SurgicalNews

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President's perspective

We've had a lot going on in the last couple of months. In September we were saddened by the passing of Her Majesty the Queen.

Queen Elizabeth II was widely admired for her grace, dignity, dedication and the inspiring leadership she provided to the Commonwealth nations and people.

Her life and legacy will be fondly remembered by many around the world. Our thoughts are with the royal family and the people of the United Kingdom.

As many of you will be aware, King Charles III in his previous capacity as Prince of Wales was the patron of the College. As he is now the king, we will seek clarification on the protocol in such circumstances, specifically whether the patronage will remain with him or transfer to his son William, now the Prince of Wales.

In early August, we welcomed the Australian Minister of Health and Aged Care, the Hon. Mark Butler and his state counterparts announcing a crackdown on cosmetic surgery 'cowboys' preventing medical practitioners who are not qualified surgeons describing themselves as cosmetic 'surgeons'.

We were pleased to hear of such significant reforms, and what amounts to a restriction placed on the title 'surgeon'. We have campaigned for this for more than a decade.

Our position as a College has always been to put patients first. Australians rightly expect surgical procedures to be performed to the highest possible standards. They expect those carrying out procedures to meet nationally established educational standards, undertake regular training and be registered in an appropriate specialty. Closing this loophole that allowed unscrupulous doctors to take advantage of patients is the right thing to do.

We were also pleased that among other changes, the ministers also limited surgery to properly accredited facilities. It is critical to patient safety that surgical procedures are undertaken by properly qualified surgeons trained by RACS as an Australian Medical Council (AMC) accredited college, and surgery is conducted in facilities that are licensed and properly regulated.

I met with Minister Butler and was accompanied by our CEO, John Biviano, and the President of the Australian Society of Plastic Surgeons, Associate Professor Nicola Dean and their CEO Kim Hanna. We discussed a range of issues pertaining to cosmetic surgery: the issue of titling, the curriculum and training that specialist surgeons undergo, and the importance of ensuring that any endorsement model reflects the high standards required to protect patient safety.

We are committed to working with the health ministers, Ahpra, the Medical Board of Australia, and surgical specialty societies to develop and implement solutions that will ensure we are keeping the safety of patients at the heart of everything we do.

In Aotearoa New Zealand, we were pleased to see the Te Whatu Ora Health NZ leaders directing all its health districts

Queen Elizabeth II was widely admired for her grace, dignity, dedication and the inspiring leadership she provided to her nation and people.

Her life and legacy will be fondly remembered by many around the world. Our thoughts are with the royal family and the people of the United Kingdom.

to book surgical slots for the 7500 people who have been waiting longer than a year for surgery.

However, I echo what our RACS Aotearoa New Zealand National Committee Chair, Associate Professor Andrew MacCormick, said when he noted that the focus shouldn't be diverted from the root cause of long waitlists and urged the government to accelerate plans to relieve worker shortages across the healthcare sector. We know that the effects of COVID-19 will continue to be felt for many years to come, so we need a long-term plan to address workforce planning and future proofing health infrastructure.

In August, I attended our Aotearoa New Zealand annual scientific meeting (ASM) in Queenstown, where I was able to korero (conversation) with colleagues and share ideas as well as learn. We had a strong attendance—an indication of the value of such meetings.

We also had a great tri-state meeting where surgeons from South Australia, Western Australia and the Northern Territory gathered to discuss artificial intelligence in surgery.

Artificial intelligence was also a strong theme at the ACT ASM, while the meeting in Tasmania focused on the humanitarian aspects of surgery.

While it is not always possible for me to attend all these gatherings, Vice President Professor Chris Pyke and I try our best to participate as they are a great way to meet you in-person. Well done to all the teams of staff and surgeons who made the events a success.

The New Zealand Association of General Surgeons conference in Wellington had two excellent presentations with speakers from Australia and USA speaking as holograms. I was extremely impressed. I hope we will see more hologram presenters in the future.

In September we launched a Foundations of Robotic Surgery course, a world-first online program designed by surgeons for surgeons.

The course, which is endorsed by the College of Surgeons, was developed by the International Medical Robotics Academy (IMRA), a leading provider of medical robotic surgical skills training in the health sector.

This unique online course, developed by pioneering expert robotic surgeons across multiple surgical specialties, is part of a linear robotic surgical training curriculum, using online education, virtual reality, 3D video, simulators, and advanced synthetic organ models. Participants will be equipped with the theoretical knowledge and practical understanding of how to set up a robot and console, the fundamentals of operating the robot, how to achieve robotic surgical competence and much more.

This exciting new course is part of the College's commitment to ensuring Fellows, Trainees, Specialist International Medical Graduates and prevocational doctors have access to the required training, assessment, feedback and support necessary to perform robotic-assisted surgical procedures competently and safely.

On a final note, we celebrated Te Wiki O Te Reo Māori, Māori language week in September. It was the 50th anniversary of the Māori language petition. Te Reo Māori is becoming part of our everyday language in Aotearoa New Zealand.

Ngā mihi.

Dr Sally Langley
President

Vice president's perspective

It's great to see some sunshine and the good news is that as winter goes we also see a decrease in COVID-19 cases in Australia and Aotearoa New Zealand with both governments dropping daily updates on COVID-19 case numbers to weekly reporting on new infections.

While the pandemic is by no means over and remaining vigilant is critical, I am optimistic about the future. Having said this, it will take us a long time to get back to normalcy. Hospitals are busy managing postponed procedures to ease pressure on the heath system. It is important to allow as many surgeries as possible to go ahead as we have many patients who are really suffering.

It is good to see Victoria taking steps to transform private hospitals such as Frankston and Bellbird for public surgery. This will boost surgical services for our communities and provide more options for patients awaiting surgery.

More recently, we signed a memorandum of understanding with the Northern Territory to enable surgical Trainees to continue their training in the Territory and not have to move to other states in Australia.

As part of this program, we will advocate for increasing the number of training positions so we can have more people based there. We anticipate the first intake of Trainees will begin in 2025.

We are committed to assisting the Northern Territory with workforce issues and improving access to surgical services and training. We know that if surgeons are local and are trained locally, they're much more likely to stay in a rural setting. We hope programs like these will improve access to rural surgery.

Congratulations to the RACS Rural Health Equity team, Councillors such as Professor Kerin Fielding, the Northern Territory government and partners such as the Charles Darwin University and Flinders University for their hard work and commitment in making this important initiative a reality.

We've also made some good in-roads in our global health work. The RACS Global Health team and three Fellows attended the Pacific Directors of Clinical Services (DCS) Meeting in Nadi, Fiji in late August and presented on RACS Global Health Pacific Islands Program achievements. This was an opportunity to connect with senior clinical leaders across the Pacific.

In early September, the team attended the Pacific Heads of Nursing (PHON) meeting. They presented to nurse leaders on what the RACS Pacific Islands Program (PIP) had achieved in building perioperative nursing capacity in partnership with the Pacific Community, an international development organisation governed by 27 members, including Pacific island countries and territories, and the Pacific Islands Operating Room Nursing Association (PIORNA).

While in Fiji, the team took the opportunity to conduct partner reflection workshops with the Pacific Community, Fiji National University, DCS and PHON.

The team also met with DFAT to continue contract discussions for the next phase of the RACS PIP.

This issue of *Surgical News*, we focus on wellbeing. The wellbeing of our people whether staff, Fellows, Trainees and Specialist International Medical Graduates (SIMGs) is important.

The RACS Wellbeing Working Group has been tasked with reviewing existing support options for surgeons and has produced a report and a Wellbeing Action Plan to be considered by the RACS Council in October. The Action Plan addresses gaps and new opportunities to advance wellbeing for Trainees, Specialist International Medical Graduates and Fellows.

The report also recommends RACS involvement in a collaborative research project on doctors' health and wellness to establish the current state of wellbeing for all specialist doctors. It also includes the establishment of an Intercollege Wellbeing Working Group to oversee implementation of the Wellbeing Action Plan.

I end by acknowledging the 25th year anniversary of the founding of the Australian Indigenous Doctors Association (AIDA). It is a timely reminder of the work yet to be done to embed our tenth competency (cultural competence and cultural safety) in both countries, and within our daily life—training, continuing professional development and our workplaces.

Professor Chris Pyke
Vice president

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news in brief

New Chair for AoNZNC

Associate Professor Andrew MacCormick is the new Chair of the Aotearoa New Zealand National Committee (AoNZNC), replacing Dr Philippa Mercer.

Andrew has been involved in the AoNZNC for some years as he was initially the Younger Fellows' representative, and was then voted onto the Committee as a member. For the last two years he has been the deputy chair.

Andrew is an Associate Professor at the University of Auckland, based at Middlemore, and works as a general surgeon with special interests in upper gastrointestinal and bariatric surgery. Beyond surgery, he has been very active in sustainability in healthcare—developing systems for reducing waste from hospitals and looking after the environment. He is a member of the RACS Environmental Sustainability in Surgical Practice Working Party.

Long-term measures to address workforce issues are critical to solving waitlist crisis

RACS welcomes early moves by the Planned Care Taskforce to address long waitlists for planned surgery, but urges the government to move faster and develop a long-term plan to recruit and retain a sustainable supply of skilled healthcare workers.

In July, Te Whatu Ora Health NZ leaders, including taskforce head Andrew Connolly, directed all 20 of its health districts (formerly DHBs) to book a surgical slot by 31 August for the 7500 people who have been waiting longer than a year.

Associate Professor Andrew MacCormick, RACS AoNZNC chair, applauded the taskforce's urgent and practical first steps to tackle planned care wait times. He said the focus should not be diverted from the root cause of long waitlists and urges the government to accelerate plans to relieve worker shortages across the healthcare sector. He also said the College was ready to work with the government to address these challenges and make sure we have a healthcare system that works, both now and into the future.

Full media release:
https://bit.ly/3BH0e6D

MoU promises to improve access to surgery across the Northern Territory

The Northern Territory (NT) government and RACS have signed a Memorandum of Understanding (MoU) as a commitment to providing high quality and equitable surgical services across the NT. A senior RACS delegation, including Dr Sally Langley, travelled to Darwin.

As part of the MoU the College and the NT government both affirmed their commitment to:

- ongoing collaboration to ensure health equity for people living in rural and remote communities
- an Aboriginal and Torres Strait Islander workforce as central to NT Health priorities
- defining a broad scope of practice is important for the community in the remote, central, and northern parts of Australia
- ongoing discussions between both parties about how they can recruit and support more specialist international medical graduates to bolster the NT workforce.

Along with signing the MoU, the delegation met with various health sector stakeholders and hosted a workshop in partnership with the Royal Australasian College of Medical Administrators.

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Australian health ministers crackdown on cosmetic surgery

The Australian Minister of Health and Aged Care, the Hon. Mark Butler and his state counterparts announced a crackdown on cosmetic surgery.

This follows the Australian Health Practitioner Regulation Agency (Ahpra) and the Medical Board of Australia's (MBA) announcement of an endorsement framework for cosmetic surgery. RACS, ASPS, ASAPS and ASOHNS released a statement (https://bit.ly/3RtEwdi) on the Ahpra and MBA review of cosmetic surgery, sharing their concerns.

The health ministers agreed to the following reforms:

1. Preventing medical practitioners who are not qualified describing themselves as cosmetic 'surgeons'.
2. Ensuring anyone conducting a cosmetic procedure has appropriate qualifications.
3. Limiting surgery to properly accredited facilities with minimum hygiene and safety standards.
4. Banning doctors using patient testimonials for cosmetic surgery including on social media.
5. Better information for patients on the risks and their rights so they can make an informed decision about any treatment.

The health ministers also asked the Medical Board of Australia to:

- better credential cosmetic surgery providers by adding an 'Area of Practice' to medical registrations
- crackdown on the use of testimonials and social media
- strengthen guidance and provide improved information for doctors in the sector
- establish a hotline for complaints.

The Australian Commission on Safety and Quality in Health Care has been tasked with developing specific safety and quality standards for where and how cosmetic surgery can be performed.

The Commission and the Medical Board were asked to report back to health ministers within two months.

The health ministers asked that the work to implement these reforms begin immediately.

To date, Ahpra has set up a complaints hotline for patients who have been harmed by cosmetic surgery. They can submit a complaint confidentially.

The public can call 1300 261 041 during business hours (AEST) Monday to Friday to report their experiences to a specialised team supporting the newly established Cosmetic Surgery Enforcement Unit. The hotline will also make it easier for practitioners to make notifications when they know about specific unsafe practice in cosmetic surgery.

The hotline is one part of the response by Ahpra and MBA to the Independent review into the regulation of medical practitioners who perform cosmetic surgery. It will make experienced staff available to ensure patients can tell Ahpra about unsafe practice in the cosmetic surgery industry.

RACS advocacy on cosmetic surgery issues – a background

Sometimes it is easy to forget how much advocacy work goes on behind the scenes. This is what your College has been doing to manage the myriad issues we face in the cosmetic surgery sector.

RACS has been working with Fellows and specialty societies advocating on the issues associated with cosmetic surgery through direct engagement with government, regulatory bodies, and the media.

