SurgicalNews

Volume 23 | Issue 3

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Meet our new vice president

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RACS ASC May 2022

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Correspondence and letters to the editor for Surgical News should be sent to: surgical.news@surgeons.org
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www.surgeons.org
ISSN 1443-9603 (Print)/ISSN 1443-9565 (Online).

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President's message

As we get into the colder months of winter, we expect to see a growing number of COVID-19 infections and influenza. This is a stark reminder that the COVID-19 pandemic is far from over and that we have many issues that need to be addressed, including the impact of long COVID and its implications for ongoing medical support.

As governments try to get the elective backlog under control, I fear that the already exhausted and burnt out healthcare workers' health and wellbeing will continue to be adversely affected. We desperately need more staff, particularly nurses and other clinical professionals.

We recently received notification from the Australian Department of Health's Health Products Regulations Group, that there is an extreme shortage of non-ionic IV contrast (Omnipaque) for radiological investigations. Aotearoa New Zealand had adequate supply when this message was published.

We wrote to our members advising that they comply with restrictions in requesting diagnostic imaging that requires IV contrast, such as angiograms, CT scans, intra-operative imaging, retrograde pyelography, ERCP, operative cholangiogram among other items.

The current stock of IV contrast should be reserved for urgent, non-deferrable indications and surgeons should consider alternative investigation methods if appropriate for the indication. This is likely to mean deferral of some planned surgery until the supply is restored in hopefully, one to two months.

We encourage surgeons to make sure their Trainees are aware of these guidelines.

In May we held our 90th RACS Annual Scientific Congress in Brisbane. It was a successful event that attracted more than 2600 attendees from more than 25 countries. It was great to see so many people in one place—enjoying catching up with friends and colleagues. I'm sure that like me, many of you were reminded of just how much we have missed in-person interaction with each other. We were able to have more meaningful conversations and make important connections.

We had a wide variety of presentations covering an interesting range of topics made by our Fellows, Trainees, overseas medical colleges, our specialty societies, and other healthcare practitioners. My special gratitude to my fellow presidents who joined us: Professor Mike Griffin, the president of the Royal College of Surgeons of Edinburgh, Professor Kean Ghee Lim, president of the College of Surgeons of Malaysia and Professor Johan Fagan, incoming president of the Colleges of Medicine of South Africa.

I attended as many sessions as possible and particularly enjoyed the theme of sustainability. It covered topics from education, individual health and wellbeing to rural surgery in Australia and Aotearoa New Zealand, and also overseas in countries such as India, where the rural areas also suffer from a lack of infrastructure and support systems on a much larger scale than we experience in our countries.

I especially want to acknowledge Associate Professor Rhea Liang, one of our Queensland-based Fellows, who stepped in at the last minute to cover for a plenary session presenter who couldn’t attend. I was impressed by how well Rhea delivered a highly polished talk at a moment’s notice. Thank you, Rhea.

I was also honoured to welcome our new Fellows at the convocation ceremony. Congratulations to you all. I know how hard you’ve worked to get to where you are. I look forward to supporting you as you embark on this new phase of your career. I encourage you to become active members of the College—it is your College and you have the opportunity to make it a College that you can be proud of and help progress.

During the RACS ASC, I also had the pleasure of launching our Building Respect Action Plan 2022, a five-year plan, which expands the College’s focus on addressing bullying, discrimination and sexual harassment, towards fostering professionalism and civility in surgery.

For the past six years we have focused on building awareness and understanding to operate with respect in surgical workplaces. The new action plan focuses on supporting actions that encourage professional behaviours that keep teams performing at their best and keep patients safe.

The 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.

We look forward to working with our members and health jurisdictions around Australia and Aotearoa New Zealand and supporting them to embrace and implement this new focus.

My thanks also go to the congress conveners—Professor Chris Pyke, Professor Deborah Bailey, section conveners, Dr Liz McLeod, the congress coordinator, our keynote speakers and visitors, and our generous sponsors. Thanks to our staff who pulled this wonderful event together and spent many hours making sure everything was working well—from technology, communications, media, accommodation, and food services.

And thank you Brisbane for your warm hospitality. We look forward to the 2023 RACS ASC in Adelaide, South Australia.

On a final note, I would like to thank you for sharing your thoughts and concerns—in support of and against—the proposed name change for the College. It is encouraging to see the high level of engagement this issue has generated. We will continue to give you the opportunity to share your views as we increase awareness of the proposal.

Dr Sally Langley
President

Royal Australasian College of Surgeons

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Meet our new vice president

Gratitude drives Professor Chris Pyke

Professor Chris Pyke is motivated by a sense of gratitude in his roles as a breast and endocrine surgeon and incoming RACS vice president.

The Brisbane-based surgeon is grateful for the free university education that enabled him to complete a medical degree, and for the many mentors and colleagues who supported and inspired him along the way.

But Professor Pyke is most grateful that he discovered a career that he enjoys, finds satisfying and gives him the opportunity to repay what he considers to be a debt to the community and the profession.

"It was a happy discovery that I really enjoyed surgery and I was good enough at it," he says.

"It's very tactile—like woodwork—and every day it's like you're involved with your patient in hand-to-hand combat against disease."

Since the death of his sister after a 20-year battle with breast cancer, Professor Pyke is aware of the toll the disease takes on families and communities.

In his area of specialty, he feels like he can make a significant impact on patients' lives and those of their loved ones.

"I have to say, if you want to affect the community, just make a disease for middle-aged women; they are front and centre of every single family at that age, and many workplaces. They're the glue of our society and diseases that affect them affect everyone," he says.

"Working in this area, you can make a real difference."

While Professor Pyke's father was a paramedic, his influence on encouraging his son to pursue a medical career was more to do with his work ethic and notion of a vocation. It was only later, when he was a medical student that Professor

"Every new generation of surgeons should be better than the one before, and that's what I'd like to help achieve."

Pyke understood the impact that his father's work had on him.

"There was a terrible accident outside our place one night and I got to see him working firsthand. It was a multi-vehicle trauma and I saw him triaging, deciding which people to rescue first—in the dark. I was rather in awe of what he was doing."

Professor Pyke and his wife have three children, one of whom has followed his father into medicine, while the other two are pursuing careers in education and law.

His wife conducts tours at the Queensland Art Gallery and Professor Pyke enjoys acting as what he describes as a "crash test dummy" to help her prepare.

In his spare time, Professor Pyke loves to bushwalk along the trails around Brisbane.

Professor Pyke's career has taken him around the globe, working at some of the world's leading hospitals alongside some extraordinary doctors.

After completing his surgical training at Mater Medical Centre in Brisbane, he undertook surgical fellowships at the Nottingham Breast Unit in the UK and the Mayo Clinic in the US.

On his return to Australia, he took up a position as a senior lecturer with The University of Queensland and completed a PhD in breast cancer risk quantification.

He combines a professorship at the University of Queensland with his work as a consultant in public and private health services, and his many administrative, board and committee positions.

Professor Pyke sat on the Board of General Surgery for almost a decade, is a past president of Breast Surgeons of Australia and New Zealand, and the Breast Section of RACS. His most recent College position was Chair of the Court of Examiners, a position as challenging as it was inspiring.

In his new position as RACS vice president, he aims to protect the high standards of the surgical profession and encourage "quality" as a unified goal for all specialties.

In line with his commitment to serving the community, he would also like to ensure surgeons offer high value care for patients and to undertake responsible stewardship of the community's health resources.

Professor Pyke sees his role as a continuation of the work of the surgeons who originally established the profession's membership body.

"At the beginning of the College in 1927, surgeons came together to ensure they had met the standard necessary to serve their community and I see my role as a continuation of that."

Ultimately, he would like to leave the profession in an even better shape than he found it.

"I benefited along the way from the magic escalator of free tertiary education, and from extraordinary teachers. Some of the role models I've had did not need to spend their time teaching me, but they wanted to make sure the profession was better when they left it.

"I'm proud to say I'm following in their footsteps. Every new generation of surgeons should be better than the one before, and that's what I'd like to help achieve," he says.

news in brief

RACS strategic and business plans

We recently published our Strategic Plan 2022–2024 and our Business Plan 2022, which outline specific initiatives to support the College in continuing our work to deliver value for our Fellows, Trainees, Specialist International Medical Graduates (SIMGs), partners and the communities we serve.

In considering our strategy for the next three years, we reviewed internal, external, and global conditions to guide our thinking and planning. Our priorities are:

- Leading a sustainable future of surgery
- Serving all communities equitably
- Enhancing member value
- Operational excellence.

Our Business Plan outlines the first year of implementation of the Strategic Plan. We feature five flagship programs in 2022:

1. Building Respect, Improving Patient Safety: From awareness to action
2. Implementing the Rural Health Equity Strategy
3. Championing Aboriginal, Torres Strait Islander, and Māori health
4. Advocating for workforce and health care sustainability
5. Improving our services.

You can find the current Strategic Plan and Business Plan and previous iterations on the RACS website: bit.ly/3wWYTrr

Join the RACS Professional Skills Assessment Working Group

We are calling for expressions of interest from Fellows who have an interest in work-based assessments to contribute to developing assessment tools and processes to support the RACS Professional Skills Curriculum.

A working group of specialty representatives and RACS education staff is being convened to undertake development of an assessment program, with integrated assessment activities to support delivery and assessment of the Professional Skills Curriculum.

The Professional Skills Assessment Working Group will also consider assessment delivery via an app being developed by RACS.

If you are interested in participating, or if you have any questions, please contact Sally Drummond via email (sally.drummond@surgeons.org) or by phone: (03) 9249 1195.

RACS concerned with decision to cancel elective surgery at Royal Adelaide Hospital

RACS South Australia State Committee Chair, Dr David King, said the decision to cancel elective surgery will result in additional delays for patients in a system that is already struggling to meet extraordinary demands on waiting lists two years into the pandemic.

Read the latest media release: bit.ly/3z60PPW

Colorectal surgery MBS changes in Australia

Changes to Medicare Benefits Schedule (MBS) colorectal surgery services will commence from 1 July 2022 following recommendations from the MBS Review Taskforce and consultation with key stakeholders. These changes will better align colorectal surgery services with contemporary, evidence-based practice.

The changes are outlined in a range of communication materials, which are now available on the MBS Online Fact Sheets page. This includes a fact sheet, Quick Reference Guide and Frequently Asked Questions, available at this link: bit.ly/3NNeU8X

Please contact the Department of Health if you have any questions.

Dr Ravi Mahajani
Plastic surgeon, NT

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Respecting one another is the right thing to do

As I reflect on my eight years at the College, the last three as CEO—and prior to that, as Deputy CEO—we have come a long way when it comes to respecting one another, whether it is between Fellows, Trainees, Specialist International Medical Graduates and College staff. Or have we?

The recent evaluation of the Building Respect initiative has demonstrated we have made some gains in achieving more respectful workplaces, but why does the problem of inappropriate behaviour persist? I still see examples of this around me and I still see Fellows turning a blind eye and not 'speaking up' when these behaviours are exhibited.

I have also experienced these behaviours myself from Fellows. Sometimes the behaviours are what some would call borderline 'micro-aggressions' or 'micro-corrections'. However, it is these behaviours that can cause the most harm when repeated and allowed to fester.

I am concerned when I see these behaviours expressed in some of the correspondence in the form of emails from our Fellows to College staff—what was the writer thinking? Did they not realise that another human being with feelings would be reading the email?

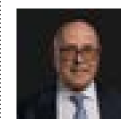
Unfortunately, this goes on, and as CEO I have instructed College staff to report these incidents as they will not be tolerated and will be dealt with. We have had some staff leave the College because of inappropriate behaviours from Fellows. It is indeed a sorry reflection on RACS when this happens, but it does.

On a more positive note, most of our members do the right thing and recognise and live the College values: Service, Respect, Integrity, Compassion and Collaboration.

I ask everyone reading this article to look at themselves in the mirror; to reflect on their behaviours and those of others around them, commit to leading a culture of respect, to call out poor behaviour when it occurs and come to the aid of affected individuals who will be suffering in silence. Our workplaces will be better for it—more kindness and less stress and frustration. In the words of the great General Morrison who addressed the 2016 RACS ASC in Brisbane … "the standard you walk past is the standard you accept."

When RACS initially committed to 'Building Respect' it was lauded by everyone and we were a leader in this area. Let us all re-commit to this pledge, to be authentic leaders, compassionate and caring, and always respectful of others.

Above all, we want the members of our profession to exemplify the values we aspire to.



John Biviano

CEO

RACS recommits to building a culture of respect in surgery: Now is the time for action

The Royal Australasian College of Surgeons (RACS) re-convened an Expert Advisory Group (EAG 2022) to review the progress made by the College community since 2015 to build respect and improve patient safety in surgery, and to recommend future actions.

The College Council has endorsed the recommendations of EAG 2022 and published a new five-year plan for cultural change by investing in leadership, training and education, fostering diversity, and strengthening a feedback culture in surgery.

'Now is the time for action. Six years has built awareness and understanding of the need to operate with respect. We are now looking for actions that encourage professional behaviour that keeps teams performing at their best and patients safe', the EAG 2022 report states.

EAG was 'struck by the seriousness of the College's ongoing commitment' and found it had 'prioritised identifying and addressing a serious problem' by rolling out an ambitious program of work.

EAG 2022 notes that a lot has changed inside and outside the College in the six years since RACS launched its 2015 Action Plan: Building Respect, Improving Patient Safety.

'Community dialogue and expectations about acceptable behaviour and culture have profoundly altered the RACS operating environment and re-shaped the wider community,' the report states.

'The College must now keep pace with community standards and expectations and keep striving to effect real change. Ongoing, concerted effort and a renewed commitment is needed to convert awareness to action and enable the profession to change and meet the expectations of the community it serves,' the EAG 2022 report states.

The report notes that 'entrenched problems in healthcare will only be solved by cross sectoral commitment and collaboration.'

'Given the limits of RACS influence over workplace settings, our recommendations rely on collaboration, leadership and shared responsibilities,' EAG 2022 notes.

RACS President, Dr Sally Langley, said the College was energised and heartened by the EAG 2022 report.

"Cultural change takes time. We're in this for the long haul because it's best for our patients and will strengthen the whole surgical community," Dr Langley said.

She said the RACS Building Respect Action Plan 2022 would require leadership, collaboration and a shared purpose with other health sector agencies.

"Agencies across the health sector in Australia and Aotearoa New Zealand have embraced the need for cultural change. At different places, we are recognising that this means disrupting the status quo and being open to new ideas and practices.

"RACS focus is shifting from raising awareness, to supporting action. We will work with the College community as we build our skills and learn to lead compassionately and collaboratively," she said.

RACS Building Respect Action Plan 2022 expands the College's focus to date on addressing bullying, discrimination and sexual harassment, towards fostering professionalism and civility in surgery.

