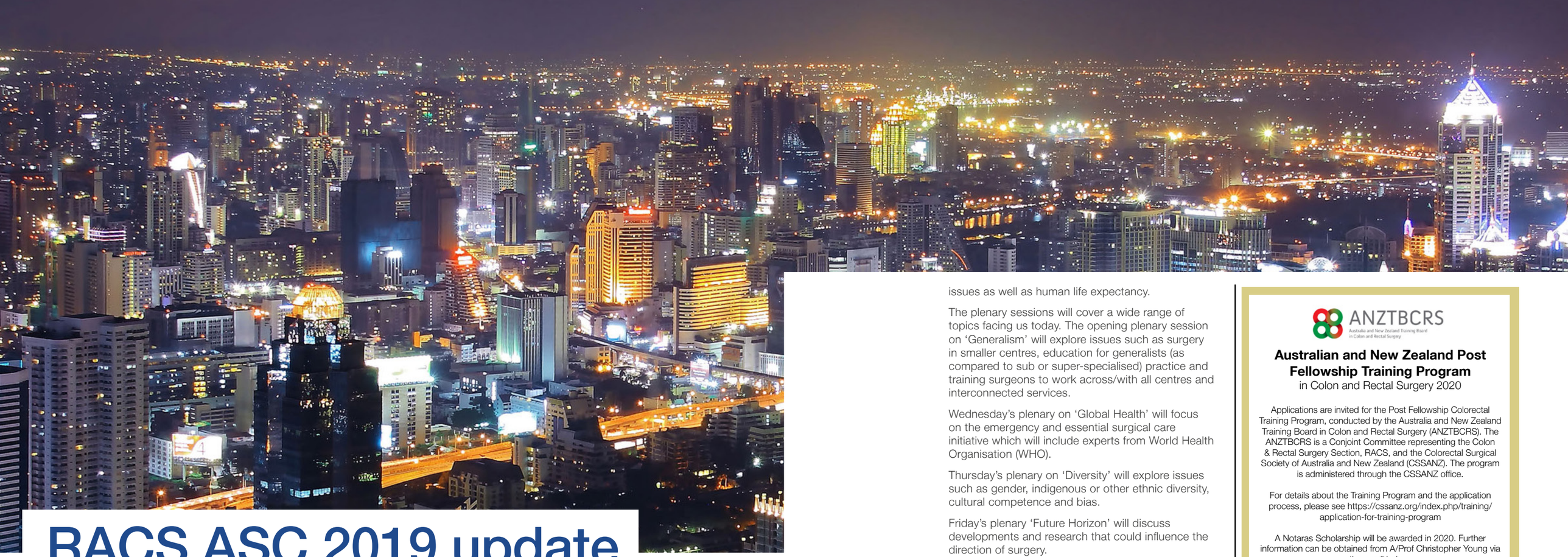
The aim of every Trainee who has been accepted into the surgical training program is to complete their training and receive those special letters 'FRACS', Fellow of the Royal Australasian College of Surgeons. In the last few months I have achieved this very goal and completed my training. Not everything along the way has been smooth sailing but I, like the majority of Trainees who enter the training scheme have emerged from the other side.

While completing the FRACS examination and training program has come with a significant degree of relief - not only personally but also for my family who have suffered through the bumpy ride along with me - there is a new kind of trepidation that comes with the achievement. As a Trainee it is easy to focus on those final hurdles and forget that the transition into independent specialist practice brings with it its own challenges. Moving from an environment where you are constantly supported and supervised into being the lead carer for your own patients can be daunting and a huge step up in responsibility. Thankfully the process of the RACS surgical training scheme makes this transition easier, knowing I have had world class training with rigorous assessment has assured me I am in the right position to take on this responsibility. Additionally, the guidance and support does not stop once you step out of training. The mentorship and teamwork built during the training period continues, and these ongoing supports are a testament to the collegial relationships built during training.

Exiting the training program also means the time has come for me to step down as the RACSTA Chair which leaves me with mixed feelings. I am happy to hand over the responsibility to another capable member of the RACSTA team and will certainly have more time to concentrate on my family and upcoming Fellowship. It is however with sadness that I step away from such a genuinely rewarding position and passionate, driven team of Trainees. Being involved in RACSTA for the last four years has allowed me to gain intimate knowledge of how decisions are made and what processes and protections are in place for Trainees, it has also provided the opportunity for me to advocate for all Trainees to the highest levels of the College. Most importantly I have had the privilege of meeting and working with many exceptional and inspirational individuals, some of whom are now lifelong friends and who without this opportunity I may never have connected with.

The key about surgical training is that overcoming the final hurdle is not the end, there is always more to be done and surgery is a process of lifelong learning. The opportunity for advocacy also does not end with RACSTA, I personally would like to continue advocating in areas I feel passionate about - Women in Surgery and Indigenous Health to name a couple. It seems once the final hurdle is reached there is a whole new exciting mountain to climb!

Dr Rachel Care
Chair, RACSTA



RACS ASC 2019 update

The 88th RACS Annual Scientific Congress (ASC) which is being convened by New Zealand surgeons will be held in Bangkok from 6 - 10 May 2019 at Bangkok's premier conference centre, Centara Grand and Bangkok Convention Centre.

Section conveners have planned an exciting program comprising international and Australasian experts to complement the theme of 'The Complete Surgeon: Backing the Future'.

The 11th Developing a Career and Skills in Academic Surgery course (DCAS) on Monday 6 May is designed to inspire surgeons and Trainees. The Hot Topic Speaker is Associate Professor Amir Ghaferi and Keynote Speaker is Professor Christobel Saunders. A large contingent of internationally renowned academic surgeons will also be present.

The Convocation on the Monday 6 May will feature the Syme Oration 'Doctoring In An Age of Data - the Future For Medical Practice' given by Professor Sir Malcolm Grant CBE. Sir Malcolm, born in Oamaru, New Zealand, is also the esteemed Medico-Legal visitor.

Among many prestigious roles Sir Malcolm was the founding chairman of the National Health Service (NHS) England when it was set up as an independent body in 2011 and recently completed a 7-year term. He was previously President and Provost of University College London (UCL) for 10 years, through a period that saw significant growth and a soaring international reputation, particularly in medical and life sciences.

By the end of his term, UCL was ranked 5th in the world in the QS global university league tables. He is currently (honorary) Chancellor of the University of York, and has previously been Pro Vice Chancellor of Cambridge University. He has served as a director of Genomics England Ltd, and is currently a trustee of Somerset House, President of the Campaign for At-Risk Academics (CARA) and an expert adviser to the French and Russian governments, and to universities in the USA, UK and Australia, on higher education.

There are also many named lectures and this year's *British Journal of Surgery* lecturer will be Professor James Kirkland, Professor of Physiology and Medicine, and consultant for the Division of General Internal Medicine; Department of Internal Medicine at the Mayo Clinic. The major focus of his work is the impact of cellular ageing on age related dysfunction and chronic diseases. Dr Kirkland is an acknowledged world leader in the field of senescence and his research publications are widely cited.

The *ANZ Journal of Surgery* lecturer is Professor Alistair Woodward, Head of Epidemiology and Biostatistics at the University of Auckland. From 2004 – 2012, he was Head of the School of Population Health at Auckland and previously led departments of public health at the University of Otago Wellington, and the University of Adelaide. A medical graduate, with postgraduate qualifications in public health and epidemiology, his research has studied tobacco, environmental health and the social determinants of health. He is an accomplished author on environmental issues as well as human life expectancy.

The plenary sessions will cover a wide range of topics facing us today. The opening plenary session on 'Generalism' will explore issues such as surgery in smaller centres, education for generalists (as compared to sub or super-specialised) practice and training surgeons to work across/with all centres and interconnected services.

Wednesday's plenary on 'Global Health' will focus on the emergency and essential surgical care initiative which will include experts from World Health Organisation (WHO).

Thursday's plenary on 'Diversity' will explore issues such as gender, indigenous or other ethnic diversity, cultural competence and bias.

Friday's plenary 'Future Horizon' will discuss developments and research that could influence the direction of surgery.

Sunday will feature the International Golden Scalpel Games, in collaboration with the Health Education and Training Institute's Clinical Surgical Training Council, while Monday will host the 8th World Health Organisation Global Initiative for Emergency and Essential Surgical Care Biennial Meeting. This global forum brings together multidisciplinary stakeholders representing health professionals, public health experts, health authorities and local and international organisations.

There will also be a varied range of Masterclasses, some of which have limited places. Register early to avoid missing out.

This year is the first time the ASC is being held in Bangkok and an exciting and stimulating program will be delivered.

In addition to the scientific program, there will be daily social and educational tours and section dinners each evening, as well as post tours to Laos/Cambodia, Myanmar, India and Sri Lanka.

Child care facilities will be offered on-site at Centara Grand, for parents bringing children. To book visit asc.surgeons.org.

Book your accommodation now because if your preference is to stay on-site at Centara Grand – then be warned – it will book out fast!

We look forward to welcoming you to our exciting ASC in Bangkok in May.

Mr Craig MacKinnon FRACS,
RACS ASC 2019 Scientific Convenor

ANZTBCRS
Australia and New Zealand Training Board in Colon and Rectal Surgery

Australian and New Zealand Post Fellowship Training Program
in Colon and Rectal Surgery 2020

Applications are invited for the Post Fellowship Colorectal Training Program, conducted by the Australia and New Zealand Training Board in Colon and Rectal Surgery (ANZTBCRS). The ANZTBCRS is a Conjoint Committee representing the Colon & Rectal Surgery Section, RACS, and the Colorectal Surgical Society of Australia and New Zealand (CSSANZ). The program is administered through the CSSANZ office.

For details about the Training Program and the application process, please see https://cssanz.org/index.php/training/application-for-training-program

A Notaras Scholarship will be awarded in 2020. Further information can be obtained from A/Prof Christopher Young via the email below.

Applications for the 2020 Program will be accepted from **1 April 2019 to 1 May 2019.**

Applications: All applicants must use the ANZTBCRS Application Template (see website link above).

Please email your application to:
A/Prof Matthew Rickard, Chair, Australia and New Zealand Training Board in Colon & Rectal Surgery
Email secretariat@cssanz.org **Phone** +61 3 9853 8013

Academic gown donation

RACS would like to acknowledge **Mr Gregory-Roberts,** for generously donating Dr Frederick C. Gregory-Roberts' academic gown to the College.

RACS maintains a small reserve of academic gowns for use by Convocating Fellows and at graduation ceremonies at the College. If you have an academic gown taking up space in your wardrobe and it is superfluous to your requirements, RACS would be pleased to receive it to add to our reserve. We will acknowledge your donation and place your name on the gown if you approve.

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

A giant leap forward for Timor-Leste

After more than five years of postgraduate specialty training, 10 Timorese doctors saw their hard work come to fruition when they graduated with a Master of Paediatrics at the *Universidade Nacional Timor Lorosa'e (UNTL)* ceremony in Dili on 10 December 2018.

These 10 doctors, nine of whom are women, have been doing their specialty training at *Hospital National Guido Valadares (HNGV)*, the national hospital in Dili since 2013 under the Australian government funded *Australia Timor-Leste Program of Assistance for Secondary Services - Phase II (ATLASS II) Program*, implemented by RACS.

Under the training and mentorship of RACS' Australian Professor of Paediatrics, Professor David Brewster, as well as other in-country and visiting Paediatricians, these 10 graduates are the first medical doctors ever to be trained at the Masters level in Timor-Leste.

The family of a paediatric patient 'Oky' with Type 1 Diabetes, whose young life was saved by the Paediatric team at HNGV in late 2017 described their experience:

"*Oky was in a coma when he arrived at HNGV. The emergency department doctors tried their best but they did not know how to help him in his critical condition.*

Then, he was admitted to the paediatric ward. Dr Lidia and Dr Maria [two of the paediatric masters candidates then in training] provided excellent care and he came out of the coma after three days. They gave their full attention to him and did check-ups every two hours for the full length of his 20-day stay.

Now he is very healthy and so happy. He can play with his friends again, and he is very smart. He is three years old now and will start school soon."

The journey to the Master of Paediatrics starts with the merit-based recruitment of doctors with at least two years' clinical work experience into the Foundation Year 12-month course, followed by a one and a half year Diploma in Paediatrics course, before completing the three year Master of Paediatrics course.

Said the program's External Examiner, Professor Peter Stanley Morris, MBBS, FRACP, PhD, Director of Paediatrics and Director of Paediatric Education (DPE) of the Royal Darwin Hospital and Menzies School of Health Research, Darwin, NT, Australia:

"*Overall, I was impressed by the quality of the candidates and satisfied that they have the clinical knowledge and clinical skills to complete their Specialist Paediatric Training. I believe that they have achieved the academic standards required for a Masters level qualification.*

All candidates can look forward to a rewarding career as a consultant paediatrician in Timor-Leste. With further clinical experience, this group has the potential to become paediatric specialists of international standing. The candidates should all be very proud of their achievement."

Maternal and child health outcomes in Timor-Leste, while improving slightly, are still among the worst in the world: one in 12 children dies before the age of five from poor neonatal health and preventable diseases.

Previously there were only four specialist paediatricians in Timor-Leste; all were trained overseas, and only two of them are currently working in clinical practice in the public sector. The addition of 10 paediatric doctors to Timor-Leste's health workforce - who will help to train the next generation of paediatricians - is a major milestone for the country.

Professor Brewster who worked at HNGV as the RACS Paediatrician from 2013-2018, congratulated the graduates on their hard work and success.

"*When I arrived in Timor, the level of paediatric care was similar to the countries in Africa where I had worked. What was different was the low level of English and medical knowledge of the doctors in Timor. I am very pleased with the improved paediatric clinical practice at HNGV and with the progress made by the Trainees.*

When asked about the achievements in child health in Timor-Leste and what he would like to see happen in the next five to 10 years, he commended the government of Timor-Leste on the provision of free health care, but reminded us that the basis of improvement in child health

A paediatric patient with Type 1 Diabetes whose life was saved by the Paediatric team at HNGV returns for a routine checkup with Masters graduate, Dr Lidia de Oliveira

is more related to social determinants of health and preventive health, than what doctors do.

"*This means improving immunisation and nutrition programs, improving schooling and living standards and similar measures. If Timor wants to improve health outcomes, then health and education budgets need to be increased substantially. The 10 new paediatric graduates need to be involved in preventive child health activities and clinical practice at the district hospitals*", he said.

RACS has been supporting health education in Timor-Leste since 2001 and is the only provider of post graduate medical education in the country. The ATLASS II in-country training program offers postgraduate courses in Surgery, Paediatrics, Anaesthesia, Obstetrics and Gynaecology, Family Medicine and Internal Medicine. RACS also delivers a PG Diploma in Ophthalmology, funded through the Foundation for Surgery as part of the East Timor Eye Program (ETEP).

Under the current program, 49 doctors have been successfully trained at the postgraduate Diploma or Masters level across seven medical specialties since 2012, and there are currently another 65 doctors in training.

