SurgicalNews

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surgeon celebrates 100th birthday

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A fresh perspective on
rural practice

Royal Australasian
College of Surgeons

SAVE THE DATE

2022 SA, NT & WA ANNUAL SCIENTIFIC MEETING

Friday 26 - Saturday 27 August 2022

Artificial Intelligence in Surgery Superpower or Peril?

Confirmed topics include:

Artificial Intelligence in Surgery: Current Practices

Digital Health: The Future of AI is Brain Computer Interface

The Future of Healthcare is Bigdata: Traditional Database and Registries vs. Bigdata and Blockchains for Surgical Care

Confirmed topics include:

Professor Caroline McMillen: Machine learning & advanced technology appplications

Dr Lauren Oakden-Rayner: AI in health systems - what could possibly go wrong?

Professor Christopher Pyke: Vice president's address

Honourable Chris Picton: Securing a technologically advanced workforce for SA

Dr Michael Cusack: AI in health systems - what could possibly go wrong?

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Cover: Dr Durham Smith: RACS Presidential portrait.

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President's perspective

Our health systems are under stress. The continuation of COVID-19 and the early onset of the influenza season in our winter are resulting in a huge surge of patients presenting to primary care and hospitals around Australia and Aotearoa New Zealand.

We also continue to have staff shortages with many health workers either sick, on furlough or in need of a break from the relentless demands on them. Workforce availability will continue to be a challenge for some time to come.

As a result of these, many hospitals are making the difficult decision to defer surgery, including urgent category-one procedures in Australia. In some regions of Aotearoa New Zealand, everything except urgent, non-deferrable surgery is on hold in public hospitals; whereas private surgery continues depending on staffing levels. Many primary care clinics in Aotearoa New Zealand are reporting that they are understaffed and patients are struggling to get appointments. We are seeing a definite increase in the use of telehealth consultations and this will certainly be the way of the future. We as surgeons must remember that we can undertake many of our consultations by technology assisted methods and this has the benefit of less travel for patients and possibly shorter consultations for the surgeon.

I hope that we will once again overcome these pandemic challenges as spring comes and the warmer weather hopefully minimises the spread and impact of COVID-19 and influenza.

On a more positive note, RACS Council approved the Aotearoa New Zealand Regional and Rural Health Equity strategy, which focuses on tailoring solutions to address the country's specific issues and apply a Māori health lens as per the principles outlined in Te Tiriti o Waitangi (The Treaty of Waitangi) and Te Rautaki Māori (RACS Māori Health Action Plan). This is supplementary to the College's Rural Health Equity Strategy, which has successfully been running activities in both countries for the past 18 months. The strategies aim to improve health equity for remote, rural and regional or provincial people in our countries by increasing the surgical workforce and building sustainable surgical services in these areas. Promoting rural equity is a key priority in the College's strategic plan and we have asked for rural representation on all RACS committees and the inclusion of a rural health equity standing item on all relevant agendas.

I recently participated in the Urological Society of Australia and New Zealand's (USANZ) annual scientific meeting held at the Gold Coast in Queensland. It was an impressive well attended event with excellent education sessions and many

national and international presenters. I noted that all Trainees in urological surgery were required to attend and there was a significant urological nurses conference. Well done, USANZ. Our vice president Professor Chris Pyke and I look forward to attending more specialty society scientific meetings and we regret not being able to attend all of them.

In June, we celebrated two significant events in both of our countries. In Aotearoa New Zealand, we had our first ever Matariki public holiday. Matariki celebrates the Māori New Year, a time for celebration, growth and renewal and for communities to come together. It also symbolises the government's willingness to acknowledge events and celebrations of importance to Māori.

In Australia we also celebrated NAIDOC Week and held several events at the College to remember the history, culture and achievements of Aboriginal and Torres Strait Islander peoples.

I would like to mention that World Sepsis Day is on 13 September. The major health problem of sepsis is a concern to all of us in medicine including all of our surgical specialties. Recently at June Council we approved the Australian Commission on Safety and Quality Health Care ACSQHC Sepsis Clinical Care Standard 2022 (Australia). Aotearoa New Zealand also has standards for sepsis care based on the National Institute for health and Care Excellence (NICE) guidelines 2016 (bit.ly/3S5juT6). This is part of the National Sepsis Program (Australia) which aims to improve early recognition, treatment, outcomes and post-discharge support for people at risk of or diagnosed with sepsis. I encourage you to look at the guidelines.

I have many people to congratulate and will start with our new Fellows who have joined the College. Welcome and congratulations on your achievement. I encourage you to be active members of the College by learning more about what we do and volunteer for one of our many initiatives we have.

Souella Cumming

My warm congratulations also to our recipients of the 2022 Queen's Birthday Honours, including Souella Cumming, our Aotearoa New Zealand Expert Community Advisor.

I would like to welcome our incoming chair of the Younger Fellows Committee, Dr Shehnarz Salindera.

Congratulations also to our three elected 2023 rotating members of Council Executive: Professor Mark Ashton, Dr Christine Lai and Professor Owen Ung who will join Council Executive in January 2023 for a period of 12 months. I look forward to working with you all.

On a final note, I would like to extend my warmest birthday wishes to Dr Durham Smith who this year celebrated his 100th birthday. What a momentous milestone! Dr Durham Smith is a past president of the College and is one of those names that have always stood out. I remember doing my elective in paediatric surgery as a sixth-year medical student at the Royal Children's Hospital in Melbourne where he was based. Please take time to read his story on page 10 and learn more about this amazing surgeon and leader.

Dr Sally Langley
President

Vice president's perspective

Our most recent Australian elections have reinforced the importance of leading a sustainable future for surgery in both our countries. Through the Health Policy and Advocacy Committee, sustainability remains high on the College's agenda. We have several cross-college alliances on climate change and environmental sustainability. We also look forward to adopting the Green College guidelines for the ongoing business of the College – both at RACS offices and how we conduct our courses.

Another lens on our sustainability is the sustainable workplace. Our attention will be focussed on the Building Respect, Improving Patient Safety initiative, where an operational group has now formed to advance the agenda outlined in the Expert Advisory Group Review of the initiative. The awareness to action momentum will address the domains of discrimination (in all its forms), feedback culture and leadership in the action plan. The leadership framework of the action plan will be particularly interesting. Leadership as an everyday activity may assist in building resilience and preventing burnout in clinicians. It may explore how experiential learning can be as nourishing and formative as it is summative.

Continuing with the sustainability theme, we have been actively advocating with governments of both countries and all states and territories in the sustainability of private practice. COVID-19 restrictions have affected both public and private health spheres in different ways. We are expecting a large period of catch up after the pandemic surges become less frequent. The community will need healthy and buoyant health systems, both public and private to ensure sufficient flexibility.

I had the pleasure of attending, on the president's behalf, the Australian and

We have several cross-college alliances on climate change and environmental sustainability. We also look forward to adopting the Green College guidelines - for the ongoing business of the College, both at RACS offices and how we conduct our courses.

New Zealand College of Anaesthetists (ANZCA) Council meeting. I enjoyed spending time with my colleagues and discussing the crossover we share in education, policy, culture, global health and the many areas in which we serve our communities.

At the College, the formation of a Global Health Steering Group and a scholarship panel in global health will see us well positioned. Fellows will fill key roles in these areas, and there will be increased fellowship representation on the International Engagement Committee. These improvements will also build local capacity in the communities we serve in the Asia-Pacific region.

My congratulations to the RACS East Timor Eye Program (ETEP) on its 20th anniversary. The program, which was started in 2000 by Dr Nitin Verma and supported by DFAT, has achieved significant milestones, including training dozens of ophthalmologists who have helped recover the sight of thousands of Timorese patients. It is pleasing to see that now surgical clinics are conducted by East Timor health professionals. My thanks go to Dr Verma, the East Timor government, DFAT and the many RACS staff and volunteers who have helped make this program such a success.

We are celebrating the program's anniversary with a special book titled the *East Timor Eye Program*. The book is available for sale so please purchase a copy and support (https://bit.ly/3uliBvo).

Another matter that has occupied my thoughts is the issue of the proposed name change for the College. It is fair to say that this has uncovered more questions than answers. Council has decided to defer the vote on the proposed name change to allow time for more education and communication.

We received an avalanche of feedback following my email to you in June, with reflective comments around how Māori has become an officially recognised national language, how the acronym RACS has a euphonic and attractive brevity, and whether the Royal should also be considered, among other issues. Please take time to read the article on page 9 from our Māori Advisory Committee.

On another matter, I'd like to mention that the College's governance principles are under continous review by Council. There is an ongoing need for streamlining and renewal for our structures. It has become obvious, however, that even the nomenclature of committees can create hidden barriers to the engagement of Fellows and can perpetuate power differentials where none should exist. Worse, they can promote a perverse autonomy of some groups within the College governance tree. Some of these names merely reflect their history.

Modern governance principles and the *Corporations Act 2001 (Cth)* require us to correct some of these discrepancies. Council approved the transition towards standardisation of naming conventions. For example, all existing RACS boards will be re-named as committees. The names of training boards will remain unchanged for now, but we will have a transition plan to change this in due course. Council also agreed that the Court of Examiners will remain as a court.

I am pleased to announce that the recently released *ANZ Journal of Surgery* Impact Factor for 2021 is 2.025, an increase on last year's figure of 1.872. This places the journal at 131/211 in the surgery category (up from 144/211 last year). The impact factor is a measure of the frequency with which the average article in a journal has been cited in a particular year. Congratulations to the team on this result.

We must be doing something good in the publication space as I am also delighted that *Surgical News* has been receiving compliments from many of you. We will continue to keep the content interesting, engaging and useful.

Professor Chris Pyke
Vice president

news in brief

Matariki holiday in Aotearoa New Zealand

On Friday 24 June, the country celebrated the Māori New Year with the first ever Matariki public holiday.

Matariki is the most significant celebration in the traditional Māori calendar, occurring when the Matariki star cluster—otherwise known as Pleiades—rises in mid-winter.

It is a time of remembrance, celebration and planning for the future. Whānau (family and friends) traditionally gather to share food and celebrate.

Matariki was made an official public holiday in April 2022. It is only the fifth piece of legislation drafted in both te reo Māori and English.

Here is a summary of the Matariki celebration (bit.ly/3Pl88br).

Bowel screening age drop for Māori in Aotearoa New Zealand

Since 2017 Bowel Cancer NZ has been calling for Māori and Pasifika to enter bowel screening from the age of 50.

Starting 2023 the bowel screening for Māori and Pasifika will be lowered from 60 years to 50 years. This will fix long-standing inequities because compared to non- Māori, a greater percentage of bowel cancer occur before the age of 50 for these ethnicities.

The government initiative will be rolled out in selected regions in 2022 to assess participation rates before being rolled out nationally from July 2023.

Find out more: https://bowelcancernz.org.nz/new/bowel-screening-age-for-maori-and-pasifika-lowered/ (bit.ly/3ItU0PP).

Online approval for PBS medicines

Services Australia has been working with the Department of Health to increase the number of Pharmaceuticals Benefit Scheme (PBS) items that can be approved in 'real time' using the Online PBS Authorities System.

From 1 July 2022, prescribers can submit certain Authority Required (written) PBS medicines on the schedule using the online system. Over time, more written PBS medicines across broader medicine groups will be added to the system for 'real time' approval.

Services Australia will work with the Department of Health to update the relevant PBS listings as quickly as possible and will share information as it becomes available.

Over the next two years, Service Australia will also be working to improve the system's digital capability and support the transition of Authority Required (written) medicines for online access.

Recipients of the 2022 Queen's Birthday Honours

Officer (AO) in the General Division of the Order of Australia

Professor Peter Fook Meng Choong AO FRACS: orthopaedic surgeon, Victoria

Member (AM) in the General Division of the Order of Australia

Emeritus Professor Marcus David Atlas AM FRACS: otolaryngology head and neck surgeon, Western Australia

Professor Graham David Barrett AM FRACS: ophthalmologist, Western Australia

Emeritus Professor Leigh Walter Delbridge AM FRACS: general surgeon, New South Wales

Dr Meron Edith Pitcher AM FRACS: general surgeon, Victoria

Dr Patricia Margaret Davidson AM FRACS: paediatric surgeon, New South Wales

Medal (OAM) in the General Division of the Order of Australia

Dr John Darrien Griffiths OAM FRACS: orthopaedic surgeon, Victoria

Clinical Associate Professor Lilian Kow OAM FRACS: general surgeon, South Australia

Dr David Clifford Moore OAM FRACS: ophthalmologist, New South Wales

Dr David Speakman OAM FRACS: general surgeon, Victoria

Dr Christian Scott Sutherland OAM FRACS FRCSEd: general surgeon, Victoria

Recipient(s) of the 2022 New Zealand Queen's Birthday Honours

Officer of the New Zealand Order of Merit (ONZM)

Professor Francis Antony Frizelle ONZM FRACS: general surgeon, Christchurch

Ms Souella Maria Cumming, DStJ: Aotearoa New Zealand Community Advisor

Why we need a name change for the College

Kia ora

We are a bi-national College and the current name of our College does not represent this. Many surgeons from Aotearoa New Zealand understand what it is like to be introduced internationally as being from the Royal Australian College of Surgeons.

Many of us on this side of the ditch would like to have our role in the College recognised. This is not the first time we have had a referendum on a name change for our College, and it may not be the last.

What is and where is Australasia? The New Zealand Oxford Dictionary gives two meanings of Australasia. One of these is: Australia, New Zealand, New Guinea, and the neighbouring islands of the Pacific. Exactly which islands are not known. Other definitions include Melanesia and parts of the Pacific. None of this reflects our binational College.

Aotearoa is a well-recognised name for our country. It is used in the United Nations and is the name Māori use in international Indigenous forums throughout the world. It is on our bank notes and in our passports. No matter what other name we call it, the first name of our country will always be Aotearoa. This name was gifted by the first navigators to discover this country—at first just for the North Island—but now accepted to mean the whole country.

When Hinewehi Mohi first sang our national anthem in Māori before the opening match of the 1999 Rugby World Cup at Twickenham, there was such an outpouring of anger that anyone would dare sing the national anthem in Te Reo Māori. However, in the years that have passed, most see this as a 'Gallipoli' moment when we grew as a country and Te Reo Māori has become an integral part of life in Aotearoa New Zealand with increasing numbers of both Māori and non-Māori accepting the challenge to learn.

Te Reo is now part of official government documents and recognised as an official language of Aotearoa New Zealand reflecting a growing pride that our country is built on the twin foundations of the best of contemporary achievement and an older, but no less valuable, Mātauranga Māori knowledge. Many other countries have now followed us in recognising the preciousness of their Indigenous languages, such as the Wallabies singing Advance Australia Fair in Eora before a tri-nations test against Argentina in 2020.

Our College has made a concerted effort to improve health outcomes for all. We all know and understand that some groups do not have the same outcomes as others. A significant and ever-increasing breadth of literature has found that we, as doctors, are playing a significant role in maintaining health inequities. We accept, or feel we are powerless to alter the status quo. We all have biases that we don't know we have and we, as a group, give and accept poorer outcomes for our Indigenous populations. This must change.

We can no longer accept the status quo. To have an equal society we must create one. We need to support changing the status quo and partnering with Māori to improve this College for everyone.

Including Aotearoa New Zealand in the College's name is a significant step towards this, acknowledging both the history but also the future of both our nations. It represents equity, it represents a partnership between our ancestors, and the making of a future for our descendants.