RACS continually raises this issue in meetings with the federal, state and territory governments, as well as in written communication, submissions and via the media. Our advocacy efforts, which have been going on for more than a decade, resulted in the tightening of policy by Aphra, predominantly in the fields of specialty practice for surgery and determining which medical professionals could call themselves specialist surgeons.

In late 2019, the COAG Health Council Minister agreed that further consultation on whether to restrict the use of the title 'surgeon' should be undertaken. The then Health Minister Greg Hunt advised RACS that following on from the Health Council's agreed position, the Victorian Department of Health and Human Services would lead a consultation 'in the first half of 2020'.

Despite the delay in the consultation due to the outbreak of COVID-19, RACS continued to raise these matters with the federal, state and territory governments.

This was included in our Tasmanian (https://bit.ly/3eqbWLf) and Western Australian (https://bit.ly/3qkCZuj) election statements, which urged both parties contesting the elections to support legislative change in order to protect patient safety. Often these issues were also shared with the media by providing comments in interviews.

In December 2021, the long-awaited Health Council Consultation 'Regulatory Impact Statement' (RIS) was released in relation to the 'use of the title 'surgeon' by medical practitioners in the 'Health Practitioner Regulation National Law'.

RACS invited a variety of stakeholders, including relevant specialty society representatives to a workshop, 'Titling Consultation and Cosmetic Surgery', to discuss developing responses to both the review and the consultation. RACS made its submission (https://bit.ly/3M9GgFg) to this consultation in April 2022 and also issued a media release (https://bit.ly/3qlvq6M).

RACS and the specialty societies—the Australian Society of Plastic Surgeons (ASPS), the Australasian Society of Aesthetic Plastic Surgeons and the Australian Society of Otolaryngology Head and Neck Surgery have on multiple occasions shared their concerns (https://bit.ly/3D7vyy0) with the media about reports of patients suffering adverse outcomes when elective cosmetic surgery is performed by medical practitioners who do not have specialist registration in a surgical discipline. This statement was addressed specifically to the question of which practitioners should be able to use the title 'surgeon'. The position outlined was also reflected in RACS main submission.

On 30 November 2021, Ahpra and the MBA announced a separate review to look into the existing regulation and regulatory practices in use by Ahpra and the relevant national boards to ensure they have kept pace with rapid changes in the cosmetic surgery industry and to make recommendations for any required changes.

The issues identified in this review related to those being dealt with in the separate Health Council consultation. RACS put in a submission in response to this review in April 2022 and endorsed ASPS' detailed submission.

Additional advocacy included a federal election statement issued ahead of the Australian federal elections. The issue of cosmetic surgery was one of 11 key priority issues that RACS identified. We also continued to encourage support from governments at a state level, including our South Australian election statement (https://bit.ly/3qiBQU0).

Image left to right: RACS CEO John Biviano, RACS President Dr Sally Langley, Australian Minister for Health and Aged Care Hon. Mark Butler, ASPS CEO Kim Hanna and ASPS President Associate Professor Nicola Dean in Canberra.

ASPS names its first female president

Plastic surgeon Associate Professor Nicola Dean aims to prioritise equal access and improve regulation of the cosmetic surgery industry in her new role

Plastic surgeon Associate Professor Nicola Dean has been named president of the Australian Society of Plastic Surgeons (ASPS).

She is the first woman in the organisation's 50-year history to be elected to the position.

In her role as president of ASPS, as in her clinical work and research, Associate Professor Dean is committed to improving the health and safety of plastic surgery patients.

Her priorities include improving the regulation of the cosmetic surgery industry and creating more equitable access to plastic surgery.

Born in Edinburgh, Scotland, Associate Professor Dean graduated in Medicine from the University of Leeds in England.

Between her fourth and fifth years of surgical training, she visited Adelaide to complete an eight-week elective in craniofacial surgery.

However, after meeting her future husband and travelling back and forth between the UK and Australia, she eventually returned to Adelaide.

She was appointed Head of Unit for Plastic Surgery at Flinders Medical Centre in 2014 and in this position she developed a dedicated breast reconstruction clinic for women who have had breast cancer.

In the clinic, Associate Professor Dean pioneers a patient-led approach to ensure patients' voices are heard.

"At the clinic we take a patient-centred approach to understand our patients' perspective on their reconstruction surgery," she said.

"Four times a year, we also involve patients in looking over our audits, our patient information sheets and our research to ensure that we are giving patients what they need."

Associate Professor Dean complements her clinical role with an interest in research and she now supervises a PhD candidate studying the health effects of post-natal muscle separation.

In the past, she has seen the significant impact that research can have on healthcare, with a 12-year study into breast reduction informing the government's approach to the procedure.

Associate Professor Nicola Dean

"We showed that breast reductions can have the same impact on the pain experienced by patients as a knee or hip replacement. It was also incredibly cost-effective," she said.

"I feel good that the research allowed us to advocate for the provision of the surgery that attracts a Medicare rebate.

"Sometimes there are inherent biases when health policymakers are predominantly male and the patients are predominately female," she said.

Associate Professor Dean is the daughter of two doctors: her father a general practitioner and her mother a psychiatrist.

However, she was not encouraged to pursue a career in medicine, due to her parents' understanding of the long hours and dedication the job required.

"Medicine is very demanding and hard work. I could see my parents working very hard, but I could also see they had a very satisfying and rewarding life," she said.

There have been significant parallels between her work and that of her mother.

As a child, Associate Professor Dean remembers stapling together a questionnaire for her mother as part of research she was co-writing on the psychiatric impact of breast reconstruction following breast cancer.

In her own career, she has witnessed first-hand the role that breast reconstruction can play in women's recovery.

"I have seen how reconstructive surgery can change people's lives," she said.

"A lot of people misunderstand reconstructive surgery and think it's all about looking glamorous or good in a bikini. But it's about allowing women who have had a mastectomy to feel whole again and leave their cancer behind them.

"It's not for everyone, but for many women it can restore their confidence and help them get over cancer from a psychological point of view."

As president of ASPS, she aims to draw on this understanding of the importance of breast reconstruction to provide more equal access to Australians, including those who live rurally and remotely.

Associate Professor Dean is acutely aware of the difficulty some women face in accessing reconstructive surgery and would like to make procedures available more equitably.

"Nationally, I am very conscious that there is not an even distribution of access to breast reconstruction after mastectomy.

"I'm working as part of a collaborative group with breast surgeons and consumers to develop principles on what should be the standards for breast reconstruction in Australia."

Associate Professor Dean hopes to tackle geographical barriers to access and improve the referral system between general surgeons carrying out mastectomies and plastic surgeons who can offer reconstruction procedures.

The regulation of the cosmetic surgery industry is another priority for Associate Professor Dean in her new role.

She is concerned about the lack of information available to patients who are treated by cosmetic 'surgeons', leading to significant risk to their health.

"It takes 12 years or longer to become a fully-trained specialist surgeon, but you can call yourself a cosmetic 'surgeon' after just five years' training. Often, they lack the basic training on safety issues like infection control, deep venous thrombosis and post operative care," she said.

Associate Professor Nicola Dean with her children

"Unfortunately, the public isn't receiving the correct information about who is a properly trained surgeon."

As a specialist plastic surgeon, Associate Professor Dean has seen the impact of procedures carried out by poorly-trained cosmetic 'surgeons' on patients' health.

"I work in a public hospital, so I don't see many primary cosmetic surgery patients. But last week I saw a patient who had a procedure to dissolve the fat in the neck suffering from very serious complications.

"As doctors we should be ensuring we are working in the patient's interests, but the lack of regulation of the cosmetic industry is a problem that is increasingly putting people in harm's way."

Associate Professor Dean would like to see the title of 'surgeon' restricted, so it is easier for the public to understand the qualifications and training of those carrying out procedures.

She is working with the Australian federal and state governments, RACS, Ahpra and other professional bodies to advocate for the changes.

While Associate Professor Dean considers herself first and foremost to be a plastic surgeon, as a woman elected to the position as president of ASPS, she is pleased to be a role model for women considering a career in plastic surgery.

She is aware of the unique pressures on women in the field, having had two children and completing her PhD within three years.

"There is no doubt that it's had its challenges balancing the need to do lots of hours to develop the necessary skills and having enough time for your mental health and wellbeing," she said.

"When I was in plastic surgery training it was very tiring and physically and mentally challenging.

"It was tough, but I loved it."

Associate Professor Dean would like to help create a more flexible system where women do not have to choose between a surgical career and motherhood.

"I think it's entirely possible to be a mother and work in this job. It's already starting to improve and it's getting more common for plastic surgeons to have children. I think that's wonderful."

Trainee wellbeing under the spotlight

The wellbeing of Trainees is a significant area of focus for the Royal Australasian College of Surgeons (RACS).

The RACS Wellbeing Working Group, tasked with reviewing existing support options for surgeons, has produced a report and a Wellbeing Action Plan to be considered by RACS Council in October. The Action Plan addresses gaps and new opportunities to advance wellbeing for Trainees, Specialist International Medical Graduates and Fellows.

The working group comprises RACS Fellows, a RACS Trainees' Association committee member and representatives from several Australian and Aotearoa New Zealand specialist medical colleges, alongside external doctors' wellbeing experts.

While both the group's report and Action Plan aims to support all doctors, the wellbeing of Trainees is a key concern that the working group, and RACS more widely, are working to address.

RACS Wellbeing Working Group member, Associate Professor Philip Truskett said the review had identified a need for a broad and collaborative approach to supporting surgical Trainees.

"A multi-pronged approach is needed, which will require more than just sitting people in a lecture theatre and telling them how they should behave," he said.

"The whole training process needs to become more interactive, with more frequent and compassionate communication and feedback to Trainees."

The report recommends RACS involvement in a collaborative research project on doctors' health and wellness to establish the current state of wellbeing for all specialist doctors. It also includes the establishment of an Intercollege Wellbeing Working Group to oversee implementation of the Wellbeing Action Plan.

Associate Professor Truskett believes the actions will be particularly pertinent following disruptions to normal training and surgical schedules caused by the COVID-19 pandemic.

"We understand Trainees might need more support than in the past, and that the goal posts have moved since COVID-19," he said.

"Everyone is really understanding of how concerned Trainees are and the College is working very hard to do its best to improve the wellbeing of these Trainees.

"We need to ensure a nurturing—not a judgemental—environment for Trainees, and that involves more Trainee-mentor interaction, the development of significant briefing and debriefing skills, and more guidance for Trainees during their training.

"There needs to be an emphasis on emotional support, alongside the technical education received by Trainees."

Associate Professor Truskett attributes some of the wellbeing challenges faced by surgical Trainees, and the wider Fellowship, today and in the past, to a range of circumstances specific to surgery.

"The profession is hands on, requires hard work, is stressful and often the stakes are high. Even though there is some teamwork, you can feel very alone at times, particularly when things aren't going well. It's a difficult profession," he said.

"Now, we are becoming more aware of the dangers of poor mental and physical health in our Trainees and colleagues. It's something that we may have tended to ignore in the past."

The working group's wellbeing review comes after the release of the Wellbeing Charter for Doctors (https://bit.ly/3cTX47w), which has been formally endorsed by a range of specialist medical colleges including the Royal College of Surgeons of Edinburgh.

The charter is an initiative led by the RACS Wellbeing Working Group and includes the Australian and New Zealand College of Anaesthetists, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, and the Australasian College for Emergency Medicine.

Associate Professor Philip Truskett

It describes the shared responsibility for doctors' wellbeing and has been endorsed by 15 specialist medical colleges in Australia and Aotearoa New Zealand.

The charter, launched in August 2021, has been an exercise in collaboration across colleges to advocate for doctors' wellbeing with a unified voice.

Associate Professor Truskett says the charter outlines the roles and responsibilities surrounding wellbeing within the profession and the workplace. It is intended to be a springboard for conversations about wellbeing.

"In the past it has been implicit, but now it is explicit."

A general surgeon at Prince of Wales Hospital in New South Wales and former

RACS President, Associate Professor Truskett was pleased to be part of the RACS Wellbeing Working Group after experiencing the importance of support and mentoring during his own traineeship.

"The training was quite different then and was done within isolated hospital rotations.

"Trainees had very little understanding of the role of the College and considered its sole responsibility to be setting the Fellowship exam that we all had to pass. As Trainees, we identified with our institution and not the College.

"I had a very positive experience as my mentors were very supportive of their colleagues and Trainees. They were nurturing role models and had a lot to do with my own professional identity.

"I know that wasn't the case everywhere."

He says improvements to wellbeing will have broad benefits for the surgical and wider community.

"It will reflect in the quality of care of the patients and the quality of life and wellbeing of doctors."

Royal Australasian College of Surgeons Trainees' Association (RACSTA) Chair Dr Sharon Jay agrees with Associate Professor Truskett about the importance of wellbeing and the impact of the pandemic on Trainees.

Dr Jay believes that measures including improving access to leave, relocation costs and paid overtime would help improve the experience of Trainees.

"We all know that training is hard, but there are things that we can do to make it better. And that's what we're trying to advocate for as a Trainee committee," she said.

The Australian Medical Training Survey in 2021 revealed only 49 per cent of surgical Trainees reported having a good work-life balance, compared with 64 per cent in other specialty colleges.

