SurgicalNews

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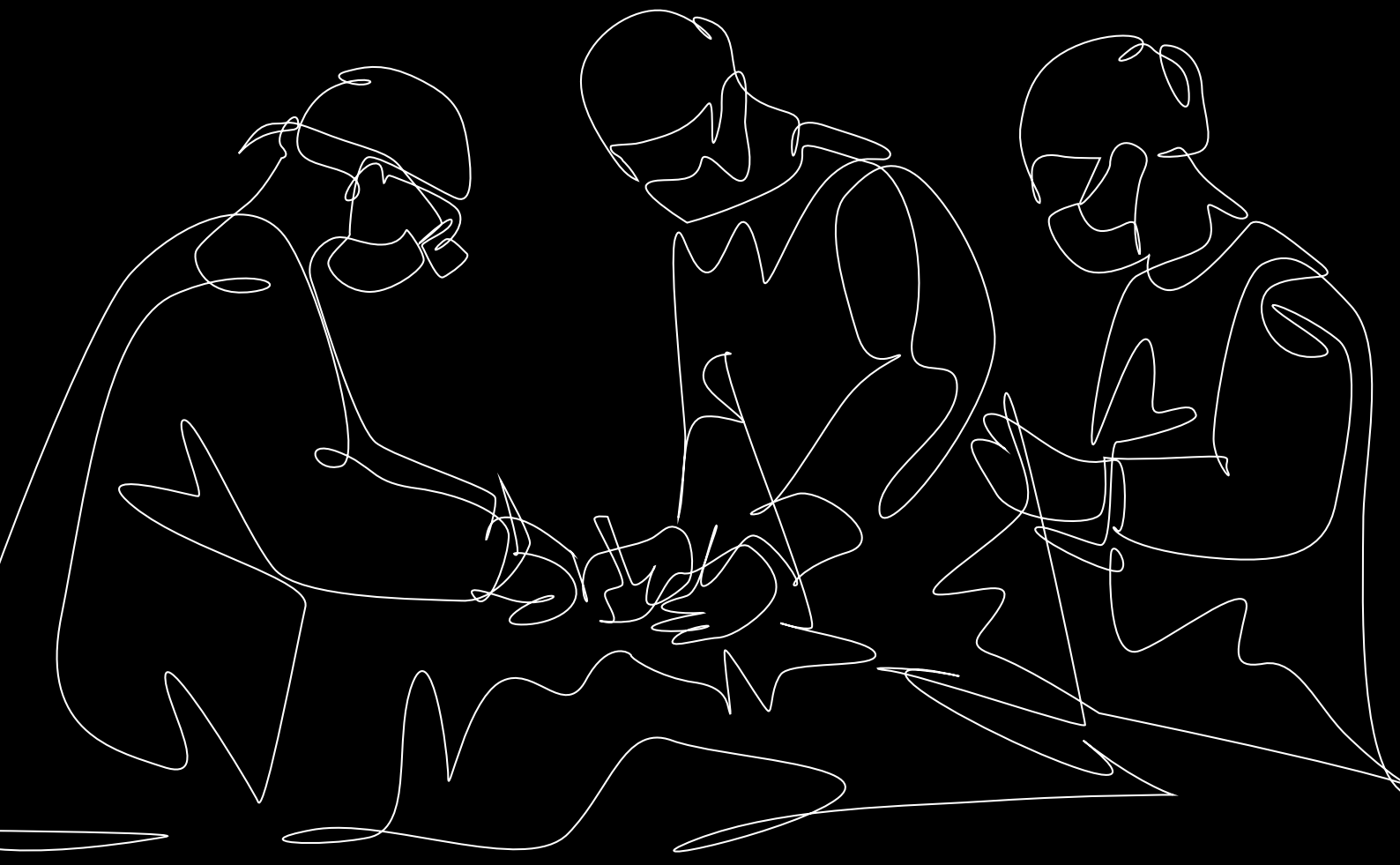

Royal Australasian
College of Surgeons

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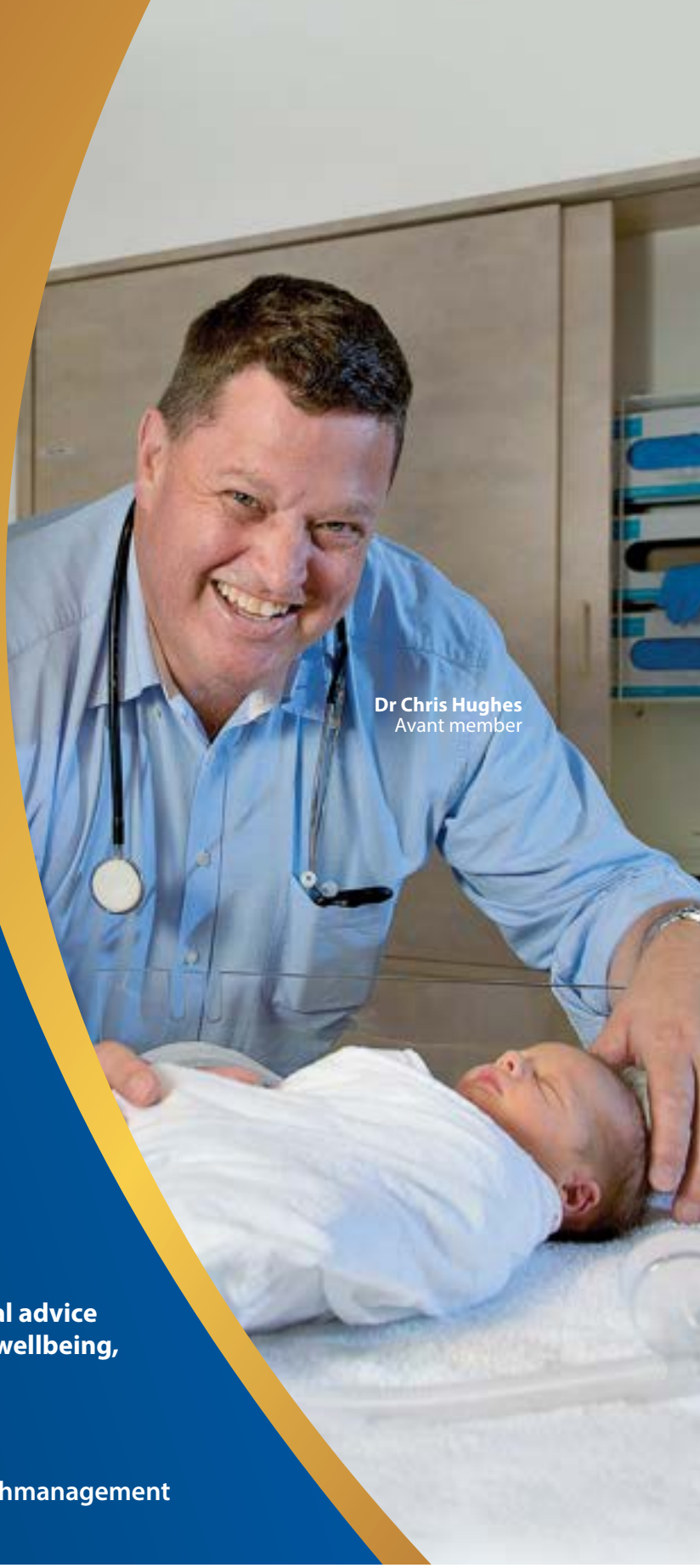

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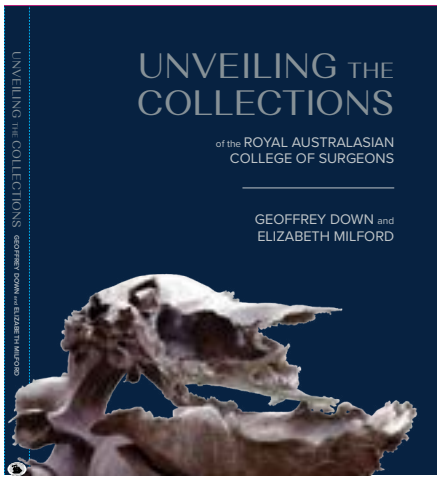
RACS leadership

Spotlight on

New beginnings



Articles of interest

Global Health

Scholarship

Research

Historical

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President's perspective

While we have entered a new year, it looks like the COVID-19 pandemic will be with us for a while longer. With border restrictions coming and going throughout December and January, I am sure it was a very different Christmas break for many and a strange, but increasingly familiar, way to start 2021.

Last year I regularly wrote about how the College had been forced to adapt by implementing processes and different ways of working that may have taken several years, or even decades, to occur had the pandemic not hit. The challenge for us in 2021 will be to continue to integrate the lessons learned and use this experience to allow us to be as productive as we possibly can be and deliver excellent value to our membership.

I ended 2020 by travelling to Canberra with the Royal Australasian College of Surgeons (RACS) CEO, John Biviano, and the General Manager – Fellowship Engagement, Etienne Scheepers. As well as meeting with Dr Brendan Murphy, the Secretary of the Australian Government Department of Health; Professor Paul Kelly, the Chief Medical Officer; Dr Nick Coatsworth, infectious disease physician; and other members of the Australian Government Department of Health leadership team, we met with the Hon Mark Coulton MP – Minister for Regional Health; the Hon Chris Bowen MP – Shadow Minister for Health; and others from the Professional Services Review Agency, the Australian Medical Association, the Private Hospitals Association and the Consumers Health Forum.

In all meetings we conveyed the view that, as Australia overcomes COVID-19 and looks to rebuilding, RACS is keen to take a more engaged role in working with government and other stakeholders to ensure the long-term sustainability of surgery in our healthcare system. Specific topics touched on during the visit included fee transparency and the government's Medical Cost Finder website, telehealth, reforms to use of the title 'surgeon', elective surgery during the pandemic and reforms to the management of the Prosthesis List, among others. It was a productive visit with most displaying significant engagement in the issues, as well as interest in collaborating more closely with the College into 2021 and beyond.

Another key topic in our Canberra discussions was rural health, and the recently released Rural Health Equity Strategic Action Plan. I would like to thank past and present members of the RACS Rural Surgery Section who led the development of this. The plan is focused

on building partnerships and raising awareness with our stakeholders to ensure there is inclusivity and a shared understanding of health equity for our rural, regional and remote communities.

Later this year, the College will convene a forum to deliver a sustainable surgical service in Remote Central and Northern Australia (RCANS). The forum will devise strategies to implement a RCANS Training Network and a RCANS selection initiative for selecting junior doctors who are already living, working and committed to a remote area.

I am also pleased to confirm that RACS will continue to support the New Fellows Rural Placement pilot in 2021, funded through the Federal Department of Health's Specialist Training Program.

Telehealth became an increasing area of focus throughout 2020, and will continue to be so this year for both rural and metropolitan surgeons. Given the potential for healthcare savings with equivalent safety outcomes and increased health equity, it is important that barriers to the implementation and use of telehealth services are investigated.

The College recently commissioned a report to investigate the factors that either prohibit or encourage the implementation and use of telehealth, and to examine patient and provider perceptions of telehealth services. The results of this review provide additional evidence to support the results of the telehealth surveys that we conducted last year, and will be used to guide RACS' advocacy. The report is available on the RACS website.

We also consulted with the Medical Council of New Zealand on telehealth, unprofessional behaviour, ending a doctor–patient relationship and revised accreditation standards.

In addition to other efforts in New Zealand, we advocated through the Ministry of Health for a change to resident medical officer rotation dates (from pre-Christmas to January-February). The change was agreed to by all District Health Boards and relevant unions and will be implemented in early 2021.

This will be a key year for the future direction of our College in many ways. Following receipt of a proposal from the New Zealand National Board in February 2020, Council approved the establishment of the College Name Change Working Group to scope a College name change. This issue is one that will garner a diverse range of opinions and suggestions. The objective of the working group is to support balanced, informed deliberations regarding the College's name, and will provide recommendations to Council about potential options and timelines for a member vote.

Continuing Professional Development (CPD) is another area of the College that is set for an exciting transformation.

The CPD team is working on a comprehensive program that is aligned with your scope of practice and supported by a streamlined and intuitive online platform. As we transition to the new program in July 2021, there will be a condensed CPD requirement from January to June 2021.

The Board of Council meeting in January also accepted an independent review of the complaints process. This contained 21 recommendations that will support further change.

Lastly, I am pleased to share a publication titled *Unveiling the Collections* with you. It was written by Geoff Down, the College curator, and Elizabeth Milford, our archivist. The book focuses on the many significant and unusual objects in the College collections.

I take this opportunity to wish you all a happy and prosperous 2021. ■

Mr Tony Sparnon
President

The College 2021 finance and budget report

The impact of the COVID-19 pandemic has been substantial for all businesses and not-for-profit organisations throughout the world. The Royal Australasian College of Surgeons (RACS) recognised early in March of 2020 that it needed to act decisively and place the wellbeing of its Fellows, Trainees, Specialist International Medical Graduates (SIMGs), staff and all its various stakeholders at the centre of its response. The financial impact was significant and Council, supported by management, initiated numerous business measures to offset the loss of operational revenues as effectively as possible. This included applying for the government JobKeeper wage subsidy scheme.

By the end of 2020, a projected revenue loss of up to 20 per cent from core operational funding activities was anticipated. Under these conditions, setting a sustainable financial plan for the forthcoming year has required a ground-up reassessment of current service delivery models, support systems and changing work practices. Council is determined that the business should continue to deliver core services to its members in a manner that is fiscally responsible. This has required a clear focus on containing expenditures to offset any ongoing variability in core operational revenues.

Despite these uncertain times, it is more important than ever that the flow of benefits to our Fellows, Trainees and SIMGs is foremost in our service delivery funding model. This budget continues to place a clear priority on strategic investment under the multi faceted Transformation Program. The benefits to our Fellows, Trainees and SIMGs will be demonstrated over the next year and into the future, with improved member engagement, a personalised experience from our website and a new IT platform to deliver more modern member services, education and training. With appropriate cross funding from accumulated reserves, the operational budget will not be materially impacted by this investment.

We know from routine monitoring of the website that library resources and services are a key area of engagement for our members. The budget further builds on this service with an increased level of annual funding to ensure we can provide a wealth of relevant content, search tools and appropriate support from professional library staff.

The budget has increased funding to support the College's commitment to remain the major funder for surgical grants, research, scholarships and philanthropic causes in Australia, New Zealand and across the Asia-Pacific region. In partnership with multiple government agencies, funding has been accounted for to deliver significant activities under initiatives such as the Specialist Training Program (STP), Audits of Surgical Mortality, Global Health and assessments of new and emerging surgical technologies by our research team ASERNIP-S.

We have also made allowance to fund important measures to continue to enhance the Trainee program, advance advocacy and support our members both professionally and personally during these times of heightened uncertainty.

It has been difficult to formulate the annual financial plan during this period. However, the core principle of service to our members remains clear. The budget has been prudently set to address the things our members value most, while continuing to build upon the significant investment in modern service delivery technologies to ensure our members are engaged and supported throughout their surgical careers.

Figure 1:
Financial Position – Trend

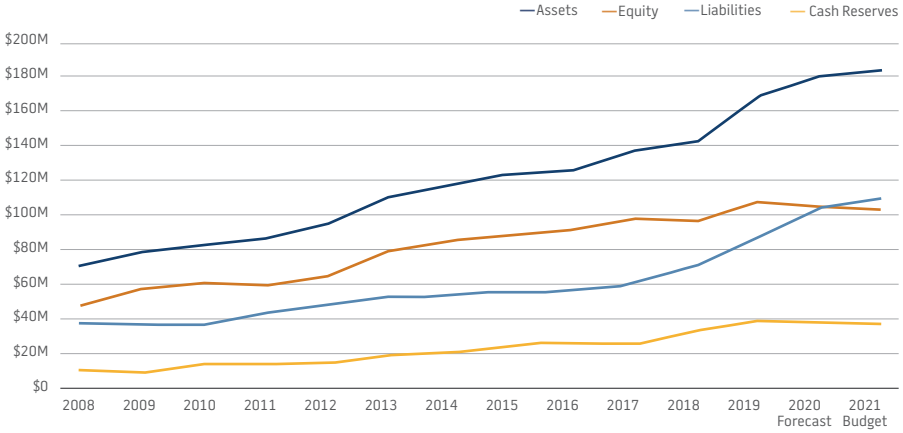
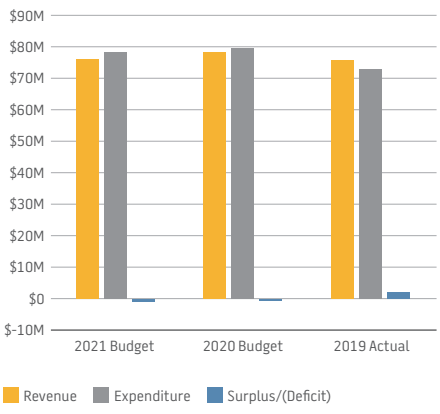


Figure 2: Budget 2020 Revenue and Expenditure, Surplus/(Deficit)



Business categories
There are three categories of activities that make up the RACS business. Council has long held that Category 1, our core business, should budget for a modest surplus of two per cent, with the aim to achieve long-term financial sustainability. Category 2 is for projects delivered under various funding agreements from third parties, primarily government agencies. Category 3, foundation and investments, are the funds our grants, scholarships and philanthropic causes.

Category 1
Core business

Category 2
Externally funded projects

Category 3
Foundation and investments

Budget 2021 by business category

Category 1
Core operations by portfolio

Education
Education Services
Training Services
Research and Innovation

Fellowship Engagement
Policy and Standards
Professional Standards
Fellowship Services
State and National Offices

People and Culture
Human Resources
Building Respect Improving Patient Safety
Communication and Marketing
Internal Services

Operations
Finance
Information Technology
General Counsel
Governance & Council Support
Transformation Program
Conference & Events (incl ASC)

Overall, the core operational budget is set for a minor surplus of $44,000, which incorporates funding for ongoing investment in the business Transformation Program and progressing with the Australian Medical Council (AMC) accreditation conditions.

Revenue growth is targeted at 3.5 per cent, totalling $53.7 million. The Education portfolio represents 57 per cent of the core revenue, being responsible for services related to examinations, skills courses, SIMG assessments and surgical training.

The other main source of revenue is from Fellows' annual subscriptions under the Fellowship Engagement portfolio. This accounts for 39 per cent of the revenue base. This funding is essential for the delivery of Fellowship Services across Australia and New Zealand, including library and information resources, continuing professional development and standards, government representation, communication via numerous sources and marketing, supporting special interest groups, visitor programs, personal support resources and leading education programs to build respect within the surgical profession.

Expenditure is budgeted to grow by 3.1 per cent, totalling $53.6 million. Again, the Education portfolio is dominant, accounting for 38 per cent of overall expenses. This is to be expected, as significant event coordination costs and professional staff are required to administer education, skills courses and related research services.

More broadly, staffing is the single biggest service delivery cost at $23.7 million, or 44 per cent of the total cost base. This represents an annual increase of 10 per cent and is inclusive of industrial reform initiatives to better support contemporary business practices, such as productivity and flexible working hours. It is also expected that the completion of both the AMC and Transformation Program will allow staff resourcing to stabilise to within annual wage growth indexation.

Category 2
Externally funded projects by portfolio

Education: Specialist Training Program (STP)
Fellowship Engagement: Research Audit & Academic Surgery (incl Mortality/Morbidity Audits and ASERNIP-S)
Operations: RACS Global Health

Externally funded project activities are significant in terms of the scope of contracted work that is performed and the committed funding arrangements. These projects provide specialist training, Indigenous and Māori health initiatives, audit and international humanitarian assistance.

RACS Global Health is the main driver for the projected overall modest deficit of $33,200. The area is being repositioned to capitalise on its external grant programs with endorsement of its financial sustainable strategy.

Revenue from various external sources is projected to be $18.2 million. The STP agreement administered under the Education Portfolio accounts for 56 per cent of this and totals $10.2 million. Other major funded activities include RACS Global Health, Audits of Surgical Mortality and ASERNIP-S, accounting for $4.4 million, $1.5 million and $1.9 million, respectively.

Expenditure totals $18.5 million with approximately $9.5 million or 51 per cent of overall expenditures related to specialist training posts and rural loading hospital payments under the STP contract. Staff resourcing to deliver all programs is the other main expenditure, totalling $4.1 million or 22 per cent of overall costs.

It is worth noting that the ASERNIP-S business, which was established in 1998 as a core surgical research group, continues to grow both its domestic and international client base and is projected over 2021 to increase its funded work by 40 per cent, with revenues of $1.9 million. ▶

Category 3
Foundation and investments by portfolio

Education:
Education Innovation Corpus
Educator Scholarship Corpus
Surgical Education Research Prize

Fellowship Engagement:
Indigenous –
Corpus/Scholarships/ASC awards

Operations:
Foundation for Surgery
Scholarship/Research grants
Investment reserve
ASC Visitors Corpus

After taking into consideration the Transformation Program source funding of $950,000, the overall result is a budgeted deficit of $865,000.

Revenue for all activities is budgeted to be $4.8 million, and mainly relates to the combined five per cent increase target for investment rate of return and funding from other sources, such as donations, sponsorship and royalties.