Between our two countries we have done many great things first–women's suffrage, the pacemaker, splitting the atom, inventing WiFi, even winning the Rugby World Cup. It takes time, hard work and courage to change the status quo.

The College of Surgeons has an opportunity to lead global medical organisations by unequivocally including and acknowledging the significance and importance of Indigenous values and status in their name—clearly defining whom they serve and represent. This would be an international first and reflect the forward-looking innovation, which has always distinguished our College. To not do so is to risk being left behind.

The integration of Māori and non-Māori customs and methodologies is already well underway in Aotearoa New Zealand. It's not whether it will happen—it already is—in cabinet, the boardroom, business, health, education, sport, the arts, street signage, even product labelling.

We support the new name for the College to represent all of us and our commitment to leadership in health and all the communities we serve: The Royal Australian and Aotearoa New Zealand College of Surgeons.

Māori Health Advisory Group
Dr John Mutu-Grigg - Chair
Associate Professor Jonathan Koea
Dr Ben Cribb
Dr Ben Wheeler
Dr Alison Scott

Surgeon celebrates his 100th birthday

Durham Smith AO, MB BS, MD, MS, FRACS, FACS

Born in May 1922, Edward Durham Smith, ex-president of the RACS from 1987 – 1989, recently celebrated his 100th birthday.

He was born in Sunderland, the port city close to the cathedral city of Durham in northern England to Australian parents. In 1922 his father, an Anglican minister, was undertaking post-graduate studies at Durham University, and the name 'Durham' was suggested by the attending nurse at his delivery. The family returned to Australia when Durham was a few months old.

Durham did his schooling in Terang, in the western district of Victoria, with the last four years on a scholarship to Melbourne Grammar School.

"I had a happy childhood; I just had no sense of boredom during that time," Durham says. "There were lots of things to do—roller skating, fishing in the local creek, swimming nude in the lakes, and all the usual things that boys did."

Leaving school in 1940, he intended to study medicine, but was interrupted by the army service in WWII. He completed his MBBS from Melbourne University in 1948. Durham describes the 20 years from 1940 to 1960 as "decidedly a mess".

After interning for a year at The Alfred Hospital in Melbourne, in 1949 his career was again interrupted as he contracted tuberculosis (TB)—a common illness at the time among residents and nurses.

"'You need an easy job for a couple of years just to let things consolidate,' I was told, so I spent those two years in sanitoria work looking after TB patients," Durham says.

"I felt perfectly well by that stage; and indeed, not only feeling well but bored to tears because the job took about two hours a day. That changed my career because I didn't do very well in the course, it was interrupted, and I went back to studies and completed all my surgical training at The Alfred Hospital in general surgery. I got my Fellowship in 1956."

On recovery, surgical training occupied the next decade—a year at the University Anatomy Department, a return to the Alfred as surgical registrar, completing a General Surgery FRACS in 1956, and post-Fellowship training in both Neurosurgery and Paediatric Surgery at the Alfred and Royal Children's Hospital (RCH).

Durham went overseas in 1959, with Fellowship privileges at the Hospital for Sick Children in London and at the Children's Medical Centre at Harvard in Boston, USA.

From 1961 he confined his career to Paediatric surgery, both in public and in private practice. He continued as surgeon in the children's ward at the Alfred Hospital for nine years, with staff appointments at the RCH until 1987.

Durham conducted research sessions at the RCH, together with clinical work, in genito-urology, hypospadias, neurogenic bladder, and anorectal pathology. He also authored and co-authored several books—*Spina Bifida, Anorectal anomalies*, and *Congenital Anomalies of the Urinary and Genital Tracts*, the latter with John Hutson as editor for the second edition.

During his career he held honorary appointments at the Royal Women's Hospital and Mercy Maternity Hospital, which gave him access to babies with anomalies, both in life and at autopsy.

Sixteen years after acquiring his FRACS diploma, Durham began a 24-year long close association with the College. In 1972 he was elected to the Victorian State Committee and was appointed as an examiner for the FRACS in Paediatric surgery—an appointment he held for 11 years.

In 1978, Durham was elected to the RACS Council. Appointments those days were for four years, with a maximum re-appointment duration of 12 years. He served as the chair of the Court of Examiners for four years, chairman of the Board of Paediatric Surgery,

council representative on the Faculty of Anaesthesia (before the anaesthetists formed their own College), vice-president and president from1987 to 89—a position held by a paediatric surgeon for the first time.

"It was very apparent to me at that time when I was president that it was such a full-time position and it really was not possible to carry on a surgical clinical practice," Durham says. "I tried to do it, the first five or six months of being the president—I kept my private practice going as I had just retired from RCH as a public consultant and I simply couldn't do it.

"This was why we created the position of an executive director for Surgical Affairs– an appointment relieving the president of some of the administrative duties. This allowed future presidents to maintain at least some part of their practice and encouraged the appointment of younger presidents still in practice."

Following Durham's retirement from Council he was appointed as the inaugural executive director for Surgical Affairs from 1989 – 1992. He continued to serve the College as coordinator for the annual scientific conferences until 1996.

Durham said he was drawn and inspired to join the College due to its ultimate objective. "The College was altruistic, to seriously pursue the highest standards of surgery in each of its Fellows.

"It was a nice feeling to be part of that objective … it doesn't mean we felt we did great things, or that we did it well, but that was our objective."

Durham is credited for his efforts to amalgamate the specialist associations of surgery into the College. These associations were strong and had largely developed independently of the College. It was important that the profession remained united, and "that we learn from one another. This was achieved by accepting the training committees of the associations to be the basis of the boards of the specialties of the College. The amalgamation meant that the specialties held programs at the annual scientific congress, allowing the cross fertilisation of surgical experience."

Durham, a respected paediatric surgeon known for his courteous and caring manner, was awarded the Devine Medal, the highest honour the College bestows.

We congratulate him on achieving another important milestone.

Elizabeth Milford,
RACS Archivist

Images (clockwise from top left): Durham Smith at Lorne lookout, Victoria; Durham celebrating his 100th birthday with his sons; John Royle, Dorothy and Durham Smith; Durham Smith portrait in RACS archives.

Younger Fellows Forum 2022

The 2022 Younger Fellows Forum was held at the beautiful Cedar Creek Lodges at Mount Tamborine, Queensland.
It provided a unique opportunity for a diverse group of Younger Fellows (those gaining fellowship within the last 10 years) to meet and have a voice in shaping the future direction of the College.

Participants gained a greater understanding on the working of the College, made new friends in a relaxed environment, and had the opportunity to debate important issues facing surgeons in 2022 and beyond. Most importantly, the forum offered a unique opportunity for younger members of the College to collectively have a voice on important issues and present several collaborative recommendations to the College Council.

Participants came from diverse backgrounds. In addition to delegates from Australia and Aotearoa New Zealand, representatives from the US Association of Academic Surgery attended in person, and international Younger Fellows from College of Surgeons of Hong Kong and Thailand presented remotely.

We'd like to thank our gold sponsor IMEDCARE, and silver sponsor Ramsey Health Care for their support.

The 2023 Younger Fellows Forum will be held at the Adelaide Hills Convention Centre in Hahndorf, South Australia, from 28 – 30 April 2023.

If you are a Younger Fellow and want to be more involved in your College and shaping its future, we encourage you to consider attending and pencil the 2023 forum dates in your calendar.

Authors: Dr Rebecca Won and Dr Harsheet Sethi 2022 Younger Fellows Forum convenors

Aotearoa New Zealand steps into a new, healthier future

The Aotearoa New Zealand health service is undergoing its biggest shake up in 20 years.

The Pae Ora (Health Futures) Act came into force on 1 July and aims to improve public health by focusing on five key areas:

- providing more equitable outcomes by creating health services designed by and for Māori
- shifting the emphasis to illness prevention and supporting healthy lives
- ensuring greater access, experience, and outcomes
- innovating and using digital technology to improve service and patient support
- future-proofing the health workforce through planning and improved training and development.

Health NZ/Te Whatu Ora

One of the big shifts is the establishment of a national body to replace the 20 district health boards.

Health NZ is responsible for planning, delivery and oversight of all health services nationwide. It has also become the employer to the sector's workforce of around 83,000.

One of the key functions of Health NZ will be to end inequitable access and delivery of healthcare across the country.

RACS Fellow, Dr Andrew Connolly is playing a key role in this, chairing the Planned Care Taskforce, which is making recommendations on how to address long waitlists and end the so-called 'postcode lottery' that currently delivers varied wait times and access to healthcare to patients across the country.

Māori Health Authority/Te Aka Whai Ora

Alongside Health NZ sits the Māori Health Authority (MHA), tasked with improving outcomes for Māori through better access and service delivery.

The establishment of the MHA is a long-awaited nod to an urgent need to address shortened life expectancy of up to 10 years in some Māori and Pasifika communities.

Both Health NZ and the MHA will work alongside the Ministry of Health, which provides stewardship of the health system.

High expectations, with some reservations

The response to the reforms, which come with a NZ$500 million (A$455.8 million) price tag, has been generally positive and there are high hopes they will iron out the inequities in the current system, especially with regards to Māori and Pasifika health.

Many see the reforms as being patient-focused and applaud their emphasis on prevention rather than the 'ambulance at the bottom of the cliff' approach of the old system.

The establishment of the MHA has been particularly well-received, with many seeing it as a potential benefit to all vulnerable communities, not just Māori.

Some fear however, the centralised system will exacerbate inequities in provision rather than solve them by placing decision makers too far away from the communities they serve, stripping the regions of their voice.

Others warn the new system will fail to meet expectations unless funding and workforce issues are urgently addressed. It is being introduced at a time of significant health worker shortages and surging demand from the COVID-19 pandemic and winter illnesses.

The opposition National Party says the new Health NZ structure will lead to massive bureaucracy with no other health outcomes. It pledges to scrap the MHA if elected, saying there should be a single system focused on individual need.

Strengthening surgical systems

Dr Rennie Qin is passionate about better surgical support for communities facing inequities in health

Dr Rennie Qin (pictured above) is a General Surgery Trainee from Aotearoa New Zealand. She has recently completed a Paul Farmer Global Surgery research fellowship at the Program in Global Surgery and Social Change (PGSSC) at the Harvard Medical School and a Masters of Public Health at the Harvard School of Public Health as a Fulbright scholar.

Rennie's interest in global health stems from her experience growing up in Papakura, South Auckland. "Travelling to remote areas of Nepal, Philippines, and Aotearoa New Zealand during medical school, I saw the same inequities I had witnessed in my community. We were not well-off. My mum did odd jobs at the supermarket to make ends meet. With the privilege of my education, I wanted to give back. Coming from a multicultural community, I always defined my community not by geographic location but by our shared experience of inequity," she says.

At the PGSSC, Rennie worked to support five Pacific Island countries—Fiji, Vanuatu, Tonga, the Cook Islands, and Palau—to develop National Surgical, Obstetric, and Anaesthesia Plans (NSOAPs) in collaboration with RACS Global Health, the World Health Organization (WHO), and Pacific Community (SPC).

"We have supported ministries of health to conduct situational analyses, convene multi-stakeholder dialogues, and draft strategies," she says. "I also helped to set up a program on safe and affordable surgery at the WHO Western Pacific regional office alongside Dr Liz McLeod.

"We seek to support countries to create sustainable ecosystems for surgical care, moving beyond short-term fixes and interventions for single areas, such as training and equipment donation. This work builds on the foundation of the RACS Pacific Island Program over the last few decades," Rennie says.

"One of the biggest lessons for me is not to assume that I know best. In clinical care, visiting specialists have obvious expertise in their specialty. However, when it comes to health systems, we all are learning," she says. "As a high-income-country Trainee, I take many health system elements for granted, such as sterilisation and waste management. My colleagues in the Pacific often have a better understanding of integrating surgery with public health."

Rennie went to Harvard looking for answers but found them back home in her region. "New Zealand is looked up as a world leader in our COVID-19 response and in decolonisation. Having learned about Māori health in medical school, it struck me that many Indigenous health principles are absent from global health, such as upholding Indigenous self-determination, worldview, and ways of knowing. Global health should just be Indigenous health everywhere. Unfortunately, this is often not the case with the structuring of global health funding and research."

Rennie looks forward to returning to Aotearoa New Zealand and starting her General Surgery training in 2023.

"I am deeply privileged by the relationship with my Pacific colleagues over the last two years and hope to continue this for years to come."

On completing her training, she hopes to be an academic surgeon focusing on health policy and systems research. "I hope to work collaboratively with colleagues in the Pacific to analyse and improve our respective surgical delivery systems and share mutual lessons in doing so."

Dr Sharon Jay
RACSTA Chair

Image (from left): Dr Rennie Qin; Dr Geoff Ibbotson (UNITAR), Dr Jemes Tudravu (Chief Medical Officer, Fiji), Dr Alfredo Borrero (Vice President of Ecuador), Dr Ifereimi Waqainabete (Minister of Health, Fiji), and Dr Kee Park (Harvard).

Tara Luck's surgical journey

Dr Tara Luck is one of two women general surgeons at the Royal Darwin Hospital

Dr Tara Luck is one of two women general surgeons at the Royal Darwin Hospital. Her work involves managing a wide range of general surgical emergencies and elective work.

Tara initially worked as a clinical dietitian and was living in Barcelona when she came back to study medicine and surgery at Flinders University in South Australia.

While working as a junior doctor at the Royal Darwin Hospital, she was successful in her application to SET training in General surgery. She completed her FRACS in Melbourne, which was followed by a Fellowship year in Upper Gastro-Intestinal Surgery.

It was always her intention to return to the Northern Territory, where she grew up and her family is based.

It has been a steep learning curve for Tara, who has just completed her first year both as a mother and as a consultant surgeon. "I feel I have jumped in feet first, and I have relied on both the excellent training I had in Melbourne, as well as the wonderful support I have both here locally, and over the phone," she says.

She also has the support of one of her good friends and fellow surgeon, Dr Richard Bradbury, who she now shares a private practice with. "We are a close group of surgeons in Darwin and our theatres are always open to each other.

"One of the hardest challenges I found was breastfeeding a newborn when I returned to work. The fatigue of going straight onto the on-call roster was a challenge but finding an appropriate room near the theatre to pump or feed in was even more so. I can't imagine having to do that as a registrar when you have much less control over your day."

"One of the hardest challenges I found was breastfeeding a newborn when I returned to work. The fatigue of going straight onto the on-call roster was a challenge but finding an appropriate room near the theatre to pump or feed in was even more so. "

Despite the challenges that face a new consultant, Tara is enjoying the diversity of operating that Darwin offers. Last month she was on-call and started the week doing a laparoscopic anterior resection for an obstructing bowel cancer, and managed a perforated gastric ulcer and multiple traumas (one requiring an amputation and the other escharotomies).

She was also on-call during the infamous Cracker Night, which notoriously keeps everyone busy for a few days. "We are home to the National Critical Care and Trauma Response Centre, so that's a big part of what we do," she says. "We are also lucky enough to now have established plastics and neurosurgical services, which means we can provide a robust trauma service.

"There is also the very real health gap that continues to exist between First Nations Australians and non-Indigenous patients here. Amputations from poorly controlled diabetes, delayed presentations of pathology and the advanced stages of pathology—some due to the remoteness of the communities and the negative associations that people have about coming in—there is quite a stark contrast between Darwin and Melbourne in these areas."

Tara has also developed an interest in looking after breast cancer patients. "I found that I was quickly getting a lot of referrals in this area, and I'm really enjoying looking after these women and being a part of the established breast special interest group."