The report found that nearly half of surgical Trainees across all specialties had experienced discrimination, bullying or sexual harassment.

Dr Jay, a SET 5 General Surgery Registrar at Christchurch Hospital, says a significant change in surgical culture is needed. She added that improving Trainees' wellbeing requires more than simply introducing wellbeing courses.

"The bottom line is that if we really want to make meaningful culture change, you don't put a band-aid on the problem.

"We need systemic change to improve surgical culture that will ultimately improve the training experience for everyone."

Dr Jay rates the current wellbeing of Trainees at three out of five and said that while there is a long way to go, the culture within the profession has already improved in the past decade, particularly since the 2015 Expert Advisory Group Report on *Discrimination, Bullying and Sexual Harassment*.

> "In the years since the Operating with Respect course was introduced, I've seen an improvement in surgical culture.

> "Things are starting to change and there's recognition within surgery that culture and wellbeing are really important.

"If you're a healthy surgeon who's happy and working in a positive, supportive environment, you're going to be a better colleague and teacher. You're also going to translate that to your care of patients and that can only improve patient care."

Dr Jay would like to see the culture continue to progress towards a more balanced model for Trainees.


Dr Sharon Jay

"I think what we should move to is more of a 'work and live well' idea; that is where we are able to both work and be well-supported to do so, but also take time to switch off and to pursue other aspects of our lives.

"This is especially important in trying to prevent burnout among Trainees and junior doctors."

Looking back at her own training, Dr Jay believes she would have benefited considerably from this approach.

"You shouldn't have to choose between your career or your health and wellbeing. Sometimes I haven't gotten those priorities right and I just don't think it has to be like that. Surely, we can do better for the next generation of Trainees, and, by extension, for Fellows," she said.

"We're now seeing flexible training being used by Trainees for parental leave or to pursue academic research interests and even higher degrees oversees, which is really exciting. I hope this will increase in the future."

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Radicchio and ricotta salad with preserved lemon dressing

This recipe was supplied to RACS by the celebrated Australian chef, Maggie Beer. She delivered our 2022 Anstey Giles Lecture, titled 'Society's Challenge - Way Beyond Politics' at the SA, NT & WA ASM in August in South Australia. The topic addressed the overlooked importance of healthy and nutritious food for aged care residents.

Serves: four to six

Prep and cook time: 25 minutes

Ingredients

1 small radicchio lettuce

1 butter crunch lettuce

½ cup young celery leaves, chopped coarsely

300g frozen broad beans

½ cup fresh flat-leaf parsley, chopped coarsely

200g very fresh ricotta

⅓ cup (25g) flaked almonds, toasted

Preserved lemon dressing

¼ cup (60ml) extra virgin olive oil

2 tablespoons verjuice

¼ cup (60ml) buttermilk

2 tablespoons finely chopped preserved lemon

Method

Boil the beans in a pan of boiling salted water for two minutes, then drain and pinch the skins off to show vibrant colour.

Remove the leaves from the radicchio and butter lettuces, wash and drain well. Tear into smaller pieces and set aside.

To make the dressing, place all the ingredients into a small bowl and stir to combine. Season with sea salt flakes and freshly ground black pepper.

To serve

Arrange the lettuces, broad beans, celery, and parsley leaves on a serving platter (or divide between individual plates). Top with sliced ricotta and almonds.

Drizzle the preserved lemon dressing just before serving.

Maintaining mental wellbeing should be part of your day job

As surgeons, you know what it's like to save someone's life, but it's a feeling most people will never experience. Sir John Kirwan has though, and it's what drives him to put his head above the parapet to talk about the taboo of mental illness.

The All Blacks legend has ascended to near national treasure status over the past 15 years when he swapped the oval ball for the microphone to share his struggles with anxiety and depression and to promote mental wellbeing.

Sir John, or JK as he prefers to be called, played 63 test matches for Aotearoa New Zealand from 1984 until 1994. He made a major contribution to the All Blacks' 23-test unbeaten run from 1987 to 1990, and to its 1987 World Cup victory.

He switched codes for a time in his early 30s to be a top scorer for the Auckland Warriors rugby league club but returned to rugby union, later becoming a coach for the Auckland Blues and the national teams of Italy and Japan.

For his services to rugby, JK was appointed a Member of the Order of the British Empire in 1989. It has been his work to raise awareness of mental health however that promoted him to an Officer of the New Zealand Order of Merit in 2007 and contributed to his later Knighthood in 2012.

As a poster-boy for Kiwi macho maleness, it was no easy thing for JK to go public about his mental health struggles.
"I thought it would ruin my career."

However, he recognised that with his public profile he had the power to help others.

"I was [feeling] so bad, I wouldn't wish it on my worst enemy.
I realised that even if I could help just one person it was worth it."

It didn't take long for his efforts to be rewarded.

"I was at a rugby game and this guy came up to me and said: 'JK, you saved my life.'"

Since then, he has written two books about his depression—*All Blacks Don't Cry* and *Stand by Me*—and has established the Sir John Kirwan Foundation (https://bit.ly/3RNNMZt) to help young people understand mental health. In 2020, he launched the mental wellbeing app Groov (https://bit.ly/3RIPlI9) formerly Mentemia. RACS was one of the first to sign on to Groov, a workplace wellbeing platform.

JK says businesses both have a responsibility and are in a strong position to affect change. He points out they have a lot to gain by supporting good mental health in terms of productivity, sick leave and staff turnover.

In the latest RACS staff engagement survey, 80 per cent of the staff said their manager cared about their wellbeing. The Groov app can be customised depending on a staff member's preferences and provides key insights and articles the RACS People and Culture team can share more broadly across the organisation.

JK often uses humour to get his messages across, for example playing up to the Jafa stereotype (you might need to ask your Kiwi colleagues what this means but think stuck up Aucklander) to encourage people to let down their defenses.
He also puts people at ease by reminding them their mental health issues don't define them.

"Mental health is just one part of you. Yes, it affects many other parts of your life, including your work and relationships, but it's not everything about you. You are your values, not your emotions."

What's the best way to improve mental wellbeing? In JK's words, "To go from surviving to thriving," he says. It's about finding what works for you and doing it, every day.

"Create a daily mental health plan and put it first. Deal with your stress and anxiety every day."

JK is a self-described "active relaxer" and finds cooking, reading, and practice playing the guitar—something he took up during the first COVID-19 lockdown and which he plays "like a strangled cat"—are great at keeping the black dog at bay.

Even now, JK says he still has off-days. That's when it's time to recharge his "triple A battery" and "acknowledge" how he's feeling, "accept" it, and "act", where possible, to turn the negative feelings around.

Taking action to stay mentally healthy is a favourite theme of JK's. He doesn't believe you can wait for others, or for fate, to solve your problems.

"If it's meant to be it's up to me."

Image above: Sir John Kirwan

Experiences of our health workers in the pandemic

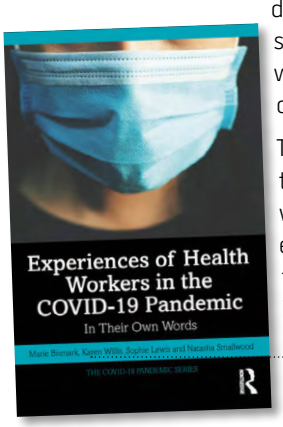
Professor Marie Bismark, a public health physician and health lawyer, has collaborated with three colleagues to publish a book, *Experiences of Health Workers in the COVID-19 Pandemic: In Their Own Words.* It draws upon nearly 10,000 responses to a survey examining the psychological, occupational and social impact of the COVID-19 pandemic on frontline health workers in Australia.

In 2020, at the peak of the second COVID-19 wave, Professor Bismark and her co-authors, Professor Karen Willis, Dr Sophie Lewis, and Associate Professor Natasha Smallwood, conducted the Australian COVID-19 Frontline Healthcare Workers Study. The survey was distributed to anyone who identified as a frontline health worker—from intensive care doctors and dentists to hospital cleaners and support workers.

Health workers submitted almost 250,000 words of raw, heartfelt stories. "That was the origin of the book," Professor Bismark said, who herself worked on the frontline, providing mental healthcare to patients in the ED, intensive care unit, and COVID-19 ward. "We knew we needed to honour our health workers by recording their unfiltered responses and making them available to others."

The book's primary purpose is to document health workers' experiences, so they don't feel alone. It's also intended as a resource to help us understand the full impact of the pandemic from a diverse range of experiences. Professor Bismark hopes that a historical perspective will be useful for managing global health crises in the future.

The study found a high number of mental health issues reported by health workers, despite high resilience scores. Professor Bismark and her colleagues were able to drill down to identify specific demographics who were most affected or at risk.



The study revealed that health workers were overwhelmingly exhausted. People talked about moral injury when they realised the quality of care they could deliver was severely compromised. GPs felt left out of policy-making decisions. Junior doctors found they shouldered the workload on wards without adequate senior support. Aged care workers felt grossly undervalued and underpaid.

High levels of post-traumatic stress disorder were reported in health workers who were involved in the separation of families while on duty. "Some of the most moving stories were from nurses who were at a patient's bedside holding an iPad while their family said goodbye," Professor Bismark said.

The study reflected deep concerns about missed routine screening procedures and delayed diagnoses, and the consequences for patients. Doctors reported that patients were avoiding hospitals because they didn't want to overburden the system or were anxious about COVID-19 infections.

"We heard from a lot of groups who felt left behind." Professor Bismark said the gender gap in surgery and medicine was widened. Healthcare workers trained overseas were disproportionately impacted by border closures, dealing with work stress while separated from their own families abroad.

"Overall, there was a strong sense that pre-existing cracks in the healthcare system were widened by the pandemic to the point where we can no longer ignore them."

Professor Bismark is a Public Health Law Principal Research Fellow at the University of Melbourne, where she leads a research team focused on the interface between patient safety, clinician wellbeing, and health regulation. She's currently based in a regional community mental health clinic in Aotearoa New Zealand, finishing her last six-month rotation in psychiatry training. She hopes to become a Fellow next year. Professor Bismark is also a member of the RACS Wellbeing Working Group and contributed to a review of wellbeing support offerings for surgeons.

"I think there are many health workers who feel they can't talk openly about their work; maybe even the people closest to them don't really understand what they do or the sacrifices they made." Professor Bismark hopes that frontline health workers can identify with and find themselves in the stories shared in *Experiences of Health Workers in the COVID-19 Pandemic*, available via the RACS library (https://bit.ly/3xZFTZz)

Image below: Professor Marie Bismark

Foundations of Robotic Surgery online course

Professor Tony Costello

The International Medical Robotics Academy (IMRA) is trailblazing in the field of robotic surgical training. Among other courses, the academy offers the Foundations of Robotic Surgery—a short online course, that introduces participants to theory and principles of robotic surgery in preparation for safe robotic surgical practice.

Students are instructed by a faculty of expert robotic surgeons, as well as world-class aviation and medical simulation educators via lectures, instructional videos, and assessments.

The course is tailored for pre-SET, SET 1 and SET 2 Trainees. It's also designed for qualified surgeons who are new in regard to robotics and are commencing robotic surgery practice.

Foundations of Robotic Surgery is the first online robotic surgery course of its kind worldwide and is endorsed by the Royal Australasian College of Surgeons (RACS)—the first credentialing body to recognise this type of training. Before this accreditation, the robot vendor provided all robotic education. Now surgeons can work with the vendors to provide more comprehensive surgical training.

Professor Tony Costello is IMRA's Founder, Executive Director, and CEO. He is an Emeritus Professor of Urology and a Robotic Surgeon. Now retired as a urologist, he is focused on developing the curriculum to train the next generation of surgeons in digital surgery through the academy.

At IMRA, based in Melbourne, Professor Costello and his team have developed a curriculum for a linear four-pillared path to proficiency in robotics, which surgeons using robots will eventually need. "We are putting a supercomputer between the surgeon and the patient to make the surgery easier and reduce complications. The next generation of surgeons must be trained to work with robots."

Professor Costello pioneered robotic surgery in Australia, performing the first radical prostatectomy using robotics at Epworth Hospital in 2003. He has performed more than 2500 robotic procedures, and trained more than 50 international robotic surgeons, who qualified after committing to a year for a Fellowship in robotics. "I soon realised that type of training wasn't going to fly," Professor Costello said. "If robots were going where I thought they would in the future—diffusing to all the surgical specialties—we needed to develop a broad, accessible curriculum to train multiple surgeons in multiple disciplines."

Following a successful completion of IMRA's revolutionary Foundations of Robotic Surgery online course, surgeons proceed to simulation and virtual reality (VR) education using proficiency-based progression, followed by 3D-narrated robotic surgery video instruction. Once these tasks are completed satisfactorily, IMRA provides low and high fidelity synthetic human organ models to teach specific surgeries, which can be scored through video as a measure of robotic surgical proficiency.

Synthetic human organ models replace the use of live animals and cadavers for training, as they offer repetitive surgical training to proficiency, unlike animals and cadavers, which only allow a single episode experience at very high cost.

Professor Costello says that robot-assisted surgery makes a surgeon's job easier. "You can see better, you are more dexterous, and you can go places you can't go with open surgery. Before robotics, we used to do some parts of surgeries blind; you had to use your hands and do it by feel, particularly with prostate cancer removal."

