SurgicalNews

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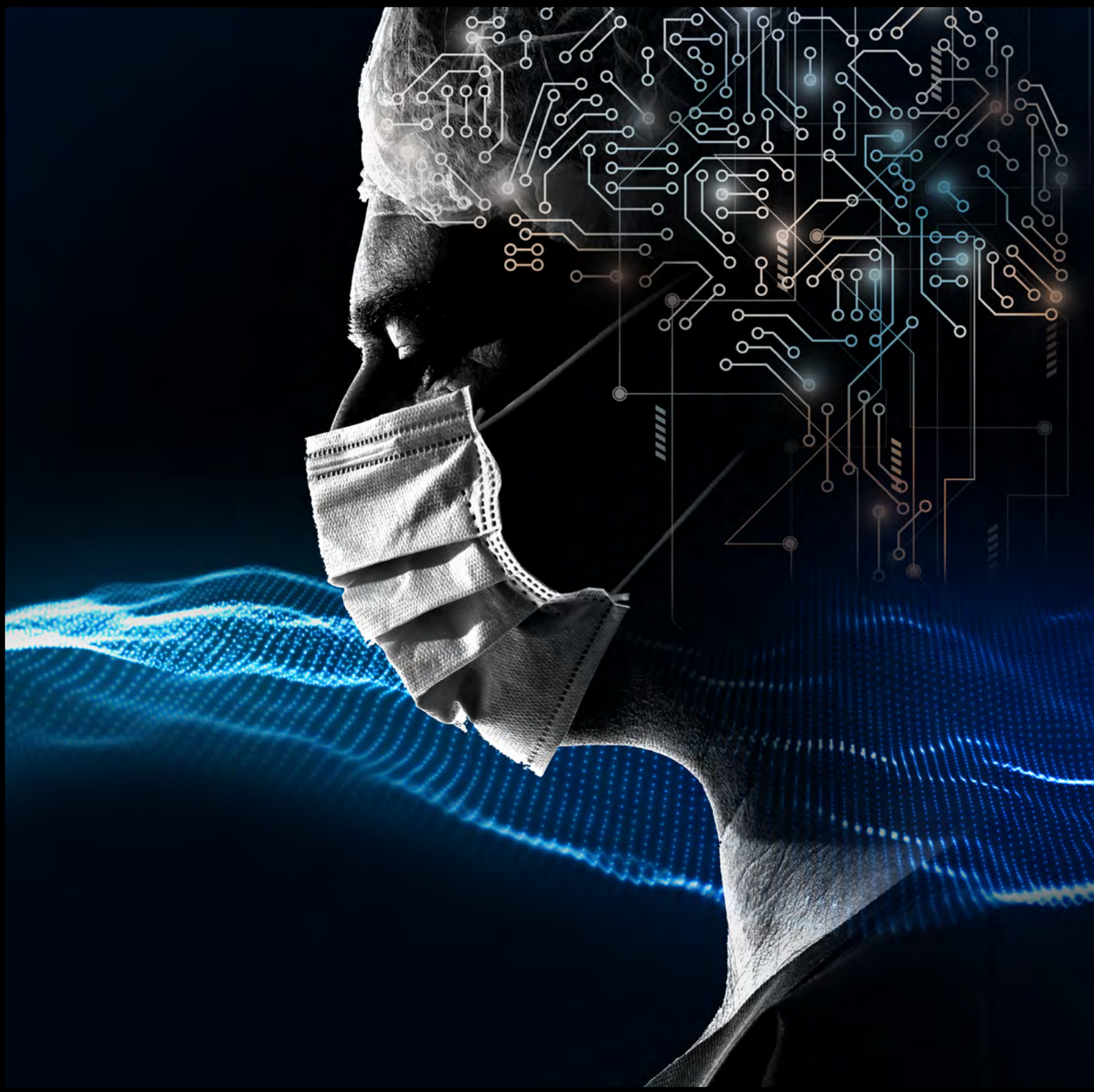

Spotlight on | Page 8
Research and innovation

Page 24
Two tragedies | burn surgeons pushed to the limit

Royal Australasian College of Surgeons

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RACS leadership

President's perspective 04
Modernising our College governance 06

Spotlight on

Research & innovation

08
Research and innovation

10
Why we should welcome artificial intelligence in surgery

13
RACS Research and Evaluation

14
A 'world-first' for 2019 John Mitchell Crouch recipient

Cover image
Illustration by Ness Flett

Articles of interest

Two tragedies push burn surgeons to the limit 24
General Surgery in Australia and New Zealand 28
Smoke 30
The first residential course for Younger Fellows, 1982 36
Exploring our College's rich history online 38
An Interplast experience 54
Meet RACSTA'S new executive 59

Research

Research on show at the November Annual Academic Surgery Conference 2019 23
Case note review 45

Scholarships

Decision-making in pelvic exenteration surgery 44
Research, education and travel scholarship and grant opportunities 72

Education

Disruptive innovation? 18
Skills training courses 2020 52
Get to know the Educator of Merit 2019 awardees 58
RACS 2020 Annual Scientific Congress 62

Global Health

1000 lives 51

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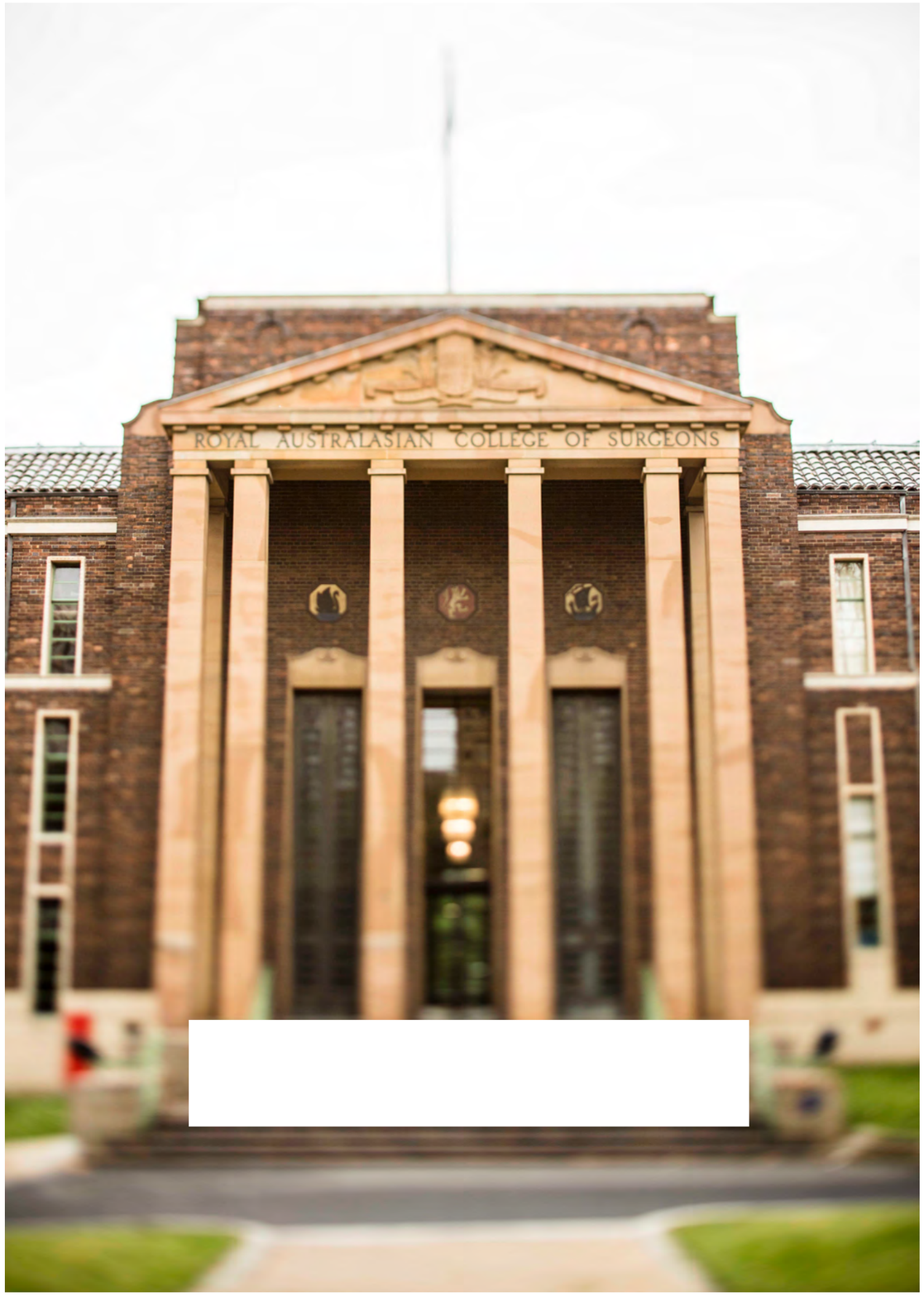


President's perspective

We started the year on a sombre note following the volcanic eruption at Whakaari/White Island in New Zealand, and fires raging in many parts of Australia. We were deeply saddened by news of the deaths and the challenges facing both those with long recoveries ahead, and those who have lost loved ones.

These tragedies also highlighted how communities came together to support each other. I was proud to see the surgical community contributing to this effort by caring selflessly for the many injured in New Zealand and Australia. In both countries, the burn surgeons in particular have been under enormous pressure.

The Australian and New Zealand Burn Association must be congratulated on their Emergency Management of Severe Burns Course they have been providing not only in our countries, but many others for years. The delivery of this course has led to a common standard and understanding that has been invaluable during these crises.

This year brings other challenges and conversely, opportunities. One area of concern is the ongoing, incorrect and inappropriate use of the title 'surgeon' by non-surgeons. We see many doctors calling themselves plastic surgeons when, in fact, they don't have the proper specialist qualifications and accreditation. Unfortunately, this has led to the media trusting and inviting 'cosmetic' and 'dermatology' doctors to comment on invasive surgical procedures. This creates public confusion and compromises patient safety.

It is important to note that the title 'cosmetic' surgeon is not recognised as an accredited surgical specialty according to the national statutory body, the Australian Health Practitioners Regulation Agency (AHPRA).

We will continue to advocate for the mandatory use of titles that are consistent with a medical practitioner's AHPRA category of registration, as well as call for increased regulation at a state, territory and national level, to ensure safe cosmetic surgery practice.

We have also been working with our specialty societies – the Australian Society of Plastic Surgeons, the New Zealand Association of Plastic Surgeons and the Australasian Society of Aesthetic Plastic Surgeons – to call for increased regulation at a state, territory and national level, to ensure safe cosmetic surgery practice. We are pleased by the progress governments have made to tighten legislation around the types of facilities where these procedures can be performed, and we acknowledge the recent COAG communique flagging changes to the National Law. We look forward to working with governments and regulators to ensure that we keep patient safety at the forefront of all these issues.

As we manage these challenges, we are also embracing opportunities that help progress the College. In January I wrote to our Fellows, trainees and international medical graduates advising that we are updating our brand. This followed a review of the RACS brand in early 2018 which many thought was dated and required a new, modern approach. Council approved an updated brand for our College in 2019 with a new logo for both RACS and FRACS. The logo designs are practical and replicate well across digital and print communication. This change was communicated to Fellows through various channels including *Council Highlights* (June and October 2019), *Surgical News* and more recently, a message from the President.

Our coat of arms will continue to be used in formal and ceremonial circumstances, paying homage to tradition and heritage as the occasion demands.

The RACS and FRACS logos are now the dominant brands to ensure that we present ourselves as one College and build a stronger identity. We have also integrated the RACS Indigenous and Māori motifs into the overall brand. We will soon advise Fellows on how to access and use the new FRACS logo.

Another opportunity we need to support and grow is our research work through the Research and Evaluation incorporating ASERNIP-S team. They provide unbiased reviews of the clinical evidence of surgical, medical and diagnostic technologies, and our reports inform the decision-making processes about public funding of healthcare. The team also assesses technologies used in medical conditions that are uncommon. This is particularly useful in scenarios where published clinical studies are lacking.

I encourage Fellows, trainees and international medical graduates to learn more about our peer review platform – the Australian and New Zealand Audit of Surgical Mortality (ANZASM). We have been using this database to inform, educate, facilitate change and improve the quality of surgical care and patient outcomes. We use it to provide feedback to individual surgeons, and to hospitals, so they can address any issues and improve patient care. This resource is available not only to Fellows but also to trainees and students who can produce valuable research directed at improvements in surgical care.

I look forward to working with you all in 2020. ■

Mr Tony Sparnon
President

Modernising our College governance

In June 2019, RACS Council established a Governance Committee, chaired by the Vice President, to engage in a comprehensive governance review with the goal of making the College contemporary, responsive and relevant to every Fellow, trainee and international medical graduate (IMG).

The concept of governance has evolved over the past decade. Your Council is charged with governance of the College, which in the past, meant 'the Council runs the College'. While many Fellows may still hold that perception, the reality of modern governance is very different.

When it was established, RACS elected a Council of Fellows to manage the College. As now, their contribution was pro bono. Unlike now, they did everything. The censor in chief 'censored' applications for Fellowship (there was no examination) and the College secretary was responsible for recording and communication.

As the College grew, the Council employed staff and the secretariat model of RACS management emerged. Secretarial staff were managed by the College secretary. The first CEO was appointed in 1997 when the first paid non-Fellow was appointed to the role. Over the next two decades, following a contemporary model of corporate governance, Council's role evolved from management to governance, with a chief executive officer replacing the College secretary role.

With this model, Council is elected by the Fellowship to govern the College – setting the strategy and holding the CEO accountable to deliver on that strategy. The CEO, employed by Council and reporting via the President, is responsible for the resourcing and infrastructure required to deliver the Council's strategy and expectations. Staff are therefore accountable not to Fellows nor Councillors but to the CEO. Maintaining this separation of governance and management roles encourages efficiency of purpose and minimises crossed communication or conflicting instructions.

However, this model has not transitioned optimally throughout RACS. Currently, committees report through what is often a cumbersome governance line to Council while staff report through a parallel management channel. The consequences can be frustrating, with mixed messages and priorities, and confusion around accountability and responsibility. At times, well-intentioned passions fail to find their mark or achieve a desired outcome.

Much of the work of Fellows for RACS is largely operational in nature – specialty training boards, skills education, scholarships, surgical audit and CPD committees are primarily operational, albeit significantly and importantly run by Fellows. Operational matters are the domain of management, not of governance. It is not expected (or desirable) that members accepting roles on RACS committees spend valuable time micromanaging committee tasks that should sit within the management structure. Importantly, staff must comply with RACS policies and procedures, which mitigate risk and ensure accountability.

These are just some of the compelling reasons to review and re-set RACS governance structures.

Late last year the Governance Committee began its review, including the role of Council and our approximately 130 committees. Some solutions were initiated quickly, including: the appointment of a company secretary (reporting directly to Council); elevation of the Indigenous Health Committee to report to Council, and the Annual Scientific Congress Planning and Review Committee to report to the Professional Development and Standards Board; expanding and clarifying Global Health governance and operations; and reviewing Council regulations.

Our objectives are to encourage broader membership engagement and to ensure that the time given so generously by Fellows is used efficiently and effectively. Current work focuses on committees of Council – understanding which committees have a clear governance role and report directly to Council, and which committees have an advisory or operational function in partnership with management. Many committees feel they are so far down the reporting chain that their views never reach Council, in part because of the long interval between committee meetings. If views and contentious issues were processed through management, key issues could be on an appropriate agenda far more swiftly.

Full implementation of this model will require a culture change. The expectation of some Fellows that RACS staff are subordinates in a hierarchical model needs to shift to a level team environment where Fellows, trainees, IMGs and staff interact on an equal and respectful basis, each valuing the expertise brought by others.

The Governance Committee is also reviewing the composition of Council and mechanisms to improve the interface between Council and the membership. The increasing diversity of specialisation, location and type of practice, has created independent groups who need a voice in the College. Currently Council has 28 members: nine elected by their specialty, two appointed as non-fellow independent directors, and the remainder elected by the Fellowship with co-option to ensure every region has a representative. Council has a fiduciary responsibility and the concept of a Councillor 'representing' another entity such as a specialty society brings potential for conflict with their fiduciary obligation to RACS.

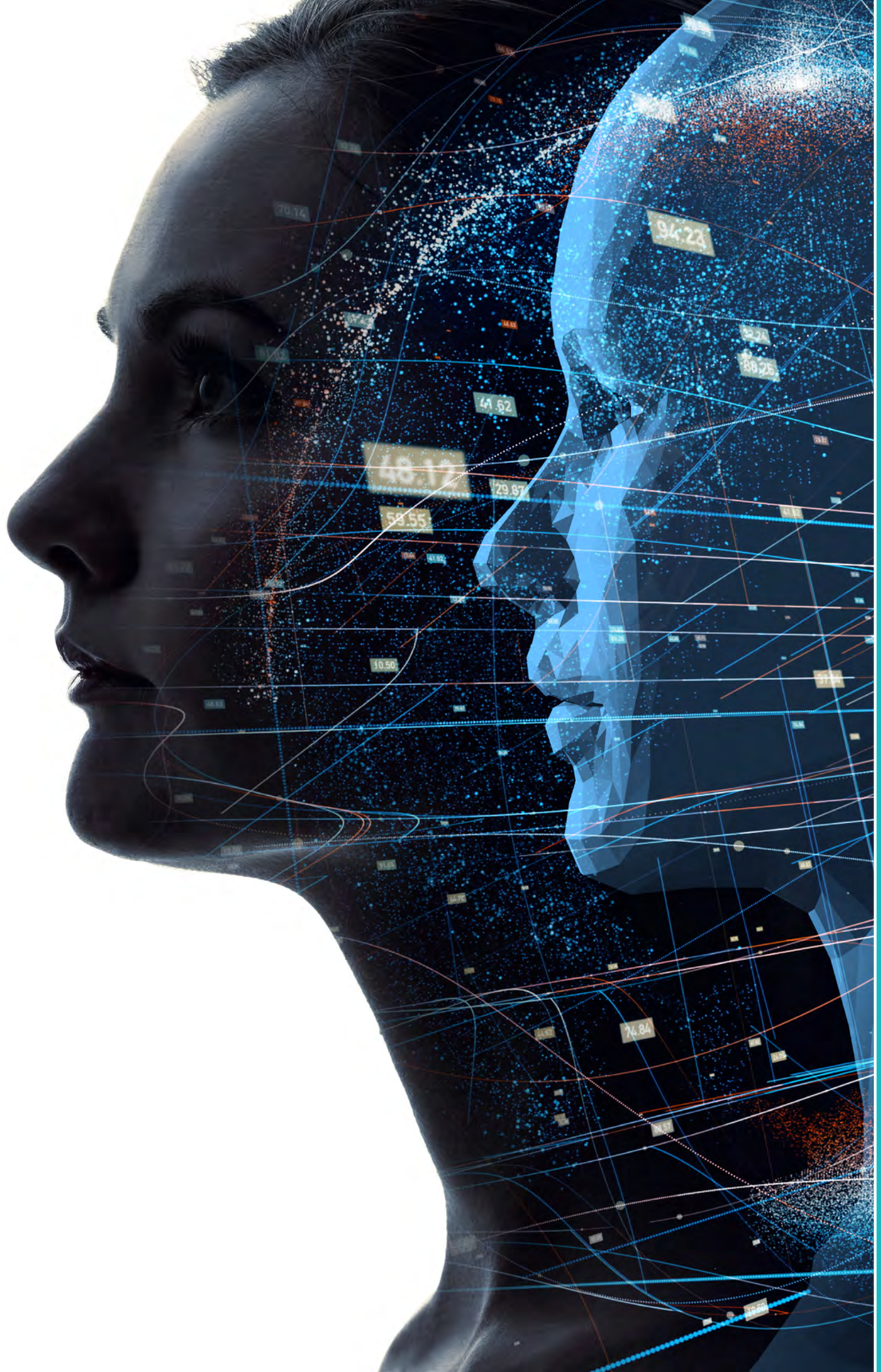
The review also seeks to identify better ways for the collective views of our profession to be gathered and heard. Among the options being considered for advisory or focus-group oriented committees is replacing them, where appropriate, with forums intent on solution-finding and outcomes. Fellows, staff and invited external experts could contribute on a level field. The first initiative of this type will be the back-to-back Binational Forum and the States and Territories of Australia Forum, to commence in May 2020. An Advocacy Forum, in partnership with specialty societies, is also planned for this year.

Once the framework for improved interaction between RACS and its various constituent interests evolves to a point where it achieves acceptance, a strong case can be made for reducing the size of Council and working towards a skills-based rather than a representation-based Council. A smaller, skilled Council would be agile, strategically focused, and willing to seek out and work with the considerable specialised clinical and other knowledge experts that reside among the Fellowship.

The RACS constitution is prescriptive about how the College should be governed, with little changing since it was written in 1928. Governance changes cannot and should not take place overnight. They must be robust and can only emerge after extensive consultation and deliberation. It is likely that Council will recommend some constitutional changes to ensure that our governance is fit for the legislative environment of our time and to ensure that RACS remains a leader into the future.

Our goal is to make RACS more relevant to every Fellow, trainee and IMG. Through consultation and collaboration, and with your broad support, we can refresh governance and management structures to ensure our College carries us strongly into the next decade and beyond. ■

Mr Richard Perry
Vice President



Spotlight on

Research and innovation

Why we should welcome AI in surgery 10
Ground-breaking neuroscience research 14
Virtual reality innovation 18
ANZASM: a living source of research 19

The principal aims of research at RACS are to inform, educate, facilitate change and improve the quality of practice within surgery. The way in which surgical education and training is delivered and assessed is being revamped worldwide, with emerging technologies poised to play a noticeable role.

RACS surgeons are leading and collaborating to bring new discoveries into the operating theatre, and allow the general public to benefit from research innovations.

From virtual reality and artificial intelligence, to Academic Surgery and ASERNIP-S, this issue highlights the breadth of work undertaken by by RACS and surgeons. Thank you to committee members and other Fellows who have contributed their fascinating research highlights to this issue.

"AI is inevitable.We have to prepare for it and be proactive, rather than react to what commercial organisations are doing."

Associate Professor Narinder Singh, FRACS

"It is an undisputed fact that clinical research and surgical audits are the foundations for advancements in improved patient care. Through the work RAAS does, we are proud to be able to support our Fellows in many facets of their practice that contribute to better patient outcomes."

Associate Professor Wendy Babidge, General Manager Research, Audit and Academic Surgery (RAAS)

"Everyone should be interested in research because it's the only way that we can really progress."

Dr Tamsin Garrod, RACS Education – Head of Research and Innovation

"AI will support more objective and reliable decision-making, reducing the limitations of human error and subjectivity related to a single specialist or team."

Professor Antonio Di Ieva, FRACS

Why we should welcome artificial intelligence in surgery

Associate Professor Narinder Singh explains how artificial intelligence is transforming medicine, surgical practice and healthcare – and why it should be welcomed.

Artificial intelligence (AI) has been around since the 1950s. Its beginnings can be traced back to a program called 'Logic Theorist' that was funded by the RAND Corporation and presented at a conference in 1956. Since then AI has been on a long and volatile road, including two long periods, known as the 'AI winters' when research and funding dried up. But all that is changing.

Narinder Singh is a Clinical Associate Professor of Surgery at The University of Sydney, and Head of the ENT Department at Sydney's Westmead Hospital. His interest in technology began when he taught himself to write machine code software on his first computer, a Commodore Vic-20, when growing up on his parents' farm in Griffith, country NSW. After studying medicine, he returned to his technology roots and was convener for the first Australian congress of the Society for Artificial Intelligence in Medicine, Surgery and Healthcare (amsah.org).

For the first time in the history of AI, "A triad of critical elements have converged," Associate Professor Singh said. "Because of these changes AI will take off and won't stop." He believes it will be game-changing, particularly for healthcare, and he's been monitoring important trends that are signalling this explosive change. "Patent applications related to AI in healthcare have more than doubled in the last four years," he said.

"The number one emerging role in healthcare is now software engineering," and "between 2018 and 2022 the biggest emerging roles in health will be data analysts and scientists".

There are more indications, of course, but these factors reveal that AI is here and its effects on medicine, surgery and healthcare are going to be monumental.

The first element of Associate Professor Singh's triad is that computers have become significantly more powerful and a lot cheaper. The second is that there's been an explosion in the amount of easily accessible healthcare data, particularly online and in the cloud, and third – AI algorithms have become vastly more accurate and effective, especially with the invention of 'deep learning' neural networks.

"AI in healthcare will automate a lot of tasks that are repetitive and that people don't like doing – and it will improve efficiency and productivity," Associate Professor Singh said. To make use of AI, the end users won't need to understand how it's working. "In the same way you drive a car, by turning on the ignition and putting your foot on the accelerator, you don't need to know how the transmission works," he said. "A well-designed tool needn't expose its inner workings to the end user."

Example: Ear disease in Indigenous Australian children (DrumBeat.ai)

Associate Professor Singh's research group is currently working on a major project using AI to accurately diagnose ear disease in Aboriginal and Torres Strait Islander children. Indigenous children in Australia have the highest rate of ear disease in the world. The World Health Organization (WHO) has identified it as a 'public health crisis' – a term WHO usually reserves for crises in developing countries.

It's difficult to get ENT surgeons out to rural and remote communities, and the community centres are staffed by nurses and community workers who are not as well trained to diagnose complex ear disease. Associate Professor Singh's research group is working with the Top End Health Service, Queensland Health Service, Aboriginal communities, the Digital Health CRC and Microsoft to develop an AI solution.

"We have a database of over 15,000 labelled images of Indigenous kids' ears, taken with a digital otoscope, and we're incorporating that into an AI algorithm," Associate Professor Singh said. "Eventually, we'll create a smartphone app so the untrained health worker out in the community can put an otoscope into the child's ear and get an instant and accurate diagnosis." This can be used to triage the appropriate medical treatment straight away, he said. "They might say: 'This child needs to go immediately to a specialist, or this child can have antibiotics and come back in a week, or this one, actually, is fine and can come back in a few month's time' – it's an immediate point-of-care tool." This approach is more efficient and faster than telehealth and it also means the ENT surgeon isn't looking through hundreds of pictures of normal ears.

Example: Automated reporting of CT scans

For sinus surgery, ENT surgeons like to have a standardised report that informs them about certain characteristics of the scan, Associate Professor Singh said. For example, they like to know whether the anterior ethmoid artery is protected in the skull base or exposed where it can be damaged during sinus surgery. Associate Professor Singh's research group designed an algorithm that can look at a scan and identify exactly where the artery is and include that in the report automatically. "We're applying the process to each individual step of the CT report, so there's a complete algorithm that can provide a comprehensive safety report," he said. By using AI, in this instance, "it frees up radiologists to look for tumours or more complex pathology".

A few years ago, there was significant concern expressed by radiologists and radiology trainees about the impact of AI on their employment prospects, Associate Professor Singh said. "What we've found over the last couple of years is that, as it's become more transparent, people have started to understand what the role of AI will be in radiology." It's turned out to be the exact opposite of what people had anticipated, he added. "AI has now led to an increased interest among trainees in doing radiology." AI will take over the more boring, repetitive tasks, and "give radiologists more time to interact with patients and look for interesting pathology", Associate Professor Singh said, noting that this was counterintuitive to what the profession had anticipated only a few years ago.