In addition to the 10 Masters in Paediatrics graduates, seven more doctors graduated with a Diploma in Family Medicine at the ceremony, joining eight others who graduated from the same program in 2016. The Family Medicine doctors are trained to provide a broad range of health services and have been posted to community health centres in rural and remote parts of Timor-Leste to increase access to essential services and improve healthcare throughout the country.

The Program is committed to supporting junior doctors to achieve their post graduate qualifications in Timor-Leste, by providing workplace-based training at the national hospital and community health centres. Training doctors in-country has many benefits. It ensures that the teaching they receive is contextually relevant and appropriate to the unique healthcare challenges of Timor-Leste, and it strengthens the national institutions' ability to develop systems, processes and skills to deliver postgraduate training, which, in time, will decrease the government of Timor-Leste's reliance on external governments and organisations to support the medical workforce needs of Timor-Leste.

The ATLASS II postgraduate medical training program is supported by the Australian government and implemented by RACS under the RACS Global Health Program, in partnership with the Ministry of Health of Timor-Leste, Universidade Nacional Timor Lorosa'e and Hospital Nacional Guido Valadares.

Australian Aid

Professor Glenn Guest
ATLASS II Program Director

with Stephanie Korin, Monitoring and Evaluation Officer, RACS

THE MERCURY, TUESDAY, 19-10-1982—1

'Lower alcohol limit to .05'

RACT presses for new laws

PARLIAMENT should legislate before Christmas to lower the legal blood alcohol limit from .08 to .05, the public affairs manager of the RACT, Mr Peter Hope, said yesterday.

"Twelve months ago, there were positive moves to amend the law to provide harsher traffic offence penalties and to reduce the legal blood alcohol limit to .05," Mr Hope said.

"However, the talks failed to produce action, and the Liberal Government now is urged to act quickly. Only a few unmarked police cars have been put on the road."

The Minister for Police, Mr Bingham, in late July foreshadowed tough new measures in a bid to counter the mounting road toll.

They included random breath-testing and a reduction in the permissible blood alcohol level to .05. Penalties for drink-driving were to be increased in line with other States and maximum penalty levels set.

Mr Bingham said in a statement on July 26 that the legislation would be introduced in this session of Parliament.

Mr Hope said the expected increase in third party insurance was directly related to the cost of car repairs and hospital fees for people involved in accidents.

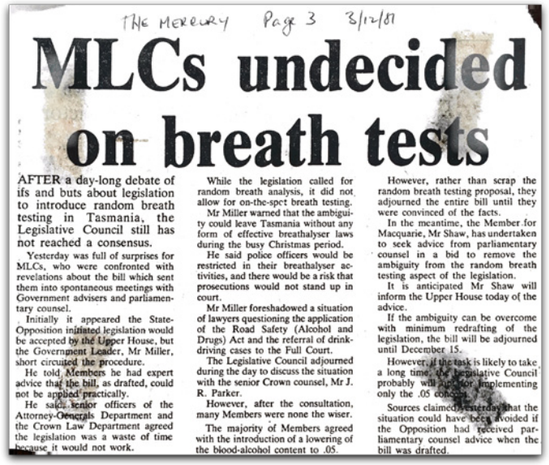
"We understand that if nothing is done, the deficit, which currently is about $20 million, could balloon out to $50 million in another 12 months," he said.

The Royal Australasian College of Surgeons said the State Government's planned drink-driving legislation would bring Tasmania into line with New South Wales, South Australia and Victoria.

"Victoria has led the way and shown beyond doubt that random breath-testing, properly enforced, does reduce the road toll," the chairman of the college's Tasmanian road trauma committee, Mr Barry Edwards, said.

"If every Australian State had followed Victoria's example, there would have been 921 fewer road deaths in 1980."

Mr Barry Edwards (left), chairman of the Royal Australasian College of Surgeons' Tasmanian road trauma committee, and Mr Wal Wagg, of AAMI insurance, at yesterday's Press conference. The smashed car, valued at $4,000, would cost $6,500 to repair.



THE MERCURY Page 3 8/12/81

MLCs undecided on breath tests

AFTER a day-long debate of ifs and buts about legislation to introduce random breath testing in Tasmania, the Legislative Council still has not reached a consensus.

Yesterday was full of surprises for MLCs, who were confronted with revelations about the bill which sent them into spontaneous meetings with Government advisers and parliamentary counsel.

Initially it appeared the State-Opposition initiated legislation would be accepted by the Upper House, but the Government Leader, Mr Miller, short circuited the procedure.

He told Members he had expert advice that the bill, as drafted, could not be applied practically.

He said, senior officers of the Attorney-Generals Department and the Crown Law Department agreed the legislation was a waste of time because it would not work.

While the legislation called for random breath analysis, it did not allow for on-the-spot breath testing.

Mr Miller warned that the ambiguity could leave Tasmania without any form of effective breathalyser laws during the busy Christmas period.

He said police officers would be restricted in their breathalyser activities, and there would be a risk that prosecutions would not stand up in court.

Mr Miller foreshadowed a situation of lawyers questioning the application of the Road Safety (Alcohol and Drugs) Act and the referral of drink-driving cases to the Full Court.

The Legislative Council adjourned during the day to discuss the situation with the senior Crown counsel, Mr J. R. Parker.

However, after the consultation, many Members were none the wiser.

The majority of Members agreed with the introduction of a lowering of the blood-alcohol content to .05.

However, rather than scrap the random breath testing proposal, they adjourned the entire bill until they were convinced of the facts.

In the meantime, the Member for Macquarie, Mr Shaw, has undertaken to seek advice from parliamentary counsel in a bid to remove the ambiguity from the random breath testing aspect of the legislation.

It is anticipated Mr Shaw will inform the Upper House today of the advice.

If the ambiguity can be overcome with minimum redrafting of the legislation, the bill will be adjourned until December 15.

However, if the task is likely to take a long time, the Legislative Council probably will opt for implementing only the .05 concept.

Sources claimed yesterday that the situation could have been avoided if the Opposition had received parliamentary counsel advice when the bill was drafted.

Road trauma and road trauma prevention

A brief history

This is one person's perspective of events which unfolded over a period of three quarters of a century. While road trauma is global, this is an Australian perspective – Brisbane in the early days and later Tasmania.

I was born in 1941 in Brisbane. By the end of the 1940s there were two cars in our street, an Oldsmobile and a T-model Ford. The milkman and the iceman made home deliveries in horse-drawn carts and the night cart man made weekly visits in a motorised cart – and left Christmas cards on the wooden toilet seat.

At aged 10 we played serious cricket matches in our street. The test matches started after school and stumps were drawn when our mothers called us for dinner. Rarely was a match interrupted by a passing car – and then it was delayed (the car that is) until the over was completed.

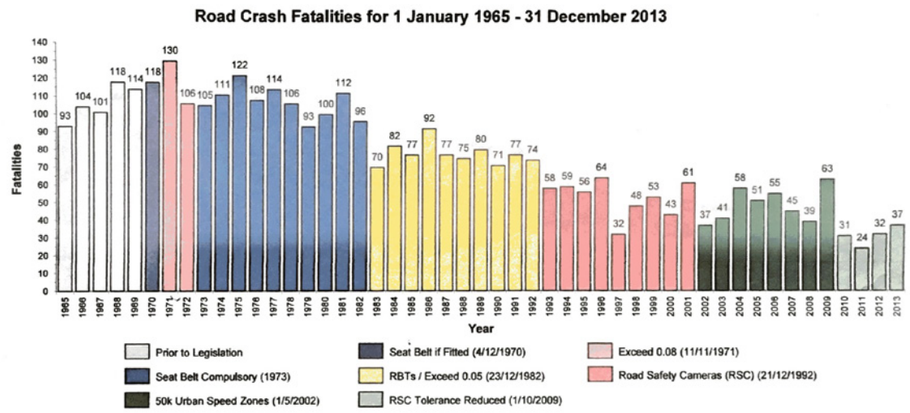
In the early 50s things changed dramatically. The average wage was $3,210.00 p.a. and the cost of a new motorcar was around $1,510.00. The Baby Boomer years, the Great Depression and WWII were things of the past and people wanted to live a normal life raising a family. Teens found rock and roll music and parents had consumer choice. Jobs were abundant and salaries good and the price of the Aussie Holden was coming down. Hire purchase was introduces in 1953.

People could now buy refrigerators and motor cars. By the late 50s everyone in our street owned a motor car and kids were driving to the beach. Alcohol, but not yet drugs, was added to the mix. The street cricket matches had become a thing of the past.

The combination of increased vehicle numbers, alcohol and faster cars all combined to produce a lethal outcome. By the mid-50s the concerning phenomenon of motor vehicle accidents was labelled a modern-day epidemic. Legislature and medical services were caught unprepared, undermanned and undertrained. Change was required and urgently.

Between 1960 and 1970, the number of deaths on Australian roads was only 388 less than the total number of Australians killed in WWII. Deaths and injuries per head of population exceeded those in the USA and doubled those in the UK.

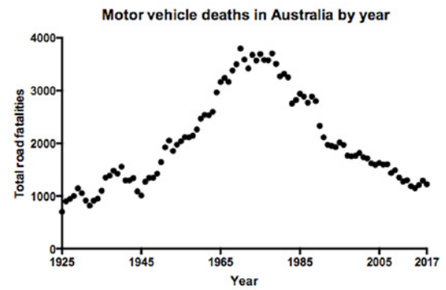
In 1965 a motion was passed by RACS to appoint a committee on road trauma. In 1970 the first RACS Road Trauma Committee (RTC) was formed with the Chairman E.S.R. Hughes, Deputy Grayton Brown, with representations from each State of Australia. Hughes was insistent that any moves to control the road toll "*will be acceptable if they are based on scientific fact and only if they are practical and capable of implementation*".



The committee had four goals.

1. Care of road accident victims
2. Promote and endeavour to bring in such measures that would reduce the number of fatalities and the severity of injuries
3. Collect and analyse data on all aspects of road trauma, trauma treatment and care; determine causes and find appropriate counter-measures and decide on the best outcome, and
4. Educational programs for members of the College and the general public.

These were inspirational goals still relevant to this day.



There were many outstanding contributions to the evidence based counter measures and what followed in the next decade 1970 – 1980 was remarkable, but not without opposition from sections of the community including civil liberty groups, the alcohol industry and politicians.

Prominent among many contributors to the cause was Melbourne surgeon Donald Hossack who performed post mortems on 400 motor vehicle accident victims between 1965 and 1969. His ground-breaking research was published in the Medical Journal of Australia (MJA) – "The Patterns of Injury" MJA 1972 (July 22), and "Investigation of 400 people killed in road accidents with special reference to blood alcohol levels" MJA 1972 (July 29).

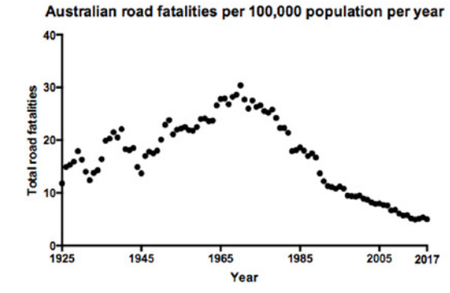
"*A small body of determined spirits fired by unquenchable faith in their mission can alter the course of history*"
- Mahatma Gandhi

The quotation is entirely applicable to the following surgeons in the fight against road trauma:

- E.S.R. Hughes 1919 – 1980
- J. Grayton Brown 1913 – 1976
- D.W. Hossack 1926

I came to Hobart in 1972 and worked my first on-call stint at the Royal Hobart Hospital during Easter. My introduction to the horror of road trauma accidents was seeing an eight year old lad with a retro hepatic vena caval tear.

Bob Mitchell, Foundation Professor of Surgery appointed first Tasmanian Chairman of the Tasmanian RTC by Bill Hughes, approached me to see if I was interested in the RTC Tasmania Chairmanship. Being



young, enthusiastic, not all that busy and following the horrendous events of that Easter, I didn't think twice.

The next 20 years involved time and energy that was well spent, rewarding and probably the most gratifying of my surgical career.

We followed in the wake of the trail blazing Victorians and were able to take a part, as other States and organisations, in the introduction of legislation in Tasmania which ultimately led to lives saved.

Along with prevention came better treatment of road trauma patients. The first Early Management of Severe Trauma (EMST) course was held in 1988. In 1991 the RTC changed to the Trauma Committee recognising that there were important trauma issues in the home, farm, factory and sport as well as natural disasters and terrorism. Newer challenges include mobile phone use and drugs other than alcohol which have been met with new counter measures, constantly under review and assessment.

What of the future? Is it impossible to completely eradicate road trauma as a cause of death on our roads? Is there an optimal base line figure? Will new technologies emerge that will lower this figure?

The driverless car is exciting new technology which may eliminate human error in road trauma accidents, estimated to be as high as 90 per cent, but will it introduce its own errors? Time will tell.

It is acceptable to refer to road trauma as a disease and a modern epidemic. The time-honoured principles of treatment of disease are prevention and treatment. Both of these principles should be evidence based and depend on research.

A) Prevention of road trauma embraces:

1. Legislation
2. Enforcement
3. Infrastructure improvements to cars and roads
4. Education

B) Treatment – begins at the roadside and involves paramedics and many other specialties.

Nothing has changed from the four goals enunciated by Bill Hughes in 1970.

Will greater enforcement impact on these figures or can technology assist? There will always be a group that deliberately and regularly exceed speed limits. Enforcement remains essential for the time being. In the longer term, new vehicle technology can have a positive safety effect on this group of road users.

In the 20 years from 1992 to 2012, Australia's population increased at 1.3 per cent per year on average. In 2012 Australia's estimated resident population was 22.7 million people. From 2008 to 2017, deaths on Australian roads continued to fall despite a rise in population of 1.6 per cent per year. All jurisdictions achieved trend reductions over the decade. High speed still accounted for the largest proportion of fatal crashes. In 2017, 45 per cent of all fatal crashes occurred in speed zones of 100 km/h or over and only 12 per cent in zones of 50 km/h or lower. Approximately 50 per cent of deaths resulted from head-on crashes or single vehicle crashes.

Population growth and traffic is still offsetting many of the benefits of preventable measures. During the ten years 2007 – 2017, total vehicle registrations increased by 23 per cent. However annual fatalities stalled in 2014 and there was a slight increase in 2015, 16 and 17. A random variation or a new trend?

We can't rest on our laurels. We need to accept the Swedish view that there is an ethical imperative not to accept death and injury as a normal consequence of road use. To do anything less is to budget for death.

One can only marvel at the changing road and trauma environment between June 1941 and June 2018 – one person's lifetime.

With acknowledgement to the Tasmania Police - Commissioner Darren Hine, Acting Commander Jason Elmer and Dr Ken Hart along with the Department of State Growth's Peter Taylor.