Working with a robot offers better ergonomics, Professor Costello said. Open surgery can require a surgeon to stand in awkward positions for hours, straining their neck and back in particular. Assisted by a robot, it's less tiring for the operator.

For the patient, robot-assisted surgery is minimally invasive and allows more precision, resulting in shorter hospital stays, lower complication rates, less blood loss, and faster return to normal activity. This results in cost savings for patients and the health system.

Artificial intelligence (AI) will play a useful role in robotic surgery as an educational tool. IMRA is developing algorithms so that the technically difficult parts of surgery can be measured for proficiency.

Will robots replace surgeons one day? "It's important to clarify that the robot is a slave to the master," Professor Costello said. "It can't be autonomous. You still need human decision-making capacity

but there may be areas in surgery where some simpler parts are autonomous."

High capital cost and instrument cost have been barriers for acquisition of robot technology in the public sector, but Professor Costello thinks most public hospitals in Australia and Aotearoa New Zealand will be able to afford the technology within five years. Until 2021, the price of robotic technology was high but the market has opened up and there are now three new robotic platforms available in our two countries, which is reducing capital cost.

"Costs will come down further with simpler types of robots. There are already robots being built for specific surgeries like microsurgery, ophthalmology, and hysterectomy in gynaecology. What we are seeing now is nothing compared to what we'll see in robot-assisted surgery in 10 years."

Professor Costello thinks almost all thoraco-abdominal and pelvic surgery will eventually be performed using robotics. There is widespread use of robotic guidance systems in orthopaedics already.

Professor Costello believes robotic-assisted surgery is the way of the near future and that all surgeons will need to have proficiency in basic robotics. "By 2032, I think there'll be a robot in every operating room."

IMRA's Foundations of Robotic Surgery online course, endorsed by RACS, is an excellent place to start building robot literacy in preparation for the inevitable shift in how surgeons work.

Foundations of Robotic Surgery

Duration: 10-15 hours to be completed over two to four weeks

How: Online course with 11 modules, using lectures, instructional videos, and assessments

Components: robot technology, safety, robot setup and fundamental operating skills, pathways to competency, non-technical skills

CPD: 10 points allocated

Cost: AUD$1250

More: https://bit.ly/3eGKrgS

Developing a Career and Skills in Academic Surgery (DCAS) Course

Speakers at the Developing a Career and Skills in Academic Surgery (DCAS) Course provided participants with useful information on how to develop a career that involves research and medicine

The 13th DCAS Course was held in a hybrid format in Brisbane on 2 May 2022.

The one-day course offered attendees motivation and advice in developing a career that involves both research and medicine. We were honoured to host guests from both the Association for Academic Surgery (USA) and Aotearoa New Zealand. The day provided attendees and faculty with ample opportunity to network.

Dr Sally Langley, President of the Royal Australasian College of Surgeons, welcomed the participants and the faculty.

The day started with a session on exploring careers in academic surgery. Professor Christobel Saunders provided insight into why every surgeon should involve academic thinking in their career and practice.

Professor Andrew Hill encouraged participants to indulge their curiosity—seeking answers and building an understanding on research methodologies and topics.

Assistant Professor Callisia Clarke elaborated on how to navigate mentor-mentee relationships and advocated for open dialogue through connecting, communicating, celebrating, collaborating, circulating and cultivating events.

Professor Marc Gladman offered his top 10 tips for supervisors of higher degree students and how to achieve timely completions.

The second session focused on new directions and challenges in surgical academia—giving insight into research with Indigenous cultures, navigating impact factors and social media, and identifying journals for research.

Professor Kelvin Kong began the session by encouraging researchers to have dialogue with Indigenous communities to understand and further improve engagement to ensure their perspective is respected.

Associate Professor Colin Martin presented on communicating research, considering cost, speed of disseminating information and whether social media can influence the spread of information. Finally, Dr Juliet Emamaullee elaborated on choosing appropriate journals to publish in and avoiding predatory publishers.

The 'Hot Topic: Burnout and mental health in academic medicine' was given by Dr Eric Levi (pictured below). He advocated for the recognition of the problem and developing a culture in departments and hospitals to improve wellbeing among healthcare professionals. Indicating that leaders influence culture, Dr Levi recommended that wellbeing should involve physical, social, mental and occupational aspects.

Session three focused on tools for academic output with Associate Professor Shipra Arya sharing the best ways to prepare abstracts. The take away points included avoiding vague titles and developing titles that are conclusion driven rather than method driven.

Associate Professor Christina Roland elaborated on how to present at scientific meetings, with suggestions on how best to optimise information on slides—leaving time for questions and delivering a strong oral presentation.

Professor Amir Ghaferi concluded the session with advice on manuscript writing, encouraging participants to frequently write, and that the adage 'write drunk, edit sober' can help with writer's block.

The keynote address from Professor Mark Smithers (pictured left) from the University of Queensland centred on building and maintaining an academic career. He challenged attendees to consider what they wanted in their careers, emphasising that collaboration is key. This along with time management skills should be focus areas of prioritisation and planning. Building a combination of skills through versatility would allow them to gather knowledge and provide them with opportunities to disseminate knowledge to other healthcare professionals.

The first concurrent workshop focused on 'finding your fit' with presentations covering translational research, clinical research involving cohort studies, collaboration and trials, and interdisciplinary research.

The second concurrent session focused on surgical research funding and elaborated on successful grant writing, identifying the best research funding for research and strategies for greater grant success with Medical Research Future Fund and National Health and Medical Research Council applications.

Finally, Professor Ian Bissett provided an overview of his early surgical years living in Nepal and Aotearoa New Zealand and overcoming obstacles in practice and research. His five lessons were interspersed among stories of having to adapt tools and troubleshoot problems in difficult situations. Professor Bissett concluded by encouraging attendees to focus on the hidden curriculum in experiences and "what you teach others when you are not focused on teaching".

Feedback from participants indicated that the presentations were well received and beneficial.

Authors

Jonathan Karpelowsky,
Co-chair DCAS Course

Colin Martin,
Co-chair DCAS Course

Apply for the Evidence Guidance Research Scholarship

This scholarship is valued at AUD$66,000 and focuses on developing clinical practice guidelines and undertaking evidence reviews.

The Evidence Guidance Research Scholarship supports the recipient in developing clinical practice guidelines and undertaking evidence reviews on topics important to surgeons and patient care. The recipient will gain a unique insight into how evidence shapes surgical practice to improve patient care that underpins reimbursement decisions.

Applications close 31 October 2022.

To find out more and apply, visit: https://bit.ly/3d3j548

Meet RACP's new president

Dr Jacqueline Small was sworn in as the new president of the Royal Australasian College of Physicians (RACP) in May 2022. She will be leading the College until 2024 through a challenging period, which will hopefully be a time of meaningful, lasting change for specialist health in Australia and Aotearoa New Zealand.

Dr Small, a developmental paediatrician in Sydney, works with two teams in her specialty. She leads a multidisciplinary team that assesses children with developmental disabilities or Global Developmental Delay (GDD). She's also the clinical lead of a specialised intellectual disability health team for children and adults with intellectual disability.

Dr Small was drawn to developmental paediatrics because she can make a big difference in children's lives, and this can have long-term benefits.

"We look at the wellbeing of children—physical health, mental health and developmental issues; the family and community around them is considered vitally important. I really like that our approach is holistic."

She says she feels fulfilled by the opportunity to advocate with people with intellectual disability, who experience significant health inequities in Australia and Aotearoa New Zealand.

Dr Small's medical journey started when she switched tracks from science to medicine in her first year at university. "I was quite interested in general practice, but after doing a paediatric term, I realised that's where my heart lay. I've always had a leaning towards a more generalist, comprehensive approach."

Her priorities as RACP president are mountainous and many. She will focus on governance, membership engagement, workforce, wellbeing, gender equity in leadership roles, and health reform that includes physicians and paediatricians as vital elements.

Dr Small hopes to build stronger engagement between RACP and its members. One of the biggest issues, unsurprisingly, is member and Trainee wellbeing, with workforce stress at an all-time high. "The wellbeing of members is vital, not just for [RACP], but for our health system. So that's a real focus for me."

She will also put timely emphasis on gender equity in leadership roles. RACP, along with RACS, is partnering with Women in Healthcare Leadership to research how best to support female healthcare professionals in their career progression.

At a turbulent time, health reform is high on Dr Small's agenda. "COVID-19 has shown us what we knew before; there are significant health inequities that current models of healthcare haven't been able to address. Our distressed workforce is an indicator that we have to do something differently."

Among her most prominent RACP roles, Dr Small spent six years as chair of the Paediatric Policy and Advocacy Committee. She's also been chair of the Chapter of Community Child Health and chair of the Paediatric Scientific Program Committee. As a member of the Executive Committee of the Paediatric and Child Health Division (PCHD) Council, she contributed to the governance of PCHD for more than six years.

Dr Small admits that maintaining wellbeing and work-life balance is a challenge. She carves out time for regular exercise and prioritises time with her partner. She recently joined a book club with other female doctors: "I find the networks very nourishing and it provides a space for dialogue that we might not have space for elsewhere."

"I'm seeing a growing commitment to working together across disciplines and specialties, which is really exciting. I think we need to be doing much more of this in the future."

Dr Small looks forward to using her deep knowledge of RACP and health system issues to guide her College through the next two years. She's anticipating purposeful, powerful collaboration across the health professions to reshape the future of healthcare in Australia and Aotearoa New Zealand. "I'm seeing a growing commitment to working together across disciplines and specialties, which is really exciting. I think we need to be doing much more of this in the future."

Kia kaha Te Reo Māori | Let's make the Māori language strong

One element that made a strong appearance at this year's Aotearoa New Zealand (AoNZ) Annual Surgeons' Meeting, held in Queenstown from 1 to 2 September, was the Māori language. There were a whole range of competencies on show but what shone through was the desire to integrate te reo, the language of the tangata whenua—Indigenous people—and an official language of AoNZ, into the everyday.

Two weeks later, from 12 to 18 September, AoNZ celebrated 50 years of Te Wiki o Te Reo Māori—Māori Language Week—with events, exhibitions and experiences held across the motu (country).

Many show their support each year by learning a new word or phrase a day, signing up to te reo language courses or learning a pepeha—a traditional way of introducing yourself in Māori.

RACS marked the occasion with a series of posts on social media with some simple ways to engage with te reo.

Te Wiki o Te Reo Māori is a government sponsored intiative, which began in 1972 and is growing in prominence as efforts to revive the Māori language increase.

Te reo is listed by the United Nations Educational, Scientific and Cultural Organization as 'vulnerable'. The government hopes to change that and has set a target of a million speakers of basic te reo and 150,000 proficient speakers by 2040. The same initiative wants Kiwis to value te reo as an integral part of their national identity.

In 2008, Google Māori—a Māori-language version of the popular search engine—was launched to celebrate Te Wiki o Te Reo Māori. The national cricket team, the Black Caps, played under the name Aotearoa to mark Te Wiki o Te Reo Māori in 2015. Two year's later the Disney film Moana was translated into te reo and, in 2021, 1.1 million people set out to speak Māori at the same time. It was also during Te Wiki o te reo Māori in 2021 that the Māori Party began its petition to adopt Aotearoa as the official name of New Zealand.

Why not have a go at learning some te reo, even by incorporating some simple greetings and sign offs into your emails?

Greetings

Hi: Kia ora

Hello to one (formal): Tēnā koe

Hello to two (formal): Tēnā kōrua

Hello to three or more (formal): Tēnā koutou

Morning: Mōrena

Good morning: Ata mārie

Sign offs

Regards: Ngā mihi

Many thanks: Kia ora rawa atu

With best wishes: Ngā manaakitanga

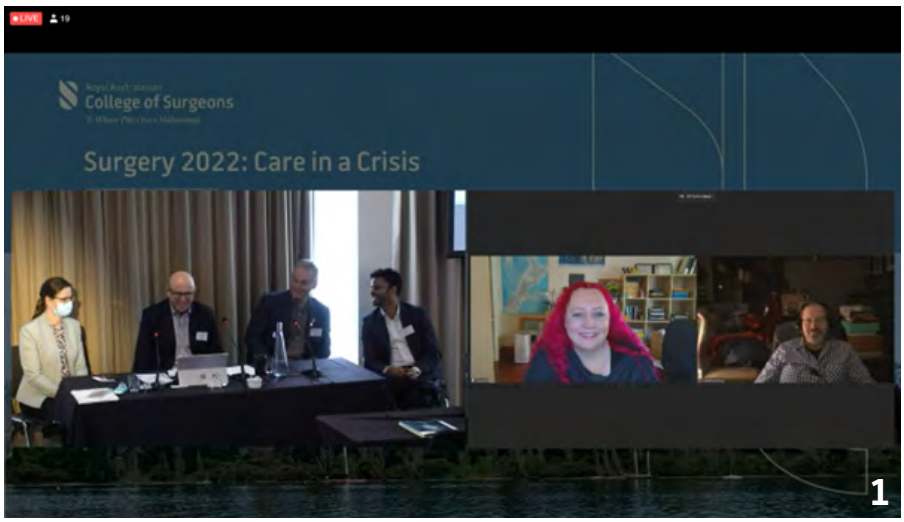
Until next time: Mā te wā

See you again: Ka kite anō

Need help with pronounciation? Try the Māori dictionary (https://bit.ly/3RCTiyr)

Want to add those pesky lines over the long vowel sounds (known as tohutō or macrons)? There are some simple instructions here (https://bit.ly/3TWJ8KV)

Surgeons reconnect in Queenstown



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Aotearoa New Zealand (AoNZ) surgeons had the opportunity to reconnect, share ideas and gain valuable new insights at the Annual Surgeons' Meeting (ASM) in Queenstown.