Expenditure allocation is budgeted to be $5.7 million including the $950,000 Transformation Program funding. This budget provides for increased commitments of $2.4 million (in 2020 it was $2.1 million) for scholarships, Fellowships, research grants and other philanthropic endeavours that are predominantly administered under the Foundation for Surgery. Council has approved a strategic funding aim for future budget years to commit to funding of up to $2.5 million annually. The budget also incorporates the restructure of funding for program resourcing and support.

Selection of key 2021 RACS fees

Fee description All GST-inclusive (unless otherwise indicated*)	AUD$ 2021	NZD$ 2021
Annual subscription	3260	3645
Fellowship entrance fee	6105	6830
SET annual training fee – RACS	3660*	4505
Fellowship examination fee	8775*	10,800
Pre-vocational – Generic Surgical Science examination fee	4650	5205

▶ For summary listing of key 2021 fees refer to RACS website www.surgeons.org
* GST Exempt

Transformation program
Since 2019, a comprehensive evaluation of our member engagement and experience has been undertaken with a specific emphasis on how systems and technologies are currently operating to deliver service to the Fellowship and all other key stakeholders. The 2021 capital budget of $4.8 million represents the second year of targeted investment in this program with clearly defined benefits set to deliver a suite of changes. This includes enhancing our business practices, supported by contemporary technologies to improve our members' service experience, engagement and value with the delivery of relevant and purposeful service that adapts to the changing needs of our members.

Throughout 2021 we will be focusing on transitioning to a new Customer Relationship Management (CRM) platform, which will establish a single record for our members. This will allow us to build on the existing foundation and embed new experiences such as personalised website content, CPD with streamlined tracking of activities, scholarship programs that are supported in a consistent manner and creating sophisticated platforms for education, training and learning. The hard work in identifying gaps has been completed and, with the detailed planning and governance oversight, the next two to three years of investment will see some very fundamental changes in how we continue as a member-based organisation, leading surgical standards, education and professionalism in Australia and New Zealand.

Budget 2021 in summary
Council supports this strategically targeted budget, which has been conservatively set to provide contingency to enable the business to address the ongoing external impacts of the pandemic. Budget 2021 ensures the core operations of Fellowship Services and education and training are appropriately resourced, and that the Transformation Program is appropriately funded. We also remain strategically committed to funding surgical research initiatives and charitable endeavours now and into the future. Budget 2021 achieves a sound budget, setting a modest deficit to build future engagement capacity with members and all other important stakeholders. ■

Dr Greg Witherow
Treasurer

Spotlight on

New beginnings

Welcome to the first issue of *Surgical News* for 2021

This new year provides a chance to reset and look forward to the many initiatives at the College. We are excited to share new research, new training programs, new offices, new interest groups and a new format for the upcoming Annual Scientific Congress.

Read on to find out more about the new beginnings happening in 2021 at the Royal Australasian College of Surgeons.

New Zealand surgeon's ground-breaking work to change patients' lives

The 2020 recipient of the Royal Australasian College of Surgeons (RACS) John Mitchell Crouch (JMC) Fellowship, Professor Greg O'Grady, is an academic surgeon who develops technological innovations that improve outcomes for patients with gastroenterology diseases.

With a strong focus on surgical recovery, Professor O'Grady's work in translational research bridges the gap between basic science and clinical practice – an approach often referred to as 'bench to bedside' research.

A PhD in bioengineering, along with a Fellowship in General Surgery from RACS, and further training with the Colorectal Surgical Society of Australia and New Zealand have provided a broad academic and clinical basis for his work. Rather than writing papers, he recently made a deliberate decision to "focus on developing real-world products that [he] hopes will be useful to a large number of people".

Professor O'Grady's research impact has led to first descriptions of fundamental physiology of the human gut, novel mechanisms of diseases, new causes of delayed or failed surgical recovery and innovative new therapies for patients suffering from intestinal failure.

Professor O'Grady founded the Surgical Engineering Lab at the University of Auckland in 2017. Then, in 2018, he was the youngest recipient and only surgeon to lead a prestigious $5 million Health Research Council Programme Grant in New Zealand. His other awards include a Master of Gastroenterology Award from the American Gastroenterology Association and the Vice-Chancellor's Research Excellence Medal from the University of Auckland.

Altogether, Professor O'Grady has helped raise more than $10 million in grant funding for translational research into gastrointestinal diseases. His work has also contributed to 21 patents and three university spin-out companies.

The JMC Fellowship is the most prestigious award offered by RACS, and it was awarded to Professor O'Grady to help support the development of four major projects through the University of Auckland. Each of these projects is 'scalable' so the solutions can be turned into real products used for routine clinical care.

1. A novel chyme re-feeding device for patients with enterocutaneous fistulas

The chyme re-feeding device is the most advanced of the four projects. It has generated a lot of interest in Europe, and has achieved CE marking approval, which means it has satisfied all the directives for safety and performance requirements for medical devices in the European Union. It has also been approved in New Zealand and is under review by the Therapeutic Goods Administration in Australia.

The re-feeding device is currently used for patients with complex gut problems, such as high-output enterostomies and enterocutaneous fistulas. "These are often surgical catastrophes that are really crippling for patients," Professor O'Grady said. "The device takes the losses that come out of the upstream stoma

Project 1: pump device

orifice and re-feeds them back into the distal gut in a safe and user-friendly way for patients to get oral nutrition back into their systems."

Patients experiencing high-output fistulas often require prolonged hospital admissions where they're stuck in bed, unable to eat and dependent on parenteral nutrition. The device, which is a compact pump that fits inside the stoma appliance, enables the patient to eat and drink again, come off their parenteral feeding, and to leave the hospital. "It is satisfying to see a major quality of life improvement for patients to date," Professor O'Grady said. "They take the device home and it becomes part of their ongoing care until we can reverse the fistula that, in some cases, can require a wait of many months."

The RACS JMC Fellowship has also assisted Professor O'Grady's team to develop a chyme re-feeding device for premature babies, who end up with stomas as a result of complex gut problems. "It's been a nice project to work on as it could help a very vulnerable surgical population," he said.

> "We have been working with paediatric surgeons to understand the problem and are now close to a clinical trial."

2. Improved management of temporary ileostomies

A lot of patients with rectal cancer end up with temporary ileostomies and the quality-of-life impacts can be distressing. They include major psychological impact, as a result of the 'incontinence' of bowel contents into the bag worn on the abdomen, risk of dehydration due to the high volume of small bowel output, readmissions to hospital, and interruptions to chemotherapy due to dehydration. There's also potential long-term bowel damage due to starvation of the gut lining from the diversion and the loss of the microbiome.

Patients may have to persevere with a stoma for several months because "there is usually a delay until it is safe to join people back together," Professor O'Grady explained. "They may be on chemotherapy or it may be too soon to do another operation." Yet, he added, "after a period of time, it's still actually safe to have what comes out of the stoma go back downstream again while waiting for reversal surgery. After about two weeks, when the join heals, it's safe to start."

Professor O'Grady and his colleagues have developed a device that he hopes could ultimately replace the stoma application that many of these patients wear for several months. Two weeks after surgery "Patients will undergo a leak test and, if their join is intact, they can change to the new device for the remainder of their course – that is, until the time of surgical stoma reversal, which averages about four months."

The device, which Professor O'Grady calls a "stoma-link", is a "virtual stoma reversal". He describes it as a piece of prosthetic gut where they "link the two bowel ends back together so that the contents flow out of one and then down the other without the need to have a bag.

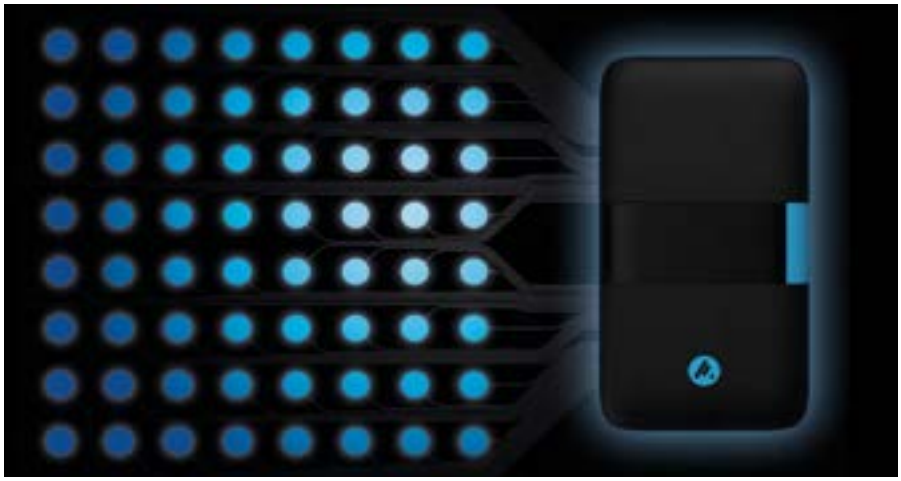
"The concept is that gut contents then flow back to the colon where they belong," he explained. It is hoped patients will regain their continence and confidence and "no longer have to worry about wearing a stoma appliance".

The stoma link has been a challenging device to perfect during a pandemic, with many research studies placed on hold for at-risk patients. But Professor O'Grady's team is making good progress. "We have had dozens of iterations and are constantly improving it. I'm confident we'll get there," he said.

3. An early detector system for anastomotic leaks

Anastomotic leaks are a principal complication of concern following gastrointestinal (GI) surgery and are the leading cause of death after colorectal surgery. Leaks are very difficult to detect early, and are often diagnosed after the patient has entered a cycle of sepsis that is hard to unwind.

"One of the worst complications of GI surgery is when the contents leak out ▶



Project 4: gut mapping device

of the staple line or suture line into the abdominal space," Professor O'Grady explained. "We want to detect this as early as possible and intervene before the patient becomes critically ill."

Professor O'Grady is leading a team of scientists and engineers in developing a novel early warning system for anastomotic leaks. The device attaches to a small surgical drain – the type that is put into patients after surgery to drain away fluid. The drain collects fluid into a small container and it is then sampled using sensors.

Considerable work has been done on this project due to support from the JMC Fellowship. Currently, the trials are preclinical and being done on animal models in the university lab, but next year Professor O'Grady is planning to take it through to first in-human trials.

4. A new diagnostic platform for gut dysmotility

Building a platform for diagnosing gut dysmotility has been one of Professor O'Grady's long-term goals. "The project has potential to be a breakthrough solution across a broad range of GI practice, to better evaluate gastric and colonic symptoms and to monitor surgical gut recovery," he said. "The gut is like a black box at present; it's very hard to diagnose what's happening – we have no good tests to check whether it's actually moving normally or not."

With an Australian designer and a group of engineers, Professor O'Grady has developed a cutaneous wearable sensor device coupled to a telemetry system that records gut activity from the body surface. A series of sensors, acting together like a sophisticated electrocardiogram for the gut, are attached to a reader device that records the small electrical signals from the body.

The test can be done in an office outpatient setting as the patient eats a meal. The device measures the electrical signals from the gut while the patient fills in a symptom-logging app on an iPad mini. All of these data are then processed in algorithms to generate reports.

With technical development at an advanced stage, there are still clinical studies to complete before the product is ready. "We're running a number of studies in parallel to now evaluate different gut disorders using the technology," Professor O'Grady said. "The engineering is certainly a world-first, and we are excited to see what the clinical results will reveal."

Funding medical research and investing in young people

The JMC Fellowship has enabled Professor O'Grady to advance his research substantially over the past year, and he thanked his collaborators, students, RACS and, most especially, the Crouch and Unsworth family.

"We depend on generosity to get these ambitious research projects off the ground," he said. "It's also important that we support the development of our talented Trainees who want to learn how to conduct surgical research. One of my current roles is Chair of the Australasian Surgical Research Society, and it is always an amazing privilege to see the quality and range of research being performed across Australasia by Trainees and medical students."

The RACS scholarships provide opportunities for people to learn academic skills at a formative stage of their careers, Professor O'Grady added. "If we can support the training of young academics, then we lay the foundations for entire careers of significant research impact. This helps the practice of surgery evolve to the benefit of our patients." ■

RACS affirms commitment to ethics in health care

In 2017, the Royal Australasian College of Surgeons (RACS) became a proud signatory to the Australian Consensus Framework for Ethical Collaboration in the Healthcare Sector (ACF), now known as the Australian Ethical Health Alliance (AEHA).

The AEHA is a collaboration between professional bodies, industry organisations, hospitals and health services associations, regulators and patient advocacy groups to tackle ethical issues within the health sector.

It is a government supported, sector-led voluntary initiative that began with five bodies (RACS included) and has subsequently grown to more than 60 signatories.

At the end of 2020, RACS was asked to complete a self-evaluation form outlining our progress against AEHA principles. In the response, the College highlighted our ongoing commitment to the Building Respect program, including new policies and standards that were introduced in 2020 that are targeted at standards of behaviour and workforce conduct. This includes the new RACS Workforce Conduct Policy.

The College's evaluation report also detailed the formation of the Environmental Sustainability in Surgical Practice Working Group, which has already led a number of important submissions to government enquiries. To read the full evaluation please visit the RACS website and search for 'AEHA guide'. ■

RACS ASC 2021

A scientific congress like no other

If 2020 has taught us anything, it is the unpredictable nature of life that we now incorporate into our work, education and daily existence. With COVID-19 restrictions currently in place, we have planned for 500 registrants onsite for the Royal Australasian College of Surgeons (RACS) Annual Scientific Congress (ASC) 2021 at the Melbourne Convention and Exhibition Centre. At the time of planning, the number appears feasible; however, we are also ready to scale either downward or upward depending on the prevailing pandemic environment.

We have been preparing for different scenarios and experimenting with new initiatives so that we can engage many of you for 2021, and in the years to come.

Hubs

We have been in discussion with your State, Territory and New Zealand (STANZ) committees and offices to form hubs in your regions. Forming a local hub is a fantastic way to bring your colleagues together to participate in the RACS ASC 2021 as a group. You can watch any sessions of your choice, including your surgical specialty, sessions of interest, the plenaries and the named lectures that suit your schedule. A hub can be any place you like, whether it be at your work, home or anywhere with the appropriate connections to stream the content.

With this flexibility, the ASC 2021 can be anywhere around the globe – get creative and share your experience using the hashtag #RACS2021.

Your local RACS STANZ offices will also host hubs and more information will be updated on the ASC website as it becomes available. The STANZ offices will also be happy to help with any questions you might have, so please reach out.

Convocation ceremony: Melbourne or local – your choice

The ASC 2021 convocation ceremony will be held at the Melbourne Convention and Exhibition Centre presided over by the RACS President and senior office bearers. In addition to Melbourne, local convocation ceremonies are also available. Fellows who are eligible to convocate in 2021 are entitled to receive complimentary registration for the ASC. An email invitation to register has been sent to those eligible to register.

Registrations

Registrations for the RACS 89th Annual Scientific Congress 2021 are now open. As previously mentioned, physical onsite registrations have been limited to 500 people, following local government guidelines and health advice. For 2021, onsite registrations have been made available only to Fellows of the RACS.

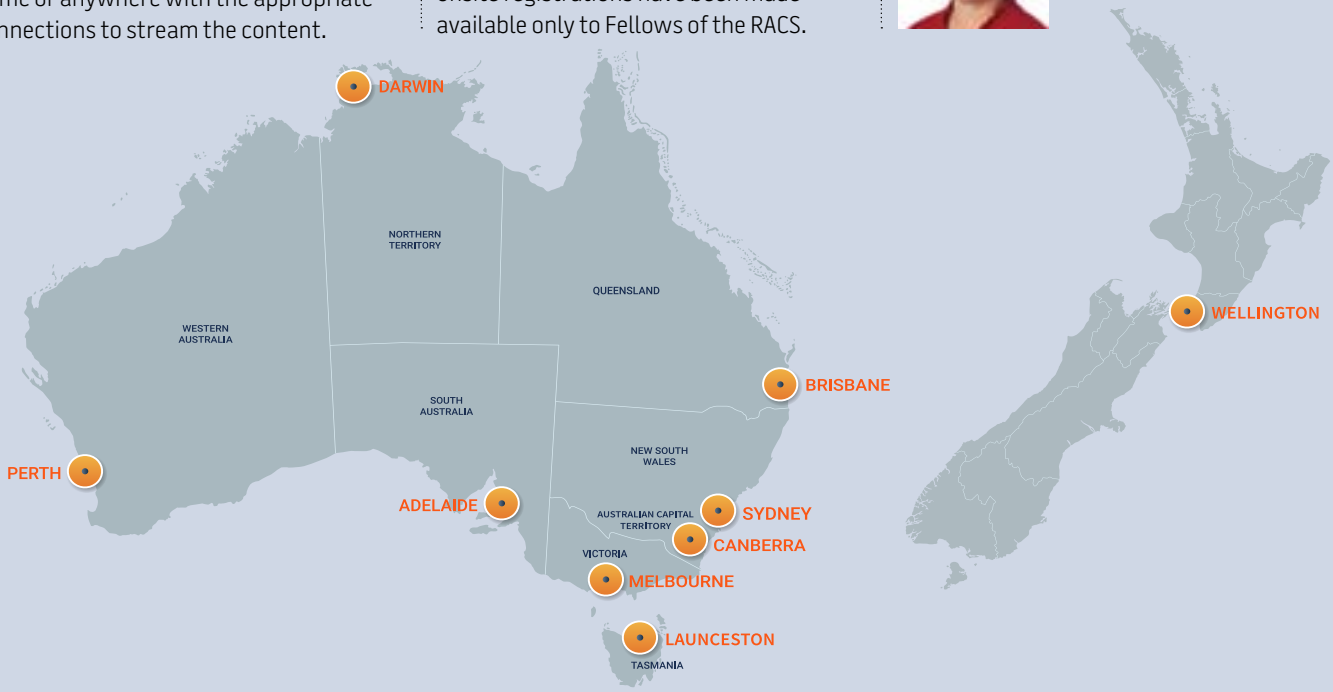
For Fellows interested in attending the ASC physically, we encourage you to go online and register now.

A new registration category for virtual attendance has been introduced for 2021. Register as a virtual attendee and you can watch the sessions wherever you are, whenever you want. All Fellows must register for RACS ASC 2021, whether physically or virtually, to obtain Continuing Professional Development points. If you are watching at a hub without registering for the ASC, you cannot claim your points.

For our regular attendees, we know this is different. For members who don't usually attend the ASC, this is a good one to try. We truly hope that many of you can join us onsite or online to make this an ASC like no other! ■

The 2021 Annual Scientific Congress will run from Monday 10 May to Friday 14 May. Find out more about how to set up a hub. If you are hosting a RACS ASC 2021 hub, please complete an online form to register your hub at tinyurl.com/h7k0lpcr.

Dr Liz McLeod
ASC Coordinator



Local instructor team conducts paediatric life support training in PNG

The Royal Australasian College of Surgeons (RACS), the Port Moresby General Hospital and Advanced Paediatric Life Support Australia (APLS) have formed a partnership and collaboratively designed a project to deliver a range of Paediatric Life Support training courses in Papua New Guinea (PNG) over the next three years.

This project, funded through the Department of Foreign Affairs and Trade's (DFAT's) Australian NGO Cooperation Program (ANCP) and RACS Foundation for Surgery, will increase the capacity of healthcare workers to effectively respond to, and manage, acutely ill and injured children presenting to the Intensive Care Units (ICUs) of hospitals in Port Moresby and Lae. These two hospitals treat over 15,000 children in their ICUs annually.

Three related courses will be provided to healthcare workers. The first in the series is a one-day introductory course covering the basics of emergency paediatric management, with a focus on the first 10 minutes of emergency care. Participants then progress to the three-day advanced course, which increases confidence and skills across a range of paediatric emergencies. One of the objectives of this project is to increase local capacity to continue providing these training courses. So a three-day instructor course will also be provided to participants identified during the advanced course as having the capacity to become effective local instructors. There are currently only eight fully accredited local instructors.

The Generic Instructor Course trains participants to become qualified Advanced Paediatric Life Support course instructors. Through this project, RACS and the Port Moresby General Hospital expect to substantially increase the cohort of accredited local instructors. It is estimated that 324 healthcare workers will have access to one or more of these vital training courses between 2020 and 2023.

In previous years, RACS has deployed Australian-based instructors, who volunteer their time and expertise, to conduct this and other important clinical training. However, due to the COVID-19 pandemic and travel restrictions, RACS has not been able deploy any Australian-based instructors to PNG since February 2020. Therefore, for the first time, the one-day introductory Paediatric Life Support course was provided in December 2020 by an entirely local team of instructors. Planning was supported remotely by RACS, with Associate Professor Bruce Lister AM, a paediatric intensivist, and Dr Zafar Smith, an emergency medicine physician. Associate Professor Lister and Dr Smith have been actively involved in training the local team of instructors over several years.

Dr Kone Sobi from Port Moresby General Hospital leads the local team of instructors and is extremely dedicated to their development and the continued provision of the training in PNG. Through his effective leadership, mentoring and support, two very competent colleagues, Dr Gwenda Anga, a paediatric oncologist, and Dr Arabella Koliwan, an emergency medicine registrar, both from Port Moresby General Hospital, were the primary local facilitators of the introductory course. Their first course was conducted for 48 healthcare workers, including doctors, nurses and community health workers, on 8 and 9 December 2020.