Outside of work, Tara lives with her husband, an anaesthetist, and their young daughter. They enjoy the active lifestyle and rich culture that Darwin has to offer, particularly in the dry season and coming up to the Darwin Fringe Festival. Last month they ran the 12 kilometre City to Surf and participated in the Katherine Ultra Challenge in July.

"There's nowhere else like Darwin. It's an amazing place to work and raise a family," she says.

How CPD can help reduce health equity and improve cultural safety

Cultural safety is essential in reducing health disparities and achieving health equity for patients in Australia and Aotearoa New Zealand.

The revised CPD standards from the Medical Board of Australia and the Medical Council of New Zealand Te Kaunihera Rata o Aotearoa each emphasise the centrality of reflective and outcome focused CPD activities in supporting the provision of an accessible and culturally safe environment for patients.

Launched on 1 July 2021, the new RACS CPD program provides greater recognition of professional development activities that assist to embed cultural safety across the health system and which improve the health outcomes of First National Australians and Māori communities.

It is one among a raft of measures RACS is undertaking to help close the health gap between Indigenous and non-Indigenous communities in Australia and Aotearoa New Zealand.

RACS Māori Health Advisory Group Chair, Dr John Mutu-Grigg hopes that these changes can help address structural inequities present in the health sector in both countries that leads to a disparity in health outcomes.

"What most people understand is that there are certain people who the current way of doing things works for, but there is another group of people that it doesn't work for," Dr Mutu-Grigg said.

"That is because the current health system is designed for the majority, which is reasonable. But now that we have a way to address the majority, it is appropriate that we start to try and address those people that have been left behind.

"These tend to be the minorities, particularly the Indigenous populations of Australia and Aotearoa New Zealand, or any single colonised country around the world."

Dr Mutu-Grigg points to a bowel cancer screening program introduced in Aotearoa New Zealand as an example of how a mainstream system can disadvantage Indigenous communities.

The program offered screening to people aged 60 to 75 years, which was the highest risk group among non-Māori.

However, the initial pilot study showed that 58 per cent of Māori females and 52 per cent of Māori males present with bowel cancer from between the ages of 50 and 60 years. Therefore, by design the new screening would knowingly exclude over half of Māori bowel cancers.

It took significant advocacy over a long period from health professionals for the program to be adjusted to include this group, but the change will not occur until 2023.

"We need to understand that different people have different requirements," Dr Mutu-Grigg said.

It is not just First Nations Australians and Māori that will benefit from improving cultural safety and health equity; surgeons will also gain new skills and improve their outcomes.

"As surgeons, we all want to get better results for all of our patients. We fly around the world to learn new things—this is one thing that we can learn that can have a big impact on our outcomes."

An existing University of Otago program that has been adapted specifically for surgeons, with input from RACS Māori Health Group.

To date, it has been rolled out to trainers, with plans to offer it to all RACS Trainees, and more widely in the future.

Two modules of the First Nations Australians Health and Cultural Safety e-learning course are now available to all RACS Fellows, SIMGs and Trainees, while another module is being developed.

The modules cover the history of First Nations Peoples, the impact of colonisation, and the flawed government policies that continue to shape their experience and perceptions.

RACS Fellows, SIMGs and Trainees will earn CPD points for participating in the new Cultural Competence and Cultural Safety Competency activities.

Dr Mutu-Grigg said a better understanding of cultural difference could help shape the way surgeons interacted with their patients.

"One example is that when sitting across from a patient, the patient might communicate through what they say, or through non-verbal cues. We might know our own culture's non-verbal cues and pick up on when someone is anxious.

"But if we miss these things, there is the risk that we might give an incorrect diagnosis. By understanding other cultures' cues, we will be able to offer better treatment and get better results."

Ear, Nose and Throat surgeon and RACS MINA Advisory Group Chair Professor Kelvin Kong says he hopes that by engaging with cultural safety and health equity, surgeons can help close the health gap between First Nations Australian and non-Indigenous Australians, and advocate for change.

"In a first world country, we have a huge disparity between the 'have' and 'have nots'. We have a really good health system and Australia ranks highly—being number two or three compared with other OECD nations—on most health scores," Professor Kong said.

"Yet when it comes to Aboriginal and Torres Strait Islanders, we're scoring in the bottom two in the OECD nations, and it's a real blight because we're under the same roof, so to speak."

Professor Kong says that while RACS Fellows might have excellent surgical skills, their patients' outcomes are often impacted by their lack of cultural knowledge and understanding.

"When an Indigenous person presents with cancer, they often have worse outcomes. They might present with later stage disease and receive different treatment regimes because of the inherent bias we all have as medical people," he said.

Professor Kong came face-to-face with the hurdles First Nations Australians experience in accessing the health system when he was a graduate treating one of his first patients, an Aboriginal Elder.

After talking to him, Professor Kong's patient started crying.

"I was devastated that I made this woman cry, thinking I'd mucked it up. She described afterwards that she had never thought she'd live to see an Aboriginal doctor.

"It tells a lot about her struggle with trying to get people to listen to her, and I think it is really sad that it took so long," he said.

"But I'm excited about the changes that are happening, for example, it's so rewarding to go to a recent College meeting and there's a Yarning Circle. Who would have thought a meeting of the College of surgeons could involve something like that?

"Not that there is always a physical 'circle', but that people are changing their mindset to such an important issue."

RACS Councillor and Indigenous Health Committee member Dr Maxine Ronald says it is important that participation in activities to improve cultural competence and cultural safety is not simply performative.

> "People think that cultural competency and cultural safety are tick the box exercises, but it has to be an ongoing education," Dr Ronald said.

"I think Fellows, SIMGs, Trainees and departments need to think about how they regularly improve, review and progress.

"As it's about personal development and growth, you can't expect everyone to go from not knowing much about cultural safety and cultural competency to being experts straight away—there will be many things that people will learn along the way."

Dr Ronald said the design of the e-learning courses meant they could be completed over an extended period and broken down into self-contained 30-minute modules.

Ultimately, Dr Ronald would like to see the program encourage surgeons to advocate for structural and policy change like that which occurred following the advocacy surrounding the bowel screening program.

"Health equity should be embedded in any decision made within the system and this program empowers people involved in healthcare delivery to understand that," she said.

"By making this part of CPD, it shows that the College has a commitment to cultural safety and health equity. Our Fellows will start to develop those skills and reflect those values, which will ultimately be of benefit to our communities, which is the point of doing this."

Access the First Nations Australians Health and Cultural Safety e-learning course here: bit.ly/3b3zbJN

Images (from far left): Dr John Mutu-Grigg, Professor Kelvin Kong, and Dr Maxine Ronald

A fresh perspective on rural practice

The case for an urban to rural change – a new Fellow's journey

From the hustle and bustle of Sydney's north shore to the laid-back atmosphere of Griffith in regional New South Wales, Dr Zainab Naseem has found what is elusive in the profession—a work-life balance. And this change in scenery came care of a pilot initiative delivered by RACS through the Specialist Training Program (STP), funded by the Australian Department of Health and called the New Fellow Rural Placement (NFRP).

The NFRP started in 2020 with two rural sites, and in 2021, two more sites were added including Griffith Base Hospital. During her search for employment and with limited openings still available, Dr Naseem took a gamble and applied for the new Fellow position at the Griffith Base Hospital in rural New South Wales. There was a lot of apprehension about the application since she was coming from a bigger urban hospital with a notable caseload for surgeons. With funding support available for salary, professional development and relocation, Dr Naseem felt it was worth finding out what life could be like as a rural surgeon. After completing the recruitment process, she was accepted and started in May 2021.

Dr Naseem did not know what to expect in a smaller hospital though she had expectations of what she would learn from this experience. "Typically in the first year as a Fellow, you're required or you should be opting for a position, which can give you immense exposure in General Surgery and a bit of independence in terms of working as a junior consultant."

She dived into the role, working with her mentor—Dr Kate Fitzgerald, FRACS, Director of Surgery at Griffith Base Hospital—who supported her in cases as a secondary operator. Armed with a professional development plan, Dr Naseem took advantage of all the opportunities that were available. She is currently involved in several research projects at the hospital and has applied for a clinical lecturer position with the University of New South Wales. She also teaches junior doctors, registrars and medical students. On top of that, she's doing her Master of Philosophy in Colorectal Surgery. Quite a challenge for a new consultant!

Dr Fitzgerald was also witness to the positive impact that the NFRP pilot had on Dr Naseem's first year as a consultant. The exposure to a broad range of cases boosted her skills development and her ability to handle difficult situations. "The degree of generality is quite different to what you do in metropolitan areas, but you also don't have that back up, like intensive care, vascular and cardiothoracic. So, I definitely think Dr Naseem is a lot more confident in her decision making."

What Dr Naseem did not expect, though, was to enjoy living in Griffith. Because she was used to the city buzz, she was surprised with the friendly colleagues, welcoming community and the easy-going lifestyle that helped her settle in. "I think it's more like cultural shock because we are so used to all the hustle and bustle and traffic jams and you know, getting delayed and then spending more time on the roads than at home. So, it was a big shift in the living situation and culture."

Wanting to discover more about the Riverina region of New South Wales, Dr Naseem went out with colleagues to restaurants, wineries and even the local bowling centre. A day of fun at the wildlife park was also on the list

Dr Zainab Naseem with her husband, Faisal

when family members came over to visit. She found the community so friendly and welcoming that she tried getting involved in local activities, such as becoming an election volunteer in Griffith. With everything a five-minute drive away, she realised living and working in rural New South Wales offered so much more in terms of work-life balance.

The warm welcome from the hospital and from the community had even extended to Dr Naseem's family, especially during a period when her mother was undergoing cancer treatment. While carrying out her work at the hospital, Dr Naseem also became primary carer to her mother. This would have been a very challenging arrangement, but the hospital's surgery

Dr Zainab Naseem with her family

department and staff pitched in to make sure no cases fell through despite her limited availability.

Dr Naseem's positive experience has been so encouraging that she has decided to stay in the Griffith area and take advantage of the benefits of a rural lifestyle.

With a plan to stay in rural New South Wales for the long term, she is looking at doing subspecialty training in colorectal surgery and bringing back this expertise to the community. It is a plan that sounds like a win-win situation where she builds on her technical skills, which will allow her to use these skills on the more complex cases at Griffith Base Hospital. "That would substantially reduce the workload in the tertiary centres. We don't have to then send a lot of patients to the city centres because we would be providing quality surgical care in such areas."

On a personal level, this decision to stay will be beneficial not only to her but also to her husband, Faisal, who is a doctor as well. After having settled in the community, he is looking at establishing his career and working in rural New South Wales. Griffith Base Hospital is supportive of this plan and Dr Naseem is hopeful that both their careers will be based in the Griffith area and that they will not need to relocate further.

Since expressing her interest in staying rurally, Dr Naseem has been offered a permanent position at Griffith Base Hospital, which she has accepted. The hospital will now have four surgeons taking on the host of surgical cases coming in, contributing to the Department of Surgery's additional capacity.

The hospital is now looking at expanding its training posts for general surgery to support its existing surgical workforce. With an increasing number of admissions annually, the hospital is looking forward to providing more services to the community and at the same time delivering a mentoring program that will help the Trainees gain experience in a supportive environment. The success of the NFRP pilot in Griffith shows how an innovative project can underpin an established program such as the Specialist Training Program (STP) and contribute to the rural training pipeline of surgical specialists.

As the new consultant at Griffith Base Hospital, Dr Naseem is eager to put her skills to work and continue teaching junior doctors and registrars. She is also keen to carry on with the initiatives she has been involved in such as sustainability in the workplace and enhanced post-surgery recovery. Living and working in rural New South Wales has opened her eyes and brought on a new perspective. As Dr Kate Fitzgerald had summed it up, "They don't realise, it's quite easy to work in an area like this, as long as you've got that support. It's not as scary as you think it's going to be."

Indeed, after taking the leap, Dr Naseem happily agrees.

The Specialist Training Program (STP) is an initiative funded by the Australian Department of Health that will enable specialist registrars to pursue training in settings outside traditional metropolitan teaching hospitals. The program aims to improve the distribution of the specialist workforce by providing quality training posts in regional, rural, remote, and private healthcare settings. For more information, visit the STP page on the RACS website: bit.ly/3R9JdcJ

Indigenous ear clinic celebrates anniversary

The clinic has provided more than 1500 instances of care in its 10 years of existence

A clinic that has helped improve the hearing of hundreds of Indigenous Victorians celebrated its 10-year anniversary in April.

The Healthy Ears Clinic was established in partnership between the Victorian Aboriginal Health Service (VAHS) and the Royal Victorian Eye and Ear Hospital, with the support of Rural Workforce Agency Victoria in 2012.

Since then, more than 220 surgeries have been carried out to improve the hearing of young Indigenous patients.

Ear, Nose and Throat surgeon Professor Stephen O'Leary has been operating at the clinic since its inception and says the clinic addresses a significant health concern within the Indigenous community.

"Ear disease is a big problem and one that starts before children are even speaking. By the time they turn one, about 90 per cent of Indigenous children have some form of ear disease.

"It might be a hole in the eardrum or fluid behind the eardrum; these problems can have a long-term effect on hearing, which impacts on education and socialisation," Professor O'Leary said.

According to the *Australia's Health 2018: In Brief* report, Indigenous children are 2.9 times as likely as non-Indigenous children to have long-term ear or hearing problems.

The partnership between VAHS and the Royal Victorian Eye and Ear Hospital was established after health professionals from the hospital spent time in Alice Springs treating ear problems.

The organisations recognised there were similar hearing needs among local Indigenous children in Victoria.

"It became clear that there was a problem in our backyard—not just in remote areas—and working in Alice Springs had given us the confidence that we could help."

Since then, the clinic has provided more than 1500 instances of care—offering audiology testing and ear, nose and throat consultations.

The organisations involved in establishing and running the clinic attended a celebration to mark its 10-year anniversary, complete with cupcakes highlighting the groups that had contributed to its success.

Professor O'Leary attributes the consistency and longevity of the service to the partnership between organisations and to the support of their respective Boards and administrations.

"Usually this kind of initiative is run on the goodwill of individuals, but this venture had the full support of everyone from the hospital board down, and that made it easier to establish a robust model, and gain and maintain, funding."

Professor O'Leary, a researcher and practicing surgeon, first developed an interest in Indigenous health when he spent three months on Thursday Island, in the Torres Strait Islands, as a final year medical student.

During that time, he visited Mer (Murray Island), the home and birthplace of Eddie Mabo. He sat on the porch of what might have been a member of the Mabo family and learnt about Indigenous land rights.

The experience opened his eyes to Indigenous issues and set him on track to build lasting and trusting relationships with Indigenous communities.

These relationships have been vital to the success of the clinic, ensuring the right care was provided in a culturally sensitive way.

Professor O'Leary's involvement in the Healthy Ears Clinic has been a professionally and personally rewarding one.

"It's meant that I have a sense of connection to Indigenous Australians that I never would have experienced otherwise," he said.

"Now I feel like I have a sense of understanding built through engagement with the community."

He also highlights the contribution made by Australia's first Indigenous surgeon, Ear, Nose and Throat surgeon, Professor Kelvin Kong in providing valuable guidance to the clinic.

"As a non-Indigenous person, it is very easy to provide what you think is best, but you need an Indigenous perspective."

Professor Kong says the clinic's success is a testament to the partnership between the organisations and individuals involved.