Surprisingly, a branch of AI, known as natural language processing, can go through medical records and extract data automatically. For example, it can identify all the patients who have a particular type of cancer and what stage it is, and it can select patients with diabetes and provide information on their diabetic control level. "AI can do all these things," Associate Professor Singh said. "It can also make predictions from medical records." By analysing medical records, it can predict the likelihood of a "patient re-presenting after discharge, with a high level of accuracy". The key factor for training AI algorithms, he said, is very good quality, large volumes of data. "So, data sets with 5,000 to 10,000 data points are typically what we're looking for, with the more data that can be fed into the AI algorithm, the more accurate its prediction."

Hospitals currently make use of AI in both administrative and life-saving ways. In ICU, for example, huge amounts of data are generated from the patient-monitoring equipment.

These AI tools are already in clinical use in ICUs around the world, Associate Professor Singh said. The AI algorithms read all the data – heart rate, blood pressure, temperature and lab results – and "from that they can accurately predict when a patient is going to go into septic shock around 12 hours before an experienced ICU specialist could detect it," he said. This means "you can actually intervene and save lives."

"AI is inevitable. We have to prepare for it and be proactive, rather than react to what commercial organisations are doing."

The problem we have right now with AI is fear, Associate Professor Singh added. "People are afraid they'll lose their jobs or that machines will take over the world like a dystopian Terminator scenario," but he is steadfast in his belief that these fears can be overcome. "The keywords are 'fear' and 'trust'," he explained. "If people understand AI – understand what we're doing – and there are established policies that deal with privacy, ethics, governance, transparency and how to handle data, then we'll establish trust and once there's trust, fear will be overcome." ■

Exploring disruptive technologies

Highlights from Research, Audit and Academic Surgery (RAAS)

The Research, Audit and Academic Surgery (RAAS) group of RACS, led by General Manager, Associate Professor Wendy Babidge, comprises of the Section of Academic Surgery (SAS) – Dr Lorwai Tan, Manager Academic Surgery; Australian Safety and Efficacy Register of New Interventional Procedures-Surgical (ASERNIP-S) – Dr David Tivey, Manager ASERNIP-S; and Surgical Audits Unit, led by Dr Helena Kopunic – Surgical Audit Manager, which oversees the Australian and New Zealand Audit of Surgical Mortality (ANZASM), Australian and New Zealand Emergency Laparotomy Audit (ANZELA-QI), Morbidity Audit Logbook Tool (MALT) and BreastSurg ANZ Quality Audit (BQA).

The RAAS teams are exploring cutting edge, disruptive technologies such as artificial intelligence, machine learning and Blockchain technology for their application in surgery. Other important work focuses on maintaining and improving surgical standards through extensive data collections, the audits of surgical mortality and the ANZELA-QI – these represent a considerable research resource for Fellows and trainees.

Trainee-led research is being conducted through the Clinical Trials Network Australia New Zealand (CTANZ), a RACS endorsed New Key Initiative, that is having a positive impact on patient outcomes and provides research opportunities for our trainees.

Academic Surgery supports Fellows who serve on committees and working parties, which promote and support surgeons passionate about research. The Clinical Academic Pathways working party is actively seeking avenues to support clinicians who want to establish a parallel research career. Through ASERNIP-S, a long-standing evidence-based program of RACS, surgeons and their patients benefit from Health Technology Assessment work which results in access to government funding of services through the Medical Benefits Schedule. Increasingly, real-world data is being used to produce real-world evidence for assessment of techniques and technologies; this provides meaningful data in a local context for evaluation. We appreciate our Fellows, Professor Andrew Hill, Dr John Crozier, Professor Ian Bennett, Professor Mark Smithers and Professor Guy Maddern, whose guidance have been instrumental in seeing RAAS grow from strength to strength. ■

Associate Professor Wendy Babidge, General Manager Research, Audit and Academic Surgery (RAAS)

RACS Research and Evaluation

Funding and partnerships success in 2019

RACS Research and Evaluation department includes the Health Technology Assessment unit, ASERNIP-S. The unit operates through external contracts with national and international departments of health, and other state governments or not-for-profit agencies.

ASERNIP-S provides unbiased reviews of the clinical evidence of surgical, medical and diagnostic technologies, and our reports inform the decision-making processes about public funding of healthcare.

Last year, ASERNIP-S attracted more clients and work; the establishment of a Health Economics Unit also contributed to another strong performance.

Also in 2019, ASERNIP-S staff developed new approaches to assess technologies when used in medical conditions that are uncommon. Our approach allows timely and fair assessment of technologies when published clinical studies are lacking. This work is in close collaboration with the Australian Government Department of Health and places RACS at the forefront of health technology assessment methodology.

Another major development is our partnerships with the University of Adelaide, South Australian Health and Medical Research Institute, and Curtin University that resulted in two successful applications to the Medical Research Futures Fund (MRFF).

These projects will use registry data (real world data) to test imaging technologies for surgical planning for breast cancer; and avoidance of unnecessary emergency department visits for residents of aged facilities following falls, suspected respiratory disease or abdominal obstruction. These MRFF topics were nominated by the Medical Services Advisory Committee (MSAC), with the latter based on work ASERNIP-S conducted for MSAC.

The ASERNIP-S team is looking forward to building on our professional and financial success in 2019 to grow our funded work in 2020. Further, the team is excited to be working with RACS colleagues on projects such as our collaboration with Dr Tamsin Garrod (Education) on a Specialist Training Program funded project to support clinical studies in a rural or remote area for surgical trainees. ■

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

A ‘world-first’ for 2019 John Mitchell Crouch recipient

Professor Antonio Di Ieva talks to *Surgical News* about his ground-breaking neuroscience research that is set to improve the diagnostic accuracy of brain disease.

The 2019 recipient of the John Mitchell Crouch (JMC) Fellowship, Professor Antonio Di Ieva, has put Australia at the forefront of medical research by establishing the world’s first computational neurosurgery laboratory at Macquarie Health.

Professor Di Ieva is a leading academic neurosurgeon and a clinical and computational neuroscientist. He is also a Professor of Neurosurgery in Italy, an Associate Professor of Neuroanatomy in Vienna, and has completed surgical Fellowships in both Canada and Australia. A world leader in neuro-oncology research, he has published more than 100 peer-reviewed papers and articles and three medical textbooks, including *The Handbook of Skull Base Surgery* and *The Fractal Geometry of the Brain*.

Currently, Professor Di Ieva operates at Macquarie University Hospital in Sydney, and consults at Macquarie Neurosurgery. He is head of the Computational NeuroSurgery Laboratory (CNS Lab), which he established last year with funds from the JMC Fellowship.

In 2018, Professor Di Ieva was a co-investigator of a successful National Health and Medical Research Council grant proposal on the application of computational modelling for the study of brain aneurysms and, in October 2019, he was awarded a $1,015,000 Australian Research Council (ARC) Future Fellowship. The prestigious ARC Fellowship will enable Professor Di Ieva to create computer technology that will have applications for several translational applications and health imaging, including brain tumour detection and classification.

While the CNS Lab aims to explore different aspects of computation and neurosurgery, Professor Di Ieva said the 2019 JMC Fellowship year was “dedicated to the use of artificial intelligence (AI) to characterise ‘fingerprints’ of brain tumours”. Fingerprints, in this context, refer to the specific architecture of the brain in its entire physiopathological spectrum – from normal to diseased. Professor Di Ieva’s aim was to successfully characterise brain tumour fingerprints to develop automated diagnosis in neuroimaging and neuropathology.

The working hypothesis for the first year of the CNS Lab was that “Computational modelling of brain tumour MR images can be used to develop AI algorithms aimed to help clinicians and surgeons in differential diagnosis and decision-making; therefore, reducing errors in judgement with the final goal of improving patients’ treatment and outcome.”

In order to investigate this hypothesis, different MRI sequences were collected from patients with brain tumours and then analysed using computational techniques to extract their features and identify their patterns. Professor Di Ieva’s expertise in computer-aided morphometric analysis of patterns in brain tumours was instrumental in this task. “We showed that it worked very well,” he said. “We’re submitting multiple papers to journals in which we’re showing that computer algorithms can recognise a normal brain from a brain that’s pathological. It can do an automatic extraction of the features of the tumour, and tell you what type of tumour and even the potential patient’s prognosis – and all this information can be brought to the multidisciplinary team (MDT).”

This research has implications for the diagnosis and treatment of brain tumours and other diseases that are heavily dependent on imaging. Diagnosis can be overwhelming for individual surgeons and MDTs when it involves examining large amounts of radiological and clinical data across several MR sequences. This is especially so when the sum of data may not be readily accessible to surgeons considering treatment plans.

Professor Di Ieva writes in *The Lancet* (16 November 2019) that MDTs can also “be limited by insufficient expertise of the single members, out-of-date knowledge on the relevant evidence-based medical literature, consolidated teams that are not open to new opinions or participants, and logistical or communication barriers.” Diagnoses can be difficult in these environments and can lead to over-treatment, such as taking an unnecessary biopsy, or under-treatment, such as diagnosing radionecrosis in a treated tumour that was, in fact, recurring.” In these cases, Professor Di Ieva said that implementing and using AI in hospitals would augment medical expertise.

The JMC Fellowship also provided funds for Professor Di Ieva to employ Dr Carlo Russo, a computer scientist who is the Research Associate at CNS Lab. Together they are capturing data on the cognitive processes of surgeons as they review imaging data and identify relevant features of images – in order to diagnose and develop treatment plans. The collected data is then transferred to a high-performance computer that has been ‘taught’ to extract features and characterise patterns of brain disease in the same way a surgeon would.

The long-term goal of Professor Di Ieva’s research is to implement the use of computerised analysis tools to assist in surgeon- and MDT-based judgement. Supporting neurosurgeons and clinicians in their diagnoses and decision-making will enable them to confirm or refute their diagnostic hypotheses with confidence. Consequently, it will provide patients with better treatment options and outcomes, Professor Di Ieva said.

In *The Lancet*, Professor Di Ieva also writes about the increasing use of AI in medicine and the underlying fear of some medical professionals that it will compete with human experts. He advocates shifting the paradigm from “human-versus-machine to human-and-machine”. Decisions made at MDT meetings of the next generation are likely to be implemented by “the machine”, he said.

> “AI will support more objective and reliable decision-making, reducing the limitations of human error and subjectivity related to a single specialist or team.”

Likewise, MDTs will also change the way they function. Professor Di Ieva said medical experts cannot be replaced but that “every expert is a human who does have limitations.” We would never ask a computer to make a decision about the best treatment, but if we combine the natural intelligence of the MDT’s members with the huge amount of data in the computer analysis tool – experts should be able to make a more informed diagnosis.

The use of AI tools to assist in the diagnosis of brain disease is especially relevant for rural and regional areas where there may be one surgeon operating. In such a setting, the surgeon could put whatever patient information they had into the computer, and a centralised assistant would provide a diagnosis and a collegial decision. “You’d get information that is helping you, not taking over,” Professor Di Ieva said. ▶

The future looks bright for Professor Di Ieva. While surgery is an important part of his life so too are neuroscience and teaching neuroanatomy. “We’re shifting the paradigm in which the surgeon is not the lonely scientist of the past – dealing with the patient in the clinic and going to the operating theatre,” he said. His research, he added, offers proof of concept that “will expand from brain tumours to other clinical applications, including computational analysis of cerebrovascular disease such as arteriovenous malformations and aneurysms, analysis of the intracranial pressure in traumatic brain injury and computerised analysis of neurophysiological data (e.g. magnetoencephalography) from neurological patients”. ■

Academic qualifications:

- Associate Professor, Macquarie University
- Professor of Neurosurgery, Italian Ministry of Education, Universities and Research
- Associate Professor of Neuroanatomy, Medical University of Vienna, Austria
- ARC (Australian Research Council) Future Fellow (2019 -2023)
- Head of the Computational NeuroSurgery (CNS) Lab, Macquarie University
- MD, summa cum laude (2002)
- European Board in Neurosurgery (2007)
- PhD in Clinical Neurosciences (2011)
- Fellow of the Royal Australasian College of Surgeons (FRACS)
- 2019 John Mitchell Crouch Fellowship, RACS
- Fellowship in Skull Base Surgery and Neuro-oncology, St. Michael’s Hospital, University of Toronto, Toronto, Canada
- Fellowship in General and Spine Surgery, Royal North Shore Hospital; North Shore Private Hospital and Sydney Adventist Hospital, Sydney
- Associate Investigator, Australian Research Council (ARC) Centre of Excellence in Cognition and its Disorders (until 2018)
- Associate Member of the Centre for Elite Performance, Expertise and Training, Macquarie University
- Board Member of the Society for Brain Mapping and Therapeutics, USA

The John Mitchell Crouch Fellowship

The John Mitchell Crouch (JMC) Fellowship is RACS most prestigious award, presented annually to an individual who is making an outstanding contribution to the advancement of surgery, or to fundamental scientific research in the field in which they are actively working.

The award was established in 1978 by Mrs Elisabeth Unsworth in honour of her son, John Mitchell Crouch.

To apply, please visit surgeons.org/scholarships

Developing a Career and Skills in Academic Surgery course – 11 May 2020

The 12th annual Developing a Career and Skills in Academic Surgery (DCAS) course, sponsored by Johnson & Johnson, will once again provide delegates with an exciting range of informative topics that promises to engage and inspire. As in previous years, the course will be held in the lead-up to the RACS Annual Scientific Congress at the Melbourne Convention and Exhibition Centre.

We are pleased to have assembled an exceptional faculty from Australia, New Zealand and the USA, who will share personal hints and tips on what it takes to start, develop and continue with a productive academic surgery career. The program begins with a session exploring the benefits of surgeons becoming involved in academic surgery and how the incorporation of a research component in one’s practice will benefit both the surgeon and their patients.

We also look forward to renewing acquaintances with our American colleagues from the Association for Academic Surgery, whose continued attendance at, and support for, our DCAS course deserves special acknowledgment.

Highlights from the program include Professor Michael Vallely from the University of Ohio addressing the hot topic of ‘First in Human Trials’. The Keynote presentation ‘Disruption and Innovation in Academic Surgery’ will be delivered by Professor Peter Choong from The University of Melbourne.

The content of the three after-lunch workshops will cater to attendees: i) new to research or academic surgery, ‘Finding My Niche/Fit and Tools of the Trade’, ii) in early career development, ‘Trainee Led Collaborative Trials’ and iii) for the more experienced, on ‘Collaboration’, with the aim to improve collaboration in the broadest sense.

The final session explores the ‘Challenges for Academic Surgery’, specifically improving diversity and inclusion, negotiating conflict and balancing between burnout and wellbeing.

Our 34 approachable and engaging faculty members encourage and welcome attendees to initiate informal discussions during breaks.

Previous attendees have frequently described the course as inspirational and transformational, and have remarked that the course seems well targeted towards them, whether they’re a medical student, prevocational doctor, trainee, research fellow or department head. Faculty regularly comment that there is nothing more satisfying than seeing attendees find benefits from the experience. For SET trainees in General Surgery, attendance at this course is acknowledged by General Surgeons Australia as equivalent to attending one compulsory trainees’ day.

We invite you to the DCAS course in Melbourne in May 2020; you will be impressed and inspired. Research is about continued improvement and progress – so come and be part of this course. ■

Please register at: tinyurl.com/DCAS2020

Authors:
Associate Professor Jonathan Karpelowsky, Co-Chair
Professor Amir Ghaferi, Co-Chair
Dr Richard Hanney, Convenor

Thinking about a career as a researcher?

Dr Tamsin Garrod, RACS Education’s Head of Research and Innovation, talks about research as a career.

Appointed Head of Research and Innovation in June 2019, Dr Tamsin Garrod is a medical researcher who has spent almost six years in research management positions at the College.

After graduating from the University of York with a Bachelor degree in biochemistry, Dr Garrod undertook a Masters in biology before completing a PhD in medical research at the University of Adelaide. Following her PhD, she completed a Master of Business Administration.

Dr Garrod is responsible for the development and evaluation of educational activities of the College. She also cultivates strong relationships with leading universities in order to enhance the capacity at RACS for surgical education research.

For more than a decade, RACS has been offering the Developing a Career and Skills in Academic Surgery course (DCAS) for clinicians who are looking to become researchers. “It’s been a very successful course,” Dr Garrod said.

“One of the best things you can do as a researcher is to go and listen to inspiring stories from others who have already been through the journey.”

DCAS is a one-day intensive course for research Fellows, trainees, medical students, early career academics and any surgeon considering publishing or presenting academic work. It includes topics such as how to get going with research, research pathways, data collection, writing abstracts, writing and submitting a manuscript, and presenting at a scientific meeting.

In 2016, Dr Garrod contributed to developing an initiative to support clinician researchers, after data from the Australian Institute of Health and Welfare (AIHW) showed that the overall percentage of clinicians who engage in research was declining in Australia. “The answer is that you need a clear pathway with defined career progression,” she said. “This is what they have in the UK, and they’ve actually reversed their declining numbers of clinician researchers.”

Universities offer a combined degree – an MBBS with a PhD – Dr Garrod said, because “evidence has shown that it has to start by early medical school to capture those people who really do have an interest in it”.

The challenge for researchers is that they have to apply for funding for themselves or the project they want to do. “It’s easier if you’re a clinical researcher because the National Health and Medical Research Council (NHMRC) has your early career fellowship, and it’s very clear how that progression happens,” Dr Garrod said. However, for clinician researchers it’s difficult because they’re generally competing for the same bucket of funds as full-time clinical researchers. “Once you become more senior and more established, it’s a lot easier to go for funding,” she added.

By contrast, the most vulnerable stage of becoming a clinician researcher is during their early career, when it can be difficult to get funding. “People tend to get a bit lost and struggle to get the funding,” Dr Garrod said. “Then they have to defer the project and the longer that goes on, the less likely they are to get the funding. It’s publish or perish.”

The College is very supportive of early career clinician researchers, and the Foundation for Surgery provides support via funding for research work. In total, almost 90 scholarships and grants valued at $2.9 million are awarded by RACS, with approximately one third of these dedicated to research projects. And each year many of those scholarship recipients produce meaningful research that breaks ground in the wider surgical community.

“Everyone should be interested in research because it’s the only way that we can really progress,” Dr Garrod said. “You don’t have to be a traditional researcher; you could be a clinician who helps recruit patients to a clinical trial – and you don’t have to spend all your time doing it. I think that everyone should feel comfortable to contribute in whichever way they wish.” ■

Disruptive innovation?

Virtual reality meets surgical education.

The rapid pace of technological development is having a marked impact on all aspects of life, with surgery being no exception.

The way in which surgical education and training is delivered and assessed is being revamped worldwide, with emerging technologies poised to play a noticeable role. Over the past decade there has been increasing interest in assessing the utility of various technological aids to surgical training. Certainly, it is not possible to cover all aspects of technological advance in a brief article, but one area of note is immersive virtual reality (VR) simulators.

It's increasingly common to see some form of high-end simulator being showcased at courses and conferences. As digital technology has advanced, surgical simulation has become more sophisticated. It now uses haptic feedback controls to simulate the feel of surgical instruments on tissue, VR to allow for immersive 360^0 environments, and a growing range of simulated scenarios with varying complexity.

One often-raised concern is the fidelity of this mode of training; is it realistic enough to transfer the learned skills to the clinical environment? The current literature shows that simulation provides a comparable technical skillset to that gained through real world operating; where it is the 'time on tools' that is the primary determinant of skill acquisition rather than the environment.

High end simulators offer many potential benefits in a controlled, reproduceable environment. The VR simulated environment can be tailored to suit the level of experience of the user. For the novice it allows the development of basic skills in a low-pressure environment, and to familiarise themselves with common procedures, creating a 'pre-trained novice'. For more experienced trainees and surgeons, VR simulation may offer an avenue to practise rare and complex procedures or learn novel techniques with steep learning curves. One randomised controlled trial demonstrated that intermediate level trainees attained higher proficiency with advanced laparoscopic procedures using VR simulation compared to the conventional operating theatre model.

A major drawback, of course, is expense. Given high-fidelity VR simulation is costly, not all training units would be readily able to implement the technology. However, given our healthcare systems are under constant pressure to improve efficiency, outcomes, and minimise risk, methods that help 'pre-train' trainees may offer some appeal.

If VR simulation is to become a ubiquitous element of surgical training in the future, there will of course be challenges with how it is integrated into current curriculums. Whether it is purely for skills training, or if it is used as a tool for trainee assessment where objective performance metrics in VR simulation are used to determine proficiency. A measured approach is needed if VR simulation is to be embraced as a part of surgical training. The risk of potentially undermining and compromising a tried and true model of surgical apprenticeship needs to be considered.

It is certainly an interesting and promising technology; one would hope that as VR simulation continues to mature it will become an accepted tool that complements and enhances surgical training. ■

Dr Herv Vidakovic
RACSTA Representative
(New Zealand
Orthopaedic Surgery)

A living source of research

The ANZASM program – informing, educating and facilitating change.

The Australian and New Zealand Audit of Surgical Mortality (ANZASM) is a prospective database and peer review platform. Its principal objectives are informing, educating, facilitating change and improving the quality of surgical care and patient outcomes.

National collection began in 2010, however some states began their collection earlier.

As a part of the audit process, ANZASM assessors determine whether there was an aspect of the patient's management that could have been better. A surgical case form (SCF) is completed by the surgeon, including diagnosis, comorbidities and management, as well as any areas of consideration, concern or adverse events. SCFs are sent to an assigned peer reviewer for first line assessment, and from the information provided, the reviewer independently flags any areas of consideration, concern or adverse events, and considers if a more robust review is required – if so, a new assessor is assigned to peer review the SCF with case notes. The assessments are fed back to the reporting surgeon, while a number of other publications are produced on de-identified and aggregated data (state and territory annual reports, hospital reports and case note review booklets).

A comprehensive dataset is collected on the risk profile of patients e.g. age, co-morbidities and ASA status; risk management strategies i.e. DVT prophylaxis, use of critical care facilities and fluid balance; cause of death; decision to operate; operative intervention (elective/emergency and timing) as well as returns to theatre and postoperative complications (frequency/type); anaesthetic problems; patient transfers and issues such as delays; infections (pre-admission/during admission and type); trauma and type; as well as peer-review outcomes e.g. clinical management issues identified (type, severity , responsible team, impact on outcome and if considered preventable). The data can be looked at by specialty, however there are stringent policies to maintain the confidentiality of data and data release is cognisant of that.

The database holds around 60,000 records in total, and thus is a rich source of information which can be used to identify mechanisms to improve patient care. Around 40 publications have been produced over the years using state and territory or national data on a variety of topics.

The ANZASM Data Management Subcommittee oversights release of de-identified data for research. A data request submission form needs to be completed for consideration by the committee. Data release requests must include a Fellow but may be for work of a trainee, medical student or another collaborative partner.

ANZASM research and publications contribute to improving patient care and safety. The data within ANZASM is a valuable resource for surgical research conducted by RACS Fellows and provides a unique opportunity to consider the contributing factors to perioperative deaths as determined by peer review.

ANZASM publications have demonstrated a consistent downward trend in reported adverse events from surgery over recent years. Publications cover a variety of research topics:

- Research has shown systemic or organisation predictors of adverse event have implications for quality improvement at the hospital or jurisdictional level.[1]
- The importance of participation in multidisciplinary discussions prior to surgery, that postoperative care is as important as the operative procedure itself, and that early detection of complications are all areas of improvement to prevent mortality, have also been highlighted.[2 3]
- ANZASM data has shown that Australia's appendicectomy mortality rate is very low compared to international figures however improvements are needed in postoperative care in the elderly. [4]
- Research has also been conducted into the relationship between geographic locations (rural vs urban) of surgical procedures of varying complexity and their postoperative complications, as previously it was thought to be safer performed at high-volume urban centres. The results show that rural centres do not have a higher prevalence of postoperative complications than urban centres, suggesting that a wide range of procedures may be safely performed at rural centres.[5 6]

The main aim of the Audits of Surgical Mortality is to educate – to provide feedback to individual surgeons, and to hospitals, so they can address issues to improve patient care. However this dataset contains a wealth of information that can be interrogated (as can be seen by the listed examples of peer-reviewed publications) to identify other areas of potential improvement. This resource is available, not only to Fellows, but also to trainees and students who can produce valuable research directed at improvements in surgical care. ■

1.Turner RC, Simpson S, Jr., Bhalerao M. Systemic predictors of adverse events in a national surgical mortality audit: analysis of peer-review data from Australia and New Zealand Audit of Surgical Mortality. ANZ J Surg. 2019.
2. Stevens CL, Reid JL, Babidge WJ, Maddern GJ. Peer review of mortality after pancreaticoduodenectomy in Australia. HPB (Oxford). 2019.
3. Stevens CL, Reid JL, Babidge WJ, Maddern GJ. Peer review of mortality after hepatectomy in Australia. HPB (Oxford). 2019.
4. Young E, Stewart S, McCulloch GAJ, Maddern GJ. Appendicectomy mortality: an Australian national audit. ANZ J Surg. 2019.
5. Ferrah N, Stephan K, Lovell J, Beiles CB, Ibrahim JE. Rural centres do not have a higher prevalence of post-operative complications than urban centres: a retrospective analysis of a mortality audit. ANZ J Surg. 2019;89(7-8):833-41.
6. Davis SS, Babidge WJ, Kiermeier A, Maddern GJ. Regional versus metropolitan pancreaticoduodenectomy mortality in Australia. ANZ J Surg. 2019.

Better health through best evidence

ACTA International Conference 2019 report

Australian Clinical Trials Alliance (ACTA) is an umbrella body representing more than sixty clinical trials networks, coordinating centres and clinical quality registries working across Australia. The alliance links clinical researchers across the research spectrum and provides a strong voice that is heard by government, healthcare policymakers and consumers on issues that impact the conduct of investigator-initiated or public-good clinical trials in Australia.

RACS Clinical Trials Network of Australia and New Zealand (CTANZ) is engaging with ACTA and was recently represented by South Australia-based general surgical trainee and CTANZ Working Party Trainee Lead, Dr Nagendra Dudi-Venkata, at the ACTA International Clinical Trials Conference 2019, in Sydney. Across five workshops and 16 conference sessions this meeting explored the theme of *'Better health through best evidence'*.

A pre-conference workshop on 'Health economic evaluation alongside randomised trials' engaged attendees with case studies which highlighted the need for economic evaluation to be embedded in clinical trials. Concepts such as incremental cost-effectiveness ratio, cost-benefit analysis, and cost-effectiveness and budget impact analysis, were considered, along with impacts on health system funders' decisions about what to support, and policy change decision making.

A second workshop on 'Getting your paper published where you want it' was led by Dr Stuart Spencer, Senior Executive Editor of ***The Lancet***, and focused on golden do's and don'ts pertinent to writing for publication – a key area of learning for any avid research trainee who has recognised that the token of currency in academia is the number of publications on their CV!

Highlighting the national importance of ACTA, the Honourable Minister for Health, Mr Greg Hunt, kicked off the conference by magnanimously tipping attendees off with great news about new funding allocations and grants supporting new clinical trials.

As involvement in a clinical trial demands awareness of best current practice, it was appropriate to move forward to explore and question what this is and what it could be. Appropriately, Professor Anne Kelso, CEO National Health and Medical Research Council (NHMRC), reiterated the inherent benefit of trials and spoke about why and how NHMRC supports clinical trials, as well as alluding to its broader remit to support a diversified portfolio of investigator-initiated and priority-driven projects, across the breadth of health and medical research in laboratory, clinical and community settings.