'Surgery 2022: Care in a Crisis' was held across two days, on 1 and 2 September, in the first in-person AoNZ ASM since the pandemic began.

The chance to touch base with colleagues from across the motu (country) is one of the things that makes the conference such a calendar highlight according to conference convenor, Dr Ros Pochin.

"The speaker line-up was a real draw and we enjoyed hearing the presentations and joining in the discussions. But it is also those incidental conversations, and friendships—both new and old—that make this an annual staple for many."

The strong attendance, despite the continued pressures of COVID-19 and winter illnesses on hospital schedules, was an indication of just how valued it is as a learning and networking opportunity. 'Surgery 2022: Care in a Crisis' had 65 in-person participants.

In a first for the conference, 'Surgery 2022: Care in a Crisis' was livestreamed, with 47 registered to attend the event.

Te reo Māori takes centre stage

What stood out at this year's meeting was the use of te reo Māori.

Some showed an impressive level of proficiency. Others gave it a go. What was clear was nearly all session chairs and speakers, including non-New Zealanders, wanted to show their respect for the lanugage of the tangata whenua—Indigenous people—of AoNZ.

There were also some interesting presentations on Indigenous health, from the sobering exploration by Associate Professor Jason Gurney of disparities in post-operative outcomes for Māori patients to the illuminating insights of Dr Courtney Sullivan, a Rotorua-based doctor, into the Māori attitude to death.

For those who don't believe there are inequities in the provision of healthcare in AoNZ, Associate Professor Gurney, a Māori epidemiologist and director of the Cancer and Chronic Conditions (C3) Research Group, said you just need to "start with the data. Disparities were found everywhere we looked—especially in elective surgery."

The human side of organ donation

What was also of note was how even surgeons, who could be expected to be somewhat hardened to the emotional side of their work, are touched by the human stories behind their patients.

The tissues came out towards the end of day one of the meeting as an organ recipient and the family of a donor shared their transplant journey.

The deep-dive into organ transplant included former Middlemore nurse and bi-lateral lung transplant recipient Amy Ng-Thomson. Amy's talk spanned the lows of her health deterioration while on the transplant waitlist to the heights of One Tree Hill (https://bit.ly/3LacTDV).

Walking up One Tree Hill is a rite of passage for lung transplant recipients. Amy said making it up to the top and taking in the view felt amazing.

"It was like, 'hell yeah, we made it. We got here'."

Amy was followed by Grant and Fiona Shennan who found a "beautiful light in the midst of tragedy" by donating their 22-year-old son's organs following a fatal car accident in the USA.

They explained what drove them to ensure their son didn't die in vain and read letters from those whose lives had been saved by their actions.

The future of the pandemic

COVID-19 might have dropped out our newsfeeds but its continued impact on the Aotearoa New Zealand health system is significant.

Participants were given a stark reminder of how lightly AoNZ came through the early days of the pandemic from those who were in the frontlines of the outbreak. Dr Avinash Sharma, an Auckland-based general surgeon, was living and working in New York in early 2020 and described it as a "full blown catastrophe" as refrigerated trucks were deployed to store the bodies of victims.

Associate Professor Siouxsie Wiles, a microbiologist and celebrated health commentator, warned against underestimating "long COVID". She urged against complacency and said the Emmental Model, where public health measures such as washing hands and staying home when sick are slices of Swiss cheese—each imperfect but strong together, is still our best defence against COVID-19.

Breaking barriers

The meeting closed with a session, which included Specialist International Medical Graduates who spoke of the barriers they encountered when trying to follow their passion in a new country.

Dr Leanne Shaw, a urologist in Hastings and the Urology Specialty Representative on the RACS Aotearoa New Zealand National Committee also spoke at the meeting.

She is one of the 12 per cent of urologists who are female. She is also left-handed and, being short, finds some surgical equipment uncomfortable or awkward to use. She was asked to present on not having the 'usual' clinical range. Dr Shaw is an 'office urologist' and only sees outpatients.

Images: 1. Panel discussion following the COVID-19 update. From L-R: Dr Sally Langley, Dr Andrew Connolly, Dr David Moss, Dr Avinash Sharma, Associate Professor Siouxsie Wiles, and Dr Matthew Dolling.

2. (L-R) Associate Professor Andrew MacCormick (AoNZNC Chair), 2022 Louis Barnett Prize winner Dr Ahmed Barazanchi and Professor Chris Pyke (Judging Panel Chair).

PRIZES

Congratulations to the prize winners—deferred due to the pandemic—on their incredible work.

Louis Barnett Prize 2022

Congratulations to Dr Ahmed Barazanchi for the 2022 Louis Barnett Prize (https://bit.ly/3dsR8mb).

His research shows the surgeon's 'gut feeling' is a good pre-operative risk predictor in emergency laparotomy, a high-risk abdominal surgery.

The Louis Barnett Prize has been recognising advanced surgical academic research from AoNZ Trainees and Younger Fellows for the past 60 years.

Professor Spencer Beasley, RACS Surgical Advisor, said the quality of this year's eight finalists, who presented at the meeting in Queenstown, was exceptionally high and covered a broader spectrum of topics and specialties than previous years. He also noted the greater use of qualitative, as well as quantitative research, and the focus on equity and access issues.

Deferred RACS ASC prizes

'Surgery 2022: Care in Crisis' also provided a chance for two RACS ASC prize winners from 2021 to collect their medals. Both recipients are AoNZ-based and were unable to attend the ASC in Brisbane earlier this year.

Dr Morrow received the 2021 John Corboy Medal, which recognises exceptional service by a Trainee.

Anna is now a Christchurch-based general surgeon and earned the award for 'leadership, selflessness, tenacity and service to Trainees set against

Dr Sally Langley and 2021 James Corboy Medal recipient Dr Anna Morrow

extraordinary personal tragedy' former RACS Trainees Association Chair Dr James Churchill said.

Dame Judith Potter DNZM was the recipient of the Companion of the College Award. This honour recognises the contributions of a person to the College and to the community through continued involvement.

Dame Judith, a lawyer and a High Court judge, joined the AoNZ National Committee (AoNZNC)—formerly the New Zealand National Board—as an Expert Community Advisor in 2012 and held the position for nine years. She was one of two AoNZ members on the Expert Advisory Group in 2016 to investigate bullying, harassment and discrimination within surgery and had a role in developing the 'Building Respect, Improving Patient Safety' initiative.

According to former AoNZNC Chair Philippa Mercer, "Her breadth of knowledge and expertise from the legal profession and her understanding of community issues such as gender bias, has enabled her to offer counsel that is clear, concise and considered. When Dame Judith had a point to make, everyone listened."

Dr Sally Langley (R) and 2021 Companion of the College Award winner Dame Judith Potter (L).

The lions that roared

Many years ago, a pair of white lions guarded the British Centre (Army headquarters) at Hyde Park, Sydney during the World War. They were subsequently bought by a Mr Godfrey and transferred to guard the portals of B.C.—the maternity ward of Hornsby and District Hospital. When hurrying through the gates at night as a registered medical officer to repair episiotomies, I felt the lions were looking after the lionesses and their cubs in the maternity ward.

When I started orthopaedic practice, I would often drive past the white lions facing Palmerston Road, Hornsby. They were the colour of plaster of Paris (POP) that had been set in a moulded majestic way and reminded me to contour my POP slabs and casts in the manner of Sir John Charnley, as set out in his book *The Closed Management of Fractures.*

The hospital, now named Hornsby Ku-ring-gai Hospital (HKH), was threatened with closure by the New South Wales government. It was saved by two surgeons, one being Dr Pip Middleton who, through the Ku-ring-gai District Medical Association, fought vigorously to avert this happening. He fought like the two white lions to keep the portals open. The other was a vascular surgeon, Dr Richard Harris, who fought very hard to have the hospital rebuilt. The first phase of this rebuild was a new mental health facility (very useful during COVID-19), and a new casualty and maternity unit. Alas, when I drove home from work, the lions had retreated into the jungle.

Subsequently, with the completion of the new hospital with its new undercover main entrance facing Palmerston Road, the lions have returned to their new pride (and joy) once again, not just maternity, but the whole hospital. When I look out through the glass door of my rooms, I can see the two white lions resolutely on duty, guarding the patients day and night.

This is the start and finish of my orthopaedic journey. HKH has survived and enjoyed a great relationship with the Sydney Adventist Hospital (fondly referred to 'the San') who have also acquired David Wilson's Day Surgery Centre across the road from Hornsby Hospital. Both have served the Ku-ring-gai area well.

I operated at the San for many years and introduced the arthroscopic camera there and promoted the use of space suits for joint replacements and spinal surgery. I remain on the HRECS (Ethics Committee) of the San, which oversees research done in the hospital.

The Australian Orthopaedic Association (AOA) registrars rotate through both hospitals, which have well-established casualty and ICU units. HKH provides in-patient mental health and the San provides oncology services for the Ku-ring-gai area.

My orthopaedic journey has been enhanced by being surrounded by outstanding mentors. I was initially mentored by Tom Hugh, who arranged for me to start filling my RACS logbook and Tom Claffey, the then AOA Censor-in-Chief, who recommended working in a teaching hospital. I worked at RGH Concord with outstanding mentors including Dr David Gillet, Head of Surgery and Dr Ken Hume, Orthopaedic VMO, and was fortunate to join the AOA training program on both sides of the harbour in Sydney.

I also worked for two outstanding professors—Ron Huckstep at Prince of Wales Hospital (POWH) and Tom Taylor at Royal North Shore Hospital (RNSH)—who were exemplary teachers in the craft of orthopaedics, trauma, and spinal surgery. I did microsurgery with Earl Owen at POWH, and Michael McGlynn (plastic surgeon) who were demonstrators at Earl's microsurgery workshops, in conjunction with Dr David Vickers from Brisbane. At the San, I was mentored by Dr Brian Hammond, one of Charnley's designated low friction arthroplasty trainers, for total hip replacement and John Grant, neurosurgeon in spinal surgery including tumour resection. I did six months with Frank Harvey in hand surgery at POWH and when he transferred north of the bridge, I did another six months of hand surgery and microsurgery with him at RNSH.

My orthopaedic journey has evolved into medicolegal consultancy, and I remain in Palmerston Road, Hornsby, where I have been for more than 40 years. I was, for four years, the chairman of the Medicolegal section of RACS and on the committee of that section for nine years. Currently, I am the president of the AOA Medicolegal Society and of the Australian Medicolegal College.

Before embarking on this final stage of my journey, I did my Master of Health Law in the then Faculty of Law (University of Sydney) in Phillip Street School of Law, opposite the Supreme Court. There, I had outstanding teachers including Professor Belinda Bennett, senior lecturer and barrister, Roger Magnusson and Ian Freckelton, QC from Victoria who lectured on expert evidence. This provided a good platform to embark on medicolegal practice and even included forensic psychiatry and advanced forensic psychiatry, taught by Peter Shea, superintendent of Morisset Hospital.

In this final phase of my journey, I have overseen the formation of the Annual AOA-RACS-AMLC Combined Medicolegal Meeting, which had its first post-COVID-19 in-person meeting in Sydney on 21 and 22 May 2022. Orthopaedic medicolegal consultancy can be a rewarding pathway towards retirement. It means one must keep up to date on recent advances, for example, newer devices and implants, newer techniques such as laser, navigation, and robotic surgery. This should be followed up with outcomes through the outstanding Australian Joint Replacement Register based in Adelaide, producing cumulative results of major joint arthroplasty, and showing trends in current arthroplasty, for example, reverse total shoulder replacement.

Dr Drew Dixon
President
AOA Medicolegal Society

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Trauma Week 2022

This year's joint symposium on family violence will be convened by Associate Professor Payal Mukherjee FRACS and Dr Ken Harrison FANZCA.

Our keynote speakers are Dr Mayet Costello, Violence, Abuse and Neglect (VAN) NSW; Professor Kelsey Hegarty, Family Violence Prevention, University of Melbourne and Royal Womens Hospital, and Dr John Sammut, President Medical Council NSW.

They will address the responsibilities of health professionals to respond to this issue to effect improved health outcomes.

The Honorable Natalie Ward MLC, New South Wales Minister for Prevention of Domestic and Sexual Violence, will open the symposium.

Register here: https://surgeons.eventsair.com/trauma2022/reg

ANZES Postgraduate Course 2022


Associate Professor Mark Sywak

The Australian and New Zealand Endocrine Surgeons (ANZES) Postgraduate Course will be held on 11 and 12 November 2022 at the Manly Pacific, Manly, New South Wales, and marks the ninth time the association has convened this important meeting.