Dr Barry Edwards
Recipient, Oustanding Service to the Community Award 2018 - RACS TAS

POST FELLOWSHIP TRAINING IN HPB SURGERY

Applications are invited from eligible Post Fellowship Trainees for training in HPB Surgery. Applicants MUST be citizens or permanent residents of Australia and New Zealand.

The ANZHPBA's Post Fellowship Training Program is for Hepatic-Pancreatic and Biliary surgeons. It is a RACS accredited PFET program. The program consists of two years education and training following completion of a general surgery fellowship. A compulsory portion of the program will include clinical research. A successful Fellowship in HPB surgery will involve satisfactory completion of the curriculum requirements, completion of research requirements, minimum of twenty four months clinical training, successful case load achievement, assessment, and final exam. Successful applicants will be assigned to an accredited hospital unit.

To be eligible to apply, applicants should have FRACS or are sitting a FRACS exam in May 2019. Any exam fails will not be offered an interview.

For further information please contact the Executive Officer at anzhpba@gmail.com or visit http://www.anzhpba.com/fellowship-training.html

Applicants should submit a CV, an outline of career plans and nominate four references, one must be Head of Unit, (with email addresses and mobile phone numbers), to Leanne Rogers, Executive Officer ANZHPBA, P.O. Box 374, Belair S.A. 5052, or email anzhpba@gmail.com.

Successful applicants will need to be able to attend interviews on Saturday 1st June in Melbourne.

Applications close midnight, Sunday 31st March, 2019.

anz HPBA
Australia New Zealand Hepatic, Pancreatic & Biliary Association

Applications close midnight, Sunday March 31st 2019

Meet the Academy of Surgical Educators recognition awardees

The Academy of Surgical Educators (ASE) presented the Educator of Merit to our surgical educators in November last year. These awards acknowledge and recognise the dedication and excellence of our surgical educators. Surgical News took the opportunity to learn more about these high achievers, their interviews being featured in the next few editions.

Mr Simon McMahon

Educator of Merit: SET Supervisor/ IMG Supervisor of the Year (New Zealand)

Fellow since 1991, in Orthopaedic Surgery


Mr Simon McMahon

What inspired you to pursue surgical education?

When we trained we were instilled with the importance of committing to career-long learning and teaching, and that this was an essential component of clinical practice. My experience is that teaching is invaluable and for me, very much a win-win. I always seem to learn much more than the Trainees and interacting with the junior colleagues is generally a lot of fun.

In your opinion, what does the future of RACS Surgical Education look like?

I think the future of RACS Surgical Education is looking good. The online library is a wonderful asset, and the skills courses available for the Trainees and Fellows are generally very valuable. Most of our Trainees are also committed to educating themselves and their colleagues. RACS's endeavours with regard to assisting the education of surgeons from developing countries is commendable.

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

Give it a try, both you and your patients will benefit.

Mr Michael Wilson

Educator of Merit: SET Supervisor/ IMG Supervisor of the Year (Northern Territory)

Fellow since 1978, in Otolaryngology Head and Neck Surgery

What is your proudest moment as a surgical educator?

My proudest moment as a surgical educator was, remembering back 40 years, when I obtained my Fellowship, and seeing the same relief, sense of achievement and pride that the younger recipients feel when their journey is complete.


Mr Michael Wilson

Any advice for new surgical educators (SET Supervisors/ IMG Supervisors/ Facilitators/ Instructors)?

The advice I would give to surgical educators is that we all look forward in many aspects but it behoves us to remember the past and the difficulties, obstructions and amount of handwork it takes to obtain Fellowship. This must be understood and the lessons learned applied to the younger Trainees.

How would you describe being a recipient of the Academy of Surgical Educators Recognition Award – Educator of Merit: SET Supervisor/ IMG Supervisor of the Year (NT)?

Everyone is happy to be recognised for their achievements. Although the award is not an achievement, as such, it is a very kind gesture from RACS to take note of the work done gladly and freely, to help the development of our surgical Trainees, not only academically but in all aspects of a sound training.

Join us for the 22 Mar 2019 International Medical Symposium – '*Visioning the impact of advanced technology on medical education*' in Auckland. For more info, please visit
www.internationalmedicalsymposium.com.au

Dr Sally Langley
Chair, Academy of Surgical Educators

With Grace Chan, Academy Program Coordinator, RACS.

L - r: ACT Chair Ailene Fitzgerald, VP Cathy Ferguson, ACT Minister for Health Meegan Fitzharris and her daughter.

Great achievements recognised at 2018 ACT ASM

Two very deserving individuals were presented with awards at this year's ACT Annual Scientific Meeting in October. The RACS Academy of Surgical Educators awards acknowledge and reward the dedication and excellence of surgical educators across Australasia.

Presented to individuals who have displayed inspirational role modelling, a deep understanding of and commitment to training and surgical education, the *Academy Supervisor of the Year Award* recognises an exceptional contribution by a surgical supervisor or clinical assessor toward supporting Trainees, registrars and junior doctors. This year's recipient is Dr Sindy Vrancic.

Dr Vrancic is the Regional Chair of Orthopaedic training for all Trainees attached to the southside New South Wales Training Program. Through this role, she is responsible for ensuring that the high level of Orthopaedic training continues throughout the southside NSW Hospitals. Dr Vrancic is one of the AOA Regional Leads for the introduction of the AOA21 Training Program, and her dedication to teaching was acknowledged at the AOA National Scientific Meeting in 2017, where she was awarded the Leadership in Orthopaedics Award.

The second award goes to a Fellow who has given long and dedicated service to his or her local community – more often than not unheralded – but without which the standard of surgical care in the community would have been less. This year's *Outstanding Service to the Community Award* recipient is Mr Ian Davis.

Mr Davis has worked at the forefront of the advancement of both colorectal and breast surgery in the ACT for more than 25 years and has served as both head of colorectal surgery and head of general surgery in the ACT, steering the general surgical unit through a significant period of workforce growth.

Mr Davis has contributed to the wider community of the ACT and surrounding regions of NSW as an advocate for the advancement of care to patients with both colorectal and breast cancer and helped advance the provision of a multidisciplinary approach to the management of these conditions. He started the Breast Cancer Treatment Project, which provided life-saving services to more than 1,200 patients, and helped establish the Breast Tissue Bank Project with 240 patients enrolled by 2013.

Mr Davis has also contributed significantly to the Canberra surgical community by teaching aspiring surgeons and mentoring many past and present doctors through their journey to becoming a FRACS, and continues to support educational opportunities offered by RACS ACT. He has proven himself to be a compassionate and dedicated surgeon providing person-centred, comprehensive and continued health care to the community for more than 20 years.

In 2017 the ACT Committee introduced the *Professor Noel Tait Medical Student Prize.* This prize is intended to engage medical students and encourage their development in medicine, and is awarded to the author of the best essay on a theme selected by the Committee each year. The prize is named after Professor Noel Tait, in recognition of his contribution to medical education in the ACT. Professor Tait is a general surgeon who specialises in surgical oncology of the breast and upper gastrointestinal tract, and who was involved in the establishment of the Australian National University (ANU) Medical School where he was Associate Professor and Sub Dean of the clinical school.

This year's essay theme was '*The role of surgeons in health advocacy*', and the competition attracted a large number of high calibre submissions. This year's prize winner is first year ANU medical student Mr Akash Patel, and below is an extract from Mr Patel's essay:

Surgeons need to continue to be strong health advocates at all levels of the spectrum they operate across. Patients at their most vulnerable need surgeons to give them a voice - for safer, more effective care. Their families and communities need surgeons to be passionate about creating change to ensure that positive health outcomes can be maintained into the future, and surgeons themselves need to have the courage to speak out for those in their specialty when they are left without support. Surgeons bring with them the inherent knowledge of their patient's issues, an innate drive for improvement and the societal standing to be listened to. These powers are unique to the profession- and surgeons need to ensure that they use these privileges for the betterment of not only their patients, but wider society as a whole.

Gabrielle Forman,
Communications and Policy Officer, RACS

'Social' media and screen time

Not so 'social' after all

B Wilderd and A Dict were a happily married Gen X couple until their Gen Z children were entering their teens. They prided themselves on being 'modern', tech-savvy parents. Their children became adept on an iPad soon after its introduction in 2010. In 2012, the kids got their own iPhones at aged 10 and embraced the social media phenomenon, Facebook (which had bought Instagram for $1bn that year), and began 'connecting' everywhere. B Wilderd and A Dict loved to share the children's amazing achievements with their own Facebook 'friends', updating the extended family across the world with carefully selected, positive, near perfect, sometimes edited, images of their young, dynamic family. Both were busy medical practitioners, often only too pleased to grab a few moments of peace to catch up on their own posts in a café, while the kids gamed or gazed in silence on the ever-present iPad. We've all seen such families in restaurants, obsessively clutching at their devices, and rarely speaking.

Fast forward to today. 'The kids', Dee Press and Anne Yus, are now moody teenagers. Their early 'amazingness' has waned. They are isolated, struggling to socialise, addicted to social media, have poor sleep patterns and are miserable. The whole family came to consult me, recognising the dangers of depression and anxiety through adolescence and beyond.

Too much television has long been associated with fear, anxiety and sleep disturbance. Social media is a modern phenomenon becoming increasingly recognised as associated with depression. Is it the lack of personal social interaction or is it the 'perfect' images that bully those of us who are not so perfect into believing in our inadequacy; or both?

Children and teenagers are deliberately sucked in through clever algorithms, designed to hook them into spending more time online. Yet the Social Media billionaires recommend limiting their own children's access to screens and social media. The late Steve Jobs did not let his children use an iPad when introduced in 2010; Mark Zuckerberg (Facebook) wrote an open letter to his newborn daughter telling her how important it is to 'go out and play'. Evan Spiegel, founder of Snapchat, limits his 7-year old stepson to 90 minutes of screen time a week. Bill Gates (Microsoft) limited his older daughter to 45 minutes screen time a day with just an extra 15 minutes on weekends.

The UK Paediatric College and UK Commissioner for children advises "Children should not watch television or go online within an hour of bedtime …. Parents should also set a good example by controlling their own phone use in front of children." Teenagers who spend long hours on social media are twice as likely to show symptoms of depression, with girls affected more than boys. Among girls, a study found depressive symptoms rose steadily the more girls used social media, with 38 per cent of those online for more than five hours a day, saying they felt miserable, tired, restless, worthless or tearful. For boys the comparable figure was 14 per cent.

Although screens are not inherently bad, and social media definitely has its uses, long hours online or watching television risk distracting children from sleep, exercise and family time. Blue light from screens is thought to interfere with production of the sleep-inducing hormone melatonin, while overstimulation also keeps children awake. Poor sleep may also cause depression. A quarter of girls in their late teens already have problems with feelings of depression or anxiety. Girls also experience more bullying (often about body image) often through Snapchat (since 2011, with 187 million daily active users in February 2018), and/or Instagram (introduced in 2010, with 10 million users within a year, bought by Facebook for $1bn in 2012, with 800 million users by 2017). A recent meta-analysis reported cyberbullying occurs at rates of 11-48 per cent.

I advised B Wilderd and A Dict to limit D Press' and Anne Yus's access to social media, and not allow screens or phones in the bedroom. This was difficult for them because of their own addiction, but their children's anxiety and depression motivated them to lead by example. They decided to follow the tech giant leaders' advice and limit screen time. A few weeks ago they told me that, although the first month was torrid, their children have started doing things with friends, and are happier and less anxious. That bodes well for their future!

DR BB-G-LOVED

Reconciliation in action

L - r: Mr Richard Perry, Ms Raelene Baker, Mr John Batten, Dr Kris Rallah-Baker, Ms Moira Truskett and Mr Phil Truskett standing next to the official AIDA conference artwork called "Two brothers dreaming" by artist Yondee. © AIDA. Image by Brad Newton Photography.

Immediate past RACS President Mr Phil Truskett and I launched the Reconciliation Action Plan in 2016, in support of RACS' strategic objective *to champion healthcare development in Indigenous communities across Australia and New Zealand. RACS adopted a strategic imperative to make a difference in Aboriginal, Torres Strait Islander and Māori health in 2017*.

The pipeline of Aboriginal and Torres Strait Islander medical students and doctors is growing. The RACS Board of Council attended the Australian Indigenous Doctors' Association (AIDA) annual scientific meeting in September, and met with Aboriginal and Torres Strait Islander medical students and doctors aspiring to careers in surgery. The Board facilitated a successful surgical skills workshop led by Councillors Kerin Fielding and Greg Witherow.

RACS was invited to speak at the AIDA and recent National Aboriginal Community Controlled Health Organisation (NACCHO) conferences about progress against the College's Reconciliation Action Plan. I was proud to represent RACS and highlight that of the plan's 59 deliverables, 54 have been completed with five still in progress.

In particular, I was happy to celebrate the leadership of the Specialty Training Boards in developing and delivering RACS' Aboriginal and Torres Strait Islander Surgical Trainee Selection Initiative. The initiative has been well received by Aboriginal and Torres Strait Islander medical students and doctors as well as from other specialist colleges.

RACS' Reconciliation Action Plan is available online. Highlights of work accomplished over the last two years include priority areas such as Relationships, Respect, Opportunities and Tracking Progress and Reporting.

Relationships

RACS' relationship with AIDA has continued to grow and AIDA is now formally represented on the RACS Indigenous Health Committee. The RACS President has attended AIDA's annual scientific meeting for the last four years as gold sponsor, and the AIDA President regularly attends RACS' Annual Scientific Congress (ASC). The organisations collaborate by leading initiatives in support of Aboriginal and Torres Strait Islander pathways into specialty medicine and in advocacy for key health issues. Immediate past RACS President Mr Phil Truskett was invited to serve as AIDA Patron.

RACS has strengthened ties with NACCHO, by presenting at it's annual meeting in 2017/18 and incorporating the organisation as a partner in RACS' *Ear Health For Life* initiative.

Professor Martin Nakata was appointed as an Education Advisor to provide strategic advice relevant to RACS' indigenous health programs. Professor Nakata has addressed the RACS Council and the Board for Surgical Education and Training, presented at the 2018 ASC program and is an active contributor to RACS' Indigenous Health Committee.

Respect

Acknowledgement and welcome to country protocols have been established. The Aboriginal and Torres Strait Islander motif has increased the visibility of Aboriginal and Torres Strait Islander health in the College and is prominently displayed during RACS Indigenous health activities.

RACS has partnered with the Koorie Heritage Trust in Melbourne to deliver cultural competency training for staff. Training is offered to all Melbourne based staff with programs investigated in the Australian states.

Aboriginal and Torres Strait Islander Health and Cultural Competence e-modules have been promoted to Fellows through the CPD program. RACS is working with AIDA with respect to their roll-out of a face-to-face Aboriginal and Torres Strait Islander Health in Clinical Practice training program that would be tailored to the needs of surgeons.