The 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.

Read more about the EAG 22 Report and the *RACS Building Respect Action Plan: From Awareness to Action*: bit.ly/3a8CyP1

Indigenous health in the spotlight at RACS ASC

The Indigenous Health section of RACS ASC was expanded in 2022. This was in response to Cultural Competence and Safety becoming the new 10th competency and the steady and continuing focus on increasing diversity and inclusion within the College.

There were two broad aims—to provide sessions suitable for upskilling by all conference attendees and to increase Indigenous participation in every role at the conference.

The result of this focus was several firsts—the first academic visit, the first section dinner, the first dedicated plenary, and the first funded research prize.

As part of a parallel aim to normalise Indigenous ways of working and doing, there was also the first Yarning Circle/ Hui Whakawhanaungatanga and an increasing use of norms such as Māori pepeha in speaker introductions and Aboriginal languages in presentations.

The section visitor was Professor Chelsea Watego. In addition to her keynote lecture, she and her team from the Institute of Collaborative Race Research hosted a workshop of guided readings examining cultural competency, or rather, the negative effects on Indigenous people when cultural competency is absent. Catering was provided by Murri Menu and it is possible that the lemon myrtle scones and kangaroo sausage rolls with bush tomato relish were also a first for the ASC.

The Indigenous Health breakfast sold out early, with current and multiple past presidents, office-bearers, and allies attending. The breakfast was opened with a welcome to country from elder Uncle Joseph and ended with a message from Haylene Grogan, Deputy Director General of Queensland Health. The Indigenous scholarship winners were presented with their awards by Dr Sally Langley.

Dr Mikayla Couch - RACS ASC Award

Dr Mitchell Smith - RACS ASC Award

Dr Toriana Murray - RACS ASC Award

Dr Nasya Thompson - RACS ASC Award

Dr Nikola Fraser - RACS ASC Award (2020 winner but due to COVID deferred until 2022)

Dr Claudia Paul - ASC Peer Support award

Dr Justin Cain - 2022 SET Trainee One Year Scholarship – Aboriginal and Torres Strait Island

Dr Jamie-Lee Rahiri - 2022 SET Trainee One Year Scholarship – Māori

Dr Lincoln Nicholls - 2022 SET Trainee One Year Scholarship – Māori

The Indigenous Health convenors would also like to thank the keynote speakers Dr Maxine Ronald, immediate past Chair of the RACS Indigenous Health committee and Dr Kris Rallah-Baker, Australia's first and only Indigenous ophthalmologist.

Thank you also to the plenary speakers Dr Rhys Jones (University of Auckland) and Professor Michael West (The King's Fund, London) and Future Dreaming panellists Dr Claudia Paul (Rhodes scholar), Dr Jamie-Lee Rahiri (PhD) and Dr Rob Grant (cardiothoracic Trainee) for contributing to such a strong and successful section.

It is clear from the attendance and the social media engagement with the activities of this section that Indigenous health is on an increasingly strong footing at RACS. We look forward to the RACS ASC 2023 where Indigenous health will be the overarching theme.

Dr Justin Cain and Associate Professor Rhea Liang

Images (Clockwise from top left): Indigenous Health breakfast; ICCR workshop; Dr Justin Cain and Associate Professor Rhea Liang; Yarning Circle/ Hui Whakawhanaungatanga.

Brisbane ushers in a successful RACS 90th Annual Scientific Congress

Brisbane played host to the Royal Australasian College of Surgeons 90th Annual Scientific Congress (RACS ASC).

More than 2600 participants attended the Congress either in-person or virtually.

We kicked off RACS ASC on Sunday, 1 May with a gala dinner hosted by the Foundation for Surgery at the Birrunga Gallery to thank the extraordinary generosity of our donors.

On Monday, 2 May we proudly welcomed our new Fellows in the evening at the 2022 Convocation ceremony. The Fellowship pledge recital was a powerful and engaging moment, highlighting that the future of surgery is in the best of hands. Our sincerest congratulations to the new Fellows.

Tuesday's plenary session was opened by RACS president Dr Sally Langley followed by a calendar full of interesting presentations.

A moving Indigenous health breakfast was the highlight of the day on Wednesday, with many past presidents in attendance. Dr Langley presented awards to several recipients before Dr Justin Cain led a panel discussion entitled 'future dreaming'. All panellists spoke optimistically about the future, noting that it was reassuring to see the College's continued commitment to Indigenous health and representation in surgery.

This year's RACS Women in Surgery breakfast and annual business meeting was opened by chair, Dr Christine Lai. Dr Langley acknowledged medical student Denna Fryer who was the winner of the Women in Surgery essay competition entitled *The myth of meritocracy: What RACS can do to dismantle it.* Denna received a RACS grant, which included entry to the RACS ASC 2022, flights and accommodation in Brisbane.

The last day of the Congress featured various presentations, including one by Australian Orthopaedic Association's President and RACS Councillor, Dr Annette Holian on 'Women who lead'. Dr Holian shared numerous stories from her personal and professional lives and the lessons she learned throughout her journey. She encouraged the audience to remember to be kind to themselves and to take ownership of mistakes.

#DestinationRural

Some statistics from the RACS ASC 2022

Our first in-person congress since the pandemic was an amazing experience for us. Here are some facts and figures:

- more than 2600 participants (in-person and virtual) participated
- total live stream viewed minutes: more than 250,000
- 664 presentations
- 1712 e-poster views
- average number of steps during a congress day – 8000
- representatives from more than 25 countries: Australia, Aotearoa New Zealand, Norway, the UK, USA, Japan, Israel, Malaysia, Belgium, Greece, France, Ireland, Netherlands, Botswana, South Africa, Brazil, Canada, India, United Arab Emirates, and Papua New Guinea to mention some.

‘Tenei au’ — Surgery in an Indigenous world

Dr Maxine Ronald, a general surgeon at Whangārei Hospital, Northland in Aotearoa New Zealand, presented a keynote lecture titled ‘*Tenei au’—Surgery in an Indigenous world* at the RACS ASC 2022.

Dr Ronald, of Ngāti Wai and Ngāti Hine descent, started her talk with a beautiful ancient Māori tauparapara or chant.

She focused on how Indigenous practice can inform surgical practice and the importance of indigenising the spaces we work in and structure of the health services.

“Medical and scientific advances have failed to improve equity for Indigenous groups. The solution to Indigenous health inequities lies with Indigenous communities,” she said.

Dr Ronald shared Māori stories with key values that can inform surgical services such as whakapapa (genealogy, relationships), whanaungatanga (connection) and manaakitanga (caring, kindness, support).

She reiterated the importance of using Indigenous knowledge as a foundation for informing health services’ structure to ensure the health system is responsive and informed by the community and also shared some solutions.

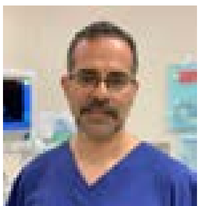
“We should support communities and whānau to be self-determining and provide healthcare that is internally integrated and reaching across sectors to include housing, education, social, cultural and environmental networks.

“We should also indigenise the health system, embedding Matauranga (knowledge) Māori frameworks and strategies.”

Dr Ronald also called for the equitable distribution of resources in the country’s healthcare system.

“We need an Indigenous measurement of health as the problem with equity is that it is defined in relation to white people. It assumes there is a limit to what Indigenous people can achieve, and has a narrow focus on disease rather than Indigenous, holistic models of health. The key to addressing Indigenous issues lies within Indigenous communities,” she added.

Why Dr Aly likes the roux en y gastric bypass



Dr Ahmad Aly, an Upper Gastro Intestinal surgeon at Melbourne’s Austin Hospital, presented a convincing argument to a captivated audience at the RACS Annual Scientific Congress 2022 on why he likes the roux en y gastric bypass (RYGB).

Dr Aly used facts, figures and a movie clip—featuring Jason Bourne—to cheekily describe the RYGB as the “Jason Bourne of Bariatric Surgery.” Alluding to the movie clip, he made the comparison saying: “It’s powerful, efficient and effective, and highly adaptable. It can solve simple (primary) or complex (revision) problems, it doesn’t need to address endless questions (around reflux or uncertainty of oesophageal function as explained later) and it leaves nothing to chance—just like Jason.”

He said the procedure had been around since the 1960s, is backed up by plenty of data and it is still here because it works. The bypass has been refined over the past decades and the modern RYGB has existed since the early 1990s.

“It is still here because it works and is the best performing of the non-malabsorptive weight loss procedures offering the most durable long-term weight loss. A recent paper from *JAMA Surgery*[1] found that 80 per cent of patients who underwent gastric bypass maintained 20–30 per cent total body weight loss at 10 years and only 3.5 per cent regained weight to within five per cent of index weight.”

Dr Aly added that while RYGB, like all surgery, carries some risk it can be effectively mitigated, and long-term complications can be minimised with attention to detail.

Acknowledging some hyperbole in presenting his arguments for this session in which several different operations were discussed, Dr Aly concluded, “All procedures have a place and we need to tailor each to the patient.”

References

Matthew L. Maciejewski, David E. Arterburn, Lynn Van Scoyoc,et al. Bariatric Surgery and Long-term Durability of Weight Loss. JAMA Surg. 2016;151(11):1046-1055.

RACS ASC 2022

RESERVED

Making media waves at the RACS ASC 2022

We present some interesting abstracts that generated media interest.

Depressive symptoms occur in almost half of stoma surgery patients

An Australian-first research has discovered depressive symptoms occur in almost half of stoma surgery patients.

The study, conducted by a team of 17 medical professionals and health researchers, led by Dr Joshua Kovoor and supervised by Professor Peter Hewett, comprised a systematic review and meta-analysis aiming to characterise depressive symptoms after stoma surgery.

Key findings included:

- overall prevalence of depressive symptoms in stoma patients after their surgery was 41 per cent
- across the included longitudinal studies, six-month postoperative prevalence was 39 per cent
- across the included longitudinal studies, 12-month postoperative prevalence was 42 per cent
- patients with a stoma had significantly higher rates and risk of depressive symptoms compared to patients undergoing surgery without stoma formation.

Dr Joshua Kovoor, a researcher, medical intern and PhD candidate with the University of Adelaide said a patient's depressive state after stoma surgery could be linked to a few key factors.

> "After stoma surgery, many patients struggle physically and mentally post-surgery, especially with a loss of self, intimacy, and body image, in response to multiple psychological stressors," Dr Kovoor said.

"The research highlights how we can improve care to stoma patients before and after their surgery.

"Stoma patients at risk of developing depressive symptoms should be identified early, and have access to mental health services, including psychologists and psychiatrists to assist with their overall care."

Professor Peter Hewett, RACS Fellow and senior colorectal surgeon at The Queen Elizabeth Hospital said when forming a stoma, the surgeon will take care to ensure it has good position and proper shape.

"A preoperative visit from a stomal therapist aids in both deciding the optimal position on the abdomen to place the stoma and gives reassurance that help will be available in the post-operative period to manage the stoma," Professor Hewett said.

Circumcision still common in private hospitals, despite the procedure being banned in public hospitals

A new study has revealed circumcision remains one of the most common surgeries performed in Australian private hospitals, despite the procedure being banned in public hospitals.

The research by Dr Darshan Sitharthan and Keeththana Thayanantharajah reports Australia's circumcision rate has fallen by 80 per cent in the past 40 years.

Key insights include:

- Male circumcision is an ancient practice that dates as far back as 10,000 BC.

((LIVE))

- Following WWI, male circumcision was widely embraced by the Anglosphere for medico-cultural reasons.
- Australia's routine circumcision rate peaked at 85 per cent between 1950–1980.
- Due to a societal and cultural shift, the 1980s saw circumcision rates fall to 15 per cent in Australia.
- Changes in political and culture sentiments saw the gradual introduction of state level bans of cosmetic circumcision. South Australia and Queensland were the first to strike in 2007 with the rest of the states following suit before the end of the year.
- In 2010 the Royal Australasian College of Physicians released a statement, which concluded the risks 'do not warrant routine infant circumcision'.
- Circumcision remains one of the most common private surgeries performed in Australia, and the single most common surgery performed worldwide.
- Globally, approximately 39 per cent of males are circumcised.
- America's circumcision rate is 81 per cent.
- Australia's circumcision rate is approximately 15 per cent.

Dr Sitharthan, a junior doctor, said despite the operation being banned in public hospitals, it remains a common procedure in private hospitals.

"Cultural and cosmetic reasons are driving the demand for circumcisions in private hospitals," Dr Sitharthan said.

"Dad is circumcised, so he wants the same for his son."

"Circumcisions in private hospitals cost between $450 to $1600. Anecdotally, the circumcision rate in regional and rural Australia is a lot higher when compared to the capital cities too."

A lack of plastic surgeons based in regional Victoria costing rural patients millions of dollars

Research has revealed a lack of plastic and reconstructive surgeons based in regional Victoria is costing rural patients millions of dollars.

The study—a two-year retrospective evaluation of patients who underwent a procedure at Warrnambool Plastic & Reconstructive Surgery—by Dr Toby Vinycomb, Dr Hanna Jones, Mr John Masters and Mr Robert Toma found there is significant increase in personal cost for travel and accommodation required for rural patients to access specialist care.

Background:

- 1860 patients in the study
- 3.5 per cent of Victorian plastic and reconstructive surgeons live and work in regional or rural areas—to cover 23 per cent of the Victorian population
- Warrnambool is a two surgeon, one Trainee plastic surgery unit that provides elective and emergency services to a population of 151,140 people and performs almost 2500 operations a year.

Key findings include:

- Patients would pay on average at least an additional $1201 in travel and accommodation for common and necessary operations in travel to Melbourne.
- Over a prospective four-week period, a total saving of $245,000 was achieved in travel and accommodation cost by 204 patients attending a rural service.
- Savings did not factor in the increased cost of prolonged displacement to Melbourne on individual and family members and economic impact of increased time off work.
- 51 per cent of patients would prefer to travel an additional 30 minutes or more to go to a rural service than travel to Melbourne.
- 93 per cent of respondents felt it very important to have a rural plastic surgery service.
- The total additional personal cost of travel and accommodation to patients if they had to travel to a metropolitan service over a two-year period was $1,707,740 for those attending South West Healthcare (Warrnambool), and reaches $6.36 million over all the health care services they operate in the south-west Victorian region.
- Median travel distance was 28 km to the Warrnambool service compared to 259 km to the nearest metropolitan service.

Mr Toma, a RACS Fellow and a Plastic and Reconstructive surgeon said regional and rural Victorian patients want to receive treatment close to where they live.

"What I would like to see is increased funding to attract sub-specialty surgeons to regional areas of Victoria," Mr Toma said.

"When I relocated to Warrnambool a decade ago, there was a lack of understanding regarding services plastic surgeons provided to the community. Fortunately, South West Healthcare, St John of God Hospital and Portland Hospital saw the benefit and supported my decision.