"It is one of the most successful outreach clinics we have in Australia," he said.

In the future, Professor O'Leary, who sits on the RACS Aboriginal and Torres Strait Islander Advisory Group, MINA, and the RACS Indigenous Health Committee, would like to see similar initiatives in which Indigenous health organisations partner with hospitals developed across specialties.

Image: far left - The 10-year anniversary, photographed by RVEEH photographer Anthony Bragaglia, and cupcakes by Victoria Edwards

Advocacy at RACS

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

We regularly advocate for these positions across several different mediums, including through the media, public campaigns, or by negotiating directly or providing written submissions to both government and non-government agencies.

Read on to find out more about our advocacy work.

Joint letter to the Australian Competition Tribunal

RACS has joined with specialty societies in writing to the Australian Competition Tribunal. The letter is regarding an application by Honeysuckle Healthcare Pty Ltd and other applicants (nib) 'buying group' and the up-and-coming Australian Medical Association hearing in the Tribunal. The letter is available on the RACS website (bit.ly/3nzSdtV).

RACS previously opposed an application by Honeysuckle Healthcare Pty Ltd and other applicants for authorisation to form and operate a buying group (bit.ly/3NGyKlV).

Australian federal election

As highlighted in the previous issue of *Surgical News*, RACS wrote to the major Australian political parties in the lead-up to the recent federal election. Our letter identified 11 focus areas and sought answers to a range of related questions.

The focus areas identified were:

- building respectful and safe workplaces for all who work in surgery and in the wider health sector
- guaranteeing the public sector provides timely access to essential surgery
- expanding surgical (and other specialist services in rural areas)
- expanding surgical (and other specialist) services for Aboriginal and Torres Strait Islander people
- protecting the public by restricting the title 'surgeon' to those with accredited advanced surgical training
- improving care through appropriate clinician-led patient outcome data collection and dissemination to clinicians and understanding the many unintended consequences of non-risk adjusted release to the public
- ensuring the Medicare Benefit Schedule provides equitable access to health services and remains contemporary
- preventing incremental moves to US-style 'managed care' and ensuring our mixed healthcare system continues to thrive
- reducing death and serious injury on our roads
- safeguarding the health of all Australians from the threat of climate change
- committing to health security and long-term health systems strengthening in the Pacific.

RACS congratulates the Hon. Mark Butler who has been sworn in as Australia's new Health Minister, and the Hon. Ann Ruston who has been appointed the Shadow Minister for Health.

Over the next four years RACS will endeavour to work with the government and the opposition to ensure that these issues and others related to public health—particularly those relating to the delivery of surgical services—remain a priority.

Transparent patient outcomes

RACS recently provided a submission to the Health Insurance Legislation Amendment (Transparent Patient Outcomes) Bill 2021. In doing so we consulted with our Fellowship within our governance structure including our state and territory committees, the Research, Audit & Academic Surgery (RAAS) division, the Rural Surgery Section (RSS), and the Health Policy and Advocacy Committee (HPAC).

We also thanked our 13 Australian and bi-national surgical specialty societies and associations for providing their presidents joint signatures in support of our submission. The attached submission is written in the format requested by the Australian Department of Health, and we look forward to participating in possible future meetings and/or hearings.

Read the full submission (bit.ly/3N1iOva).

Want to know more about RACS Advocacy?

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

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

Dr Paul Heitmann, Peter King Research Scholar

Dr Paul Heitmann from Adelaide was awarded the 2020 Peter King Research Scholarship. The Peter King Scholarship supports research on a topic relevant to the practice of surgery outside metropolitan areas and recognises the contributions the late Dr Peter King, FRACS made to RACS—particularly in rural surgery.

Dr Heitmann completed a PhD during his scholarship term and was awarded the Flinders University higher degree by research student impact prize for his thesis, titled *Colonic and Anorectal Function in Defaecation and Continence*.

"Disorders of defaecation, such as faecal incontinence, are common but poorly understood," Dr Heitmann said. "There has been a lack of standardisation in clinical investigations and there is limited success with current treatments. The intent of my thesis was to further our understanding of the physiology of defaecation and normal continence as well as the pathophysiology of disorders of defaecation."

Dr Heitmann's thesis included a combination of clinical studies as well as in vivo and ex vivo human studies. This work was presented at national and international conferences and generated seven publications, including a review article in *Nature Reviews Gastroenterology and Hepatology*, which was additionally featured on the cover of the November 2021 issue.

Medicine wasn't Dr Heitmann's first area of study after leaving secondary school. He started a Bachelor of Physiotherapy and then deferred midway for a few years and even played in a rock band. After returning to study somewhat ambivalently, Dr Heitmann undertook a placement in an acute hospital trauma ward as a physiotherapy student, where he was drawn to surgery.

"I was really drawn to the acuity of surgery," Dr Heitmann said, "in that an illness or disease can be treated with an operation that can result in an immediate benefit for the patient (if all goes to plan!). I was also attracted to the mastery of hands-on skills, in that you never stop striving to improve and develop your technical skills during a career in surgery."

Professor David Wattchow, a colorectal surgeon at Flinders Medical Centre and Professor of Surgery at Flinders University, was both a mentor and one of Dr Heitmann's PhD supervisors.

"Professor Wattchow maintained a very busy clinical workload as well as teaching and research roles during his career. His ability to maintain roles as both a surgeon and scientist was influential to me in terms of developing my career to include research, teaching, and clinical work."

While he was a medical student at Flinders University, Dr Heitmann undertook extracurricular research projects in colorectal surgery. He developed relationships with Professor Wattchow and Associate Professor Phil Dinning, the scientist leading the Flinders gastrointestinal motility laboratory. So, when an opportunity arose for him to join the research team, he applied.

The scholarship from RACS enabled Dr Heitmann to focus on the research without the pressure of a busy clinical workload to support his young family.

> "You have nothing to lose by applying and, if you are successful, a RACS scholarship is hugely beneficial both personally and professionally.

Now that his PhD is complete, Dr Heitmann and his colleagues have established an ongoing international collaboration with similar research groups in the USA, UK, France, and Mexico. The aims of this collaboration are to characterise the prevalence of disorders of anorectal function, and to assess the diagnostic and clinical utility of existing and novel measures of anorectal function.

"I've also returned to General surgery training, for which I have two years remaining, with a plan to then undertake subspecialist training in colorectal surgery."

He encourages other doctors to apply for RACS scholarships. "You have nothing to lose by applying and, if you are successful, a RACS scholarship is hugely beneficial both personally and professionally. I really appreciate the support from the College and the impact it has had on my career."

RACS offers more than 70 scholarships and grants valued at more than $2.5 million annually through its Scholarships and Grants Program. To learn more, visit www.surgeons.org/scholarships

RACSTA and CTANZ collaboration 2022

Formed in late 2017 as a RACS New Key Initiative, Clinical Trials Network ANZ (CTANZ) aims to provide the necessary tools for surgical Trainees to design, implement and lead investigator-led multicentre clinical trials and cohort studies. It provides a platform for surgical Trainees, junior doctors, and medical students to conduct high quality surgical research and trials to enhance patient care.

Recognising that Royal Australasian College of Surgeons Trainee Association (RACSTA) is the voice of SET Trainees and is responsible for ensuring they receive the highest standard of education and surgical training during their time as Trainees, CTANZ seeks to engage RACSTA through RACSTA representation on the CTANZ Working Party (steering committee).

CTANZ aims to facilitate culture change within the surgical community[1] by encouraging networking and collaboration to deliver meaningful research outcomes. It is actively supporting a shift from competition to collaboration. It is also creating opportunities for involvement in research through study design, patient recruitment, data entry, data analysis, manuscript writing and presentation at conferences.

We spoke with Dr Nicholas Lyons, RACSTA representative on the CTANZ Working Party, for his perspective on where CTANZ can support, enhance and add value to the surgical training, specifically through involvement in large prospective cohort or randomised clinical studies.

How can CTANZ support RACSTA members?

Nicholas Lyons:

The demands for Trainees to participate in high quality research, either for SET applications or as a part of a SET training program, continue to rise. This poses a challenge for Trainees working in rural

areas where opportunities and support for research has historically been scarce. Without the support of experienced researchers, producing high quality research can be extremely difficult.

We are encouraged that RACS recognises that rural inequity issues exist, and these disparities are being proactively addressed. We see CTANZ playing a vital role in facilitating networks that operate equitably across the spectrum from major metropolitan teaching hospitals, to smaller hospitals in rural settings. It also supports rural Trainees by providing tangible resources such as documentation and guidance on how to structure a governance body when establishing a Trainee-led network in the rural setting.

Assistance with how to efficiently satisfy the requirements of the different state and territory based human research ethics bodies is welcome as not many Trainees have had much experience in preparing and submitting ethics applications. Any help with the logistical and administrative challenges associated with clinical research is also appreciated.

RACSTA is keen for rural based Trainees to feel that they are a part of the larger cohort of predominantly metropolitan based Trainees. This means having the same access to infrastructure. The CTANZ model of linking rural based Trainees into existing networks or providing points of contact with appropriate researchers or institutions is ideal as it provides a sense of community.

Rural based Trainees, even though they may be hundreds of kilometres from colleagues in a metro hospital, can still have detailed discussions over Zoom about generating ideas for clinical studies or if participating in an ongoing study, can take ownership and actively drive that study in their hospital. They also have the opportunity to provide leadership from locations outside of major teaching hospitals.

How do you see RACSTA's role in supporting the RACS aspiration of serving all communities equitably?

Nicholas Lyons:

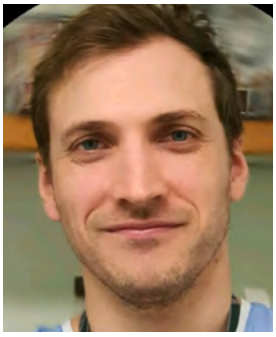
RACSTA has an important role in advocating for Trainees and communities across a broad range of issues such as gender equality, supporting Indigenous doctors and Trainee wellbeing. RACSTA, through its widespread representation on the diverse boards and committees of RACS, advocates on behalf of otherwise under-represented groups on a diverse range of issues.

RACSTA is advocating for the recognition of the importance of paternity leave for Trainees and the benefits of flexible training in helping Trainees returning from maternity leave.

The CTANZ model fits nicely with our advocacy stance because these multicentred clinical studies ensure continuity of each study outside the constraints of half yearly training terms. This allows Trainees to recruit patients while rotating across different hospitals.

The CTANZ model also reduces barriers to entry faced by individual Trainees with heavy workloads. The patient recruitment and data collection can be shared within small teams of registrars, junior doctors, and medical students. This model can be replicated across all surgical units.

RACSTA is extremely grateful to RACS for the opportunity to advocate on behalf of Trainees and we hope that, through implementing changes for Trainees, over time similar changes will be adopted more widely throughout surgery and for other healthcare workers.



Dr Nicholas Lyons

Furthermore, we hope that the culture of openness to change and collaboration fostered by RACSTA will stay with our members long after they have completed their training and moved into established clinical practice.

Reference

1. Watson DI, Tan L. Trainee research collaboratives: developing a new culture? ANZ J Surg. 2022;92(5):942-3.

Authors: Professor David Watson and Dr Lorwai Tan

Summary

CTANZ is well placed to assist Trainees in developing the research networks required to develop their skills as surgeon scientists and to address clinical issues or questions that cannot be addressed in one rotation or from one centre alone.

In Australia and Aotearoa New Zealand, we now have collaborative research groups working on a variety of clinical questions, many of which are Trainee-led and Trainee-delivered.

Some of the strengths of the collaborative model are that the studies better reflect the diversity of the Australian and Aotearoa New Zealand populations. Additionally both small and large hospitals are empowered to collaborate on an equal footing to deliver clinical evidence that is practice changing.

Matthew Read - recipient of the Senior Lecturer Fellowship

Dr Matthew Read is a general and upper gastrointestinal surgeon. A recipient of the Senior Lecturer Fellowship from the Royal Australasian College of Surgeons (RACS) in 2020 – 21, he believes this is a great support, especially for those on the path to becoming an academic surgeon.

With the Fellowship, he has established a research program in oesophageal cancer and mentors students interested in academic surgery. "This Fellowship is probably one of the very few funding sources around Australia that actually help academic surgeons in the early phase of their career," Dr Read says.

After completing his Bachelor of Medicine and Bachelor of Surgery from Monash University, Melbourne in 2003, Dr Read completed his internship and resident training at the Western Hospital, Melbourne. Despite his keen interest in surgery, his initial applications to the surgical program were unsuccessful. Following this initial setback, Dr Read gained further clinical experience by focusing on other areas such as critical care and remote medicine. After working in the Northern Territory, Dr Read returned to Melbourne before successfully being accepted into the general surgical program.

Dr Read's first rotation as an accredited Trainee was in Thoracic surgery where he gained an appreciation for the complexity of operating in the chest. "This led me to pursue my interest in Upper Gastrointestinal surgery, as I saw it as an opportunity to combine elements of both General Surgery and Thoracic surgery," he says.

Later, Dr Read undertook a PhD in surgical oncology at The Peter MacCallum Cancer Centre, Melbourne. Under the supervision of Professor Wayne Phillips, he successfully developed a series of pre-clinical models for the study of oesophageal cancer.

After returning to clinical training in 2016, Dr Read completed his General Surgical Fellowship and was accepted by the Australian & Aotearoa New Zealand Gastric & Oesophageal Surgery Association (AANZGOSA). He completed two years of subspecialty training in Upper Gastrointestinal surgery, which included training at both St Vincent's and The Alfred hospitals in Melbourne.

Following this, he secured a Fellowship at the University Medical Center Utrecht in the Netherlands. This surgical oncology Fellowship, with a special focus on robotic surgery, gave him the opportunity to work with Professor Richard van Hillegersberg, a leader in robotic surgery for the oesophagus.

> "I clearly had to prioritise the things that were important to me ... given that there are key things that I want to achieve."

It was at the end of his term in the Netherlands when he was awarded the Senior Lecturer Fellowship by RACS. With this support, Dr Read helped establish a collaboration with a goal of finding better ways of predicting how patients with oesophageal cancer would respond to treatment. It also gave him the opportunity of working under Professor Hans Clevers at the Hubrecht Institute—a guru in the field of stem cell biology.

Dr Read's interest in research stems from the fact that patient outcomes are universally poor with oesophageal cancer. A rapidly increasing cancer worldwide, he rues there is very little funding and awareness.

Dr Read's public affiliation is with St Vincent's Hospital, and he has an honorary appointment through the University of Melbourne for both his teaching and research roles.

Throughout his career, Dr Read has received numerous scholarships and awards. These have included the Francis and Phyllis Thornell Shore Memorial Scholarship through RACS and the John Ham Medal through General Surgeons Australia.

With so much going on, Dr Read has found the perfect balance between his family and work life. "I was self-reflective very early on. After returning from overseas it was evident that I was too busy. I was overworked and time-poor and realised it wasn't going to be sustainable long-term. I clearly had to prioritise the things that were important to me, especially given that there are key things that I want to achieve," he says.

"To get to where I am now has been 25 years of training. It's a long haul and I'm only just at the beginning," he says.

RACS offers more than 70 scholarships and grants valued at more than $2.5 million annually through its Scholarships and Grants Program. To learn more, visit www.surgeons.org/scholarships

Online courses on offer for surgeons

RACS professional development provides surgeons equitable opportunities for professional development regardless of their geographical location, through online learning.