NHMRC's new grant program structure is now allocating $70 million annually to clinical trials and cohort studies, welcome news considering CTANZ is supporting an increased rate of participation in cohort studies, with recent successes including IMAGINE and GLOBAL Surg. Significantly, these funding opportunities are not limited to metropolitan hospitals, as funding of approximately $100 million, available under the umbrella of the MRFF, is explicitly focusing on support for clinical trials in rural, remote and regional settings, opening an opportunity to better develop opportunities for surgical trainees rotating to regional Australia.

The value of clinical trials lies in robust design and efficiency, a concept that Dr Pamela Tenaerts from Clinical Trials Transformation Initiative, USA, suggested can be implemented by applying the concept of 'Quality by design (QbD)'. A strong argument was put forward for a paradigm shift in research to bridge the gap between what can appear to be two parallel universes – clinical care and clinical research.

The opportunity is to bring both within one universal learning healthcare system in which clinical research takes place during patient care by designing 'embedded adaptive clinical trials'. This design uses a more pragmatic approach than the conventional randomised controlled trial (RCT) to deliver personalised answers which are tailored to individual patients, and thereby improves the odds of better outcomes for patients who are within the trial cohort, compared to those who continue with standard clinical care.

The UK model of consumer engagement, wherein research was carried out 'with' or 'by' members of the public rather than 'to', 'about' or 'for them', enlightened attendees on day two. This initiative of involving patients in research can improve the likelihood of reaching recruitment targets, and as a result, enhance the study's success. It does this by ensuring clarity of purpose, mission focus, better design with a clear understanding of 'service' versus 'research', and political support.

A session on the minefield of data mining touched a sensitive nerve for many researchers on the last day. Whether or not data from trials should be shared openly was hotly debated from three different perspectives – journal, investigator and organisation. Professor Virginia Barbour, Director of the Australasian Open Access Strategy Group, stressed that a transparent, truthful, ▶

open approach to science, following recommendations such as FAIR (Findable, Accessible, Interoperable and Reusable) guiding principles for scientific data management and stewardship and public communication, are ways to optimise value to society and enhance research integrity.

The final session explored how to embed clinical trials in routine clinical practice. Professor Neena Modi from Imperial College, took attendees on a journey of creating a National Neonatal Research Database in the UK, and then using real-world data to improve healthcare and health services. Even though she spoke about the principles of embedding a clinical trial in neonatal care, the audience was challenged to consider that the general paucity of research addressing clinical practice is actually a patient safety issue. The solution she proposed was a brave new paradigm of research in which randomisation would be the default and standard of care for comparative effectiveness evaluation. She emphasised that real-world data can lead to personalised medicine with real-world care, with findings having high generalisability. Such an approach will require a change in mindset for many clinicians, as they will need to consider default randomisation to be the ethical approach to routine patient care.

A huge challenge and barrier identified was the culture of various health services, and the need for a seismic shift to a culture that values clinical trials as part of a Learning Healthcare System (LHS). Conveying this to patients and the broader public was identified to be the sector's next challenge. Demonstrating that this is all possible was the example of registry based RCTs underpinned by the Australia and New Zealand Dialysis and Transplant Registry (ANZDATA).

I found attending the ACTA conference to be invigorating. As the CTANZ Working Party Trainee Lead, I saw a cultural change in the surgical trainee cohort, with increasing engagement and participation in clinical research. Initiatives such as new requirements for research training embedded in general surgical training and GRANULE workshops for early trainee researchers, could potentially deliver a more diverse research exposure and experience, with the aim of developing a cohort of research-literate surgeons who will progress the profession across their careers. There is opportunity for surgeons to engage with ACTA to tap into its immense resources and networks to create and sustain ongoing future collaborative research projects. CTANZ is actively progressing the linkage of RACS into this broader network. ■

For more information, please contact CTANZ@surgeons.org.

Dr Nagendra Dudi-Venkata
CTANZ Working Party Trainee Lead

Clinical Trials Network ANZ Medical Research Future Fund Award

Clinical Trials Network ANZ (CTANZ) was awarded $782,256 in 2019 as part of the MRFF International Clinical Trials Collaboration grant program. CTANZ is a RACS endorsed New Key Initiative supported by Clinical Director, Professor David Watson.

Dr Peter Pockney, Senior Lecturer in the University of Newcastle's School of Medicine and Public Health, is leading the team of Australian researchers from CTANZ who are contributing to a multi-centre international randomised controlled trial. This study aims to determine the impact of single-use negative pressure dressings on the incidence of surgical site infection following emergency laparotomy. It will provide, for the first time, high level evidence to either support or refute the contention that these dressings can reduce the risk of this negative outcome.

The Australian arm of the Single Use Negative pRessure dressing for Reduction In Surgical site infection following Emergency laparotomy (SUNRRISE) Trial is contributing over 200 patients to the planned international recruitment of 840 patients. SUNRRISE is designed to be carried out by surgical trainees, rather than by established clinicians and researchers. It is now running in trainee led clinical research networks in General Surgery across mainland Australia. SUNRRISE is a collaboration with CTANZ sister organisation, Clinical Trials UK, which is supported by the Royal College of Surgeons of England.

International Women's Day

Victorian Women in Surgery cocktail evening

Please join local Victorian female surgical specialists, along with RACS Women in Surgery representatives, for a cocktail evening to celebrate International Women's Day.

Professor Sanziana Roman will speak on 'Diversity and Belonging in Medicine: Practical Approaches to Moving the Needle'.

Tuesday 3 March 2020 | RACS Courtyard | 250-290 Spring Street, East Melbourne

6:30 - 8:30pm

Registration is free at tinyurl.com/IWDRegistration2020

Professor Roman's ESS presentation will also simulcast via webinar

Research on show at the November Annual Academic Surgery Conference 2019

The Section of Academic Surgery and Surgical Research Society of Australasia Annual Conference was held on 7 and 8 November 2019 at RACS Melbourne with the Academic Surgery Conference taking place on day one and the Surgical Research Society (SRS) annual conference on day two.

The conference showcases the breadth and depth of research undertaken by medical students, junior house officers, trainees and Fellows. This research represents the genesis for assessment and improvement of surgical practice and patient outcomes. The conference was well attended with over 70 participants daily. The outstanding quality of the ninety-nine abstracts submitted to the SRS made the selection process a difficult one, with 36 submissions selected for presentation.

Winthrop Professor Fiona Wood opened the conference and her insights into being a surgeon scientist were inspirational. The addresses of Dr Kristalyn Gallagher from the University of North Carolina, representing the Association for Academic Surgery, and Professor Taylor Riall, past president of the Society of University of Surgeons (USA), around issues such as sexual harassment, resident (registrar/trainee) resilience and wellbeing, were timely given the RACS implementation of the Operating with Respect program.

Professor David Watson provided a progress update on the Clinical Trials Network, Australia and New Zealand (CTANZ) which is built on a trainee-led, collaborative and multi-centred model. Professor Watson highlighted the recent MRFF International Clinical Trials Collaboration $780,000 grant success. We strongly encourage our colleagues to reach out to the CTANZ executive (CTANZ@surgeons.org) if interested in becoming involved in clinical trials research.

This year's Jepson Lecture was presented by distinguished neurosurgeon, Professor Jeffrey Rosenfeld, who provided insight and inspiration based on his career spanning academia, the military and many aspects relevant to neurosurgery. Professor Rosenfeld's extensive experience highlighted the value of developing a career that accommodates both research and surgery.

The Young Investigator Award was won by Plastic Surgery trainee Dr David Sparks, who has been researching biological methods for replacing loose segments of long bone. The 'Developing a Career in Academic Surgery' award was presented to medical student Ms Gillian Lim who presented research into the physiology of the gastric sleeve performed at bariatric surgery.

The recipients of the four travel grants were Urology trainee Dr Marnique Basto, prevocational doctor Luke Peters, prevocational doctor Sam Francis and prevocational doctor Melissa Stieler.

Feedback from attendees again indicated that presentations were well received with most rated as very good to excellent.

We would like to thank and acknowledge Medtronic for their continuing support for this Conference. The November 2020 Annual Conference will be held in Adelaide, South Australia.

To learn more about the Section of Academic Surgery or to become a member, please email academic.surgery@surgeons.org ■

Professor Mark Smithers
(Chair, Academic Surgery Committee) and
Professor Marc Gladman
(Chair, Surgical Research Society of Australasia)

Images from left:
Dr Kristalyn Gallagher with Prof Mark Smithers; Dr Taylor Riall with Prof Mark Smithers; Prof Mark Smithers (l), Prof Jeffrey Rosenfeld (m), Prof Marc Gladman (r).

Two tragedies push burn surgeons to the limit

Australian and New Zealand burn surgeons have been working around the clock this summer with multiple critically ill patients.

Summer had barely begun when New Zealand's most active cone volcano Whakaari/White Island erupted into the Bay of Plenty. With only 30 per cent of the volcano visible above sea level, it's easy to underestimate its size. Built up by 150,000 years of continuous volcanic activity, it is the largest volcanic structure in New Zealand.

When Whakaari/White Island erupted on 9 December 2019, a reported 47 people, mostly tourists, were on the volcano. Twenty-one people were killed or have since died (at the time of writing); the youngest was 13 years old. Twenty-six people remain seriously injured.

Volcanic burns are rare and complex, and it remains extremely challenging for burns surgeons providing care in New Zealand (Auckland, Waikato, Hutt Valley and Christchurch) and Australian (Sydney and Melbourne) hospitals. Much of what they are dealing with is unprecedented from both their hands-on surgical experience and the medical literature. Mr Jeremy Rawlins FRACS, plastic surgeon and president of the Australian and New Zealand Burns Association (ANZBA) said it "was a unique set of circumstances that would have tested my colleagues, particularly in Auckland and across New Zealand, when they were first faced with these horrible injuries".

Plastic surgeon Mr Richard Wong She FRACS, is the clinical leader for burns at the National Burn Centre at Middlemore Hospital in Auckland. On the morning of the volcanic eruption he was in a meeting with management expressing concern about his burn team. In the previous week, they'd worked long hours and were suffering from "sheer exhaustion", he said. But later that day when Whakaari/White Island erupted it redefined what he'd called 'busy' and 'overworked'.

Looking back on the days that followed, Mr Wong She said:

"We all made a point of looking after each other – of sending each other out for breaks and trying to get each one of us to have some 'time out' to recharge and refuel."

And looking ahead, he explained "It's a marathon and we are still far from finished, but I will never, ever complain about being busy or overworked again."

People caught up in the volcanic eruption suffered extreme burns, as well as inhalation burns to their lungs and airways from breathing chemicals such as sulphur dioxide and methane. They also suffered substantial blast injuries. "When a volcano goes off, it's like a bomb going off," Mr Rawlins said. "It's a big blast injury – a blast load of air hits the body, along with all the rocks, rubble and so forth that erupt out of the volcano."

Blast injuries, regardless of the nature or size of the missile, can cause major damage. "The depth of some of the blast injuries with volcanic ash blasted through the skin of the back down to spinous processes was hard to comprehend," Mr Wong She said. What complicated the burn injuries, he added, "were a combination of thermal and chemical insults on a background of physical trauma associated with the blast, along with associated degrees of inhalational injury."

Not only were the burn injuries "incredibly challenging to treat, requiring more than anticipated debridement", but in the early days after the eruption the treating medical teams were also at risk of harm themselves, Mr Wong She said. "Words cannot describe the physical discomfort and exhaustion of trying to breathe super-heated air through an N95 mask in a hot (30°C+) operating theatre while fully gowned and performing physically demanding surgery," he explained. Despite the physical discomfort and potential risk to personal safety, "people worked ▶

Images, from top:
Mr Richard Wong She; Mr Jeremy Rawlins.

around the clock – and I do mean around the clock – without complaint," Mr Wong She added.

While the time since 9 December has been difficult and often problematic, it hasn't been without the occasional uplifting moment. "The sight of an 80 per cent plus burn patient sitting up and alert, and wanting ice-cream in an ICU bed at the end of a week of surgery was also hard – but in a nice way," Mr Wong She said.

The role of the Australian and New Zealand Burns Association

The remarkable coordination and camaraderie between the Australian and New Zealand burn surgeons is part of the ANZBA ethos, according to Mr Rawlins. "We're a really close-knit group of people, irrespective of whether we're working in Auckland or Perth or anywhere in between," he said. "We know each other; we're a small group" and this comradeship is of enormous value when things like this happen because "the connections are already there", he explained. "The phone numbers are already in the mobile."

That support extends to video-conferencing, emailing and picking up the phone to ask 'How are you going?' and 'Can we help?' to 'I think you're doing the right thing,' Mr Rawlins said. "It's very important to have back-up from your colleagues because we're all human and, in this case, it helps to deal and cope with the Whakaari/White Island burns." This active support continues, Mr Rawlins said, because in the weeks after the volcanic eruption, when patients were transferred to Sydney and Melbourne hospitals, "we were able to really come together because we knew what our colleagues were dealing with."

For Mr Wong She, the support of his fellow burn surgeons was immeasurable. "Surgeons came to Middlemore Hospital from Brisbane and Adelaide to provide additional support at different times, for varying lengths, since the beginning of the incident," he said. "These 'fresh' minds, hands and eyes provided a much-needed boost to the team, which has had to deal with an unprecedented volume of additional work." More locally, Mr Wong She's fellow burn surgeons delayed holiday travel plans to "help operate when we needed them most at the beginning of the disaster". Other plastic surgeons within the department came to assist as well, by taking over responsibilities, such as acute on-call Plastic Surgery commitments and clinics, to allow the burn team to focus solely on Whakaari/White Island patients. The demands on busy acute hospitals continued regardless.

The Australian bushfires

When Whakaari/White Island erupted, bushfires in Australia were already causing significant damage. By mid-January, 28 people across the country had died and 10 million hectares had burned. "Every year we prepare ourselves for bushfires," Mr Rawlins said. "We anticipate that people will want to protect their properties; that firefighters will succumb to a number of burn injuries associated with bushfires."

While the size and scope of the 2019–2020 bushfires has been labelled unprecendented, and the fatalities tragic, thankfully, the number of fatalities has not matched the might of the fires, when compared to the 2009 Black Saturday fires and the 1983 Ash Wednesday fires. "What we've learned is that, for the most part, we're dealing with the walking wounded ambulant burns, rather than massive burn injuries," Mr Rawlins said of the recent bushfires. People have either lost their lives or have had smaller burns that can be treated as outpatients. It still requires ongoing vigilance, he added, as well as looking out for colleagues in other states to ensure they're coping.

The Emergency Management of Severe Burns (EMSB) course

The surgical and operational principles taught in the EMSB course were thoroughly tested during the Whakaari/White Island eruption and the Australian bushfires. Two simultaneous tragedies across the two countries pushed the burn teams to their limits, and, from all accounts, the principles of the course held true. Mr Rawlins, Mr Wong She and others in the burn community have no doubt that the EMSB course was invaluable in having multiple teams across two countries working together so effectively.

"It's vitally important that when tragedies like this happen and we've got a lot of patients with major burns, we're all speaking the same language and doing the same things," Mr Rawlins said. "It's well-recognised that it minimises death and maximises positive outcomes when major burns are managed in the standardised EMSB way."

The EMSB course is recognised as the best course in the world for the education of healthcare professionals dealing with major burns. It was created by ANZBA surgeons and is mandated by the boards of Plastic Surgery and Paediatric Surgery. Many general surgeons undertake the course as well.

Collaboration between specialties

While the double tragedy of the New Zealand volcanic eruption and the Australian bushfires has pushed the ongoing workload of burn surgeons to the next level, they are supported by the remarkable work of ANZBA. One of the key reasons burn surgeons across the two countries operate as a "tight-knit group of people" who "look out for each other" is because they're "a group of surgeons who have smudged the boundaries between General Surgery, Plastic Surgery and Paediatric Surgery – and we are burn surgeons," Mr Rawlins said.

The relationship shared by ANZBA's burn surgeons is unique, Mr Rawlins added. "I can learn a lot from a general surgeon or a paediatric surgeon and they can learn from me and, between the three of us, we are able to offer, I think, a far better standard of surgical care than if a single specialty were looking after these patients."

"Collaborative care is the 'norm' for burn care in Australia and New Zealand," Mr Wong She said. However, with the Whakaari/White Island patients the teamwork extended beyond surgical specialties to include "intensive care, anaesthetics, nursing, radiology, infectious diseases, hospital management, procurement, and New Zealand and Australian government officials – the number and diversity of skills truly beggar belief," he said.

Mr Wong She added that "collaborative care is also the 'norm' for the care of any patient, and the importance of teamwork, communication and respect, which RACS has been championing through the Operating with Respect program for the past few years, has been personally highlighted to me over the past few weeks".

Lessons learned and contributing to the medical literature

There is very little in the available literature regarding human survival in volcano eruptions. Historically, most deaths were caused by pyroclastic surges and wet debris flows, and rescue was deemed impossible from the central points of eruptions. These days, modern warning systems and continuous monitoring provide greater warning of volcanic eruptions although, sadly, a number of people believed to be on the floor of Whakaari/White Island's crater perished when it erupted.

Mr Wong She said many valuable lessons had been learned in their response to the disaster. While the academic observations and experiences are of vital importance to the global literature, there are also other lessons of a more personal nature that are important in both emergencies and everyday life.

The National Burn Service of New Zealand was developed using the experiences and lessons learned from disasters around the world, and this system was able to cope with "two, ten or in this case, 31 simultaneous referrals… so some things worked as planned", Mr Wong She said. However, the burns team encountered other challenges that required new solutions. "We also learnt the value of teamwork, communication, compassion, treating others with respect, and resilience – things that need to be reinforced as an integral part of surgery in 2020, rather than a tick-box exercise," Mr Wong She said.

"All of us who work in burns are passionate about what we do, and we want to help our colleagues," Mr Rawlins said. The burn surgeons who are looking after the Whakaari/White Island patients will present their findings at the ANZBA meeting in October this year. More importantly, he added, "those papers will be written up for the international literature so that next time this happens there will be a greater understanding of how to manage it." ■

The 2020 EMSB Program

The course is for healthcare professional who may be involved in the care of a severely burn-injured patient within the first 24 hours.

- 29 February – CHW Sydney
- 21 March – Darwin
- 28 March – Adelaide
- 4 April – Auckland
- 4 April – Melbourne
- 6 June – Perth
- 20 June – RNSH Sydney
- 20 June – Brisbane
- 25 July – Hobart
- 8 August – Townsville (tbc)
- 15 August –Christchurch, NZ
- 19 September – Sydney (Concord)
- 7 November – Brisbane
- 21 November – Melbourne
- 21 November – Wellington
- 28 November – Sydney (RNSH)

For further information, email info@anzba.org.au or phone +61 7 3325 1030.

Spotlight on our surgical societies

General Surgery in Australia and New Zealand

Mr Trevor Collinson General Surgeons Australia President

Surgery was Mr Trevor Collinson's second career. His first was architecture. But after completing his degree at the University of Adelaide and working for two years as an architect, he made the decision to study medicine at Flinders University.

During his advanced surgical training, Mr Collinson took part in the development of laparoscopic surgery, and for him it was a meaningful and symbolic connection between his two career paths. "A keyhole operation is a three-dimensional operation done on a two-dimensional screen," he said, "Whereas, architecture is a three-dimensional building designed on a two-dimensional piece of paper or, nowadays, a screen."

After completing his Master of Surgery degree, including performing the first sentinel node biopsies in breast cancer in Australia in 1995, Mr Collinson undertook a Fellowship in the UK in minimally invasive surgery. Soon after, he was persuaded by a senior colleague to return to Adelaide and take over his surgical practice and has been back now for 23 years. During this time, he's built a legacy as a general surgeon with sub-specialist interests in breast and endocrine surgery, advanced laparoscopic surgery and, recently, robotic surgery.

Mr Collinson has been on the General Surgeons Australia (GSA) Board since 2012, Vice-President from 2014–2017, and President since 2017. On behalf of RACS, GSA manages the selection of general surgical trainees, administers the general surgical training program, and manages the international medical graduates (IMG) program for General Surgery. The RACS Australian Board of General Surgery is administered by GSA and oversees the Surgical Education and Training (SET) Program in General Surgery in Australia, reporting to the SET board (BSET) and the RACS Council. Mr Collinson has "enjoyed a close relationship with RACS and, in particular, the president who needs to be informed of what is happening in all the specialty societies."

GSA is one of the largest specialty societies of the College. In 2019, it had 470 trainees, 19 IMGs, 280 junior doctors and 950 consultant surgeon members. "It would not be possible without our incredible staff of 11, working in our offices across Australia, led by Sarah Benson," Mr Collinson said. He also noted, "We owe a lot to surgeons throughout Australia who teach and nurture our trainees."

General Surgery is a specialty that requires a broad scope of practice. This is especially true in rural and regional areas. "Many general surgeons in the country are expected to be able to do a neurosurgical operation for a patient with a head injury, or an emergency thoracic procedure," Mr Collinson said. "The challenge is adequately training surgeons who plan to work in regional and remote areas, as well as surgeons who will work in cities."

With this in mind, GSA is developing a Post-Fellowship Education and Training (PFET) Program in Rural Surgery. It will enable surgeons undertaking a career in rural and regional surgery to 'tailor make' a program around the areas in which they intend to practice. The program has wholehearted support from several sub-specialty surgical societies and will join other PFET programs in transplantation and trauma surgery.

In 2018, GSA ran a combined Annual Scientific Meeting (ASM) with the Pacific Islands Surgeons Association, in Fiji. It was a tremendous success, both surgically and politically, and an opportunity for more than 80 Pacific Islands surgeons and trainees to strengthen their relationships with their Australian counterparts. This was made possible by about 20 Australian general surgeons, who undertook locums across the Pacific, allowing local surgeons to attend the Fiji meeting.

In 2019, GSA combined its ASM with the Spring Meeting of the Colorectal Surgical Society of Australia and New Zealand, in Hobart. It was also a big success. "There's a lot of common ground with Colorectal Surgeons" Mr Collinson explained. He also stressed the value of camaraderie between surgeons of all disciplines. "There's an attitude that when you finish your training you should be perfectly competent to do everything by yourself, but that's not what it's like," he said. "You need to have mentors and be able to ask: 'Hey, can you come and give me some moral support and help me do this operation? People are flattered when you ask, as are you when they ask!" he said.

Mr Julian Speight New Zealand Association of General Surgeons President

When Mr Julian Speight travelled to New Zealand from St Thomas' Hospital in London to complete a requirement of his UK Fellowship in 1996, he didn't know that he would one day call the far-off country his home. But Aotearoa, 'Land of the Long White Cloud', made a lasting impression.

There was such a "wide breadth of surgical ability," he said of General Surgery. "On their lists they had everything from colorectal resections, upper GI cases, vascular surgery, breast and endocrine to thoracic surgery."

After he completed his Fellowship with the Royal College of Surgeons in Edinburgh in 1999, Mr Speight emigrated to New Zealand. He worked in the North and South islands, while undertaking his Fellowship for the Royal Australasian College of Surgeons (FRACS). Then, in 2007, he returned to the UK for a year to do additional training in Colorectal Surgery at the Royal United Hospital in Bath.

In 2008, Mr Speight accepted the role of Consultant General Surgeon at Southland Hospital in Invercargill. There are six general surgeons at the hospital, each with their own area of interest. "In our elective workloads, we tend to sub-specialise to some extent," he said, "but all of us are generalists." When the surgeons are on call, they cover everything that comes in. "Because we don't have neurosurgery, ENT, cardiothoracic or vascular onsite we need to manage everything in the first instance", he explained, although some patients may then be transferred to Dunedin Hospital.

Southland is a busy general hospital, and its proximity to Queenstown means that skiing accidents and tourist misadventures often end up needing care at the hospital. The Southern District Health Board (DHB) has the largest land area at just over 62,000 km^2 and a population of more than 300,000. This means that low-population rural areas in this DHB are often some distance by road from either hospital.

"When you're working in a smaller centre, you do have to be a generalist," Mr Speight said. "The FRACS syllabus is designed with this in mind, and prepares surgeons very well in this regard." However, he noted that on completion of their FRACS most trainees now plan to progress to sub-specialty Fellowships and, once they've completed those, may feel overqualified to work in smaller centres and be unprepared for the breadth of general surgical practice required. Mr Speight is pleased that a Post-Fellowship Education and Training Program in Rural Surgery is being developed and "hopes it will encourage some newly qualified general surgeons to consider pursuing a career in a non-metropolitan centre".

The New Zealand Association of General Surgeons (NZAGS) was incorporated in 1992, and its main role is to advocate for general surgeons. The Association also convenes an annual scientific conference. NZAGS works closely with the other sub-speciality societies, and the President sits on the RACS New Zealand National Board. About eight years ago, on behalf of the College, NZAGS took over the role of providing Advanced Surgical Training in General Surgery in New Zealand. Recently, a decision was made to divide the bi-national Board in General Surgery into two national boards. "The medical systems were different, and this allowed more autonomy in training for both countries," Mr Speight explained. The boards are working closely together to introduce the new five-year competence-based training curriculum for 2021. "This is a huge body of work, and I'd like to acknowledge all the hard work being undertaken by surgeons on both sides of the Tasmin. Not to mention the time and effort invested by surgeons involved in the day-to-day training," Mr Speight said.

There are 190 surgeons and 90 trainees in NZAGS, and this represents about 80 per cent of the general surgeons in New Zealand. Most of the surgeons have trained together at some point and all trainees get together twice a year. The training program is a national program, so trainees work in many different places throughout both the North and South islands.

"You don't just know the people in your training cohort," Mr Speight said. "You know those above and below you as well." One of the advantages of working in the New Zealand surgical community is being able to reach out to a colleague for assistance. "It's a very small social community. Everybody knows everyone and there's a real sense of collegiality." ■

Images:
Above, left–right: Mr Trevor Collinson, Mr Julian Speight.

Smoke

Normally this column advises readers to get out of doors and enjoy fresh air, exercise and a moderate amount of sunshine. At the start of 2020 this advice might still be appropriate for New Zealanders on most days, but dangerous and ill-advised in some parts of Australia.

By early 2020 the summer season bushfires had burned over 10m hectares, destroyed more than 2000 homes, killed millions of animals and 28 people. Tragically these figures will be increased by the time this column is printed. The emotional, economic and environmental costs are enormous for those suffering directly from the blaze of the fires. Let us not forget their impact on the affected rural populations as we also consider the health implications that does not spare neighbouring rural and city dwellers.

On 5 January 2020, the smoke cloud engulfing southern New South Wales, Canberra and eastern Victoria was the size of continental Europe and, by mid-January, was expected to circle the globe, with a stratospheric height of over 17km. Even those who live far from the fires in metropolitan areas are suffering by inhaling air polluted with hazardous concentrations of smoke particle matter (PM). People who previously walked or cycled to work in Canberra, Sydney or Melbourne cannot safely do so.

As respiration is essential for life we take about 25,000 breaths per day but those living in many parts of Australia in the last couple of months have not had clean air. This has resulted in more hospital admissions and asthmatics suffering increased rate of attacks. The young, the old and those with cardiopulmonary disease are also at risk. There will be longer-term respiratory and coronary artery implications to come. These will be immeasurable and are currently largely unknown.

Air quality is measured in by an index (AQI) and the daily, historical and forecast AQI can be read on a free air quality app available at aqcn.org. The AQI measures five air pollutants: ground-level ozone, particle pollution (particulate matter – PM10 and PM2.5), carbon monoxide, sulphur dioxide and nitrogen dioxide. AQI grades range from good (0-50), moderate (51-100), unhealthy for sensitive groups (101-150) to unhealthy (151-200), very unhealthy (201-300) and hazardous (→301).