"Ten years on, the community is reaping the rewards of that decision because they don't have to travel to Melbourne for surgery and be thousands of dollars worse off."

Dr Toby Vinycomb, a plastic surgery registrar said the research highlights the disparity of services available to Victorians based in rural areas of the state. ▶

"Rural and regional Victorians generally earn less than those based in Melbourne and Geelong. However, they are currently being asked to pay more to access healthcare," Dr Vinycomb said.

"Surgeons who train in rural and regional areas of Victoria often want to return when their training is complete, however, there needs to be appropriate funding to make it happen.

"It's a win-win situation. There will be more sub-specialty surgeons setting up shop throughout regional Victoria, which in turn will drastically reduce the amount Victorians based outside the metro centres will have to pay to access healthcare."

Males more likely to suffer from Carpal Tunnel Syndrome

A 20-year review of Carpal Tunnel Release (CTR) trends in Australia has revealed for the first time, males are more likely to suffer from Carpal Tunnel Syndrome than females, with the rate of CTR in males almost doubling in the past two decades.

The research conducted by Dr Arunan Jeyakumar analysed Medicare data over the past 20 years.

Key findings over the past 20 years include:

- 302,211 CTR operations were subsidised by Medicare Australia.
- CTR was most common among ages 55 to 64 for females and 65 to 74 for males.
- The yearly incidence of CTR has increased by 30 per cent over the past 20 years.
- While females made most of the claims (59.3 per cent) in 2020, the incidence for males has eclipsed females for the first time (108.2 vs 103.2 per 100,000 population).
- The rate of CTR in males has nearly doubled over two decades (59.8 to 108.1 per 100,000 population).
- This increase is largely attributed to two age groups: 75 to 84 (+180 per cent) and over 85 (+201 per cent).
- For females, the incidence has remained largely unchanged over the past 20 years, with a decline seen for some age groups 45 to 54 (-32 per cent) and 55 to 64 (-20 per cent).

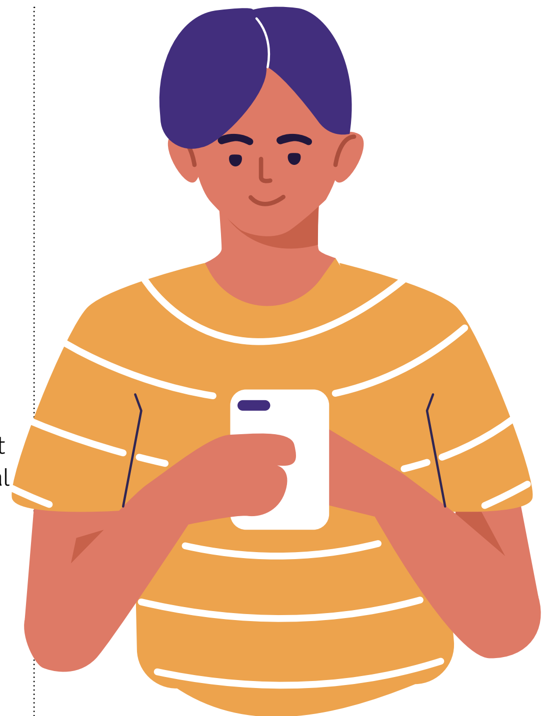
Dr Arunan Jeyakumar, a surgical resident at Brisbane's Princess Alexandra Hospital said CTR is one of the most performed hand surgeries. The procedure aims to treat Carpal Tunnel Syndrome (CTS), a painful disorder of the hand caused by pressure on nerves that run through the wrist. Anything that aggravates and inflames the tendons can cause CTS, including repetitive hand movements, pregnancy, and arthritis.

"It's a growing problem, with CTR surgery rates increasing by 30 per cent every year for the past 20 years," Dr Jeyakumar said.

"Historically, CTS has been associated with females—thought to be related to hormonal changes secondary to pregnancy and menopause. However, the research unexpectedly revealed a significant increase in the number of males requiring CTR surgery over the past 20 years," Dr Jeyakumar said.

"Males are likely undertaking activities that require repeated movement of the wrist, which could include using a keyboard and mouse, machine work or sports-related activities.

"With the percentage of males requiring CTR surgery trending up, it is important for the healthcare system to identify how they can allocate resources to meet the growing demand."



Breast reconstruction surgery post mastectomy jumps 125 per cent in past decade

Exclusive research has discovered the national rate of breast reconstruction (BR) following mastectomy has jumped 125 per cent in the past decade.

The study by Nirmal Dayaratna, Dr Chu Luan Nguyen, Associate Professor Cindy Mak, Associate Professor Sanjay Warrier and Dr Joseph Dusseldorp included patients who underwent mastectomy with or without reconstruction for invasive or in situ breast carcinoma from 2010 to 2019 in Australia and Aotearoa New Zealand.

Key findings include:

- Women who underwent mastectomy between 2010 and 2019 was 42,279.
- The national BR rate over the 10-year study period was 21.46 per cent.
- The yearly rate had steadily increased from 12.84 per cent in 2010 to 29.01 per cent in 2019.

- All states and territories, except South Australia and the Northern Territory, showed a steady increase in BR rate from 2010 to 2019.
- The BR rate increased from 22 per cent to 41 per cent in Victoria, nine per cent to 33 per cent in New South Wales, eight per cent to 20 per cent in Queensland, and 22 per cent to 28 per cent in Western Australia over the 10-year study period.
- South Australia has had a relatively low BR throughout the 10-year study period with a BR rate of eight per cent identified in 2019.
- BR was found to be significantly more common in younger women, being most common between the ages of 40 and 54 and falling sharply from age 70 onwards.
- The majority of BR was performed in private hospitals, except in South Australia, where most of the procedures occurred in the public setting over the 10-year study period.
- 74 per cent of BR cases in New South Wales were performed in a private hospital in 2019.
- 69 per cent of BR cases in Western Australia were performed in a private hospital in 2019.
- 51 per cent of BR cases in Victoria were performed in a private hospital in 2019.
- 52 per cent of BR cases in Queensland were performed in a private hospital in 2019.
- Women living in metropolitan areas had a BR rate of 33 per cent and this rate falls sharply in regional and rural areas .
- Hospitals in rural and remote areas have a lower BR rate compared to metropolitan areas.

Dr Dusseldorp, a RACS Fellow and Plastic and Reconstructive surgeon at Chris O'Brien Lifehouse in Sydney said BR following mastectomy has proven, positive quality-of-life benefits.

"The rise in uptake over the past decade is encouraging. However, there is an ongoing need to address the barriers to equitable access to BR," he said.

"The rise in BR following mastectomy since 2010 is patient driven.

"There is a better understanding of the surgery, greater acceptance of the procedure, and improved access to support groups. There are also more trained oncoplastic breast surgeons."

"It's important to acknowledge not every woman wants BR following a mastectomy, however, without analysis and knowing what the trends are, it is impossible to make informed decisions about the allocation of health services and funding."

Surgical competence – a surgeon's perspective

Abstract
Throughout our lives we work in a fiercely competitive world for a living. Competence matters more than ever before, especially in surgical practice. Competence means the ability to make decisions to do the tasks on hand well—a lifelong process.

Introduction
The Oxford dictionary defines compete as to 'take part in a contest' and competence as **'the ability or the state of being competent'**. But the origin of the word 'compete' has nothing to do with competing against one another. 'Compete' comes from the Latin word competere—com (together) and petre (aim at, seek). The Oxford English Dictionary defines the verb, which has its modern origins in the 17th century, as 'to seek together, to come together, agree, and be suitable'.

Nevertheless, in the real world we compete to gain access to the necessary knowledge to be licensed as practising surgeons for the health and wellbeing of patients, which is commercialised and governed by public and private bodies.[2-5]

'To err is human'; prevention is better than cure
In reference to human factors training the Royal College of Surgeons in Ireland states: 'It has been estimated that only 25% of the important events that occur during a surgical procedure are related to manual or technical skills and that 75% relate to human factors such as decision-making, communications, teamwork and leadership'.[6]

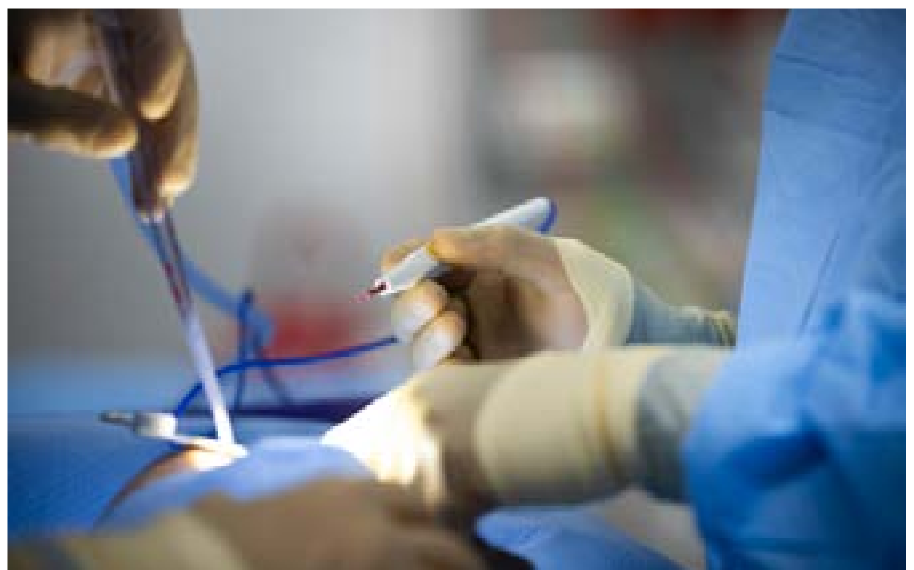
Even the most experienced and safety conscious surgeon can make a mistake as revealed by Henry Marsh in his scholarly article[7]. Surgeons working at the coal face, often in trying circumstances, may rightly feel exhausted and depressed leading to 'burn out'.[8]

In reference to surgical malpractice I quote Sokol, '...The risk of being sued, like surgical complications cannot be eliminated but it can be reduced'.[9]

Against this backdrop a surgeon must necessarily update their knowledge and skill base and be able to decide when to operate or when not to for the best possible care for the patient.[10]

As surgery becomes increasingly specialised and multidisciplinary requiring teamwork, coupled with high expectations of the public at large, surgeons need to adapt in a fast-changing, fiercely competitive digital world.

Measuring competence
Nevertheless, measuring competence and outcomes is a complex task. It depends on the ability to collect accurate meaningful data without any bias and confounding factors coupled with the ability to interpret and implement practical measures towards improving the outcome. For surgical competence, colleges have embraced MALT (Morbidity and Audit Log Book Tool) combined with SNOMEDCT (Systemised Nomenclature of Medicine Clinical Terms) as measurement tools among many other means for delivery of surgical care by surgeons, collaborating with other disciplines to the public at large—there being no certainty of the outcome.[11-14]



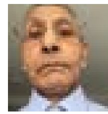
Continuous improvement

There needs to be continuous improvement in technology, processes, and skill and expertise. This will enable a team to capture accurate meaningful data and be able to assess where things went wrong (with resulting poor outcomes), why the error took place, and how the situation can be improved.

Everyone should be aware that 'to err is human' and that no two patients, circumstances, their treating surgeons, and the teams providing their care are the same. There is no perfect health service anywhere in the world.[15-19]

Conclusion

A career in surgery does carry risks, as well as rewards, with happy outcomes and anyone wishing to be a surgeon will have to do whatever it takes to get there. There is no one set of rules that will apply everywhere and one should be able to give and take in an uneven world. Those measuring competence should be able to demonstrate that current tools of measurement lead to better outcomes in keeping with the demands of society without compromising the time available to do the actual work and earn a living.



Dr Ratnakar Bhattacharyya
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Challenging management of an elderly patient

The difficulties of managing a confused, non-compliant, elderly patient

A woman in her early 90s was admitted to hospital following a low-speed motor vehicle accident where she drove her car into a stationary object.

She subsequently sustained an open fracture to her right radius and ulna, as well as facial fractures. The patient had a history of hypertension, atrial fibrillation and some confusion. She presented through the emergency department and was admitted under the care of the orthopaedic surgical team.

A combined approach was led by the plastic surgical team as there were significant skin coverage issues with her forearm injury. An initial surgical procedure was undertaken where the fractured forearm was treated with internal fixation and skin graft coverage by the plastic surgical team. The patient's forearm was protected with a back-slab plaster splint postoperatively. Unfortunately, in the two days post-surgery, the patient became more confused and removed her back slab—causing dehiscence of the skin graft and exposure of the underlying internal fixation plates. As a result, further surgery was necessary to stabilise the fracture with an external fixator and to facilitate further skin grafting of the soft-tissue defect by the plastic surgical team.

It is evident from the record of episodes noted by the family that the patient was confused prior to admission. This confusion persisted throughout the admission and seemed to fluctuate. At times when the patient was lucid, she consented to surgical intervention and understood the ongoing treatment (i.e. dressings required to the forearm), but there were also periods when the patient was confused and was not able to comply.

Over the course of the admission, the patient became increasingly medically unwell. She had episodes of tachycardia/atrial fibrillation that were attended to by the medical and geriatric teams. She was noted to be anaemic, and a blood transfusion was done to treat this.

The patient had a prolonged admission of 15 days before succumbing to her injuries, despite the excellent medical management and awareness of her deteriorating condition. The family were well informed and involved with decision-making as she began to deteriorate. There did not appear to be any significant fault of the treating medical teams. This patient had prodromal confusion as well as significant health issues, and it is likely that she would have succumbed to a medical condition in the future given her state on admission.

Discussion

Overall, reading the clinical records, she was managed extremely well. A confused patient is difficult to treat at the best of times, but the multidisciplinary team approach that was undertaken is to be commended. All teams (i.e. orthopaedic surgery, plastic surgery, general medicine, and gerontology) were involved in this patient's care. They clearly communicated treatment and management plans throughout the admission, and everyone worked collaboratively to achieve a good outcome for this patient. There is excellent documentation of this, and the surgical and medical teams should be recognised for their excellent recordkeeping and communication between disciplines.

The only possible area of consideration would be pertaining to the management of the patient's initial dressing.

After the first surgery, she became confused and removed the back slab and wound covering. This may not have been preventable. However, it is possible that a higher level of nursing care may have stopped her from removing the dressing and thereby exposing her underlying internal fixation hardware. This may have prevented the need for further surgery where the external fixator was applied. Avoiding a second surgery may have improved the patient's mental state and reduced the chance of subsequent medical complications due to a second anaesthetic.

There were no specific concerns with fluid balance, anticoagulation management or the use of high dependency or intensive care interventions.