Our course mix comprises of:

- solely face-to-face courses
- face-to-face courses with an online option
- courses that are offered only online.

Several courses have been developed by the RACS Professional Development team and faculty.

Courses with both face-to-face and an online options are:

Foundation Skills for Surgical Educators

This is an introductory interactive course designed to expand knowledge and skills in surgical teaching and education.

Participants look at how these concepts can be applied into their own teaching context and can reflect on their personal strengths and weaknesses as an educator. By attending the course, participants will be provided with opportunities to reflect on their own teaching skills and how likely they can influence their learners and the learning environment. Participants will also further their knowledge and skills in teaching, and learning concepts to enhance their skills in surgical education and apply these principles into their own teaching context.

Difficult Conversations with Underperforming Trainees

This course aims to assist surgical supervisors to undertake a procedurally fair conversation with a Trainee who is not meeting required standards despite feedback. The course provides surgical supervisors with a comprehensive framework to follow, including how to prepare for and conduct the conversation and the steps to take after the conversation. The course builds on skills learned in the Foundation Skills for Surgical Education (FSSE) course, with a focus on how to prepare for and structure a difficult conversation.
It also explores the role of trust in giving and receiving feedback and the importance of procedural fairness related to difficult conversations.

Online only courses

Clinical Decision Making

This course is designed to enhance a participant's understanding of decision-making process and that of their Trainees and surgical colleagues. The course starts with three online e-learning modules, followed by a webinar, which provides a roadmap or algorithm of how surgeons make decisions. This algorithm illustrates the attributes of expert clinical decision-making and was developed to address poor clinical decision-making processes as a guide for surgical supervisors dealing with a struggling Trainee or as a self-improvement exercise.

Keeping Trainees on Track

This course is self-paced and is designed to support SET supervisors and trainers with a suite of best practice tools and frameworks when managing underperforming Trainees and help them get back on track. The course framework is also designed to support well-performing Trainees—using the same principles, tools and frameworks to extend and foster their learning, and optimise their trajectory for development.

Induction for Surgical Supervisors and Trainers

This course provides surgical supervisors and SET trainers with an introduction to their roles and responsibilities, including how to support and provide high-quality education and training to RACS Trainees. It is aimed at the newer surgical supervisors and trainers.

Educator Studio Sessions

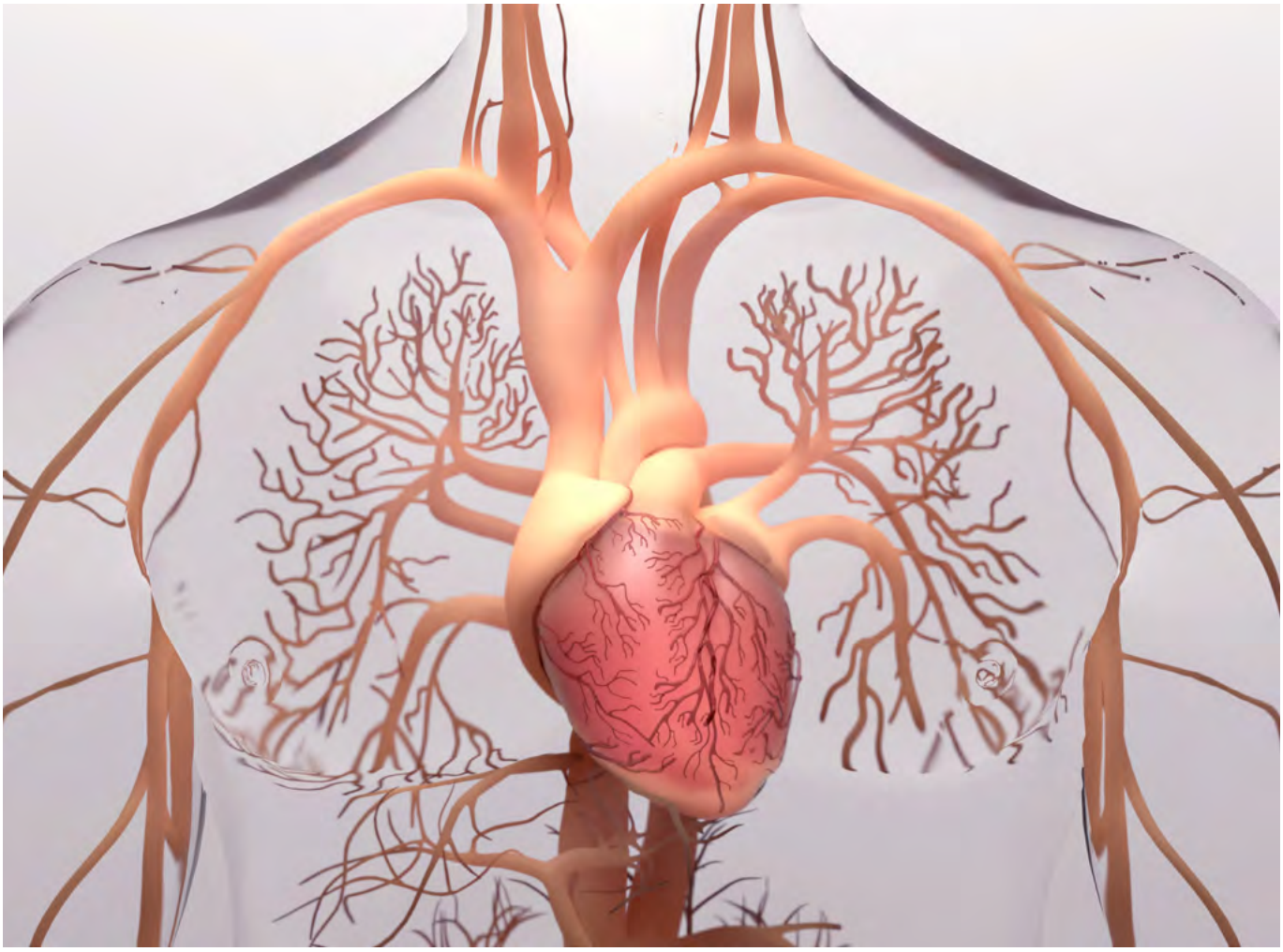
The Academy of Surgical Educators hosts several Educator Studio Sessions with speakers from Australia and Aotearoa New Zealand every year. Each session is for an hour, an online informative event curated to provide a deeper understanding of the issues, themes and topics that matter.

Education activities

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

Course (Online only)	Date
Keeping Trainees on Track	Thursday 1 September – Friday 30 September 2022
Difficult Conversations with Underperforming Trainees	Monday 5 September – Sunday 9 October 2022
Induction for Surgical Supervisors and Trainers	Tuesday 6 September – Tuesday 20 September 2022
Educator Studio Session	Wednesday 14 September 2022
Online Surgical Education Journal Club	Tuesday 20 September 2022
Foundation Skills for Surgical Educators	Monday 17 October – Monday 28 November 2022
Clinical Decision Making	Wednesday 19 October 2022
Leading Out of Drama	Wednesday 16 November – Monday 28 November 2022
Conflict and You	Thursday 17 November 2022

For more information email PDactivities@surgeons.org or visit our website: bit.ly/3bSAWK4



Case note review: pulmonary hypertension and protamine

Summary

A 75-year-old woman was admitted electively for a right axillobifemoral bypass as treatment for bilateral critical limb ischaemia.

In the audit forms, she was reported to have short distance claudication (approximately five metres) and occluded aortoiliac vessels. Her medical history was significant, including ischaemic heart disease with previous stenting of the left anterior descending artery, oesophageal cancer with liver metastases (treated with chemo-radiotherapy and reportedly in remission), paroxysmal atrial fibrillation (anticoagulated with apixaban and clopidogrel), pulmonary hypertension, gastroesophageal reflux disease, scleroderma, CREST syndrome, type 2 diabetes mellitus, and a permanent pacemaker for sick sinus syndrome. An echocardiogram performed eight months before the operation demonstrated evidence of decreased ventricular function (ejection fraction at 35 per cent, which was likely overestimated due to moderate mitral regurgitation), and severe pulmonary hypertension (right ventricular systolic pressure [RVSP] estimated at 60 mm Hg, also likely masked by moderate tricuspid regurgitation).

The patient was reviewed by the anaesthetic team prior to the procedure and risk stratified as American Society of Anesthesiologists (ASA) physical status 4 given her extensive comorbidities. There was no documentation provided regarding the patient's review with the vascular surgeon prior to the operation. The admission notes stated that the patient was able to walk 500 metres with a wheelie-walker. This was in contradiction to the booking form, which noted the patient had bilateral critical limb ischaemia. The booking form also stated that the surgeon had requested her apixaban not be ceased prior to the

operation, which should be noted given the invasive nature of the procedure being undertaken along with the fact that the patient was also on clopidogrel.

The operation was performed with unfractionated heparin administered (5000 units), in addition to the apixaban and clopidogrel. The consultant surgeon mentioned in the audit form that after closure of the anastomoses and reversal with protamine, the patient became coagulopathic and unstable with uncontrolled bleeding. Review of the anaesthetic records suggested a sudden change in parameters with evident loss of output, drop in end-tidal CO^2, and elevation in central venous pressure. The patient was given an additional dose of protamine, and massive fluid and blood product resuscitation was administered. A second anaesthetic consultant attended to perform transoesophageal echocardiography (TOE), which demonstrated biventricular failure. Cardiopulmonary resuscitation commenced with administration of adrenaline, but due to massive pulmonary oedema with fluid within the endotracheal tube inhibiting ventilation, the situation was determined to be futile and the patient died.

Discussion

Apixaban intentionally continued at the time of the operation along with clopidogrel and weight-based unfractionated heparin is worth noting. The combination of a factor Xa inhibitor, antiplatelet agent and heparin throughout the procedure would have made haemostasis challenging. It is uncertain why apixaban was not withheld and bridged with either low molecular weight heparin or unfractionated heparin if there were ongoing concerns with regards to interruption of anticoagulation. This is an area for consideration.

The lack of preoperative clinical notes to demonstrate discussion of risks and the indication for the procedure makes it difficult to produce meaningful commentary regarding the choice of operation. Given the patient's extensive comorbidities, an axillobifemoral bypass would have been reserved for limb salvage. The documentation within the admission paperwork suggesting the ability to walk 500 metres assisted is unlikely to be accurate.

Anaesthetic documentation throughout the admission was disappointing, as the records are very limited. It is unclear at what time the protamine was given in reference to the change in the patient's parameters. There was no blood gas performed for over an hour and a half at the most critical time in the operation when the patient was unstable, with evident concerns regarding coagulopathy. Note is made of activated clotting time being monitored following administration of protamine. Perhaps a rotational thromboelastometry (ROTEM) may have given a more accurate assessment of correctable coagulation. A preoperative coagulation screen would also have been beneficial.

Use of protamine in the setting of known severe pulmonary hypertension—while not an absolute contraindication—would need to have been closely considered and given with extreme care. In the absence of right heart catheterisation and an accurate wedge pressure it would be assumed that the estimated RVSP was even higher than 60mm Hg, as this would have been masked by the moderate tricuspid regurgitation. The use of protamine in this setting put the patient at high risk of right heart failure. It is not stated within the anaesthetic record the time period over which the protamine was administered. If given rapidly, this could have further contributed to the right heart failure. There were concerns following administration of the protamine with evident patient deterioration, which was likely further exacerbated by the second dose of protamine. Consideration for elective use of intraoperative TOE throughout this procedure in a high-risk patient would have further mitigated risks with the use of protamine.

This was a high-risk patient undergoing limb salvage surgery. Given her poor medical reserve, she was unable to survive the physiological challenges faced throughout the operation.

Clinical lessons

This case highlights the importance of preoperative assessment of high-risk patients. The decision to operate on a patient with significant medical comorbidities with unclear indications for the type of surgery performed is an area of concern. The preoperative management of anticoagulation may have also contributed to the poor outcome in this patient. Poor perioperative anticoagulation management continues to be a significant contributor to mortality in surgical patients.

Protamine may induce an anaphylactic reaction with hypotension, bradycardia and pulmonary vasoconstriction with pulmonary hypertension as the severe clinical manifestation[1]. The use of protamine in a patient with known severe pulmonary hypertension would need to be done with extreme care.

References

1. Boer C, Meesters MI, Veerhoek D, Vonk ABA. Anticoagulant and side-effects of protamine in cardiac surgery: a narrative review. Br J Anaesth. 2018;120(5):914-27.

Celebrating 20 years of ETEP

RACS Global Health celebrates the 20- year anniversary of the East Timor Eye Program with his Excellency President José Ramos-Horta

The RACS Global Health team were honoured to meet with his Excellency President José Ramos-Horta to celebrate and launch the 20-year anniversary of the *East Timor Eye Program* book.

Dr Horta is an advocate of the East Timor Eye Program (ETEP), providing political support and advocacy for this critical program over many years. The ETEP is now well integrated in the national health system of Timor Leste. Based in Dili and at the National Eye Centre in Hospital Nationale Guido Valdares (HNGV), the program continues to be supported by Dr Manoj Sharma, the RACS Global Health resident ophthalmologist.

The program commenced in 2000, when Professor Nitin Verma (RANZCO president) began treating an influx of East Timorese refugees at the Royal Darwin Hospital eye clinic. He was contacted by the World Health Organization (WHO) in relation to plans for the provision of eye care in Timor-Leste. Eager to get involved, Dr Verma made his first trip to Timor-Leste in 2000.

During his visit, Professor Verma negotiated with the Red Cross team stationed there. They offered to provide basic accommodation if he returned with a small team of eye specialists. Thus, the East Timor Eye Program (ETEP) was born.

On the 20th anniversary of the ETEP book (2021), Dr Horta said: "As I recall, before the program, there was not a single ophthalmologist in Timor-East, and there were zero activities in terms of looking after people with cataracts, not to mention other far more serious eyesight complications. And so, I thought it was great, it was a priority, in that it met the needs of our people. So, I was, from the outset, extremely pleased with the program, welcoming the doctors from RACS who came here a few times a year to do surgery. For me it has been one of the most successful programs since our independence within the health sector."

Over the next few years, the program grew and became part of the RACS Global Health program, enabling the Australian Government Department of Foreign Affairs and Trade (DFAT) funding.

In 2005, the next stage of the program begun. Encouraged by the political and medical leaders of Timor-Leste, Dr Verma and RACS Global Health started planning to build an integrated and sustainable program and infrastructure for eye care in Timor Leste.

Twenty years later the ETEP has supported the training of 14 fully qualified Timor Leste ophthalmologists. It has also enabled the treatment of complex eye conditions and recovered sight of thousands of Timorese patients. The program is fully integrated into the national health system, enabling national work force capacity, and implemented by Timorese doctors, surgeons, nurses, and allied health professionals.

As Professor Verma notes, he and his international team of eye surgeons no longer conduct surgical visits as the new wave of East Timor health professionals take on clinics and surgical procedures. For Dr Verma this is a sign of great success and a key indicator that the program's journey towards sustainability is well underway.

RACS Global Health would like to thank His Excellency Dr Ramos Horta, Professor Nitin Verma, Dr Manoj Sharma and the RACS Timor Leste country office team for their ongoing support and coordination of this important program.

If you would like to learn more about the East Timor Eye Program and the 20-year anniversary book visit: https://bit.ly/3uliBvo

Left to right: Janvario Gusmao (RACS Global Health Officer), Philippa Nicholson (RACS Head of Global Health Operations), HE José Ramos-Horta (President, Timor Leste), and Dr Manoj Sharma (RACS Global Health Resident Ophthalmologist)

Australian Aid

The inaugural 3SCTS 2022

A meeting of cardiac and thoracic surgeons, anaesthetists and perfusionists of Australia and New Zealand in conjunction with the ISMICS 2022 workshop.