In partnership with the Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS), RACS has led a two year *Ear Health For Life* campaign in support of reducing the burden of ear disease in Aboriginal and Torres Strait Islander communities. A coalition of supporters has been developed including ear health researchers, allied health providers and peak bodies including NACCHO and the Australian Medical Association. A research road map was presented to the Australian Medical Research Advisory Board which guides investment in the Medical Research Future Fund at a Roundtable which aimed to set research priorities to improve Indigenous health. Discussions with the Health Minister Greg Hunt and Minister for Indigenous Health Ken Wyatt and the opposition have been ongoing. Wins to date have included a new $30 million investment in hearing assessments over four years, federal government support for the $7.9 million program addressing otitis media in the Northern Territory, and the establishment of a Hearing Health Sector Committee led by Minister Wyatt and development of national key performance indicators as part of the Council of Australian Governments (COAG) process.

RACS secured a 2.5 year $460,000 grant from the Australian Department of Health in September last year, to support a review of needs across nine surgical specialties in terms of Aboriginal, Torres Strait Islander health and cultural safety.

Miss Satya Hallewas and Mr John Batten. © AIDA. Image by Brad Newton Photography.

L - r: Miss Tahnee Carter, Kr Isaiah Attkins, Associate Professor Julie Mundy, Mr Byron Davis © AIDA. Image by Brad Newton Photography.

Opportunities

The Aboriginal and Torres Strait Islander Surgical Trainee Selection Initiative has been implemented by eight of nine training boards. The first Trainee selected as part of the initiative will start training in 2019.

The Aboriginal and Torres Strait Islander Health Network was launched to connect Fellows interested in supporting Indigenous health initiatives, and a list of Aboriginal and Torres Strait Islander suppliers has been formalised and promoted to encourage the use of indigenous suppliers.

RACS scholarships in support of Aboriginal and Torres Strait Islander medical students and doctors have increased from $15,000 in 2016 to $72,500 in 2018 funded by RACS, the Foundation for Surgery, RACS Fellows and with support from Reconciliation Action Plan partner Johnson & Johnson Medical Devices.

Tracking progress and reporting

In addition RACS has presented public updates on its Reconciliation Action Plan progress to key stakeholders at the AIDA Conference in 2016 and 2018, and in 2017, to the Leaders in Indigenous Medical Education Conference.

RACS reports annually to Reconciliation Australia.

Dr David Murray
Deputy Chair,
Indigenous Health Committee

Research, education and travel scholarship and grant opportunities

Open 1 March 2019

From 1 March, the Foundation for Surgery Scholarship and Grant Program is open. Apply now for research, education and training opportunities for 2020.

The ANZ Scholarship and Grant Committee invites Fellows, Trainees, International Medical Graduates (IMGs) and other eligible applicants to apply for the following scholarships, fellowships and grants for 2020:

These advertised opportunities are to be used as an initial guide only. Please consult the RACS scholarship website (www.surgeons.org/scholarships) for detailed information including application forms and policies. The values of these awards are in Australian dollars for a tenure of one year, unless otherwise stated.

Applications must be received by midnight **ACST 15 April 2019.**

RESEARCH SCHOLARSHIPS, FELLOWSHIPS AND GRANTS

John Mitchell Crouch Fellowship ($150,000)

The John Mitchell Crouch Fellowship is awarded to an individual who is making an outstanding contribution to the advancement of surgery, or to fundamental scientific research in this area. The Fellowship commemorates the memory of John Mitchell Crouch, a RACS Fellow who died in 1977 at the age of 36.

Applicants must be a Fellow of RACS, resident in Australia or New Zealand, with their RACS Fellowship or comparable overseas qualification obtained within the past 15 years (2004 or later). They must currently be working actively in their field and the Fellowship must be used to assist with the continuation of this work.

The successful applicant is expected to attend the convocation ceremony at the RACS 2020 Annual Scientific Congress held in Melbourne in May for a formal presentation and be prepared to make a 20-25 minute oral presentation on their research work including the contribution arising from the award.

Tour de Cure Cancer Research Scholarship ($125,000)

Tour de Cure is a health promotion charity that raises funds for cancer research through cycling and other events. Together with the Foundation for Surgery, Tour de Cure fund the prestigious Tour de Cure Cancer Research Scholarship.

Applications are open to Fellows, Trainees and IMGs on a pathway to Fellowship who propose to undertake an important cancer research project. Gross value of this scholarship is $125,000 comprising $112,500 stipend plus $12,500 departmental maintenance. Recipients are expected to procure $25,000 of this amount from his/her research department, with income from the Tour de Cure corpus supplying the remaining $100,000.

Academy of Surgical Educators Surgical Education Research Scholarship ($10,000)

This scholarship has been established to encourage surgeons to conduct research into the efficacy of existing surgical education or innovation of new surgical education practices. It is governed under the auspices of the RACS Professional Development and Standards Board through the Academy of Surgical Educators. Applications for the scholarship are open to Fellows, Surgical Trainees and IMGs.

Brendan Dooley and Gordon Trinca Trauma Research Scholarship ($10,000)

This scholarship was established to honour both the late Mr Gordon Trinca and the late Mr Brendan Dooley for their contributions to the prevention of road trauma. Open to Fellows, Trainees and medical scientists who are conducting a research topic relating to the prevention and treatment of trauma injuries in Australia and New Zealand.

Catherine Marie Enright Kelly Scholarship ($66,000)

A kind bequest from the late T D Kelly FRACS, enabled the establishment of this scholarship. It is open to Fellows and Trainees enrolled in or intending to enrol in a higher degree. $66,000 funding comprises of $60,000 stipend plus $6,000 departmental maintenance.

Reg Worcester Research Scholarship ($66,000)

The Reg Worcester Research Scholarship was developed after a gift from the late Alan Worcester FRACS, to memorialise his brother, Reg, a great educator, doctor and humanitarian. It is open to Fellows and Trainees enrolled in or intending to enrol in a higher degree. $66,000 funding comprises of $60,000 stipend plus $6,000 departmental maintenance.

> Research is four things: Brains with which to think, eyes with which to see, machines with which to measure and, fourth, money.
>
> *Albert Szent-Gyorgyi*

Eric Bishop Research Scholarship ($66,000)

The establishment of this scholarship was made possible due to a generous donation from the late Eric Bishop, a Queensland pastoralist. It is open to Fellows and Trainees enrolled in or intending to enrol in a higher degree. Recipients are expected to procure 25 per cent of this amount ($16,500) from their research department, with income from the Eric Bishop Scholarship corpus supplying the remaining $49,500.

Foundation for Surgery New Zealand Research Scholarship ($66,000)

Open to Fellows and Trainees enrolled in or intending to enrol in a higher degree. Applicants must be a New Zealand citizen currently residing in New Zealand. Recipients are expected to procure 25 per cent of this amount ($16,500) from their research department, with income from the RACS Scholarship corpus supplying the remaining $49,500.

Foundation for Surgery Research Fellowship ($66,000)

Open to RACS Fellows. Preference is given to academic surgeons early in their career. Tenure is for up to three years. $66,000 funding comprises of $60,000 stipend plus $6,000 departmental maintenance.

Foundation for Surgery Research Scholarship ($66,000)

Open to Fellows and Trainees enrolled in or intending to enrol in a higher degree. Recipients are expected to procure 25 per cent of this amount ($16,500) from their research department, with income from the RACS Scholarship corpus supplying the remaining $49,500.

Foundation for Surgery Small Project Grant ($10,000)

This grant is for a Fellow or Trainee who wishes to or is already undertaking a small clinical or research project, or requires funding to purchase equipment to carry out a research project.

Francis & Phyllis Mary Thornell-Shore Memorial Trust for Medical Research Scholarship ($66,000)

Established in recognition of the generosity of Mr Francis and Phyllis Mary Thornell-Shore, this scholarship is open to Fellows and Trainees enrolled in or intending to enrol in a higher degree. Recipients are expected to procure 25 per cent of this amount ($16,500) from their research department, with income from the Thornell-Shore Scholarship corpus supplying the remaining $49,500. $66,000 funding comprises of $60,000 stipend plus $6,000 departmental maintenance.

Health Technology Assessment Scholarship ($66,000)

This scholarship is intended to support Fellows, Trainees and Junior Doctors who wish to take time away from their clinical positions to undertake a systematic review as part of a Health Technology Assessment (HTA) under the supervision of a clinical supervisor and an HTA expert. Applicants who are enrolled in a Master's program are encouraged to apply. Production of a systematic review and a peer-reviewed publication is a minimum requirement on completion of the scholarship. Junior Doctors need to conduct this work in conjunction with the RACS ASERNIP-S program in Adelaide as a collaborative research project on a mutually agreed topic. Tenure is for one year full-time or two years part-time.

Herbert and Gloria Kees Scholarship ($66,000)

This scholarship was established by the late Gloria Joyce Kees and her compassionate foresight to leave a bequest to support medical research and/or the advancement of surgical technologies, techniques and treatments. Applications are open to Trainees, IMGs on a pathway to Fellowship and Fellows who have had their Fellowship for five years or less (since 2014).

John Loewenthal Project Grant ($100,000)

The John Loewenthal Project Grant was established in honour of Sir John Loewenthal who served as President of RACS (from 1971-1974) to promote surgical research. Applications are open to RACS Fellows and Trainees (individual or group applications are accepted), wishing to undertake clinical or research projects or for funding of an innovative service or piece of equipment. Tenure is for up to two years.

Lumley Surgical Research Scholarship ($66,000)

This scholarship enables a Fellow or Trainee to spend a year undertaking research in the United Kingdom. An international airfare is funded in addition to the scholarship.

MAIC-RACS Trauma Scholarship ($66,000)

This scholarship was established from a grant from the Queensland Motor Accident Insurance Commission (MAIC) and has been matched by the Foundation for Surgery to enable annual funding for research into trauma. Fellows and Trainees are invited to apply. The proposed research may be in epidemiology, prevention, protection, rehabilitation and/or immediate or definitive management in trauma. While it is not a requirement of this

scholarship that the research be conducted in Queensland it must be shown that the potential benefits are flowing from the research will assist people in Queensland.

Paul Mackay Bolton Scholarship for Cancer Research ($66,000)

This scholarship was established by Harry Bolton in memory of his late son, Professor Paul Bolton. Professor Bolton was a distinguished surgeon, teacher and researcher who died from colorectal cancer, aged 39. The applicant's research topic must focus on the prevention, causes, effects, treatment and/or care of cancer. Preference may be given to those currently working in Queensland or Tasmania. Young researchers, who are relatively early in their careers and show promise, may be prioritised. Projects which are likely to have clinical relevance within a relatively short period, as well as to applicants who are enrolled in or intend to enrol in a higher degree will also be looked upon favourably. Gross value $66,000 per annum, comprising $60,000 stipend plus $6,000 departmental maintenance. Recipients are expected to procure 25 per cent of this amount ($16,500) from their research department, with income from the Paul Mackay Bolton Scholarship corpus supplying the remaining $49,500. Tenure is for two years.

Peter King Research Scholarship ($66,000)

The Peter King Research Scholarship was established in recognition of the contributions of Mr Peter King to RACS and rural surgery. The purpose of the scholarship is to support research on a topic relevant to the practice of surgery outside metropolitan areas and applications in support of this topic will be given preference. Applications for the scholarship are open to Fellows and Trainees enrolled in, or intending to enrol in, a higher degree. $66,000 funding comprises of $60,000 stipend plus $6,000 departmental maintenance.

Professor Philip Walker RACS Vascular Surgery Research Scholarship ($10,000)

This scholarship is funded thanks to a generous bequest from the late Professor Walker, an internationally educated Vascular Surgeon, a distinguished teacher, researcher, examiner and active surgeon. Applications for the scholarship are open to Trainees who are undertaking a postgraduate higher degree with research that is in an area related to vascular surgical disease.

Surgeon Scientist Scholarship ($77,000)

Supported by RACS to encourage combined PhD/FRACS programs, this scholarship is open to Fellows and Trainees enrolled in or intending to enrol in a PhD. Tenure is for up to three years. Funding comprises of $77,000 per annum ($65,000 stipend plus $12,000 departmental maintenance).

Senior Lecturer Fellowship ($132,000)

The Senior Lecturer Fellowship is intended to provide salary support for a surgeon, early in their career, to assist them to establish themselves in an academic surgery pathway. Applications are open to Fellows who are permanent residents or citizens of Australia or New Zealand to fund research and/or educational activities. Academic department matched funding is required.

RACS will fund $66,000 and the applicant's institution will be expected to co-fund to the same amount ($66,000). Tenure is for up to two years.

Previous recipient

You are encouraged to read the inspiring letter from Dr Sarah Aitken, the 2015/16 Foundation for Surgery Senior Lecturer Fellowship recipient, in which she encourages all aspiring clinical academics to consider applying for this Fellowship. This letter can be found on the RACS Research and Scholarships web page at www.surgeons.org/scholarships

Sir Roy McCaughey Surgical Research Scholarship ($66,000)

This scholarship was founded thanks to a kind bequest from the late Sir Roy McCaughey. It is open to Fellows and Trainees enrolled in or intending to enrol in a PhD. The research must be conducted in NSW. Gross value $66,000 per annum comprising $60,000 stipend plus $6,000 departmental maintenance. Recipients are expected to procure 25 per cent of this amount ($16,500) from their research department, with income from the RACS Scholarship corpus supplying the remaining $49,500. Tenure is for up to three years.

WG Norman Research Scholarship ($66,000)

This scholarship is open to Fellows and Trainees enrolled in or intending to enrol in a higher degree. This South Australian scholarship arose from a compassionate bequest from the late Dr W G Norman of Adelaide to fund research with a trauma focus. Applicants must be a resident and conduct their research in South Australia. Topics which have a trauma focus will be given preference. $66,000 funding comprising of $60,000 stipend plus $6,000 departmental maintenance.

EDUCATION AND TRAVEL SCHOLARSHIPS, FELLOWSHIPS AND GRANTS

Margorie Hooper Travel Scholarship ($65,000)

This scholarship has been made possible thanks to the generous bequest of the late Mrs Margorie Hooper of South Australia (SA). The scholarship is open to Fellows and Trainees who reside permanently in South Australia. It is designed to enable applicants to travel overseas to learn a new surgical skill for the benefit of the SA surgical community (preference). Alternatively, applications will be accepted for the recipient to undertake postgraduate studies and reside temporarily outside the State of SA, either elsewhere in Australia or overseas.

It is mandatory for the scholarship holder to make a presentation at the SA, NT & WA Annual Scientific Meeting in the year following the conclusion of the scholarship year. Accomodation and travel expenses will be funded in addition to the scholarship value.

Anwar and Myrtha Girgis IMG Scholarship ($10,000)

Dr Anwar Riad Girgis initially undertook his medical training in Egypt, and then undertook postgraduate training in the England. Dr Girgis appreciated the assistance given to him by generous colleagues in the England and Australia. Upon his death his children Mona and Peter Girgis pioneered the establishment of this scholarship to support refugee, asylum seekers and migrants.

This scholarship is open to doctors who are of refugee or asylum seeker background, or who are recent migrants, and who wish to gain the professional development required to practice surgery in Australia or New Zealand.