Clinical lessons

Elderly emergency surgical patients whose presentation are complex and who are frail can benefit from specialist geriatric care. Early management planning with clear communication between specialists comprising a multidisciplinary team involved in the care of an older person brings a lot to the table. Patients as well as families benefit from thoughtful collaboration between all parties.

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SUNRRiSE boosts Trainees' skills

RACS Trainees gained valuable clinical research experience in an international study of the efficacy of negative pressure dressings after operations.

More than 130 Australian surgeons, with their counterparts in the UK, gathered data in the SUNRRiSE (Single Use Negative pRessure dressing for Reduction In Surgical site infection following Emergency laparotomy) clinical trial.

Trainees played a vital role in coordinating the study, in which 840 patients were recruited across health services in England, Scotland, New South Wales, Queensland, South Australia, Victoria and Western Australia.

The study aimed to assess the effectiveness of negative pressure dressings on reducing infection following emergency laparotomy procedures, compared with regular dressings.

Data collection for the multi-centre, randomised and controlled study began in 2020 with the results announced in April 2022.

The researchers found that the far more expensive negative pressure dressings, which cost up to $500 each (compared with about $20 for regular dressings) did not reduce the risk of infection.

These results will inform the use of negative pressure dressings after procedures, discouraging health service spending on a product that does not improve outcomes for patients.

The study was the first time many of the Trainees involved had participated in clinical research. A survey of those who contributed to the study found that 60 per cent had either never been involved in clinical research before or had only been involved in one study in the past.

More than 70 per cent of collaborators confirmed that the experience had broadened their clinical research skills and 95 per cent want to be involved in future clinical trials.

Clinical Trial Coordinator, Kristy Atherton says the high level of involvement of Trainees in this study provided valuable experience for Trainee surgeons to develop their research skills.

"The SUNRRISE study provided quite a unique opportunity for Trainees to collaborate in an international clinical trial," she says.

"The Trainees coordinated the research at a site level effectively and ensured that the data collected by their team was thoroughly checked, resulting in a high-quality dataset, and clear study results.

"It was exciting to be involved in a clinical trial with such an enthusiastic team of researchers, resulting in robust data that will be practice-changing."

Newcastle colorectal surgeon Associate Professor Peter Pockney says that while the outcome of the study was satisfying, it also played a crucial role in introducing Trainees—who led the data collection efforts—to clinical research.

He says the experience would improve their ability to interpret research throughout their surgical careers.

"In medicine there is this assumption and expectation that we use evidence-based research. But what is the quality and the power of the evidence?" he asks.

"I believe that until you have really engaged with the research process in a systematic, organised and disciplined way, you don't really understand the strengths and weaknesses of research."

> "This research provided quite a unique opportunity for junior doctors to participate in clinical research."

"Involving Trainees in a study like this means that for the rest of their careers, they are going to be much better at consuming evidence; even if they never do another study, they'll be better for this experience."

Associate Professor Pockney believes another benefit of participating in the study is that Trainees gained insight into an alternative clinical career pathway for surgeons.

"A bonus is that some of them realise these sorts of things can be fun, and they go on to become researchers themselves."

One Trainee who is reaping the benefits of coordinating the SUNRRiSE trials is South Australian General Surgery Fellow Dr Yick Ho Lam, who recently completed SET training.

Dr Lam was the Trainee lead for the SUNRRiSE study at Flinders Medical Centre. While he had never considered research to be part of his professional pathway, the experience has inspired him to take part in further international research collaborations.

"It was very satisfying to be part of this research. In medicine we do a lot of things without knowing if they're worth the money we spend in case they do make a difference, so it is a big achievement to get a result that provides real answers."

Dr Lam says the research provided him with an international network of surgeons and valuable experience coordinating the collection of data for a significant and influential project.

It also reinforced his decision to work part-time, which enabled him to take up the offer to be involved in the project.

"It just happened that I had the opportunity to work part-time as a Trainee, and that gave me the chance to do this research," he says.

"That then led to the COVIDSurg-3 study that I'm involved with now."

As a result of his experience, Dr Lam would like to encourage other surgeons to consider a period of part-time work to help them plan their professional pathway—whether that involves working on a research project or sampling other opportunities—and to get the most out of their training.

"Part-time really gave me the chance to slow down and look at my training and understand what I wanted to do and how to do it properly."

Dr Lam believes that alongside its personal rewards, being part of international research collaborations can improve surgical care in Australia, as local data helps ensure that studies incorporate the local experience and perspective. ▶

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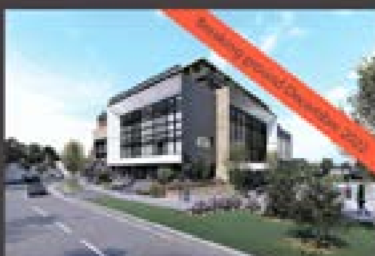

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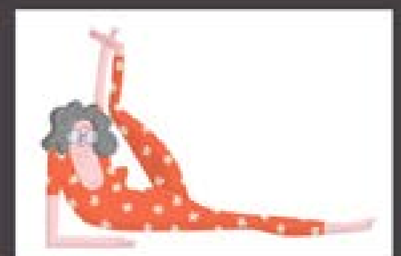

Images: Clinical trial coordinator Kristy Atherton, Dr Madelyn Gramlick, Associate Professor Peter Pockney, Professor Toby Richards, Dr Yick Ho Lam.

The timing of the study—when all clinical research was suspended in the UK due to COVID-19 and Australian hospitals paused elective surgery—enabled South Australian surgeons, in particular, to play a more significant role in data collection.

While Australia had been expected to recruit 200 patients, the changed surgical conditions during COVID-19 resulted in being able to recruit more than 300 participants locally—a significant contribution to the study.

Dr Lam agrees with Dr Pockney's belief in the importance of local involvement in international studies.

"Research collaborations were never big in Australia as we didn't have the volume of patients to do large-scale clinical trials. But now with international collaborations, it opens a lot of doors and that makes it exciting.

"If the only research is carried out on UK patients, then it doesn't really relate to our context in Australia. If we are sharing our own patient data internationally, then we can achieve outcomes that are relevant to us as well," he says.

Fellow Trainee, Madelyn Gramlick, was the Trainee Lead for the Newcastle arm of the trial. She says the experience provided her with valuable skills, and the confidence to participate in future research.

"I learned a lot about the mechanisms of running a clinical trial, and the greater complexities of running a trial with international collaboration. Multinational collaboration is an increasingly common style of research in medicine, so it was great to experience this early in my career," she says.

"Research is such an essential part of surgery, and I think most surgeons will have research involvement at some point in their careers. My experience has given me the confidence to be involved in a range of research projects."

Clinical academic, specialising in large clinical trials, Professor Toby Richards, has been actively involved in research development and student and Trainee collaborations for more than a decade.

He advocates for more involvement from Australian surgeons in clinical trials like SUNRRiSE in the future.

"I would like to see more of these studies happen as they provide a platform of high-quality training in research methodology with opportunities for all levels of enthusiastic Trainees to develop their knowledge of data to understand research in an organised, well supported and meaningful environment," he says.

"By doing this, the Trainees achieve a meaningful output that changes patient management and also grows the research culture in medicine to develop high quality studies for the future."

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ACT Annual Scientific Meeting 2022

Role of the Surgeon into the Future

Our premier event on the 2022 RACS ACT Event Program is growing in significance within the Australian Capital Territory (ACT) and across local regional hospitals every year.

The ACT Annual Scientific Meeting (ASM) is a one-day event featuring themed sessions and free research paper presentations across the issues relevant to surgeons.

The event is an opportunity for Fellows, Trainees and SIMGs, as well as medical students and other interested parties to discuss issues that are non-specialty specific and relevant to the ACT and local regional areas.

The Scientific Program includes plenary sessions, research papers and poster presentations. This is a catered session, with break out space for trade demonstrations and networking.

The 2022 ASM will be co-convened by Dr Sandra Krishnan and Dr Adrian Fernandez.

Our 2022 theme is the Role of the Surgeon into the Future and will explore sub-themes including:

- artificial intelligence from a clinical perspective
- environmental and climate change responsibilities
- use of PPE in a post pandemic world.

More information on - bit.ly/3lSDvxm

To register for the event - https://surgeons.eventsair.com/actasm22/actasm22reg/Site/Register

Date: Friday, 12 August 2022

Venue: Australian National Museum, Peninsula Room

The Queensland Trauma Committee

"What is the mechanism for the injury? Is there anything that could be changed to reduce the rate of injury such as product design?"

The Queensland Trauma Committee (QTC) is a longstanding sub-committee of the Royal Australasian College of Surgeons (RACS). It reports to the RACS Trauma Committee (bi-national) and the Queensland State Committee (QSC).

QTC's purpose is to contribute to injury prevention and related matters of public interest, and support surgeons in trauma care.

The Trauma Committee's work is broad, including areas such as road trauma, alcohol-related trauma, falls in the elderly, and domestic violence. The areas of greatest significance are defined by the Trauma Committee.

QTC's membership is made up of senior representatives of the Queensland Statewide Trauma Clinical Network (STCN), the Jamieson Trauma Institute (JTI), the Queensland Audit of Surgical Mortality, Queensland Police and Ambulance Services, the judiciary, Queensland Retrieval Services, Royal Automobile Club of Queensland (RACQ), and a wide range of surgeons.

Dr Matthew Hope (pictured, right) has been Chair of QTC since 2017. Based in Brisbane, he's an orthopaedic surgeon who specialises in foot and ankle surgery. He also sits on the RACS Trauma Committee and the Australian Orthopaedic Association Executive Committee.

Dr Hope says of his work with QTC: "It's interesting and it takes you out of the sphere of clinical practice, in which we can all get tied up. I'm seeing many injuries in my work. What is the mechanism for the injury? Is there anything that could be changed to reduce the rate of injury such as product design?"

Activities of QTC over the past 30 years have involved investigating blood alcohol levels associated with driving and working to mandate seat belts and child restraints.

More recently, QTC has reviewed quad bike injuries, with a focus on rollover prevention. In 2020, quad bikes were the most common cause of on-farm fatalities.

Over a 10-year period, QTC has been associated with changing safety regulations for quad bikes, in consultation with various organisations, including the Australian Competition and Consumer Commission (ACCC). In October 2021, legislation was finally passed requiring all new quad bikes to have rollover protection.

There are still many older quad bikes in circulation, but QTC is expecting to see a reduction in the number of injuries as more quad bikes with rollover protection come into use under the new legislation.

E-scooters have also been a recent area of interest. Hire e-scooters were brought in by Brisbane City Council in late 2019. Hospitals saw a rapid increase in injuries as a result. Now, riders of faster, privately-owned e-scooters have been subjected to high-energy trauma.

QTC has reviewed data collected by JTI on e-scooters and related injuries. This was taken to Brisbane City Council and the Department of Transport and Main Roads, along with several other key stakeholder groups. Recent e-scooter reforms now restrict the speed on footpaths to 12 km/hr and tougher fines will be implemented.

Brisbane, Moreton Bay and Logan are three of the top four local government areas for motorcycle fatalities in the past 10 years. QTC, with JTI, has identified that lower limb and pelvic injuries are 26 times more likely to occur in a motorcyclist than a car occupant. Ongoing work will look at the financial burden of these significant injuries.

The Foundation for Alcohol Research and Education (FARE) has spoken with QTC about collecting blood alcohol measures in emergency departments. QTC is currently working with JTI to explore the high frequency of alcohol-related trauma.

QTC does not manage funds or collect data itself. The committee relies on the collaborative support of its members. QTC identifies preventable causes of trauma in Queensland and then works with a team like JTI to collect relevant data.

JTI aims to advance trauma prevention and research to deliver the best possible care for people who suffer a traumatic injury. They analyse data collected from existing health care data systems to better understand the causes, trends, patterns, burden, costs, and outcomes of trauma in Queensland.

Professor Kirsten Vallmuur (pictured, left) is Chair of Trauma Surveillance and Data Analytics in a joint position between the Australian Centre for Health Services Innovation and JTI. "We monitor the numbers, types and causes of injuries coming through Queensland emergency departments and hospitals. We provide summary data to stakeholders around the patterns we're seeing … times of day, days of the week, locations, severity of injury, and what the outcomes are for those patients."

E-scooter and electric personal mobility device (ePMD) injuries are primary examples of the types of data currently being collected. Any area where there is public debate about safety has the potential for analysis.

The data JTI collects is key to providing evidence of the need to address a public safety issue. Having reliable data to back up safety recommendations is a driving force for change with regulatory groups.

The main barrier to JTI's work, Professor Vallmuur says, is time. Ethics and governance applications and site-specific agreements can take enormous amounts of time to complete before data can be collected. Professor Vallmuur says checks and balances are important but she hopes processes will be streamlined as digital health platforms become more commonplace, allowing more rapid approvals and access to data—enabling timely reporting of injury patterns and emerging trends.

Currently, the whole process, from initial collaborative discussions to collecting data and forming recommendations that are eventually legislated, can take up to 10 years. "It's not a quick process and you have to be patient. There's lots of work in the background with consultation documents," says Dr Hope.

To achieve effective results in trauma prevention, Dr Hope says that knowledge and resources are shared between QTC, JTI and STCN through close collaboration. Defining the roles of each organisation has reduced duplication and improved the level of teamwork.

Professor Vallmuur thinks the future of trauma care is exciting. By 2032, she predicts that we will have the technical capability and infrastructure to support apps installed in our vehicles, phones and wearable devices that are linked with emergency and trauma services. Data will be interpreted and shared more efficiently, enabling faster access to appropriate care.[1]

She also thinks that data on patient outcomes will improve in the future as technology improves; such data are not routinely captured from all patients. Professor Vallmuur says patients will have opportunities to be more engaged in contributing data (for example, quality of life, pain measures or mental health measures) in more automated ways—most likely via wearables and apps.

On the horizon for QTC is work potentially reducing lawn mower injuries. Surgeons see adults and children who have sustained devastating hand and foot injuries requiring extensive reconstructive surgery. QTC will review data and consider if safety recommendations could be made for lawn mower design or use to reduce injuries.

QTC has also reviewed data on child injuries from dog bites. Dog ownership has increased during the pandemic. Children aged three to five are most at risk from a dog known to them and will usually be injured in the head and neck area. These injuries may be reduced through education—potentially via antenatal classes, vet services, doctors' surgeries, and groups advocating for child safety and the wellbeing of dogs.

QTC will continue its collaborative work with many groups to reduce the incidence of trauma and improve public safety in Queensland.

Reference

The Future of Trauma Data is a vision for 2032: https://vimeo.com/692767731

Dr Bridget Clancy

Sustainability in the dispersed workplace

Rural Surgery Section (RSS) Chair and Rural Health Equity Steering Committee (RHESC) Vice Chair, Dr Bridget Clancy, delivered the Australian and New Zealand Journal of Surgery (ANZJS) lecture in the plenary session: *The dispersed workplace – Lessons from the extreme.* The title was *Excellence through Equity*.