Bushfire smoke carries PM2.5 particles defined by their having a diameter of 2.5 micrometers or less. The World Health Organization (WHO) standard for clean air is to maintain PM2.5 particle levels below 10ug/m3 by 2030. Australia's clean air standard is 8ug/m3. AQI levels in many regions of Australia in early January were well above the WHO safety zone and the Australian standard.

Sydney, normally ranked as one of the healthiest cities for air quality because its inhabitants historically have enjoyed AQIs around 7, are experiencing indices ranging from 88-152, though for many days in December 2019 the levels were worse and reached the 700s, the equivalent of smoking 37 cigarettes. On 5 and 6 January, Canberrans choked in the hazardous zone with an AQI over 400, and since then some parts have exceeded the Beijing-like levels of 885 ug/m3 that ACT recorded on 1 January. On 6 January, returning civil servants in Canberra were told to work from home if possible.

> There will be longer-term respiratory and coronary artery implications to come. These will be immeasurable and are currently largely unknown.

In early January, Melbourne had 'very unhealthy' days in the 200s and above depending on the direction of the wind.

Surgical masks are ineffective to filter out particles of 2.5 micrometers or less. P2 industrial face masks filter out most PM2.5s providing they fit well. The NSW health department rightly recognised they cannot fit everyone with a P2 mask and advised the population to stay indoors as much as possible on bad days, and to avoid outdoor exercise (cycling trebles respiratory rate and so trebles smoke inhalation). The evidence for this seemingly wise advice is lacking.

Whilst staying indoors, air conditioners are not likely to be very effective in filtering out PM2.5s and may increase indoor pollution. Air purifiers with a specific high efficiency particulate air (HEPA) filter can be effective for a particular area of a house but one air purifier will not work for the whole building.

The bushfires are not only an economic, emotional and environmental disaster. The consequent air pollution is a health one. A *Lancet* Commission on pollution and health estimated air pollution causes 6.5 million deaths globally per year and particularly targets the poor, the young and the old. The *Lancet* Planetary Health reported that in India alone particulate matter and household air pollution claimed 1.24 million lives in 2017, 12.5 per cent of the national mortality. From a search on aqicn.org (6 Jan 16:00 AEST), the AQI in Delhi ranges in the 'very unhealthy' range between 201-300, Beijing in the 150s, Los Angeles 78, Paris 40-70 and Mexico City, the 120s. These comparisons show how bad the levels are in parts of Australia and why the number of people killed by the smoke may exceed that from the fires. ■

Dr BB G-loved

Climate change and the surgeon – what can be done now?

Surgeons and other health professionals should be speaking out on the medical consequences of climate change. In a special article published in the *ANZ Journal of Surgery* (November 2019), Professor Alistair Woodward called for healthcare to seize opportunities to reduce greenhouse gases produced by the industry. Often there is a chance to simultaneously improve population health.

"We understand that existing risks to health are multiplied by the physical changes to the global climate, so we should be looking at what actions we can take now to reduce that impact," Professor Woodward said.

The University of Auckland School of Population Health Professor says there are many ways for health systems to reduce their carbon footprint, including:

- tele-medicine and video-conferencing to reduce travel
- provision of public transport vouchers for patients and families
- encouraging bikes, carpooling and electric cars
- switching to renewable sources of energy where possible
- minimising the use of anaesthetic gases that are significant climate polluters
- continuing with a commitment to 'green' operating theatres through recycling and reduction of theatre waste.

Transport is the fastest growing source of emissions. The increase in numbers of vehicles and distance travelled, as well as the 'massification' of our car choices in Australia and New Zealand, have cancelled out the gains from electric vehicles.

"We know that human activity has disrupted earth systems, and the global climate has been knocked off course. The world is heating, the oceans acidifying and the seas are rising, but we can introduce changes now if we are willing," Professor Woodard said.

RACS is committed to employing the principles of Reduce, Reuse, Recycle, Rethink and Research; to effectively reduce waste management and lessen the impact of surgery on the environment. Please visit surgeons.org and search 'environmental impact' to read our position statement on this important topic. ■

Supporting trainees to pursue rural surgical careers

PSA 2019 Annual Scientific Conference and the Rural Coach Program

The 55th Provincial Surgeons of Australia (PSA) Annual Scientific Conference was held in early November 2019 in the picturesque regional city of Ballarat, Victoria. For the past few years, General Surgeons Australia (GSA) has generously given Rural Coach and Rural Surgery grants to trainees, junior doctors and international medical graduates who attend the PSA ASC and are interested in pursuing a rural surgical career. The Australian Society of Otolaryngology Head and Neck Surgery offers a similar grant to ENT trainees.

The GSA grant recipients found the conference provided invaluable opportunities for networking, support and information. They share with *Surgical News* their reflections on the PSA conference.

Dr Jack Cecire, Junior Doctor, New South Wales
The highlight of the program was without a doubt the presentation by Mr Christopher Wakeman. His presentation on the Christchurch shooting disaster provided a first-hand insight into the events of that day and the weeks that followed. The sobering recount of the unimaginable experiences of those involved left the audience feeling a deep sense of sorrow. The teamwork and whole-of-hospital response that was evidenced deserves recognition. You could tell the audience was proud of the extraordinary efforts of our New Zealand colleagues and the public response.

Dr Matthew Watson, Junior Doctor, South Australia
The PSA conference was well organised with a stimulating scientific program. Attending the conference allows junior doctors like myself to identify role models and foster connections with those who aspire to or are already working as a rural surgeon. This ranges from listening to an oral presentation from a rural surgeon with a lifetime of knowledge, to enjoying a drink together at the PSA Gala Dinner. This exposure is invaluable to further encourage junior doctors to work in rural areas. A highlight for me was the live theatre cases as part of the Colorectal Laparoscopic Skills workshop – this was a unique learning experience and was well received by all attendees.

Dr Siobhan Clayton, Junior Doctor, New South Wales
The PSA kicked off with an innovative session on colorectal surgery, live streamed from Ballarat hospital's operating theatres. In terms of surgical education, nothing really compares to watching an expert operate with live stream video and commentary, with concurrent lectures on the topic by two other surgeons. This was complimented by the opportunity to complete a simulated right hemicolectomy during the lunch break. As an aspiring rural surgeon, the PSA ASC provides me with a great opportunity to hear about unique training opportunities, to meet the surgeons who have paved the road before us and to catch up with new and old friends.

Dr Sergei Tsakanov, SET 6, New South Wales
Ballarat has delivered with a great venue and a plethora of educational and insightful talks from a variety of experts from rural Australia and around the world. Surgical education is a particular interest of mine and Professor Glenn Guest's talk on setting up a Regional Surgical Training network was particularly insightful.

Dr Danielle Taylor, Junior Doctor, Victoria
One of the highlights was the Jim Pryor Begonia Awards where anyone; medical student to consultant, can present their innovative ideas and inventions. I really enjoyed the opportunity to meet trainees and surgeons from all over Australia and overseas. The social events were great, a lot us of enjoyed the chance to let our hair down and have a dance. I am really looking forward to attending PSA 2020 in Bega.

Dr Tina Dilevska, SET 3, Western Australia
This was my first PSA experience and I have to say, I have never felt so welcomed at a conference before. The theme this year was 'Operating in a big country: enhancing outcomes from major surgery in provincial cities.' The ensuing four days demonstrated that big things do happen in small towns. My conference experience began with an interactive laparoscopic colorectal skills workshop run by Drs Caroline Vasey, Bruce Stewart and John Lumley. We spent the day watching three live colorectal cases, discussing pertinent topics, exchanging 'tips and tricks' and practising skills on simulators.

Dr Andrew Evans, SET 4, Queensland
I attended the PSA ASC once again, this year in Ballarat, Victoria. Now a SET 4 trainee in General Surgery, I've attended most of the PSAs over the years since I was an intern and from each one I've come away feeling my prospects have been furthered on one or more fronts. Best of all, this seems to happen whilst having a good time in excellent company! This year was no exception.

Dr Shantanu Joglekar, SET 4, Victoria
As the unit registrar, I was privileged to be closely involved in the all-day live Colorectal Surgery telecast. Each case had an element of challenge – Bruce Stewart demonstrated TAMIS in an anteriorly based lesion, Carolyn Vasey performed a Laparoscopic Right Hemicolectomy on a BMI 37 patient, and John Lumley from Brisbane gave a masterclass in Laparoscopic Ultralow Anterior Resection in a radiated pelvis. There was witty commentary from the operating surgeons and facilitators which made for robust discussion about technique, and attendees could also visit theatre and put on the 3D glasses or hone their skills on the TAMIS and lap colectomy simulations.

Dr Roderick McMurray, SET 4, Western Australia
Presentations from invited speaker Samantha Quade gave us insights into her robotic colorectal practice in Seattle, USA. Several video demonstrations highlighted the principles of these procedures. It was described that in her home state of Washington, several regional hospitals have DaVinci Robots – this approach is becoming more common with metropolitan and tertiary institutions. Could this be the future for us here in regional Australia? Is this something for us to aspire to? I am grateful to have had the opportunity to attend with the support of the Rural Coach grant. This meeting was an inclusive and inspiring experience for the budding rural surgeon.

Dr Domenic La Paglia, SET 3, Victoria
I had a very positive experience at the PSA conference in Ballarat. Highlights of the conference included the intra-operative care/trauma session, where I learned about the challenges associated with trauma management in various geographical settings ranging from Horsham in regional Victoria to Everett in Washington, USA. It was interesting to hear from Samantha Quade, who spoke about her journey from regional Victoria to the USA and shared her current experience working as a colorectal surgeon. As a trainee, I was fortunate to hear Damian Fry's talk and insights into training in regional Queensland. Attending has helped to further my knowledge about regional surgery, the challenges faced, and more importantly, the benefits of working in a regional setting.

▸ Save the date – PSA 2020 Annual Scientific Conference

The PSA 2020 ASC will be held from 6-8 August 2020 in Bega, New South Wales. To register, please visit psa.generalsurgeons.com.au

About the Rural Coach Program for surgical trainees

The Rural Coach Program has identified and supported more than 100 trainees interested in a rural surgical career. The program, overseen by a rural-based clinical director (mentor), provides pastoral care and advocacy while also assisting to build trainee connections. The clinical director's experience in rural and or remote clinical settings helps them identify career opportunities for trainees, and their established network in rural and remote areas can be accessed for the benefit of the trainee to achieve their career potential as it relates to rural Australia. Trainees contact the clinical director who then determines where the trainee would like to commence practice, advises on the likely vacancies and puts the trainee in touch with one or more of the surgeons in that area.

As of 2019, the clinical director is Dr Damian Fry FRACS. Damian joined the Rural Coach Program in 2015 as a General Surgery SET trainee in receipt of the RCP GSA Registration Grant.

Trainees interested in participating in the Rural Coach Program are encouraged to contact rural.coach@surgeons.org

New pilot a big win for regional health

Two Australian hospitals will receive a boost to their workforces as part of a new pilot that is being launched by RACS and the Commonwealth Department of Health.

The 'New Fellow Rural Placement Pilot' will see Royal Darwin Hospital (RDH) and Cairns Hospital both receive funding for an additional surgeon at their hospitals.

The aim of the pilot is to provide new Fellows with a comprehensive, high quality experience in a rural location that will help them consolidate their skills, with the intention to encourage them to consider working in a rural setting long-term.

RACS Northern Territory Chair Mr Mahiban Thomas, who is also the Director of Surgery at RDH, has been a passionate advocate for rural and regional surgery, and said that the announcement was a major win for RDH and the Territory.

"In the NT we face unique challenges because of our geographical isolation and low population density. We have experienced ongoing issues trying to attract and retain surgeons, particularly those at the start of their careers who might potentially look to base themselves here long-term.

"I know an additional full-time placement may not seem that significant to those based in a major metropolitan area, but for regional communities, initiatives like this are significant. The pilot is a great opportunity for us to sell the amazing lifestyle that Darwin has to offer, and forms an important part of our strategy to attract new surgeons to the area."

These sentiments were echoed by vascular surgeon Dr Roxanne Wu who led the application process for the Cairns bid.

"It is absolutely terrific to bring in new people to Cairns and to be able to share the wealth of work that there is to do and to show them that working in a regional area does not mean working in isolation", Dr Wu said.

"We have great clinical resources, great clinical work, and there are so many amazing rewards that you get from working with patients that have such a real need for your services.

"We are very grateful for this opportunity and I think that the way the pilot is structured is a really good model that will benefit everybody involved."

South West Victorian Ear Nose and Throat Surgeon, and Chair of the College's Rural Surgery Section Committee, Dr Bridget Clancy, said that is was often difficult to attract metropolitan based surgeons to regional locations for a number of reasons. This included the perception that there will be added expectations of on-call work and overtime.

"Our rural and regional communities are fantastic places to work and live. From a professional perspective there is usually a diverse caseload mix which is excellent experience especially for younger surgeons just starting out.

"As part of the pilot we asked hospitals to demonstrate that they could meet a number of criteria, including having at least two practising consultant surgeons already based in the hospital, and a willing mentor.

"A commitment to safety and sustainability was also required, with surgeons rostered in keeping with RACS Safe Hours Policy. In addition to this, the funding provided will be divided between a mixture of salary support, professional development, and relocation assistance.

"We will shortly begin advertising the two positions with a view to the pilot commencing in 2020. If it is successful we hope to be able to incorporate it as part of our broader rural health strategy aimed at providing better access to surgical care in our regional communities." ■

Dr Charles New promoted to Surgeon General of the Australian Defence Force Reserves

The first orthopaedic surgeon to be appointed Surgeon General of the Australian Defence Force Reserves, Dr New has contributed immensely by providing surgical support to Australian troops abroad.

RACS Fellow Dr Charles New has been appointed Surgeon General of the Australian Defence Force Reserves (ADF-R). Dr New is the first orthopaedic surgeon to be appointed to this role, and the third RACS Fellow to take up the position.

With an impressive history of leadership roles in both civilian life and military service, Dr New holds the rank of Major General in the Royal Australian Army Medical Corps (RAAMC). He has seen active service in Rwanda, East Timor and Banda Aceh.

Dr New's military career commenced in 1992 when, as a final year registrar, he enlisted in the RAAMC as a captain. Assigned to the 1st Parachute Surgical Team in Holsworthy Sydney, he trained to support airborne forces and provide surgical support.

In 1993, Dr New travelled to the UK, where he was Spinal Fellow at the prestigious Royal National Orthopaedic Hospital in London while on exchange to the British Army and the 23rd Parachute Field Ambulance Aldershot as an orthopaedic surgeon. It was there that he learned about the reputation of the British Royal Army Medical Corps (RAMC). "We have a history in our corps of staying with our troops," he said. "We serve by providing the best medicine possible in an austere environment."

The following year, in 1994, Dr New's International Spinal Fellowship at the North Shore Hospital in Sydney was interrupted when he was deployed to Rwanda for three months. In 1999, he was deployed to East Timor as part of the Parachute Surgical Team that went in with the surgical forces. And five years later, in 2004, Dr New was part of the same East Timor team deployed this time to Banda Aceh.

To be a surgeon in Banda Aceh can only be described as "extreme medicine", he said. In Banda Aceh, where the temperature at midnight was 38 degrees with 96 per cent humidity, "they still had a civil war going the same time as the earthquake and the tsunami". All these places, Dr New said, "were very troubled and then there's medicine in the middle of it". Dr New's contingent in Rwanda was awarded the Meritorious Unit Citation 'OP TAMAR RWANDA', recognising sustained outstanding service in warlike operations.

Dr New has been awarded an Order of Australia for services to medicine, is an Adjunct Professor of Surgery at the University of Sydney, and an Associate Fellow of the Royal Australian College of Medical Administrators, as well as the Australian College of Aerospace Medicine.

Since 1995, Dr New has practised at the Nepean Hospital in Penrith.

"All of my colleagues have been supportive of me going away and doing military service," he said. "They've backed me up and looked after my practice. That's a genuine fellowship."

Of his new military role, Dr New said "I'm there to provide good clinical advice and sound governance; and to promote a legacy of recruitment and mentoring of the next generation." Any member of RACS who is interested in

the ADF-R – particularly orthopaedic surgeons, neurosurgeons and general surgeons – can contact Dr New and have a confidential chat. "Should anybody wish to test themselves and come with us, I would be more than happy to be contacted," he said. "If anybody wants to talk to me, they'll be talking to a senior colleague." Dr New can be contacted at his consulting rooms: +61 2 4731 4855 ■

'The Lion Tamers' – the First Residential Course for Younger Fellows 1982

The Younger Fellows Forum is a professional retreat of RACS Younger Fellows held prior to the RACS Annual Scientific Congress.

Peter Burke, a member of the first Residential Course for Younger Fellows in 1982, discusses the origins of that course, the course outcomes and now, as such gatherings grow from strength to strength, how they embody the true meaning of 'Fellowship'.

Images (clockwise from top left):
R C Bennett; The 1982 group; 1982 program detail; Fax gloriae as illustrated in the RACS Arms.

In his 2002, *The Mantle of Surgery,* an account of the first 75 years of the Royal Australasian College of Surgeons, author Wyn Beasley provided alternatives for the translation of the Latin College motto, *'Fax mentis incendium gloriae'*: the preferred version, 'The flame of glory is the torch of the mind'; an alternative, 'The torch of glory inflames the mind'.

Latin dictionaries define *'fax'* as a torch or a firebrand, and a closer examination of the College Arms granted in 1931, confirms the presence of one such significant torch, the *fax gloriae*.

The Fellowship of RACS signifies not just successfully negotiating examinations and proceeding to a career in surgery; what is less appreciated is the obligation to pass knowledge from one generation of surgeons to another; the science and importantly, the art of surgery.

Intangible knowledge must be passed down from senior fellows to younger fellows: just as pertains in the Olympic Games, RACS has its own 'torch' relay in the form of the Younger Fellows Forum.

In 1975 two significant members were appointed to College Council, Arthur Wynyard Beasley from Wellington, New Zealand, and Richard Clayton Bennett from Melbourne.

To quote from Beasley's 2002 history, *'as the class of '75 became firm friends, round the table and off duty alike, we came to reflect on the fact that our friendship had to wait, by and large, until our election to the Council. Dick Bennett's thoughts went one stage further: how much better if we had been given an opportunity to become friends earlier in our surgical careers – well then, let the College give such an opportunity to the next generation of surgeons'.*

In June 1980, Bennett submitted a document to Council entitled *'Promotion of Excellence and Leadership'*: the Executive Committee made several amendments to the document which was circulated on 29 August 1980 to all Honorary Secretaries of the state and New Zealand committees,

concluding with, *'those committees are now invited to give this matter consideration. Council would be pleased to receive worthwhile suggestions on:*

1. *The selection and sponsoring of fellows.*
2. *The proposed name, organisation and content of 'camps' or 'schools'.*
3. *The promotion of the overall programme.'*

With the exception of the Victorian Committee, which wrote to advise that it *'does not support the principle of a camp, but that it does support the concept of a R.A.C.S. Travelling Fellowship'*, there was general approval and support for the document.

Accordingly, in the *'RACS Bulletin'*, Vol. 1 No 2 of July 1981, the precursor of today's Surgical News, there appeared a small notice headed *'Special Course for Young Fellows, Wellington, January- February 1982'*, which continued, *'applications are invited from Provisional Fellows and Fellows of up to five years standing for selection to attend the above course which will be held immediately after the 55th GSM (ASC) in Christchurch.*

'Attendance will be limited to 20, with a full geographic distribution. Selection will be undertaken by the State and New Zealand Committees. The purpose of the course is to advance the participants' knowledge of the Science of Surgery with special emphasis on professional excellence, leadership, and involvement in College affairs.

'The programme, to which each participant will be expected to make significant personal contributions, will include clinical, research, and professional topics. Sporting and social functions will be included, and participants will meet with Council, during its meeting. Accommodation will be in university colleges. This and the social functions will be without cost to participants.'

It came to pass that with 19 male participants, the very first 'Residential Course for Younger Fellows' was conducted at Everton Hall and the Wellington Clinical School of Medicine, New Zealand, from Saturday 30 January to Thursday, 2 February 1982.

RACS Council was represented by John Clarebrough OBE PRACS; Professor Dick Bennett RACS Treasurer and Chairman of the Editorial Board of the *ANZ Journal of Surgery*; Sam Mellick, Chairman of the Board of Examiners; and Wyn Beasley, New Zealand Censor and Course Convener.

Most mornings course members presented scientific papers at the Wellington Clinical School, reached with a 45 minute walk of some four km over challenging terrain, from their somewhat spartan accommodation in the flats of Everton Hall, Victoria University of Wellington.

Lunch was usually on return to Everton Hall, followed there by group discussions on prearranged topics such as 'Quality assurance in surgery' and 'Surgical manpower'.

One glorious day was spent at the magnificent homestead '*Orongorongo*', a 50 minute drive from Wellington, with all course members and many College Councillors participating in various leisure and sporting events. During the return bus trip to Wellington, many stories were exchanged, including one concerning a lion tamer instructing a potential apprentice in the art.

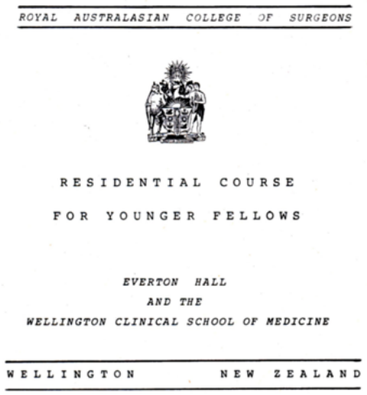
During morning tea on the following day, in the auditorium of the Wellington Clinical School of Medicine, there was a Presidential directive that this story be repeated: the request was complied with, complete with improvised 'chair and whip', receiving mighty applause.

The transmission of knowledge, from old to young, struck a chord with all in attendance: as Wyn Beasley recorded in his History of the College, all the Younger Fellows and attendant members of Council agreed that they be known henceforth as, *'The Liontamers'*.

Courtesy of Lion Breweries, Wellington, a tie was acquired and worn at all future meetings by members of the group, including memorable dinners hosted by Sam Mellick at the Queensland Club in 1997 and 2009.

At the conclusion of the course a consensus report was prepared taking the form of three recommendations which course members requested Council to consider.

These were, firstly, that advanced training in general surgery should consist of four years in accredited general surgical positions; secondly, that the College should oversee and promote the establishment of senior registrar positions for Fellows who wish to pursue a special interest; and thirdly, that all training programs be organised and supervised at a regional level rather than at the level of individual hospitals.



ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

RESIDENTIAL COURSE

FOR YOUNGER FELLOWS

EVERTON HALL
AND THE
WELLINGTON CLINICAL SCHOOL OF MEDICINE

WELLINGTON NEW ZEALAND

The seven page report, forwarded on 16 February 1982, signed by all course members, concluded, *inter alia,* with these comments: *'the composition of the course was excellent, with the group representing a spectrum of age, nature of practice and geographical origin', 'we would like to suggest that such courses continue to be held at regular intervals', 'the residential nature of the course should be maintained', all attendees 'were unanimous in their praise of Council for establishing this Course.'*

The College President, John Clarebrough, replied on 1 September 1982:

'On behalf of Council may I congratulate the Young Surgeons on a well thought and carefully considered report. Its substance will influence Council thinking, even if all the recommendations have not immediately been accepted.

'The Council believes it to have been a very successful exercise. I would hope that future courses will be as successful as the first.'

Such annual assemblies of Younger Fellows continue, moving from strength to strength: no longer need one attend a College meeting without knowing any other Fellow; there is an enhanced sense of 'belonging' and true Fellowship.

Sadly, those original mentors have recently left us: Dick Bennett in 2018 and Wyn Beasley and Sam Mellick in 2019: our debt to them is immense.

Responsibility now falls on the shoulders of current Fellows to continue the College 'relay', handing on the *fax gloriae*, the torch of glory, fulfilling the true meaning of Fellowship. ■

Mr Peter F. Burke, FRACS 'Lion Tamer'.

Exploring our College's rich history online

Over the past three years the historical content of the College website has undergone considerable expansion and re-formatting to aid navigation and research. This has been the result of efforts by the College curator, the College archivist and the website developers. The historical and archival sections now offer both directly accessible content and links to important sites relevant to our history.

Initial access is from the College home page via the 'About the College of Surgeons' link. This provides access to three major sub-sections:

- Our heritage and archives
- Museum and art gallery
- In memoriam

The 'Archives' section, to quote from the website is 'the corporate memory of RACS from its origins... to the present day' and is divided into topics: A brief history; Early history; Archives; Digital exhibitions; Collections, and Publications about RACS history.

The 'brief history' section is very brief and is probably more designed for the public with the 'early history' section containing a slightly expanded version covering the establishment of the College from 1920 to 1935 by the late Wyn Beasley. The 'comprehensive archive' is contained under the publications page, with a detailed history of the College (including a digitised copy of *The Mantle of Surgery*), a history by Julian 'Orm' Smith covering the years 1920 to 1935 and a second article, also from the *ANZ Journal of Surgery* and covering the years 1935 to 1960 by Sir Douglas Miller. These articles are nicely complimented by Gordon Low's article written in 2007 which celebrates 80 years of College history. The archives also contain a second view of early College history written as a BA (Hons.) thesis by Andrew Newton, a descendant of Sir Alan Newton.

The digital exhibitions area of the website presents a number of PDF flipbooks based upon presentations written by the College archivist and the curator over the past several years. These cover aspects of surgeons in conflict, early women surgeons and their involvement with the provision of surgical services during World War I and a detailed history of the College site in Melbourne from early European settlement through the construction of the original College building and its subsequent modifications and expansions. Each flipbook contains a substantial history presented in an engaging fashion accompanied by appropriate illustrations. Their content is an electronic version of the information panels compiled by the College archivist and curator that have been on display at the College in Melbourne and some of which are being circulated to our offices throughout New Zealand and Australia.

Under the heading 'Publications about RACS history' is an interesting article by Sir Patrick Kenny on the 41 Founder-Fellows of the College. Written in 1984 in a 'Lives of the Fellows' format, past President Patrick Kenny and his co-authors have written a fascinating account of the careers of the Australian and New Zealand surgeons who responded to the founding letter from Sir George Syme and who subsequently formed the nucleus of what became the Royal Australasian College of Surgeons. An even earlier presentation is listed under the section headed 'History of surgery in Australia and New Zealand' → 'How Surgery Came to Australasia' – this was presented at the opening of the College in 1935 by the honorary librarian of the English College, Sir D'Arcy Power FRCS. And this is complimented by a paper by Rowan Nicks in 1980 titled 'Australian Surgeons and Society'.

The 'In Memoriam' section is a list of departed Fellows arranged in the year of their death. Where an obituary has been lodged with the College, this is highlighted. Additionally, our archivist welcomes CVs from Fellows when they retire. Please send your CV to Elizabeth.Milford@surgeons.org.

In summary, the online history of the College is now a very useful resource for research or for background information for Fellows and the public. Its content is still being developed and repeat visits will prove worthwhile. ■

Mr Campbell Miles
Chairman of the Heritage and Archives Committee

Images left to right:
Meeting of the College executive in the 1940s; Founding Fellows who attended the College Congress in Dunedin in 1927.