Hugh Johnston Travel Grant ($10,000)

This Grant was established thanks to the late Mrs Eugenie Johnston, in memory of her late husband, Mr Hugh Johnston. It is designed to assist needy and deserving Fellows and Trainees to gain specialist training overseas.

Hugh Johnston ANZ ACS Travelling Fellowship ($8,000)

This Fellowship is intended to support an Australian or New Zealand Fellow to attend the annual American College of Surgeons (ACS) Clinical Congress in October 2020. It forms part of a bi-lateral exchange with the ACS and is open to those who have gained their RACS Fellowship in the past ten years (2009 or later). Applicants are expected to have a major interest and accomplishment in basic or clinical sciences related to surgery and would preferably hold an academic appointment in Australia or New Zealand. The applicant must spend a minimum of three weeks in the United States of America in the year of their Fellowship. While there, they must attend the ACS, participate in the formal ACS convocation ceremony and visit at least two medical centres in North America before or after the ACS to lecture and to share clinical and scientific expertise with the local surgeons.

John Buckingham Travelling Scholarship ($4,000)

The late John Buckingham was a well-loved specialist breast cancer surgeon who pioneered the sentinel node mapping technique. This scholarship was established to encourage international exchange of information concerning surgical science, practice and education, as well as to establish professional and academic collaborations and friendships among Trainees. It is open to current Trainees to enable them to attend the annual ACS Clinical Congress in 2020.

More information about the ACS can be found at www.facs.org

Ian and Ruth Gough Surgical Education Scholarship ($10,000)

This scholarship was established thanks to former RACS President Professor Ian Gough and his wife Ruth Gough, to encourage surgeons to become expert surgical educators. Fellows and Trainees are invited to apply.

Morgan Travelling Fellowship ($10,000)

This Fellowship was formed by the generosity of retired surgeon, Mr Brian Morgan FRACS, to fund a Fellow to travel overseas to gain clinical experience or to conduct research. To be eligible, the applicant must have gained their Fellowship in the past five years (2014 or later), from any specialty.

Murray and Unity Pheils Travel Scholarship ($10,000)

Thanks to a generous donation by the late Professor Murray Pheils this scholarship supports a Trainee or recent Fellow to travel overseas to obtain further training and experience in the field of colorectal surgery. Similarly, overseas graduates planning to obtain further training and experience in a specialist colorectal unit in Australia or New Zealand are also eligible to apply.

Pickard Robotic Training Scholarship (A total of $100,000 will be awarded to three to five applicants)

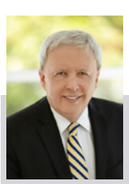
Mr Gordon Pickard has been a strong supporter of robotic surgery in South Australia. In support of his vision, he has generously donated funds to provide training opportunities for South Australian surgeons and other clinicians to expand their expertise in innovative robotic surgical techniques. RACS Fellows and Trainees as well as other clinicians are eligible to apply for this scholarship. To be eligible, you are required to reside in South Australia or have a clear contractual commitment to the South Australian public hospital system for a period of two years immediately following the conclusion of the scholarship.

Stuart Morson Scholarship in Neurosurgery ($30,000)

This scholarship was established following a generous donation by Mrs Elisabeth Morson in memory of her late husband, Mr Stuart Morson. It is designed to assist Neurosurgical Trainees or young Neurosurgeons who are within five years of obtaining their FRACS (2014 or later), to spend time overseas furthering their neurosurgical skills by undertaking research or training. It is also open to exceptional young surgeons who are registered to practice neurosurgery in Australia or New Zealand but are not RACS Fellows. Overseas surgeons who plan to spend time in Australia or New Zealand to further their training and/or research in neurosurgery are also eligible to apply. Applicants cannot have commenced travel prior to applying for the scholarship.

Additional information and links can be found at www.surgeons.org/scholarships. For any other queries, please contact the Australia & New Zealand Scholarship and Grant Coordinator, Mrs Sue Pleass, on +61 8 8219 0924 or at scholarships@surgeons.org.

Applications close midnight ACST 15 April 2019



Mr Christopher Perry
Chair, Australia & New Zealand
Scholarship and Grant Committee

The Henry Joseph Windsor Lecture

Management of ruptured abdominal aortic aneurysm
Delivered by Sam Mellick, Launceston – 22 October 1976

Sam Mellick, Chairman of Vascular Surgery at the Princess Alexandra Hospital, Brisbane (PAH) 1961-1985, was invited by the RACS President at the time to give the seventh Henry Joseph Windsor lecture, following a Tasmanian state committee recommendation in 1976. The lecture, which, at the time was very well received, has been tucked away for forty-two years and is finally being shared, thanks to the efforts of Associate Professor Felix Behan.

In 1976 Henry Windsor, a remarkable surgeon known for his utmost concern for his patients and love of the profession, was still active in part-time practice at the age of 90. He died after a brief illness on the morning of Saturday, 3 July seventeen days before his 91st birthday, in the Mater Hospital, Brisbane. Sam inevitably provided the first memorial lecture for Henry Windsor, tempered by much sadness.

“Earlier lectures have described the career of this revered surgeon in considerable detail. To me he was always a very proper and very senior consulting surgeon, and it was a privilege to treat his patients. I owe a great debt to the Windsor family, particularly to Henry's son Morgan, a thoracic surgeon to the Brisbane general hospital in 1950, whose first registrar I became. It was Morgan who stimulated my initial interest in vascular surgery.

My seniors and teachers in surgery regarded Henry Windsor as an exceptional abdominal surgeon, a tireless worker, whose long and meticulous gastric operations in the early days of that surgery were already legendary when I became a medical student.

The vascular unit at PAH receives annually an average of 15 patients suffering from rupture of an abdominal aortic aneurysm, and this most serious complication of aortic aneurysm sometimes presents great diagnostic difficulty. Once diagnosed, however, the patient requires urgent surgical treatment followed by intensive post-operative support, principally for cardio-respiratory and renal problems. In this lecture, I intend to discuss some of these problems of diagnosis, surgical procedure, post-operative care and results.

Diagnosis

If a male patient aged over 50 years presents with a sudden onset of abdominal and/or back pain, associated with hypertension, and the presence of a pulsating intra-abdominal swelling, the diagnosis of a ruptured aneurysm is a simple matter. However, this symptom may be less pronounced, and with containment of leaked blood in the retroperitoneal tissues, recovery from the hypotensive phase may allow the patient to present at a time when he is not shocked, and bodily obesity may make palpitation of the haematoma and the pulsitile mass difficult if not impossible.

It is at this stage that most of the missed diagnoses occur. If the bleeding is not excessive and if it continues to be contained retroperitoneally the patient may linger for several days or even weeks, losing small amounts of blood intermittently, and the occurrence of a loin haematoma visible as external bruising may be the first indication that haemorrhage has occurred. As well, containment of blood in the retroperitoneal and perianal areas causes pain similar to renal colic, but renal colic alone does not produce shock.

A high level of suspicion of rupture should attach to any patient known to have an aortic aneurysm, no matter how small. If pain is felt anywhere adjacent to that lesion, it is much better to diagnose ‘rupture’ and operate on an unruptured lesion, for the technical surgical procedure is vastly simpler before rupturing has occurred.

Perhaps the most galling experience occurs when a patient who has previously refused definitive surgery for an aneurysm, suffers a rupture and then requests, or even demands, urgent life-saving surgery, usually in much less favourable circumstances than would have been the case had the initial advice been accepted.

Surgical procedure

Any patient diagnosed as having a ruptured aneurysm should immediately be taken to an operating theatre if he is considered suitable for surgery. It would however be remarkable if every patient admitted to hospital with a ruptured aortic aneurysm reached the operating theatre alive, and had a graft performed.

In our unit of 168 patients admitted to the hospital, 59 did not reach surgery due to delays caused by prolonged attempts at resuscitation, time lost for xrays and blood studies, and delays in transportation to the operating theatre. 21 were misdiagnosed and 26 were considered medically unfit. Of 109 patients who were in fact operated on 11 did not reach the stage of grafting because of death, usually associated with inability to obtain control of the aortic haemorage before cardiac arrest occurred. Grafts were inserted in 98 patients over the period reviewed (1965-1975).


Dr Henry Windsor

The patient should be quickly anaesthetised, and the abdomen opened through a full length left paramedian incision. Compression of the aorta above the retroperitoneal mass can usually be achieved quickly with an atraumatic clamp, applied in a sagittal plane, across the aorta just below the renal arteries. If this cannot be done quickly and easily, suprarenal aortic clamping through the lesser sac is a useful alternative. Distal clamps are applied to the aorta beyond the aneurysm, or to the common iliac arteries, and the patient should immediately be given a full intravenous dose of heparin (1.5mg per kg of body weight). If the aneurysmal sac extends well up towards the renal arteries, exposure here may be made difficult by the left renal vein being stretched tightly across the front of the sac. In such cases, this vessel may safely be divided to facilitate exposure.

Compatible whole blood should now be rapidly given through a warming coil, and an attempt made to restore the circulating blood volume to normal. Bicarbonate should also be given as necessary, and it is our present policy to give intravenous methicillin and cephaloradine early during the operative procedure.

Definitive surgical repair is now commenced by opening the sac widely and removing thrombus and debris from within it. The orifices of the inferior mesenteric, middle sacral and lumbar arteries are over-sewn from within the sac if they bleed. Care should be taken to ensure that the ligature around the inferior mesenteric artery is placed as near as possible to its origin to retain all of its branches for collateral supply to the left colon.

In placing sutures in the aorta, deep bites should be taken in that vessel, rolling up a ridge of the vessel wall as a cuff. Prolene is recommended as the best material for this, and the dacron should be of woven type to limit bleeding after clamp removal. Suturing the graft to a ridge of aneurysmal sac usually prevents the tearing out of sutures through a thinned-out aortic wall, but should this occur, particularly on the anterior aspect of the suture line, it may be necessary to wrap this line with a sleeve of dacron. Once the graft has been sutured in place, distal clamps are removed and the proximal clamp is slowly released, with intravenous administration of protamine sulphate to neutralise the heparin. When the clamps have all been removed and the area is dry, the remnants of aneurysmal sac are double-breasted over the graft, ensuring that the suture lines are covered and thereby isolated from the duodenum. If this is not possible because of too little remaining sac, a portion of the omentum should be laid across the graft area. This separation is the most important factor in preventing subsequent aorto-duodenal fistulae.

The operation is completed by closing the posterior parietal peritoneum over the sac, and the abdominal wall is closed.

Post-operative care

Post operatively the patient is transferred to the intensive care unit for assisted ventilation through an intratracheal tube, naso-gastric suction, and supervision of renal function. Chest infection and pulmonary problems are common in this group of patients, and while tracheostomy was needed quite commonly earlier in this series, its use now is very infrequent. Temporary cardiac irregularities and even myocardial infarction are also frequent problems. Jaundice occurred in 10 patients in this series and of these patients, five died. Wound dehiscence occurred five times, an incidence of approximately five per cent. Peripheral arterial embolism requiring catheter clearance occurred four times, but has not been seen in recent years since the use of total heparinisation. Limb infarction occurred three times, and one patient lost both lower limbs, but this patient had dead feet on admission. Colonic ischaemia was very uncommon and was positively diagnosed only three times. Renal failure requiring dialysis occurred three times. One patient in this series had an infection of the graft, followed by hemorrhage and death, while a second patient developed a small bowel fistula from damage to the intestine during separation of adhesions at the time of securing aortic control. A large infected retroperitoneal haematoma resulted, and the patient succumbed. One patient developed an aorto-duodenal fistula three weeks after discharge from hospital following an otherwise successful repair of a ruptured aneurysm, and died during operation for repair of this fistula.

In assessing results, it needs to be stressed that our unit receives patients from as far north as Mt. Isa and Cairns, and from Lismore and Grafton in the south. Some of these patients have already been operated on for their ruptured aneurysms and in some instances, the distance travelled by a patient with a rupture already present has been as much as 1,600 kilometres. Between 1964 and 1975, 98 grafts were inserted in patients with ruptured aortic aneurysms. Of this group, a total of 47 survived. In the first half of this period, there were 32 patients grafted with seven survivors, and in the second five years, of 66 grafts performed, 40 patients survived.

In conclusion, it is gratifying to be able to report that our results have improved considerably in the period studied, and over the last five years, 61 per cent of patients survived aortic grafting. I am now firmly convinced that all abdominal aortic aneurysms, whose diameter is at least twice that of the adjacent host aorta, should be resected as soon as possible after diagnosis if the patient's general condition is reasonable: and as a corollary, patients with ruptured aneurysms need urgent surgery involving rapid aortic control, restoration of circulating blood volume, graft replacement, and intensive post-operative care. Only by such management can the present survival rate be raised.

Professor Sam Mellick
FRACS

Update on issues for Australian surgeons

A number of surgeons have been involved in the Medicare Benefit Schedule (MBS) Review process. You may have had opportunities through various societies and through RACS, but it has been at times a frustrating exercise. A significant number of MBS Review Taskforce clinical committee reports have been recently released to targeted stakeholders. However, while the MBS taskforce has deliberated on recommendations over the last several years, the profession has had very little time to respond.

The Australian Medical Association (AMA) Medical Practice Committee has been tasked with reviewing and responding to expansive documents. I've found that significant changes to schedules can occur somewhat under the radar and unnoticed. One example for instance, is the MBS group T8 three-item rule. When it was initially proposed by the MBS Review Principles and Rules Committee (PRC) that procedural plans in an episode be limited to three items, it was understandable that considerable concern was expressed.

In response, in March 2017, the taskforce wrote to the President of the Australian Society of Otolaryngology, Head and Neck Surgery (ASOHNS) advising of the deferral of the three-item rule from the final recommendations of the PRC. The AMA membership was therefore reassured that this rule was not likely to be pursued further for any specialty, based on feedback already received.

At RACS's October Council meeting, surgical society representatives discovered that the issue had not gone away. It is concerning that while on one hand the PRC deferred its decision regarding the three-item rule with ASOHNS due to consultation feedback, on the other hand, this recommendation has been taken forward and applied in a specialty clinical committee report (e.g. urology) without regard or reference to any previous profession feedback on the recommendation. Obviously, better transparency is required. The AMA and RACS have asked for the strongest assurances that the three-item rule be further discussed with the relevant colleges and societies, so as to come to a position of mutually agreeable changes that are consistent across the specialities and do not lead to disadvantage for patients.

Another new regulation that the PRC proposed was to remove the ability of surgical assistants to bill independently, with responsibility falling to the surgeon. Clearly, that would contravene a fundamental right of any doctor to protect the use of their personal provider number and would also add a further burden to the principal surgeon. While such arrangements for billing sometimes exist, in all circumstances it should be an agreement between the assistant and the surgeon rather than a regulation from the MBS. An arrangement whereby the surgeon is compelled to pay the assistant directly for their services is strongly opposed by RACS and the AMA. Surgical assistants are independent practitioners, as are anaesthetists. The recommendations set a dangerous precedent for bundled payments. The Medical Surgical Assistants Society of Australia also opposes such changes.