Dr Koliwan reported that the local instructors were surprised by how well they were able to independently conduct the training. This is a testament to their modesty, but also to their skills as accredited instructors, which Dr Sobi, Associate Professor Lister and Dr Smith have all played a huge role in developing. We had every confidence in the local team and the COVID-19 pandemic gave them the opportunity to demonstrate their training ability.

During the two days of training, Chris Graham, First Secretary at the Australian High Commission in PNG, was on hand to present training certificates to the 48 participants and to formally hand over an Advanced Paediatric Life Support kit, funded by DFAT through RACS' PNG Clinical Support Program, to the Port Moresby General Hospital. ■

PNG Paediatric Life Support Instructor Team with Course Coordinator Sister Iobuna.
Photo credit: Dr Arabella Koliwan

New framework to increase access to surgery for bariatric patients

With almost 12.5 million Australians suffering from obesity, the medical consequences of this disease have created a serious challenge for the Australian healthcare system.

Mr Ahmad Aly

While exercise and medication can be effective methods of weight loss for some patients, it is rare for these non-surgical procedures to have a long-lasting effect in cases of morbid obesity. By contrast, bariatric surgery has proven to be an effective treatment that generates substantial weight loss and can be sustained over the medium to long term. Bariatric surgery also has a demonstrable track record of reversing or mitigating obesity-related health risks and complications, particularly diabetes.

But approximately 90 per cent of the 24,000 bariatric procedures in Australia have been conducted by the private hospital sector. According to National Bariatric Registry data from 2019, only 22 public hospitals have conducted bariatric surgical procedures, with 10 performing more than 75 procedures annually. A recent survey from the Australian and New Zealand Metabolic and Obesity Surgery Society (ANZMOSS) suggested only 15 hospitals have a structured elective bariatric surgery program.

Because obesity is a disease that is more common among less affluent people in the community, limited access to bariatric surgery through the public hospital system has generated a serious problem of healthcare inequity.

Mr Ahmad Aly, Head of Upper Gastrointestinal Surgery at Melbourne's Austin Hospital, is leading an initiative to redress the socio-economic inequity of access to bariatric surgery. Three years ago, surgeons from ANZMOSS and several collaborating bodies, including the Commonwealth Government's Medical Services Advisory Committee (MSAC), formed a joint taskforce to address the problem.

The taskforce discovered that only four per cent of total bariatric surgical procedures were "completely publicly funded", Mr Aly said. He noted that the current system has evolved around the implicit expectation that patients would have private health insurance, or would otherwise be able to self-pay for their surgery. He added there was a worrying trend over recent years for patients to use their superannuation or life-savings to pay for their surgery.

"We were concerned about this inequity of access," he said. "It is for us, to some degree, a social justice issue." As a result, the taskforce focused on more effective means of "delivering what is well-proven life-saving care to patients who simply can't access it at the moment".

Composed of medical professionals, health administrators, government officials and representatives from obesity clinic stakeholder groups, the taskforce produced the Public Bariatric Surgery Framework. Published in October 2020, it is a roadmap to remediate the burgeoning public health and social equity problem.

The Framework recommends the adoption a new set of eligibility criteria called the Edmonton Staging System for Obesity. This staging system focuses on mortality as an outcome, which does a more accurate job of anticipating patient prognoses than reliance on mere BMI alone. On this basis, "we can say with confidence that if we treat patients at a particular stage of obesity, we'll be saving lives", Mr Aly said.

Mr Aly noted that a long-running study of obesity in Sweden has demonstrated the tangible benefits of this approach. Out of 4047 obese Swedish patients who enrolled in the study, 2010 received bariatric surgery while a control group of 2037 received conventional non-surgical treatment. Those who underwent surgery enjoyed "a 38 per cent reduction in cancer deaths and a 32 per cent reduction in cardiovascular death", he said.

But patients' direct involvement in their weight-reduction treatment doesn't end when they leave the operating theatre. In order to enjoy the long-term benefits of bariatric surgery, patients must modify their post-operative lifestyles in terms of diet and exercise.

"It's all about the patient's willingness and dedication," explained Mr Aly. "We want to know that the patient is invested in the program." This is why the framework also recommends "preoperative engagement processes that give patients the opportunity to be certain that it is right for them".

This initiative to broaden access to bariatric surgery is also fiscally sustainable, Mr Aly pointed out, because out of 1.5 million obese Australians, "it's likely that only two or, at most, three per cent of patients would actually seek it".

Commonwealth Treasury officials have also recognised the fiscal logic of increasing access to bariatric surgery to moderate aggregate healthcare costs generated by medical conditions associated with obesity.

"It's not going to happen overnight," Mr Aly said. "But we're accumulating the tools that generate enough goodwill to get this done." ■

RACS and First Australians – the Indigenous Surgical Pathway Program

For many decades the Royal Australasian College of Surgeons (RACS) members have demonstrated a desire to contribute to improving the general health and wellbeing of First Australians. In recent years, our College has formalised its ongoing commitment to Indigenous health. This has included a multifaceted approach to First Nation health encompassing areas such as increasing the surgical workforce, awareness by the Fellowship of the disparity between Indigenous and non-Indigenous health, and using our leadership position for positive influence, all starting from within the College.

RACS is among the leading Australian institutions in this field, contributing to solution-driven policies and actions that impact First Australians.

One significant example of this commitment is expressed in the RACS 2013 Indigenous Health position paper, which recognises that Indigenous people are more likely to present for, and comply with, treatment guidelines if increased numbers of Indigenous people were represented in the medical workforce at all levels of care.

According to 2016 Australian Bureau of Statistics data, there are approximately 800,000 First Australians. To achieve the same ratio of doctors to patients as non-Indigenous Australians there need to be 3200 First Australian registered doctors. According to available data, there are approximately 400 First Australian registered doctors.

There are currently almost 7000 active RACS Fellows, Trainees and SIMGs. This translates to roughly 3500 patients per surgeon in Australia. If applying the same 'population per surgeon' formula to First Australians, we should have 219 First Australian surgeons. Currently, we have three.

This (rather simplified) demographic breakdown helps puts into perspective the unique circumstances and challenges faced by the Indigenous Health Committee (IHC) when implementing the RACS 2013 Indigenous Health position paper to help rectify this inequity. Converting policy into action, and then ensuring such action produces the desired outcome is challenging at the best of times.

There are so many international achievements from a minority population of 800,000 within a world population of 8 billion (such as CNN anchor Stan Grant and Captain Reginald Saunders, recipient of a United States Presidential citation) despite historical government policies relegating First Australians to the fringe of mainstream Australian society. In fact, the only impediment to more success is the power differential created by racism, limiting their ability to reach critical mass in the number of doctors and surgeons.

The Indigenous Surgeons Pathway Program (ISPP) is a long-term, multi-pronged initiative that recognises the need to support those wishing to contribute to health equity for First Australians. The solution is, in part, changing the culture within our institution to honour the rights and value the amazing contributions First Australians have to offer.

Our goals are to inspire First Australians (school students, medical students, those in other health careers) to consider a career in surgery. To support them through preparation for, application to and completion of Surgical Education and Training (SET); develop a mentor program to support RACS Fellows who wish to support the program; coordinate and facilitate collaboration between stakeholders; and support our current SET Trainees.

The pilot project for the ISPP is being led by the Royal Darwin Hospital. Health service, departmental and mentorship standards will be defined and, ultimately, a package will be developed to be introduced and applied Australia-wide.

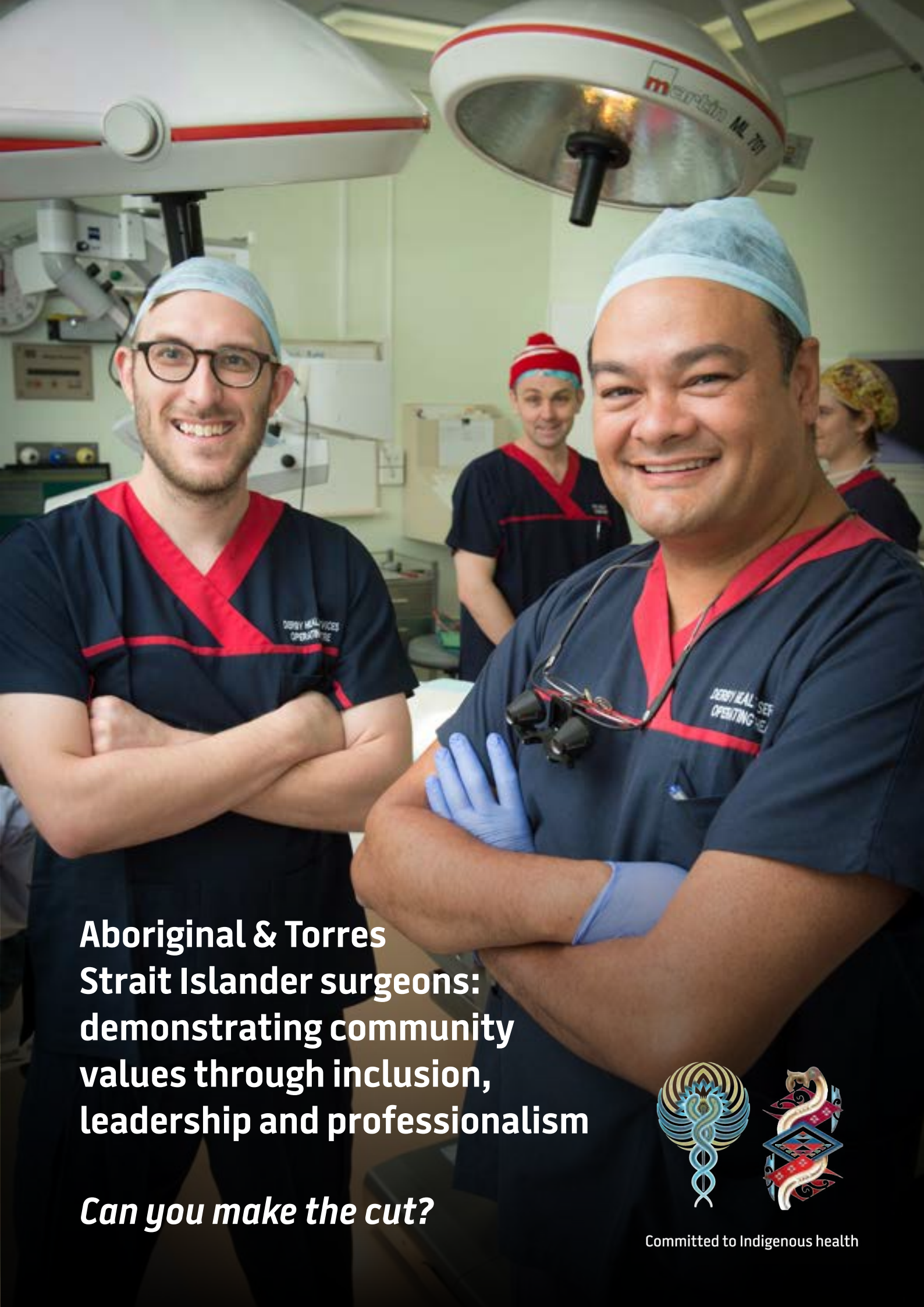
The challenges faced by the ISPP working group can be unique and often multigenerational, requiring unique and multigenerational solutions.

Underpinning the ISPP is the preparedness to adopt a First Australian holistic approach to wellbeing and health, and draw on the commitment of RACS Fellows and RACS administrative staff, as well as upon First Australian community values. Moreover, an appreciation of Australian Government policy history, and an understanding of First Australian community values and the unique circumstances impacting upon First Australians is needed.

We look forward to the collective support and contribution from RACS, as a whole, and hope to be able to demonstrate our ongoing leadership, innovation and professionalism when contributing to Australia's wellbeing as a complete community. ■

The ISPP is partly funded by the Australian Government Department of Health through the Specialist Training Program (STP).

The ISPP will be officially launched later in the year. If you would like to know more about RACS Indigenous health initiatives visit surgeons.org/about-racs/indigenous-health.



Aboriginal & Torres Strait Islander surgeons: demonstrating community values through inclusion, leadership and professionalism

Can you make the cut?

Committed to Indigenous health

Scholarship supports new renal transplant program for patients with high BMIs

The Pickard Robotic Training Scholarship has enabled Mr Shantanu Bhattacharjya to reach the final stages of developing a robotic renal transplant program in South Australia for patients with a high body mass index.

Patients with a high body mass index (BMI) are unlikely to make it to the kidney transplant waiting list because a BMI higher than 35 makes the transplant technically difficult and the outcome less than optimal.

Of particular concern are the number of Indigenous patients who need to stay on dialysis indefinitely because being overweight excludes them from the waiting list.

Mr Bhattacharjya's concern isn't singular. As well as these patients missing out on kidney transplants, he worries about the cost of ongoing dialysis to the taxpayer. It can cost around $85,000 annually for dialysis in an urban setting and up to $124,000 in a remote setting. Annual home haemodialysis costs about $43,000.[1]

While the cost of dialysis is about the same as a transplant in the first year, in the second and subsequent years it is substantially less.

"A transplanted patient is a huge cost saving to the taxpayer."

Referring to a 10-year study by the University of Illinois at Chicago, published in 2019, Mr Bhattacharjya said the study has demonstrated that robotic surgery can be used successfully for kidney transplants on recipients with median BMIs up to 41.

The study reported "one- and three-year patient survival rates of 98 per cent and 95 per cent, respectively, among patients with obesity". Out of 239 recipients, only 17 developed graft failures and went back to dialysis, "resulting in 93 per cent three-year kidney graft survival".[2] When compared to a national United States database, these results were similar to those seen in non-obese patients across the same period (2009-2018).

Mr Bhattacharjya completed his General Surgery training in India, then higher surgical training in the Oxford training scheme in the United Kingdom (UK) with Fellowships in hepato-pancreato-biliary surgery and transplantation. He performed the first live donor simultaneous pancreas and kidney transplant in India in 2008, then worked as a consultant in the UK for seven years. After immigrating to Australia in 2016, he set up a steroid-free whole organ pancreas transplant program that's had 100 per cent patient and graft survival rates since its inception. More recently, Mr Bhattacharjya completed his training in robotic surgery.

For his research on robotic kidney transplants, Mr Bhattacharjya and his team developed a large animal model of heterotopic kidney auto-transplantation, similar to the procedure performed in humans. "We did four cases of robotic and four cases of laparoscopic kidney transplant surgery," to ascertain which technique was more robust and easier. Now, after developing the model, performing the transplants, observing the outcomes, and being trained in robotic surgery, "we're almost in the position of offering it as a clinical program," he said.

For a robotic kidney transplant program to be truly effective, its design has to cater for deceased donor transplantation, an unpredictable service, rather than a living donor program that is more planned and predictable. This means robotic transplants would likely be provided out of the Royal Adelaide Hospital – the only quaternary hospital in South Australia that offers transplantation. Mr Bhattacharjya consults there, although other options, such as public–private partnerships, are being explored. He is hoping the hospital will be able to procure a da Vinci Xi robotic surgical system, which is the new generation robotic system optimised for complex surgery with minimally invasive surgical options.

"There's a learning curve associated with any new program," Mr Bhattacharjya said. "At first you take a standard risk and as the team experience and confidence grows you move on to more complicated cases – in this case transplant recipients with higher BMIs."

Dr Shantanu Bhattacharjya

Robotic surgery provides the combination of three-dimensional vision and the flexibility of being able to rotate your instruments inside, Mr Bhattacharjya explained. "It's the seven degrees of freedom that you get with instrumentation. If you're doing laparoscopic surgery, you're actually operating in two straight lines; whereas, robotic surgery is more natural – almost like operating inside the patient."

Mr Bhattacharjya said he is grateful to the Royal Australasian College of Surgeons and the Pickard Robotic Training Scholarship for supporting his research and reaching the final stages of the robotic renal transplant program. The program, aimed at Indigenous people with increased comorbidities including obesity, will enable them to live normal lives and engage more readily in exercise and weight loss. ■

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Welcome to new RACSTA Chair, Dr Charles Jenkinson

Dr Charles Jenkinson, a Cardiothoracic Surgery Trainee and the new Chair of the Royal Australasian College of Surgeons Trainees Association (RACSTA), believes advocacy and Trainee representation have given a fuller and more rounded sense of purpose to his surgical journey.

"It started out when I became the Cardiothoracic Trainee representative," he said. "My goals were to improve communication between Trainees, as well as act as a conduit to our Speciality Training Board. We are a small Trainee cohort, only numbering 40 across Australia and New Zealand, so I never understood why we weren't more connected and engaged, especially approaching 2020."

Dr Jenkinson grew up and was educated in Mandurah, 80 kilometres south of Perth, Western Australia. His father ran a veterinary practice and spent the best part of a decade treating horses and other big animals over a large portion of country Western Australia. Dr Jenkinson's love for medicine (and surgery in particular) arose from trips to horse properties and visits to his father's consulting rooms and operating theatre as a child.

After high school, Dr Jenkinson attended the University of Western Australia, completing his Bachelor of Medicine and Surgery in 2008. He started his career at Royal Perth Hospital and spent half of this time seconded to Broome Hospital as one of their very first interns.

Three years later, he married Clare, who he met in high school some years before. They now have two children – Cora (six) and Georgia (two). "Being a parent really changed my perspective on life, work and workplace culture," Dr Jenkinson explained. "I started questioning whether our culture was really conducive to good patient outcomes, good career satisfaction, and personal health and wellbeing. At the same time, I was representing Trainees to our training board, professional society and RACSTA. These opportunities provided a forum to explore ways in which we can do things better. Joining the RACS Operate with Respect Committee also shaped my way of thinking about behaviour, professionalism and culture."

Dr Jenkinson views issues such as leave portability (especially as they affect Trainees changing states or countries), access to parental leave, flexible training, and gender equity as his main passions. "RACSTA has made some great headway into these areas, even just during my time on the committee," he noted. "Still, there is much more work to be done."

Dr Jenkinson currently works as a heart transplant registrar at St Vincent's Hospital in Sydney. "2020 was a challenging year," he said. "My family remained in Perth while I moved to Sydney. With COVID-19 and border closures, the anticipated frequent trips across the country have not been possible. We're lucky to have spent a couple of blocks of time together, but I hope that people can be kinder and more compassionate towards those who are kept apart from their loved ones by the pandemic." ■

Dr Charles Jenkinson

Open house at RACS South Australia

While 2020 was a difficult year, it ended on a positive note in South Australia as the state office hosted an open house event to welcome Fellows, Trainees and Specialist International Medical Graduates (SIMGs) to the College's new purpose-built office at 24 King William Street in Kent Town.

The open house provided attendees with the opportunity to tour the building, which has been designed to host a wide variety of meetings, symposia, workshops, courses, exams, receptions, dinners and other social functions. The building also houses all South Australian-based staff, who previously worked out of two separate office buildings in North Adelaide.

In attendance at the open house were RACS President, Dr Tony Sparnon, and RACS South Australia Chair, Mr David King, as well as several past state chairs. Dr Sparnon spoke at the ceremony to thank all those involved in the move, and said that he was looking forward to the next exciting chapter for the College in South Australia.

Mr King also spoke at the event and said that the College in South Australia had come a long way since he first commenced his training, when the South Australia office operated out of a small office at the Australian Medical Association South Australia building. Mr King thanked the many past chairs in attendance for their foresight in purchasing the previous South Australia building in Palmer Place North Adelaide, as well as those who contributed to the move into the new office.

An official opening for the building will occur in early 2021, with more details to follow. In the meantime, Fellows, Trainees and SIMGs are welcome to visit the building at any stage during office hours and familiarise themselves with the facilities.

The building has three available rooms on level one and six rooms on level two. All rooms will be equipped with the latest technology. An online booking system will be implemented shortly. In the meantime, if you would like to confirm any bookings in 2021 please contact the South Australia office via email at college.sa@surgeons.org. ■

Image:
L-r: Gayle Bradbrook, John Biviano, Lesley Dunstall, Mark Morgan, Maria Cogman, Travis Dawe, Daniela Ciccarello, Etienne Scheepers and Allan Chapman at the launch of the new office.

Unveiling the Collections: a new RACS publication

The idea for a book about the College collections had its origins in a Heritage and Archives Committee meeting in 2017. The College centenary was 10 years away, but there was concern that Wyn Beasley's two seminal books about the College, *Portraits at the Royal Australasian College of Surgeons* (1993) and *The Mantle of Surgery* (2002), needed updating.

Initially, the committee discussed the possibility of simply updating the Portraits book, but Professor John Royle had another suggestion. He proposed a publication that included both recent presidential portraits and a selection of 'treasures', highlighting the College's important history by 'unveiling' some unusual objects from its extensive collections. It would also serve to acknowledge the contribution of the more recent past presidents.

Significant objects from the collections were chosen by Professor Royle and the College curator, Geoff Down. Works were categorised and, in 2018, Les O'Rourke, a photographer, began the difficult task of photographing objects that were often located in awkward places. Geoff has been the curator since 2001, and the task of writing the descriptions was made easier by referring to his numerous articles in *Surgical News*. However, some of the items still needed researching, and investigating the rare books was undoubtedly one of the most rewarding tasks.