An invitation from the Foundation for Surgery and the D'Extinguished Surgeons

Please RSVP to foundation@surgeons.org by 20 March 2020

Royal Australasian College of Surgeons
Foundation for Surgery

The Significance of Apothecaries – an historical overview

The Worshipful Society of Apothecaries of London, founded in 1617, remains an important, active and innovative medical institution. Offering qualifications in unique areas of medical practice, the Society is the examining body for seven different diplomas, including the Diploma in the History of Medicine.

This lecture will be delivered by Mr Peter F. Burke FRACS, who gained his Diploma in the History of Medicine in 1978.

12 noon , Friday 3 April 2020
RACV City Club,
501 Bourke Street,
Melbourne, VIC 3000

Lunch will follow the presentation.

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

New Zealand Chair update

Ngā mihi o te tau hou! Happy New Year and I hope that 2020 is a healthy and fulfilling one for you.

In Aotearoa/New Zealand, 2019 was book-ended by two tragic events that highlighted the crucial role that surgeons and their teams play in such traumatic times.

In March, the shootings at two Christchurch mosques resulted in weeks of unstinting work for surgical teams, operating around the clock to try and save as many lives as possible and limit the long-term harm caused by those injuries. Twelve operating theatres at Christchurch Hospital were active and the amount of emergency work completed was unprecedented, especially the scale of penetrating trauma which is rare in New Zealand.

Surgeons in both New Zealand and Australia are still caring for survivors of the volcanic eruption on Whakaari/White Island last December. The nature and extent of burns injuries sustained by people at one time was again unprecedented in New Zealand. The injuries were complicated by the mix of toxic gases and chemicals from the eruption.

No amount of training prepares you for traumatic events such as these and on behalf of the RACS New Zealand National Board I want to express my sincere thanks to all our colleagues from New Zealand and Australia who have done such incredible work caring for people injured in these tragic events.

In 2020, an event I am greatly looking forward to is RACS New Zealand's Annual Scientific Meeting, *Surgery 2020*: *Reflecting on Practice*, which will be held in August. We warmly invite you to attend. This will be a great event for a number of reasons:

- The keynote speaker, Professor Peter Brennan, consultant oral and maxillofacial surgeon at Queen Alexandra Hospital in Portsmouth, England, lead editor for the new *Gray's Surgical Anatomy* and internationally renowned expert in human factors and patient safety. I have been fortunate to hear Peter speak on a number of occasions and can guarantee he will inspire you and encourage you to approach your day to day work in a refreshingly different way.
- The opportunity to reflect, catch up with colleagues and make new acquaintances. Although as individuals we may go home after a day's or evening's work and think about what we were happy or unhappy with, meetings such as *Surgery 2020* enable us to reflect as a larger group on our roles and the broader issues that confront us as a profession. And we often come up with some wonderful ways of addressing those issues. This meeting is also a great way to meet up with former colleagues and establish new relationships.
- The destination. *Surgery 2020* will be held in Queenstown, in the heart of New Zealand's stunning Southern Alps with arguably the best ski fields in the country. Be sure to tag on a day or two before or after *Surgery 2020* and explore the amazing Central Otago region with some of the finest wineries in Australasia if not the world, spectacular cycling and hiking trails, and – given that it's New Zealand's adventure capital – some breathtaking experiences from bungy jumping and luging through to jetboating and paragliding.

There will be more information about *Surgery 2020* throughout the year on the New Zealand section of surgeons.org but you will need to book flights and accommodation soon as Queenstown gets very busy in winter!

Nicola Hill, Chair,
New Zealand National Board

A new chapter begins

New digs for RACS South Australia

On 19 December 2019, RACS South Australia representatives braved the Adelaide heat to attend the official soil turning ceremony to mark the first stages of the South Australian Fellowship's move to a new purpose-built facility in the suburb of Kent Town.

The ceremony follows a decision by the Board of Council in April 2019 to approve the sale of the current South Australia (SA) office, and the relocation of all South Australian staff (currently located in two separate buildings) to a single premise as part of a long-term rental agreement.

The new building will provide many benefits to the Fellowship, with its flexible floor plan catering for a wide variety of meetings, symposia, workshops, courses, exams, receptions, dinners and other social functions.

Among the attendees at the turning ceremony were RACS President Dr Tony Sparnon, current RACS SA Chair Dr Phil Worley and Vice Chair Dr David King. Also present were former SA chairs, Mr Glen Benveniste, Mr Michael Jay and Mr Suren Krishnan, who were all instrumental in the purchase of the current RACS SA building at 51-54 Palmer Place in North Adelaide.

Speaking at the ceremony, Dr Worley acknowledged the important role that the Palmer Place property has played to the Fellowship for more than two decades, while also highlighting the exciting chapter that lies ahead.

"I wish to acknowledge the vision of Glen Benveniste and Michael Jay who, in 1994 – 1996, proposed the purchase of 51-54 Palmer Place, North Adelaide, to RACS President, the late Mr Colin McRae, and the RACS National Council. "This building has seen 22 years of many significant College activities, big and small, including the hosting of a lunch for The Hon John W. Howard, Australian Prime Minister, on 7 July 2004.

"In April of this year, like Glen, I found myself in the same position presenting to Council (Executive) the proposal to bring RACS to 24 King William Street, Kent Town.

"Looking to the future for our membership and that of our College, this brand-new, contemporary purpose-built facility will accommodate many RACS activities and build on what we have been able to bring to South Australia at Palmer Place, plus more," Dr Worley said. ■

Image left to right:
Mr Glen Benveniste (RACS SA Chair 1996-98) and Dr Phil Worley (current SA Chair)

AHPRA mandatory reporting

Mandatory notifications are an important part of patient safety. AHPRA needs to know when patients may be at substantial risk of harm from a registered health practitioner.

AHPRA wants to ensure that practitioners with health issues feel safe to seek treatment without fear of an unnecessary mandatory notification being made about them. An important part of being a health professional is getting the healthcare you need, without fearing a mandatory notification.

AHPRA encourages practitioners to seek professional advice for their health. A treating practitioner is only required to make a mandatory notification in very specific circumstances: in cases of sexual misconduct or when there is a substantial risk of harm to the public. This is a very high threshold for reporting and will rarely apply.

"Healthy practitioners are good for patient safety. We want all registered practitioners to know what the changes mean for them and to seek advice and support for their own health and wellbeing, without fear of an unnecessary mandatory notification," AHPRA CEO Mr Martin Fletcher said.

New resources have been published to explain mandatory notifications, and when they do and do not need to be made, in preparation for new requirements that take effect in early 2020. Produced by AHPRA and the national boards regulating Australia's health practitioners, the resources aim to support practitioners to understand changes to the law about mandatory notification requirements which were made by health ministers.

The resources can be found on the AHPRA website under the 'Concerns about practitioners' bar.

The National Law amendments to mandatory notifications are expected to take effect in early 2020 and will apply in all states and territories except Western Australia, where mandatory notification requirements will not change. ■

Kelvin Kong recognised with Graham Coupland Medal

Inspirational Newcastle surgeon and RACS Fellow, Associate Professor Kelvin Kong, was recently presented with the Graham Coupland Medal in recognition of his distinguished career.

The medal was presented to Associate Professor Kong by Dr Ken Loi, Chair of the College's New South Wales State Committee, as part of a special ceremony at the NSW Parliament House to mark the end of Surgeons Month in NSW.

When presenting the medal, Dr Loi said, "The medal is named in honour of a brilliant and natural surgeon, Graham Coupland. The intent is to recognise surgeons with a dedicated history of service not just to our profession, but also to the broader community.

"Through his tireless efforts and committed advocacy in a range of different areas, Kelvin has made an enormous contribution to our society and improved the lives of so many Australians. He is most deserving and is the embodiment of what this award stands for."

Upon gaining his Fellowship in 2007, Associate Professor Kong became Australia's first Aboriginal surgeon. Today he is one of only three Indigenous surgeons in Australia, and is passionate about addressing the disparity in health outcomes between Indigenous and non-Indigenous children.

In particular, Associate Professor Kong has been a key driver in improving the ear health of Aboriginal and Torres Strait Islander children. The World Health Organization has previously estimated that Aboriginal children have among the highest rates of chronic otitis media (ear disease) in the world. Some studies have suggested that up to 90 per cent of Aboriginal and Torres Strait Islander children in remote communities present with otitis media.

When left untreated, the disease can result in hearing impairment and contribute to behavioural problems that affect a child's social, emotional and educational development.

Each year, Associate Professor Kong spends a portion of his time working in, and for, remote Australian communities providing access to quality healthcare that would otherwise be limited or unavailable. He has also been at the forefront of campaigns such as #EarHealthForLife and worked with governments at all levels to try and achieve better health outcomes.

Earlier this year, Associate Professor Kong helped to launch the Yarn for Life initiative, a new initiative by Cancer Australia. Figures suggest that on average Indigenous Australians are 40 per cent more likely to die from a cancer diagnosis than non-Indigenous Australians. The initiative aims to reduce the impact of cancer within Aboriginal and Torres Strait Islander communities by encouraging and normalising discussion about the disease.

As part of the ceremony, Associate Professor Kong delivered the Graham Coupland Lecture where he spoke of his passion for paediatrics and surgery, his belief in education and the pride he derives in serving the broader community.

"From the age of near birth right though to two or three years of age, it's a crucial time that we learn to hear, speak and see," Associate Professor Kong said.

"There is nothing more unequal than the equal treatment of unequal people. Rather than focusing on equality, we need to achieve equity. We can predict some of the younger patients, their health outcomes, education outcomes, life-long employment prospects and social support changes as they grow from five years to 25 years.

"We are in the position of influence and power to improve, advocate for patient accessibility and influence those in positions of power and decision making to achieve diversity and equity."

Associate Professor Kong's Graham Coupland Medal adds to an already impressive list of achievements, including a recent Honour Roll mention for Australian of the Year. ■

Image left to right:
Dr Ken Loi and Associate Professor Kelvin Kong

Decision-making in pelvic exenteration surgery

Dr Cherry Koh talks about decision-making in pelvic exenteration surgery, a radical procedure for patients with advanced cancers in the pelvis that removes all organs within the pelvis that are involved in the recurrent cancer. The magnitude of this surgery and the prolonged recovery following surgery is often underestimated by patients, and for surgeons it is a complex and challenging procedure.

Dr Koh works at the Royal Prince Alfred Hospital (RPA) in Sydney where 70 to 80 of these operations are performed every year. Pelvic exenteration is offered in all Australian states but the more complex procedures are commonly referred to RPA, which is internationally renowned for developing many of the novel surgical techniques for pelvic exenteration. The unit has also published widely in the field to help advance knowledge and understanding.

In her research, Dr Koh found a gap in the literature around "what we understand about how surgeons and patients make decisions about treatment choices, particularly when the stakes are high." Dr Koh went on to examine the following three components of decision-making.

The first component, surgeon decision-making, looked at the surgical margins needed to consider the resection complete. Dr Koh also conducted a survey of colorectal surgeons and found that many are comfortable offering small exenterations, but feel patients should be referred to referral centres for major pelvic exenterations. In addition, the survey explored what complications and risks surgeons were willing to accept by putting themselves in the shoes of the patients faced with pelvic exenteration.

The second component of Dr Koh's research looked at societal decision-making and whether exenteration surgery was cost-effective. She discovered, contrary to popular opinion, that it is cost-effective. "What we forget is that patients who don't have surgery still need ongoing treatment, whether it's chemotherapy, immunotherapy or radiotherapy," she said. "Plus, as the cancers continue to grow, there will be further complications and repeated presentations and admissions, despite not having the initial costs associated with surgery." Even with the high upfront costs associated with surgery, Dr Koh said, "It is cost-effective in the long term because of improved survival rates and improved quality of life."

Third, Dr Koh looked at patient-decision-making. "It's a really big operation," she said. "Why would patients want to put themselves through this?" As well as the invasive nature of the surgery, patients must decide whether they'll undergo the operation knowing there's a 50 per cent chance they won't be alive in five years even with surgery. They're not usually undergoing surgery because they want to return to work, as a lot of these patients have retired, Dr Koh said. "They do it for their family, for themselves and so they can return to recreational activities."

Dr Koh's research into patient decision-making has informed the patient journey at the RPA Hospital, and counselling is an essential part of that journey. "We don't just engage with the patient, but encourage them to attend with their family," she said. "Anywhere between two to five people turn up, often, the entire family." To facilitate patient recovery, there is also a well-established multi-disciplinary team that helps prepare the patient for surgery from improving their nutritional status to managing their pain, pre-operative anxiety and distress. It's a tailored prehabilitation program that has been in place for a number of years.

The clinical nurse coordinators also play a vital role in helping the patient through their journey. Patients who have been through it understand what patients need and many offer to speak to prospective patients to help them out with their journey. The good news for patients is that their quality of life (QoL) after their procedure does, over time, return to their baseline QoL.

Dr Koh is about to complete her PhD research into decision-making in pelvic exenteration surgery, and is grateful to RACS for awarding her the Foundation for Surgery Research Scholarship to assist in this important work. The scholarship supports Fellows who wish to take time away from clinical positions to undertake a research project under the supervision of an experienced investigator. ■

For further information on the Foundation for Surgery Research Scholarship, please visit the scholarships section of the RACS website.

Left–right: Dr Cherry Koh, Professor Brendan Moran, Dr Daniel Steffens

Case note review

Transfer to inappropriate hospital and unnecessary imaging delays in drainage of infected hip.

Case details: An elderly nursing home patient with early dementia was admitted to the emergency department of a regional hospital with pain and an inability to weight bear on the right hip. Baseline x-rays of the joints were normal. The white cell count (WCC) was approximately 3 x 10^9/L, and the C-reactive protein (CRP) was greater than 500mg/L.

Two days later, and recognising that the patient was unwell, the regional hospital transferred the patient to the general medical team at a smaller metropolitan hospital. The computed tomography (CT) scan performed on admission was not available to review, but a later note suggests it revealed a multi-loculated gas collection in the right thigh.

The patient spent two days at the metropolitan hospital before being transferred to a tertiary hospital for further investigation and treatment. By this stage, the patient had a confirmed streptococcus G bacteraemia with several potential sources. On arrival at the tertiary hospital, the WCC was greater than 12 x 10^9/L, and the CRP greater than 450mg/L. The patient's Glasgow Coma Scale was 9/15.

Two days after arrival at the tertiary hospital, a further CT scan was undertaken and confirmed the right thigh collection, now greater than 11cm. From the report, it was much larger than the first CT scan. This was drained the same day and 'pure pus' aspired. The WCC result (approximately 18 x 109/L) was only repeated four days after admission. The CRP was not repeated.

Subsequent to this, the patient deteriorated and after discussion with the family and the treating teams, a decision was made to cease active treatment.

Surgical lessons: On initial admission to the regional hospital, this patient had a streptococcal bacteraemia. The source was not obvious, and it was two days before the patient was referred to a smaller metropolitan hospital with a CT scan. Despite that scan, done on admission, showing a soft tissue infection, no drainage was undertaken, and after two days the patient was referred to a tertiary hospital. The patient then waited another two days before the CT scan was repeated. Only then was the abscess drained. So there was a total delay of six days before the septic source feeding the overall septicaemia was definitively treated.

There was a delay in transfer, assessment and management of this patient. It is very difficult to understand how both the metropolitan hospital and tertiary hospital permitted a septic patient with a known focal source to lie untreated for two days. The mortality for such sepsis is extremely high even with perfect treatment. Whilst there is no certainty that more timely intervention, be that radiological guided drainage or surgery, would have changed the outcome, without drainage death was inevitable. This avoidable delay was a major contributing factor to the outcome.

At the regional hospital, a septic patient with right hip pain should have been discussed with an orthopaedic surgeon rather than being transferred to a smaller metropolitan hospital with no on call orthopaedic service.

The final decision whether or not to operate is not well documented and, whilst in this case radiological drainage may have been appropriate, some documentation as to why this decision was reached would have been useful. ■

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

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

Correction – Searching for a new AAA screening tool (November–December 2019)

In the December issue of *Surgical News (p35)*, it was reported that after the death of Professor Philip Walker, Dr John Bingley took over the role of Dr Vikram Iyer's research supervisor. We would like to note that along with Dr Bingley, Professor Jon Golledge was also Dr Iyer's supervisor and provided the research set-up at James Cook University for the project.

Enriching our surgical community

Mr Prashant Joshi came to Australia as an international medical graduate (IMG) in search of better educational opportunities for his children. What he found was a better life for his whole family.

Cardiothoracic surgeon Mr Prashant Joshi joined Melbourne's Monash Medical Centre as an IMG in 2009, but it wasn't the first time he'd worked in the country he now calls home.

After completing his undergraduate and Masters degree in General Surgery at the prestigious Nagpur University in central India – also one of the country's oldest universities – Mr Joshi went on to Bombay University where he specialised in Cardiothoracic Surgery. Then, in 1993, he came to Australia to complete a cardiothoracic fellowship at the Prince Charles Hospital in Brisbane. Unfortunately, at that time there was no IMG pathway for cardiothoracic surgery in Australia, so he accepted an opportunity to work in Malaysia at Sarawak General Hospital (SGH) in Kota Samarahan – a university town known among Malaysians as 'The Knowledge Town'.

At Sarawak General Hospital, Mr Joshi set up the hospital's Heart Centre and ran it from 2000–2009. During these years, he operated on 7000 patients – both adults and children – including those with congenital cardiac diseases. Many of these patients had come from the rainforest region in remote and secluded parts of Borneo in Malaysia.

"There were 2.8 million people with no cardiac surgery access," Mr Joshi explained. So, together with Australian-trained cardiologist, Dr Sim Kui Hian, who was a Malaysian citizen from Sarawak, they set about providing expert surgical care to patients in need of life-saving operations at the Heart Centre.

In order to establish the highest surgical standards possible, Mr Joshi and Dr Sim set up collaborative mentoring relationships between the cardiothoracic surgeons and cardiologists in Australia and Malaysia. "The Australian surgeons and cardiologists supported us and we were able to provide services with the same standard as Australia," he said. "We succeeded in raising the bar very high."

While Mr Joshi enjoyed his work at the Heart Centre, he was becoming increasingly aware of the need to find somewhere for his two sons to gain a comprehensive education. So, together with his wife, anaesthetist Dr Vaishali Anant Londhe, they made the decision that he should apply to become a RACS Fellow and look to move to the Antipodes for their sons' ongoing schooling.

In 2009, Mr Joshi attended his panel interview for his RACS Fellowship and also commenced working part-time at the Monash Medical Centre in Melbourne. While it can be a challenging time for IMGs adjusting to a different culture and ways of practising medicine, he was well prepared.

Throughout this time in Malaysia he had stayed in touch with RACS. "I presented and attended College meetings regularly," he said. "I came to annual scientific meetings and that helped me know what was required." According to Mr Joshi, the contribution of the College in those early days was "so important". Once you understand, as an IMG, that "people are going to help you" to understand the required process you naturally want to "become further involved and you become part of the system very quickly," he added.

It was also helpful that he reached out to other IMGs from different parts of the world whenever he could. "There was a lot of interaction," he said. "I have always had contact with Fellows" who were on the same IMG journey and settling into Australian life.

For highly qualified IMG surgeons it can be quite a daunting proposition to undergo retraining when they already have extensive training and expertise in their specialty from abroad. But Mr Joshi said he accepted that his level of experience needed to be examined. They need to "make sure that your practice is up to the standard expected of you", he said.

In Malaysia, Mr Joshi had been a consultant and head of the Department of Cardiothoracic Surgery at Sarawak General Hospital, as well as professor of Cardiothoracic Surgery at the University of Malaysia Sarawak. He was highly respected as a cardiothoracic surgeon, and also in his teaching role as a professor who taught and mentored medical students and junior doctors. But his surgical skills shone as brightly in Melbourne as they did in Malaysia and it didn't take long for his surgical expertise to be recognised in his new home country.

In Australia, Mr Joshi earned the respect of his surgical colleagues as he worked alongside them during operations. "Senior members of staff would stay around in order to lend support," he said, and over time he began operating on his own patients.

The Monash Medical Centre was also very supportive when the time came for Mr Joshi to apply for permanent residency. "I applied and when the residency came through, I was encouraged to apply for citizenship," he said. It was then that he learned his fellow surgeons in the department had unanimously endorsed his application for a full-time surgical role at Monash.

"I was very fortunate... The surgeons who were there at the time all reduced their hours and gave me some sessions and that was very generous of them." Their collegiality was reciprocated. " I don't want to work in any other hospital". It is clear his loyalty to the hospital and colleagues who supported him is steadfast.

"I was very fortunate," he explained. "The surgeons who were there at the time all reduced their hours and gave me some sessions and that was very generous of them." Their collegiality was reciprocated. "I don't want to work in any other hospital," he explained. It is clear his loyalty to the hospital and colleagues who supported him is steadfast.

Monash is a busy hospital and about 550 open heart surgeries are performed every year, as well as 600–700 thoracic procedures. "We all share the work," he said, referring to his surgical colleagues. Back in Malaysia, he was on call seven days a week, 24 hours a day, and this heavy workload was necessary because Mr Joshi was the only surgeon in the entire state. "I used to do all the emergency work as well as the elective work. It was very busy," he said. "Here in Melbourne, it's very busy, but also very supportive."

Mr Joshi became a full-time consultant at the Monash Medical Centre in 2013 and, in addition to his surgical work, he has been successful in securing a number of research grants. He has also been the principle investigator on four cardiac surgery trials and presented scientific papers in Asia, the UK and Australia.

Although his work as a cardiothoracic surgeon at Monash keeps him busy, Mr Joshi was able to return to Sarawak General Hospital's Heart Centre in 2013, under a sponsorship program, to perform operations on patients in dire need of life-saving surgery. On that trip, he performed about 30 complex adult and congenital cardiac procedures over two weeks. Again, in 2014, over five days he operated on nine patients – five children born with defective hearts and four adults with severe heart failure. Malaysian Chief Minister Tan Sri Abdul Taib Mahmud called the work of Mr Joshi and the medical staff at the hospital a "life-saving service to the people". In 2015, Mr Joshi again travelled to the SGH to perform more operations under the sponsorship program.

Mr Joshi's wife, Dr Vaishali Londhe, passed her IMG exam "on her first attempt," he said proudly. She is now working in Melbourne as an anaesthetist. Their two sons have both followed them into medicine. One graduated from The University of Melbourne and is doing his residency, and the other is a second-year medical student at Monash University.

Mr Joshi is deeply grateful for the opportunities he and his family have been able to enjoy in Australia. "This is the best place in the world to live," he said. "Our experience here has been so good that our children took on our profession. Our children saw how happy we were in our work." ■

Highlights from the RACS Trauma Week 2019 symposium

Pedestrians – Staying Safe

Each year the RACS Bi-National Trauma Committee hosts a symposium during 'RACS Trauma Week' which focuses on an area that needs attention and has the potential to reduce the devastating effects of trauma (injury) within the community. The 2019 symposium, *Pedestrians – Staying Safe*, brought together leading advocates, experts, researchers and clinicians to discuss the challenge of pedestrian safety.

Dr Valerie Malka, Director of Trauma Liverpool Hospital and Chair Road Trauma Advisory Committee, convened the symposium and coordinated a comprehensive program which included experts from key stakeholders exploring distraction, education, law enforcement, vehicle, road and future city design, safe speeds and alcohol.

Pedestrians are amongst the most vulnerable road users and in Australia make up a significant percentage of visitors to various areas daily. Pedestrian safety is an interconnected public health issue, which is related to city design, road rules, speed limits, road user perceptions and attitudes, street and footpath design – all of which impact pedestrian safety outcomes.

In concentrated urban environments, pedestrians comprise a majority – in Melbourne's CBD they account for two-thirds of the more than half a million daily visitors.

Pedestrian priority zones versus shared zones

The use of language plays a significant role in how signage is interpreted by road users and pedestrians. Harold Scruby, CEO, Pedestrian Council of Australia, advocated for a change of language from the use of 'shared zones' to 'pedestrian priority zones' in areas such as schools and carparks, reframing pedestrian safety as a top of mind priority for road users. During the symposium Harold was awarded a RACS plaque in recognition of his lifetime commitment as an advocate for pedestrian safety.

Safe speed limits

Professor Raph Grzebieta, Professor of Road Safety at the Transport and Road Safety (TARS) unit, focused on the importance of addressing safe speed limits in Australia to improve pedestrian safety outcomes. Across much of Europe, in high pedestrian traffic areas, speed limits are 30km/h. In numerous high-traffic pedestrian areas in Australia, speed limits of 50km/h (and sometimes higher) remain. The risk of serious injury or death to a pedestrian who collides with a vehicle at 50km/h is substantial.

Walkable communities and city design

Australian cities follow a North American city model, which are vehicle-centric in their design. This has numerous implications for pedestrian safety. Examples were given about the contrast between the pedestrian experience in Australia versus Europe, where numerous areas in CBD European cities are vehicle-free. To improve pedestrian safety in Australia, we need to rethink our design and start making spaces more pedestrian friendly. This can start as simply as ensuring pedestrians have adequate time to cross at busy intersections.

Investment

Hafez Alavi, Director Transport Safety - Strategy and Infrastructure at Road Solutions, noted that for real change to occur with pedestrian safety outcomes, equal investment to the scale of the issue had to be sought.

An elderly pedestrian, if hit at 40km/h, is almost 95 per cent likely to be killed. The injury data from Victoria's Transport Accident Commission (TAC) show pedestrians have a significantly higher risk of trauma. While approximately 11 per cent of serious road trauma is pedestrian trauma, the analysis of whole-of-life costs of road trauma shows over 18 per cent of road trauma costs are due to pedestrian trauma. This means serious pedestrian trauma is more costly than other serious road trauma.

Reviewing road safety infrastructure investments in Australia shows that only one to three per cent of these investments are spent on pedestrian safety infrastructure. Considering the magnitude and cost of serious pedestrian trauma, this level of investment falls significantly short. Currently, investment in pedestrian safety initiatives and infrastructure does not match the scale of the issue.

Towards Zero

The TAC presented on Towards Zero – Victoria's plan to work towards no serious injuries or deaths on our roads. The Towards Zero road safety principles have been implemented across most states in Australia; as well as internationally. This vision rests on four key principles – safe roads, safe speeds, safe vehicles and safe people.

We were fortunate at the symposium to have had support from the TAC (Transport Accident Commission), Victoria, and the NCCTRC (National Critical Care and Trauma Response Centre). Both agencies are keen be involved and lend support to road safety.

With thanks to the following speakers who contributed to the success of the day:

- *Introduction and overview,* Valerie Malka, Convener, Trauma Director, Liverpool Hospital
- *Pedestrian Case Presentation,* Mary Langcake, Trauma surgeon
- *Distracted Walking,* Grant Christey, Trauma Director, Waikato Hospital Waikato, NZ
- *The Scooter Epidemic,* Harold Scruby, CEO, Pedestrian Council of Australia
- *Intoxicated Pedestrians,* John Crozier, Chair RACS Bi-national Trauma Committee
- *Safe Speed Limits,* Raphael Grzebieta, Professor Road Safety, Transport and Road Safety (TARS) unit
- *Pedestrian Public Health,* Rebecca Ivers, Injury Epidemiologist, The George Institute
- *Vehicle Design for Pedestrian Protection,* David Logan, Senior Research Fellow, Monash University Accident Research Centre
- *Law Enforcement,* Ray Shuey, Pedestrian Advocate
- *Walkable Communities,* Ben Rossiter, Executive Officer, Victoria Walks
- *Road Safety Education and Schools,* Eric Chalmers, Co-Vice President, Australasian College of Road Safety
- *Pedestrian Friendly Road Design,* Bruce Corben, Road Safety Consultant
- *Future City Designs,* Jason Thompson, Melbourne School of Design
- *Re:act – a Road Safety Initiative,* Jerome Carslake, Manager National Road Safety Partnership Program
- *Smarter Planning for Pedestrians,* Hafez Alavi, Director Transport Safety - Strategy and Infrastructure at Road Solutions

To view the 2019 *Pedestrians – Staying Safe* presentations, please visit the RACS website at surgeons.org and search 'Trauma Week 2019'. ■

Image:
Presenters at RACS Trauma week

One thousand lives

Today I saved a thousand lives. I'm not certain about the number – it might have been only 100 or maybe only 10 – it might have been several thousand. I am not sure of the number but I am sure that lives will be saved. It was very easy. It only cost me $24,600. That is somewhere between $2,460 and $24.60 per life.