These recommendations aim to limit improper use of item numbers and improve informed financial consent for patients. RACS and AMA of course support these principles, but it has been pointed out that the issue of the management of out-of-pocket expenses is not within the remit of the MBS Review. Their role is to align the MBS with contemporary clinical evidence and practice to improve health outcomes for patients, and assurances were given from the outset that the MBS Review was not a cost reducing exercise.

On the issue of billing services, the vast majority of surgeons believe in fair professional fees, and would welcome a limitation to out-of-pocket expenses for their patients. But it needs to be understood that this is not determined only by the surgeon's fee, but largely a function of the MBS and private health fund rebate. The AMA schedule of fees has always served as an appropriately indexed schedule, but the absurdity of Medicare indexation and subsequently Private Health Fund rebates have led to an ever widening of the gap. The recent RACS census contained two questions about your billing practices and your perception of fair professional fees. It will be enormously helpful to understand what the surgical profession thinks.

My Health Record (MHR) has the potential to ensure clinically important information is available at the point of care. For benefits to be realised the system would need to be self-sustaining and therefore have the trust of patients and practitioners. Following initial privacy concerns, the AMA successfully lobbied to improve safeguards. Changes proposed are now in the bill to be passed by parliament. These include increased penalties for improper use of the system. Improper access by insurers and employers is prohibited, and there are greater protections for young adults and people at risk of family and domestic violence. Law enforcement and other agencies require a court order to access the MHR, and it has been made clear that the system cannot be privatised or used for commercial purposes. So, the privacy standards are now much higher than *The Privacy Act 1988* requires. I've lost count of the many times, more timely access to patient information could have made a significant difference. Sure, there will always be concerns about the currency of information, but that also goes for hard copy perhaps even more so.

More than 6.3 million Australians already have a My Health Record, and there are more than 14,000 health care professional organisations connected. Hopefully these changes will provide the assurances the public requires to have that confidence. Though the opt-out period (31 January 2019) has now passed, Australians can still permanently delete their records and any back-ups at any time if they still have concerns.

Another area of considerable involvement by RACS, AMA and our medical defence organisations has been the review of the national laws relating to the regulation of Australian health professions. Notification processes need to be protective of patients but also fair to practitioners. It is difficult to comprehend that medical practitioners who are named in tribunal procedures are offered less protection from discrimination than a person who has served a prison term.

Much of the proposed change to regulation lacks analysis and information. The AMA made strong representations that changes should not proceed without adequate identification and quantification of any 'problem' without a full analysis of the impact of the proposed 'solution'. There was disappointment that at the last COAG Health Council, an opportunity to properly evaluate the effectiveness of the health practitioner regulation national law was squandered. Doctors in these regulations are not offered the same assurances of confidentiality with mandatory reporting rules, and this would lead to a discouragement of impaired doctors perhaps seeking much needed help.

The profession strongly supports accreditation that enables medical practitioners to be qualified, safe and receive medical education and training that meets international guidelines. RACS is currently reviewing its Continued Professional Development (CPD) program to ensure that it is relevant to the needs of the Fellows and the patients they care for.

AMA President, Dr Bartone, also called for the scrapping of the concept of a non-medical chair of the Medical Board of Australia, a position considered too important and challenging to someone who does not have an understanding of medical practice.

The Morrison government recently announced that the last child has been removed from Nauru. RACS along with the AMA and other medical colleges have been united in the position that children and their families should not be subjected to prolonged detention and that the health of an individual overrides all other concerns and is a basic human right. There is no doubt that the sustained pressure on government from the medical profession has resulted in better outcomes for affected asylum seekers and particularly children. As citizens we understand the reasons for border protection measures and as doctors we must advocate for healthcare. Challenging as it is, we must find that sweet spot that addresses both issues.

Colleagues frequently ask me – "What is RACS doing for me?", or "Why should I join the AMA?" I've only scratched the surface in describing just some of our recent activity. Yes, we need to address the issues that directly affect our profession. As professionals we have a moral obligation to make ethical patient service our priority but also at times participate in social discourse.

Professor Owen Ung
RACS Councillor, AMA Councillor

Farewell to Associate Professor Franklin Bridgewater OAM FRACS

MALT Clinical Director

The Morbidity Audits team in Adelaide recently bid farewell Franklin Bridgewater, after four years working as Clinical Director Morbidity Audit and Logbook Tool (MALT), and announcing his retirement. Through his expertise, passion for surgery and influence among the surgical community, Franklin has made a valuable contribution to RACS.

Franklin graduated from the University of Adelaide with a Bachelor of Medicine and Bachelor of Surgery in 1963. Soon after, Franklin was posted as a Medical Officer to remote single-doctor outstations in Papua New Guinea for four years.

Franklin undertook surgical training at the Royal Adelaide Hospital gaining his Fellowship with RACS in 1971. During 1972-1974 Franklin worked in England where he gained his Fellowship with the Royal College of Surgeons in 1973.

On return to Australia, Franklin worked at the Queen Elizabeth Hospital as a Senior Surgical Registrar initially and subsequently as a Consultant General Surgeon with clinical, under-graduate and postgraduate teaching/training responsibilities.

Franklin has an interest in gastrointestinal surgery and the surgical management of injuries and cancer. He has been a Senior Instructor for the RACS programme, the Early Management of Severe Trauma and has represented RACS on the National Council of the Australian Resuscitation Council.

He has been a member of the Medical Advisory Committee for the SA Ambulance Service, and Chief Surgeon for St John Ambulance Australia and Commissioner for St John in South Australia. Franklin lectured at Flinders University and the University of Adelaide; teaching undergraduates in medicine and ambulance studies, and postgraduates in surgery. He was appointed as Clinical Associate Professor at the University of Adelaide in 2008. Franklin also served in the Royal Australian Army Medical Corps as a reservist General Surgeon. During 2000-2006 he was deployed to Bougainville, East Timor and Banda Aceh.

In 2004, Franklin received the Medal for the Order of Australia for service to the community, particularly the development of ambulance services in South Australia. In 2015, Franklin was awarded the RACS Outstanding Service to the Community Award in recognition of his dedicated service.


Professor Franklin Bridgewater

After retiring from operating in 2014, Franklin took up his role as Clinical Director of the Morbidity Audit and Logbook Tool (MALT). During his time in this role he attended the Morbidity Audit Committee and provided advice, guidance and clinical support in the development of MALT. Some of the specific areas where he made a significant contribution include providing clinical expertise to:

- Implementation of SNOMED-CT as the source of procedure lists
- Migration of logbook data from non-SNOMED logbooks
- Development of peer-review audit reports and audit capabilities
- Collaboration with stakeholders including the CSIRO and training boards.

Franklin's clinical expertise and guidance leaves a legacy, ensuring that MALT continues to be relevant and beneficial to the membership. Of significance is his role providing clinical input for the procedure list MALT now uses — a world-first comprehensive list of all surgical procedures, extracted from SNOMED. This list is now publicly available for use in electronic medical records and patient data systems anywhere in the world.

The Morbidity Audits team would like to take this opportunity to thank Franklin for his commitment and dedication over the years, wishing him and his wife Audrey all the best for the future and a well-earned retirement!

Kylie Harper,
Morbidity Audits Team Leader, RACS
with Katherine Economides, Morbidity Audits Manager, RACS

RACS Visitor Grant Program for 2020

RACS is committed to excellence in surgical education and practice and recognises that Fellows within sub-specialties and other groups wish to enhance their Annual Scientific Meetings by inviting visitors of note from Australia, New Zealand and internationally. RACS supports these initiatives through the RACS Visitor Grant Program.

In the last three years RACS has supported 47 speakers across 16 surgical specialties. In 2019, another 17 speakers will be supported.

Applications for meetings in 2020 will be accepted until 18 March 2019. The application form is now available on the RACS website.

Eligible groups are invited to apply for funding towards the cost of travel, accommodation and registration for visiting speaker(s) to their 2020 Annual Scientific Meetings. Applications are open to any recognised society or association of surgeons.

For details please see www.surgeons.org/member-services/racs-visitor-grant-program/ or contact Paul Cargill, Manager, Fellowship Services, on +61 3 9276 7415.

Ruth Bollard
Chair,
Fellowship Services Committee

Seeking feedback on *Surgical News*

Following feedback received, we are embarking on a review of the publication schedule for *Surgical News*.

For relevance, quality of articles and cost it has been suggested to move to six editions per year.

We would like to know what you think.

Let us know what you think via email:
Surgical.News@surgeons.org

Foundation for Surgery
Passion. Skill. Legacy.

The Foundation for Surgery and the D'Extinguished Surgeons warmly invites you

12 noon
Friday 12 April

Lecture:
"Sharing our Surgical Heritage- how a Virtual Museum can protect and project the profession "

This lecture will be delivered by
Mr David Kaufman FRANZCO FRACS
Museum Curator RANZCO

RACV City Club,
501 Bourke St,
Melbourne
VIC 3000.

Lunch will be served after the lecture.

Guests welcome.
Please feel free to bring colleagues, friends and family.

Thanks to the D'Extinguished Surgeons for their ongoing fundraising efforts in support of the Foundation for Surgery.

RSVP
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***Online registration form** is now available (login required).*

Mandatory courses

With the release of the RACS 'Action Plan: Building Respect and Improving Patient Safety', the following courses are mandated for Fellows in the following groups:

- Foundation Skills for Surgical Educators course: Mandatory for SET Surgical Supervisors, Surgeons in the clinical environment who teach or train SET Trainees, IMG Clinical Assessors, Research supervisors, Education Board members, Board of Surgical Education and Training and Specialty Training Boards members.
- Operating with Respect one-day course: Mandatory for SET Supervisors, IMG Clinical Assessors and major RACS Committees.

Foundation Skills for Surgical Educators course (FSSE)

16 February 2019	Melbourne	VIC
18 February 2019	Sydney	NSW
22 February 2019	Adelaide	SA
8 March 2019	Sydney	NSW
21 March 2019	Brisbane	QLD
23 March 2019	Sydney	NSW
29 March 2019	Melbourne	VIC
29 March 2019	Perth	WA
7 April 2019	Sydney	NSW
12 April 2019	Brisbane	QLD

FSSE is an introductory course to expand knowledge and skills in surgical teaching and education. The aim of the course is to establish a basic standard expected of RACS surgical educators and will further knowledge in teaching and learning concepts. Participants will look at how these concepts can be applied into their own teaching context and will have the opportunity to reflect on their own personal strengths and weaknesses as an educator.

Operating with Respect course (OWR)

18 February 2019	Brisbane	QLD
23 February 2019	Melbourne	VIC
23 March 2019	Perth	WA
29 March 2019	Brisbane	QLD
5 April 2019	Wellington	NZ

The OWR course provides advanced training in recognising, managing and preventing discrimination, bullying and sexual harassment. The aim of this course is to equip surgeons with the ability to self-regulate behaviour in the workplace and to moderate the behaviour of colleagues, in order to build respect and strengthen patient safety.

Academy of Surgical Educators Studio Sessions

13 February 2019	Melbourne	VIC
7 March 2019	Canberra	ACT
30 April 2019	Sydney	NSW

Each month, the Academy of Surgical Educators presents a comprehensive schedule of education events curated to support surgical educators.

The Educator Studio Sessions are presented around Australia and New Zealand and deliver topics relevant to the importance of surgical education and help to raise the profile of educators. They provide insight, a platform for discussions and an opportunity to learn from experts.

All sessions are also simulcast via webinar. Register here: www.surgeons.org/studiosessions

Advanced Feedback in Surgical Education (AFSE)

19 February 2019	Liverpool Hospital	NSW
27 March 2019	Royal Brisbane Hospital	QLD
2 April 2019	Austin Hospital	VIC
21 May 2019	Royal Adelaide	SA
18 June 2019	Royal Perth	WA

New for 2019, the AFSE course is for Surgeons who'd like to get better results from the feedback they give. You'll learn all steps of the feedback process and how to give negative feedback to challenging Trainees. The course will be an evening session at a range of hospital locations across Australia and New Zealand.

Register here for courses throughout 2019:

https://www.surgeons.org/for-health-professionals/register-courses-events/professional-development/advanced-feedback-in-surgical-education/

Surgeons as Leaders in Everyday Practice

29 - 30 March 2019	Auckland	NZ

Surgeons as Leaders in Everyday Practice is a one and a half day program which looks at the development of both the individual and clinical teams' leadership capabilities. It will concentrate on leadership styles, emotional intelligence, values and communication and how they all influence their capacity to lead others to enhance patient outcomes. It will form part of a leadership journey sharing and gaining valuable experiences and tools to implement in the workplace. All meals, accommodation and educational expenses are included in the registration fee. The evening session will involve an inspirational leadership speaker.

Process Communication Model Seminar 1

15 -17 March 2019	Sydney	NSW

Patient care is a team effort and a functioning team is based on effective communication. PCM is a tool which can help you to understand, motivate and communicate more effectively with others. It can help you detect early signs of miscommunication and thus avoid errors. PCM can also help to identify stress in yourself and others, providing you with a means to re-connect with those you may be struggling to understand.

Before the Introductory PCM course each participant is required to complete a diagnostic questionnaire which forms the basis of an individualised report about their preferred communication style.

Clinical Decision Making

13 April 2019	Sydney	NSW

This four-hour workshop is designed to enhance a participant's understanding of their decision making process and that of their Trainees and colleagues. The workshop will provide a roadmap, or algorithm, of how the surgeon forms a decision. This algorithm illustrates the attributes of expert clinical decision making and was developed as a means to address poor clinical decision making processes, particularly as a guide for the supervisor dealing with a struggling Trainee or as a self improvement exercise.

Non-Technical Skills for Surgeons (NOTSS)

16 March 2019	Melbourne	VIC

This workshop focuses on the non-technical skills which underpin safer operative surgery. It explores a behaviour rating system developed by the Royal College of Surgeons of Edinburgh which can help you improve performance in the operating theatre in relation to situational awareness, communication, decision making and leadership/teamwork. Each of these categories is broken down into behavioural markers that can be used to assess your own performance as well as your colleagues.

Writing Medico Legal Reports

26 March 2019	Sydney	NSW

This evening workshop helps you to gain greater insight into the issues relating to providing expert opinion and translates the understanding into the preparation of high quality reports. It also explores the lawyer/expert relationship and the role of an advocate. You can learn how to produce objective, well-structured and comprehensive reports that communicate effectively to the reader. This ability is one of the most important roles of an expert adviser.

Please contact the Professional Development Department on +61 3 9276 7440, PDactivities@surgeons.org or visit the website at www.surgeons.org and follow the links from the Homepage to Activities.