Dr Clancy emphasised that the poorer health outcomes rural people experience are due to lack of access to care—not due to a poorer standard of care. There is ample evidence of rural excellence in surgical training, surgical innovation and surgical outcomes. Dr Clancy was awarded the ANZJS Lectureship in recognition of her research, strategy development and advocacy in rural health equity.

Dr Clancy reported that rural medical school graduates earn higher academic scores than their urban counterparts. The AHPRA Medical Training Survey 2021 found SET Trainees are more satisfied with their rural training experience and more likely to recommend their current rural training post to their peers, compared to Trainees in urban posts.

Dr Dinah Hippolyte-Blake and other researchers in a recent quantitative study of '… the incentives and barriers that influence preferences for rural placements during surgical training in Australia' (ANZJS 2022) found that SET Trainees value rural training, provided their sociocultural needs are met, and they can prepare for their exams. Respondents cited more first-operator experience, direct consultant supervision and broader case mix compared to urban posts.

The audits of surgical mortality show rural surgical outcomes are the same or better than urban outcomes—despite equal or greater patient complexity and more advanced disease at presentation.

Dr Derek Mao presented a talk entitled *A comparison of the causes of death between patients treated in metropolitan versus rural centres following emergency colorectal resection* from the Queensland Audit of Surgical Mortality. He concluded patients who have emergency surgery in rural centres had a higher mortality rate due to advanced stage at presentation and lower mortality due to surgical complications or new medical complications. Several presenters confirmed equivalent oncological outcomes for breast cancer surgery in rural hospitals.

Surgical volume for some procedures, regardless of location, is associated with improved patient outcomes. Pancreaticoduodenectomy is one such example, with high volume considered as being 20 or more procedures per year. This is as per research conducted by surgical PhD candidate Dr Joshua Kovoor—although the availability of specialised infrastructure may be equally as important as volume.

Dr Kevin Tree, an unaccredited surgical registrar, reported similar outcomes and survival from emergency palliative open gastrojejunostomy in a regional setting compared to international benchmarks. He noted metropolitan centres are more likely to have facilities for endoscopic stenting.

Dr Kishore Loganathan, an unaccredited surgical registrar, found comparable outcomes in operative time, length of stay and complications for adrenalectomy in a low volume regional

hospital, benchmarked against high volume centres.

Associate Professor Mahiban Thomas, Fellow, and Executive Director of Integrated Surgical Services at Royal Darwin Hospital, dissected low vs high volume care research, noting that only three hospitals signed the volume pledge in the USA.

For many procedures there is no volume-outcome effect and using volume as a sole determinant may be an imperfect de-facto measure of hospital, human and physical resources. Focusing only on volume ignores other factors that affect outcome, including inequity in patient access to high volume centres, rescue of the deteriorating patient, and access to care post discharge when complications occur.

It is not helpful or desirable to ask rural patients to simply travel to high volume centres. Considering context (the patient, the procedure, the surgeon's training and skill, and the facility resources) and focusing on outcomes—while being flexible on how services are delivered—yields innovations to improve access to, and quality of care.

Dr Toby Vincomb, plastic surgery registrar at Western Health in Melbourne, presented the positive impact of a rural plastic surgical service in reducing the economic burden associated with travel to metropolitan services.

In the plenary session—*Sustainable Breast Surgery from Coast to Country*—Dr Emilia Dauway, general surgeon in Hervey Bay Hospital Queensland, described how she visited every clinic and hospital in the large geographic area she services. She listened deeply to understand what rural women and rural health facilities needed from her, with the goal of delivering quality care with equivalent outcomes to urban benchmarks.

Innovations in breast lesion localisation techniques are ideal for low resource settings, removing the need for additional infrastructure, like image intensifiers and radiographers at every surgical site. Dr Jessica Wynn, surgical resident in regional Victoria, reported on initial outcomes with implementing similar localisation techniques by a single specialist breast surgeon in a regional centre.

ANZHNCS ASM 2022

The Australian and New Zealand Head & Neck Cancer Society 23rd Annual Scientific Meeting (ASM) will be held from 26 to 28 August 2022, at the Gold Coast Convention and Exhibition Centre, Queensland.

The Australian and New Zealand Head & Neck Cancer Society (ANZHNCS) ASM is the leading education and networking event for the head and neck cancer community in Australia and Aotearoa New Zealand.

The organising committee has developed an engaging program with four international speakers, along with talented local speakers and a guest speaker for the Chris O'Brien oration. We are looking forward to meeting you in-person—with the program available after the meeting (on-demand) for those delegates unable to travel to the Gold Coast.

Thanks to the support provided by RACS, through which the attendance of one of our keynote speakers is made possible. Dr Ehab Y. Hanna, M.D., FACS, (pictured) is an internationally recognised head and neck surgeon based in Houston, USA. He is an expert in treating patients with skull base tumours, and head and neck cancer. Dr Hanna will be presenting in person at the Gold Coast.

Dr Hanna will conduct multiple keynote lecture presentations including 'Neoadjuvant Therapy in the Management of Advanced Sinonasal and Skull Base Cancers' on Friday, 26 August 2022, and the 'Value Based Health Care Delivery in Head and Neck Cancer' on Sunday, 28 August 2022.

Dr Ehab Y. Hanna, M.D., FACS, is professor and vice chair of the Department of Head and Neck Surgery with a joint appointment in the Department of Neurosurgery. He also serves as an adjunct professor of Otolaryngology, Otorhinolaryngology and Communicative Sciences, Head and Neck Surgery at Baylor College of Medicine.

He is the medical director of the Multidisciplinary Head and Neck Center and co-director of the Skull Base Tumor program. Dr Hanna is leading the development of minimally invasive and robotic applications in skull base surgery.

In addition to patient care, Dr Hanna is actively engaged in clinical and translational research with emphasis on skull base tumours. He is the past president of the North American Skull Base Society (2014) and the past president of the American Head and Neck Society (2018). He is the Editor-in-Chief of the journal *Head & Neck*, which is the official journal of the International Federation of Head and Neck Societies.

Registrations for both physical and virtual/on-demand are currently open. The registration brochure is now available and includes information about our speakers and their involvement, the provisional program and registration information.

Visit www.anzhncs.org for more information.

Five million procedures logged

The Morbidity Audit and Logbook Tool (MALT) is the College's electronic logbook and audit platform, which has been used by our members since 2012. It is a secure, convenient, and easy-to-use system for recording surgical experience, self-audit and can accommodate whole of unit peer-review audits.

Milestone reached – five million procedures

On 18 February 2022, the five millionth procedure was recorded in MALT. This is a significant milestone, which illustrates the value of MALT as a date resource and highlights the usage uptake.

The five millionth procedure was a 'complex surgical repair of wound' performed at the Royal North Shore Hospital in November 2021. The case was entered by Dr Derek Liang, Plastic and Reconstructive Surgery Trainee.

MALT data and research

MALT data can be used for educational research to enhance training programs and benefit the surgical community.

During 2021, several research projects using MALT data were conducted with support from the Australian Board in General Surgery, the Aotearoa New Zealand Board of Orthopaedic Surgery, and the Aotearoa New Zealand Board of Plastic & Reconstructive Surgery. These were:

- the association between genders of Trainees and surgical autonomy in the Aotearoa New Zealand Orthopaedic Surgery training program
- investigating if there is a difference between male and female New Zealand Plastic and Reconstructive Surgery Trainees regarding level of operative autonomy throughout training
- assessing the depth and breadth of operating experience in the field of Upper GI Surgery among Trainees at completion of training
- investigating the impact of COVID-19 on General Surgery operative training.

Multiple papers have resulted from the above projects with abstracts submitted to the 2022 RACS Annual Scientific Congress and specialty-specific annual scientific meetings. Peer reviewed journal articles are also being developed.

Future of MALT

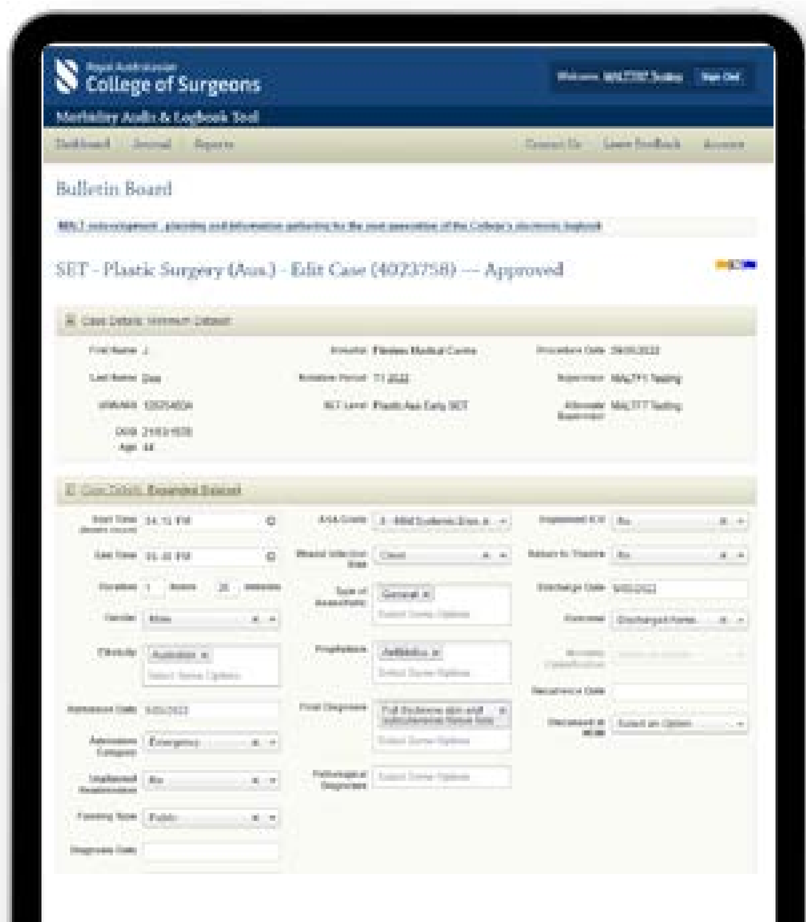
The MALT is now more than 10 years old and the College is planning its replacement. Please share your ideas and suggestions on what you would like to see in the new logbook.

For more information or to share your ideas contact:

The Morbidity Audits Team via email at MALT@surgeons.org

Complete our survey at https://www.surveymonkey.com/r/SXQFZMN

Scan the following QR code:



RACS releases results of a survey of Australian senior surgeons' views about retirement

In April 2021, the Royal Australasian College of Surgeons (RACS) surveyed Australian Fellows (65+ years of age) regarding their retirement plans; potential plans for continued work; and their concerns, with a specific focus on medical registration, medical indemnity insurance and continued professional development.

A 2020 workforce census report showed that close to 39 per cent of surgeons are over the age of 55, and 17.4 per cent are aged 65 years or older (defined as senior surgeons), with research indicating one in four surgeons are planning to retire within five years.

As this substantial proportion of highly experienced surgeons approach or consider retirement, surgical workforce modelling carried out by RACS has warned of a workforce shortage crisis by 2025. The modelling showed that to avert the crisis, there was a need for a further 80 surgeons per year to enter the workforce, in addition to the average yearly 184 new surgical graduates, an increase of over 43 per cent. However, training new surgeons comes at high cost, estimated to be over A$900,000 per surgeon.

Within this context, the continued contribution of senior surgeons is highly valued with regard to various aspects of surgical work, including clinical practice, mentorship, teaching, management, governance, as well as help with the retention and career progression of younger surgeons.

However, transition to retirement and maintaining some participation in the workforce can be a complicated process, with major concerns regarding financial and medicolegal issues, among others. In addition to the cost of compulsory full medical registration, which requires the often high cost of medical indemnity insurance. In addition, there are other requirements that must be met by senior surgeons who wish to participate in the workforce albeit in a more restricted scope, such as recency of practice and continued professional development.

As an initial step towards understanding the perspective of senior surgeons, the RACS Senior Surgeons Section Committee commissioned a research project. A survey was sent to all Australian senior surgeons (aged 65 years or above) regarding retirement plans/status, potential plans/desire for continued work, and any concerns they might have, with specific focus on medical registration, medical indemnity insurance and continued professional development.

The RACS Senior Surgeons Section Committee is pleased to present the results of this research to the surgical community. Please read the RACS Senior Surgeons Section, MDO Report here https://bit.ly/3N1P698

The Committee is developing a strategy to include the valuable perspectives of the New Zealand Fellowship in our work and to further explore the themes, opportunities and challenges raised in this report.

Authored by:

Senior Surgeons Section Committee,
Royal Australasian College of Surgeons

Daniel Chan’s multifaceted career

Dr Daniel Chan is a research fellow at the University of Western Sydney and a recipient of the Sir Roy McCaughey Research Scholarship. The scholarship is awarded to surgeons and Trainees undertaking research as part of a PhD and is valued at $66,000. Daniel received the award for two consecutive years, in 2020 and 2021. “I feel very privileged to have received the award. It has enabled me to complete most of the work for my PhD,” he says.

Daniel describes his pathway into medicine as “a linear progression”. He started his undergraduate degree at the University of New South Wales and progressed directly as a surgical Trainee in general surgery, attaining his Fellowship at 30 years of age.

“My family background is in the legal profession. From a young age I was dragged to the UNSW Law Library and photocopied case law, and that world kind of made sense to me. Medicine didn't make sense and that’s what made it interesting,” he says.

During 2019–2020 Daniel travelled to Hong Kong for post-fellowship Upper GI training. “That year at a high-volume centre in the Prince of Wales Hospital in Hong Kong was fantastic. The course was made more interesting by protests and the start of the COVID-19 pandemic,” he says.

As a part of his scholarship Daniel looked at the objective assessment and management of the oesophageal hiatus and associated pathology. He was able to coordinate international collaboration between St George Hospital in Sydney, the Prince Wales Hospital in Hong Kong, and the Western Sydney University in several research projects and publications.

“Hiatal hernia surgery is an area where we haven’t managed to get results like in other hernia surgery. There’s still a significant recurrence rate after repairs. Perhaps the controversies in management are related to a lack of objective preoperative assessment,” Daniel says.

“We looked at hiatal hernia diagnosis within a Hong Kong population using preoperative endoscopy, and then intraoperative findings. Preoperative high-resolution manometry was also compared to intraoperative findings in an Australian revisional bariatric surgery population.