All I did was donate that money to a project that is organised by the Foundation for Surgery. The project in question was a scholarship to support two Timor Leste doctors to undertake post-graduate training in surgery at the Fiji National University. The project was funded for three years but a sudden change of government policy resulted in a shortfall and meant that 'for the want of a shoe the horse was lost and for the want of a horse the battle was lost'. The actual shortfall was less than 20 per cent of the total project costs.

The two Timorese medical graduates have successfully completed the Postgraduate Diploma in Surgery (PGD) in Timor. They have been selected to spend three years in Fiji at the Fiji National University to obtain a Masters of Medicine in Surgery (MMed Surgery).

Currently there are eight national consultant surgeons, seven of whom are working at the national hospital. One is undertaking subspecialty training abroad. Two PGD Surgery graduates are currently enrolled in the MMed Surgery at FNU and are expected to return to Timor in 2020. This is for a population of 1,200,000 people of whom 72 per cent live in rural or remote areas. We may think that Timor Leste is a small country (it as about quarter of the size of Tasmania) but transportation is difficult and there is a need for surgeons in parts of the country other than the capital.

Think about it – eight surgeons and a population of 1.2 million. One surgeon per 150,000 people equates to one surgeon for Ballarat or Albury and maybe two for Hobart. None of the regional centres in Western Australia or South Australia warrant a surgeon. Fifty kilometres from Dili is not a 30 minute car ride but a full day's travel. Not easy if you have a compound tibial fracture or a bursting appendix or an obstructed labour.

I think my investment was a bargain, whether it be $24.60 per life or $2,460 per life. This investment bargain is available for all surgeons at a price determined by you. ■

This article was written by a surgeon who contributed to the Timor Leste program.

If you would like to make a personal contribution to the Foundation for Surgery please go to surgeons.org/foundation-for-surgery or call Jessica: +61 3 9249 1110

Royal Australasian College of Surgeons
Foundation for Surgery

Skills training courses 2020

The College offers a range of skills training courses, supported by volunteer faculty across a range of medical disciplines, to eligible medical graduates.

Eligible candidates can enrol online for RACS Skills courses.

ASSET: Australian and New Zealand Surgical Skills Education and Training

ASSET teaches an educational package of generic surgical skills with an emphasis on small group teaching, intensive hands-on practice of basic skills, individual tuition, personal feedback to participants and the performance of practical procedures.

EMST: Early Management of Severe Trauma

RACS has launched 10th Edition Emergency Management of Severe Trauma across Australia and New Zealand. EMST teaches the management of injury victims in the first hour or two following injury, emphasising a systematic clinical approach. It has been tailored from the Advanced Trauma Life Support (ATLS®) course of the American College of Surgeons. The course is designed for all doctors who are involved in the early treatment of serious injuries in urban or rural areas, whether or not sophisticated emergency facilities are available.

CCrISP®: Care of the Critically Ill Surgical Patient

RACS has launched Edition 4 of the Care of the Critically Ill Surgical Patient (CCrISP®) course across Australia and New Zealand. The CCrISP® Committee have extensively reviewed materials provided by the Royal College of Surgeons of England (RCS) - resulting in an engaging new program which is highly reflective of current Australian and New Zealand clinical practice and standards in management of critically ill patients.

CLEAR: Critical Literature Evaluation and Research

CLEAR is designed to provide surgeons with the tools to undertake critical appraisal of surgical literature and to assist surgeons in the conduct of clinical trials. Topics covered include: Guide to clinical epidemiology, framing clinical questions, Randomised controlled trial, Non-randomised and uncontrolled studies, evidence-based surgery, diagnostic and screening tests, statistical significance, searching the medical literature and decision analysis and cost effectiveness studies.

TIPS: Training in Professional Skills

TIPS is a unique course designed to teach surgeons-in-training core skills in patient-centred communication and teamwork, with the aim to improve patient care. Through simulation participants address issues and events that occur in the clinical and operating theatre environment that require skills in communication, teamwork, crisis resource management and leadership.

Email: skills.courses@surgeons.org

Visit: surgeons.org and select 'Education and Training', then select 'Skills Training courses'

Skills training course dates

February - April 2020

ASSET - surgeons.org/asset	
Fri 6 – Sat 7 March	Auckland
Fri 13 – Sat 14 March	Brisbane
Fri 3 – Sat 4 April	Adelaide
Fri 17 – Sat 18 April	Melbourne

CCrISP - surgeons.org/ccrisp	
Thurs 30 April – Sat 2 May	Auckland

CLEAR - surgeons.org/clear	
Fri 6 – Sat 7 March	Sydney
Fri 3 – Sat 4 April	Brisbane

EMST - surgeons.org/emst	
Fri 21 – Sun 23 Feb	Wellington
Fri 20 – Sun 22 March	Perth
Fri 20 – Sun 22 March	Wellington
Fri 27 – Sun 29 March	Gold Coast
Fri 3 – Sun 5 April	Auckland
Fri 3 – Sun 5 April	Brisbane

TIPS - surgeons.org/tips	
Fri 21 – Sat 22 Feb	Melbourne
Sat 14 – Sun 15 March	Sydney
Fri 17 – Sat 18 April	Melbourne

Courses available at the time of printing

ASOHNS meeting 2020

The Australian Society of Otolaryngology Head and Neck Surgery Annual Scientific Meeting 13 – 15 March 2020.

The Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS) Society's Annual Scientific Meeting (ASM) is the premier education and networking event for the otolaryngology head and neck surgery community in Australia, and this year marks the 70th anniversary of the Society's Annual Scientific Meetings.

Sponsored by RACS, invited speaker Professor Howard Francis (pictured), a neuro-otologist from the United States, will present on a range of topics including: 'Otological education, skill development and the learning curve', 'Vestibular schwannoma management – a US perspective', 'Neuro-otology: Lateral technique tympanoplasty' and 'Contemporary management of vestibular schwannoma (surgery, radiotherapy, observation and new therapies)'.

Howard W. Francis, M.D., M.B.A., FACS is professor and chief of the division of Head and Neck Surgery & Communication Sciences in the department of Surgery at Duke University Medical Center, Durham, North Carolina. As a neurotologist, Dr Francis' clinical interests span the full scope of this subspecialty including the management and conditions of the ear, skull base and associated nervous system. His research interests include the determination of best practices of acoustic neuroma treatment, the examination of functional outcomes of cochlear implantation in young children and older adults, and the study of best practices in surgical education. Recent publications include multifactor influences of shared decision-making in acoustic neuroma treatment, clinical and psychosocial risk factors of hearing outcome in older adults with cochlear implants, and personal characteristics of residents that may predict competency improvement. He serves on editorial boards of the *Cummings Otolaryngology Head and Neck Surgery* text, the *Otology & Neurotology* journal and the *World Journal of Otorhinolaryngology-Head and Neck Surgery*. He is a member of the Otolaryngology Residency Review Committee of the ACGME and is a member of the Board of Directors of the Alexander Graham Bell Association for the Deaf and Hard of Hearing. He was the 2018 president of the Society of University Otolaryngologists.

After completing his high-school education in Jamaica, and his bachelor's degree at the University of Southern California in Los Angeles, Dr Francis earned his medical degree from the Harvard-MIT division of

Health, Science and Technology at Harvard Medical School, and then completed his internship, residency and fellowship training at Johns Hopkins Hospital. He completed his Master's in Business Administration with a focus in medical services management at the Johns Hopkins Carey Business School. After 19 years on the faculty at Johns Hopkins, during which he served as Residency Program Director, Director of the Johns Hopkins Listening Center and Vice Director of the Department of Otolaryngology-Head and Neck Surgery, he was appointed Chief of the Division of Head and Neck Surgery & Communication Sciences in the Department of Surgery at Duke in March 2017.

For further information on the ASOHNS ASM and to register, please visit: asm.asohns.org.au ■

RACS Visitor Grant Program for meetings in 2021

RACS is committed to excellence in surgical education and practice and recognises that Fellows within subspecialties and other groups wish to enhance their annual scientific meetings by inviting visitors of note from Australia, New Zealand and overseas. RACS supports these initiatives through the RACS Visitor Grant Program.

Over the past four years RACS has supported 64 speakers across 16 surgical specialties. In 2020 another 16 speakers will be supported.

Applications for meetings in 2021 will be accepted until **16 March 2020**. The application form is now available on the website by searching 'RACS Visitor Grant Program'.

Eligible groups are invited to apply for funding towards the cost of travel, accommodation and registration for visiting speaker(s) to their 2021 annual scientific meetings. Applications are open to any recognised society or association of surgeons. ■

▶ For details please visit surgeons.org and search for Visitor Grant Program or contact Paul Cargill, Manager, Fellowship Services: +61 3 9276 7415.

An Interplast experience

With a volcanic exposure at Tanna in the Pacific Rim

OPUS LX11

The recent volcanic eruption on the New Zealand Whakaari/White Island at the Bay of Plenty was the genesis behind this story. Let's not forget Captain Cook passed the Bay of Plenty and documented this volcanic activity in the 1770s from a Western perspective. These events stimulated me to recount one of our Interplast trips located in the Pacific, to the islands of Efate and Tanna, in Vanuatu, on the Pacific Volcanic rim. The French Colonial influence was another factor in my interest to volunteer for this program. Our team consisted of plastic surgeon Julian Peters and myself, and our theatre sister Brenda Linsell and the late Warren Saunders, our anaesthetist. We were privileged to visit a Garden of Eden of the Pacific in June 2002.

Brenda subsequently emailed me her clinical notes of her Vanuatu experience. She organised our surgical needs from theatre cases to post-operative resuscitation at the Villa Central Hospital on Efate Island. Julian Peter mainly operated on the cleft lip and palates and my commitment focused on the tumours and scar deformities.

Between theatre cases and over umpteen coffees I perused the theatre library textbooks at the Vila Central Hospital. I came across one of the original publications of a microvascular textbook, of the late 1970's edited by Roland Daniels and Julia Terzis. It included a chapter by Professor G Ian Taylor AO of the Royal Melbourne Hospital on his original microvascular free flap ankle reconstruction and another by the Alfred Health team, John Anstee, John Snell and Graham Miller relating to their original microvascular scalp replacement. What a collector's item in the Pacific.

The personal rewards of surgery are comprehensive in any setting, particularly in relation to reconstructive surgery. We are all grateful to the College of Surgeons and to Interplast, who have been supported over the years by Rotary clubs and districts. Such valuable surgical efforts have had far-reaching implications for many of these indigenous Melanesian communities where specialist surgical care, such as plastic and reconstructive surgery, is often unavailable. Local communities in Vanuatu have been very appreciative of the support of volunteer surgical teams from Australia, sent through RACS and Interplast programs. It needs no elaboration how our surgical commitments lead to personal satisfaction. A *London School of Economics* round-up of psychological reviews and studies reveals that altruistic contributions to the welfare of humanity bring the most rewarding aspects in personal happiness.

An additional stimulus in writing about Tanna was a viewing of the 2015 film of the same name with its Romeo and Juliet story located in the South Pacific, a little distant from the European background of the Shakespearean play. Yes, love is the perennial factor, which is lost and gained forever and a day. In this film, the conflict between the peoples of Kastom Road and Imedin Tribe was the focus of the controversy. The young couple of Kastom had their secret affair, against the approval of the tribal elders who govern all aspects of community life. The film revealed how the young couple absconded, leaving their families behind, and lived in the pristine native surroundings of Tanna, not far from the volcano. They eventually died from mushroom poisoning, which brought back to my mind the story of Buddha who died the same way.

This film won the 72nd Venice Film Festival audience award Pietro Barzisa. The *Guardian Australia* film critic, Luke Buckmaster, praised its spectacular cinematography and the *Washington Post* critic, Stephanie Merry, talked about its spectacular setting that introduced us to a corner of the world we never knew existed. In 2017 *Tanna* became the first and only Australian film nominated as the best foreign language (now best international) film category. Thankfully Interplast gave our surgical team one such opportunity.

Following the recent New Zealand volcanic episode, I personally spoke to our former team member Brenda Linsell. Her words on the phone struck a chord in my mind, "Oh my gosh", no doubt subconsciously revealing a little belated anxiety about a potential catastrophe. However, on our trip all went well.

That second week of our trip, when we flew to Tanna, the island revealed itself as a unique and verdant growth in a tropical setting, which is indelibly impressed upon my mind. Years ago Sir Benjamin "Benny" Rank, my senior mentor in Plastic Surgery in the 1970s, remarked to me that green was a relaxing colour. Yes, nature has a way of initiating a state of relaxation in the human mind. Hence the surgical drapes at Victorian Plastic Surgery Unit had to be green. Even in his office the same green thinking applied with textured green wallpaper. Professor Julian Smith of Monash University recalled how Julian Ormond "Orm" Smith, his uncle and an eminent Melbourne surgeon with a photographic talent, was a friend of Benny's. Benny had these images in the office, which he titled, "The Green Room" where many a Plastic Surgery career began or, should I say, ended.

During a break from our surgical commitments at Tanna, one afternoon we ventured across the island to view the volcano, which is still active (see image). The tour operator assured us of its safety but let's not forget the same reassurances presumably were given to the recent lost lives in the New Zealand eruption, and the death total is now 21.

We went to inspect the molten lava firing into the atmosphere a few hundred metres away. It was not an extravagant manifestation that would preclude any close contact. But, a Japanese tourist had had an unfortunate outcome when taking a close photograph three weeks earlier. We were all not as adventurous. Brenda reminded me of the name of the mountain; it was called Mount Yasur with belching smoke and insufferable sulphurous fumes bubbling around the molten lava. Yes, we were a little anxious but suffered no untoward consequences.

The following day the local community gathered in a similar manner as depicted in the Tanna film. The elders all came around in that very same familiar area, in an open quadrangle under a lovely canopy of greenery where they discussed council matters. On this day the gathering was to say thank you also to the Interplast surgical team for its surgical contribution to the community.

Now let me amplify one particular clinical case: a 19-year-old had a burn contracture, which significantly impacted her ability to walk. She tolerated this physical disability for a period of 10 years. This developed as a consequence of a burn that she sustained as a young girl, which restricted her skeletal development. Her knee was almost into a ¾ flexed position due to the burn's contracture over the popliteal fossa.

A standard method for correction for relief of the problem was to excise the scar tethering the popliteal site, ▶

which restricted joint movement, and replace it with fresh tissue. However, Julian Peters and I designed a keystone fascial lined island flap based over the gastrocnemius muscle perforators. This rhomboidal shape allowed one to rotate a soft tissue cover into the excisional defect. Most keystone flaps can be closed under tension, as the hypervascularity from the increased perfusion allows blood flow at a fascial level to eventually reaching the subdermal plexus (in spite of white lines of tension which subside). This mirrors a sympathectomy effect, I suspect.

Surgically the knee became almost fully extended and pain-free and when we went to review the patient the following day, not only was she thrilled to have a functionally almost normal appearance after the knee release (although stiff), but the foot oedema, a morbidity factor extending over the last 10 years, seemed to have resolved overnight. This was my first observational finding at a clinical level of the value of the keystone in possibly dilating obstructed lymphatic channels. This finding is not dissimilar to the vascular hyperaemia a characteristic manifestation of the keystone perforated island flap. Needless to say, the clinical outcome was very pleasing to the parents of the young woman who gave me a knitted palm mat as a small token of appreciation for treating their daughter. There is no more satisfying aspect to surgery than to be enveloped in the crying embrace of a person who has lived with such a disability for most of her teenage years. Thanks to Interplast and the late Professor Donald R Marshall AM we were privileged to have this experience. Yes, the tears of the mother crying on my shoulder in gratitude for this simple surgical trick is something I will never forget.

Julian, Brenda, Warren and I drove home in the evening after our volcanic exposure back to our accommodation centre. The roads were black as pitch with only the headlights of the van as a guide. The driver knew the way by instinct and with headlights on we passed various people in the middle of the night. Every time the truck's headlights brightened the surroundings the night hunters would immediately turn their heads, protecting their eyes from the headlights' glare. I asked my usual question, why is it so? (quoting the late Julius Sumner Miller). The driver said the direct headlights ruin their night vision. Therefore, they must wait for their visual fields to adjust, which takes some hours, preventing them from returning to their homes.

Following this episode, we safely returned home but these recent events in New Zealand reminded us of the possible folly in some of our excursions, even these many years later.

P.S. The volcano image contained in this article is through courtesy of Brenda Linsell and her excellent filing system. Needless to say, my garage filing system failed me abysmally.

Associate Professor
Felix Behan

The moral duties of an assessor of impairments

With examples of iatrogenic opiate addiction

While assessing impairment of disabilities, is a medico – sworn to do no harm or to abate pain – still a morally obligated practitioner? Being detached from treatment or even from commenting on therapy, the assessing medico is supposed to be neutral and objective, assessing the whole truth and nothing but the truth.

What if the assessor had to account for certain medical issues that would contradict their values with which they have practised for many years? What if the assessor recognised certain dangers or inaccurate treatments received by the person to be assessed?

Here I offer clinical cases from my medico-legal practice that I found objectionable, perhaps bordering on immoral, incorrect or dangerous acts.

Case 1: Male, aged 41, with an arthroscopic sub-acromial decompression five years earlier. He was reviewed once by a pain management specialist and treated by his family practitioner, gradually reaching 185mg Endone a day. He was sleepy, at times confused in conversation, and complained of being unable to have intimate contact but he was driving! He was assessed with whole person impairment (WPI) equivalent to six per cent.

Case 2: Male, aged 37, with a low back injury, receiving conservative treatment for three years, reaching to 80mg Endone a day. The patient became quarrelsome, his wife divorced him, his children were leaving home and he was abandoned by his friends. He found refuge in the nearby pub, becoming an alcoholic. He was assessed with WPI six per cent.

Case 3: A 66-year-old woman who looked significantly older, she was rather cachectic, slow moving and sleepy, and was 10 years following a one level decompressive cervical laminectomy. She remained out of work all this time, suffering as stated from continuous pain and was dependent on a gradually increasing dosage, by now of 80mg oxy-contine a day. She was inactive and was totally dependent on assistance for every activity.

What have we achieved? These cases of iatrogenic addiction to opiates were "incidental findings" being partially related to the assessed person, considered as inappropriate or perhaps even negligent treatment. What is my moral duty? Should I contact the police for driving under the influence?

How would the authorities react? How would the assessed person and their legal representative react to interference in treatment? Whilst my sole duty is 'assessment of impairment', is it my duty to warn the practitioner (who had to consult the patient 24 times a year, as the maximal script for opiate is only for two weeks)? Is the practitioner's treatment abusive and responsible for the addiction?

Would my views be attracting legal consequences or, on the other side, would I be immoral, abrogating my commitment under the medical oath by choosing not to get involved? Am I legally protected in either direction?

Should I be inert in allowing further deterioration in the first case, or in the second case, allow further physical and or mental deterioration with no return, due to the opiate combined with alcoholism?

All the above questions were raised when these topics were discussed at a WorkCover meeting in Sydney and at the Annual Conference of the Australian Medico-Legal College, in Queensland 2019.

My inclination – at the risk of being appealed against or sued (a real one in today's rather aggressive anti-doctors atmosphere) – would be to comment on the situation in my report rather than abdicate my views and remain silent. ■

George M. Weisz

MD, FRACS, BA, MA, FAMLC

Adjunct Associate Professor, School of Humanities UNE and Adjunct Senior Lecturer, School of Humanities, UNSW.

Professional Development upcoming activities

Register your place today visit: surgeons.org/education/professional-development

Course	Start Date	State/ Region	Location
Academy of Surgical Educators Studio Sessions	Tuesday 3 March 2020	VIC	Melbourne
Difficult Conversations with Underperforming Trainees	Thursday 5 March 2020	VIC	Melbourne
Foundation Skills for Surgical Educators	Monday 9 March 2020	NSW	Sydney
Academy of Surgical Educators Studio Sessions	Thursday 19 March 2020	ACT	Canberra
Non-Technical Skills for Surgeons	Saturday 21 March 2020	VIC	Melbourne
Process Communication Model Seminar 1	Friday 27 March 2020	VIC	Melbourne
Clinical Decision Making	Friday 27 March 2020	NSW	Sydney

Get to know the Educator of Merit 2019 awardees

Every year, the Academy of Surgical Educators presents the Educator of Merit award to recognise the exceptional contribution by our surgical educators. Let's hear from them.

Educator of Merit – SET Supervisor/IMG Supervisor of the Year (Tasmania): Professor Richard Turner
Fellow since 1995, in General Surgery

What is your proudest moment as a surgical educator?

It is hard to think of a single moment but one of the most gratifying things I do is teaching expedition doctors for the Australian Antarctic Division. Using generously bequeathed fresh cadavers, we do a series of life-saving acute abdominal procedures, including open appendicectomy. In recognition of my commitment to this course, I scored a fascinating fact-finding trip to Casey Station in 2016. I wouldn't say no to a return visit!

Any advice for new surgical educators just getting started?

If you are engaged with your subject matter, your enthusiasm will be infectious. It does help, however, to be familiar with the language of medical education to maintain credibility as an educator.

How has the Academy of Surgical Educators (ASE) impacted you as a surgical educator?

By its existence, the Academy validates the mission of all those who include teaching as part of their job description.

Educator of Merit – SET Supervisor/IMG Supervisor of the Year (Victoria): Mr Richard McMullin
Fellow since 1993, in Urology

How do you feel receiving the ASE Educator of Merit award?

I feel a combination of embarrassment and gratitude. I am delighted that my colleagues have nominated me as a surgical educator of merit. I am embarrassed to think that I now have such a label and will have to live up to it.

What is your proudest moment as a surgical educator?

There is no single moment which stands out over others with respect to education. I share the pride of our trainees as they achieve their Fellowship from the College. I appreciate the thanks I receive for education. Perhaps, most of all, I enjoy those moments where a trainee acquires something new and valuable. It may be a specific surgical skill, a new or deeper understanding of a concept or a higher-level approach to being a surgeon. 'Ah, hah!' moments in life are rare and precious, and to contribute to such moments in those you teach is like gold.

Any advice for new surgical educators just getting started?

I have no inspirations here, just boring practical advice. It relates to two habits. The first is to schedule teaching on a regular basis and stick to the routine. My example is a regular Tuesday breakfast radiology teaching session. This pattern was established by Don Moss in the 1990s and I have continued it ever since. I have a bank of teaching x-rays collected over decades and each has a message. The second habit is simply opportunistic teaching. Almost every clinical encounter, x-ray image and pathology result can be a way into a discussion which can lead into general principles, related examples, patterns and pitfalls. These are unplanned moments of exchange where you can both teach and learn. ■

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

Images (from top):
Professor Richard Turner; Mr Richard McMullin.

Meet RACSTA's new executive

The Royal Australasian College of Surgeons Trainee Association (RACSTA) includes representatives from all surgical specialties, national and state committees, who provide input at all levels through to the RACS Council. In this way, RACSTA strongly advocates for trainee issues such as the quality of training, workplace culture and wellbeing. RACSTA works with many RACS boards, committees and specialty groups and is regularly asked to comment on matters affecting trainees.

The 2020 RACSTA executive are:

James Churchill – Chair

Ragavan Manoharan – Education portfolio

Linda Tang – Training portfolio

Adam Philipoff – Communications portfolio

Imogen Ibbett – Immediate past Chair

The Support and Advocacy Portfolio position will be filled at the February 2020 RACSTA Meeting.

In this issue of Surgical News, we meet three of the new executive.

Dr James Churchill – incoming Chair

Dr James Churchill, a Urology trainee commencing his final year of training, is RACSTA's incoming Chair and the 2020 RACS Council trainee co-opted councillor. Originally from Victoria, he has been based in New South Wales and the Australia Capital Territory for training since 2016.

Dr Churchill believes "effective trainee representation and advocacy is essential to the improvement of RACS surgical training programs and trainees' experiences". He has been a trainee representative to the Board of Urology and prior to surgical training was Chair of the Australian Medical Association's Council of Doctors-in-Training and President of the Australian Medical Students' Association.

A constant theme of his approach to trainee advocacy has been "the strengthening of accreditation processes to improve training quality, development of tools to gather and act upon trainee feedback, professionalism skill education and striking a balance between safe working hours and quality training".

"RACSTA is in a unique position to be able to advocate within RACS for improvements in surgical training, and so with much enthusiasm I look forward to an exciting and productive year as RACSTA Chair," Dr Churchill said.

Dr Imogen Ibbett – immediate past Chair

Neurosurgeon Dr Imogen Ibbett was the 2019 RACS Council trainee co-opted councillor and the outgoing RACSTA Chair.

"Being the Chair of RACSTA last year really opened my eyes to the various challenges faced by trainees. It made me recognise that each individual has a very different journey and, unfortunately, for some it can include very negative experiences. That's why our role as the RACSTA committee is so important in advocating for trainees and trying to improve training for everybody.

"I have now finished my training but feel very honoured that I can continue to work with RACSTA as the immediate past Chair. I hope my experience and knowledge of RACS will be valuable to the committee in continuing this vital work," Dr Ibbitt said.

Dr Ragavan (Raj) Manoharan – Education portfolio

Dr Raj Manoharan, a Neurosurgery trainee based at Westmead Hospital, joins the RACSTA Board Executive in the Education portfolio.

"What I like about being a part of the RACSTA Board is that it brings together a group of people who are motivated to advocate for trainee wellbeing. It provides a forum for us to effect change and discuss issues that we might otherwise just complain about. The best part of being on the RACSTA Board is definitely the opportunity to form friendships with colleagues across surgical subspecialties," Dr Manoharan said. ■

Fear of failure – a surgeon's perspective

In an interview produced by the Pineapple Project and re-printed in *The Australian* during 2019, Dr Sarah Coll discussed imposter syndrome. She explained that patient expectations, as well as her own worries about surgical complications and circumstances beyond her control, have developed into an ongoing, internal monologue of self-doubt. She says it's a burden to shoulder the public's God-like faith in surgeons' abilities when surgeons know that things might go wrong and that they can make mistakes.

She is not alone. UK neurosurgeon and author Dr Henry Marsh described the emotional burden of responsibility he carries, when he wrote about facing his mistakes in and out of the operating theatre in his books *Admissions* and *Do No Harm*. His sessions at the Sydney Writers' Festival in 2017 were packed with audiences eager to ask questions about surgical error and patient expectations.

In the US, well-known endocrine and general surgeon Dr Atul Gawande is lauded for his opinion on the topic in regular articles, books and media appearances. In his best-selling books *Being Mortal, Complications* and *The Checklist Manifesto*, he describes myriad procedures or services that have not delivered a good result and what steps can be taken to prevent future failures.

Exploring this topic, Dr Sarah Coll speaks with *Surgical News*.