Unveiling the Collections begins with the archetypal symbol of the College, the Great Mace. It continues with an exploration of a diverse group of objects loosely bound together by type and is divided into sections: presidential portraits, other portraits, landscapes and seascapes, books and documents, surgical instruments, sculpture, ceramics and bronzes, and silverware.

An example comes from a miscellany of surgical instruments, dating mainly from the 19th and 20th centuries. A carbolic spray used by Lord Joseph Lister at the Glasgow Royal Infirmary was the first object to enter the collections. Developed in 1869, the spray was designed to kill airborne bacteria, but had some side effects. Everyone attending the operation inhaled the spray, and the carbolic landed on the open operating site, causing significant burning of the tissues. At the other end of the spectrum, a large collection of historic medical books illustrate anatomy and the development of surgery. The collection contains many rare and early editions, such as those by Andreas Vesalius and Ambroise Paré.

As the College approaches its centenary in 2027, it is important to reflect on its rich history. Although consisting of inanimate objects, the College collections help show how that history evolved. Most of the objects have interesting stories connected to them, and they contribute to the complex web of relationships that have created a 21st century surgical College.

Unveiling the Collections confirms the importance of valuing and preserving heritage. The publication will benefit present and future generations. ■

Elizabeth Milford, RACS archivist

Main picture: *Mr Tony Sparnon, Elizabeth Milford and Geoff Down present the book.*

Above: *The cover of* Unveiling the Collections.

Introducing the Global Health Section

Among the many disruptions to our daily lives caused by the COVID-19 pandemic, one of the most significant has been the transition to working from home and the rise of the digital workplace. We are deeply interconnected globally through the online world, and we have come to rely on these digital connections to bridge the physical and other divides that increasingly separate us.

We are committed to drawing opportunity from this worldwide challenge and Global Health are working to establish the Royal Australasian College of Surgeons (RACS) Global Health Section for Fellows and other professionals interested in global health, both in Australia, New Zealand and the many countries in which we work internationally.

Across RACS, our sections cater to the specific needs of interest groups of Fellows where the interest is multidisciplinary or cross specialty. The creation of the Global Health Section is part of our wider effort to revitalise our governance structure, including broadening engagement across the Fellowship. The Global Health Section will bring together members including Fellows, anaesthetists, perioperative nurses, other clinicians and international development partners in a collaborative, supportive and respectful online space.

Members of the section will be encouraged to form hubs in areas such as specialty interests, geographical regions, specific diseases or academic focuses. These hubs will have the opportunity to meet online as often as necessary to support the needs of their members in alignment with the interests of the RACS Global Health Strategic Plan.

"The intention for the section is to have easy connectivity between health professionals across the Asia-Pacific region – a constellation of clinical networks linked by common interests to accelerate our mutual learning and provide the best care to our communities," Chair of Global Health, Ms Annette Holian explained. "The network will allow free communication and the sharing of ideas and documents without having to book meetings through RACS staff. The number of hubs will be limited only by member interests."

The Global Health Section will serve a variety of interconnected functions, including:

1. to provide a forum for surgeons from all disciplines and other professionals engaged in global health to connect and support the RACS Global Health Strategic Plan

2. to focus on capacity building efforts in order to meet the World Health Organization Sustainability Development Goals in Health (SDG3)

3. to focus on strengthening surgery and health systems, with the aim of providing timely access to safe affordable surgical care for people in our region

4. to enable non-surgeons who contribute to global health to apply for membership of the section

5. to support partnerships to advance professional development through health education, along with systems development.

"The Global Health Section is an opportunity to share the wealth of knowledge, diversity of experience and technical expertise across the health and international development sector," Head of RACS Global Health, Philippa Nicholson, said. "RACS Global Health would like to enable transparent sharing of information to support a constantly growing program based on current experiences and standards."

Philippa also spoke of the section's potential to better connect peers internationally. "We at RACS Global Health see this as a forum as much for Australian and New Zealand practitioners as for colleagues in the Asia-Pacific and globally."

Membership is open to any RACS Fellow, surgical Trainee or Specialist International Medical Graduate on a pathway to Fellowship, and medical staff registered with the Australian Health Practitioner Regulation Authority (AHPRA) or Medical Council of New Zealand (MCNZ). Registered medical and nursing staff in partner countries may self-nominate for membership. Each partner country will have a representative doctor, a Clinical Lead, nominated by their Ministry of Health who will be the hub lead for that country. ■

If you are interested in joining the Global Health Section, please contact Global Health Engagement Coordinator, James O'Keefe, at global.health.section@surgeons.org.

Dr Samantha Pillay, paving the way for many firsts

It was work experience, at the age of 15, in Cardiothoracic Surgery that cemented Dr Samantha Pillay on a surgical career path. Now she is a self-published author of *The No Recipe Cookbook* – a cookbook for people who don't cook.

Dr Pillay's journey over 35 years, from work experience to author, has been an interesting one. She was the first female to complete surgical training in adult Urology in South Australia. She further trained in female Urology – concentrating on women's incontinence – becoming the first urologist to exclusively sub-specialise in female pelvic medicine and reconstructive surgery.

As the first female section chair in South Australia for the Urological Society of Australia and New Zealand (USANZ), Dr Pillay served on both the National Board of the Continence Foundation of Australia and as their state chairperson from 2011 to 2013.

Born with congenital hip dysplasia, Dr Pillay started school in a wheelchair. "Surgery maybe wasn't an ideal career choice for someone who experienced pain on standing, but I was driven, stubborn and the harder it was, the more I wanted to do it," Dr Pillay said. "Urology had a lot of sit-down surgery and procedures under two hours. I had to be sensible about what speciality I chose and I enjoyed the endoscopic side," she added.

From 2007-2013 Dr Pillay served as chair of the Female Urology Special Advisory Group for USANZ. In 2007, she became the first female scientific chair for the USANZ Annual Scientific Meeting.

"It was a great honour to serve in these roles – to be the custodian and to progress the area of female Urology. We grew the content of female Urology in the curriculum and at scientific meetings.

"This attracted surgeons into female Urology and grew recognition from our peers. There are now more women in Urology," Dr Pillay reported. "When I started my training, Professor Helen O'Connell AO was the only female urologist in Australia. Today that number has grown, although we are still far from a place where being a female in Urology, choosing a career in female Urology, or being a woman and not choosing a career in female Urology, are the norm," Dr Pillay said.

Bringing awareness has been a driving force in Dr Pillay's life, and she's carried this into healthy eating in *The No Recipe Cookbook*, which took her 18 months to write and recently reached number one in several Amazon categories. Taking on extra responsibilities at work and at home during the COVID-19 pandemic refined Dr Pillay's time-management skills and healthy meal planning. Shopping once a fortnight saved her time and money, while also reducing her stress and food waste.

"At the end of the day I'm 'hangry' [hungry and angry] and I have decision-fatigue," Dr Pillay said of her own experience. "I don't want to choose from a menu or wait for a meal when I can have dinner on the table in under 20 minutes." There are no intimidating glossy pictures in her book. "I call it the 'anti-fancy' cooking movement," Dr Pillay said of this choice. "Cooking without a recipe allows me to be creative, take risks and embrace mistakes. Something I don't get to do when I'm operating." ■

Dispatch from New York

Dr Diana Kirke's COVID-19 experience

I clearly remember one of my final days at work before our second daughter was born. It was 12 March 2020, and I was at Elmhurst Hospital Center in Queens, New York City. I work there twice a week as part of my role as Assistant Professor at Mount Sinai Hospital, where I am both a laryngologist and head and neck microvascular surgeon.

That particular day we had our first suspected COVID-19 case in the clinic and the residents came to me, looking for guidance. Their anxiety reflected the mounting tension in both the city and its hospitals since the first case had been diagnosed on 1 March. By the end of the day our fears had been realised. As I left the hospital it resembled a scene out of an apocalyptic zombie movie, with hordes of unwell patients filing into the hospital and languishing in the entryway chairs. I was 37 weeks pregnant at the time and I rang my husband, Reade de Leacy, immediately and told him I did not believe it was safe for me to return to work. He had been saying that for weeks.

I did go to work the following day at Mount Sinai Hospital but, perhaps rather fortuitously, I had our second child the following week on 18 March, two weeks early. I thought her early arrival was due to anxiety, but my obstetrician thinks it may have been because I had COVID-19, due to a similar trend of patients she was seeing. I will never know for certain, given the lack of testing at that time, but I do clearly recall having fatigue and extreme shortness of breath, to the point of feeling suffocated, the week prior. At the time I attributed these symptoms to being in my third trimester.

The day of Elodie's birth was chaotic. Everyone was extremely distracted by the surge of patients arriving at the hospital and rumours of the imminent city-wide shutdown. Elodie and I were out of the hospital in under 36 hours and back home sheltering in place with my husband and our older daughter, Delphine.

My husband, a neurointerventionalist also at Mount Sinai Hospital, soon found himself treating more strokes than usual due to increased COVID-19 related thromboembolism,[1] and was 'redeployed' to the frontline to look after COVID-19 patients in Neuro-ICU. Every day he would return home, remove his clothes at the front door, place them directly into the washing machine and then jump immediately into the shower. These are practices we still partially adhere to. After our daughters were asleep we would have a daily debrief on the patients he was treating and the new developments, including the field hospital that was being built in Central Park across from the hospital and the new patient pods being built in order to expand bed space in the Mount Sinai atrium, originally designed by I. M. Pei, of the Louvre pyramids fame.

I felt torn as I talked to my colleagues, who had very quickly pivoted to respond to the new normal.[2] I clearly appreciated that I had a different role protecting our newborn and oldest daughter (which was certainly a challenge without any help), but I felt a sense of survivor's guilt that I was not on the frontlines as I had been trained to be. To help alleviate this I did what I could remotely. I provided counsel with my residents at Elmhurst Hospital Center via weekly Zoom calls. This hospital, which is in one of the most ethnically diverse neighbourhoods in New York City, had very quickly turned into the epicentre of the epicentre. This group of residents, some of whom were interns, were now staffing their own ICU. Like my husband, they looked destroyed emotionally and physically. I rarely cry but they had me in tears on a weekly basis with the stories they shared and the strength and teamwork they demonstrated. For a detailed account of their experience I highly recommend an article recently published in JAMA Otolaryngology Head & Neck Surgery, 'If not us, who? And if not now, when?: Perspective from a COVID-19 Intensive Care Unit run by Otolaryngology residents.'[3]

For eight weeks I barely left our apartment, but we were luckier than most, having a large apartment (by New York City standards) with rooftop access. As the weather improved, we would picnic up there and audibly track the severity of the pandemic by the number of times we heard the ambulance sirens in an hour. This was easy for us to do as we live just down the street from Lenox Hill Hospital. At night, after the 7pm clap for essential workers, you could hear a pin drop. Anyone who has been to New York City would know how strange that is for the city that never sleeps.

I returned to work after eight weeks on 18 May, approximately one month after the peak of the surge, when more than 2000 COVID-19 patients were

Dr Diana Kirke with her family

hospitalised across the Mount Sinai Health system. By that stage, Reade and I had personally known people who had passed. I had heard about the refrigerated trucks stationed behind the Elmhurst Hospital Center to store the deceased, but it was still jarring to see them first hand. One of the first cases that I performed on my return was a COVID-19 tracheostomy. By that stage the protocols in place had very quickly adapted and matured.

I felt, and still do in the midst of a second surge, extremely well protected at work and I have recently received the first dose of the Pfizer vaccine. It was bittersweet, however, when I developed mild airway swelling and have been subsequently told not to take the second dose.

Since May we have been seeing a lot of post-COVID-19 patients with voice, airway and swallowing disorders and in response to this we have established a post-COVID-19 voice, airway and swallowing unit at Mount Sinai Hospital, of which I am the lead, to understand and treat this subset of patients.

I strongly applaud the Australian and New Zealand federal, state and territory governments' response to the pandemic, and there have been times when we have had bouts of homesickness. However, while this past year has brought extreme challenges, I am grateful to have been witness to this historic time and to still have the love of my young family to return home to each day. ■

Dr Diana Kirke, FRACS

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A new course for supervisors

In 2020 the Royal Australasian College of Surgeons (RACS) implemented a new, more contemporary course for surgical supervisors and trainers, designed to better meet their current and future needs. Following a review of the Supervisors and Trainers for SET (SAT SET) course, the course was retired and a new course, Induction for Surgical Supervisors and Trainers, was developed.

While the course primarily aims to support surgical supervisors and trainers in fulfilling their role, it also looks to improve the Trainee experience through educating Supervisors and Trainers with more contemporary content based on best practice and evidence-based pedagogy. The course provides greater support and engagement to supervisors and trainers, which, in turn, will enhance working relationships and improve feedback techniques with their Trainees.

As part of the ongoing professional development strategy to provide greater accessibility of courses, and also in response to the COVID-19 pandemic, the RACS education team, together with surgical stakeholders, has taken an integrated approach in the development of the new course. Delivered through the RACS eLearning platform, the Induction for Surgical Supervisors and Trainers course will be a combination of three online eLearning modules and two webinars.

By the end of this course, participants will be able to:

- identify the relationship and the communication pathways between RACS and its training boards
- identify RACS policies/procedures
- describe roles and responsibilities of SET supervisors, trainers and trainees
- discuss how to support trainee learning and provide a safe learning environment
- identify RACS assessment requirements
- plan how to evaluate their supervision.

The first online Induction for Surgical Supervisors and Trainers course is scheduled for mid-2021, with registrations opening shortly. To register your interest in attending this course, please email pdactivities@surgeons.org

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SAVE THE DATE

Creating healthcare cultures of safety & respect

22—23 April 2021

These virtual sessions will focus on creating a culture of safety and respect in the workplace, by facilitating an assembly of health leaders and culture change practitioners with a common goal of eliminating bullying, discrimination, harassment and incivility in healthcare.

Keynote Speakers

Professor Russell Mannion PhD, FRSA, FAcSS. University of Birmingham
Professor Gerald Hickson MD, FAAP. Vanderbilt University Medical Center

For more information: tinyurl.com/4f3o6agx
Registrations: tinyurl.com/1shmawiq

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Cultural change and patient safety: a joint summit

Health practitioners across Australia, indeed the world, are working towards cultural change. But what is culture? How is it linked to patient safety? How does cultural change happen? And what can be achieved when it does?

The evidence linking respectful behaviour with patient safety is well established and continually increasing. But even with a shared commitment to professionalism, achieving cultural change is recognised as a challenge that takes time. After all, most health practitioners already do what they think is best for their patients, and many of us are inherently (and often subconsciously) resistant to change.

Five years ago, the Royal Australasian College of Surgeons (RACS) committed to the Action Plan: Building Respect, Improving Patient Safety. Since then, calls for a safety culture have become louder and other leaders across the health sector have joined the chorus. In 2017, the Medical Board of Australia named 'collaborations to foster a positive culture of medicine' a cornerstone of professional performance.

Professor Russell Mannion and Professor Gerald Hickson are established leaders in the field of patient safety and cultural change, and both are keynote speakers at the summit RACS is hosting with Macquarie University, St Vincent's Health Australia and the Royal Australasian College of Medical Administrators. Recognising that collaboration is key, the summit aims to foster discussion and share expertise across the health sector to support constructive change.

Professor Mannion, who is an Honorary Professor with the Australian Institute of Health Innovation, has published extensively on culture in the health sector: what it is, what shapes it, how it is linked to quality and safety, and how changing it can improve care and performance. He refers to a demonstrated "consistent association between positive organisational and workplace cultures and beneficial clinical outcomes, including reduced mortality rates across a variety of health settings".

Often, he argues, culture "is a metaphor for some of the softer, less visible aspects of health sector organisations and how these become manifest in patterns of care", less visible, but no less powerful in influencing patient outcomes. He advocates that an under-nuanced understanding of what shapes and defines culture in health care can limit the impact of the link between culture and performance.

"Clearly, the relations between culture and quality, safety or efficiency are unlikely to be straightforward. Culture, although important, offers no magic bullet, and the challenge becomes one of understanding which components of culture might influence which aspects of performance," he said.

Professor Mannion has closely examined the importance of health sector employees speaking out and raising concerns when they see poor quality care or unsafe practice, in the interests of patient safety. He also recognises how complex this request can be, given there is a "widely held perception among health professionals that they will be victimised, ostracised or bullied if they raise legitimate concerns about the work of colleagues or about poor care".

Professor Hickson is well known in the RACS community and has been an influential adviser as the College has strived to build a culture of respect in surgery. He consistently warns that the journey of cultural change is more a marathon than a sprint.

Values, he says, are a powerful driver in creating a culture of safety, partly because we all want alignment between what we do and what we believe.

"Culture has an impact on patient safety. And culture represents our values, knowledge and experience in action, on behalf of the patients we serve," he said.

He encourages surgeons and other health practitioners involved in cultural change to start from shared values rather than focus on barriers to change. Fostering a culture in which people feel safe to speak up is at the heart of building a culture of respect.

Ask "what are our shared priorities and values, and how can we link these to strengthen our performance and make it safe for people to speak up," he said.

"In a 'safety culture', everyone feels respected and, therefore, able to work in an undistracted way. They can speak up when they see something that needs to be heard," Professor Hickson said.

He recognises that cultural change is not for the faint hearted and there is no single path that will get organisations to a new cultural destination swiftly.

"Change happens when an organisation is values-driven and has made a commitment to working together and making it easy for team members to do the right thing and voice concerns in a constructive way," he said. "Speaking up supports patient safety. We all work in teams; we all have different skills and abilities. When team members are all respected, nothing gets in the way of their performance." ■

In April 2021, RACS is co-hosting a virtual summit on Creating Healthcare Cultures of Safety and Respect, featuring Professor Mannion and Professor Hickson. A joint initiative of RACS, Royal Australasian College of Medical Administrators, Australian Institute of Health Innovation at Macquarie University and St Vincent's Health Australia, the summit is open to people across the health sector working to achieve cultural change.

Results of the telehealth survey

Last year RACS and the Hunter Medical Research Institute conducted an ethics-approved academic-level survey of surgeons and their patients in relation to telehealth. I would like to thank everyone who took the time to complete this survey and to share it with your patients.

With more than 600 responses by surgeons and more than 1100 responses by patients, the response-rate was significantly better than expected. The data that has been generated from the surveys allows us to develop a better understanding of individual experiences with telehealth and guide our advocacy efforts and representations to government.

I am pleased to be able to share the following results from the survey with you all, and I look forward to providing further updates throughout 2021. ■

If you would like to know more about the outcomes of the survey or the College's advocacy in this area please email racs.advocacy@surgeons.org.

Professor Mark Frydenberg

Chair, Sustainability in Healthcare Working Group

93% of patients were satisfied with the quality of their telehealth consultation

91% of surgeons believed that telehealth was appropriate for clinical meetings and to arrange investigations

77% of surgeons felt that a satisfactory level of care could be delivered via telehealth in half or more consultations

Patients on the whole had a good experience with telehealth

97% thought their surgeon was able to answer their questions clearly and satisfactorily

93% were satisfied with the quality of their telehealth consultation

75% thought telehealth provided same level of care as a face to face conversation

84% would recommend telehealth to their friends

Having a telehealth consultation resulted in 'efficiency gains' for many patients

- Nearly 60% would have had additional expenses with a face to face consult
- 93% of patients agreed or strongly agreed with the statement 'using telehealth allowed me to attend my appointments with less interruption to my routine'
- 18% would have had to have time off work
- 18.5% would have had to travel more than 100kms
- 49% would have had transport costs
- 6.1% would have had accommodation costs

Surgeons on what they would use telehealth for after the pandemic

- Initial consultation 51%
- Pre-operative Review 50%
- Routine follow-up 88%
- Distance, frail aged, disabled patients 89%
- Post-operative review 77%
- Other 6.7%

Although 88 per cent of surgeons said they would continue to use telehealth after the pandemic, many commented on the additional administrative burden of telehealth during the pandemic, and that this was not sustainable from a financial perspective.

Get to know your Educators of Merit

Every year the Academy of Surgical Educators (ASE) presents the Educator of Merit award to recognise exceptional contributions by our surgical educators. Some 2020 winners share their thoughts on being an educator.

Educator of Merit – SET Supervisor/SIMG Supervisor of the Year (Victoria): Dr Kate Martin. Fellow since 2008.

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

Very humbled! Teaching is a very rewarding part of being a surgeon and I'm now senior enough to have seen a few of my Trainees all the way through from intern to consultant.

But I'm only carrying on a tradition that I was the beneficiary of from my most junior years. I was given the learning opportunities as a junior doctor by a number of senior surgical colleagues (registrars and consultants) and I realised quite early that passing on the privilege to the next generation is all of our responsibility.

What is your proudest moment as a surgical educator?

While it's always lovely to see the smiling faces of Trainees as they receive their scarf or tie at the Fellowship exam, and I'm always proud when a Trainee achieves other great milestones in life, such as becoming a parent. But what I am probably most proud of is seeing them become the next generation of teachers.

Any advice for new surgical educators just getting started?

Don't forget what it was like to be a junior doctor or surgical Trainee. What do you wish had been done for you? What did you find really important and helpful? Keep this in mind.