The conference will take place over two days—both in-person and virtual participation for those delegates unable to travel to Manly.

ANZES was established in 1997 to promote excellence in endocrine surgery in our region. The group brings together surgeons who are dedicated to the art and science of thyroid, parathyroid, adrenal and neuro-endocrine tumor surgery. The membership incorporates national leaders in endocrine surgery, who make a tremendous contribution to teaching, clinical research and basic science advancement. The group encourages multidisciplinary care for patients, including the expertise of endocrinologists, Head and Neck surgeons, pathologists, and nuclear medicine physicians.

The 2022 program has been prepared by the scientific committee, which includes Associate Professor Christine O'Neill, Dr Christine Lai, Associate Professor Anthony Glover, and Dr Steven Craig.

The format includes interactive case-based discussions, videos and presentations from leading experts in Australia and Aotearoa New Zealand.

Highlights of the course include presentations on parathyroid fluorescence by Professor Brian Lang (Hong Kong) and the role of radiofrequency ablation for thyroid nodules by Associate Professor Catherine Sinclair.

We are also excited to have Professor Anthony Gill discuss advances in endocrine histopathology and Dr Venessa Tsang and Dr Matti Gild presenting on advances in targeted molecular therapy in thyroid cancer treatment.

The course will be of great value to surgeons and senior Trainees preparing for fellowship examinations (FEX). A session focused on preparation for FEX will be led by Dr David Walsh on 12 November.

The ninth ANZES Postgraduate Course provides a great opportunity to keep up to date with the latest advances in thyroid and parathyroid surgery. It will give Trainees the opportunity to meet and network with surgeons from Australia and Aotearoa New Zealand and observe the dynamics of true multidisciplinary care.

We are looking forward to welcoming you in the wonderful surrounds of Sydney's Northern Beaches.

Author: Associate Professor Mark Sywak MBBS MMed Sci (Clin Epi) FRACS
University of Sydney Endocrine Surgery Unit,
President Australian and New Zealand Endocrine Surgeons
Chair, Section of Endocrine Surgery and Examiner in General Surgery RACS.

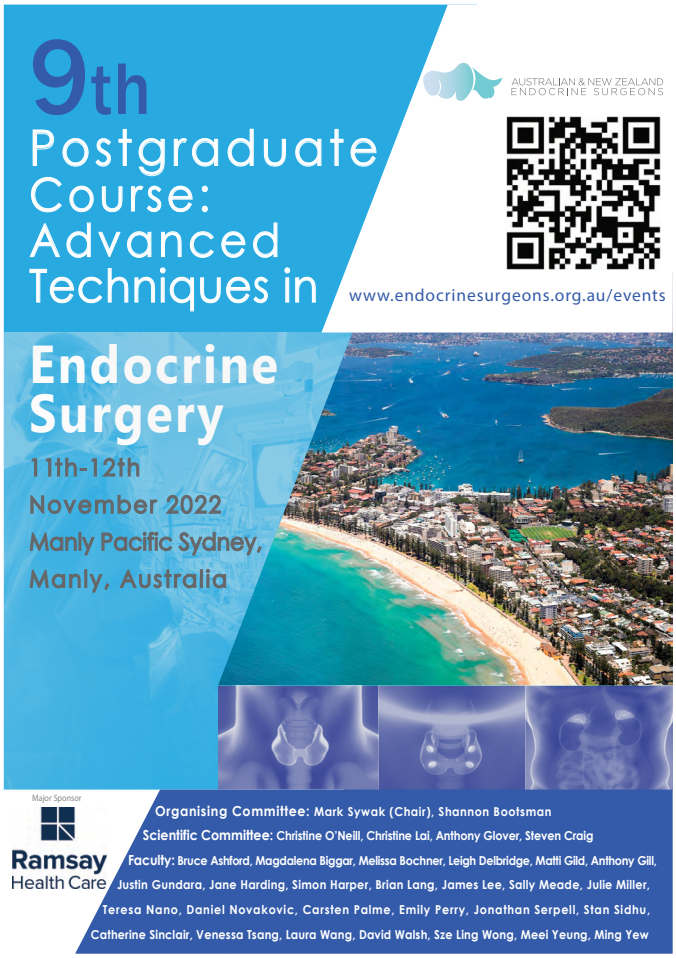
Scientific committee (pictured above)

Dr Christine Lai: Senior Consultant Surgeon, Breast and Endocrine Surgical Unit, The Queen Elizabeth Hospital, South Australia, Senior Lecturer, Discipline of Surgery University of Adelaide.

Associate Professor Anthony Glover: Program Director, Master of Surgery, Sydney Medical School Education Office, University of Sydney, Endocrine Surgical Unit.

Dr Steven Craig: Endocrine Surgeon and Surgical Oncologist.

Associate Professor Christine O'Neill: Specialist General Surgeon, Associate Professor, School of Medicine and Public Health, University of Newcastle.

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Progress for surgery in the Northern Territory

There's plenty of positive change in sight for surgery in the Northern Territory (NT). The remote territory has been working hard to gain much-needed acknowledgement and advocacy for its distinctive needs, which will hopefully improve long-standing health inequities compared to other areas of Australia. Dr Hemi Patel is leading the charge.

Dr Patel is an Ear, Nose and Throat (ENT) surgeon based in the NT. He's head of department at Royal Darwin Hospital and has his own private practice, Darwin ENT. He's also chair of the Northern Territory Medical Board and chair of the Northern Territory Committee for the Royal Australasian College of Surgeons (RACS).

Dr Patel trained in the UK before moving his family to Darwin, in 2007, to learn more about the challenging ear disease that's unique to the NT. He admits he had only planned to come to Australia for one year. "But within a month, we fell in love with the laid-back, tropical lifestyle. There's an unending supply of interesting work here and you feel like you can make a difference."

Dr Patel says he probably chose ENT as a specialty because of a positive internship under the wing of two ENT mentors, who were very supportive and let him experience interesting work. He also likes the variety. "As a rural ENT, you see people of all ages. You can do microscopic, endoscopic or major open head and neck surgery. It's a unique specialty, which can cover anyone's potential interests."

In the UK, as a metropolitan surgeon, he was heading down a very defined subspecialty path. "In the Territory, I have much more of a generalist hat on. I enjoy the challenge of having to be multi-skilled and ready for any case that comes through the door."

Dr Patel is a strong advocate for surgery in the NT. The most pressing health issue, he says, is closing the gap. "Indigenous Australians have worse health outcomes across the spectrum of diseases. Health literacy is low and there are the usual social determinants for health—poor sanitation, overcrowding, maternal smoking, poor nutrition, alcohol abuse, and lack of access to healthcare. There are also language barriers and the remoteness of communities to consider."

Thirty per cent of people in the NT are Indigenous Australians. Dr Patel is part of an outreach program. He and his team spend close to half the year in rural communities and estimates that up to 60 per cent of his patients are Indigenous.

He says RACS can best support the NT by providing ongoing recognition and advocacy. "The College is already exploring ways to support initiatives to redistribute the surgical workforce and surgical care where it's needed in regional and remote areas, potentially through training models. RACS also needs to keep talking to Indigenous Australians, to understand what they want and how they want to do it."

"If we can recruit from regional medical schools, get people interested in surgery locally, and train them in regional centres during their formative years, they'll be more likely to build a life and stay there."

In a very positive step forward, RACS has recently approved the establishment of its first office in Darwin, which means better administrative support for the NT Committee and their role in the Territory. It also means NT will be more present and included in College business and activities.

Dr Patel is excited about a recently proposed model to reverse the hub and spoke model of surgical training in regional areas. Currently, Trainees are primarily based in big city hubs, spending only six to 12 months in regional centres. Soon, recruitment will also happen in regional centres so that most of the training can be completed there, as a regional hub. Trainees will then be going to metropolitan centres as needed for their training, while retaining the NT as their base. The details and design of this model still has to be finalised.

"If implemented, that will be a fundamental shift in surgical training models," said Dr Patel. "If we can recruit from regional medical schools, get people interested in surgery locally, and train them in regional centres during their formative years, they'll be more likely to build a life and stay there."

In a landmark move, in April 2022, RACS executed a Memorandum of Understanding (MoU) with the NT Health to achieve four mutual goals:

- improve local pathways for surgical training
- train Indigenous surgeons
- improve Indigenous health outcomes
- improve retention of NT's surgical workforce.

"Currently, we only have about 25 Fellows in the NT, so until now, our lobbying power for advocacy and action has been very limited. This MoU between RACS and NT Health is an important pillar by which to talk, collaborate and take action."

For Dr Patel, the most exciting aspect of the MoU is the prospect of recruiting and retaining more local talent. "Locally trained surgeons will be more likely to stay in the region for the span of their careers. Local surgeons also mean we have more culturally safe practices, as we understand the local context in how we deliver care. We have different patients, resources, and infrastructure to other places."

In another recent development, Dr Patel says the Australian Society of Plastic Surgeons (ASPS) visiting plastic surgery service model has been very beneficial for NT patients and local surgeons. "In future, we could potentially run similar visiting surgical models long-term to have sustainable services in the Territory, supporting local surgeons serving the local community."

Dr Patel and his team are involved in a ground-breaking project (Drumbeat.ai) that could change the future of ear disease diagnosis in rural and remote areas. They are working with Microsoft and several Australian universities to develop an AI model for diagnosing ear conditions from images of ear drums and hearing tests. Their work is not only pivotal for equitable access to ear healthcare, it shines a light on the NT health and research.

Dr Patel has many hopes for NT's future. He wants to see the gap close for Territorians, with easier access to suitable healthcare. NT urgently needs more local nurses, GPs and surgeons, and more funding invested in primary prevention and care.

"We need access to robotic surgery, lasers and other technologies that are now at the forefront of the profession. The next generation of young surgeons are going to demand it," he said.

"Surgeons can be benevolent and altruistic and want to make a difference, but if we want to attract bright, talented young people to stay in regional areas for their whole careers, we must be able to offer them professional satisfaction."

Dr Patel has a message for surgeons contemplating a career in regional and rural surgery: "Get on the next plane. You are much needed in the Territory. The opportunities in regional centres are exciting and you have a higher degree of autonomy. You don't necessarily have to choose a subspecialty; you can practise as a generalist in your chosen specialty in a regional centre and have a rewarding career with good work-life balance."

Image: Dr Hemi Patel

Policies needed to support pregnant Trainees and parents

Almost a century ago, Dr Lillian Cooper became the first woman admitted to the Royal Australasian College of Surgeons[1] Since then, considerable strides have been made towards gender parity in medicine. Women graduates have consistently outnumbered their male counterparts in Australian and Aotearoa New Zealand medical schools for more than a decade.[2]

Despite these advances at a medical student level, we have not seen this gender equality translate to the surgical workforce. Only 30 per cent of active SET Trainees are women, and among consultant surgeons, this is further reduced to 15 per cent (20 per cent in General Surgery, five per cent in Orthopaedic Surgery).[3]

A 2021 analysis from the United States determined it would take another 326 years to achieve gender parity (50 per cent women) in Orthopaedic Surgery at the current compounding annual growth rate of two per cent.[4]

Through research conducted in the UK, Europe and North America, there is greater awareness of the impact that persisting structural and attitudinal barriers have on women pursuing surgical careers. These include a lack of policies on working while pregnant, provision of parental leave, and assistance for their return after childbirth. As the number of female medical graduates increases, these barriers must be actively challenged to achieve true gender equity and increase diversity within surgery.

My aspirations to become a doctor began in childhood, and as a SET 4 General Surgery Trainee I have no regrets about my chosen path. However, as a junior doctor, I remember the comments of concern from my peers and seniors—had I considered the difficulty of combining a surgical career with parenting? Did I even want children? Had I planned for egg freezing or in-vitro fertilisation? I often wondered if my colleagues who are men would be asked the same questions. While these comments were often well-intentioned, research demonstrates they can have a cumulative effect of discouraging women from pursuing surgery and may contribute to rates of attrition once in training.[5,6,7]

I presented my research on the *Pregnancy and parenthood experiences of Australian and Aotearoa New Zealand Surgeons and Trainees* at the 2022 RACS Annual Scientific Congress (ASC) in Brisbane in the Surgical Education stream. We conducted a cross-sectional anonymised electronic voluntary survey of women surgical Trainees and surgeons working in Australia and Aotearoa New Zealand. The survey examined numerous domains including pregnancy experience, access to parental leave, post-partum support, as well as workplace culture and career satisfaction. Out of the 199 surgeons and Trainees (140 women, 59 men) who were surveyed, almost 60 per cent had one or more children. An additional 55 pre-vocational doctors also completed the survey providing insights into their perceptions on the above issues.

Surgery is a demanding speciality—both physically and mentally—and there has been increased interest in the impact of surgical training on pregnancy outcomes. Recent evidence suggests that night shifts and prolonged operative hours during the third trimester are associated with a higher risk of major obstetric complications.[8] These findings were replicated in our study. Yet, despite holding concerns for their and their baby's health, the surgeons and Trainees we surveyed reported working long hours late into pregnancy. More than 80 per cent worked more than 40 hours a week during their third trimester, with 35 per cent continuing to work beyond 38 weeks gestation. In addition, 50 per cent suffered pregnancy and neonatal complications—significantly higher than the population average—and almost a third considered leaving surgery.