16 – 19 November 2022, Cairns Convention Centre, Cairns, Queensland

Abbas El-Sayed Abbas, MD
Chief of Thoracic Surgery, Lifespan and Chief of Thoracic Oncology, Lifespan Cancer Institute

Thanks to the support of RACS one of our international keynote speakers will attend the inaugural Tri-Society Cardiac & Thoracic Symposium (3SCTS). Dr Abbas El-Sayed Abbas will present at the upcoming inaugural symposium that will be held from 16 – 19 November 2022 at the Cairns Convention Centre.

Dr Abbas is an internationally recognised expert in thoracic surgery and is renowned for his minimally invasive surgical skills and experience in translational and clinical research oncology. He is the chief of thoracic oncology at the Lifespan Cancer Institute and the chief of thoracic surgery with both The Warren Alpert School of Medicine at Brown University and Brown Surgical Associates.

He was previously the system thoracic surgeon-in-chief and system director of the Foregut Disease programs and Thoracic Oncology programs with Temple University Health System in Philadelphia. He earned a medical degree, with honours, at the Ain-Shams University School of Medicine in Cairo, Egypt.

Dr Abbas completed his internship and residency at the University of Pennsylvania along with a postdoctoral research Fellowship in gene therapy for thoracic malignancies. Additionally, he completed a Fellowship in cardiothoracic surgery at the Mayo Clinic College of Medicine and Science, Rochester, Minnesota and later pursued postdoctoral research in mechanical cardiac support at Penn State University.

In 2018, Dr Abbas served as the 56th president of the Eastern Cardiothoracic Surgical Society. Since then, he has held several leadership positions at different academic institutions.

Dr. Abbas has extensive expertise in robotic surgery for mediastinal, esophageal and lung disease.

He has authored numerous papers and chapters in the fields of thoracic surgery and minimally invasive surgery and is frequently invited to speak at national and international meetings. His research includes ongoing studies in robotic thoracic surgery, esophageal dysmotility, gastroesophageal reflux disease and cryospray therapy.

On behalf of the organising committee we invite you to attend the symposium.

For further information and to register please visit www.3scts.com

The next D'Extinguished lunch lecture will be held from 12pm on Friday 7 October 2022 at the College of Surgeons in Spring Street in the Hughes Room.

Professor Julian Smith, Editor-in-Chief of the *ANZ Journal of Surgery*, will give a presentation on the transition of the journal into an online format.

As an acknowledgement donation forms for the Foundation of Surgery will be made available on the day.

RSVP by 16 September 2022 to foundation@surgeons.org

Inquest to investigate the Finke Desert spectator death

The biggest annual sporting event in the Northern Territory has also created the busiest weekend of the year for the Alice Springs Hospital.

RACS has welcomed a decision of the Northern Territory government to hold a coronial inquest into the death of a spectator at the 2021 Finke Desert Race.

The annual event is held across two days of the Queen's birthday long weekend. Commencing in Alice Springs, drivers race across approximately 230 kilometres of harsh remote terrain, eventually finishing in the town of Aputula (formerly Finke). Competitors then complete a return leg the following day, with drivers split in to two categories across both days—motorbikes that race in the early morning, and cars that race later in the day.

From modest beginnings in the 1970s, the race has grown in stature and profile in recent years. It now attracts around 750 entrants across the two categories. Typically, there are approximately 10,000 spectators every year, many of whom set up campsites along the length of the remote track.

While the race has become one of the biggest annual sporting events held in the Northern Territory, unfortunately it has also created a situation where the Queen's birthday weekend is now inevitably the busiest weekend of the year for the Alice Springs Hospital.

As an example, 42 race participants and 11 spectators required emergency treatment in Alice Springs for injuries related to the 2021 race. These numbers were higher than in previous years, despite the cancellation of the return leg of the race. To put this in context, Alice Springs Hospital sees an average of 150 presentations on a 'normal' day, making the relative extra burden from the Finke Desert race considerable.

Given the limitations of Alice Springs Hospital to manage complex spinal and orthopaedic patients—or those that need high levels of critical care—significant extra pressure is also placed on the health service of Adelaide, where the majority of these higher care patients are transferred.

In 2021, eight patients required medical evacuation from Alice Springs to Adelaide for management of life-threatening injuries with several patients needing specialised spinal transport and admission to ICU on arrival. This has a number of financial, health and social implications. The retrieval process itself is not quick, with flight times alone being two to three hours one way. Weather can play a role and extra crews from the Royal Flying Doctor Service are often required to try and mitigate the effect of the race and minimise the need for patients not associated with the race who need medical retrieval for other reasons to wait several days before a retrieval asset is available. Cost of the flight, equipment and staffing can also be considerable.

Following the 2021 Finke Desert Race, I wrote to the event organisers, Motorsports Australia, to highlight the concerns of RACS Road Trauma subcommittee. In this letter I encouraged an urgent reconsideration of the race, and at the very least for increased emphasis to be placed on spectator protection, participant qualifications, and improved medical support.

While the organisers reaffirmed their commitment to hosting the race, I was nevertheless pleased to see some changes made to previously lax safety guidelines ahead of the 2022 race. This included tougher entry requirement standards for drivers, improved safety standards for spectators, and the removal of quad bikes from the race.

The College welcomes any change that will reduce the risk of death or serious injury from the race, and the Road Trauma subcommittee believe that the coronial inquest presents an important opportunity for reflection and review. I recently joined with Dr John Crozier (Chair of RACS bi-national Trauma Committee) to co-sign a letter to the NT coroner in preparation for the inquest.

We sincerely hope that this inquest will prompt meaningful discussion and action to reduce the trauma and burden on not only the participants, spectators and families, but also the wider community. We strongly feel that the number of injuries and deaths associated with the Finke Dessert Race are excessive and we will continue to advocate for a safer environment for all.

I will also endeavour to keep you updated on any public findings that are made by the coroner in the future issues of *Surgical News.*

Dr Jodie-Kate Williams,
Chair, RACS Road Trauma Advisory Subcommittee

Dr Trevor Kwok: Lumley Surgical Research Scholarship recipient

Researching intelligent, automated instrumentaion for vascular and endovascular intervention

The Lumley Surgical Research Scholarship offers Royal Australasian College of Surgeons (RACS) Fellows and Trainees the opportunity to spend a year undertaking research in the UK.

The scholarship—offered in partnership with the Royal College of Surgeons of England—was first awarded in 1962 following a donation by Mr Edward Lumley. The funding is supported by the Henry Lumley Charitable Trust.

Dr Trevor Kwok, a vascular surgeon and computer engineer, was the winner of the scholarship for 2020. He used the funding to research intelligent, automated instrumentation for vascular and endovascular intervention.

Dr Kwok started out as a computer engineer. His interests led him to biomedical engineering where he crossed a bridge into medicine. Eventually, he left the technology industry to put himself through medical school.

Vascular surgery attracted him, he says, because the specialty is versatile and draws on two completely different skillsets. "Open vascular surgery uses more traditional surgical skills. Endovascular procedures are less invasive, radiographically guided, and demand very different technical skills. Modern-day vascular surgery often combines the two approaches to treat a clinical problem."

Dr Kwok is also drawn to the connections with people his specialty brings. "We often develop long-term therapeutic relationships with patients and there's frequently a need to collaborate with colleagues from other specialties to treat complex medical problems."

The Lumley Surgical Research Scholarship gave Dr Kwok his first real opportunity to merge his skills as an engineer and a surgeon, focusing on two different research ideas. His main goal was to develop and perform assessment of a robot to perform endovascular interventions. The secondary goal was to develop and assess automatable techniques for personalised stent-graft manufacture.

> "If you have sufficient time, funding, and the right collaborators, then it's possible to develop a complex idea."

A robot has the potential to revolutionise endovascular surgical techniques, as well as bringing many safety advantages for the patient (such as reducing tissue damage) and the surgeon (less x-ray radiation exposure).

Dr Kwok collaborated with engineers to streamline robot design, then conducted a user study, comparing manual and robot teleoperation for a set of tasks performed on a silicone phantom. An animal study evaluated the system in an in vivo porcine model.

Dr Kwok's research has established feasibility and safety of the robot system, and identified areas for further engineering development, after which a larger animal study and eventually a clinical trial can be envisaged.

The ability to rapidly manufacture personalised stent-grafts could save lives by eliminating the current long lead time in producing customised stent-grafts. In his secondary research, Dr Kwok evaluated three methods of creating fenestrations (including a novel technique, laser cutting) in two prosthetic vascular graft materials. Evaluation included feasibility, tensile strength and water permeability.

His work has established feasibility of the techniques and has opened the door for engineering development of an automated stent-graft manufacturing platform.

It's early days for Dr Kwok's research in robotic endovascular surgery, but he feels invigorated about the future in the field. "I don't think this particular research will directly benefit patients in the immediate future, but it's instilled in me a feeling of the ability to do further work in medical device development. The outcomes could have positive impacts for patients five to 10 years down the track."

Dr Kwok says the scholarship was a brilliant opportunity to work overseas and do research at one of the best science and technology universities in the world, Imperial College London, while receiving financial support. The funding meant he could allocate dedicated time to pursue an academic interest in an area where he can hopefully make a difference, as a strong link between medical engineering and surgery.

"The experience opened my eyes to the process involved in developing a medical device. It's a long pathway to develop technology that will end up being used with a patient. But it showed me that if you have sufficient time, funding, and the right collaborators, then it's possible to develop a complex idea."

RACS offers more than 70 scholarships and grants valued at more than $2.5 million annually through its Scholarships and Grants Program. To learn more, visit www.surgeons.org/scholarships

Empowering the next generation

The RACS Global Health team is building paediatric critical care capacity and confidence in Fiji

Advanced Paediatric Life Support (APLS) courses are widely recognised as best practice in paediatric emergency training. Courses are recommended as additional training for hospital staff working in clinical environments where children and adolescents are cared for. RACS Global Health has been supporting APLS training in PNG and Fiji for several years.

As a RACS Global Health Volunteer Mobilisation Advisor, I had the opportunity to travel to Lautoka, Fiji with the Australian APLS faculty members, Jane Stanford, Dr Mike Starr and Dr Julie McEniery in June 2022. This provided a valuable first-hand experience to observe the skilled Australian and Fijian APLS faculties working collaboratively to conduct very intensive APLS courses. The Generic Instructor Course (GIC) training was also conducted for 21 Fijian doctors, nurses and paramedics from Suva, Labasa, Lautoka and other regional locations. I also observed how hard RACS training volunteers work while they are on overseas deployment. This revealed the full extent of their compassion and commitment to developing the clinical capacity of their in-country counterparts.

This was the second deployment of RACS volunteers to Fiji in 2022, to help consolidate the growing cohort of accredited Fijian APLS instructors capable of independently delivering these courses.

APLS courses are designed to provide participants with skills to respond to the admissions of young people presenting with severe illness or injury. The Fiji-based courses are structured the same as those taught in Australia, with added emphasis on empowerment for in-country participants. This is done through the translation of learning concepts and development of confident communication skills. It allows course participants to work alongside respected local physicians and to watch and apply their skills in scenarios designed to simulate real clinical situations as they occur in ICUs and emergency departments.

Using training kits supplied by RACS, course instructors manipulate the vital signs of patients. Participants methodologically run through checklists and act out their responses on mannequins as they would do in real life, to stabilise a child. Participants are rotated through each training scenario and everyone is given the opportunity of going first, while their colleagues observe. Although appearing nervous to begin with, it was evident that as the three-day course progressed, the participants became increasingly confident in their participation, which also simulates, to the extent possible, clinical pressure.

During the course proceedings, I spoke with Dr Rigamoto Taito, who previously was the Head of the Department for Paediatrics at Lautoka Hospital. Dr Taito has been teaching GIC and APLS courses since 2008. Reflecting on her many years of service, she highlighted the importance of participants acquiring soft skills—not only to communicate effectively with their colleagues but also to provide appropriate support to patients and their families as well.

The course held several interactive plenary sessions in between training scenarios to allow for whole group reflection and inclusive discussion. In addition, course instructors would give one-on-one feedback to participants to commend positive actions as well as highlight specific areas requiring improvement. Despite the high workload and stressful demands, many participants reported that the course was very insightful and beneficial to their professional development.

Thanks to the efforts of our RACS volunteers on this trip, the Fiji APLS team have recommended an additional two experienced GIC instructors to train APLS instructors and have identified four potential candidates as APLS instructors. RACS will continue to support the Fiji APLS faculty to conduct APLS training for Fijian clinicians, and in the future, clinicians from other Pacific Island countries.

Author: Nick Taylor

Image: APLS course participant act out an emergency scenario using patient simulation software.

Registrations are open for the ANZSVS Conference 2022

You are invited to join the Australian and New Zealand Society for Vascular Surgery (ANZSVS) for their Annual Scientific Conference.

It will be held from 21 - 24 October 2022 at the Hotel Grand Chancellor, Hobart, Tasmania.

The conference will be filled with engaging scientific sessions, centred around the theme of Resilience, Respect and Refinement.

You can expect delicious dining experiences and opportunities to explore all that Hobart has to offer!

If you are unable to travel, virtual registration is available.

Register now at anzsvs.com

A master of the knife – Sir Alfred Downing Fripp (1865-1930) KCVO CB MS FRCS

Vanity Fair magazine (VF), first published in 1868, came to be the most influential 'top people's' magazine in Britain in the late 19th century. Its appeal stemmed from the quality of its journalism and its caricatures of people prominent in society, politics, sport, and the professions.

More than 2300 caricatures were published, including 53 medical practitioners, of whom 16 practised in surgical fields. Of the latter, a handful such as Paget and Treves were well known, the balance, less well known. Among the latter group was Sir Alfred Fripp's, *A Master of the Knife*, published on 18 September 1907.

VF noted, 'Sir Alfred Fripp was born in 1861 and went to Merchant Taylors' School where he professes never to have worked, except at 'rugger' football and at cricket. He went from Merchant Taylors' straight to Guy's, where again he found his way at once into the 'rugger' and cricket teams, but where, also he began to study, and in time took his degrees at London University.'

In 1883 on a visit to his older half-sister studying at Cambridge, Fripp also called on his godfather, Canon John Dalton, the Chaplain of Queen Victoria.

Dalton was governor to Prince Albert Victor, the Duke of Clarence and the eldest son of Edward, Prince of Wales, while the prince was ostensibly studying at Trinity College, Cambridge. The prince greatly enjoyed undergraduate life over 1883-5, prior to being excused from exams and becoming an officer in the 10th Hussars.

Fripp and the prince were introduced, and a year later, spent a few days together again at Cambridge, their friendship growing. Six years then passed, for Fripp, in medical studies, sporting activities, and the acquisition of post-nominals.

One of Fripp's first postgraduate activities was a two-week locum tenens with William Jalland, FRCS, in York. Ironically, he was asked to attend his acquaintance, the Duke of Clarence, with a dislocated ankle. Fripp made so favourable an impression that he was then presented to Queen Victoria, her son, the Prince of Wales, and the Duke of York, the future King George V, younger brother of his patient.

Prince Albert Victor, then insisted that Fripp accept the unofficial position of doctor-in-residence, and subsequently a three-person royal tour of South Wales was undertaken, comprising the Prince, Fripp and the prince's equerry, George Holford.