Remember our Trainees have lives outside of surgery. Being organised will give your Trainees plenty of time to prepare, whether it's for tutorials, rotations or projects. You also need to be reliable. It can be very easy to say 'yes' far too often. If you have been asked to give a tutorial, ensure you prioritise it accordingly. I avoid teaching when on call – you can't be in two places at once. This is harder for those in a rural setting who are, no doubt, on call more frequently, but it is much better to schedule teaching when you are available.

Finally, you never stop learning new teaching skills. Watch those who you regard as good teachers. Use their techniques. (You can even quote them!)

Educator of Merit – SET Supervisor/SIMG Supervisor of the Year (Australian Capital Territory): Dr Bryan Ashman. Fellow since 1989.

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

I was very proud to be awarded the ASE Educator of Merit for the ACT. I have been involved in teaching surgery for over 30 years to medical students, residents, registrars, Fellows and colleagues.

What inspired you to pursue surgical education?

I have always been interested in teaching surgery, and took the opportunity in 2013 to start the Master of Surgical Education degree. I completed this in 2016 by minor thesis, looking at what motivates senior surgeons to learn new surgical techniques. I have been involved in teaching spine surgery with the Spine Division of the AO Foundation since 2005.

What is your proudest moment as a surgical educator?

Being elected as the chair of the AO Spine International Education Commission in 2017, overseeing spine surgery education in more than 70 countries and over 200 educational events annually.

Educator of Merit – SET Supervisor/SIMG Supervisor of the Year (New Zealand): Mr John Lengyel. Fellow since 2017. ▶

What inspired you to pursue surgical education?

With the growth of the internet and readily accessible information, I was interested to know how the next generation would use it to their advantage. There has been a move by many institutions to provide courses and up-to-date online content, assuming that simply transmitting information from reputable sources results in learning.

Change in behaviour that comes from learning occurs when there is a drive to find an answer to a problem, or a hurdle, in the form of an examination. There are many barriers to learning, which are enhanced when information is only available with payment, or when content has a political agenda or a strong viewpoint.

I have nothing to lose and no axes to grind. Unfortunately, education today is prescribed and driven by political correctness. I don't consider myself mainstream, and I encourage my Trainees to think rather than be taught.

What do you hope to see in the future of education?

I would like to see the Royal Australasian College of Surgeons (RACS) move away from politics and compulsory educational campaigns. Surgeons have the ability to change the course of pathological processes that have defined end points. RACS should promote evidence-based surgical practice because, unfortunately, much decision-making is still cloaked in dogma.

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

I would encourage them to think about the best learning experiences they have had, those that changed the way they practise, and find methods to replicate that experience for their juniors. Lead by example, but be humbled by the fact there are many junior surgeons who can still teach us – if we are willing to accept change. ■

The Educator of Merit awards consist of the SET Supervisor/SIMG Supervisor of the Year Awards, which recognise the exceptional contributions by a surgical supervisor/clinical assessor towards supporting Trainees and Specialist International Medical Graduates (SIMGs), and the Facilitator/Instructor of the Year Award, which recognises the exceptional contribution by a course facilitator or an instructor teaching on Professional Development or Skills Education courses.

Nominations will be open from 1 February to 31 March 2021. Submit your nomination by including your name and contact details, the name and contact details of a seconder, and supporting comments on the nominee. Please send nominations to ase@surgeons.org.

One College Transformation: making it easier to support you

As part of the One College Transformation program, we are upgrading and enhancing our current member profile platform, which is outdated and limited in its self-service capability.

The One College Transformation seeks to better support and advance your needs in today's constantly changing digital world.

We want to improve your online experience with the College by progressively replacing your ePortfolio with Microsoft Dynamics 365, which will be mobile, secure and connected to all College platforms, instead of working in a silo.

The new platform will be called eHub, and it will personalise content for you, providing you with a 360-degree view of your information and overall journey with RACS. We are reducing inefficiency in our systems to improve value for you.

Using one platform for all our existing functions, which are currently spread out over numerous platforms throughout the College, will help us to personalise and extend the service we provide.

You will notice the following changes when you log in to your member profile, or eHub from February 2021.

1. When you log in to your member profile, you will see an enhanced log-in page.

2. When you click on 'My Details' in your profile, you will see a new and improved modern profile section where you can update your:

- contact details
- areas of practice
- emergency contact information
- dietary requirements for events
- communication preferences.

3. When you click on 'My CPD', you will be able to navigate to the new interim CPD system by clicking on 'CPD 2021', where you can:

- create your 2021 CPD Learning Plan
- submit an exemption request
- download your 2021 CPD statement (when made available by RACS).

These improved features will set us up to serve you in an enhanced, more personalised way in the future. This is the first release of several that are scheduled to occur over 2021. We look forward to sharing updates with you as we progress on the work and planning required.

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

Please email 1CT@surgeons.org if you have any questions. ■

Education activities

The Professional Development Program aims to support surgeons in aspects of their professional life, encouraging professional growth and workplace performance. Life-long learning through professional development can improve our capabilities and help us to realise our full potential as surgeons as well as individuals.

Face-to-face courses

Course	Date	Region
Operating with Respect	Thursday 11 March 2021	Sydney, New South Wales
	Friday 19 March 2021	Perth, Western Australia
Process Communication Model: Seminar 1	Friday 19-Sunday 21 March 2021	Brisbane, Queensland
Operating with Respect	Saturday 20 March 2021	Melbourne, Victoria
	Thursday 25 March 2021	Adelaide, South Australia
Non-Technical Skills for Surgeons (NOTSS)	Friday 26 March 2021	Canberra, Australian Capital Territory
Operating with Respect	Thursday 15 April 2021	Auckland, New Zealand
Foundation Skills for Surgical Educators	Friday 23 April 2021	Sydney, New South Wales
Operating with Respect	Thursday 29 April 2021	Brisbane, Queensland
Conflict and You	Friday 30 April 2021	Melbourne, Victoria

Online courses

Course	Date
Leading out of Drama	Monday 15-Thursday 25 March 2021
Academy of Surgical Educator Studio Session	Thursday 18 March 2021

For more information email PDactivities@surgeons.org or visit our website surgeons.org/for-health-professionals/register-courses-events/professional-development/

Professional Development Faculty expressions of interest

Prospective faculty are invited to submit an expression of interest (EOI) to join the Surgical Faculty for two courses:

- Induction for Surgical Supervisors and Trainers course
- Difficult Conversations for Underperforming Trainees course

Download the position description at the end of this article for an overview of each course. Faculty selection will be based on the applicant meeting the requirements of the position descriptions:

- Induction for Surgical Supervisors and Trainers position description can be found at tinyurl.com/6urtjgbg
- Difficult Conversations with Underperforming Trainees position description can be found at tinyurl.com/6umfjvsm

Applications to join the Surgical Faculty will be reviewed by a selection panel consisting of Chair or senior representatives from an applicable education committee, RACS education specialists and management.

Professional Development Faculty Benefits include:

- sharing your knowledge with like-minded professionals
- contributing to the quality improvement and review of professional development programming
- the opportunity to enhance your own facilitation skills
- keeping abreast of the latest development in surgical education
- contributing to the future development of the surgical community
- claiming Continuing Professional Development (CPD) points (refer to CPD program for more information)
- becoming part of a collegiate faculty group
- reimbursement of travel expenses incurred where travel is required.

If you would like to be part of the Faculty for Induction for Surgical Supervisors and Trainers, or Difficult Conversations with Underperforming Trainees courses, you are invited to express your interest by visiting the relevant link below. If you wish to express interest in both courses, please complete both forms.

Expression of Interest – Induction for Surgical Supervisors and Trainers can be found at: research.net/r/YGZBX5T

Expression of Interest – Difficult Conversations with Underperforming Trainees can be found at: research.net/r/YF7PLTH ■

Highlights from the November Annual Academic Surgery Conference 2020

The Section of Academic Surgery and Surgical Research Society of Australasia Annual Conference was held as a virtual event on 5 November 2020. The compact one-day conference showcased the breadth and depth of research undertaken by medical students, junior house officers, trainees and Fellows.

This high-quality, ongoing research will almost certainly pave the way for improved surgical practice and patient outcomes. Registration for the day exceeded expectations with 243 registrations covering both the morning and afternoon sessions.

The November Annual Academic Surgery Conference continues to grow and improve year-on-year, both in terms of the content and the amount and calibre of research being conducted in Australia and New Zealand. We were extremely pleased by the quality and number of abstracts submitted, which totalled 105. The abstract judging panel was hard pressed to arrive at the final 40 entrants selected to present on the day, with a further 20 offered the opportunity to present an e-poster.

The morning session for the Section of Academic Surgery (SAS) started with an update on the Clinical Trials Network Australia and New Zealand (CTANZ) by Professor David Watson, followed by the Association for Academic Surgery (USA) Best Abstract Winner, Dr Sarah Tevis from the University of Colorado, speaking on opioid over-prescription in breast surgery.

The next session, on 'Global Surgery and Equity of Care', included a brief exploration into climate change followed by a panel session with special guests Dr Sarah Tevis, Professor Allan Tsung, Dr Jean-Frederic Levesque and Dr Bridget Clancy.

Attendees then heard an inspiring keynote presentation by Professor Allan Tsung from Ohio State University on how to 'Maintain the Passion', highlighting the importance of curiosity, perseverance and adaptability. The final session explored training surgeons for the future.

This year's Jepson Lecture was presented by distinguished surgeon and immediate past Chair for the Academic Surgery Committee, Professor Mark Smithers from the University of Queensland. Professor Smithers provided the inspiring advice to focus on what information and skills you 'scatter' rather than those that you 'gather' throughout your life.

The afternoon session for the Surgical Research Society of Australasia provided ample opportunity for presenters to demonstrate the variety and depth of research being conducted in Australia and New Zealand. The future of research in academic surgery is in good hands, judging by the calibre of the winning presentations. Dr Brodie Elliott (JDoc) won the Young Investigator Award, while the DCAS Award was presented to surgical Trainee Dr Georgina Riddiough. Four Travel Grants were awarded. They went to Ms Sita Tarini Clark (Honours medical student), Dr Paul Heitmann (SET Trainee), Dr Chen Liu (SET Trainee) and Mr Chris Varghese (Honours medical student).

The feedback from attendees indicated that presentations were well-received, with most rated as very good to excellent.

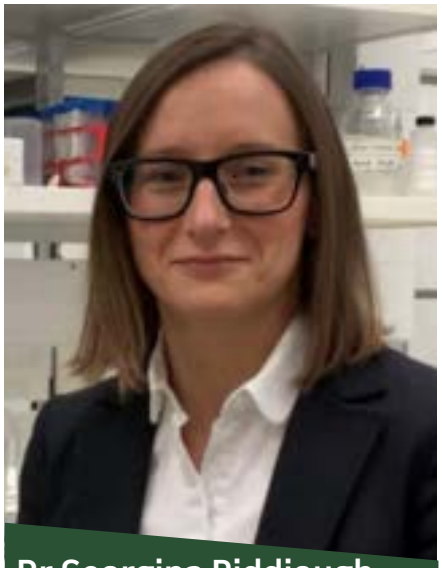
We would like to thank Medtronic for their continuing support of the SAS's activities and also thank all the contributors. We hope 2021 will see a return to in-person Academic Surgery and Surgical Research Society meetings, although we have gained many new insights from hosting a virtual meeting. ■

Professor Greg O'Grady
Chair, Surgical Research Society of Australasia

Professor Marc Gladman
Chair, Academic Surgery Committee

Dr Chen Liu
Travel Grant Award

Dr Brodie Elliott
Young Investigator Award



Dr Georgina Riddiough
DCAS Course Winner

Professor Mark Smithers
Jepson Lecturer

Mr Chris Varghese
Travel Grant Award

Dr Paul Heitmann
Travel Grant Award

Ms Sita Tarini Clark
Travel Grant Award

Professor Allan Tsung
Special guest

Dr Sarah Tevis
Association for Academic Surgery (USA)
Best Abstract Winner

Case note review

The College must embrace public reporting of clinical quality registries

Clinical quality registries (CQRs) are mechanisms for monitoring the quality of health care delivered to a specified group of patients through the collection, analysis and reporting of relevant health-related information. CQRs have long been established overseas, but Australia has been much slower in introducing them despite local evidence showing they deliver significant value.

CQRs traditionally use a data manager to collect general information. The analysis is typically published many months later and is often of little relevance to those reviewing it. Particular difficulties occur if an outlier is identified because previous poor care cannot then be addressed. Other issues include that performance is normally assessed comparative to others, so while half are better than the average, the average may be low. An additional complexity is the uncertainties related to risk adjustment, and few CQRs use absolute, external standards as their benchmark.

Quality improvement (QI) is the framework to systematically improve outcomes. Processes have characteristics that can be measured, analysed, improved and controlled. QI is widely used in industry, but there are few examples of its application in medicine. Future CQRs are likely to use prospective QI methods such as run charts (line graphs of data plotted over time that helps to identify trends or patterns in a process) to return clinically relevant data at near real-time, benchmarked against defined standards. A particular advantage of QI is that poor performance will not suddenly emerge, but will be seen to evolve over time, allowing remedial action to be taken before harm occurs.

A significant difficulty with clinical datasets has been case ascertainment and full completion of the clinical dataset, even with dedicated data managers. Administrative data is often recorded in different programs, making it almost impossible to integrate within a single hospital, let alone across different providers.

In contrast, financial organisations use common application programming interface (API) protocols, which permit instant communication across the world. Electronic medical records, health APIs and artificial intelligence (AI) are addressing these hurdles to permit administrative data from disparate sources to be downloaded and combined into a single repository.

The future challenge will be adding clinical data. Cloud computing will enable the addition of clinical data to databases without geographic restriction. In the recently reported Australian and New Zealand Emergency Laparotomy Audit – Quality Improvement report, real-time clinical data from around the country was entered onto a cloud database. Run charts were returned each month and hospital outcomes benchmarked against evidence-based standards. The results showed that recording of preoperative risk assessment – a key QI standard – increased almost three-fold over two years.

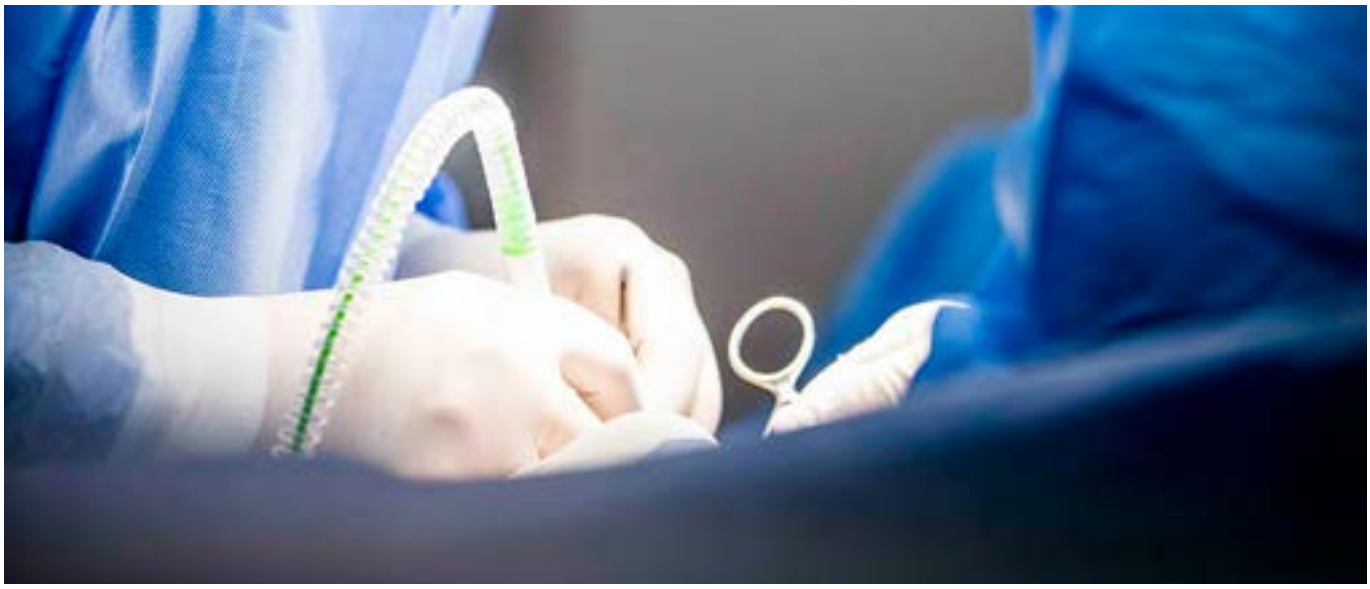
In 2014, the Australian Commission on Safety and Quality in Health Care (ACSQHC) released its framework for Australian CQRs. In 2019, a 10-year national CQR strategy was published under the auspices of the Australian Health Ministers' Advisory Council. Its vision is to integrate national CQRs into health informatics systems.

Clinicians will have greater incentive to collect clinical data if it directly facilitates their daily work. For example, cancer multidisciplinary team (MDT) meetings require access to histopathology stage. If this was placed directly into a central repository it would be readily available for the MDT and others who may require it.

QI run charts can be directly relevant to immediate patient care. A single-point example assessing hospital performance is 'door to needle' time for patients presenting with chest pain or stroke, which can be compared against agreed benchmarks. A multipoint example assessing clinical performance could be total treatment time for a patient with sepsis, covering the time from arrival in the emergency department (from hospital administrative data), to the time of objective assessment of sepsis (from emergency department electronic clinical record), to the time of antibiotic administration (from electronic prescription record). Any deviation from established clinical benchmarks would be immediately evident at an individual patient level.

The value of any CQR is greatly diminished if there is not full case ascertainment, a complete record, and if hospitals and clinicians do not view and act on their own data in a timely manner. Overseas CQRs have shown that public reporting at the hospital, and even at the clinician level, has improved data quality and outcomes.

The draft national CQR strategy makes it clear that public reporting is coming to Australia. In advance of this, the College must show leadership and act proactively to ensure that Australian surgical CQRs are surgeon-led.



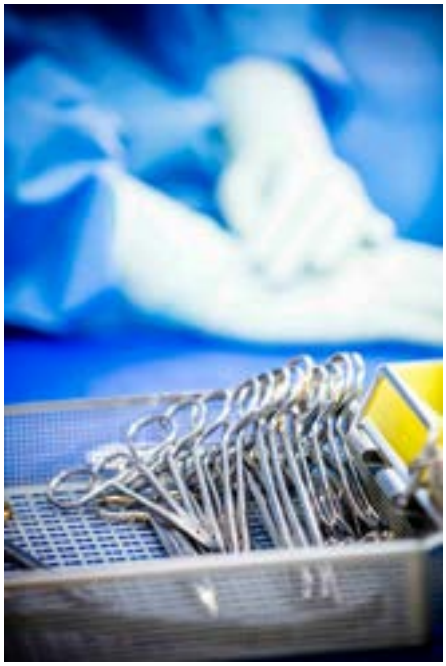
One step to achieving this is to make our continuing professional development (CPD) program substantially more robust. Full and timely participation in all CQRs established by the College or its specialty associations should become a mandatory part of a surgeon's CPD accreditation and the accrediting of training posts. Surgeons and hospitals must be required to report their compliance with the College's Mortality and Morbidity meeting guidelines. Surgeons accessing their CQR data should be a CPD requirement. Surgeons are unlikely to regularly access a CQR seeking their personal results. They will almost certainly read an email that arrives with their personal data.

For any non-compliance there must be real and timely penalties, such as withdrawing CPD or training accreditation. While this might seem draconian, failure to meaningfully lead on this issue will cede control to others.

However, the College cannot do this alone. The greatest barrier to the establishment of CQRs is government's failure to address the difficulties that confront fledgling CQRs when seeking national ethical approval, with the variable requirements for site-specific approval, governance of the data and sustained funding. These barriers have been acknowledged by the ACSQHC. It is difficult to understand why these have been almost insurmountable hurdles in Australia, but not overseas. It reflects a lack of government leadership that is contrary to their stated aims. Legislation to remove these barriers is long overdue.

By showing leadership, the College is likely to be invited to contribute to the organisation of CQRs. It can then ensure important safeguards are included; for example, that a national outlier policy incorporates the involvement of an external, independent surgeon. ■

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



One stop shop for plastic surgery trainees established

Plastic surgery is a problem-solving specialty that manipulates and repurposes cells, tissues and organs to achieve its goals across a broad spectrum of anatomical sites and disease states. There is a strong focus on developing new and novel techniques and technologies to address unmet clinical needs in Plastic and Reconstructive Surgery.

However, like many specialties, it has been difficult to coordinate research efforts across multiple centres to generate high-impact, clinically relevant research, as evidenced by the quality and low proportion (3.2 per cent) of randomised controlled clinical trials in plastic surgery research.[1,2] The Australian Society of Plastic Surgeons (ASPS) has endorsed the creation of Australasian Clinical Trials in Plastic, Reconstructive & Aesthetic Surgery (ACTPRAS) to encourage high-quality research output, a development supported by the Royal Australasian College of Surgeons' Clinical Trials Network Australia and New Zealand (CTANZ).