Dr Wendy Liu

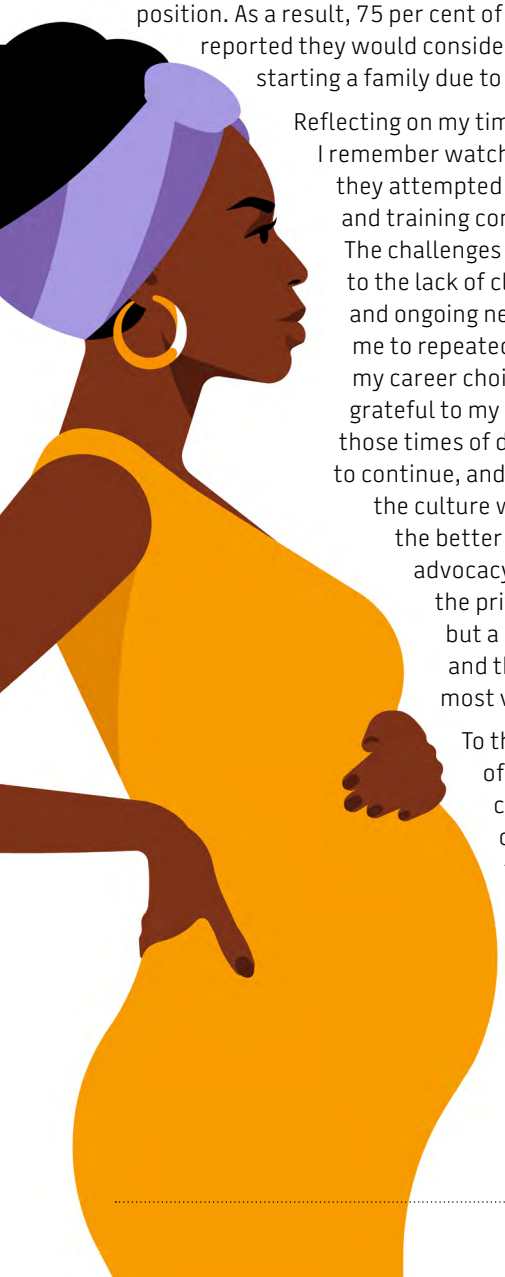
Our survey also revealed ongoing issues with access to parental leave, as 16 per cent of pregnant Trainees and 42 per cent of male parents stated they did not qualify for or were declined parental leave. This was often due to mandatory rotations across jurisdictions with no recognition of prior accrued entitlements. However, progress in this space is being made with continued advocacy from RACS. Even when eligible to take leave, most respondents reported there was a persistent negative stigma associated with taking leave. Our research supports the need for protective policies that reflect best practice and the changing culture in medicine.[9]

There were near universal requests for greater mentorship by Trainees as they transition into the dual roles of parents and surgeon. However, more than half of the surveyed parents reported a lack of support from their departments or RACS when returning to work. Additionally, 40 per cent of mothers reported practical barriers to continued breastfeeding including challenges expressing between clinical duties and a lack of suitable lactation facilities. We need to

learn from some of the other medical specialties as well as the many corporate organisations that have recognised the benefits of formalised mentorship and taken active steps to offer personalised support through the multiple transitions related to parental leave.

In keeping with societal trends, most respondents expressed a desire for greater work-life balance, as well as options for flexible and part-time training. Of concern, 40 per cent of surgeons and Trainees reported surgery had a negative impact on their family relationships.

The experiences of surgeons and Trainees have a clear impact and 'trickle-down' effect on pre-vocational junior doctors who hope to pursue surgery. After witnessing negative comments being made about taking parental leave by colleagues and supervisors, almost 90 per cent worried about how they would be perceived if they were to be in a similar position. As a result, 75 per cent of pre-vocational doctors reported they would consider delaying or did delay starting a family due to their training.



Reflecting on my time as a junior doctor, I remember watching my colleagues as they attempted to balance their family and training commitments. The challenges they encountered due to the lack of clear supportive policies and ongoing negative stigma caused me to repeatedly pause and reconsider my career choice. I will be forever grateful to my mentors who—during those times of doubt—encouraged me to continue, and who assured me that the culture was slowly changing for the better through their ongoing advocacy. Because of them, I have the privilege of not only a career but a calling, to help patients and their families during their most vulnerable times.

To the future generation of surgeons, if you're currently in that place of career uncertainty that I frequented, know that we will continue to advocate for you. We will advocate for institutional change, more proactive policies, and formalised support for all surgeons who may fall pregnant or want to start a family during training.

Author: Dr Wendy Liu

Dr Wendy Liu is a General Surgery Trainee at Royal North Shore Hospital, and a Clinical Associate Lecturer at the University of Sydney School of Medicine. She has a passion for medical education and health advocacy, with long-term aspirations to influence policy and combat healthcare inequities both in Australia and abroad.

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Dr Justin Chan – winner of the 2020 Marjorie Hooper Scholarship

For cardiothoracic surgeon Dr Justin Chan, winning the prestigious 2020 Marjorie Hooper Scholarship offered by the Royal Australasian College of Surgeons (RACS) was an "incredible opportunity".

It came at a time when he had just finished training in Cardiothoracic surgery at the Royal Adelaide Hospital and was looking at the next phase of his surgical career.

"I was planning on sub-specialising in transplantation, but there was no cardiothoracic transplant service in South Australia. Extracorporeal membrane oxygenation (ECMO) services at the time were nascent and ran as an ad-hoc service, shared between cardiothoracic surgery and ICU," Dr Chan said.

So, he turned his focus towards spending time at the Toronto General Hospital (TGH), one of the pioneering centres in lung transplant. He would go on to complete lung transplantation and general Thoracic surgery fellowships and work with noted cardiac surgeon, Dr Tirone David.

The other key focus of his fellowships was working with Dr Marc de Perrot and Dr Laura Donahoe on the Chronic Thromboembolic Pulmonary Hypertension (CTEPH) program. CTEPH is an uncommon condition, which can affect up to five per cent of patients after a pulmonary embolism. The surgery requires cardiopulmonary bypass as well as deep hypothermic circulatory arrest.

"There are not many high volume centres for this operation in the world, so it was a great opportunity for me to work with world experts in this field, to do some research, as well as learn this operation," he said.

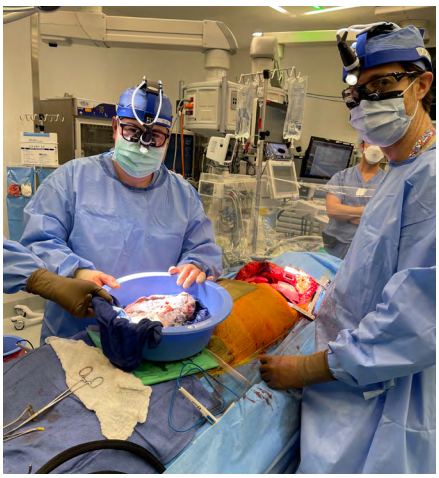
At TGH, Dr Chan gained experience in complex thoracic surgery, pulmonary thromboendarterectomy, and ECMO—the latter of which became a huge focus as the COVID-19 pandemic hit. It was in the middle of his fellowships.

The pandemic changed Dr Chan's career trajectory. Instead of returning to Australia, where incidentally, the hiring of surgeons was affected, he ended up at New York University working in their cardiothoracic transplant department.

Today, as a cardiothoracic transplant surgeon and as the surgical director of the CTEPH program at NYU Langone, he has a busy schedule. He also runs the CTEPH program, which is growing in volume as awareness about the condition and the possible treatments increase.

When not doing clinical work, Dr Chan tries to fit in research, mentoring and teaching students, residents, and Fellows.

He encourages anyone thinking about applying for a RACS scholarships to take the shot. "I would never be where I am today had it not been for seeing the email saying that the scholarship was open. The RACS scholarships are more than about the funding. The fact that you receive the scholarship provides the motivation to succeed."



Dr Chan's current goal is to increase the awareness of CTEPH. "Surgery is incredibly effective but can only be done if the diagnosis is correctly made. I am looking at building a world class CTEPH program, which will incorporate all forms of treatment from surgery to balloon angioplasty and targeted medical therapies," he said.

Given his hectic and unpredictable schedules, work-life balance is something he struggles with at times. "Luckily, I have a wife who is very understanding," he said. "It is not infrequent to return home (or leave for work) in the small hours of the morning. The unpredictability means that we have to be very flexible with our plans."

On weekends, the couple love exploring the city. "I'm grateful that I can spend a lot of our free time seeing different parts of the city and enjoying everything that it has to offer."

Born and raised in Australia, Dr Chan hopes to return and use the skills and experience he has gained overseas for the benefit of the Australian public.

He maintains links with the surgical community in Melbourne and Adelaide, and mentors Australian medical students and surgical residents through the long and difficult journey of surgical training.

"I hope that my journey can serve as a role model for others with similar aspirations," he said.

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

College runs Pacific Island Program reflection workshops

Since 1995, the Royal Australasian College of Surgeons (RACS) has worked with health partners in Pacific Island countries to improve access to surgical care through the Australian Aid-funded Pacific Islands Program (PIP).

The program aims to increase access to surgical care across 11 Pacific Island countries. It does this by providing education and training to Pacific surgeons, nurses and other health workers, and by supporting surgical teams to deliver surgeries locally.

The PIP is a component of the Department of Foreign Affairs and Trade's (DFAT) regional program, the Pacific Clinical Services and Health Workforce Improvement Program. This also includes the activities of the two other implementing partners—the Pacific Community (SPC) and Fiji National University (FNU). The current phase of RACS PIP ended in September 2022. The RACS Global Health team has been working with DFAT, SPC, and FNU to design the next phase of the regional program.

In late August, two reflection workshops were held by RACS Global Health in Nadi, Fiji, to reflect on the previous phase of the program. The first was with RACS implementing partners for the PIP, SPC and FNU. This workshop provided an opportunity to reflect on the health of these partnerships and on ways of working together.

The second workshop was held with the 11 Pacific Island countries' Directors of Clinical Services (DCS) and Pacific Heads of Nursing (PHON) representatives. The workshop provided them with the opportunity to reflect on the effectiveness and impact of the PIP in their country. Both workshops provided RACS with important feedback on the strengths, weaknesses and achievements of the previous phase, which will be used to improve the next phase of the PIP.

In Fiji, RACS Fellows and Global Health staff were also invited to attend and present at the DSC and PHON meetings, convened by SPC. These important forums provided RACS with insights on the latest clinical service developments and ongoing challenges in the Pacific. One key overarching theme to emerge from the meetings was the need to increase health workforce capacity in rural areas, including the need to address clinical capacities, which are further stretched by the COVID-19 pandemic, resulting in staff sustainability issues and burnout. Unreliable internet access and the impact it has on service delivery and training was another common theme that emerged. The number of requests from the region for scholarship, equipment and biotechnology capacity support and funding was also noted by RACS.

The Pacific countries shared many examples of the power of partnerships and the importance of shared learning, collaboration and mentoring across the region. These included the establishment of Pacific Island Associations and Partnerships. A great example of this is how RACS—in collaboration with the Australian College of Perioperative Nurses (ACORN)—has supported the Pacific Island Operating Room Nursing Association (PIORNA) with the development of the Standards of Perioperative Nursing in Pacific Countries and Territories.

RACS also worked with Interplast, who specialise in deploying volunteer plastic and reconstructive surgeons, to establish learning with a manual and online training module. These manuals and accompanying module, were launched by PIORNA in Fiji, with the objective of helping improve the processes of care and patient outcomes in Pacific countries.

The Pacific Islands Program is an Australian Aid initiative implemented by RACS on behalf of the Australian government and delivered in partnership with the Pacific community, Ministries of Health, specialist colleges and associations, and partners.

If you are a health professional interested in volunteering or supporting RACS Global Health, please contact volunteer@surgeons.org

Image: Pacific Island Countries' Directors of Clinical Services (DCS) and Pacific Heads of Nursing (PHON) representatives Reflective Workshop

Australian Aid

Small kindnesses have big benefits for wellbeing


Dr Tony Fernando

A surgeon kneels down, still in his waterproof surgical boots, to massage the calves of a dying patient. Nothing heroic but a small gesture to ease the suffering in a patient's final moments.

In his presentation to the Aotearoa New Zealand annual surgeons' meeting in Queenstown, Dr Tony Fernando explains how a little act such as this are all that is required to show compassion.

A consultant psychiatrist and senior lecturer in Psychological Medicine at the University of Auckland, he specialises in research into sleep medicine, medical compassion and physician wellbeing.

His presentation at 'Surgery 2022: Care in a Crisis' focused on how surgeons can find compassion even under pressure, when complications occur, for example, in the resus room or emergency theatre.

He says medical compassion is vital, both to improving patient outcomes and the wellbeing of healthcare professionals.

Studies show patients who have been shown medical compassion have better clinical outcomes, fewer complications and are less likely to make complaints. Medical professionals who practise compassion see benefits, too. They enjoy their work more, find it less tiring and feel happier in themselves.