PROFESSIONAL DEVELOPMENT WORKSHOP DATES: February - April 2019

ACT		
Academy of Surgical Educators Studio Sessions	7 March	Canberra
NSW		
Foundation Skills for Surgical Educators	18 February	Sydney
Advanced Feedback in Surgical Education	19 February	Sydney
Foundation Skills for Surgical Educators	8 March	Sydney
Process Communication Model Seminar 1	15 March	Sydney
Foundation Skills for Surgical Educators	23 March	Sydney
Writing Medico Legal Reports	26 March	Sydney
Foundation Skills for Surgical Educators	7 April	Sydney
Clinical Decision Making	13 April	Sydney
Academy of Surgical Educators Studio Sessions	30 April	Sydney
NZ		
Surgeons as Leaders in Everyday Practice	29 March	Auckland
VIC		
Academy of Surgical Educators Studio Sessions	13 February	Melbourne
Foundation Skills for Surgical Educators	16 February	Melbourne
Non-Technical Skills for Surgeons	16 March	Melbourne
Foundation Skills for Surgical Educators	29 March	Melbourne
Advanced Feedback in Surgical Education	2 April	Melbourne
WA		
Foundation Skills for Surgical Educators	29 March	Perth
SA		
Foundation Skills for Surgical Educators	22 February	Adelaide
Keeping Trainees on Track	5 April	Adelaide
SAT SET Course	5 April	Adelaide
QLD		
Foundation Skills for Surgical Educators	21 March	Brisbane
Advanced Feedback in Surgical Education	27 March	Brisbane
Foundation Skills for Surgical Educators	12 April	Brisbane
TAS		
Safer Australian Surgical Teamwork	6 April	Hobart

Register online

For future course dates or to register for any of the courses detailed above, please visit https://www.surgeons.org/for-health-professionals/register-courses-events/
Contact the Professional Development Department on +61 3 9276 7440 or email **PDactivities@surgeons.org**

2018 RACS Combined Tasmanian Annual Scientific Meeting and Trauma Symposium

Each year the RACS Bi-National Trauma Committee hosts a trauma symposium to coincide with the annual face-to-face meetings of the Trauma Committees. Trauma surgeons and representatives from other Colleges including anaesthesia, intensive care and emergency medicine meet to investigate, review and pursue initiatives in trauma care. To capitalise on this gathering of trauma experts, the symposium provides an opportunity to explore issues that, if addressed, have the potential to reduce the devastating effects of trauma (injury) within the community.

The meeting was held in Hobart in November with more than 130 delegates attending the two-day event, and this year, the Tasmanian Annual Scientific Meeting (ASM) combined with 'Trauma Week', the theme – *Regional Trauma in Australasia: What is possible and how far can we reach?*

Dr David Hoyt, Executive Director American College of Surgeons, was invited to speak on his extensive knowledge of trauma verification in America, trauma systems, research and lessons learned through the American College. The Trauma Verification Program benchmarks a hospital's level of trauma care. His acceptance to attend and participate in the event sealed the deal and a tight organising committee was formed with scientific co-conveners, Dr Michael Ee, Paediatric Surgeon and Professor Richard Turner, General Surgeon.

The meeting was a great success with record numbers of registrants and sponsors. The program highlighted regional trauma services and hospitals in Australasia, RACS Trauma Advocacy and other trauma prevention initiatives, as well as the evolution of the trauma verification program and varying trauma systems.

It was an excellent opportunity to acknowledge and thank Dr David Hoyt for his involvement in the inaugural Australasian trauma verification review in 2000 when he was a guest speaker at the Annual Scientific Congress in Melbourne. Dr Hoyt presented on the evolution of trauma systems in the USA – and the development of the Trauma Verification Program which was established to accredit every major trauma service in the country on a regular basis. He stressed that the principles of Trauma Verification are relevant to all surgery and have led the way to major change and improvements in patient care.

Professor Mary Sheehan, keynote speaker and research professor at Queensland University of Technology, highlighted the troubling over-representation of crashes on country roads. Her presentation drew on findings from a study of Queensland coroner's reports and linked hospital and other relevant data with all fatal crashes between 2010–2015. The study compared crash investigation reports, autopsy findings, toxicology and emergency reports – all contributing factors in urban, regional and rural regions.

As *trauma advocacy* was a main topic of the meeting, gun safety was high on the agenda. General Surgeon Dr Stephen Wilkinson gave a moving and poignant presentation on his involvement at the Royal Hobart Hospital at the time of the Port Arthur tragedy. Only days before the massacre, health professionals at the hospital had received training in Early Management of Severe Trauma (EMST) – a timely and fortunate course which helped hospital staff coordinate the avalanche of victims. Not a sound from the auditorium could be heard as the impact of Dr Wilkinson's words found their mark.

Dr Bryan Walpole, who was an Emergency Physician at Royal Hobart Hospital at the time of the Port Arthur tragedy, spoke of his involvement with the radical unification of the federal and jurisdictional governments as they unanimously agreed to create a National Firearms

L-R: Louise Niggemeyer, Alaina Campbell, Kellie Gumm

L-r: Professor Stephen Deane, Cathy Edwards, Dr Barry Edwards, Dr John Crozier.

Agreement – the Agreement which has proved to be one of Australia's most successful public health measures.

Dr John Crozier and Neurosurgeon, and Trauma Committee member Associate Professor Mark Sheridan, spoke of their passion for trauma prevention especially in terms of road trauma prevention and the recently published National Road Safety Strategy report which explored the rise of road trauma over the past decade. Dr Crozier read out an email he had serendipitously received that day from a patient who recalled how he had held her liver together some 30 years ago when she was a young girl involved in a car crash. Dr Crozier was a registrar working at the Royal Hobart Hospital at the time. This was an early marker for Dr Crozier in pursuing a career in trauma, and in caring for the injured. He knew he would not rest until the job of road trauma prevention was done and *vision zero* was achieved. Professor Sheridan spoke with authority about the efficacy of bicycle helmets, the mountain of evidence there is to support this and the importance of mandatory bicycle helmet law.

A wide range of speakers at the event included Dr Roland Watzl who spoke about managing trauma in the Antarctic, Dr Alicia Tucker who gave an account of trauma from an astronaut's perspective, and Dr Li Hsee and Dr Warwick Teague who both provided a glimpse into the future of trauma care.

The meeting dinner was held at the Seagrass Long Point restaurant in Sandy Bay – a perfect spot to mingle, relax, celebrate and congratulate. Dr Barry Edwards was presented with an Outstanding Service to Community Award for his long-term commitment to and involvement with road safety. Funds raised at the dinner through the auction of a painting during the evening were directed to the *Damian McMahon Trauma Research Travel Grant for Trainees.*

RACS is fortunate to have had great support from the following sponsors; Bongiorno Group, Medtronic, Hobart Private Hospital and the Tasmanian Government Department of Health for which we are most grateful.

Convenor Dr Ee said that he was impressed with the event and is looking forward to seeing some of the advances in trauma care discussed.

"It was an excellent meeting of minds, spirits, will and expertise providing the 150 speakers, registrants and sponsors a great opportunity to interact with like-minds," he said.

"It provided a chance for Tasmanian Fellows to connect with the wider trauma community and to gain insight into the challenges facing the trauma community of Tasmania – and the wider picture in Australia, New Zealand and America."

Lyn Journeaux,
Executive Officer, Trauma Committee, RACS

RACS visit 2018

Reaching out

RACS in Cairns

In 2017 Cairns figured in State Committee business on several occasions. It made for a well-attended course in the middle of the year followed by the State's Annual Scientific Meeting. Brian McGowan, State Committee Chairman also contacted me later, about the presentation of RACS awards to individual Far North Queensland surgeons being at the Ivan Lester Memorial meeting in November. This well attended event garnered a large audience and Associate Professor Bernard Whitfield representing the Chairman, presented RACS medals to three worthy beneficiaries, John Knott, Lawrence Perrett and Paul Muscio.

Following the success of this inaugural Cairns RACS event, Brian invited me to Brisbane in March 2018 to continue discussions that had arisen in Melbourne and elsewhere, on the need to address the disparities in Training and Specialist positions between town and country. Professor Richard Murray, Dean of the College of Medicine and Dentistry, James Cook University had made important contributions to this end with particular reference to the establishment of Regional Training Hubs throughout northern Queensland as a result of Australia-wide Federal Government grants.

Particular difficulties we face in surgery in Cairns, despite remarkable individual contributions, are a matter of record. The long-established tradition of RACS having State and National representative's travel centrifugally has not overcome the consequences of isolation. Our general surgical service is presently unfit for purpose, and needs to expand to take on more surgeons and Trainees.

Using the Ivan Lester Memorial Lecture meeting again as a basis, Brian suggested that we precede the 2018 Lecture with the RACS Queensland State Finals Prize and the Neville Davis finals. In my role as Associate Professor of Surgery at James Cook University, I embraced the opportunity and also proposed using this opportunity to attempt more serious engagement.

Slowly a program evolved thanks to the valuable input of David Watson, RACS Queensland State Manager, and his team from the State Committee as well as Penny Phillips and the James Cook University, Regional Medical Training Team in Cairns. Our State RACS representative Gareth Evans was a pillar of support and our new RACS councillor Sarah Coll was gracious in her support though we did not have sufficient time to fully involve her in the program. We incorporated the Department of Surgery with the enthusiastic support of H.C. Chiam, Acting Director of Surgery and Susan Henderson, Director Intensive Care, Women's and Perioperative, as well as the majority of our senior surgeons. We were also able to mobilise a wider network with Sean McManus, a senior anaesthetist and intensivist on the Hospital Board, the Directors of ICU, anaesthetics and Accident and Emergency (A&E), the orthopaedic Director Arvind Puri, and the Medical Education Unit led by Julie Napoli, among many others.

But the size of the agenda was daunting. 'What do they actually want?' I thought, 'What do I want to achieve?' I must say I was short of coherent answers. Brian McGowan seemed serene and so we plodded on.

Brian had of course serious RACS business to transact. This involved presentations on Building Respect and Improving Patient Safety, J-Docs and formal meetings with all of the surgical Trainees. We had a meeting hosted by Daryl Wall with input from Zsolt Balogh (travelling between Newcastle and Melbourne) to discuss Trauma Verification. The very able trauma team we have assembled here in Cairns articulated their frustrations at their inability to progress this project. Some members of the visiting team properly pointed out that we had serious issues with budget deficits in Cairns which had led to the resignation of the CEO and The Board of Cairns Hinterland Hospital Health Service (CHHHS) in 2016, which may have had some bearing on funding issues now.

It was decided that the Wednesday morning meeting, a focal point of the visit, should be a RACS meeting by invitation. Invitations were sent to all surgeons, members of the CHHHS Board, the CEO and senior administrators, as well as the CEO of Cairns Private Hospital, seeing as discussions were not necessarily Cairns Hospital focused but more community focused on improving training pathways and surgical services in the region as a whole.

Michael Zanco represented Queensland Health. I prepared an ambitious agenda which was supported by Brian who was to Chair. I had given myself the opening slot, presenting *Looking back and looking forward* and to follow, allocated several consultants five-minute slots to present their cases. Despite short notice and busy schedules the surgical turnout was positive. Fortunately guests ignored the time allocation and Brian chaired well to allow a most interesting and thoughtful series of presentations.

My own presentation was quite personal. When I first came to Cairns as a locum for David Graham in 1995 the General Surgical Service was run by one full-time staffer and a handful of VMOs, about 4.5 FTE's all up. At that time there were six part time physicians, one orthopod, one anaesthetist and a few VMOs, and an A&E with skeleton staff. These departments have now grown to remarkable proportions. I recently looked at the Medical on-call roster, and stopped counting at 50. Of anaesthetists, a fine department of about 20 staff and innumerable teaching positions, there is an orthopaedic team of 10 consultants many with solid academic credentials. General surgeons have remained at about five FTE's, now supported by three SET positions of variable seniority. We are presently one SET position down. Our allocated senior SET declined to come up, making a precarious position worse, and I wondered how RACS had come to agree to this. Our general surgeons are overwhelmed by our emergency admissions and the regular reality of operating well outside comfort zones. Many are seriously looking at exit strategies. I stopped on-call duties as a VMO after nearly 20 years on the roster, as it was simply unsafe given the inadequacy of junior support. Whenever VMO's are mentioned in polite company, the automatic response seems 'Acute Surgical Unit'. My own view, in regional settings particularly, is that VMO's should be a fundamental part of surgical service, bringing their unique skills and experience, but being adequately supported, and that our service, driven as it is by its metrics and waiting lists, may well produce a service inadequate for our community, the region and indeed, the Nation. I also believe that the short-termism of sending the bulk of elective work to a Private Hospital to manage waiting lists, will degrade our surgical workforce further. We need to render unto Caesar, but not destroy our service in the process. Patients we do send should be supported by a quality framework, and as the person who first started Morbidity and Mortality meetings in this town, I have concerns about this. Our general surgical service should largely look after its own business.

Nathon Brunot, who has helped to develop the Trauma Team in the hospital presented brilliantly on the great need for us to move on this issue of development. This was supported by Darryl Wall with thoughtful comment. H.C. Chiam gave a good outline of where we are as a service, and how we in fact were pretty much 'on metric' despite the emergency workload.

Christian Sorensen our new Norwegian plastic surgeon who speaks Glaswegian, and is a real asset, gave an excellent account of the challenges of skin cancer here, and some interesting ideas regarding GP engagement on the issue.

Roxanne Wu, with her usual energy and insight, spoke to the problems of peripheral vascular disease and the chronic ill-health in the Cape and Torres Region.

Sean McManus gave a brief review of the importance of respectful and trusting relationships across departments, and the cost to us all when these are ignored.

Brian and Michael Zanco summarised, Brian with a sense of hope, and Michael with a sensible and avuncular reality, but appreciative of our problems.

The meeting ended with a few appreciative and kind remarks from the Executive.

But the intensity in the room, the goodwill shown all round, and the sense of intimacy in a shared project remained. We had a common purpose, and a great deal to gain.

The program for the Thursday ran seamlessly into the RACS and Neville Davis presentations, followed by the Ivan Lester Memorial Lecture given on this occasion by Paul Muscio, FRACS who presented *Sports Injuries: What price our Gladiators pay* which was warmly received. The large crowd funnelled into the rooms adjacent the auditorium, enjoyed our traditional hospitality, and with that the visit came to an end.

What have we achieved? We have enhanced human relationships across barriers that are sometimes viewed as impenetrable parallel universes. That isolation can be turned into an advantage if we utilize all of our assets to our common purpose and we grow bigger than the sum of our parts.

A special highlight for me? To sit at dinner between Daryl Wall, and Michael Zanco and savour two eloquent and powerful views of our combined history.

Associate Professor Alan de Costa, OAM
FRACS

Update from New South Wales State Chair

As the RACS NSW Committee Chair, I am encouraged by the amount of work that is carried out for the Fellows, Trainees and International Medical Graduates (IMGs) across both Australia and New Zealand by our College. The NSW Committee, as an example that I can give, regularly share, influence and educate key stakeholders within NSW, and I have come to realise that this is replicated across all of the States and Territories and in New Zealand, and also at Council. Before joining the Committee, I had little idea of what it would be involved in. I assumed that College committees were for more senior surgeons, however all of us have valuable insight that we can bring. The NSW Committee is made up of an incredibly diverse group, representing many specialties, backgrounds, and interests that representation of the Fellows is therefore natural on issues as diverse as rural workforce support, private health insurance changes and trauma.