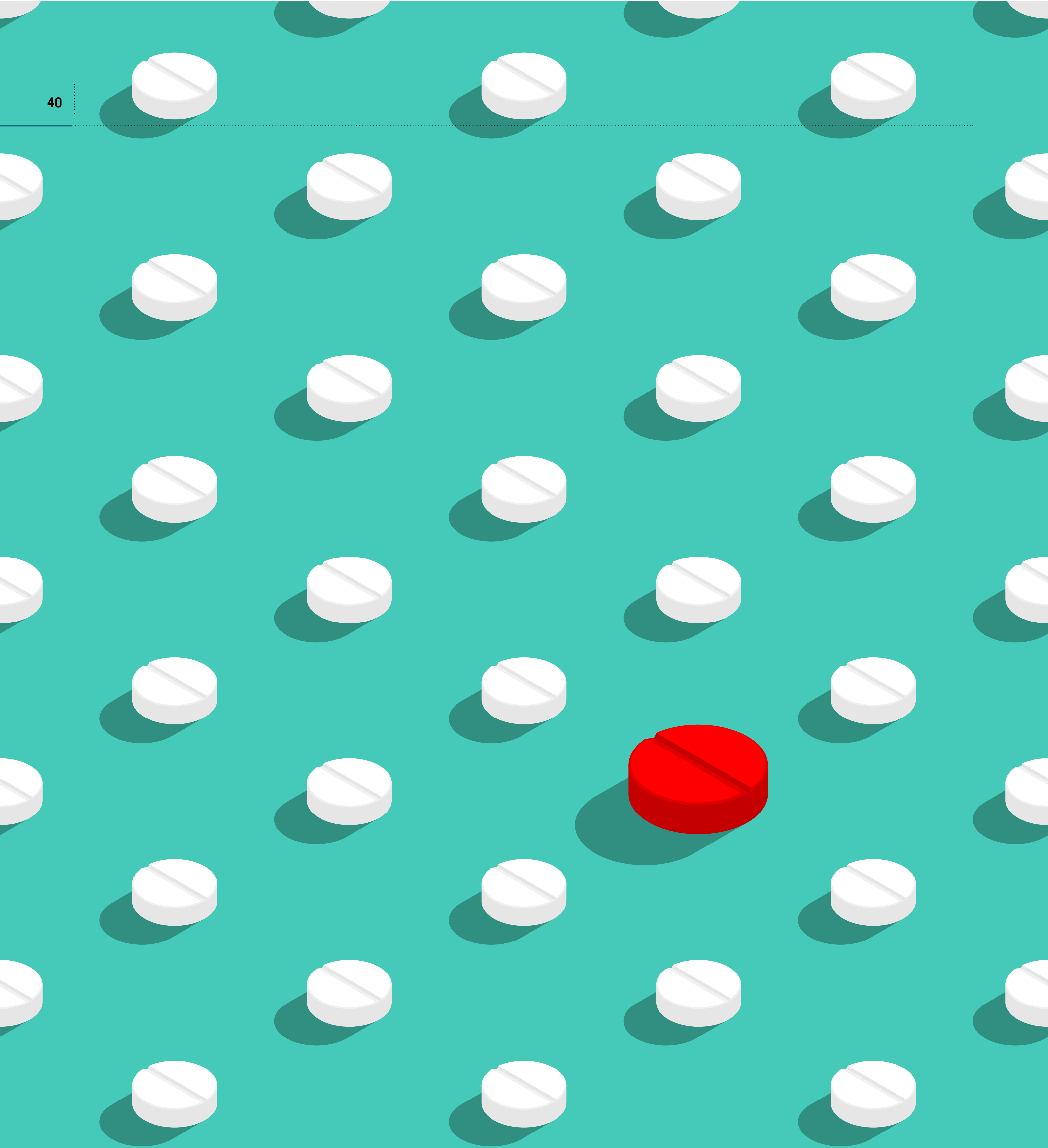
“Techniques like barium swallow are over a century old and quite subjective. High resolution manometry is now being used to interrogate the oesophageal hiatus, but it only provides a vertical assessment and doesn't reflect the three-dimensional nature of the hiatus. Multi-planar measurements with CT and perhaps MRI may have a growing role.”

Daniel is also a major in the Australian Army Reserves. He has served on an operational deployment to the Solomon Islands, embarked on HMAS Adelaide, and served domestically in the New South Wales bushfires from 2019–20.

In late 2021 he was deployed to Baghdad, Iraq for four months where he worked as a general surgeon with a highly specialised tri-service team of Australian Defence Force medical professionals. Alongside his US counterparts in the 11th Field Hospital, their team cared for US, Australian and coalition forces, and host nation soldiers.

“I enjoyed providing surgical services to Australians and others aboard. It’s another opportunity to practice our values of Service, Compassion and Collaboration—albeit in a more austere environment,” Daniel says.

Daniel and his wife have two young daughters with whom he enjoys spending time. He also volunteers with St. John Ambulance, Australia (NSW) and enjoys spending time on his fruit and vegetable garden.



Student researchers collaborate for success in opioid study

OPERAS (Opioid PrEscRiption and usage After Surgery)—an international collaborative study-led by students and Trainees from Aotearoa New Zealand and Australia

Surgically inclined medical students, junior medical officers and surgical Trainees across Aotearoa New Zealand and Australia are leading a multi-national research project aimed at understanding one of the perceived key drivers of the opioid epidemic—the prescription and use of opioids following discharge from hospital after surgical procedures.

The researchers, through their collaborative organisation—TASMAN (Trials and Audit in Surgery by Medical students in Australia and New Zealand)—have so far enrolled close to 100 hospitals in Aotearoa New Zealand, Australia, the Middle East, North Africa, Europe, the USA, and Mexico in their study.

The project extends a pilot undertaken in Newcastle, New South Wales over the past three years by General Surgery SET Trainee Dr Luke Peters. His work, as part of his research higher degree, looked at opioids that are prescribed to surgical patients on discharge, how much of this they use, what they do with the surplus, and how satisfied they are with the pain management they achieve in the first week out of hospital. The findings of the pilot are significant enough to justify validation on a wider scale before they might be used to influence prescribing policies and guidelines.

In 2020, TASMAN took this idea up after a 'shark-tank' process to identify their major research project for 2022, with guidance from a panel of senior CTANZ academic surgeons. Study co-lead Chris Varghese says, "This study has provided opportunities for medical students—new to research—to contribute meaningfully, take on leadership roles, and direct the coordination and delivery of this study."

This is evidenced by a large group of TASMAN researchers subsequently working together to refine the research questions, design a study protocol and structure that can be scaled to hundreds of hospitals, recruit volunteer data collectors and hospital organisers, enlist the support of consultant investigators at these sites, manage ethics and governance processes in Aotearoa New Zealand and Australia, design databases and statistical analysis plans to handle and process the data, and keep up with their studies and training.

Aya Basam, study co-lead, says, "It has been incredibly exciting to see the enthusiasm of students getting involved with OPERAS, and their eagerness to learn while taking on new roles within such a large study."

> "As someone who is relatively new to the collaborative research sphere, being involved in the leadership of OPERAS has been an incredible opportunity to refine and further develop my skills, while delivering a high-quality, impactful study." Aya Basam

For William Xu, study co-lead, "The OPERAS study has certainly demonstrated that despite challenges, medical students in Australia and Aotearoa New Zealand are able to design, lead, coordinate, and execute an international multi-centre study."

This motivated group of TASMAN researchers are demonstrating the effectiveness of a truly collaborative student-led research model.

"The enthusiasm shown by students to step-up and take on leadership roles for OPERAS has shown the incredible potential of collaborative efforts, upskilling a significant population while delivering high-quality research," says Aya.

She also acknowledges the personal benefits of being involved in OPERAS, "As someone who is relatively new to the collaborative research sphere, being involved in the leadership of OPERAS has been an incredible opportunity to refine and further develop my skills, while delivering a high-quality, impactful study."

The study is guided by a trial steering group comprising Chris Varghese, William Xu (both from The University of Auckland), Aya Basam (Monash University), Venesa Siribaddana (University of Newcastle) and Lorane Gaborit (Australian National University). The universities of Newcastle and Otago, the Hunter Medical Research Institute in New South Wales, and the Maurice and Phyllis Paykel Trust have provided project sponsorship, professional support services and database capability.

Dr Deborah Wright (University of Otago), Associate Professor Amanda Dawson (University of Newcastle), Associate Professor Peter Pockney (University of Western Australia) and Professor Jennifer Martin (University of Newcastle) have provided supervision and specialist clinical and trial expertise to the steering committee.

The project will recruit patients between April and August 2022. If you would like to be involved or are looking for more information, visit us at the project hub:

Website: https://anzsurgsocs.org/tasman/operas-study-hub/

Facebook: https://www.facebook.com/TASMANCollab/

Twitter: @TASMANCollab

Dr Luke Peters, Aya Basam, Lorane Gaborit, Venesa Siribaddana, Chris Varghese, William Xu.

Gendered titles, barber surgeons and all that ...

The Royal Australasian College of Surgeons (RACS), in providing a background document supporting the removal of gendered titles, noted that surgery is the only profession that continues to use gendered titles in Australia and Aotearoa New Zealand.

The document's supporting references included an article from the *British Medical Journal* of December 23, 2000, entitled, *Why are [male] surgeons still addressed as Mr?* The author, a medical historian, wrote: 'to understand how the tradition arose it is necessary to go back to the beginning of the 18th century'.

The RACS background document noted that the use of the term 'Mister' for surgeons, dates to the 16th century when 'barber surgeons' performed operations at the direction of physicians. Such statements warrant both clarification and closer scrutiny.

The barber surgeon was one of the most common European medical practitioners of the Middle Ages and as Europe emerged from the Dark Ages, surgery was at an elementary level. Barbers originally aided monks, who by the early 14th century were the traditional practitioners of medicine and surgery. The barber's assistance was necessary, as following the Council of Tours in 1162, monks were forbidden to let blood.

Religious and sanitary monastic regulations required that monks maintained a tonsure—the traditional baldness on top of the head of Catholic monks—assuring a steady need for barbers. In addition to hair cutting and shaving, barbers performed simple surgical procedures including the lancing of abscesses, cupping, bloodletting, and the extraction of teeth.

The existence of a Barbers' Company was first evident in 1308. However, it was not until the Royal Charter of 1462 that the Worshipful Company of Barbers was finally incorporated. The barbers

being granted armorial bearings by the Clarenceux King of Arms in September 1451, described as, '*sabull a cheveron bytwene iii flemys of silver*'. A flem or fleam, is a form of lancet, representing the bloodletting activities of the early barber.

In 1368 the surgeons had been allowed to form their own unincorporated Fellowship or Guild. They were granted a cognisance, or badge, by Henry VII, customarily flanked by the patron saints of surgeons, St Cosmos and St Damian. In heraldic parlance, the cognisance described as, 'a spatter thereon a rose gules, crowned golde'. The spatter, which is visible beneath the crowned red rose, is a spatula, symbol of the surgeon's craft: in fact, it is most difficult to discern in the final armorial bearings of 1569.

When Henry VIII enacted the dissolution of monasteries in England between 1536 and 1539, many monks with a knowledge of elementary medicine and minor surgery, found themselves homeless, among the general population, and they undertook medical or surgical work to survive.

Their exodus was perhaps not without influence in leading to Henry VIII's decision to unite the Barbers Company and the Fellowship of Surgeons by an Act of Parliament in 1540, thereby forming the Company of Barber-Surgeons, and thus regulating those services provided.

Thomas Vicary, surgeon to Henry VIII, also played a pivotal role in the establishment of the new company, concerned as he was about the appropriate regulation of surgeons practising in the City of London.

That memorable union is forever commemorated by the magnificent painting of Hans Holbein, detailing the monarch presenting Thomas Vicary, accompanied by surgeons and barbers, with their Charter. The original painting currently hangs in the Barber-Surgeons' Hall in Monkwell Square, City of London: a cartoon is in the collection of the Royal College of Surgeons of England.

The timing of this union was fortuitous as the works of Hippocrates and Galen were soon to become available to western European readers, and textbooks in English were to be written within a few

decades: anatomy was about to be revived by the publication in 1543 of the *De Humani Corporis Fabrica* of Vesalius.

The Act of 1540 also allowed the bodies of four executed criminals to be an anatomised annually at public demonstrations. The teaching of anatomy became an important function of the Company: an anatomy theatre was designed for the Barber-Surgeons by Inigo Jones in 1636.

To become a member of the Company, apprentice training would occupy seven years within the household of an experienced barber-surgeon; apprentices would assist in surgical care and gain hands-on experience in such tasks as setting bones and suturing wounds. As surgical training was by apprenticeship—and not academically—the Member title used was, Mister.

Until the end of the 17th century the only general hospitals in London were St Bartholomew's and St Thomas'. However, in the 18th century the Westminster, St George's, Guy's, Middlesex and London hospitals were built, and surgeons increased in number and importance.

The Barber-Surgeons' Company of London had controlled surgery in the metropolis for 200 years: and although initially the barbers outnumbered surgeons 20:1, gradually a greater part of the company's income came from increasing numbers of surgeons, who began to desire independence.

In early 1745, a Bill was introduced in Parliament to again separate the surgeons and the barbers of London into two separate and distinct corporations. The Bill soon became an Act to which the Royal signature was affixed on 2 May 1745, and an independent Company of Surgeons was thus formed.

That company, in 1800, became the Royal College of Surgeons in London, and, subsequently in 1843, the Royal College of Surgeons of England, retaining the eponymous lectures and scholarships of the previously combined body, and also the gendered titles. One difference was immediately evident, the desire of the surgeons to sever their former connection with the City of London.

The Worshipful Company of Barbers came again into being following the dissolution of 1745; the Barbers retaining both the Barber-Surgeons' Hall and the name of the hall, the silver, and much of the treasure, including Holbein's portrait of Henry VIII. There has since been no modification of the Arms granted by Queen Elizabeth I in 1569, and the Company of Barbers, to this day, incorporates the original badge given to the surgeons in 1492. The company's Latin motto is De Praescientia Dei, or from the foreknowledge of God.

The Barber-Surgeons' Hall was destroyed in the Great Fire of 1666, rebuilt, and destroyed again by German bombing in 1940. A new Barber-Surgeons' Hall was opened in 1969 by Her Majesty, Queen Elizabeth, the Queen Mother. Today, the company has some 350 members, half of whom are medically qualified, and half of the latter being surgically qualified.

Although the company has long lost its direct connection with the barbers' trade, it flourishes and has important charitable aims, which include support of the teaching of anatomy at the Royal College of Surgeons, grants to medical and dental students, and support of schools in the city.

Your author worked with John Chalstrey, an upper gastro-intestinal surgeon, at the Hackney Hospital in 1977. John later became Master of the Company of Barbers, and, in 1995, the first surgeon elected as Lord Mayor of the City of London, following which he was knighted.

A tour of the Barber-Surgeons' Hall is recommended for the London visitor. It is a magnificent building adjoining the old Roman Wall of the City, housing a truly impressive collection of royal charters and seals, records of the practice of barbery in early times, portraits and silver: tangible memorials of past surgical times.