ACTPRAS is a one stop shop for trainees seeking to get involved in clinical trials in plastic surgery. There are roles in each study for medical students, pre-SET and SET Trainees, and consultants. It is a central portal for ideas through an interactive platform (found at www.actpras.com). Our trainees are supported by academic surgeon and surgical specialty lead Mr Michael Findlay as ACTPRAS provides and collates opportunities for research, a forum for ideas, and a platform to disseminate results in conjunction with local, national and international colleagues.

Since its inception in 2020, ACTPRAS has engaged 300 followers through online media accounts and coordinated two international studies, partnering with the United Kingdom Reconstructive Surgery Trials Network.

The first, CANVAS, a service evaluation focusing on absorbable versus non-absorbable sutures after skin lesion excision, has run since August 2020 with 16 collaborators. CANVAS has engaged plastic surgeons, plastic surgery trainees, Australian General Practitioners, ear, nose and throat surgeons and dermatologists to ascertain current suture choice in modern practice. Along with the United Kingdom networks, 100 clinician surveys and data on 1000 unique patients have been collected.

The second project, CIPHUR, is a service evaluation examining chlorhexidine vs. betadine for upper limb surgery. Out of 300 data collectors worldwide, 26 Australasian plastics and Orthopaedic Surgery contributors have been recruited.

Future projects include: AWAKE, a study on the efficacy of WALANT surgery, and ABACUS, a study of the ReCell® spray-on-skin system.

In conjunction with partner organisations, we are developing suitable resources to assist researchers to develop successful studies, identify potential collaborators and participate in others' studies. ACTPRAS should be a starting point for trainees and medical students interested in research. It forms an essential resource for more experienced clinicians to expand their research horizons and broaden their impact across Australia and New Zealand, as well as internationally. ■

Dr Guy Stanley

Mr Michael Findlay FRACS

Mr Cody Frear

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Exceptional DCAS program planned for the 2021 RACS ASC

After the unfortunate cancellation of the 2020 Developing a Career and skills in Academic Surgery (DCAS) course, due to the COVID-19 pandemic, we are excited to announce that the 12th annual DCAS course will be held Monday 10 May 2021, leading into the Royal Australasian College of Surgeons Annual Scientific Congress at the Melbourne Convention and Exhibition Centre. This year, we have adapted our course delivery to include virtual sessions to give everyone the opportunity to attend this exciting course in person or online.

The morning session will consist of a hybrid online and in-person format, and afternoon sessions – including breakout sessions – will only consist of in-person attendance. As always, we will provide delegates with an exciting range of informative topics that promise to engage and inspire.

We are pleased to have assembled an exceptional faculty from Australia, New Zealand and the United States who will share personal experience and tips on what it takes to start, develop and continue a productive career in academic surgery.

As always, we look forward to renewing acquaintances with our American colleagues from the Association for Academic Surgery, whose continued support for our DCAS course deserves special acknowledgement. We are thrilled to welcome them in the most appropriate format come May 2021.

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 practice will benefit both the surgeon and patients.

Other highlights from the program include Professor Michael Vallely, from the Ohio State University Wexner Medical Center, on the 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. Furthermore, this year's program will include talks on navigating the virtual academic environment and a discussion on diversity, equity and inclusion in academic surgery.

The content of the two afternoon workshops will cater to onsite attendees: firstly those new to research or academic surgery, with the topic 'Finding My Niche/Fit and Tools of the Trade'; and secondly, those in early career development, with the topic 'Trainee-Led Collaborative Trials'.

For those attending onsite, the day will end with a networking function, where our approachable and engaging faculty members encourage and welcome attendees to initiate informal discussions.

Previous attendees frequently described the course as inspirational, transformational and well targeted to every level, from medical students to department heads. Faculty regularly comment that there is nothing more satisfying than seeing attendees benefit 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 attend the DCAS course, whether by joining us in Melbourne or in a virtual space, in May 2021 – you will be impressed and inspired. Research is about continuous improvement and progress, so come and be part of this course. ■

Associate Professor Jonathan Karpelowsky
Co-Chair

Associate Professor Colin Martin
Co-Chair

Mr Richary Hanney
Convenor

Further details including registration costs and the provisional program can be found at:
http://www.tinyurl.com/DCAS2021

Digging deeper into Australia and New Zealand road crash statistics

2020 not a good year for road safety

It was a terrible year on the roads in Queensland. In total, 59 more people were killed on the state's roads in 2020 than in 2019 (276 deaths in 2020 compared to 217 in 2019).

But despite this alarming statistic from Queensland, every other Australian jurisdiction and New Zealand recorded a reduction in their annual road crash deaths.

Normally a reduction in fatalities would lead to a feeling of cautious optimism, but 2020 was anything but a normal year. When you take a deeper look at the statistics there is nothing to celebrate.

Take, for example, Victoria – the jurisdiction hardest hit by the pandemic. According to the Transport Accident Commission there was an approximate 20 per cent reduction in the number of road fatalities. And so there should have been!

As we know, our own Royal Australasian College of Surgeons (RACS) Melbourne office asked staff to work from home from March and they did not return to the office for the rest of the year. It was a similar story right across Melbourne and Victoria. Our social media was flooded with images of normally bustling streets that were completely deserted. When you consider such a dramatic change in lifestyle, a 20 per cent decrease in fatalities seems rather modest.

It is worse when you consider that Victoria's road death toll in 2020 was one person higher than 2018. To put this into perspective, one more person died on Victoria's roads during a year where the state had what was considered by many to be the 'world's strictest lockdown' and Melbourne was a ghost town, than two years earlier in a year when travel and movement were virtually unencumbered.

It is a similar story in other parts of Australia. In South Australia there was a reduction in fatalities, but let's not forget that 2019 was a horror year on the state's roads – the worst in over a decade, in fact. Comparing the 2020 and 2018 figures, the 2020 figure is more than 15 per cent higher, despite the restricted travel.

We have seen a similarly disturbing trend in New Zealand. For example, Otago experienced its worst year on the roads in almost 15 years and has seen a rise towards the end of the year. We also saw another rise in the number of motorcycle deaths in 2020, compared to 2019.

While the new year has ticked over, it has not been a good start to 2021. A rising trend in pedestrian deaths has been highlighted by the tragic deaths of five young pedestrians in New South Wales in less than two months. This prompted me to speak out in a recent media article.

"It's time for change when people are not even safe to walk on footpaths. What is particularly distressing is that often it's the result of someone getting behind the wheel when they never should have. Repeat offenders need to be off the road," she said.

Since these deaths, a Brisbane community has been left reeling in the aftermath of the death of a young Brisbane couple killed by a car while they were walking their dogs.

A range of existing vehicle technologies, including Lane Keep Assist and Autonomous Emergency Braking, or infrastructure enhancement, such as wire rope safety barriers, may have helped prevent these tragedies.

The New Zealand Government and governments across Australia are to be commended for the way they have responded to the challenges posed by the COVID-19 pandemic. A similar response is required to the epidemic that is road trauma.

We are at a pivotal moment in our two countries with respect to road safety. We cannot afford to allow the progress of recent decades to stagnate and for our unacceptably high road fatality and serious injury rate to simply become 'the new normal'. We must continue to look at 'new ways of working', set ambitious targets and dedicate the necessary resources to eliminate the devastating consequences that road trauma has on our society. ■

Dr Valerie Malka
Chair RACS Road Trauma Advisory Subcommittee

Specialist Training Program supports rural health strategy

The Royal Australasian College of Surgeons (RACS) Specialist Training Program (STP) is pleased to announce that the New Fellow Rural Placement Pilot, which had its inaugural year in 2020, has been approved to continue in 2021.

In 2020, two General Surgery positions were funded: one at Royal Darwin Hospital and one at Cairns Hospital. Both Fellows have had an excellent experience and given positive testimony through various RACS media channels.

Following this success in 2020, the Australian Department of Health approved an extension of the pilot into 2021, with four positions funded. After a short Expression of Interest round, the following four hospitals were successful in securing funding: Rockhampton Base Hospital (General Surgery), Royal Darwin Hospital (General Surgery), Cairns Hospital (Orthopaedics) and Griffith Base Hospital (General Surgery).

The STP initiative began in 2010, with the main purpose being to provide funding support for accredited training posts in non-traditional healthcare settings. In addition to funding accredited training posts, RACS STP funds several educational projects that support the success and sustainability of delivery training to rural and/or Aboriginal and Torres Strait Islander Trainees.

The Rural Training Positions Gap Analysis is an STP support project that aims to increase access to surgical care across Australian rural settings. The project is a qualitative study of the barriers to selecting rural placement and practice, strategies to overcome these barriers, and will make recommendations to the Department of Health and RACS based on research findings.

Between September and November 2020, RACS interviewed 29 participants, consisting of Trainees and Fellows, about their experience in a rural health service. Reported findings are currently being collated for a final report to the Department of Health.

Another STP-funded project is Supporting Clinical Studies in a Rural Remote Area. Undertaking clinical studies in a rural or remote setting can be challenging for surgical Trainees. They are faced with issues such as lack of resources, mentorship, governance and established structural support, which are more readily available to Trainees in metropolitan areas. The project aims to support surgical Trainees to undertake clinical research in rural and remote areas, as they are best placed to understand the barriers faced in clinical decision-making and implementation within their specific settings.

Indigenous Health is a major priority for RACS as part of its Diversity and Inclusion Plan. The Aboriginal and Torres Strait Islander Health and Cultural Safety project team has worked closely with the RACS Indigenous Health Committee members to implement a range of College-wide changes. These include the introduction of a dedicated Cultural Competency, Cultural Safety competency and integration of Indigenous Health and Cultural Safety wording across a range of RACS face-to-face and online courses. The project also introduced Course 1 and 2 in the online learning suite of the new multi-level Aboriginal and Torres Islander Health and Cultural Safety courses.

RACS recognises that the strategy to close the gap for Aboriginal and Torres Strait Islander people is a long-term plan. STP has funded the new Indigenous Surgeons Pathway Program for Aboriginal and Torres Strait Islander people interested in a surgical path, which aims to increase the number of Aboriginal and Torres Strait Islander surgeons via staged career guidance, starting as early as high school. ■

If you or someone you know is interested in any of the above projects or opportunities, we encourage you to contact the respective sites or our team. More information about STP and its various initiatives can be found at surgeons.org/en/Education/specialist-training-program.

The Specialist Training Program is funded through the Australian Department of Health.

SAVE THE DATE

BACK TO THE FUTURE
Lessons from the Past, Prospects for the Future

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Wednesday 10 – Saturday 13 November 2021

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Australian and New Zealand College of Perfusionists (ANZCP) and
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The case for separation

The term 'Australasian' in the name of our College must really grate with New Zealanders. So often it is misread or even miswritten as Australian, thereby excluding our New Zealand colleagues. Even when written correctly, many people do not know what it means. Some definitions of Australasia include Australia, New Zealand, New Guinea and the neighbouring region of Melanesia. Others say it includes all of Oceania. I can understand why the New Zealand members of our College might desire recognition of their country in the name of our College.

The College has previously considered this question. A ballot of Fellows was taken around 2005, on whether to change the College's name to the 'Royal Australian and New Zealand College of Surgeons'. It was approved in New Zealand but not in Australia and, as a two thirds majority of members is required for a change to the Constitution, the name remained the same.

This question has arisen again, but I would like to raise a deeper question. Is it time for a separation of the two countries? A divorce by mutual agreement, without acrimony and with a vision to the future.

When the Royal Australasian College of Surgeons (RACS) was established in 1928, the population of Australia was 6.3 million and that of New Zealand was 1.5 million. Now the corresponding numbers are 25.5 million and 5.1 million. New Zealand currently has 65 per cent of the population that both countries combined had in 1928.

Is this enough to justify a separate College of Surgeons for New Zealand? Maybe.

However, if we look at the medical population of the two countries, we see that in 1927, in New Zealand, there were 1283 registered medical practitioners. The corresponding figure in Australia is harder to find because the states had individual medical boards. A reasonable estimate (based on the figures from the Medical Board of Victoria and the Australian census data) is that in 1933 there were 6500 registered medical practitioners in Australia, giving a total for the two countries of about 8000. In 2019, in New Zealand, there were 16,908 registered medical practitioners, double the number of the two countries in 1928. Is this enough to justify a separate surgical college for New Zealand? In my view, the answer is a resounding yes.

Medical colleges are not just about numbers, but are also about the commonalities of interests and goals. All surgeons and surgical organisations in our countries aim to improve their surgical skills and knowledge. It is relevant that, of the nine surgical specialties that our College trains, four have training boards in New Zealand that are autonomous from their Australian equivalents (General Surgery, Plastic and Reconstructive Surgery, Otolaryngology and Orthopaedic Surgery). Does this imply a degree of desire for separation?

Our medical systems are also different. New Zealand has a single Ministry of Health compared to Australia's eight state and territory departments of health, as well as our federal department. Private practice is a greater component of surgical practice in Australia and medical indemnity more of an issue. The New Zealand Accident Compensation Commission removes the need for the large premiums required of Australian surgeons.

There is ample evidence of the contributions to our college by our New Zealand cousins – in the form of Presidents, Councillors and Chairs of important committees. New Zealand has the committed and experienced Fellows necessary to perform the voluntary work that keeps our College functioning well.

Separation does not mean that the common things need necessarily go. The Annual Scientific Congress will continue, but it must be remembered that New Zealand has its own Annual Surgical Meeting, which has run successfully for many years. New Zealand has its own National Board and Chair. Some training programs may wish to remain bi-national. Basic science exams may be run as a joint effort.

The main point of this article is to ask Fellows, particularly New Zealand Fellows, to think about the future of our College. Do we simply look at a name change again, or do we look more deeply into the issues? Should there be a Royal Australian College of Surgeons and a College of Surgeons of New Zealand? ■

Mr Glenn McCulloch
FRACS

Deux et deux font cinq (2 + 2 = 5)
When things do not add up
The equation – part II

OPUS LXVII

The first 'Equation' article in December 2020 in *Surgical News* recounted the principles implied in the expression, 'when things do not add up'; in particular, when dictates and dogmas need to be questioned, and modern insights supersede entrenched clinical practice. George Orwell's statement about 'Big Brother', one of the most quoted phrases in the 20th century, is evident throughout this essay.

Orwell was an Eton graduate and became a war correspondent during the Spanish Civil War, opposing Franco and fascism. His wartime experiences reflected his opposition to totalitarianism and his support of democratic socialism.

Dick Galbraith, renowned eye surgeon, had his own experience of the 'big brother' quote in an episode when flying in a twin engine Cessna back to base from one of the Fiji islands, when he was operating in the Pacific. The aircraft became engulfed in the dense cloud of an approaching tropical storm. Visibility was zero. Nothing was said, but the mood was ominous with anxiety. An SOS was radioed and, thankfully, received by one of those stratospheric American surveillance aircraft almost 50,000 feet above – part of a global peace initiative.

Their immediate response guided the Cessna to the closest landing site. As Dick recounted, "What a Godsend". The Cessna crew conveyed their grateful thanks, but the response from above came back cryptically in an American drawl, "big brother is watching you."

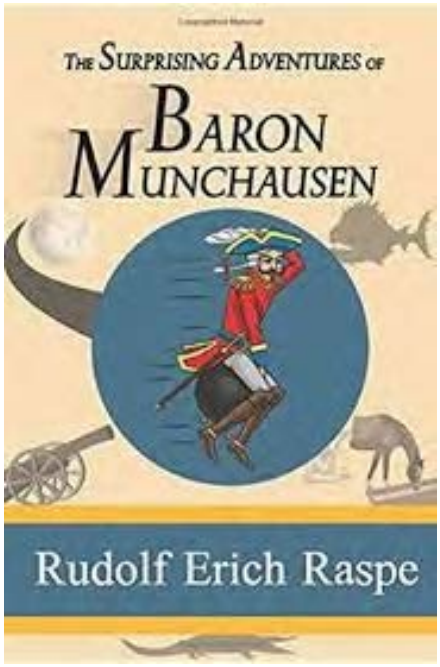
Dick told this story at the Head and Neck meeting at the Royal Melbourne Hospital (RMH) on his return. These RMH meetings were held every Monday morning at 7.30am – one of the first of their kind in Melbourne to discuss major head and neck problems in a consultative capacity. The late Brian Fleming, who trained under Howard Eddy in head and neck surgery, was 'Chairman of the Board'. Hugh Millar and Steve Kleid were part of the ear nose and throat contingent; and Dick and David Kaufman were part of the ophthalmological team. John Hueston, in the Plastic and Reconstructive Surgery field, initiated these meetings. Incidentally, it was John who invited me to attend on my return to Melbourne in 1974, after three years working in head and neck surgery in London and the Marsden.

Who would have thought that Orwell would have been quoted at a Head and Neck meeting at the RMH. Needless to say, I only realised its significance later.

Now let me turn the page over to the clinical domain, where 'when things do not add up' bells should ring – sonnette d'alarme. These clinical cases recall the Munchhausen pattern of fabrication.

The Baron Munchausen was a soldier in the Russo-Austro-Turkish War of the 1730s. He survived and returned to publicly reveal his experiences of daring exploits and heroic deeds – all fictionalised. Baron Munchausen was, in fact, a creation of German writer, scientist and con artist Rudolf Erich Raspe. He would falsify and fabricate while entertaining the masses. As Mark Twain said, "Never let the truth get in the way of a good story".

However, when fabrications and falsehoods occur in a treatment environment, these patients show psychological tendencies that can



The Surprising Adventures of Baron Munchausen *by Rudolph Eric Raspe*

border on psychopathy, including Machiavellian scheming. Cognitive dissonance creeps into the equation when actions and behaviour do not match. Note, my findings are based on observations without any psychiatric qualifications.

Here's a worker's compensation case where bells should have rung earlier, before the operations reached double figures.

A patient rotated between consultants orchestrating and even suggesting future procedures to improve function – all under workers compensation. A mallet finger splint failed, as did the K-wire, as did the tendon graft that became infected. This produced septic arthritis of the distal interphalangeal

joint (DIPJ) leading to a fusion, before terminalisation, which was repeated down the digit (neuroma problems) to an eventual Ray amputation.

I met the patient in my medico-legal practice and this is the basis of the accurate details from his clinical records.

Another story reflecting Orwell's writing: "If liberty means anything at all it means the right to tell people what they do not want to hear."

Here I was caught in the mistaken belief that we should always believe the patient's story – well, initially.

A policeman had a seatbelt injury from a motor vehicle accident, injuring his abdominal wall. Multiple repair procedures were done at St Vincent's Private Hospital as the wounds kept breaking down. After six weeks and multiple visits to theatre the wound was finally healed. The patient was ready for discharge and even conned one of the nursing staff for $15 to pay for his dry-cleaning bill. I was somewhat inexperienced and did not suspect anything at the time.

Ten years later, almost to the day, who was admitted to the Western Hospital following another accident? The very same police officer. Gillian Farrell was the consultant in charge of his admission and was preparing to operate later that day. But the repeated clinical story of a seatbelt injury caused my memory bells to ring and I recognised him immediately! I verbally confronted him about his clinical trend.

1984 *by George Orwell*

He discharged himself immediately – most likely to the care of the next clinician.

Here is another Munchausen vignette. A nursing aide burnt her digit over the interphalangeal joint on a steriliser, which resulted in a graft, which failed, which was repeated, which failed again. The joint exposure needed a cross finger flap and after division (the fourth operation) bells were ringing. She decided to go elsewhere. The next clinical contact I had with her was in my medico-legal practice where the hospital documents listed the sequence of workers compensation procedure to date – it reached double figures.

In other words: multiple operations may equate to a psychologically disturbed personality.

Another Munchausen story came from Shepparton, where Tony Heinz sent me a case of an abdominal wound that failed to heal after six operations. On referral, I offered a keystone solution to the problem, which are usually successful. In the postoperative phase the patient was full of praise about the surgical expertise at the Western Hospital. But my bells of experience began to ring and I warned my surgical team about such gratuitous adulation.

One evening, on the removal of sutures before discharge, the wound broke down and the patient demanded more narcotics, disturbing the harmony of the sleeping ward.

I re-explored the wound along the convex arc of the keystone from the wound on the right side in this right-handed patient. I surmised she had undermined the wound using her hand, up to the limits of her fingertips. On explaining my findings to her, and my suspicions about her possible personality traits or addictions, I copped a tirade of vindictive abuse. My initial warnings to my registrars were prescient.

Now let me conclude with a few lines on surgical education because observation is the basis of sound medical practice (as enunciated by Sir William Osler in 1905 when he was appointed to the Regius Professor of Medicine at Oxford).

I revisited these clinical episodes during our 2020 enforced sabbatical one day as I listened to Carl Orff's *Carmina Burana* (a Peter Callan favourite). Carl Orf's other writings awakened my consciousness to some important facts relevant to surgical teaching. He said, of music, "experience first, then intellectualise", but I say this can be applied to the surgical domain. This is pertinent to any young registrar climbing the publication ladder (publish or perish) in any career advancement.

Incidentally, I think heads of unit should be the prime authors on major papers reflecting their experiences. This avoids delegating to a junior mind lacking the experience, who is really acting as someone's supervised amanuensis. Experience puts validity into anyone's writings. As I had with Benny Rank about a Volkmann's contracture case of his. I proposed putting this into print. He discounted my presumptuous offer and his accurate response reflected my inexperience.