Is it right to shield patients and relatives from the possibility of surgical failure?

I believe we should talk about surgical error when discussing other realities such as infection, failure to heal or, in my patients, conditions such as tendon or bone weakness. When an operation doesn't succeed and the consequences are irreversible, I feel responsible. So how can I expect the patient to forgive me?

Could surgeons make the same mistake more than once?

There have been times when I was due to perform the same or similar procedure on another patient, 30 minutes after a similar procedure failed. I am trained to identify failure and expected to learn from it quickly. Yet, I could never guarantee that the same mistake won't happen again.

Are surgeons more prone to burn out because they feel they can't afford to fail?

Acceptance of failure is part of success. It challenges our beliefs around success if we assume that all those who have succeeded have never failed. In a cycle of continuous improvement, an adverse outcome leads to learnings and improvements.

How would you manage burn out to prevent the fear of failure becoming exaggerated?

We need to manage our own doubt in order to avoid imposter syndrome. At least one episode of imposter syndrome is estimated to be experienced by around 70 per cent of the population – especially among women who are high achievers. We must accept that failure will occur at times, or else we risk losing the surgical innovations that result in remarkable or unexpected solutions for patients. Innovation in surgery leads to trials, improved surgical procedures and progress in health knowledge. While scientifically based, the first aortic graft procedure must have been a brave undertaking given the mortality rates of patients with that condition.

The previously named surgeon-authors have successfully shown the world a view of surgeons that is the opposite of arrogance – they want others to understand that surgeons are fallible and surgery is not predictable. Do you agree and what action do you recommend if a surgeon is troubled by this?

We make mistakes, even after years of dedicated study and experience, but we must commit to reflect, share, discuss and learn from those mistakes. We are not robots, and while the practice of medicine is ever-evolving and more robots are likely to be used for some procedures, these need the input of surgeons who are managing patients and making medical decisions together.

Do you believe that failure is stigmatised by the surgical profession?

I've looked recently at a US study of high reliability organisations (HRO) where common themes include a focus on encouraging feedback from all employees on the front line so that failures – big or small – are reported and thoroughly analysed in order prevent them in future. HROs are organisations that deal with high risk situations where catastrophes could occur, such as nuclear power plants, air traffic control systems or aeroplanes. A flight crew, for example, has a co-captain and another officer in the cabin to check and report safety concerns to the captain. Operating theatres, on the other hand, can have a hierarchy where individuals may be too intimidated to speak up and where a registrar may not be confident enough of their skillset or ability. A colleague of mine once placed a tourniquet on a patient's leg in preparation for a procedure only to discover it was the wrong leg, thanks to a theatre technician speaking up. So I believe it's time to be more realistic with colleagues and with patients.

Interview with Dr Sarah Coll, MBBS, FRACS, FAOA, GAICD, CIME, AMA(M)

Orthopaedic surgeon, upper limb specialist, hip and knee arthroscopy

RACS Councillor

AMAQ Board Director and Councillor

RACS ASC 2020 update

Welcome to 2020 and happy new year to you all! By the time you are reading this, the 2020 organising committee will be finalising the scientific programs for the Annual Scientific Congress. We have highlighted a few more programs in this issue.

The Art of Communication

On Thursday 14 May the Council Plenary will focus on the 'Art of Communication'. This session will explore ways that we can improve outcomes for our patients through improved communication. Dr Amir Ghaferi is an Associate Professor of Surgery and Business at the University of Michigan. He is the founding director of the Bariatric Surgery Program at the VA Ann Arbor Healthcare System. He is also the Program Director of the Michigan Bariatric Surgery Collaborative, a consortium of 40 hospitals and 80 surgeons focused on improving the safety and quality of bariatric surgery. He will be discussing how we can better utilise information gathered in registries through better communication.

Mr Russell Blakelock is a paediatric surgeon who has retrained as a psychiatrist. He will be discussing techniques that will allow us to better communicate with our trainees to enhance performance.

Dr Maria Dahm has a background in applied linguistics and combines her passion for patient-centred health research with her expertise in qualitative and mixed methods approaches in health communication and health services research. She has an interest in diagnostic error and will be discussing how improved patient outcomes can be obtained through better communication with our patients.

Dr Kym Jenkins is the immediate past-president of the Royal Australian and New Zealand College of Psychiatrists (RANZCP). She has a clinical and academic interest in the health and welfare of the medical profession and has spent the last 10 years in the role of Medical Director of the Victorian Doctors Health Program. She will be discussing the importance of maintaining our own health as we treat others.

Breast surgery

The breast surgical sessions are co-convened by Caroline Baker and Jocelyn Lippey; the sessions run from Tuesday 12 May to Thursday 14 May inclusive. This will follow on from a level 1 oncoplastic workshop hosted by BreastSurgANZ on Monday 11 May.

We are thrilled to announce a varied and rich program this year with numerous combined sessions and an interesting masterclass series. We also include a dedicated drawing session for surgeons, facilitated by Dr Michael Schwarz, NGV affiliate.

Our international speakers are Miss Fiona MacNeill, from The Royal Marsden Hospital in London, and Dr Abigail Caudle, from the University of Texas MD Anderson Cancer Center, who bring a wealth of knowledge and experience. Keynote lecture topics include neoadjuvant radiotherapy, targeted axillary dissection and the art of avoiding litigation in breast surgery.

There will be a dedicated session exploring de-escalation of breast surgery as well as the BreastSurgANZ invited lecture from local Professor Bruce Mann on tailored breast screening and early breast cancer. We have three combined sessions with the plastic surgery section covering the art of mammoplasties, lymphoedema (avoidance and management) as well as breast reconstruction. There is also a dedicated surgical oncology combined session which will focus on cancer endpoints and quality of life issues and is bound to stimulate some great discussion. The combined general surgery session will focus on balancing risk and patient expectation and features a talk from Dr Catherine Parker from Alabama, USA.

Our dinner is scheduled for Wednesday night combined with our endocrine colleagues and it will be held at Eureka 89, which offers stellar views of greater Melbourne. It promises to be a highly sought-after, spectacular event for our local, interstate and international guests. The highlights are sure to be the display of the artistic output from our drawing skills masterclass as well as a special photographic display from Flesh after Fifty.

Colorectal surgery

The colorectal surgery program has been carefully put together after many months of deliberation and consideration. We'd like to invite all colorectal surgeons, general surgeons with a colorectal practice and trainees to join us as we explore the more divisive aspects of this specialty. The program not only celebrates mastery of new skills, technologies and treatment advances, but also touches on the history of the specialty: its achievements and controversies, lessons learned and what the future holds. We look forward to focusing on colorectal surgical education, exploring non-surgical options for rectal cancer especially in the Australasian context, as well as a masterclass on robotic surgery techniques.

Our two international guests are Professor John Monson and Professor Patricia Roberts. John is well known to many of us. He currently works in Orlando, Florida at AdventHealth, where transanal minimally invasive surgery (TAMIS) was first described. During his time in the UK, he is credited with leading the development of laparoscopic colorectal surgery in the UK as well as serving as a chair of the UK's National Training Program. He currently spearheads the National Accreditation Program for Rectal Cancer, looking to lift standards in rectal cancer across the USA, and is a co-editor of *Diseases of Colon & Rectum*. Patricia is Chair Emeritus of the Department of Surgery at the Lahey Hospital and Medical Center in Burlington, Massachusetts as well as a Professor of Surgery at Tufts University School of Medicine. She has been a leading woman in surgery and was the second female president of the American Society of Colon and Rectal Surgeons. Patricia has a strong interest in the development of leadership in surgery as well as the interplay between different generations.

We are also honoured to host Associate Professor Tarik Sammour, one of the younger RACS Fellows. He is a colorectal surgeon at the Royal Adelaide Hospital and an Associate Professor of Surgery at the University of Adelaide. Tarik undertook two years of accredited post-fellowship training in colorectal surgery at the Royal Melbourne Hospital and the Royal Adelaide Hospital. He then travelled to the University of Texas MD Anderson Cancer Center in Houston, USA, to complete an additional fellowship. Tarik has authored over 100 peer-reviewed publications and seven book chapters. We look forward to hearing about his research interests, including total neoadjuvant therapy.

We want to draw special attention to the colorectal surgery dinner at the Arts Centre. Through the generous support of Medtronic, Johnson & Johnson and Device Technologies, this dinner looks to be unmissable and is always oversubscribed. There will be very limited tickets available at the ASC itself, so early reservations are important. In addition, on the Tuesday morning, for the first time, there will be a robotics colorectal surgery masterclass sponsored by Device Technologies. As usual, the Mark Killingback research prize will be heavily contested on the Tuesday afternoon. Lastly, on Wednesday morning there will be a session on 'watch and wait'. Australasia has been slow to adopt this strategy and we have an exciting line-up to discuss the local experience and compare this to the world stage.

HepatoPancreatoBiliary surgery

The HepatoPancreatoBiliary (HPB) surgery section, co-convened by Kaye Bowers and Adrian Fox, presents a diverse series of sessions covering a spectrum of liver, pancreatic and biliary surgical disease. With a focus on multidisciplinary care and complex decision making, the program includes talks from prominent HPB surgeons, along with gastroenterology, interventional radiology and oncology ▶

Social program:

Moroccan and Middle Eastern Cooking Class with Spice Bazaar

Description: Spice Bazaar cooking classes are hands-on, relaxed, fun, inspiring and loaded with flavour. Experience a private cooking class and feast on Moroccan and Middle Eastern food.

Food is the ultimate social glue. Everyone must eat, and cultures have bonded and socialised at the dinner table for millenniums. The cooking class ensures that all attendees have a valuable role to play, regardless of your cooking experience level. The whole experience is instructive, social, fun and delicious and will definitely be a day of feasting you will remember. You'll take home the recipes and knowledge to recreate the dishes for your own friends and family.

Date: Monday 11 May

Commences/Departs: Bus will depart from the convention centre at 9.30am to arrive at Spice Bazaar for a 10.00am class. Please arrive at the convention centre registration desk ready for departure at 9.15am

Concludes: The class will conclude at 2.30pm, with the bus departing Spice Bazaar at 2.45pm. The bus will arrive back at the MCEC at approximately 3.15pm

Duration: 5.75 hours

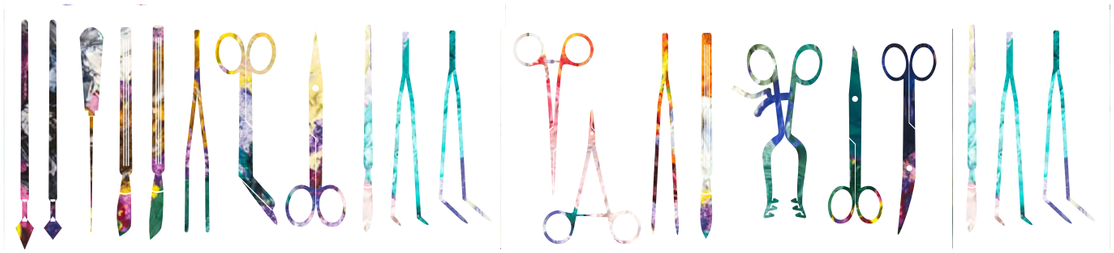
Cost: $175.00 per person including GST

(Children under the age of 10 will not be able to join this tour)

Inclusions: Two glasses of wine, two dining sittings, apron for use during the session, all recipes and ingredients provided, return bus transfers

Bring (optional): Camera

Clothing: Comfortable clothing and closed shoes



Social program:
Contemporary Art in the City Tour

Description: Visit a number of leading contemporary art galleries along with up-and-coming art spaces in the laneways and historical buildings of Melbourne's CBD. Join Monash University Museum of Art's Director, Charlotte Day, for a morning tour of Melbourne's vibrant art gallery scene.

Visit a selection of Melbourne's best commercial galleries including Anna Schwartz Gallery, Tolarno Galleries and Sarah Scout Presents, followed by a visit to the iconic Nicholas Building, a creative hub of galleries and small businesses. During this tour, you will meet gallery directors, curators and exhibiting artists, and hear about different gallery models and approaches to creative practices.

Date: Tuesday 12 May

Commences/Departs: Tour begins at 10.00am. Please meet inside The Atrium, Federation Square, Swanston Street Melbourne

Concludes: This tour will conclude at 1.00pm at The Atrium, Federation Square, Swanston Street Melbourne

Duration: 3 hours

Cost: $120.00 per adult including GST (no child fee applies)

Inclusions: Guided tour in the city and entry into selected galleries

Bring (optional): Camera, bottled water

Clothing: Suitable walking shoes and clothing

experts in HPB disease management.

The HPB surgical program features three international speakers, all renowned in their own subspecialty area of interest. Each will deliver key lectures covering both treatment advancements in surgical HPB disease as well as non-technical aspects of HPB surgical practice. Associate Professor Sean Cleary, from the Mayo Clinic in Minnesota, is an expert in minimally invasive management of HPB surgical disease. He has published extensively on the genetic epidemiology of pancreatic and hepatocellular cancers. Sean will be delivering a number of talks throughout the program as well as leading a masterclass on surgical decision making in hepatocellular carcinoma (HCC) and giving a keynote lecture on cutting edge treatments in HCC.

Associate Professor Carol-anne Moulton is an HPB surgeon in Toronto, Canada. Carol-anne's unique area of research focuses on the psychosocial and cultural factors associated with surgical performance, decision making and surgeon identity. The highlight of Carol-anne's program will undoubtedly be her keynote lecture discussing her research. She will also be leading a masterclass on the management of HPB surgical complications.

Associate Professor Trevor Reichman, an HPB and liver transplant surgeon who is also from Toronto, brings his expertise in liver and transplant surgery, including the developing role of liver transplantation for malignant conditions beyond HCC. Trevor will be delivering lectures on surgical limits in the presence of a marginal future liver remnant and liver transplantation for colorectal liver metastases as well as a keynote address discussing the evolution of augmented reality in HPB surgery.

The final keynote lecture for the program, presented by Professor David Fletcher, promises to provide great insight and sage advice for the innovators among us, outlining lessons learnt from the introduction of laparoscopic cholecystectomy in Australia 30 years ago.

Medico-legal program

The 2020 medico-legal program reflects the many ways in which surgery and the law intersect. We have a diverse program, partnered with other sections spread across the ASC. On Tuesday we are partnering with senior surgeons to explore facts about performance, best tests and remedies in maximising the contribution of senior surgeons, information and lessons that are applicable across the decades of practice. On the Wednesday evening we partner with the neurosurgeons and pain medicine surgeons for our section dinner at Arc One Gallery, an Andrew McConnell fuelled opportunity for networking and relaxation in Melbourne's CBD.

Thursday and Friday are our main contributions. We start Thursday with a masterclass (registration required) exploring the place of medico-legal work and understanding in Building a Segment of Your Practice, in conjunction with the Younger Fellows Section. The speakers will consider the requirements of a surgeon as the treater in providing necessary reports and information about their patients, as well as medical negligence and third-party compensable cases within the practice. Next we have 'Managing the Poorly Performing Surgeon', again in conjunction with the Younger Fellows. This session covers the processes that occur with regulators such as the Medical Board but also within private and public hospitals at the case review performance level.

Chronic pain is a topic of interest both for treaters and in the context of ongoing disability after injuries of all sorts. The medico-legal section will share an enlightening debate with the pain medicine & surgery section: 'Central Sensitisation – Fact or Fiction?' Our program for the Thursday afternoon will be completed with our section's Annual Business Meeting.

We kick off on Friday morning with 'Return to fitness – how soon? To sport, work, life' with speakers discussing objective criteria and methods for measuring and providing guidelines in areas of concussion, orthopaedics with shoulder and knee injuries and a rehabilitation perspective.

Our invited visitor and guest speaker is Mr Michael Gorton AM, whose engagement with the College over many years is well known as honorary college solicitor. Michael has held and holds many roles on government advisory, regulatory and hospital health boards. He will present the James Pryor lecture on Friday 'Reflections from the health practitioner regulator – AHPRA and beyond.'

Medico-legal factors impact on many aspects of our surgical life and we invite you to join in with the program and join up with the section.

Senior surgeons program

'Celebrating the Artists Within Us' will encompass the music of Hamilton Russell and the art of POWs of Changi in World War II. Chris Constant (Cambridge, UK) will present the association of the anatomy and its effect on Renaissance artists. There will be other presentations on hidden art of plastic surgeons and the challenges of dealing with dysfunctional bureaucracies.

The keynote presentation will be a talk on the basic science of music, the brain, creativity and surgery from Professor Sarah Wilson, Faculty of Medicine, Melbourne University. Chris Constant (Cambridge, UK) has a keynote presentation on the challenges that senior surgeons face in the UK and Europe. Senior surgeons will combine with global health in their session on teaching anatomy in the developing world on Wednesday afternoon.

Surgical history program

Peter Burke is the convener for this section, ably assisted by co-conveners John Collins and Campbell Miles.

Our 2020 visitor is Mr Michael Crumplin, a retired surgeon from North Wales, whose specialties included gastrointestinal, vascular and trauma surgery. During his active career he was elected as chairman of the Court of Examiners of the Royal College of Surgeons of England and he also worked as an intercollegiate examiner for the UK. Michael is an honorary curator and archivist at the Royal College of Surgeons England and was treasurer/trustee of the Waterloo Committee and member of the Waterloo200 committee, involved in preparatory work for the bicentenary of the Battle of Waterloo in 2015.

He has set up a unique surgical museum on the Battle of Waterloo Heritage site and was recently elected a Fellow of the Royal Historical Society. After studying the medicine of the Napoleonic and many other wars for over 45 years, Michael now devotes time to writing and lecturing, providing advice for students, research workers, authors and the media.

His principle purpose is to promote interest in the human cost of conflict and the often-forgotten efforts of military medical men: his three ASC Visitor Lectures accurately reflect his encyclopaedic interests: 'Waterloo: the Darker Side of Victory – Case notes, Sketches and Surgical Results after the Waterloo Campaign'; 'Losing Sight of the Glory – Six Centuries of Combat Surgery'; 'Armageddon - Surgical Challenges in World War One'.

The very full surgical history program will also include no less than three memorial lectures. The Archibald Watson Memorial Lecture, 'The emergence of science, sensibility and professionalism in surgery' will be delivered by Professor John Collins from Auckland, the former Dean of Education at the RACS. The Herbert Moran Memorial Lecture is to be given by Mr Campbell Miles, current chair of the RACS Heritage and Archives Committee, on the topic, 'The twelfth century Renaissance and the Institutionalisation of Medical Education.' The Rupert Downes Memorial lecturer is Mr Andrew Connolly MNZM, another respected visitor from Auckland, who has chosen to address the topic, 'Striving for excellence -enhancing recovery in the Great War.' ▶

Social program:
Gardening Australia's Sophie Thomson and Austin Health Gardens and Grounds Project Officer Steven Wells

Description: Hosted by gardening media personality Sophie Thomson, this tour will include insights into Melbourne's Austin Hospital Therapeutic Garden, which was developed by Steven Wells, a nurse and horticulturalist. Steven is the recipient of a Winston Churchill Memorial Trust fellowship, which led to him study hospital gardens around the world. Both Sophie and Steven are passionate advocates for the role gardening and greening can play in hospitals, and their ability to contribute to patient recovery and resilience. Both are well-known speakers in this area.

Date: Wednesday 13 May

Commences/Departs: Bus will depart from MCEC at 9.15am to arrive at Austin Health Gardens for a 10.00am start. Please arrive at the MCEC Registration Desk ready for departure at 9.00am

Concludes: The tour will conclude at 12.30pm. The bus will arrive back at the MCEC at approximately 1.45pm

Duration: 4.5 hours

Cost: $161.00 per adult including GST $25.00 per child including GST (This cost applies to children aged between 10 and 17 years of age. Children under the age of 10 are not suited to this tour)

Inclusions: Tour of the Austin Therapeutic Garden; return bus transfers

Bring (optional): Camera, sunglasses, bottled water

Clothing: Umbrella, raincoat, closed shoes

There will be a comprehensive selection of free papers of wide general interest, where possible chosen to complement the ASC theme of 'Celebrating the Art of Surgery'.

Transplantation surgery

We'd like to acknowledge the effort, diligence and support of all medical colleagues from rural areas in which the recent bushfires have brought suffering and grief to our communities. We'd also like to thank all medical societies, including the RACS, dealing with these catastrophic events in New South Wales and Victoria.

As surgeons involved in organ transplantation, we aim to provide the best care for our patients, focusing on outcomes. With that, the organising committee for the 2020 ASC in Melbourne welcomes you to our outstanding annual event. This year our transplant section will be focused on the art of surgery – particularly in organ preservation, organ allocation and the kidney exchange program.

We will have the North American perspective on NASH and paediatric liver allocation from Associate Professor Trevor Reichman. We will also have Associate Professor Peter Hughes, the Director of the ANZ Paired Kidney Exchange Program, as our invited speaker. Lastly, we will have a session on organ allocation featuring the recent changes in the UK national liver offering scheme and its implications in transplantation.

Together with the ASC 2020 executive and the section conveners, we are excited to see you in Melbourne. Registration is open online and make sure you register before 15 March to secure the early bird registration rate!

Article provided by:

Professor Wendy Brown FRACS

Dr Jocelyn Lippey FRACS and Dr Caroline Baker FRACS

Mr Raymond Yap FRACS and Mr Raaj Chandra

Dr Kaye Bowers FRACS and Dr Adrian Fox FRACS

Mr Gary Speck FRACS

Mr Max Esser FRACS and Mr Alex Cato FRACS

Mr Peter Burke FRACS

Associate Professor Marcos Perini and Mr Ian Michell

ASC COORDINATOR

The RACS Annual Scientific Congress, held every May, is the major educational activity for Australasian surgeons and attracts a large cohort of leading international surgeons.

Expressions of interest are invited for this pivotal position which supports the ASC activities. Working closely with the RACS Conferences and Events department, and the committees supporting the ASC, the role is critical to ensuring the ASC delivers outstanding opportunities for all Fellows, trainees and international medical graduates.

Mentoring and assisting the section conveners and each ASC Executive is critical to its success.

The time and travel requirements would make this position suitable for someone who works part-time in a surgical capacity. Applicants must be a Fellow.

This is a fixed-term part-time contract @ 10.5 hours per week plus an additional allowance for compulsory travel to ASC and RACS Council meetings.

Remuneration will be at the appropriate senior specialist level (pro-rata). Closing date is Sunday 8 March.

Potential applicants may contact the ASC manager for more information, email: lindy.moffat@surgeons.org

Annual Scientific Congress call to artists

We invite all artists and creatives to consider donating an individual artwork or a creative piece to a very special auction.

Preparations for the 89th Annual Scientific Congress (ASC) are well underway with the exciting theme 'Celebrating the art of surgery'. This year the ASC will be held between 11 and 15 May at the Melbourne Convention and Exhibition Centre at South Wharf by the Yarra River, and we're working to make it an engaging and memorable event.

Among our community we have surgeons who are also authors, artists, photographers, playwrights, musicians, potters and even winemakers – as well as many art lovers. We invite all our creatives to donate an individual piece to the ASC charity auction, which will be conducted during the congress program.

Whether you've written a medical textbook or a novel, painted a landscape or photographed wildlife, we want to hear from you. If you've recorded a song, made bottles of wine or just finished glazing your pots in the kiln, it is all art, and we want to hear from you, too.

If you have a family member or friend who'd like to contribute to the auction, we'd be thrilled to include their creative work as well.

All proceeds from the auction will go to the Foundation for Surgery. The Foundation has been providing training, research and surgical support to communities in need for 35 years. Across Australia, New Zealand and developing countries in the Asia-Pacific region, it has made a world of difference to thousands of children and adults.

More than 2,000 surgeons, trainees and other medical professionals are expected to attend the ASC this year, and we have an exciting program to share. There will be a broad range of activities and experiences for attendees, as well as an entertaining social program of visits to museums and galleries.

The closing date for donating auction items is 30 March.

Professor Wendy Brown, ASC convener

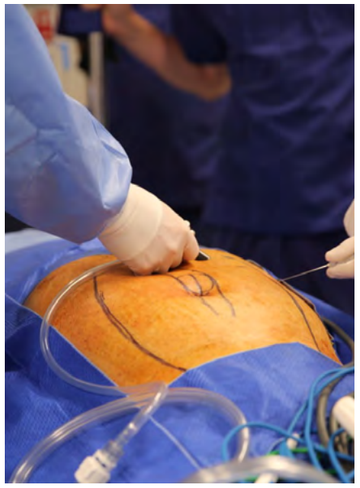
DO YOU HAVE AN ARTISTIC FLAIR?

Donations close 30 March.

Please contact:

Professor Wendy Brown
at wendy.brown@monash.edu

Introducing the ANZ Hernia society



Towards quality improvements in hernia repair, introducing the ANZ Hernia society

Hernia is a major health issue in Australia and New Zealand, with approximately 60,000 patients having hernia surgery annually at a cost of over $350 million.

The management of hernia is undergoing substantial growth and development. With the introduction of multiple new techniques including abdominal wall reconstruction and the use of robotics, new mesh is being introduced on a regular basis leading to a variance in treatment and outcomes, with a paucity of data to guide the surgeon on specific operation for the individual patient. Despite the introduction of new techniques and the utilisation of prosthetic mesh in hernia repair, the long-term recurrence rates remain unacceptably high.

Recent media exposure on the class action, and resultant successful legal proceeding regarding uro-gynaecological mesh, has led to confusion and a loss of consumer confidence in governance and the use of mesh prosthesis.

The lack of high quality evidence on the effectiveness, long term safety profile and morbidity of meshes has led to the device regulator, the Therapeutic Goods Administration (TGA), reclassifying mesh prosthesis to a Class III device with more stringent registration requirements and post insertion surveillance data being called for in a significant effort to address these matters. There is also a need for leadership in matters relating to governance, best practice, advocacy, research and training standards in hernia repair.

It is timely to introduce ANZ Hernia – an incorporated society-specific craft group involving Australian and New Zealand surgeons with an interest in hernia, endorsed by the RACS. Its primary aims are communication, education, research, governance and promulgating best practice in hernia repair.

ANZ Hernia will oversee an ANZ Hernia Clinical Quality Registry, which will provide mechanisms for long term post insertion surveillance of hernia mesh and help monitor and improve outcomes in hernia repair.

ANZ Hernia has in principle support from RACS, the Americas Hernia Society and the Americas Hernia Surgery Quality Collaborative, which has primary aims of improving the outcomes of hernia repair, the European Hernia Society, the International Hernia Collaborative, the TGA and industry.

In a plenary session at the May 2020 RACS Annual Scientific Meeting in Melbourne, the working group anticipates launching ANZ Hernia with an open and transparent election of office bearers. A pilot study and recruitment of patients for the Clinical Quality Registry will begin sometime following this meeting.

It is critical to the success of this venture that surgeons interested in hernia repair engage in ANZ Hernia and the ANZ Hernia Clinical Quality Registry as it is developed and rolled out, in order to improve outcomes for patients under their care. ■

For further information, please visit ANZHernia.org

Dr Harsha Chandraratna

Dr Alex Karatassas

Dr Chris Hensman

Images left to right:
Chris McDonald, Igor Belyansky and Alex Karatassas.

Fellow visits Solomon Islands for update on hospital relocation

Dr Tony Heinz visited the National Referral Hospital in November to meet with hospital officials about the relocation plans for the hospital.