Mr Peter F Burke
FRCS FRACS DHMSA

Images (Clockwise from top-left): Henry VIII and the Barber-Surgeons 1540. Hans Holbein; Barbers' arms.1451; Armorial bearings Worshipful Company of Barbers, 1569 to present time; Barber-Surgeons Hall. Cpy admitting a new member 1844:note Holbein portrait in the background; Surgeons' cognisance 1492; Tonsured monk.

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 the media, public campaigns, and by negotiating directly or providing written submissions to both government and non-government agencies.

Over the past two months, some of the advocacy work the College has undertaken includes:

Environmental advocacy Joint letter

RACS has joined with 10 other medical colleges to co-sign a letter to Australian political leaders highlighting the risks of climate change, and warning of the under-preparedness of the Australian healthcare system to deal with these risks. The letter is available here: bit.ly/3PLU1gm

The letter follows a report (bit.ly/3x0cRZX) that was developed in 2021. The comprehensive report was commissioned by the Royal Australasian College of Physicians (RACP) and prepared by the Monash Sustainable Development Institute. Members of the RACS Environmental Sustainability in Surgical Practice Working Party (ESSPWP) played a key advisory role in the report's development.

Presentations

In 2022, the ESSPWP has increasingly sought opportunities to engage with RACS members and promote environmental sustainability as an advocacy priority. Earlier this year the ESSPWP hosted a webinar, which can be viewed on the RACS website.

At the ASC, members of the ESSPWP participated in a scientific session on 'Climate Change and Surgery.' Among the speakers in this session was ESSPWP Chair, Professor David Fletcher. He highlighted the history and some of the recent actions taken by the Working Party, including a contribution to the RACS Australian Federal election statement: bit.ly/3wXJV4D

Another member of the working party, Dr Maria-Pia Bernardi has been invited to speak at the ACT Annual Scientific Meeting (ASM) in August and will deliver a presentation on behalf of the ESSPWP. To register for the ASM please visit the conference website: bit.ly/3lSDvxm

Transparent patient outcomes

RACS recently provided a submission to the Health Insurance Legislation Amendment (Transparent Patient Outcomes) Bill 2021. We consulted with our Fellowship within our governance

structure including all 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 reached out to our nine Australian and binational surgical specialty societies and associations and thanked them for providing their presidents' joint signatures in support of our submission. The submission is written in the format requested by the Australian Department of Health, and we look forward to participating in any possible future meetings and/or hearings.

Read the full submission: bit.ly/3N1i0va

Consultation Regulatory Impact Statement on use of title 'surgeon'

Following input from HPAC and approval by the President, RACS made its submission in April. The RACS submission takes a principled approach based on the RACS position on titling that was previously approved and published in early 2021.

RACS does not support the use of titles such as cosmetic surgeon or dermatologist surgeon in principle, but supports oral and maxillofacial surgeon, obstetrics and gynaecology, and ophthalmology based on their Australian Medical Council (AMC) accredited training.

In addition, as rural GPs play an important role in rural communities by providing accessible health services RACS position would enable rural GPs who completed the rural generalist pathway and have undertaken AMC accredited advanced skills surgical training to refer to themselves as rural GP surgeons.

Read the full response: bit.ly/3M9GgFg

Trauma advocacy

e-scooters

The rate of injuries from e-scooters is a continuing challenge to the community. The Tasmanian State Chair met with Minister Jeremy Rockliff to discuss the e-scooter trial that started in Hobart in December 2021.

The Tasmanian State Office is liaising with the Jamieson Trauma Institute, the Queensland Trauma Committee and the Road Trauma Advisory Subcommittee regarding published articles about the increase in Brisbane Emergency Department admissions from the use of e-scooters.

Finke Desert Race

The Road Trauma Advisory Subcommittee is liaising with the Northern Territory coroner regarding preparing a submission into the inquiry surrounding the Finke Desert Race where a spectator was killed in 2021.

Alcohol Liquor Licensing Association Forum (ALLAF)

RACS Trauma Chair, Dr John Crozier was invited to represent RACS at the Annual ALLAF conference in Adelaide from 12–13 May 2022 to address harm minimisation, among other things.

The forum featured liquor licensing regulators from across Australia and was an important opportunity for RACS to continue our alcohol harm minimisation advocacy.

Senate committee takes on board RACS concerns about mandatory reporting and notifications

A senate committee looking at AHPRA's administration of registration and notifications appears to have heeded to RACS concerns regarding mandatory reporting requirements for medical practitioners, and its concerns about notifications processing, among other issues. RACS made a submission to the Senate inquiry (bit.ly/3wXKs6D) in mid-2021 and was invited to participate in a hearing.

The Senate inquiry's final report was tabled in early April 2022 and is available here: bit.ly/3t4Z4ig

To find out more visit the RACS website: bit.ly/3NK60cE

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 editions, please email the RACS Policy and Advocacy Team at RACS.Advocacy@surgeons.org

RACS Global Health working in partnership for the Pacific Island Program

In April 2022, the RACS Global Health Department and Fellow Dr Liz McLeod had the opportunity to join the Pacific Island Program (PIP) Phase 2 Workshop in Suva, Fiji. Fellows and partner organisations also joined this workshop online. The purpose of this workshop was to join the three PIP partners—RACS, Fiji National University (FNU) and South Pacific Community (SPC) and donor agency DFAT—in planning discussions for the next four-year phase (2022–2026) of the critical program.

The PIP sits within the broader DFAT Pacific Regional Clinical Services and Health Workforce Improvement Program, which aims to contribute to the high-level goal: 'health care in Pacific island countries is affordable, appropriate to local needs, of good quality and accessible'.

The PIP is one of the three streams implemented under this regional project. The other components are managed by FNU and the SPC. PIP's program objective is 'to strengthen and consolidate specialised clinical service delivery in the Pacific region'.

The PIP is implemented across 11 Pacific Island Countries (PICs) with a total population of 2.4 million people—the Cook Islands, Federated States of Micronesia (Micronesia), Fiji, Kiribati, Nauru, Republic of the Marshall Islands, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu.

The PIP program goals are:

- Prioritised Pacific specialised clinical service professionals have improved competencies
- Pacific Island countries receive quality visiting medical teams that meet their priority clinical and training needs
- Pacific Ministries of Health better identify and prioritise specialised clinical service and training needs, to inform Ministry of Health planning
- Pacific specialised clinical education institutions and Pacific professional clinical organisations have better educational resources.

An independent mid-term review was conducted remotely by the Nossal Institute from May to August 2020. It included a review of program documents and broader literature, 35 key informant interviews, and online surveys completed by 48 Visiting Medical Team members and 31 Pacific Island clinicians.

Findings included that RACS should continue to support remote capacity building activities and develop more remote clinical professional development training models in collaboration with Pacific professional clinical organisations. RACS was also recommended to consider opportunities for the PIP to support Ministry of Health-led planning for the development of:

- specialised clinical services
- the workforce to support those services, ensuring that the former drives the latter to the extent possible.

The recent workshop in April 2022 enabled all partners and the key donor, DFAT, to come together to discuss the future programming—not only for PIP—but for the Pacific Regional Clinical Services and Health Workforce Improvement Program.

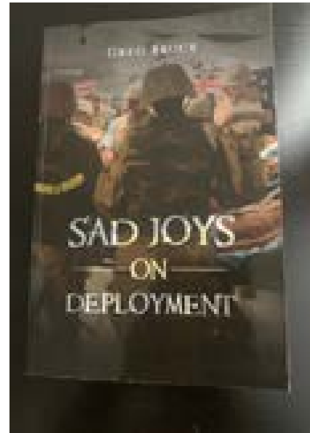
The partners and clinical Fellow representatives agreed that the model needed to acknowledge the increasing shift towards localisation and regionalisation of development resources. There was also consensus that the two key objectives of quality clinical services and health workforce development were relevant and needed to be continued into Phase 2 of the PIP.

RACS Global Health Fellows and staff would like to thank partners SPC and FNU and our donor, DFAT, for the opportunity to join this valuable partner reflection process. We look forward to sharing information on the PIP Phase 2 as we progress planning on this critical program.

Good reads

Sad Joys on Deployment

Greg Bruce



This engaging memoir is based on Dr Greg Bruce's 10 deployments with the Australian Defence Force (ADF) as an orthopaedic surgeon in the Royal Australian Air Force Specialist Reserve.

Dr Bruce describes the challenges of military surgery—the good and bad, and the satisfying and distressing aspects of immersion in a war zone.

Dr Bruce's first deployment was in Rwanda in 1995 in response to the terrible massacre of the Tutsi people by the Hutu. He shares his many learnings, including the inadequacy of the UN. His second deployment in 1998 was to Vanimo in Papua New Guinea in response to the tsunami.

He went on further deployments in East Timor, the Solomon Islands and then onto Iraq, which he describes as his 'longest, most confronting, most stressful, most demanding and most interesting of all'.

Dr Bruce was sent to Iraq in late 2004 after the USA had declared 'mission accomplished' but was still having problems exerting control in the country. Suicide bombings and high-velocity gunshot wounds were common. The hospital he worked in provided emergency medicine, trauma surgery, intensive care and aero-medical evacuation for combat casualties and orthopaedic and general surgeons with subspecialties such thoracic, vascular, neurosurgeon, among others.

His ninth deployment in Bali was brief and dramatic. He was sent there in response to the second terrorist bombing of October 2005, which saw the death of 20 people and more than 100 people injured.

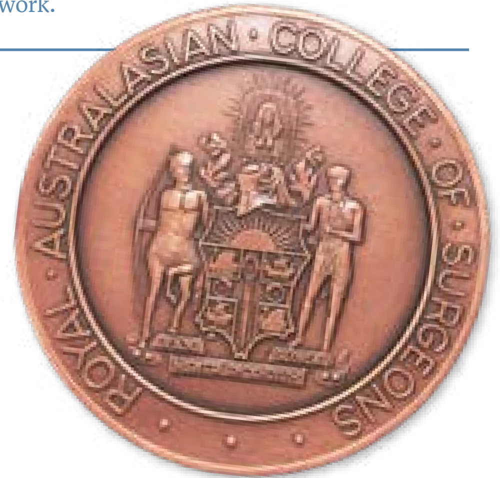
In 2008, Dr Bruce returned to the Middle East, this time based in Afghanistan as the orthopaedic surgeon component of an ADF Medical Task Force.

Dr Bruce describes the contrasts and similarities of his deployments in an engaging manner, sharing his growing experience and management of surgical cases in what were sometimes quite challenging conditions.

Dr Bruce's book is available to buy from all bookselling websites.

RACS Trainees recognised for leadership skills

Congratulations to the worthy recipients of the John Corboy medal for their exemplary work.



Dr John Corboy (1969–2007) was elected chair of the RACS Trainees' Association (RACSTA) in 2007. He was described as a great leader, a selfless representative of RACS Trainees—generous with his time and wisdom. His energetic service to the profession, coupled with his tenacious passion for surgery, despite personal adversity, was remarkable.

The John Corboy Medal is the highest award given to a Trainee at RACS. Awarded by RACSTA, the medal represents a Trainee who has embodied outstanding leadership, selfless service, tenacity, and service to Trainees of the College.

Dr Christopher Conyard - 2020 recipient

Dr Christopher Conyard is the 2020 recipient of the John Corboy medal. When he was nominated, Dr Conyard was an Orthopaedic Surgery Trainee. He was awarded the medal in recognition of his outstanding leadership, and selfless, tenacious service to the Trainees and the community.

Currently a Fellow, Dr Conyard continues to embody those qualities. Described as personable and warm, with an easy manner, his interest in others enabled him to build positive relationships with his peers on the training program, including with senior members of the Australian Orthopaedic Association (AOA).

Dr Conyard was the president of the Australian Orthopaedic Registrars' Association (AORA) from 2018–2019. In this role he represented approximately 230 Trainees and was a voting member of the AOA Federal Training Committee and the AOA Board.

The high standards he set for himself contributed to him developing a non-profit organisation to support improvements in the management of melanoma patients.

In 2014, Dr Conyard's sister-in-law, Phoebe, passed away from melanoma. In 2016, Dr Conyard established the Million Metres for Melanoma (MM4M) with a team of friends, including plastic and reconstructive surgeon Dr Nathan Schaefer, orthopaedic surgeon Dr Adam Parr, and orthopaedic surgery Trainee Dr Simon van Rosendal. The aim was to raise money to support melanoma research by competing in endurance events.

Over the past six years the team has broken a Guinness world record as the fastest to run one million metres and a Concept 2 world record for the fastest team to row one million metres. This record was subsequently broken by a group of ex-Olympic rowers from Denmark. The team has raised nearly $500,000 towards melanoma research.

In June 2022, Dr Conyard and the Million Metres for Melanoma team will continue to raise money and awareness by attempting to break the world rowing record. They aim to raise $250,000 for the melanoma unit at the Princess Alexandra Hospital in Queensland.

If you would like more information on how to get involved with MM4M go to the Million Metres for Melanoma website.

Dr Anna Morrow - 2021 recipient

Dr Ahrin Anna Morrow (nee Choi) is the 2021 recipient of the John Corboy medal. She was a General Surgery Trainee in Christchurch, Aotearoa New Zealand,

when she was nominated for the medal. She is known for her leadership, selflessness, tenacity, and service to Trainees—set against extraordinary personal tragedy.

Dr Morrow, currently a Fellow, was an exemplary General Surgery Trainee, a leader by example with strong principles of fairness and confidence in calling out unacceptable behaviour. She is known for her drive, organisation, and selfless efforts to provide continuity of care for her patients and to support and teach her colleagues—going beyond expectations and consistently putting others' needs ahead of her own.

When she was in her third year of training in 2018, her newborn son, Cormac, was diagnosed with a rare, serious genetic condition soon after birth. He passed away when he was 17 months old and Dr Morrow contemplated ending her surgical career. She credits the Christchurch surgical community for supporting her decision to persevere and continue training—a decision her community will be grateful for in the future.

Dr Morrow returned to General Surgery training with notable inner strength, maturity, and dignity. She continued to provide exemplary service to her peers—coordinating selection interviews for her junior colleagues and replacement mock examinations for senior colleagues when the first round was cancelled due to the tragic Christchurch mosque shootings in 2019.

Immensely respected by her peers, students, colleagues and surgeon mentors in Christchurch, Dr Morrow's story is one of tenacity in the face of personal tragedy and exemplifies the spirit of Dr Corboy's memory.

Dr Amanda Nikolic - 2022 recipient

Dr Amanda Nikolic is the 2022 recipient of the John Corboy medal. She is a General Surgery Trainee who has shown outstanding leadership skills and service to Trainees through her teaching and tutoring of General Surgery training. She created a virtual educational program at St Vincent's Hospital Melbourne, for general surgical Trainees and the After-Hours Surgical Education Series—a weekly teaching seminar at Shepparton Hospital in regional Victoria.