Tragically, this prince, the heir apparent, died in the influenza epidemic of 1892. Fripp then considered that his royal days were over, however, his friend George Holford was then appointed equerry to Prince Edward, Prince of Wales. Unsurprisingly, in 1897 Fripp was appointed as Prince Edward's Surgeon-in-Ordinary.

Wheels within wheels began to turn; with

Holford's help and Fripp's persistence, the Prince of Wales was persuaded to preside over the Guy's Hospital Fund, ensuring the financial security of the hospital. Fripp did not then have a post at Guy's; remarkably, it was not long before the hospital Board created an assistant surgeon post for him.

This position along with his private practice in Harley Street established Fripp as a doctor, teacher, and surgeon. A year later he established himself as a consultant in his own home at 19, Portland Place. Over the next 30 years aristocrats, plutocrats and famous stage personalities were frequent visitors, both as patients and friends.

VF noted: 'Sir Alfred Fripp disarms criticism by attributing his rise in the world to luck.'

In June 1898, Alfred Fripp married Margaret Scott Haywood; Canon Dalton officiating and George Holford as best man. The Fripps were to have five children, the eldest, Alfred Thomas Fripp FRCS, an orthopaedic surgeon, who died in 1995.

In late 1899 it was apparent that the Boer War was not going to be 'over by Christmas'. The yeomanry of the shires were asked to enlist, to augment the regular army, who were being killed, more by an enteric epidemic than by Boer snipers.

Fripp had much to do with the organisation of the Imperial Yeomanry Hospital and went with it to South Africa

as chief civilian surgeon attached to the Deelfontein Hospital. Throughout 1900 he contributed a series of articles to the *British Medical Journal* describing the state of that hospital.

Fripp transformed the idea of how to run a base hospital, and despite being criticised, he took many more nurses than those provided by the Royal Army Medical Corps (RAMC). He even took three specialists who would never have been taken to war before—a physician, a dental expert, and an x-ray specialist.

Fripp asserted that the modern steam sterilising unit that he had shipped from England, saved more lives than medical expertise, and that it was more necessary than the most up-to-date medical implements.

A committee under the chairmanship of Mr Brodrick, Secretary of State for War, was formed which included Fripp and Sir Frederick Treves, to examine how to improve the RAMC. The chief recommendation was that an advisory board—consisting in part of civilians—be established and that the RAMC be under its direction. Periods of study leave were also provided for, and the army nursing staff was reorganised.

VF described these outcomes as follows: 'Sir Alfred Fripp got his knighthood for helping to carry out reforms in the Army Medical Corps. He sat on a committee which Mr St John Brodrick got up, and which ended by giving better pay and longer leave to medical officers in the Army, with the happiest results.'

During the 1914–18 war, Fripp was appointed a consulting surgeon to the Royal Navy.

Plarr's *Lives of the Fellows of the English College of Surgeons* observed: 'as a surgeon Fripp was a good operator, but without deep interest on the scientific side. The individuality of his patients, especially of the children, appealed to him, and he was for many years an active member of the invalid Children's Aid Association. As a man he had great social gifts with a handsome presence. He had too a peculiar skill in raising money for charity.'

As well as scientific articles, Fripp co-authored in 1911, *Human Anatomy for Art Students*. This book has continued over the years, with an edition as recently as 2006, and is now recognised as 'culturally important.'.

Fripp retired from Guy's Hospital in 1925, famous in London and environs. When he died in 1930, he had become a household name throughout Britain: the reason: Ye Ancient Order of Froth Blowers (AOFB).

An ex-serviceman, Bert Temple, founded this fundraising body in 1925, in gratitude for life-saving surgery by Fripp: membership was five shillings, with each member receiving a pair of silver, enamelled 'AOFB' cuff-links: their motto, Lubrication in Moderation.

Notwithstanding the obloquy of the Temperance Movement, Fripp spoke nationally at more than 200 meetings. By 1928, there were more than 700,000 AOFB members, who raised more than £100,000 (many millions today).

In appreciation of his many contributions, Fripp was made a Governor of Guy's Hospital and he provided money to Durham University for an annual lecture on Happiness and Success—the first given in 1932 by Stanley Baldwin, later UK Prime Minister in 1935.

Alfred Fripp died on 25 February 1930. His Times obituary, A Man of Many Friends, included a reference to his Froth Blowers—'These, by their innocent mirth, have contributed largely to charities, and have entertained and brightened the lives of innumerable children'.

Images (clockwise from far left): Sir Alfred Fripp, 'A Master of the Knife', 'Spy' caricature 1907; Merchant Taylors' School, Charterhouse, 1875; Alfred Fripp; Fripp family, early 20th century; AOFB cufflinks; AOFB member's booklet.

Dr Peter F Burke
FRCS FRACS DHMSA

History, heritage and archives

In late 2021, RACS Council approved a merger of the Heritage and Archives Committee and the Surgical History section. Now combined, its new name is the History, Heritage and Archives Section. The section, which sits within Fellowship Services, officially came into being in March 2022. It aims to broaden the section membership and oversee activities such as the Cowlishaw Symposium and the researching and planning of the RACS 2027 centenary celebrations—a huge milestone for the College.

The College of Surgeons was established in 1927, almost 100 years ago, and has a long and fascinating history. The first meeting of the College council was held in Dunedin, Aotearoa New Zealand, with Sir George Syme appointed as the inaugural College president. Since then, the College has grown and changed, generating a history, that has fed a rich and extensive historical collection.

The RACS museum and archives—hidden in the basement of the 1960s wing of the Melbourne building—are managed by a small and passionate team. The collection houses surgical instruments, photos, gifts, rare books collection, artwork, and memorabilia—all of which will be spotlighted in the upcoming 2027 centenary.

The book *Unveiling the Collections of the Royal Australasian College of Surgeons* was published in 2021 and highlights many important pieces within the museum. It is available for purchase through the College of Surgeons website (bit.ly/3Igdv9v).

Helen Laffin, who has worked at the RACS museum for six years, tracks each item that comes through the museum doors with an image, description, donor details and location. Her personal highlight is the Sidcup and Heidelberg collection

which "shows the huge efforts made by surgeons (after World War 1 and 2 respectively) to help patients with facial injuries."

Elizabeth Milford, the RACS archivist, says that celebrating and preserving surgical history is important because it "enriches our understanding of the world, for example—pandemics are not exclusive to 2020 to 2022. There have been pandemics throughout history and knowledge of these can help our understanding of the current pandemic." She continues: "Surgical history enables surgeons to see how their treatments, methods and instruments have changed—it can give a focus to their work in improving standards, patient outcomes, etc."

One of the significant items in the collection is the Great Mace, presented to the College by the Royal College of Surgeons England (RCSE) in 1930. It is a heavy and intricate work of cast and chased silver gilt, which is housed in the RACS museum. It is taken to the Council room when Council convenes in Melbourne, and if a meeting takes place offsite, a 3D replica created in 2021 is sent in its place.

A significant collection of scholarship that resides in the College is the Cowlishaw Collection, a large repository of books on medicine and related subjects, containing many early, classic, and rare editions. It was purchased in 1943 from the estate of Dr Leslie Cowlishaw, a physician and bibliophile in Sydney. The collection is housed in purpose-built bookcases donated by the Faculty of Anaesthetists in the RACS Council room.

Every two years, the College organises a symposium intended to use the items in the collection. Talks range from British naval medicine, the history of medical ethics, and bone-setting in 15th century France. The symposium was halted during the pandemic but is aiming for a comeback in 2023.

The Deputy Chair of the new History, Heritage and Archives section is Dr Su Mei Hoh, a Younger Fellow with an interest in surgical history. When asked what piqued her interest in the section, she said she is fascinated by the stories of social and technological change that brought about the modern practice of medicine and surgery. Dr Hoh believes that it is important to know the origins of surgical practice because "understanding the reasons behind the invention of a tradition is at the core of growth and reinvention. There is a Māori saying, Ma Muri Ki Mua, which means walking backwards into the future. Without knowing our history, I think it's impossible for future progress without repeating the failures of the past."

Another project being developed by the committee is a book to commemorate 100 years of the College. This will add to the *Portraits at the Royal Australasian College of Surgeons* (1993), *The Mantle of Surgery* (2002), and *Anzac Surgeons of Gallipoli* (2013).

We encourage those interested in surgical history and heritage to join the section and be part of the exciting projects in development. With many new projects on the horizon and the centenary around the corner, it is an exciting time to re-examine our understanding of surgical history and celebrate the history of RACS with a fresh perspective.

RACS backs shared commitment to cultural change

RACS has pledged its support for a health sector wide commitment to create a positive culture in medicine.

Agencies across the health sector have been invited to endorse a Statement of Intent proposed by the Medical Board of Australia at its May 2022 Cultural Change Symposium.

The Statement of Intent recognises the link between patient safety and medical culture, affirms collaborations to foster change, and acknowledges the value of agencies working together to navigate shared challenges towards common goals.

The statement will be published on the Medical Board website, co-badged by medical and health sector agencies that share a commitment to positive cultural change.

RACS Council proudly endorsed the statement, because it aligns with the College's demonstrated, long-term commitment to building a culture of respect in surgery and our *2022 Building Respect Action Plan,* which will guide the next chapter of our work.

The statement is consistent with recommendations from the RACS 2022 Expert Advisory Group (EAG 2022) to address entrenched cultural problems with cross sectoral commitment and collaboration.

The RACS *2022 Building Respect Action Plan* involves leadership, collaboration, and a shared purpose with other health sector agencies, which feature in the Statement of Intent.

The RACS action plan sets out a program of work that aims to strengthen leadership and professionalism,

increase cultural safety and diversity, address racism, support speaking up and providing feedback, and leverage collaborations and partnerships.

As an invited presenter, RACS shared the highlights and challenges in our *2022 Building Respect Action Plan* program of work and identified opportunities for collaboration as we move from raising awareness, to fostering action in the next phase of our work.

Sustainable cultural change in the health sector relies on collaboration. Accountabilities and responsibilities for action are shared between employers, jurisdictions, educators, regulators, and others. We need to work together to address problems that result from interdependence and overlap between agencies.

Building a positive culture in medicine is now a shared goal across the health sector. We look forward to working with all signatories to the Statement of Intent championed by the Medical Board, including other medical colleges, as we collaborate and create a culture of medicine that we can all be proud of.

Under the *2022 Building Respect Action Plan*, RACS focus for future action is the workplace—in the hospitals where surgeons train and work, as well as in the College. We cannot meet this challenge by working alone.

We aim to work across the College community, with specialty societies and specialty training boards, as we map a path towards our shared goals. RACS will also foster collaborations with colleagues in hospitals, specialist medical colleges, other employers and governments to improve the culture of medicine and create safer places for surgeons to work and train.

Read the *RACS Building Respect, Improving Patient Safety: From Awareness to Action plan* on the RACS website: bit.ly/3a8CyP1

The 2023 Learning and Development Grants applications are open!

The 2023 Learning and Development Grants applications open on 16 August and will close on 12 September 2022.

Advance your career and find the right grant to support your goals and unique learning journey. With more than $500,000 being offered across 28 grants, you will find a grant to suit your needs.

The Learning and Development Grants can be used to fund professional development activities such as travel and accommodation to conferences, training courses, exam fees and more. Each grant has specific eligibility requirements, outlined in the table below. You can apply for more than one grant.

Below is an overview of the grants being offered in 2023:

Anwar and Myrtha Girgis SIMG Grant

$10,000

Supports professional development required to practice surgery in Australia or Aotearoa New Zealand.

Who can apply? Doctors who are recent migrants or of refugee or asylum seeker background.

Aziz Hamza Rural Surgery Grant

$1500

Assists in delivering quality surgical care to people in remote and regional Australia and Aotearoa New Zealand.

Who can apply? RACS Fellows (within their first 10 years of Fellowship) and SET Trainees.

Bongiorno National Network Younger Fellows Travel Grant

$10,000* (one grant)

$7500* each (up to two grants available)

Supports post-Fellowship studies and furthering surgical experience overseas.

**Note: the amount offered will be based on the successful applicants' requirements*

Who can apply? RACS Fellows (within first ten years of Fellowship)

Fellowship Examiners Grant

$10,000 each (up to two grants available)

Supports travel and accommodation to visit a surgical college overseas.

Who can apply? RACS Fellows who are current members of the Full Court and CPD compliant at the time of both the application and the visit.

Hugh Johnston ANZ ACS Travel Fellowship

$8000

Supports recipients who will travel to the USA to attend the ACS Annual Clinical Congress and visit medical centres.

Who can apply? RACS Fellows (within their first 10 years of Fellowship).

Hugh Johnston Travel Grant

$10,000

Supports international travel to gain specialist knowledge and expertise.

Who can apply? RACS Fellows (within first ten years of Fellowship).

John Buckingham Travel Grant

$4000

The grant funds travel to attend the ACS Annual Clinical Congress in October in the year after the grant is awarded.

Who can apply? SET Trainees who are members, or applicants of the ANZ Chapter of the ACS.

Medtronic Younger Fellows Travel Grant

$7500 each (up to two grants available)

Supports post-Fellowship studies and furthering surgical experience overseas.

Who can apply? RACS Fellows (within first ten years of Fellowship)

Morgan Travel Fellowship

$13,000 each (up to two grants available)

Supports travel to gain clinical experience or conduct research.

Who can apply? RACS Fellows (within first ten years of Fellowship)

Murray & Unity Pheils Colorectal Travel Grant

$10,000 each (up to two grants available)

Supports travel to obtain further training and experience in the field of colorectal surgery.

Who can apply? RACS Fellows and SET Trainees

Pickard Robotic Training Grant

$100,000 – divided among recipients

Supports training and/or research opportunities to expand expertise in innovative robotic techniques.

Who can apply? South Australian residents only - RACS Fellows, SET Trainees, non-RACS surgeons and other health professionals.

Poate Family Plastic & Reconstructive Surgery Travel Grant

$3500 (divided among recipients)

Supports travel to obtain further training and experience in plastic and reconstructive surgery.

Who can apply? Plastic and Reconstructive SET Trainees.

Care of the Critically Ill Surgical Patient (CCrISP) Coordinator Grant

$3500 - divided among recipients

Supports attendance to a clinically related activity.

Who can apply? CCrISP coordinators.

Early Managemenet of Severe Trauma (EMST) Coordinator Grant

$6500 – divided among recipients

Supports attendance to a clinically related activity or external course.

Who can apply? EMST coordinators.

Rural Junior Doctors Surgical Skills Course Grant

$1500

Supports surgical skills course activity in a rural or regional location.

Who can apply? Rural or regional junior doctors - registered with JDocs and members of the Rural Surgery Section.

Rural Surgery Fellowship for Provincial Surgeons

$10,000 each (up to three fellowships available)

Supports regional and rural surgeons to travel and develop existing skills or acquire new skills.

Who can apply? RACS Fellows (non-metropolitan based)

Queensland Younger Fellows Grant

$2500

Supports travel to obtain post Fellowship training, and/or supports return to practice in Queensland.

Who can apply? Queenslanders only - RACS Fellows (within first ten years of Fellowship)

Skills Training Faculty Grant

$10,000

Provides professional development to senior Skills Training faculty.

Who can apply? Senior instructors or directors in a RACS Skills Training program.

Stuart Morson Neurosurgery Grant

$40,000

Funds travel to advance experience and skills in neurosurgery.