I was fortunate at the Western Hospital to be a little independent without too much 'big brother' intrusion into my clinical development and lateral thinking. Such ideas usually evolve while doing midnight emergencies looking for a quick exit home. However, 'big brother' surfaced later because all my publications were peer reviewed. Our musical expert and later head of the Plastic Surgery Unit at the Western Hospital, Mickey Pohl, likened my independence there to the composer Joseph Haydn at the Esterhazy Court. As a cloistered musician there he composed up to 100 symphonies and established the quartet as a compositional style. He did not need to compete on the world stage from London to Paris and the wide appeal of the audience acted as his peer-review process indicating universal acceptance.

P.S. And it has just come through on the international news services from China that everyone there is digitally rated out of a score of 10 in all aspects of their personality, reflecting ability, honesty, integrity and commitment et cetera – yes, job interviews are possibly now superfluous! What a big 'big brother'. ■

Associate Professor
Felix Behan

Sir William Arbuthnot Lane (1856-1943)

Surgical innovator: health educator
Bt. C.B. MB BS (London) FRCSMS Hon. FACS

Sir William Arbuthnot Lane appeared in *Vanity Fair* on 31 May 1913, with the magazine noting, 'in these days it is well to note that Mr Lane comes honestly by his honours. He is the eldest son of a Brigade-Surgeon for one thing. He is known as the great exponent of the operative treatment of fracture by plating for another.

'Great as is Mr Lane's prestige among the Britishers, he is even perhaps as well known in America. These strange people admire his type of surgery. It is so skilful and wise and daring. It is "like the pies Mother made."'

William Arbuthnot Lane was born on 4 July 1856 at Fort George, near Inverness, Scotland, the eldest of the three sons and four daughters of Benjamin Lane, assistant surgeon, 80th Regiment of Foot. His family always called him Willie, and thus the title of his *Vanity Fair* portrait was provided.

As the family followed its army regiment, young William attended schools in eight countries on four continents before he was sent to school at Stanley House, Bridge of Allan, in Scotland. He matriculated at Edinburgh University and then decided to follow his forebears in the study of medicine.

His father, being then stationed at Woolwich, entered William as a student at Guy's Hospital in October 1872. The hospital, which was close to London Bridge Station, allowed for easy commuting.

This was the beginning of Lane's long association with Guy's Hospital: his earlier ambition to be a physician was replaced with surgery as he was more likely to find a vacancy sooner on the surgical rather than the medical side at Guy's. He qualified as a Member of the Royal College of Surgeons (RCS) in 1877.

Lane was then advised to take a London degree, which involved retracing his steps, beginning with matriculation. He did well, gaining the gold medal in Anatomy at the intermediate examination and the Gold Medal in Medicine at the final examination in 1881. The following year, he became a Fellow of the RCS and in 1883 proceeded to his M.S.

He was then appointed assistant surgeon to the Hospital for Sick Children, Great Ormond Street, and five years later, at 32, was elected assistant surgeon to Guy's Hospital. He worked there until he retired in 1920.

Lane's appointment to Guy's was preceded by six years there as a demonstrator of Anatomy, where he revealed his skills of observation, initially with skeletal changes resulting from occupations – changes in bones, cartilages and joints due to occupational posture, pressure, and strain. He subsequently wrote papers on 'The anatomy of the charwoman' and 'The anatomy of the shoemaker'.

Lane preferred to work with his own methods rather than accept standard practice. It was in 1883 that he began writing on fractures and he concluded in the early 1890s that splints were likely to produce permanent injury and that for intractable fractures open reduction with rigid fixation was necessary.

Lane began operating on fractures from 1892, insisting on the most scrupulous asepsis. He introduced the 'no touch' technique, thus pioneering aseptic surgery and advancing beyond antiseptic surgery. He introduced sterile caps, masks and gowns in 1900, collaborating with Down Brothers to design instruments for this new form of surgery, in which no part of an instrument that entered the wound was to make contact with the surgeon's hand.

Accused of turning simple fractures into compound, Lane insisted that the surgeon do as neat a job 'when repairing broken bones as a cabinet maker mending the legs of broken chairs'.

The frontispiece of his surgical text, published in 1913, reveals the incredible breadth of Lane's surgical procedures: he improved whatever he touched. His innovations included the removal of a portion of a rib when treating empyema in a child, an operation for cleft palate early in life, and plating fractured long bones to obtain perfect apposition.

Lane exhibited imperturbable calm at any difficulties encountered during operations. He fascinated his assistants with his extraordinary dexterity and became renowned on both sides of the Atlantic as the only surgeon the Americans travelled to visit in London. He operated on socialites, politicians, and royalty – the latter inevitably leading to his baronetcy in 1913.

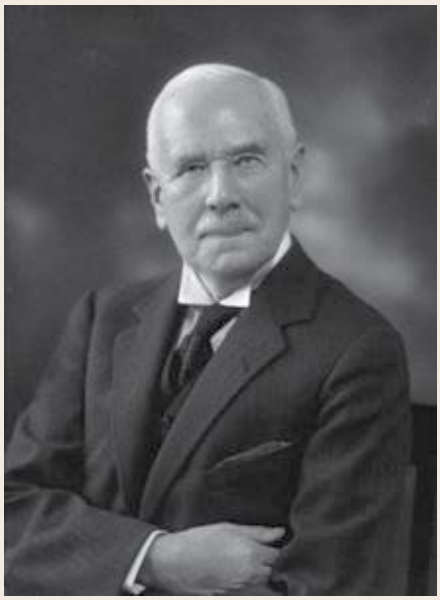
Lane joined the Royal Army Medical Corps on its formation and, during the war of 1914-18, organised the Queen's Hospital at Sidcup for the treatment of facial injuries, where Harold Gillies and Henry Tonks laid the foundations of modern plastic surgery. For this Lane

was appointed Companion of the Most Honourable Order of the Bath (CB).

He had a successful private practice generating an income of £20,000 per annum by the early 1920s. Contemporary newspapers described him as 'the best-known surgeon in Britain'.

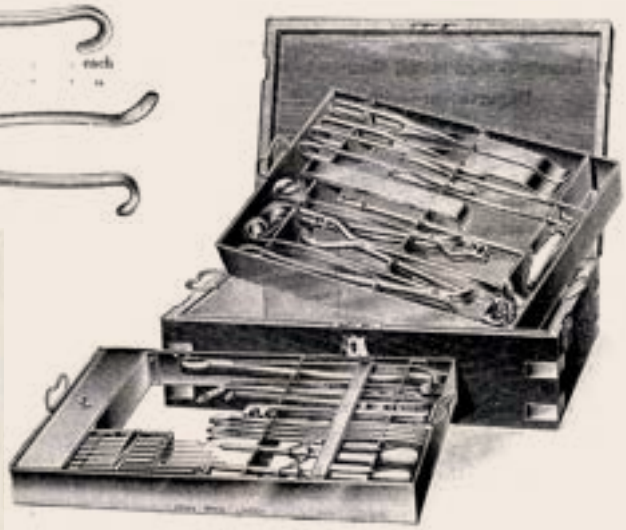
Lane gained a high social position, as distinct from institutional influence. He did serve on the Council of the RCS from 1908 to 1916; however, he was never interested in examining – attending societies to preach rather than exchange opinions. A bibliography of his published writings 1883-1938 was privately printed in 1938, listing almost 400 entries.

The last phase of his career began when, using his position, he founded the New Health Society in 1925, a private charity, to spread popular health education throughout the country. Active from 1926-1937, the society's motto was 'prevention rather than cure'. Once again, he was a pioneer. His views were frowned upon by the medical profession, particularly by the British Medical Association (BMA).



Lyons Tea Shops in England were then at the peak of their popularity; the chain opened a Vita-Sun Café at which health foods were available and their vitamin content rated on the menu. Lane provided articles such as 'The Athlete's Diet', which were printed on these menus. He also wrote many similar articles for the *Daily Mail*.

This was seen by some, particularly by the BMA and the General Medical Council (GMC), as a form of indirect advertising.



To avoid litigation, Lane resigned from the BMA, remaining in practice at his home, where he was registered with the GMC until November 1932, when he voluntarily ceased to practise.

He became obsessed with the danger to general health caused by chronic constipation and he commenced operating on the large intestine with short-circuit procedures that came to be known as 'Lane's operation'. His entry in the *Dictionary of National Biography* (DNB) includes the tag, 'Sir Arbuthnot Lane, colon, semi-colon, full-stop.'

In his text, *New Health for Everyman*, he set out his '10 golden health rules', which to the modern eye appear eminently reasonable. Eat meat only in moderation, include in your daily diet wholemeal bread and citrus fruit, drink at least six tumblers of water a day, work/sleep in well aired rooms, and exercise night and morning for 10 minutes. Lane himself walked four miles every day, wet or fine.

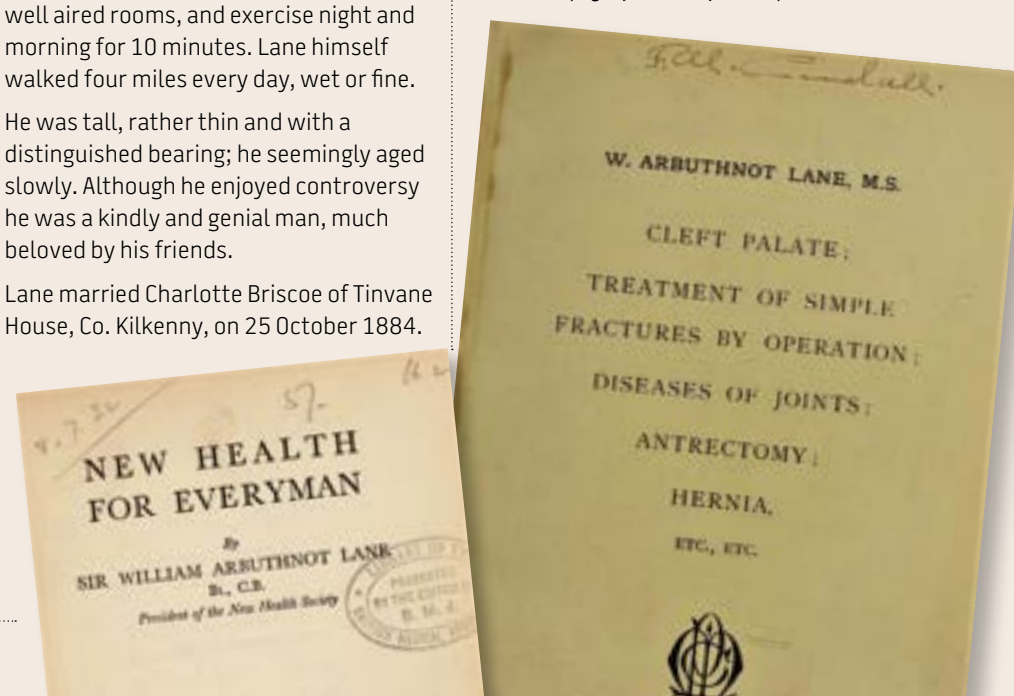
He was tall, rather thin and with a distinguished bearing; he seemingly aged slowly. Although he enjoyed controversy he was a kindly and genial man, much beloved by his friends.

Lane married Charlotte Briscoe of Tinvane House, Co. Kilkenny, on 25 October 1884. She bore him three daughters and a son, who succeeded as second baronet. Lady Lane died in April 1935, six months after their golden (50th) wedding anniversary. 'Willie' then proceeded to marry his son-in-law's sister, Jane Mutch, five months later, at 79!

He died at his London home on 16 January 1943, aged 86: Jane survived him. A memorial service was held at Guy's on 21 January 1943. ■

Mr Peter F Burke
FRACS

Images:
Over page: 'Willie', portrait from Vanity Fair. *Above: Lane's instruments – bone-holding forceps, bone plates and instruments for fracture management. Left: Sir William Arbuthnot Lane. Below: title pages for some of Lane's publications.*



Thank you to our Educators of Commitment

The Educator of Commitment Awards acknowledge the contribution of the Royal Australasian College of Surgeons (RACS) registered Surgical Education and Training (SET) supervisors, Specialist International Medical Graduate (SIMG) supervisors and facilitators over a sustained period of time.

Nine years
SET supervisor

Mr Naveed Alam
Mr Adam Zimmet
Dr Carina Chow
Mr Henry Dowson
Mr Etienne Truter
Mr Kenneth Wong
Dr Ian Elbourne
Associate Professor Francis Miller
Dr Renata Bazina
Dr Maurice Day Jnr
Mr Michael Edger
Mr Wan Seow
Mr Nikitas Vrodos
Dr Mark Winder
Mr Ian Jacobson
Mr Michel Neeff
Mr David Pohl
Professor Stephen O'Leary
Mr Simon Dempsey
Mr Peter Ferguson
Dr Craig McBride
Dr Neil Price
Dr Elizabeth Whan
Mrs Toni-Maree Wilson
Mr Scott Ferris
Dr Kevin Ho
Associate Professor Damian Marucci
Dr Elias Moisidis
Dr Carmen Munteanu
Dr Graham Coombes
Ms Lydia Johns Putra
Mr Jonathan Masters
Dr Francesco Piscioneri
Dr John Preston
Associate Professor Ravi Huilgol
Dr Lubomyr Lemech
Dr Mathew Sebastian
Mr Ramesh Velu
Mr Janaka Wickremesekera

Nine years
Professional development facilitator

Dr David Sainsbury
Dr John North
Mr Alan Scott
Associate Professor Marianne Vonau
Mr Zet-Sheng (Michael) Ee

Six years
SET supervisor

Dr Pragnesh Joshi
Mr Muhammad Abdullah
Mr Nigel Barwood
Dr Joanne Dale
Mr Adrian Fox
Dr Nishanthi Gurusinghe
Mr Mohan Jayasundera
Mr Michael Johnston
Dr Marianne Lill
Dr Mark Romero
Dr Emmanouel Roussos
Mr Franko Sardelic
Associate Professor Graham Stewart
Dr Gabriella Vasica
Mr James King
Dr David McCrystal
Dr Suchitra Paramaesvaran
Dr Adnan Safdar
Mr Edward Smith
Mr Michael Switajewski
Mr Matthew Taylor
Mr Murali Reddy
Dr Michael Wagels
Dr Muhammad Abdul-Hamid
Dr Hin Chan
Dr Adrian Clubb
Mr Alastair Hepburn
Mr Melvyn Kuan
Mr Daniel Marshall
Dr Arvind Vasudevan
Dr Danella Favot
Mr Franklin Pond
Mr Timothy Wagner

Six years
SIMG supervisor

Mr Peter Ferguson

Three years
SET supervisor

Mr Harsh Singh
Professor Tristan Yan
Dr Sergey Fedorine
Associate Professor Jonathan Hong
Mr Tristan Leech
Dr David Logan
Mr Damien Loh
Dr Seow Loh
Mr Timothy McCullough

Dr Thembekile Ncube
Dr Devinder Raju
Dr Michael Tan
Mr Patrick Tan
Dr Andrew Thompson
Dr Anna Wilkes
Dr Katherine Wilson
Mr Edward Yeboah
Dr Aileen Yen
Dr Shinn Yeung
Dr Alexandra Gordon
Mr Simon Harper
Dr David Anderson
Dr Arul Bala
Dr Paul Smith
Dr Aanand Acharya
Dr Ronaldo Bova
Mr Andrew Bridger
Dr Andrew Chang
Dr Daron Cope
Professor Peter Friedland
Dr Raefe Gundelach
Dr Claire Iseli
Dr Yuresh Naidoo
Mr Sumit Samant
Dr David Waterhouse
Mr Christopher Birks
Mr Jason Donovan
Dr Thomas Sharpe
Mr Askar Kukkady
Mr Damon Thomas
Dr Sydney Ch'ng
Mr Michael Findlay
Mr Robert Gilmour
Dr John Kippen
Associate Professor Thomas Lam
Mr Julian Liew
Dr Alexander Phoon
Dr Sandrine Roman
Dr Kieran Rowe
Mr Michael Thomson
Dr Wysun Wong
Dr Janelle Munns
Dr Bradley Newell
Mr Dinesh Patel
Mr Michael Pether
Mr Rajinder Singh Rai
Mr Daniel Steiner
Dr Philip Tan
Dr Aleksandra Vujovic
Dr Lik-So Yuen
Dr Andrew Bullen
Mr Charles Fisher
Dr Lachlan Maddock
Dr Juanita Muller
Dr Shannon Thomas
Dr Catherine Thoo
Dr Yew Wong
Mr Michael Wu

Three years
SIMG supervisor

Dr Eric Guazzo
Mr Roderick Borrowdale
Professor Deborah Bailey
Dr Sharon Kelly
Mr Hugh Macneil
Dr Samuel Martin
Dr Shane Anderson
Dr Babatunde Salman
Dr Milos Kolarik
Mr Idris Arogundade
Professor Alasdair Sutherland
Mr Michael O'Brien
Dr Peter Harris
Dr Patrik Tosenovsky
Dr Jacob Van Der Westhuizen

Three years
Professional development facilitator

Dr Garry Dyke
Mr Richard Grills
Dr Richard Hocking
Miss Sarah Hulme
Mr Guy Rees
Dr Susan Taylor
Dr Mary Theophilus
Ms Lynn Hemmings
Ms Julie Napoli
Dr Tzu-Chieh (Wendy) Yu
Dr Mariolyn Rajakulenthiran
Mr Jose Cid Fernandez
Dr Andrew Chang
Dr Erica Jacobson
Dr Lynette Reece
Dr Benjamin Teague
Dr Veronika Van Dijck
Mr Robert Boustred
Associate Professor Douglas Fenton-Lee
Dr Maria Teresa Nano
Mr Brian McGowan
Dr Juanita Muller

The Academy of Surgical Educators and the affiliated RACS departments endeavour to publish these lists as accurately as possible. If you know someone whose name is missing from the list, please contact ase@surgeons.org

Research scholarship and grant opportunities for 2022

The common facts of today are the products of yesterday's research
–Duncan MacDonald

Apply now! Travel, education and research scholarship and grant opportunities for 2022

For more information, visit surgeons.org/scholarships

Last year was undoubtedly a challenging one as the world grappled with the onset of COVID-19. While many of our scholarships, grants and Fellowships (scholarships) were put on hold, we now look with optimism at this year's program.

Thanks to our Fellows' dedication and donors' generosity, the Royal Australasian College of Surgeons (RACS) scholarships, grants and Fellowships have grown over the decades. RACS and the Foundation for Surgery are proud to offer up to 64 scholarships this year. This represents a significant philanthropic contribution to surgical research and training in Australia, New Zealand and the Asia-Pacific region.

Following Council approval in 2019, a series of program activities (following) have been undertaken to ensure that as our Scholarships and Grants Program grows, it achieves maximum impact for our members and the surgical community.

RACS is now poised to be an international leader in the provision of scholarships for the surgical community. On behalf of the Australia & New Zealand (ANZ) Scholarship and Grant Committee, I thank the many Fellows who commit their time and expertise to the program. We can be proud that these opportunities benefit not only the individuals who receive them, but also contribute to the development of research, surgical practice and leadership in our local and global surgical communities.

Professor Henry Woo
Chair, Australia & New Zealand Scholarship and Grant Committee

The scholarships and grants program year ahead

Streamlining our governance
Scholarships have now been consolidated from across the College into one program, under the ANZ Scholarship and Grant Committee's governance, supported by expert selection panels. New policies and procedures will ensure a robust approach to program administration through the RACS Scholarships and Grants department.

Research and Learning and Development opportunities
To support our streamlined governance, scholarships are now offered in two rounds: Research (opening in March) and Learning and Development (opening in August).

Research scholarships provide opportunities to pursue major research projects of between one and three years duration. They are usually undertaken through an approved research institute in Australia or New Zealand. Research opportunities are paid as a stipend, often via the institute, on behalf of RACS and may include departmental maintenance.

Learning and Development grants offer the opportunity to pursue professional development, training or small investigative research activities in Australia, New Zealand or overseas. They are usually undertaken over a shorter timeframe of several weeks or months and are paid as a lump sum directly to the recipient.

All scholarship recipients are required to report on their activities.

Improving the digital experience
Planning is underway for the development of a dedicated online platform that will enable streamlined applications, selection, recipient reporting and administration. Importantly, the platform will allow RACS to improve the delivery, monitoring and evaluation of the program to steer the strategy for future success. The scholarships web pages are also being redeveloped with new search functionality, allowing easier navigation and updated content.

Promoting social inclusion and gender equity
A series of affirmative actions are being implemented to encourage equity and diversity in our processes and communications.

Boosting our marketing and promotion
Our marketing and promotion efforts will be boosted as we include multimedia to promote scholarships through our partner networks, social media and online. This will raise the program's profile and encourage high-quality applications.

Research Scholarships, Grants and Fellowships

Research applications open 1 March and close at midnight ACST 12 April 2021.

Are you thinking of undertaking research in 2022? The Scholarships and Grants Program is offering the following research opportunities.

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

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

In August 2021, learning and development grants will be advertised and open to submit applications.