Her selfless service resonates in the creation of First Incision*, a podcast launched in 2020, on how to prepare for the Fellowship exam. The podcast covers topics from the curriculum and has guest episodes with surgeons talking about trickier topics, including talks with recent Fellows to discuss exam techniques. General surgical Trainees, from around the country, access the content she creates, and applaud the effort she puts in, which goes above and beyond what is expected of a Trainee. Dr Nikolic has also authored the *Trainee handbook General Surgery SET Interview: The Ultimate Preparation Guide***.

Dr Nikolic showcases her tenacity through her outside interests including completing an Iron Man triathlon during her training as well other triathlons and half marathons over the past five years.

She has also created and hosts an online blog, which offers nutrition advice, recipes, fitness sessions, and health motivation. In 2021 she received the Herbert and Gloria Keys Research Scholarship from RACS and during her medical training has received many accolades and nominations related to her excellence as an intern.

**First Incision podcast can be found on your favourite podcast apps - Spotify (https://spoti.fi/3wZxk0l), Google Podcast (bit.ly/3x1oWwN) and Apple (apple.co/3z24DBU).*

***General Surgery SET Interview: The Ultimate Preparation Guide is available as an eBook on Amazon with a second edition and paperback coming out in 2022 (amzn.to/38Yz4ye)*

Nominations for the 2023 John Corboy Medal are now open. For more information on how to nominate a Trainee, visit the RACS website.

College of Surgeons | Converge

The Melbourne surgeon and the iconic Chloe

OPUS LXXV

Who would have thought these two disparate personalities would have been acquainted—the distinguished Melbourne surgeon art collector and the painting Chloe, a product of the Impressionist period in France of the 1870s? Yes, she continues to be clothed in controversy.

The Chloe portrait, on permanent display at Young & Jackson hotel, in Melbourne, was recently featured at the MONA Exhibition in Tasmania.

Chloe was originally owned by Sir Thomas Naghten FitzGerald, an eminent Melbourne surgeon, but little is known about him. RACS archives are scant. Hence, my decision to do a Sherlock Holmes, don my deerstalker hat and investigate, pulling out all stops.

My sleuthing activities revealed many facts and it offers a different view to Mark Twain's quote of 'not letting truth get in the road of a good story'. Thanks to the McDonald article in *The Dictionary of Biography* of 1972, Katrina Kell's thesis on Chloe and her publication *Evanescence of an Artist's Model,* and Brian Collopy's book on Diamond Jim a lot of unifying truths emerged.

In March this year, *The Age* journalist Gabriella Coslovich reviewed the Chloe exhibition (illustrated), mentioning its surgical ownership.

The MONA exhibition in Tasmania

And Jane Clark, the curator of Walsh's MONA Gallery in Tasmania, had to seek heritage permission to ensure Chloe's return to Melbourne for ANZAC Day.

Chloe was painted by Jules Lefebvre, winning him the gold Medal of Honour at the Paris Salon of 1875. Sir Thomas bought her for 850 guineas in Sydney from the touring French exhibition. He housed the painting at Rostella—his magnificent Italianate mansion at 460 Lonsdale Street, Melbourne (illustrated). Sadly, all that remains now are the front gates on Rostella Lane.

'Rostella' at 460 Lonsdale Street in the vicinity of the Supreme Court

Its initial exhibition at the National Gallery was cut short because of religious controversy but was kept on display to the passing parade from his home at Rostella.

Sir Thomas' intriguing life story of dedication invites a review. He graduated from Dublin University, gaining his Licentiate Royal College of Surgeons of Ireland in 1857. From being a dresser (assistant) to Mr Richard Butler, then the Queen's surgeon, he arrived in Melbourne in 1858. Sir Thomas then became an honorary surgeon in 1860 at The Melbourne Hospital at the age of 22—the Royal was added in 1935 by Royal Charter. He finally retired in 1901 after 50 years of public service.

Let us not forget, all public hospital medical service—even now—contributes to our surgical teaching (when we teach, we learn: quoting Seneca the Roman philosopher). Here, peer review and collegiate debate, maintains standards.

Private practice also benefited from the duality of this contribution, as initially established by Sir Thomas. However, I could only manage 40 years at both Peter MacCallum and the Western Hospital public service, thanks to Benny Rank's advice, to hone my skills there.

Both Sir Thomas and Gerry Moore at The Melbourne Hospital, were keen advocates of the emerging Listerian principles. Their avid readership of overseas publications was vital in this domain. Moore, the first plastic surgeon in Australia, quoting Benny Rank's book, was critical of the then surgical habit of surgeons in street clothes in the golden days of wealthy Melbourne, wandering into the theatre—sometimes via the mortuary—to don the communal protective leather apron before operating. Even Diamond Jim Beaney practiced surgery with his bejewelled hands, with little respect for sterility—mentioned in Brian Collopy's book. Both Sir Thomas and Moore banned Laparotomies at The Melbourne Hospital because of the then high fatality rate. Thanks to Moore's research and practice of simply lime washing hands and donning clean theatre garb, the mortality rate was reduced from 80 per cent to less than 20 per cent.

Academically, Sir Thomas was offered the first clinical lectureship in surgery at the University of Melbourne, linked to the Melbourne Hospital. His surgical skills were universal, embracing everything from head to toe—a master of all sites. He even matched the speed of amputations of Sir James McGrigor of Waterloo fame, quoted at five minutes. And 'biting the bullet' was the common practice then as a pain distractor for this procedure.

The plaque in The Melbourne Hospital foyer honouring Sir Thomas' 50 years of surgical service, must now be lost in some archival hole. However, Sir Thomas' portrait remains (illustrated) resplendently, recalling historically his contribution. My physiotherapist, Hannah Ware, who works at the Royal

Melbourne Hospital, recently alerted me to his displayed portrait.

Sir Thomas Naghten FitzGerald (1838-1908)
The 1890 portrait of FitzGerald by Ugo Catani in the RMH foyer donated by his daughter, Mrs Lumsden from Scotland

Sir Thomas was the first to receive a knighthood for Colonial Medical services in May of 1897 before going off to the Boer War—as detailed in the *Medical Journal of Australia* of December 1900.

He died in 1908 at 80 years of age and the obituary notices by Harry Allen, Professor of Pathology, and Graeme Syme, were glowing in their praise of his surgical contributions. Syme, a laconic personality who lived by the sobriquet of 'silent Syme', called him a 'genius'—what an attribution from someone so verbally restrained. Syme later became the inaugural President of the Royal Australasian College of Surgeons in 1927.

At an auction of his estate, Chloe was bought by Young & Jackson for much the same figure and Sir Thomas' daughter subsequently bequeathed funds to The Melbourne University to establish the Naghten Fitzgerald Scholarship—still current—with the latest recipient being Simon Julian Maciburko, Department of Surgery, St Vincent's Hospital in 2017.

I gather from these stories that Sir Thomas had a surgical instinct and one presumes this was the keynote of his success, allowing him to modify procedures to optimise outcome. Like Ernest Dieffenbach of the 1850s, he exemplified what we call that sixth sense, combining intuitively the blend of confidence and experience. In my own surgical exposure, there are certain personalities who exhibit this trait, but not all have it.

- Brian Cortice in Brisbane was regarded as one of the best operators. I experienced this during my training with him in general surgery (yes, I have a General Fellowship).
- John Hueston became a world figure earning a reputation in his field of Plastic and Reconstructive Surgery ranging from Hands to Oncology and Aesthetics. With the largest practice in Australia by repute and known as the best, his clinical practice included local, interstate, and international patients. His numbers reflected his ability, and his insomniac 5am ward rounds were notorious—if not legendary.
- Don Marshall was of the same ilk.
- Charlie Westbury at The Westminster likewise had the oncological experience in head and neck and melanoma management.

All these factors above have contributed to my ongoing surgical development.

Here is a recollection from another eminent surgeon—Sir Rodney Smith, of St George's, London in the 70s—where we worked—became president of the College, specialising in Hepatobiliary Surgery. He had his own brass plaque for his elbow at the St George's bar, overlooking Hyde Park—a consultant tradition.

He once said to me, "Felix, I am a self-taught surgeon with a great respect for his mentor." Another acerbic line was about his violin playing, of concert platform quality. When asked why he did not follow this career line he casually replied, "being a surgeon, I can do both."

Now let us spend a little time with Chloe—in a literary sense.

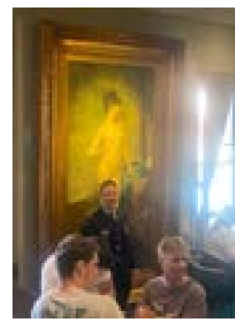
Katrina Kell recalls how Lefebvre painted Chloe for the Paris exhibition of 1875, even including his studio image.

Chloe's present-day confines—really her mausoleum—is on the first floor bar at Young & Jackson, in Melbourne and is currently insured for more than $5 million.

Marie Pellegrin was Lefebvre's model for the Chloe portrait. A Parisian born in 1856-57, she posed as an artist's model for the portrait of 1875. Controversy surrounded her relationship with Lefebvre, who eventually ended up marrying her sister. Could this have contributed to her suicide some two years after the successful prize-winning exhibition? Yet, she has been immortalised in paint.

Kell recalls a café in Montmartre, Café Nouvelle Athens, where the likes of Manet and Degas would dine on elegant French cuisine (after a successful sale, no doubt) and discuss this new genre of Impressionism. Vincent Van Gogh in the 1880s was also a regular visitor here, working at the nearby Goupil art gallery, which incidentally prepared Chloe (framing etc.) for that exhibition in the *tres controversée* Impressionist times.

Lefebvre's studio on Rue de la Bruyere was two blocks away from this Goupil gallery, a mingling site of these artistic personalities.



'Chloe' and the serviceman acting as her 'fig leaf'
Taken 25th April 2022 at Y&Js

Chloe still contributes to the ANZAC memorial at Young & Jackson.

Stories surfaced of many of the troops having their last drink or two there, toasting her image before sailing off to war. The hotel owners earlier recalled how letters of endearment arrived addressed to Chloe. These were really an apostrophe from the trenches (a homage to a personified entity) before being forwarded to the soldier's relatives.

With 60,000 Australian troops perishing in WWI, a third of these would have been Victorians, how many would have toasted Chloe before their departure? Hence, the Heritage Foundation stipulated that Chloe must be back in town from the Tasmanian exhibition for the ANZAC Day memorials—remembering them.

P.S. Guess who visited Young & Jackson's on ANZAC Day to recount Chole's contribution to the welfare of the ANZACS? And a stranger even bought me a beer.

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.

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

Mr Edward (Ted) Schultz

Dr John Aberdeen

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

Dr Eric Graham Holmes, FRCS (Edin) FRACS

Urologist surgeon

1 February 1939 – 1 November 2021

Graham Holmes was a country boy born in Bundaberg and raised in Sarina, North Queensland, a beneficiary of his father's small business. Life in Sarina included caddying for his parents' golf tournaments—their success obviously due to the skill of the caddie! A lifelong love of golf was born.

Secondary school meant being a boarder at Church of England Grammar School in Brisbane. Rugby became another sporting interest. On completion of high school, Graham entered the University of Queensland graduating in 1964 with an MBBS degree. St Johns College was his home during his undergraduate years. During the following two years, he served as a resident at the Royal Brisbane Hospital.

The desire to undertake surgical training saw him travel to the UK, working in Nottingham and Edinburgh Royal Infirmary. He decided to become a urologist when he returned home in 1970 to join the staff at Princess Alexandra Hospital (PAH) having been granted the FRCS (Edin).

The year 1971 was a momentous one—successfully achieving his FRACS (Urol) as well as marrying a PAH nurse, Sandra Piper (Pip). Undergraduate nurses had only been granted permission to marry but even so, Graham had to seek permission from the matron to marry one of her nurses. Team Holmes was created!

Graham was appointed Consultant Urologist and Urologist to the Spinal Injuries Unit PAH, where he was admired and respected during his practicing life.

His teaching skills and professional enthusiasm have contributed to many deciding to train in Urology. In 1991, respect from his colleagues was reflected in his being elected president of the national Urological Society—now the Urological Society of Australia and New Zealand. As president, he set a new standard for conducting the Annual Scientific meeting of the Society. His search for positive change was evident in his own urological practice.

He instigated the concept of a joint practice with a colleague and the Brisbane Urology Clinic was established. This expanded and the dynamic clinic is now an integral part of urological service in our community.

Graham will be remembered as a loyalist—loyal to his family and friends, his professional colleagues and institutions and the community in general.

A reflection of his life would not be complete without acknowledgement of his infectious sense of humour and love of life. Like his parents, he met with golfing success but for him participation was what counted. The members of the Brisbane Golf Club have been fortunate to count him as a member and friend.

He will be fondly remembered by all who knew him.

The obituary was provided by Mr Ross Cartmill FRCS FRACS OAM

Surgical News would like to apologise for the error in Dr Holmes' obituary in the previous issue–Ed.

Dr Alan M Cuthbertson

23 October 1929 - 2 November 2021

Alan Cuthbertson passed away peacefully at the age of 92. He was a member of the Royal Melbourne Hospital senior medical staff from 1962 to 1989.

He was a wise and gifted colorectal surgeon who practised and taught the essential skills that benefitted countless patients—his own and those of his Trainees, who were fortunate to have him as their teacher.

Alan's surgical technique was neither flamboyant nor hurried, but exhibited an absence of wasted or repetitive movements. This meant he completed operations in about half the time it took his colleagues to perform the same procedure.

He was a superb and generous surgical teacher and for his Trainees, it was a joy to watch him undertake difficult pelvic surgeries. His technique of dividing the inferior mesenteric vein inferior to the pancreas to allow the colon to reach the pelvis was until then little used but was decisive in ensuring anastomotic integrity. This was one of those priceless pearls of wisdom that Alan was so good at sharing. A modest man, he cared deeply about the welfare of his patients, and was a generous colleague and friend to many.

Dr Charles William Butcher

29 September 1937 – 14 April 2022

Charles William Butcher was the quintessential humble, reserved and extremely talented all-around general surgeon, who received an OAM in 2007.

He provided a selfless one in two on-call surgical emergency service to the Derby and Alice Springs hospitals for several decades. He always enjoyed teaching and passing on his skills and experience to junior doctors in training. His surgical career took him to Ireland, Scotland, Western Australia and the Northern Territory.

Charles maintained the highest of professional standards and was committed to his patients and the hospital staff with whom he worked. He served as an executive member and president of the RACS Division of Rural Surgeons for nine years. Charles was one of the first recipients of the Rural Surgeon of the Year award.

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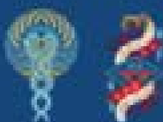

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