We are fortunate to have Councillors in NSW, Kerin Fielding, Jenny Chambers, John Crozier and Geoffrey Lyons, and I would like to highlight the sagacity that they bring and the value that they add to the NSW Committee.

Engagement is an area that all the State, Territory and New Zealand Committees are trying to address. We want the College to be relevant to all of our Fellows, not just as a necessary requirement, but as an asset that is flexible enough to support the Fellows, Trainees and IMGs throughout their careers and life.

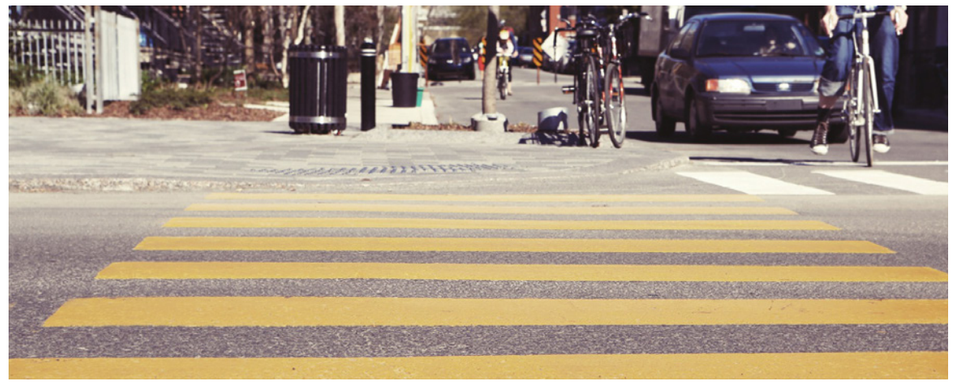
To this end NSW developed Surgeons' Month which has now been running for five years. Last year's Surgeons' Month was a massive success, where we tried, as a state committee, to give greater return, and to support smaller groups. Beyond the Prep for SET (aimed at prevocational) and the Younger Fellows Preparation for Practice (aimed at Younger Fellows) we held an Australian Defence Force event at Victoria Barracks in Sydney, and the turn-out of military surgeons was very impressive. It was great to share and discuss the life of a military surgeon and what they experience. Secondly as part of our Women in Medicine event we were able to share the evening via video conference with Lismore, and a special thanks to Sally Butchers for developing this. The Women in Medicine evening was a positive sharing of ideas on how to get ahead, and we were fortunate to have Kerin Phelps (Independent member of Parliament) as our keynote speaker. Our celebration evening, Surgeons' Evening, was held at the NSW Art Gallery where we celebrated our Fellows, heard excellent presentations and were able to share in a relaxed atmosphere. We have already started looking at ideas for Surgeons' Month 2019 and are aiming for bigger and better events and support. We also facilitate other events throughout the year, whether CPD related or interest related, which I would invite all of you to keep an eye out for and attend.

The NSW Committee, as with the other State, Territory and New Zealand committees, address advocacy issues that are relevant to our location and if there is something that you feel needs addressing please do not hesitate to contact any of the committees. A sense of belonging is paramount to our future as a college, we should all feel free to engage with each other, and if we can maintain this, we create a stronger bond, promoting unity and strength as we benefit surgery and health in our communities.

Dr Ken Loi
Chair, New South Wales State Committee

A case note review

No consideration for a decompressive trauma craniectomy



Summary

This patient, aged in her early 50s, was struck by a cyclist while walking and fell, striking her head. The incident occurred close to a major trauma centre and she was promptly brought to the emergency department.

While the patient had been agitated at the scene of the incident, her Glasgow Coma Scale score declined rapidly after arrival. She was intubated, ventilated, and a trauma series of scans was performed. There was significant evidence of a severe head injury: bilateral frontal subdural haematoma with adjacent subarachnoid haemorrhage and parenchymal contusions.

An intracranial pressure (ICP) monitor was inserted and the patient was taken to intensive care. Over the next few days the patient had blossoming of the cerebral contusions and ICP spikes. On day five a neurosurgical registrar made an unsuccessful attempt to insert an external ventricular drain to siphon cerebrospinal fluid.

It does not appear as though there were any attempts to insert a ventricular drain prior to the unsuccessful attempt on day five. There was also no evidence that consideration was given to decompressive trauma craniectomy once the attempt at ventricular drain insertion had failed.

Discussions were held with the neurosurgical team on day nine, with the conclusion that no further medical options were available. The patient's ICP peaked at 116 while she was being transported to imaging for a repeat computed tomography brain scan. Both pupils became fixed and dilated. Further discussions were held with the family regarding the patient's poor prognosis, and comfort measures were implemented with physiologic support. One-way extubation was undertaken the following day and the patient passed away.

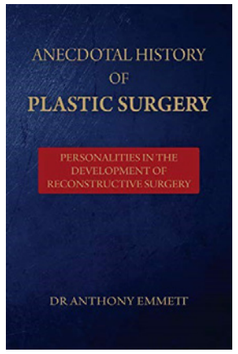
Comments

It does not appear that consideration was given to early insertion of a ventricular drain, yet insertion of the drain within the first few hours of admission may have benefitted the patient. It is of concern that there was only one attempt by a neurosurgical registrar to insert a ventricular drain, and that this was quite delayed, taking place several days after admission. Of further concern is that a decompressive craniectomy was not performed after the failure to insert the ventricular drain. Decompressive trauma craniectomy would likely have facilitated control of the ICP. There was no mention or discussion of the procedure in the patient's history, and so the presumption is that it was not considered a surgical option. This raises the concern that had a ventricular drain been inserted earlier, the ICP may have been monitored and successfully treated.

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

Donations to the library collection

Anecdotal History of Plastic Surgery: Personalities in the Development of Reconstructive Surgery by Dr Anthony Emmett FRACS



The development of plastic surgery owes much to the need of repair from warfare and in particular the wars of Napoleon with the Battle of Leipzig in 1813, the American Civil War of 1861-5, World War I of 1914-9, the Spanish Civil War and World War II of 1939-45. These suddenly produced large numbers and types of injury to healthy young men desperately in need of repair. Each of these times produced a response in terms of surgeons and techniques developed and used.

The author finds connection to the surgeons developing repair techniques in ancient times, and he has attempted to link stories of some of the interesting people who have given their lives to the science and art of plastic and reconstructive surgery of living humans now and through the ages.

Development of social records requires that these stories through time are developed and leave their mark on our civilisation in one form or another. If wars are a dark part of the picture of life then the surgery of repair is a lighter part.

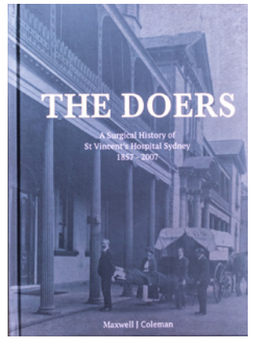
As well as focussing on individuals, countries and places, there is a chapter introducing plastic surgery and another which looks at its wider developments such as those in the areas of surgical instruments, skin grafts breast implants and sex changes.

Donated by the author.

The Doers: a Surgical History of St Vincent's Hospital Sydney 1857 – 2007 by Maxwell J Coleman, FRACS

From the forword of the book (written by Moira O'Sullivan RSC, PhD – Sisters of Charity Historian):

For anyone who has lived through the decades of progress, the changes seem close to miraculous. Women stayed in bed days, even weeks after childbirth. Sometimes having a cataract operation forty years ago risked blindness unless immobilised afterwards.



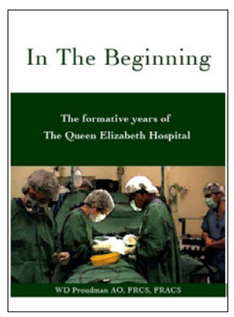
Yet today these procedures and many more are taken for granted, the consequences of thinkers and doers who asked questions, sought answers, researched, then risked trying something new. The author acknowledges that not every surgeon was adventurous. Those who were almost always faced opposition from the cautious or the frugal. Some who succeeded were praised in the media and given honours.

Some who assisted were often just as skilled and necessary, but often unsung. All deserve gratitude for their quest for excellence. It is a great gift to have their stories recorded for us.

A list of books authored by St Vincent's Hospital surgeons is included at the back as well as many photos and biographies and an extensive list of references.

Donated by the author.

In the Beginning: the formative years of the Queen Elizabeth Hospital by W.D. Proudman, FRACS

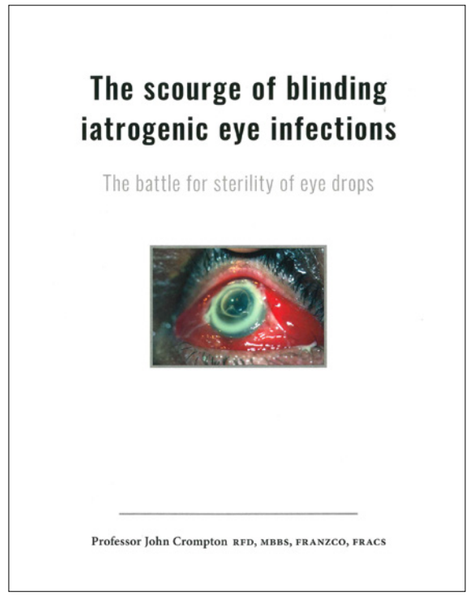


From the book's forword by Ross Johnson FRACS:

In the Beginning is a long overdue record of the formative years of the Queen Elizabeth Hospital in Adelaide. The person most equipped to document what many would describe as the halcyon days of the hospital is undoubtedly Bill Proudman.

The book is refreshingly honest in its approach and records an era remembered by a diminishing band of close friends. Of particular importance is Bill's detailed description of the first successful live donor renal transplant procedure performed in Australia.

Donated by the author.



The Scourge of Blinding Latrogenic Eye Infections: the Battle for Sterility of Eye Drops by Professor John Crompton, FRACS

From the book's preface:

While this book is the biography of David Crompton, it deals with safety in eye surgery particularly in the most common operation: the removal of cataracts. It covers what a cataract is, development of cataract surgery and anaesthesia, post-operative infection and prevention thereof up until the mid – 1950s. It then shows how Crompton became interested in asepsis following disastrous preventable visual loss at the Royal Adelaide Hospital. This led to collaborative laboratory research leading to ways of producing safe, sterile and effective eye medications (eye drops and ointments).

The book follows David Compton's family upbringing, his army experiences at the Royal Adelaide Hospital and dealings with bureaucracy, links to his tenacious battles and ultimate victory for the common good.

Donated by the author.

Thank you

A sincere thank you to the 1,961 Fellows who completed RACS' 2018 Workforce Census. The census provides support for RACS workforce advocacy across Australia and New Zealand. Including, detailed information on the issues surgeons face.

While the current census data is being analysed, we invite you to review previous reports as well as RACS annual activities report from: https://www.surgeons.org/government/workforce-and-activities-reports/

RACS Post Op podcasts

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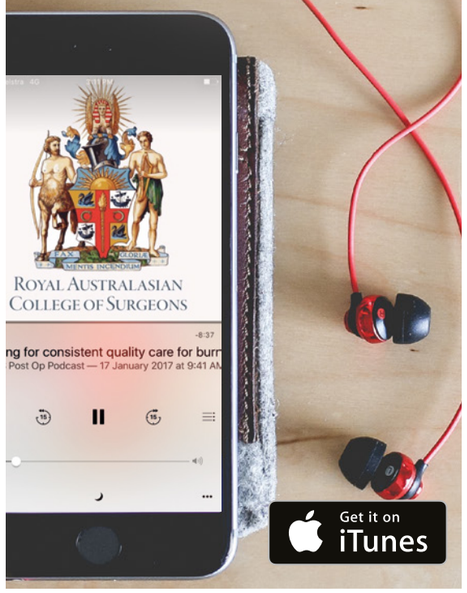

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IN MEMORIAM

Our condolences to the family, friends and colleagues of the following Fellows whose death has been notified over the past month:

Michael Moreny (QLD)
Terence Farrell (QLD)
Peter Alfred Staer (WA)
Donald Marshall (VIC)
Geoffrey Chiam (Singapore)
Paul Kierce (VIC)
Barry Bracken (NSW)
Neil Bright (NSW)
Thomas Parker Davis (NSW)
John Payne (NSW)
Thomas Connelley (NSW)
Colin Lomas (QLD)

Informing RACS

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

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In memoriam

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

Brendan John Dooley FRACS
Orthopaedic Surgeon
1929 - 2018

Brendan Dooley was one of four boys, all born at home to James and Catherine Dooley. Two of his brothers became dentists, while the oldest, Desmond, became a specialist obstetrician gynaecologist in Brisbane. Following in his brother's footsteps, Brendan Dooley graduated from the University of Melbourne St. Vincent's Hospital medical school in 1952.

Right from the start he showed himself to be the best, not necessarily of his fellows, but certainly the best that he could be of himself. Brendan Dooley excelled at almost all that he did claiming, on graduation, first class honours in Surgery and receiving the Ryan Prize and Beaney Scholarship on his way to overall second in his final examinations.

Full obituary can be read at https://www.surgeons.org/member-services/in-memoriam/brendan-dooley/

Geoffrey Chiam FRACS
General Surgeon
1931 - 2018

Dr Geoffrey Chiam graduated from Melbourne Universty in 1958, and was listed as one of the top 20 medical gratuates in Victoria at the time.

Geoffrey studied and worked in Melbourne for more than 17 years. He completed his internship at Prince Henry's Hospital in Melbourne and studied surgery at the Royal Melbourne Hospital - he was mentored by "Weary" Dunlop and Sir E. S. R. Hughes.

Full obituary can be read at https://www.surgeons.org/member-services/in-memoriam/geoffrey-chiam/

Thomas J. Connelley FRACS
Neurosurgeon
1926 - 2018

Assistant Neurosurgeon, St Vincent's Hospital, 1963 -1971 Neurosurgeon, St Vincent's Hospital, 1971 -1992.

Thomas Connelley was born on 15 April 1926 and educated at St Ignatius' College, Riverview, in Sydney. He enrolled in the Faculty of Medicine of the University of Sydney, graduating Bachelor of Medicine and Bachelor of Surgery in 1951. His father had also been a medical graduate of the University of Sydney.

Full obituary can be read at https://www.surgeons.org/member-services/in-memoriam/thomas-connelley/

Donald Marshall FRACS
Plastic and Reconstructive Surgeon
1934 - 2018

A passing comment, A mind quiet superb, With a generous personality, Dedicated to his craft, Tireless in his art, Academically inclined, While clinically refined, Conveying his talent, For the benefit of mankind

ave atque vale

- Felix Behan

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