Dr Heinz has developed a special interest in helping the people of Solomon Islands after working for 32 years as a general surgeon at Goulburn Valley Health in Shepparton. The natural disasters and rising flood waters often restrict the capacity of local doctors to deliver adequate surgical services and this is of particular concern to Dr Heinz.

Honiara is located on Solomon's largest island, Guadalcanal, and the National Referral Hospital (NRH) is situated in a low-lying area of the city where sea levels are rising. The country's main hospital suffers from overcrowding and flooding, a regular occurrence in Honiara. The abundance of ocean and river water, together with torrential rainfall, often lead to sanitation problems and multiple mosquito-borne illnesses.

The Lowey Institute reported in 2018 that "diarrhoea is a common illness for more than a third of people in Honiara," and a 2017 UNICEF report on children in the Solomon Islands suggested that most deaths under the age of five years were due to pneumonia.

Dr Heinz travelled to Honiara in 2018 to visit his son, who was working there as a legal volunteer for the Department of Foreign Trade (DFAT). After visiting the NRH, he became concerned about the state of the hospital and made enquiries to see how he could assist. As a result of his research and meetings with hospital officials, he was pleased to discover that a long-term plan to relocate the NRH had been launched in 2015.

"The hospital currently doesn't have an adequate drainage system or public toilets," Dr Heinz said. "It is a ramshackle, crumbling set of buildings on the coastline." He also noted "chronic shortages of medical supplies" and cancellations of elective surgeries due to "lack of resources".

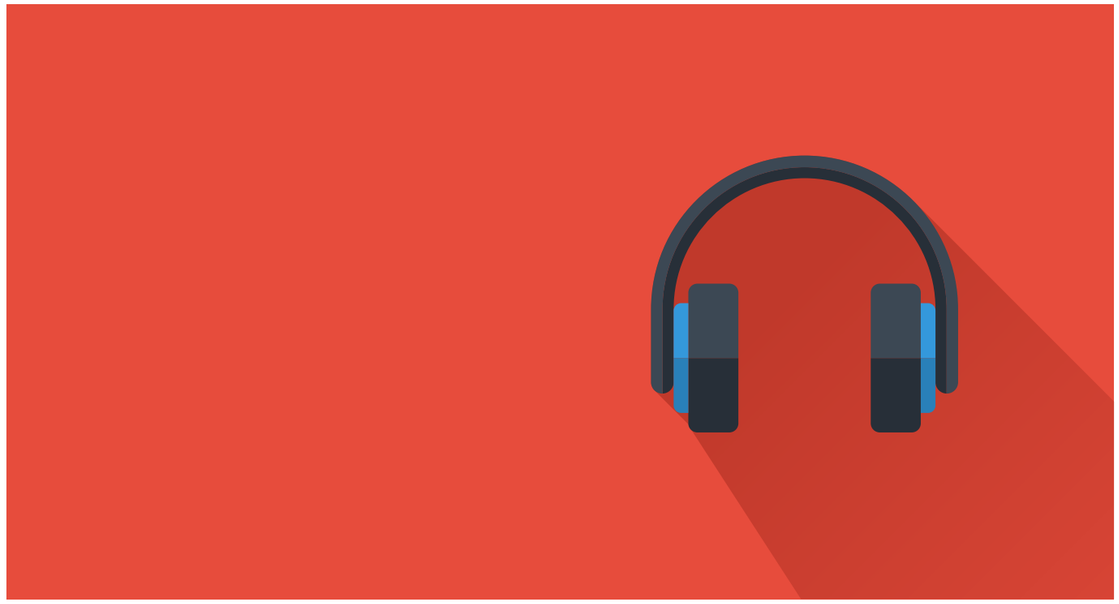
When the plan to relocate the NRH was launched, a new task force was created. A master plan and service plan were initiated as well. Following discussions with the Asian Development Bank last year, a business case was developed using an Australian consultancy firm. Strict terms of reference were given including, first, to set up three additional centres in Honiara to deal with primary and secondary presentations in order to relieve pressure on the NRH, second, to find the best way to maintain the current hospital site in the interim, and third, to locate a new site for relocation.

The Australian consultancy firm is expected to deliver a business plan, including funding options, in February 2020 with a view to full relocation in 10 or so years. Dr Heinz said he is hoping there will be additional funding to assist with the relocation of the NRH.

The 2015 Demographic and Health Survey suggested that by 19 years of age, about 21 per cent of teenage girls in Solomon Islands have become mothers. There are significant disparities between rural and urban areas in relation to births attended by skilled health professionals. In 2018, Australia and Solomon Islands announced the construction of a new national birthing centre in Honiara that will provide care for both mothers and babies.

Australia is the largest aid partner to Solomon Islands and provides about two thirds of Solomon Island's development assistance. In 2018, Australia provided $24 million in direct budget support to the Solomon Island's government to improve service delivery in health, education and infrastructure. These funds are linked to key performance indicators.

If you'd like to contact Dr Heinz, he can be reached at theinz51@hotmail.com. ■



Good listens

The RACS Post Op podcasts are brought to you with the generous support of the Bongiorno National Network. Listen on Apple podcasts, Google podcasts or Spotify.

RACSTA: an important support for surgical trainees

RACSTA – the College's Trainee Association – serves an important role in representing the interests of surgical Trainees. Dr Imogen Ibbett, former Chair of RACSTA, explains the good work the organisation does and how it strongly advocates the quality of training, workplace culture and well-being of Trainees.

Port Macquarie: Tale of two surgeons in a regional city

Living and working in regional parts of Australia can be immensely rewarding for surgeons. Port Macquarie on the New South Wales mid-north coast, has been an attractive place to call home for both Dr Kesley Pedler and Dr Rupert Snyman and their respective families. They discuss why they made the move, the work that they do, some of the challenges of working in a regional city, and why they want to stay.

Celebrating the work of surgeons during NSW Surgeons' Month

Specialist upper gastrointestinal surgeon, Dr Ken Loi, has a number of priorities he'd like to address as regional chairman of RACS NSW committee. In this episode, Dr Loi also discusses NSW Surgeons' Month which helps recognise and celebrate the wide variety of work that surgeons do.

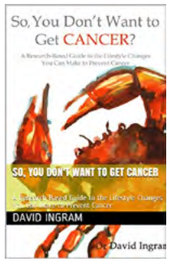
Benefits of surgical overseas volunteering

Volunteering overseas is a goal for many doctors. While it's not for the faint hearted, it's also incredibly rewarding, as Dr Thomas Schaefer, an orthopaedic surgeon in Western Australia explains. Making a difference to in-need communities like those in Gaza, is what humanitarian work is all about for Dr Schaefer. He shares with us his journey from Switzerland to working in WA and volunteering overseas when and where he's needed.

Good reads

So, You Don't Want to Get Cancer: A Research-Based Guide to the Lifestyle Changes You Can Make to Prevent Cancer

David Ingram FRACS



David Ingram wants to help us stay free from cancer. As a cancer surgeon, he has seen too much of the suffering that cancer can wreak.

In *So, You Don't Want to Get Cancer*, Ingram claims that as much as 40 per cent of cancer can be prevented by changes in lifestyle, and he clearly sets out the changes we can and should make to reduce our chances of developing many common cancers.

The book covers a wide range of topics including alcohol, diet, organic food, medications to prevent cancer, smoking, excess body fat and bariatric surgery, physical activity, ultraviolet (UV) exposure from sunlight, vaccinations, vitamins and minerals, stress, cancer-preventing surgery, radiation exposure including x-rays and scans, cell phone use and pesticide and herbicide exposure. All the common cancers are discussed in detail.

Cancer can forever change our lives or lead to death. This book, based on quality, medical research, discusses simple changes that might prevent this from happening.

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

'Ladies and Gentlemen, this is your Surgeon speaking': Exploring the Human Factor in Aviation and Surgery

Geoff Hay

Geoff Hay is an international airline pilot with 30 years of aviation experience – the past 18 years as a training captain. In *Ladies and Gentlemen, this is your Surgeon speaking*, Hay explores the parallels between the flight deck and the operating theatre, examining, through past aviation accidents and incidents, whether surgery could benefit from the lessons learned in aviation.

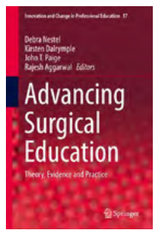
Hay looks at modern day pilot training, particularly in the area of human factors and the science of 'why we do what we do' i.e. how do humans perform under stress in terms of decision making, teamwork, leadership, situational awareness and communication? The book also examines chain of command, use of technology and the pressures faced by both professional spheres.

Prior to his career in aviation, Hay completed his general nursing training at the Royal North Hospital in Sydney. He has worked extensively in the operating theatre, enabling him to see potential benefits for surgical practice from human factors training.

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

Advancing Surgical Education: Theory, Evidence and Practice

Edited by Debra Nestel, Kirsten Dalrymple, John T. Paige and Rajesh Aggarwal



Focusing on residency and post-residency training, *Advancing Surgical Education* provides a comprehensive description of the theories, the evidence and the practice of modern surgical education, with unique insights into the many aspects of education.

The first section deals with historical aspects, the role of leadership and governance in surgical education.

The second section delves deeply into the theories that underpin educational practices, exploring the science of learning and the science of teaching.

The third section, dedicated to the practice of surgical education, is in itself a complete compendium dealing with the design and implementation of surgical education and training activities at the intersection of service and education.

A number of chapters have been written by RACS Fellows.

Available as an e-book at bit.ly/2uSNiMI

Research, education and travel scholarship and grant opportunities

Supporting you to forge higher levels of excellence in surgical practice and patient care

Apply now! Travel, education and research scholarship and grant opportunities for 2021

For more information, visit surgeons.org/scholarships

Are you thinking of undertaking research or training or continuing your surgical education in 2021? If so, the Foundation for Surgery Scholarship and Grant Program might be able to help. Applications are currently open and you are invited to apply for the following scholarships, Fellowships and grants.

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

Applications must be received by midnight ACST 14 April 2020.

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

Research scholarships, fellowships and grants

John Mitchell Crouch Fellowship

$150,000

The prestigious John Mitchell Crouch Fellowship is open to Fellows who are making an outstanding contribution to the advancement of surgery or 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 resident in Australia or New Zealand, with their RACS Fellowship or comparable overseas qualification obtained within the past 15 years (2005 or later). They must currently be working actively in their field and this Fellowship must be used to assist continuation of this work.

The successful recipient is expected to attend the convocation ceremony at the RACS 2021 Annual Scientific Congress (held in Perth in May) to deliver a formal 20-25 minute oral presentation on their research work including the contributions expected to arise from the Fellowship.

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. Fellows, trainees and IMGs who wish to undertake a significant cancer research project are eligible to apply for this scholarship.

Academy of Surgical Educators Surgical Education Research Scholarship

$10,000

This scholarship is open to Fellows, trainees and IMGs to fund their 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.

Brendan Dooley and Gordon Trinca Trauma Research Scholarship

$14,000

Gordon Trinca and Brendan Dooley both made significant contributions to the prevention of road trauma. This scholarship has been developed in their honour to fund Fellows, trainees and medical scientists to conduct research relating to the prevention and treatment of trauma injuries in Australia and New Zealand.

Catherine Marie Enright Kelly Memorial Research Scholarship

$66,000

A bequest from the late T D Kelly FRACS enabled the establishment of this scholarship in 1987. It is open to Fellows and trainees enrolled in or intending to enrol in a higher degree.

Eric Bishop Research Scholarship

$66,000

The establishment of this scholarship was made possible due to a kind 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.

Foundation for Surgery New Zealand Research Scholarship

$66,000

This scholarship is open to citizens of New Zealand who currently reside in New Zealand. It is open to Fellows and trainees enrolled in or intending to enrol in a higher degree.

Foundation for Surgery Research Fellowship

$66,000 per anum up to 3 years

This scholarship is open to Fellows who are conducting important research. Preference may be given to academic surgeons who are early in their career.

Foundation for Surgery Research Scholarship

$66,000

This scholarship is open to Fellows and trainees enrolled in or intending to enrol in a higher degree.

Francis & Phyllis Mary Thornell-Shore Memorial Trust for Medical Research Scholarship

$66,000

Established in recognition of the generosity of Francis and Phyllis Thornell-Shore, this scholarship is open to Fellows and trainees enrolled in or intending to enrol in a higher degree.

Health Technology Assessment Scholarship

$66,000

This scholarship is intended to support Fellows, trainees and Junior Doctors who wish to take time away from 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. If the applicant is enrolled in a Master's program their application may be given preference. Production of a systematic review and a peer-reviewed publication is a minimum requirement on completion of the scholarship. Junior Doctors will need to conduct this work in conjunction with the RACS ASERNIP-S program 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

The late Gloria Joyce Kees had the compassionate foresight to leave a bequest to support medical research and/or the advancement of surgical technologies, techniques and treatments, which has resulted in this scholarship. Applications are open to trainees or IMGs on a pathway to Fellowship and Fellows who have had their Fellowship for five years or less (since 2015).

James Ramsay Project Grant

$83,000 per anum up to 2 years

Substantial bequests made by the late Mr James Ramsay and the generosity of the late Mrs Diana Ramsay brought about the development of this grant. It recognises James Ramsay's father, Sir John Ramsay, co-founder of RACS. Applications are welcome from Fellows and trainees wishing to undertake clinical or research projects with an emphasis on innovation and definite aims and outcomes. Applicants who are from South Australia or who can demonstrate a clear benefit to the people of South Australia may be given preference.

MAIC-RACS Trauma Scholarship

$66,000

This scholarship was established with 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 is conducted in Queensland, it must be shown that the potential benefits flowing from the research will assist people in Queensland.

Paul Mackay Bolton Scholarship for Cancer Research

$66,000 per annum for up to 2 years

Harry Bolton established this scholarship 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 proposed 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, those relatively early in their career and/or those who are enrolled in or intend to enrol in a higher degree.

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. Research applications focusing on the practice of surgery outside metropolitan areas may be given preference. Applications for the scholarship are open to Fellows and trainees enrolled in or intending to enrol in a higher degree.

Professor Philip Walker RACS Vascular Surgery Research Scholarship

$20,000

The late Professor Philip Walker was an internationally educated vascular surgeon, a distinguished teacher, researcher, examiner and clinically active surgeon and this scholarship is funded thanks to a generous bequest from him. 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. ▶

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.

Research Scholarship in Surgical Ethics

$66,000

Fellows, trainees and non-RACS applicants sponsored by a RACS Fellow with a special interest in the ethical issues of modern surgery are eligible to apply for this scholarship, which was established to promote research about and public awareness of the ethical problems confronting surgery.

Richard Jepson Research Scholarship

$66,000 per annum — up to 3 years

The late Professor Richard Jepson was the foundation Chair for Surgery at the University of Adelaide. This Scholarship was created in his honour due to a generous donation from his wife, the late Dr Mary Jepson. It is open to younger Fellows (since 2010) and trainees enrolled in or intending to enrol in a higher degree.

Sir Roy McCaughey Surgical Research Scholarship

$66,000 per annum — up to 3 years

This scholarship, which was founded thanks to a bequest from the late Sir Roy McCaughey, is open to Fellows and trainees from New South Wales who are enrolled in or intending to enrol in a PhD.

Small Project Grants

$10,000 each

These grants are for Fellows or trainees who wish to or are already undertaking a small clinical or research project, or those who require some funding to purchase equipment to carry out a research project. Up to five grants are awarded each year.

WG Norman Research Scholarship

$66,000 — $60,000 stipend plus $6,000 departmental maintenance

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 bequest from the late Dr W G Norman of Adelaide to fund research with a trauma focus. Applicants must be a resident of and conduct the proposed research in South Australia. Applications with a trauma focus will be given preference.

Travel and Education Scholarships, Fellowships and Grants

Margorie Hooper Travel Scholarship

$65,000 — plus accommodation and travel expenses

Thanks to the generous bequest of the late Mrs Margorie Hooper of South Australia, this scholarship has been made available to Fellows and trainees who reside permanently in South Australia (SA). It is designed to enable them to travel overseas to learn a new surgical skill for the benefit of the SA surgical community (preference). Alternatively, applications will be accepted those who wish to undertake postgraduate studies and reside temporarily outside the state of SA, either elsewhere in Australia or overseas. The recipient will be asked to make a presentation at the NT, SA and WA Annual Scientific Meeting in the year following the conclusion of the scholarship.

Anwar and Myrtha Girgis IMG Scholarship

$10,000

Dr Anwar Riad Girgis initially trained in medicine in Egypt and then undertook postgraduate training in the UK. Dr Girgis appreciated the assistance given to him by generous colleagues in the UK and Australia. Upon his death his children Mona and Peter Girgis pioneered the establishment of this scholarship to support refugees, asylum seekers and migrants. If you are a doctor of refugee or asylum seeker background (at any time in your past), or a recent migrant (within five years of migration), and you wish to gain the professional development required to practice surgery in Australia or New Zealand, you are encouraged to apply for this scholarship.

Aziz Hamza Rural Surgery Scholarship NEW

$10,000

This new scholarship has been established by Dr Saud Hamza to honour the legacy of his father, Professor Aziz Hamza. Professor Hamza (1937-2019) was a professor of English Literature at the College of Education, University of Baghdad, Iraq. The objective of this scholarship is to assist in delivering quality surgical care to people in remote and regional Australia. It is open to Younger Fellows who are in the first ten years of their Fellowship (since 2010) and trainees who wish to attend RACS professional development activities, meetings, conferences or workshops to improve surgical services in remote and regional Australia. Preference will be given to applicants who are currently located in or originally from regional Australia.

Hugh Johnston Travel Grant

$10,000

This grant was established thanks to the late Eugenie Johnston in memory of her late husband, 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 has been established for an Australian or New Zealand Fellow who wishes to attend the annual American College of Surgeons (ACS) Clinical Congress in October 2021. It forms part of a bilateral exchange with the ACS and is open to those who have gained their RACS Fellowship in the past ten years (2010 or later). Applicants must 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. Successful applicants must spend a minimum of three weeks in the United States (US) in the year of their Fellowship. While in the US, they must attend the ACS, participate in the ACS convocation ceremony, visit at least two medical centres in North America and share clinical/scientific expertise with 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 2021.

Ian and Ruth Gough Surgical Education Scholarship

$15,000

Thanks to the former RACS President Professor Ian Gough and his wife Ruth Gough, this scholarship was established to encourage Fellows and trainees to become expert surgical educators.

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 conduct research. To be eligible applicants must have gained their Fellowship in the past five years (2015 or later), from any specialty.

Murray and Unity Pheils Colorectal Travel Scholarship

$10,000

Thanks to a generous donation by the late Professor Murray Pheils this scholarship supports a colorectal trainee or younger Fellow (2010 or later) 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

Total $10,000 — to be awarded to 3–5 recipients

Mr Gordon Pickard has been a strong supporter of robotic surgery in South Australia. Through these scholarships, he wishes to provide training opportunities to South Australian surgeons to expand their expertise in robotic surgery. RACS Fellows and trainees, as well as other surgeons and non-surgeons, who are undertaking robotic surgical training and/or research are eligible to apply for a scholarship. To be eligible, applicants must reside in South Australia or have a clear contractual commitment to the South Australian public hospital system for two years immediately following the conclusion of the scholarship.

Poate Family Plastic and Reconstructive Surgery Travel Grant NEW

$3,600

Following a generous donation by Mr William James Poate FRACS on behalf of his wife and family, this new grant has been established to assist a trainee to travel overseas to obtain further training and experience in the field of plastic and reconstructive surgery. Mr Poate, a retired Fellow, was a foundation member of the Australian Society of Plastic Surgeons and one of the first seven plastic surgeons in Sydney and was a keen early advocate of the development of breast reconstruction after mastectomy.

RACS Aboriginal and Torres Strait Islander SET Trainee One Year Scholarship

RACS Māori SET Trainee One Year Scholarship

$20,000

These scholarships have been established to support trainees who identify either as Aboriginal, Torres Strait Islander or Māori. Funding could be used to cover SET registration fees, SET course fees, SET examination fees, research projects, mentoring programs, travel, accommodation and registration fees for successful applicants to attend conferences and/or other relevant professional development activities.

Applicants for the RACS Aboriginal and Torres Strait Islander Trainee One Year Scholarship who identify as being an Aboriginal or Torres Strait Islander must fulfil the eligibility requirements for membership of the Australian Indigenous Doctors' Association (AIDA). Details can be found on www.aida.org.com.au/membership/eligibility/.

To be eligible for the RACS Māori SET Trainee One Year Scholarship applicants need to fulfil the eligibility requirements for membership of Te Ohu Rata o Aotearoa (Te ORA). Details can be found on www.teora.maori.nz/membership

Stuart Morson Scholarship in Neurosurgery

$30,000

This scholarship has been established following a generous donation by Mrs Elisabeth Morson in memory of her late husband, Stuart Morson. It is designed to assist neurosurgical trainees or young neurosurgeons who are within five years of obtaining their FRACS (2015 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. Travel must not have been commenced before applying for the scholarship. ■

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

Applications close midnight ACST 14 April 2020.

Royal Australasian College of Surgeons
Foundation for Surgery

In memoriam

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

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

Geoffrey Wynne-Jones (NZ)
Geoffrey R. Gibson (NSW)
Graeme Douglas Campbell (NZ)
John M Harrison (NSW)
David Collis Burke (VIC)
Douglas Ivor Roberts (TAS)
Laurence Simpson (VIC)
Kevin Orr (NSW)
Ross David Gurgo (QLD)
Louis Waller (VIC)
Brian Courtice (QLD)
Anthony Lawler (VIC)
William Robertsal
Alan Trist (NSW)

Informing RACS

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

ACT: college.act@surgeons.org
NSW: college.nsw@surgeons.org
NZ: college.nz@surgeons.org
QLD: college.qld@surgeons.org
SA: college.sa@surgeons.org
TAS: college.tas@surgeons.org
VIC: college.vic@surgeons.org
WA: college.wa@surgeons.org
NT: college.nt@surgeons.org

David Melville Birks FRACS

5.7.1945 – 17.3.2019

David Melville Birks was destined to be a surgeon, a good one, and an educator.

His grandfather Melville Birks FRCS, an Adelaide graduate, worked at the London Hospital and in rural South Australia, finally becoming Surgeon Superintendent of Broken Hill Hospital, where he also undertook much important research work on miners' silicosis and lead poisoning.

Melville's son, Walter 'Gordon' Birks BEM FRCS, operated through the Blitz in London in WWII before returning as Surgeon to the Yallourn Hospital, and serving the Moe District of Victoria with distinction over the period 1951-1977.

David, the eldest of Gordon's two sons, attended primary school in the Latrobe Valley prior to the Geelong College, where he excelled in rowing and Australian Rules Football, continuing these sports at Ormond College, University of Melbourne.

During his six undergraduate years at the Melbourne Medical School, he met and married a fellow medical student, Kaye Pamela Harris. Their union produced a daughter and two sons: one son is currently practising as a General Practitioner in Moe.

David then elected to pursue a surgical career, commencing at the Royal Melbourne Hospital and culminating in the well-established path of postgraduate studies abroad: along the way he gained the surgical fellowships of the Canadian College, the Edinburgh College and, in 1977, the Australasian College. While in Vancouver he took up running, and on returning to Victoria continued with this pastime, running in ten consecutive Melbourne Marathons.

Mr Peter F. Burke FRACS

Honour roll thank you

Royal Australasian College of Surgeons
Foundation for Surgery

Thank you for your extraordinary compassion and generous support of the Foundation for Surgery. Thanks to you, many more children, families and communities have access to quality surgical care when they need it most.

Every donation makes an incredible difference throughout Australia, New Zealand and the Asia Pacific Region. We would like to make special mention and honour the valuable contribution of our **2019 Platinum, Gold and Silver donors:**

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▸ To find out more, please visit surgeons.org/foundation

Royal Australasian College of Surgeons
Foundation for Surgery

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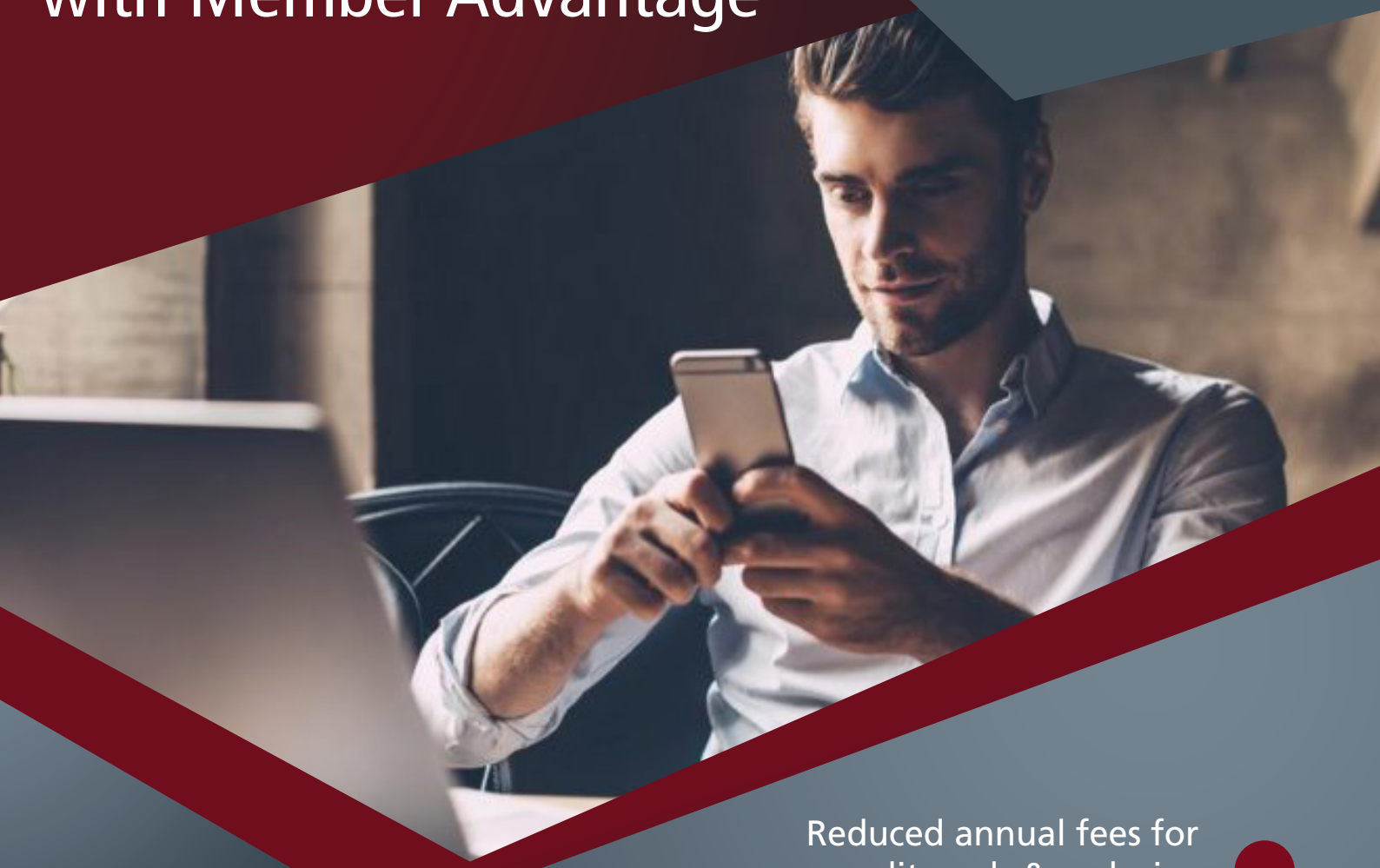

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