Who can apply? RACS Fellows (within their first 10 years of Fellowship), SET Trainees and non-RACS neurosurgeons.

Younger Fellows Leadership Exchange Travel Fellowship

$5000 (funds recipient's airfares, accommodation, transfers and conference expenses).

Supports a Younger Fellow to attend the AAS Congress, held in the United States every February.

Who can apply? RACS Fellows (within first ten years of Fellowship)

Indigenous Program – ASC Grant

Up to $5000 each (up to six grants available)

Supports participation at RACS 2023 Annual Scientific Congress.

Who can apply? Aboriginal, Torres Strait Islander and Māori doctors and final year medical students.

Indigenous Program – ASC Peer Support Grant

Up to $5000 each (up to two grants available)

Supports participation at RACS 2023 Annual Scientific Congress.

Who can apply? Aboriginal, Torres Strait Islander and Māori doctors and final year medical students who have previously attended an Annual Scientific Congress.

Indigenous Program - Johnson & Johnson MedTech SET Scholarship

$20,000 each (up to three grants available)

Funds professional development, research projects, fees and travel.

Who can apply? Aboriginal, Torres Strait Islander and Māori SET Trainees.

Indigenous Program – Career Enhancement Grant (Junior Doctors)

$5000 each (up to six grants available)

Supports the acquisition of knowledge and skills that will strengthen surgical career pathways.

Who can apply? Aboriginal, Torres Strait Islander and Māori junior doctors.

Indigenous Program – Career Enhancement Grant (Medical Students)

Up to $2000 each (up to six grants available)

Supports the pursuit of a surgical career.

Who can apply? Aboriginal, Torres Strait Islander and Māori final year medical students.

Indigenous Program – Davison Family Grant

$2500 per year (for up to three years)

Supports doctors to undertake postgraduate surgical training.

Who can apply? Aboriginal and Torres Strait Islander doctors.

Indigenous Program – Ngarra Grant

$1000

Funds an educational activity.

Who can apply? Female Aboriginal and/or Torres Strait Islander RACS Fellows, SET Trainees, junior doctors and final year medical students

Indigenous Program – Williams Family Grant

$15,000

The grant may fund an activity or a field of study to advance the health and wellbeing of Aboriginal and Torres Strait Islander people.

Who can apply? Aboriginal and/or Torres Strait Islander RACS Fellows and SET Trainees.

Visit www.surgeons.org/scholarships and click on Learning and development grants for more information and to apply.

ANZAC II: Walers and a 'Chloe' sequel

OPUS LXXVI

I had an ANZAC Day experience this year in my efforts to get a photograph of Chloe used in the previous issue of *Surgical News*. I even asked one of the servicemen to walk by the portrait so discretion would obtain. The ANZAC spirit still pervaded the first-floor bar and I was even offered a beer by a stranger (did I look like one of the old brigades?).

How does the word Waler come into this title? My habit of asking every patient in this medico-legal phase of my career their occupation—'I am a Waler' surfaced once and my mind went straight to the 1850s novel *Moby Dick* by Herman Melville, about the albino whale and Captain Ahab who went hunting for the big white brute, the size of his sailing ship.

Walers were the brumby horses from western New South Wales, the breed favoured by the Australian Light Horse Regiment in WWI. They would have been part of that contingent of 120,000 horses sent to the Arabian Peninsula. These Walers had stamina, endurance and could work all day, 'even without a drop to drink'. Their characteristic resilience in the desert was the hallmark of their success.

Actual Beersheba image

In the Battle of Beersheba, these characteristics were their saving grace—carrying heavy weapons, guns and ammunition, and military supplies, weaving their way in and out of the Turkish trenches, eventually capturing the regiment, then arriving at Damascus on the way to Jerusalem. Later that day Lawrence of Arabia in his Rolls Royce (illustrated) claimed it as a British victory.

Incidentally, John Hanrahan, a former president of the College in the 90s, when hearing of this article would enlighten me that it was an ANZAC dentist who was the first man to set foot in Damascus. Thanks to this tip I discovered an article in the *Sydney Morning Herald* that the person was lieutenant-colonel Olden, who hailed from Ballarat.

Most of the Walers had to be left behind as the cost of transport and quarantine precluded their return to Australia. Some ended up with the British forces in Egypt and India.

Some of the soldiers in WWI could not handle the thought of losing their best friend in a foreign land and had to resort to euthanasia—one of the saddest days in their lives they said. Being killed in a war is incidental because that is where the story stops.

Major Bridges had a horse, Sandy, and was the only Waler to return to Australia. A sculpture of the horse's head, acknowledging the Walers, is on display at the Australian War Memorial.

The Shrine of Remembrance – Melbourne

Here is another ANZAC recollection piece from the Shrine of Remembrance in St Kilda Road. The building was designed by architects Philip Hudson and James Wardrop in the classical style of the mausoleum tomb of Halicarnassus and the Parthenon. Etched in marble there are the words 'Greater Love Hath no Man' (John 15:13). Every year on 11 November at 11am (Remembrance Day), a ray of sunlight is designed to shine through an aperture in the roof to highlight the word Love.

The sanctuary in the Shrine of Rememberance

Lodge Bros, the construction engineers and their foreman of works—a returned veteran—was my patient at The Western Hospital, suffering from multiple skin cancers.

After umpteen admissions he was grateful for the work done by the plastic and reconstructive team, so much so that one day on the ward round he offered me a little token of gratitude. "Felix, I have a present for you," he said. "You can have my marquette of the Shrine." A marquette is a miniature replica of a major construction.

Not to seem too intrusive in accepting such a gift and being a little tardy in following up this gesture, the family overruled the patient's wishes and I lost out. I had intended to give it to the College as a memento for the likes of Weary Dunlop and Bertie Coates for their wartime contribution. Even Bertie Coates later said, "memories of times past are our most treasured possessions," as I keep trying to recall.

Now let us dive back to T.E. Lawrence and his Welsh background. Historically, a life story emerged recently on one of those David Portillo train excursions into Wales on SBS Great British Rail Journeys. Lawrence was the unplanned son of Sir Thomas Chapman, an Anglo-Irish baronet, and his housemaid—born at Snowden Lodge in Wales.

Snowden Lodge

Saint Thomas More's quip in Bolt's play *A Man for all Seasons* stated, 'It profit a man nothing to give his soul for the whole world … but for Wales!' But Wales played an important part in WWII in protecting the National Gallery collection when bombs were peppering the Trafalgar Square. Sir Kenneth Clark was the director of the National Gallery then and avoided sending the collection to Canada because of the German submarines in the North Sea. The collection was housed in the slate mines of Wales, offering protection for the Titians and Tintorettos etc.—all revealed in the train story.

Lawrence's Oxford days reflected his endurance and independence, refusing to attend lectures—'I can write better than this', he once said. Eventually his superiors compromised, and he graduated and went on an archaeological sabbatical to Syria spending four years there. The Bedouin link in his story are reflected in the film Lawrence of Arabia based on his book *Seven Pillars of Wisdom*. Incidentally, I bought a copy, a collector's edition, for $5 at the Brotherhood of St Lawrence recently, which stimulated me to write this article.

Lawrence recounts his role as advisor to the Bedouin forces against the Ottoman Empire of 1916 – 1918 before being accepted back by the British Army. Yes, he always wore the Arab gear, which was incidentally not a standard British uniform issue. British history records it was Lawrence who captured Jerusalem after the Battle of Beersheba, driving up in a Rolls Royce (illustrated), unaware of the earlier ANZAC victory. Didn't Churchill say, 'Those who write history own it,' but someone subsequently said, 'Accurate historical recollections become the province of later generations'.

T.E. Lawrence arriving in his Rolls Royce after the fall of Beersheba

After the war, Lawrence's quest for speed was evident, even designing speed boats. These were subsequently used to rescue English and allied pilots from the Channel in the Battle of Britain. It was McIndoe who observed the value of the saline solution—from dunking in the Channel—in burns management to improve outcome, now a standard clinical practice.

Lawrence's insatiable desire for speed was his undoing. He bought a Brough Superior motorcycle, capable of 100mph in the early 1930s. Once skirting through the hedgerows of Surrey he tried to avoid crashing into a group of children on a school excursion, and went down an embankment and suffered a major head injury that was eventually fatal.

It was managed at the new department of neurosurgery at the University of Oxford, founded by a South Australian surgeon called Sir William Hugh Cairns, as Damien Jensen revealed to me.

Sir William Hugh Cairns of Scottish descent and serving in the armed forces in WWI

Even General S. Patton, with his ivory handled pistols on his hips, was admitted to the same unit following a crash in his jeep outside Paris. He eventually died. Damien's awareness of head injuries ordained that he wore a motorcycle helmet when driving his two-door coupé. He could also recall that neurosurgery lives on the value of ancestor worship quoting the late Keith Henderson merely following the leader. At St Vincent's Hospital, for example, Francis Morgan trained Keith Henderson who trained Damien in neurosurgery, all under the Cushing umbrella (where Adson's forceps come from, used in every plastic surgical procedure). Some little pearls that surfaced like tea leaves in the tearoom at The West between cases—thank you Damien.

My recent publication on Chloe created interest. Touchingly, we revealed how these past veterans sent correspondence home to their Melbourne 'girlfriend' eventually to be forwarded to their families. What a consolation on the home front from the desolation of the Somme, thanks to a beautiful Parisian artist's model.

In a recent Napoleonic documentary, the words Lest we Forget, surfaced and I thought this was an ANZACISM—there is nothing new under the sun. And to hear the French President Macron—when entertaining our Prime Minister Albanese recently at the Elysée Palace—say, "We can never forget the debt France owes to the Australian forces in WWI including the Battles of the Somme and Fromelles." (Thanks to the SBS French news)

And to quote a little bit of history from Lawrence Binyon in his poem *For the Fallen:*

'Age shall not weary them, nor the years condemn'.

We will remember them.

Associate Professor
Felix Behan

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.

The College has received notification of the passing of the following Fellows between August 2021 and May 2022:

Dr John William Owen
Dr David Robert Holden Kennedy
Dr John Hargreaves Hodgson
Dr Hugh James Tighe
Dr Irwin Hunter Hanan
Dr Wylie Gibbons
Dr Brian Swan Purssey
Dr Kush Raj Shrestha
Dr Trevor Pickering OAM
Dr John Campbell Gillman
Dr Noel Wesley Kinny
Dr Michael Joseph Barry
Dr Maurice Maguire
Dr Michael James Kamenjarin
Dr Michael Eagleton
Dr William Renton-Power
Dr Neil Thompson
Dr Kenneth Phoon
Dr John Rice
Dr William Thomas
Dr Douglas Reiunehr
Dr John Rutherford
Dr Peter Alan Harbison
Dr Robert Mulligan
Dr Joseph Devadetta
Dr Kerry Kelsall Larkin
Dr James Kevin Evans
Dr Kenneth Stuchbery
Dr Robert Francis Clifford Jones
Dr Gregory Mitchell
Professor Gabriel Kune
Dr David Bracy
Dr Harry Watts
Dr Gabriel Reisner
Dr Albert Victor Forage
Dr David Stewart Forbes
Dr Peter Battlay
Dr Richard O'Connor
Dr Bryan Chester
Dr David Charles Johnson

Dr Andrew Alexander MacDiarmid FRCS(Ed) FRACS

Orthopaedic surgeon

9 November 1950 – 19 October 2021

Andrew (known to most of us as Andy) MacDiarmid was highly regarded as an orthopaedic surgeon in the Bay of Plenty. He was a passionate advocate for every patient, treating all equally—no matter their background or station in life. He was one of the pioneers in Orthopaedic Outreach to the Pacific Islands, first going to the Cook Islands as a Trainee intern in 1974 and continued to visit the Cook Islands annually. He was instrumental in raising the standard of orthopaedic care in the Cook Islands.

Dr Douglas George Sneddon FRACS

Orthopaedic surgeon

7 June 1947 – 25 November 2021

Doug was an outstanding Perth orthopaedic surgeon and his dedication to orthopaedic trauma care was outstanding, with long hours spent in the trauma theatre. His interest was piqued when his colleague John Kagi introduced the Ilizarov technique to Perth in the early 1990s and it was here that Doug found his life's work. He developed vast experience in the use of Ilizarov technique for complex upper-and lower-limb trauma, and was acknowledged as a world expert, often invited by overseas trauma societies to share his experience. His work saw him awarded the Evelyn Hamilton Trust Prize for the Best Scientific Paper at the 1996 Combined Scientific Meeting.

Dr Nicholas Constantine Anastas, FRACS

Orthopaedic surgeon

30 June 1933 – 3 September 2021

Nick was awarded the Royal Australasian College of Surgeons Fellowship in 1967 and had long and esteemed careers at Princess Margaret Hospital for Sick Children and Royal Perth Hospital as a consultant orthopaedic surgeon. He accumulated many grateful patients over the years, some returning to visit in midlife, having been treated by him as babies with congenital orthopaedic disorders.

Professor Errol John Maguire FRACS

General surgeon

15 June 1940 – 12 April 2022

Errol was born in Cairns and was medically dedicated to his work. He missed his son's 30th birthday when one of his patients presented with a complication of internal bleeding, which couldn't be controlled. Errol having O negative blood un-scrubbed and transfused fresh blood into the patient—two units were used. The bleeding ceased and the patient was saved. In his latter life, he played an integral role in setting up James Cook University's medical program to provide opportunities to regional Queensland. He was the inaugural professor of surgery at Bond University, ultimately moving to Griffith University in the same role.

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

Royal Australasian College of Surgeons
Foundation for Surgery

Thank you for your extraordinary compassion and generous support to the Foundation for Surgery in June and July.

Thanks to you, many more children, families and communities have access to quality surgical care when they need it most.

Every donation makes an incredible difference throughout Australia, Aotearoa New Zealand and the Asia Pacific Region.

Gold

Ms Helen Henderson

Silver

Dr Stephen Brough
Dr Nigel Broughton
Dr Donald Cameron
Dr Siew Cheah
Dr Daron Cope
Dr Peter Heathcote
Dr Johannis Kilian
Dr Jonathan Livesey
Prof John Royle
Dr Alan Saunder
Dr Neil Smith
Dr Russell Taylor
Ms Hilary Wallace

Bronze

Assoc Prof Ned Abraham
Dr Semisi Aiono
Dr Adrian Aitken
Prof Munjed Al Muderis
Dr Michael Anderson
Dr David Angus
Dr Brett Archer
Dr Mohammed Awad
Dr Stephen Baker
Dr Catherine Banks
Dr Michael Barnes
Dr Adrian Bauze
Dr Peter Berton
Dr Conrad Bishop
Dr Alison Blatt
Dr Janusz Bonkowski
Dr Laszlo Borbely
Dr Bernard Bourke
Dr Franklin Bridgewater
Dr Ingra Bringmann
Dr Andrew Broadhurst
Dr Graeme Brown
Dr Peter Brydon
Dr Daniel Bunker
Dr Stephen Byrne
Dr Michael Byrom
Dr Anthony Cadden
Dr Alessandra Canal
Dr Michael Caughey
Dr Simon Ceber
Dr Sean Chan
Dr Abhilash Chandra
Dr Lean Peng Cheah
Dr Jacob Chisholm
Dr Neil Cleaver
Assoc Prof Harvey Coates
Dr Neil Cochrane
Dr Allen-John Collins
Dr Sarah Condron
Dr Aaron Cook
Dr Gerard Coren
Prof Minas Coroneo
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