Advertised opportunities are an initial guide only. Please visit the RACS scholarship website (surgeons.org/scholarships) for detailed information. The values of these awards are in Australian dollars and are for a tenure of one year unless otherwise stated. Where a higher degree is required, it is for a Masters, PhD or the equivalent, or as indicated. Early-career surgeons are Trainees or Fellows within 10 years of obtaining Fellowship. FRACS applicants may apply where eligible for all opportunities listed for Fellows, providing they can provide evidence of completing all Fellowship requirements by 1 December in the year of application. SET applicants may also apply where eligible, providing they can provide evidence of acceptance into the SET Program by 1 December in the year of application.

John Mitchell Crouch Fellowship

$150,000

RACS' most prestigious scholarship, the John Mitchell Crouch Fellowship, is awarded to a Fellow who is making an outstanding contribution to the advancement of surgery or to fundamental scientific research.

Who can apply: RACS Fellows who have obtained their Fellowship (or comparable overseas qualification) since 2006, and are currently working in their field with the intention of using this Fellowship to assist continuation of this work.

Tour de Cure Cancer Research Scholarship

$125,000 (the scholarship will fund $100,000. Recipients are required to gain co-funding of $25,000 from their research department.)

Raises funds for cancer research through cycling and other events, supported by the Foundation for Surgery and Tour de Cure.

Who can apply: RACS Fellows, SIMGs, SET and Trainees.

Academy of Surgical Educators Research Scholarship

$10,000

Supports research into the efficacy of existing surgical education or innovation of new surgical education practices.

Who can apply: RACS Fellows, SIMGs, SET Trainees and SET applicants.

Brendan Dooley and Gordon Trinca Trauma Research Scholarship

$14,000

Encourages research into the prevention and treatment of trauma injuries.

Who can apply: RACS Fellows, SIMGs, SET Trainees, SET applicants and medical scientists who have not previously received this scholarship.

Catherine Marie Enright Kelly Memorial Research Scholarship

$66,000

Supports surgeons and Trainees to take time away from clinical positions to undertake a research project.

Who can apply: RACS Fellows, SIMGs and SET Trainees enrolled (or intending to enrol) in a higher degree.

Eric Bishop Research Scholarship

$66,000

Supports surgeons and Trainees to take time away from clinical positions to undertake a research project focusing on medical research.

Who can apply: RACS Fellows, SIMGs and SET Trainees enrolled (or intending to enrol) in a higher degree.

MAIC-RACS Trauma Research Scholarship

$66,000

Established with a grant from the Queensland Motor Accident Insurance Commission (MAIC) and matched by the Foundation for Surgery to support trauma research in the areas of epidemiology, prevention, protection, rehabilitation and immediate or definitive management in trauma. The potential benefits flowing from the research must assist Queenslanders.

Who can apply: RACS Fellows, SIMGs and SET Trainees.

Margorie Hooper Scholarship

$65,000 plus $10,000 accommodation and travel expenses

Enables successful applicants to either travel overseas to learn a new surgical skill that will benefit the South Australian community (preference), or to undertake postgraduate studies and reside temporarily outside South Australia. It is mandatory for the recipient to make a presentation at the South Australia, Northern Territory and Western Australia Annual Scientific Meeting in the year following the conclusion of the scholarship.

Who can apply: RACS Fellows, SIMGs and SET Trainees who reside permanently in South Australia.

Surgical Education Research Fellowship

$77,000 per annum for up to two years

Offered in partnership with the Southeastern Ontario Academic Medical Organization and may be used to fund travel, accommodation and living expenses. In addition, tuition and related expenses are funded by Queen's University. The commencement date of the degree is determined by Queen's University within 18 months of being awarded.

Who can apply: RACS Fellows who intend to enrol in a Master's Degree in Health Professions Education Program at the faculty of Health Sciences, Queen's University, Canada.

James Ramsay Project Grant

$88,000 per annum for up to two years

Supports innovative projects or the purchase of state-of-the-art equipment.

Who can apply: RACS Fellows, SIMGs and SET Trainees, applying as either an individual or as the lead researcher in a group. SET applicants are ineligible for this grant.

John Loewenthal Project Grant

$100,000 per annum for up to two years

Supports surgeons and Trainees to undertake a surgical research project or to fund an innovative service or piece of equipment.

Who can apply: RACS Fellows, SIMGs and SET Trainees, applying as either an individual or as the lead researcher in a group. SET applicants are ineligible for this grant. Previous recipients can only receive this grant once.

Foundation for Surgery Research Fellowship

$66,000 per annum for up to three years

Supports Fellows to take time away from clinical positions to undertake a research project. Preference will be given to early-career Fellows.

Who can apply: RACS Fellows.

Foundation for Surgery Research Scholarship

$66,000

Supports surgeons and SET Trainees who wish to take time away from clinical positions to undertake a research project.

Who can apply: RACS Fellows, SIMGs and SET Trainees enrolled (or intending to enrol) in a higher degree.

New Zealand Research Scholarship

$66,000

Assists New Zealand-based surgeons and Trainees to undertake a research project.

Who can apply: New Zealand RACS Fellows, SIMGs and SET Trainees residing in, and who are citizens or permanent residents of, New Zealand. Applicants must be enrolled (or intending to enrol) in a higher degree.

Paul Mackay Bolton Scholarship for Cancer Research

$66,000 per annum for up to two years

Supports a surgeon or Trainee to take time away from a clinical position to undertake a research project on the prevention, causes, effects, treatment and/or care of cancer. Preference may be given to projects that are likely to have clinical relevance within a relatively short period, applicants currently working in Queensland or Tasmania, enrolled (or intending to enrol) in a higher degree, and early-career surgeons.

Who can apply: RACS Fellows, SIMGs and SET Trainees.

Peter King Research Scholarship

$66,000

Preference will be given to applicants whose research topic is relevant to surgery outside metropolitan areas and early-career academic surgeons.

Who can apply: RACS Fellows, SIMGs and SET Trainees, enrolled (or intending to enrol) in a higher degree.

Professor Philip Walker Vascular Research Scholarship

$20,000

Supports vascular surgery research.

Who can apply: RACS Fellows, SIMGs and SET Trainees, enrolled (or intending to enrol) in a higher degree with research related to vascular surgery.

Reg Worcester Research Scholarship

$66,000

Supports research, preferably with relevance to the surgical care of patients.

Who can apply: RACS Fellows, SIMGs and SET Trainees, enrolled (or intending to enrol) in a higher degree.

Senior Lecturer Fellowship

$132,000 per annum for up to two years. RACS will fund $66,000, and the applicant's Academic Department will be required to co-fund to the same amount ($66,000)

Provides salary support for a Fellow, early in their career, to assist them in establishing themselves in an academic career in surgical research and education. The Senior Lecturer position is defined as working up to 50 per cent clinical load and the remainder in research and teaching.

Who can apply: RACS Fellows. Preference will be given to those enrolled (or intending to enrol) in a higher degree.

Small Project Grant

$10,000

For a surgeon or Trainee who wishes to undertake, or is already undertaking, a small clinical or research project or who requires some funding to purchase equipment to carry out a research project. Up to four grants will be awarded. Previous recipients can receive this grant up to four times.

Who can apply: RACS Fellows, SIMGs and SET Trainees.

Sir Roy McCaughey Surgical Research Scholarship

$66,000 per annum for up to three years

For RACS Fellows, SIMGs and SET Trainees enrolled (or intending to enrol) in a higher degree undertaking research in New South Wales

Who can apply: RACS Fellows, SIMGs and SET Trainees.

Surgeon Scientist Research Scholarship

$77,000 per annum for up to three years

Assists surgeons and Trainees to undertake their PhD.

Who can apply: RACS Fellows, SIMGs and SET Trainees enrolled (or intending to enrol) in a PhD. SET applicants are ineligible for this scholarship.

Herbert and Gloria Kees Scholarship

$66,000 per annum for up to three years

Supports the advancement of surgical research, technologies, techniques and treatments.

Who can apply: Early-career RACS Fellows, SIMGs and SET Trainees.

Applications close midnight ACST 12 April 2021■

Additional information can be found at surgeons.org/scholarships. For any other queries, please contact the Scholarships and Grants Team on +61 8 8219 0924 or at scholarships@surgeons.org.

Royal Australasian College of Surgeons
Foundation for Surgery

Establish your own named perpetual scholarship

Would you like to start your own scholarship or grant in your area of passion or speciality?

You can establish your own grant to change lives and see the results of your philanthropy in your lifetime. Please call Jessica Redwood, Manager, Foundation for Surgery, on +61 3 9249 1110 or email foundation@surgeons.org today.

RACS Post Op podcasts

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

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

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

Listen on iTunes

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

Listen on Stitcher

Search 'RACS Post Op Podcast' on stitcher.com

Good reads

Cut with Conviction

Mr Mike Damp

The cheetah had been disrespectful of his grandchildren... Enough reason for a 40 kilogram, 1.4metre tall Bushman grandfather to track down and kill a ferocious predator with a stabbing spear in solitary combat in the Kalahari Desert, only to suffer near fatal injuries himself.

This was one of many such patients confronting Mr Mike Damp in this wonderful tale of a world that now seems so impossibly far away – a heady mix of one man's adventure through the sort of medical and cultural challenges few modern-day western physicians would ever expect to encounter.

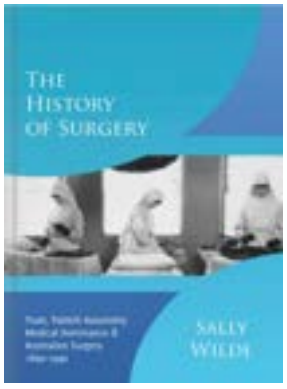
This is a story of perseverance and great dedication as well as a reflection of how man's best intentions and tireless efforts can so easily turn to dust and decay. But above all, *Cut with Conviction* is a love story; the despairing love for a continent and its people fast being reclaimed by a heart of darkness as unstoppable as the forces of nature that both nurture and destroy as it washes over the vast plains and rivers and mountains of a lost paradise.

Then there is the mix of exhilarating joy and sheer terror in a flying doctor's life in Zululand, of transporting critically ill patients in all weather conditions over some of the most inhospitable terrain, often with little or no navigational aids, while a fellow doctor, seated next to the patient in the cramped space of a small plane desperately tries to keep life going with the aid of basic life-support equipment.

Africa is a land of unique and rare beauty that mystifies many with its great contradictions. This story unfolds during the apparent stability of grand apartheid and the turbulent times during its collapse and aftermath. *Cut with Conviction* is a must-read for all who love adventure, medical issues, flying, travel and Africa.

The History of Surgery

Sally Wilde

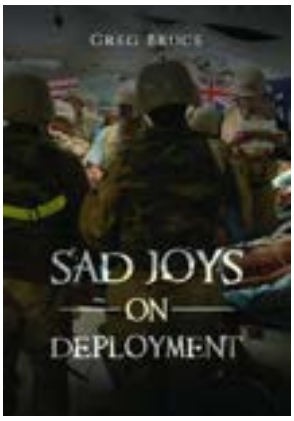


Why do we trust surgeons? After all, allowing strangers to work on our unconscious bodies with knives requires an enormous leap of faith. How have we come to believe that surgeons will act in the best interests of our health, rather than in the best interests of their wallets?

This unconventional history of surgery charts the early twentieth century transformation of public attitudes from 'buyer beware' to 'doctor knows best,' as surgeons invented traditions appropriate for gentlemanly, and occasionally ladylike, but above all trustworthy, experts.

Sad Joys on Deployment

Greg Bruce



A civilian surgeon is taken from his routine practice in Sydney, Australia, and finds that military surgery in war zones distressed by civil war, humanitarian disasters and battlefield conflict is very different from the comforts of home and civilian surgery. This book describes:

- The challenges of military surgery
- Surgery for combat wounds
- Differences in treatment for friendly forces, enemy forces and local civilians
- Conditions during the deployment – accommodations, meals, keeping healthy
- Travel to and from the deployment
- The good and bad, the satisfying and distressing aspects of immersion in a war-zone
- Relationships with the friendly and unfriendly, the helpers and the resisters
- Interaction between local civilians and visiting military
- Military and cultural tourism
- Adjusting back home

Donegal's Atlantic Way

Michael Sugrue

Donegal's Atlantic Way is a 208 page coffee table photographic book of over 200 images capturing's Donegal's beauty combined with a new collection of 25 poems. The pictures tell a story of the unfolding of the day from dawn to dusk and beyond in Donegal's hinterland in the Northwest of Ireland.

The poems are for most part linked to the photographs. Through combinations of light, lines and lyrics this book is a must for those who love nature and its rhythm. The production is the end result of eight years labour of love by Michael Sugrue. The introductions from Donegal's Nobel Laureate in Medicine and Physiology, Professor William Campbell, and Donegal's favourite son, Mr Daniel O'Donnell, set the scene for the illustrated poetic journey that awaits you.

With Pauline, his other half of 36 years, Michael has walked, cycled, climbed, crawled or kayaked nearly every part of Donegal. Originally a Galway man, known to speak a "cúpla focal" or "giota beag", he is forever torn trying to bypass beautiful locations to get to an end photographic destination in Donegal. Michael likes to surf at Ballymastocker Bay Fanad and says the waves are at times too imaginative for him! He just loves the sea, especially if his four boys are home.

Mr Sugrue was inspired by North West Words poetry group to put pen to paper. He is grateful to many who have helped on this eight year journey: his literary editor Gerard Beirne and photographic mentors Eimhear Collins and Rodney O Callaghan. Donegal County Council and local business have supported the project and the income raised from *Donegal's Atlantic Way* will be donated to three charities, Donegal Mind Wellness, Letterkenny Hospice and Breast Centre Northwest Research and Development.

Michael hopes the book can do justice to some of those magic moments he had capturing them.

Introducing the new refreshed look of your benefits platform.

Providing RACS members real-time discounts and offers, your benefits platform has recently refreshed its design. Explore the improved access to your savings and recently launched new benefits!

All your shopping needs including real-time and fast access to discounted e-gift cards, whitegoods, and electronic accessories.

New vehicle offers and corporate programs at Tesla, BMW and more

Accommodation, tours, airline lounges and more travel benefits for as business travel returns.

Dedicated brokers for insurance needs, from health and life to income protection.

Financial offers on international money transfers, financial planning and credit cards.

surgeons.memberadvantage.com.au

Royal Australasian College of Surgeons

Member Advantage

For more information
e: customercare@memberadvantage.com.au
ph: 1300 853 352.

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.

James T Cummins
John A B Hokin
Jacob Johannes (John) de Geus
John Hunter Williams
G E Scarff
P A Rogers
David Cull
Ronald Geoffrey Kay
Patrick John Molloy
G K Williams
R N Westmore
D Ch Healey
J H Alexander
C D Lewis

Informing RACS

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

ACT: college.act@surgeons.org
NSW: college.nsw@surgeons.org
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

Mr John Andrew Baird Hokin FRACS
Plastic and reconstructive surgeon

28 November 1936–29 December 2020

John Hokin was a prominent Adelaide plastic surgeon, whose career spanned 50 years. He is remembered for his talent as a surgeon, his generosity as a teacher, and his innovative approach to making plastic surgery more easily available to his patients.

In the mid-1990s he pioneered the concept of free-standing day surgeries for plastic surgery in South Australia, saving patients the inconvenience and the costs of an overnight stay in hospital.

John was a country boy born in the small South Australian town of Balaclava, 90 kilometres north of Adelaide. He was the eldest of four children. Both his parents were teachers, which meant the family moved from country town to country town for several years. He attended Victor Harbor High and then moved on to Adelaide High School.

Richard Hamilton MBBS FRACS

Jacob Johannes (John) de Geus
FRCS FRACS
Plastic and reconstructive surgeon

6 July 1940–20 October 2020

John was born in the Dutch East Indies in 1940, to Dutch parents who were missionary teachers. The Japanese invaded in 1942 and John and his family spent the next three years in Japanese Internment camps (John and his mother and sister were imprisoned separately from his father). They endured significant hardship, to say the least. After the 1945 liberation of what would become Indonesia, John and his family returned to The Netherlands; subsequently they were part of the large Dutch emigration to New Zealand in the 1950s.

They spent time living in Whitford and Taupaki, but settled in West Auckland where John attended Avondale College. Despite speaking no English on his arrival in New Zealand, he worked very hard and excelled in both sporting (he was a champion swimmer) and academic fields. John attended Otago University graduating MB ChB in 1964. He spent his house officer years in Wellington, obtaining basic surgical training, and married Ros Allen. Having decided on a career in surgery, he travelled to England for further surgical training gaining his FRCS (England) in 1971.

Cary Mellow FRACS

John Hunter Williams
FRCS, FRCS(Ed), FRACS
Plastic and reconstructive surgeon

26 June 1925–20 November 2020

John Hunter Williams was born at Wharewhitu Private Hospital in Dannevirke. His father, Charles Skinner Williams, was an Orthopaedic and General Surgeon (who was also involved in veterinary Orthopaedics) in the Manawatu area. He was given the name John Hunter in memory of the 18th century Scottish anatomist-surgeon from St Bartholomew's, who along with his brother, William Hunter, was a famous anatomic and surgical pioneer (and possible grave robber) – thus John's fate was sealed – he just had to become a surgeon.

Charles 'retired' from surgical practice in Palmerston North and became a Surgeon and general practitioner in the Far North, based at Kaeo Hospital. Thus started a love of the Far North for John. John attended Hadlow Preparatory School in Masterton (he was one of 18 pupils). As a teenager he contracted polio and was left ith left sided weakness; he was able to recover sufficiently to study at Whanganui Collegiate.

He took up study at Dunedin staying at Selwyn College (his father Charles had been at Knox).

Cary Mellow FRACS

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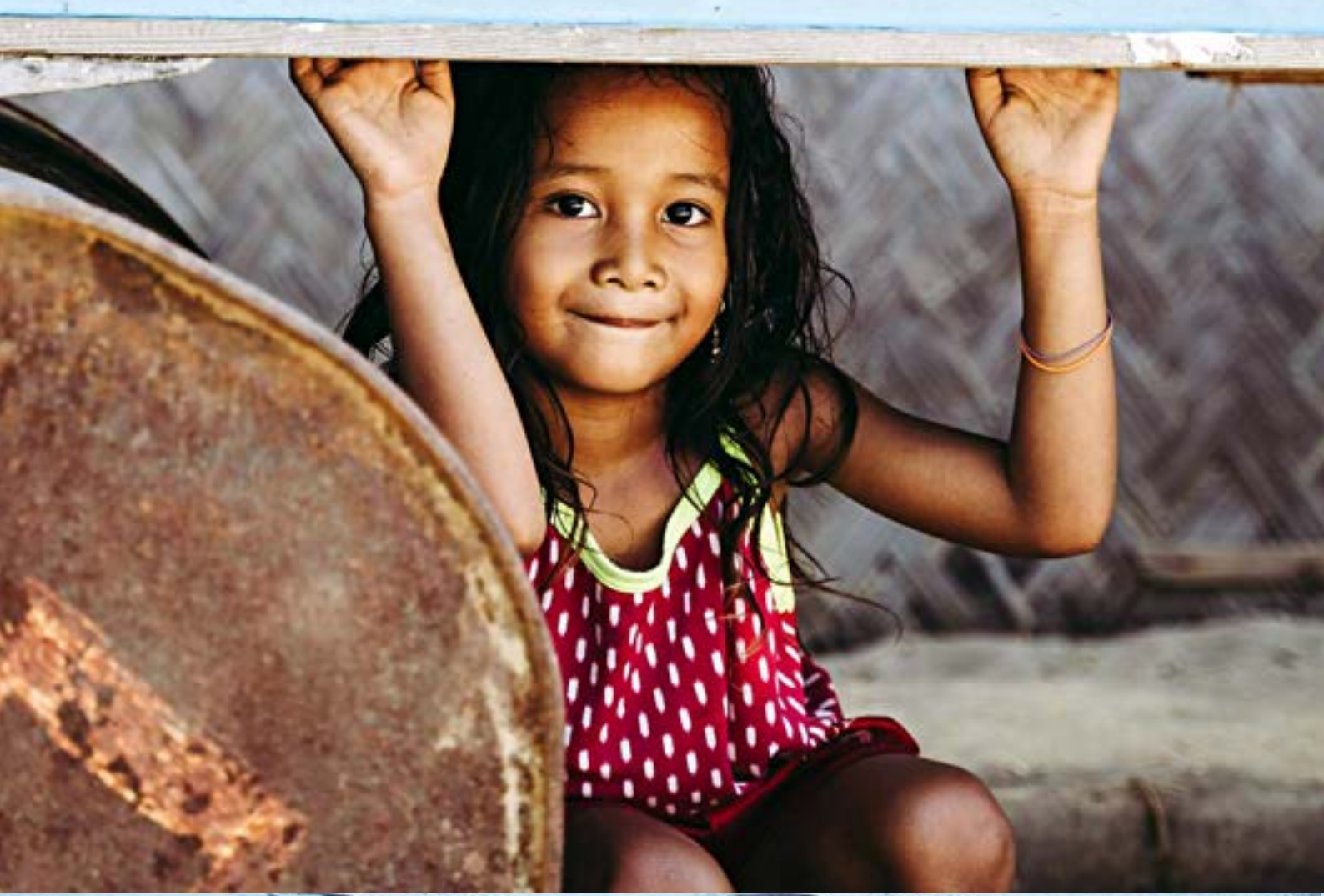

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