Compassion is not a default setting, says Dr Fernando, and we can easily slip into indifference when under stress. He pointed to data showing 60 per cent of senior doctors report burnout and said this chips away at their ability to act compassionately.

Tiredness, external distractions, and systemic issues like bullying and unsupportive management can lead to surgeons showing less kindness, too.

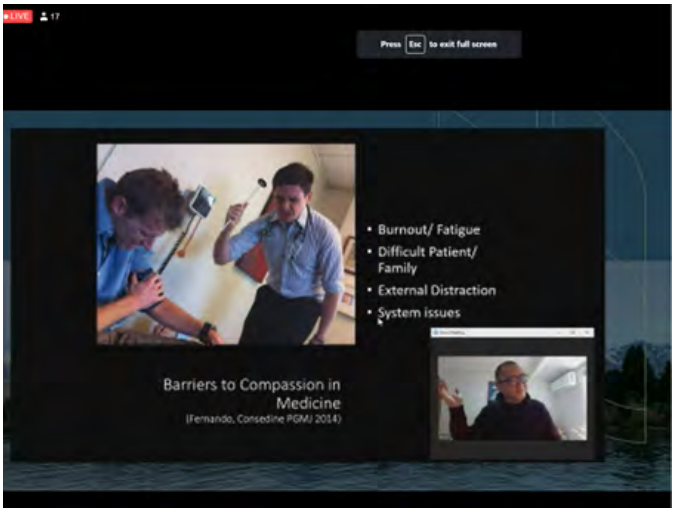
Dr Fernando also warned of unconscious biases in who we are most compassionate towards. We view those most like us as more deserving of our compassion than those who we perceive as different. One Aotearoa New Zealand study shows patients lower down the socio-economic ladder receive less kindness.

He says hospital management should look at environmental and systematic issues that could ease the stress load on medical staff.

It is also down to the individual to make change and Dr Fernando said, like any skill, it is possible to learn to be more compassionate. Using anchors to concentrate the mind and keep you focused on the moment can be a useful technique. Dr Fernando said there is a statistically significant correlation between practicing mindfulness and being compassionate.

He also urges surgeons to practise "self-compassion", silencing the inner critic.

"There is an epidemic of self-criticism. That voice telling you you're not good enough. If we don't address it, it's a recipe for depression and burnout."



Sally Griffin's wellness advice

Clinical dietitian and researcher Sally Griffin's work is fused with a passion for improving perioperative care for patients with obesity and associated modifiable risk factors through dietitian-led intervention. She is known for her research on the use of a Very Low Calorie Diet (VLCD) to optimise patients with obesity for elective, non-bariatric surgery.

After completing her Bachelor's degree in Exercise Science and Nutrition and Master of Dietetics, Sally worked as a dietitian in Logan Hospital. It was at the busy dietitian outpatient clinic here that she noticed the increasing number of referrals from surgeons for patients requiring weight loss before surgery. These included gynaecological surgery, joint replacements, and cholecystectomy.

"I realised that the usual method was not sustainable, and our patients weren't losing weight. We couldn't give them incentive because the surgeries were often so far away, sometimes up to a year of waiting. Patients lost motivation as it wasn't really a structured program," Sally said.

That is when she started thinking about how to improve that preparation and ensure the outcomes were what the surgeons were looking for.

"Based on the literature that was available, we made changes and implemented a dietitian-led model of care combining VLCD with timely surgery dates, and found it very successful," she said.

Sally evaluated the model and published the results as part of a Master of Medical Research. "I wanted to disseminate the results to show that this can be done because it was the first kind of model that I was aware of in Australia." Combined with her guidance, this evidence allowed other healthcare sites to gain funding to implement the model.

Currently, as a specialist clinical dietitian at Logan Hospital, Queensland, Sally is also pursuing a PhD on the impact of preoperative VLCD on surgical outcomes.

She believes people's quality of life generally improves because of changing their diets. "Research tells us that consuming a diet rich in wholegrains, vegetables, unsaturated fats, and including nuts and legumes provides our bodies with the nutrients that we need. That's wellbeing at a broad level in terms of reducing risks for a lot of chronic conditions and improving your resilience and mental health," she said.

As a dietitian dealing with individuals, to be well overall depends on what that person needs to achieve based on their condition and treatment, Sally said.

For surgeons and Trainees, given their long hours and shift work, there are very basic principles to follow. "We know from research that shift work can be a health hazard. With long hours in the theatre, regular meals and being prepared are the two basic things. That way you can fuel your body for the shift. If you skip meals, your energy levels aren't regulated."

Sally said hydration is another important aspect that people forget. "For a surgeon, if you are trying to maintain concentration and long hours, it is really important to have at least two litres of water a day."

A big advocate of mental health, Sally said what we eat impacts our mental health. "Research is showing us there is a definite link between the gut and the brain. I see it in practice too—people start to feel a lot better mentally once they improve their diet, that's a huge change you can see in them."

Importantly, she believes improving overall wellbeing is linked to social wellbeing. "We always encourage people, even if they are on VLCD, not to miss out on social gatherings where food plays an important role in overall wellbeing. It's about balance—having the things you enjoy when you need to, to keep yourself happy."

Sally keeps her wellbeing on track fostering rescued greyhounds. "I do a lot of walking with them; they take up my time apart from my work and research. It keeps me happy."

Reducing the toll of prostate cancer

Prostate cancer is one of the biggest killers of men in Australia and Aotearoa New Zealand.

It is expected to claim the lives of more than 3500 Australians this year—a significant increase from 1370 deaths 30 years ago.

In Aotearoa New Zealand, deaths due to prostate cancer have increased from 487 in 1993 to an estimated 700 in 2022.

While effective new treatments have been developed in the past five years, the impact of COVID-19 on testing and diagnosis is likely to see a further increase in the toll of the disease in coming years.

The Urological Society of Australia and New Zealand (USANZ) president, Associate Professor Prem Rashid, hopes to improve early detection rates by advocating the value of prostate specific antigen (PSA) testing.

The USANZ has produced a position statement calling for an urgent update of clinical practice and RACGP Red Book guidelines to align with the latest data on PSA testing.

“There has been a global rise of different types of cancers and in the last decade we have seen a steady increase in the cases of younger men with more aggressive disease,” Associate Professor Rashid said.

“We are confident that better access to the PSA test can improve the detection and management of prostate cancer and lead to better outcomes.”

The test has attracted conflicting opinions in the past, when it was believed to have led to the over-treatment of conditions that were unlikely to progress. However, developments in the diagnosis and monitoring of prostate cancer mean that the risk of overtreatment or side-effects has decreased significantly in the past five years.

Recent improvements include:

- the use of transperineal biopsy rather than transrectal biopsy, significantly decreasing the risk of infection
- the increased use of MRI scanning to identify prostate cancer earlier
- the introduction of PSMA PET scans to accurately detect any spread of cancer (replacing CT and bone scans)
- the improvement of therapeutics.

“The use of MRI scanning has been a game-changer in that it allows us to better stratify risk,” Associate Professor Rashid said.

The changes in recent years vastly reduce the risk of unnecessarily treating a patient who has an elevated PSA level, which can result from something as simple as a vigorous bike ride.

“We are increasingly better at locating cancers we need to find and managing conservatively those who aren’t a risk.

Prostate cancer statistics

Prostate cancer is one of the most commonly diagnosed cancers in Australia and New Zealand, and it is now the most commonly diagnosed cancer among men.

Prostate cancer is the second most common cause of death from cancer in Australian men and the third most common cause of cancer-related male deaths in Aottearoa New Zealand.

24,217 Australian men will be diagnosed with prostate cancer in 2022.

3507 Australian men will die from prostate cancer in 2022.

66 Australian men are diagnosed each day with prostate cancer, and about 10 Australian men will die each day from the disease.

240,245 Australian men are alive today after a diagnosis of prostate cancer between 1982 and 2017.

In New Zealand approximately 4000 men are diagnosed with prostate cancer each year and 700 men die from it each year.

Indigenous men in Australia and Aotearoa New Zealand have a higher prostate cancer mortality attributed to specific cultural issues affecting presentation, treatment challenges and other health conditions coupled with healthcare disparities and reduced prostate cancer awareness.

"In some cases, the patient will need active surveillance and a urologist will only provide treatment if the cancer has progressed."

Evidence from the US reinforces the value of the PSA.

In 2012, a recommendation for PSA screening was abandoned, leading to an increase in the incidences of advanced and metastatic prostate cancers.

The decision was overturned in 2018 and PSA testing was again recommended.

Once a urologist has identified prostate cancer using a combination of clinical assessment, imaging and biopsy, there are three primary treatment options: removing the prostate, external radiation therapy with gold seeds (fiducial markers) to accurately locate the position of the prostate (with spacing gel to protect the rectum), and internal radiation using radioactive seeds.

A variety of other therapeutics are available for different stages of the disease.

While Associate Professor Rashid is optimistic about developments in diagnosis, monitoring and treatment in recent years, he is concerned about their accessibility to Indigenous men in Australia and Aotearoa New Zealand, and those living in rural and remote areas.

"Equity in access is a huge concern to everyone in healthcare," he said.

"We would like to see access to advice and PSA testing more widely available but in some rural communities there is little access to even basic healthcare, so preventative testing is further down the list of priorities.

"I don't have the answers but there is a strong desire from all parts of the healthcare community to improve access.

"Unfortunately, good healthcare is expensive and many of the investigations and treatments we need are very expensive."

Associate Professor Rashid is hopeful that the USANZ position statement will result in an update to the Royal Australian College of General Practitioners guidelines and recommendations from other healthcare authorities on both sides of the Tasman to recommend PSA testing for men over the age of 50, and younger for those at specific risk.

Associate Professor Prem Rashid

These include Indigenous men and those with a family history of prostate cancer or the BRCA2 gene.

He believes offering PSA testing will be particularly important given the impact of COVID-19 on access to general practitioner services.

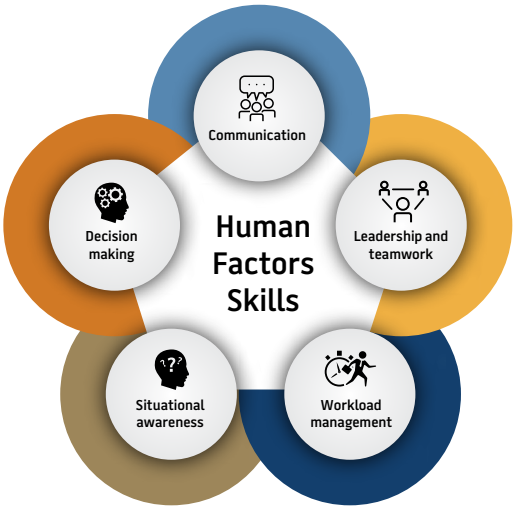
"I don't think the impact of COVID-19 on prostate cancer data has filtered through yet, but it's a huge worry, not just in this area, but in all areas of healthcare," he said.

Human Factors and Safety in Surgical Patients

Venue: Queensland Regional Office Conference Centre

Date: Friday 18th November 2022

Royal Australasian College of Surgeons
Queensland Audit of Surgical Mortality



QASM's 2022 annual seminar 'Human factors and safety in surgical patients' will be held on Friday 18 November at the RACS Queensland office's conference room.

This will be a hybrid seminar with onsite seminar registration at 8.30 am for a 9am start.

Speakers for the 'Human factors and safety in surgical patients' morning session include:

Dr Sally Langley (RACS President)
Dr Chiara Santomauro (Research fellow and lecturer, Griffiths University specilaising in errors in interruptions)
Dr Juanita Muller (Vascular surgeon)
Dr Terence Chua (General surgeon)

There will be an hour-long panel discussion before a light lunch at 1:00pm.

Register here to join online: https://bit.ly/3bSKyVx

QASM will hold a masterclass from 2pm entitled 'Non-technical skills in the management of complex surgical environments'.

Please register separately for the masterclass, which is limited to 24 onsite attendees.

Presenters for the 'Non-technical skills in the management of complex surgical environments' afternoon session include:

Dr Nathan Brunott (General surgeon)
Dr William Butcher (Vascular surgeon)
Dr David Sainsbury (Anaesthetist)
Dr Chiara Santomauro (Research fellow and lecturer)

Register here: bit.ly/3Am2LUL

The unique challenges of rural training with curriculum

Research undertaken by the Royal Australasian College of Surgeons (RACS) has identified some unique challenges rural surgeons and Trainees face in their day-to-day work. The study investigated what knowledge and experience could be enhanced to better prepare practitioners in rural, remote, and regional settings to address these challenges. This helped to develop recommendations for a rural-facing surgical curriculum to magnify the impact of positive rural work exposure for Trainees.

The project aligns with the one of the recommendations in the 'Train for Rural' chapter of RACS Rural Health Equity Strategic Action Plan (https://bit.ly/3QpSXxK). Funding of this study was provided by the Australian Government Department of Health Specialist Training Program.

One of the key challenges identified during the research process of working rurally was the unique nature of rural relationships and how this may impact judgement and clinical decision-making. Surgeons and Trainees in rural environments often develop both professional and social relationships with patients, colleagues, and local communities. The line between professional and social relationships may be less distinct than those formed in urban healthcare systems. Relationships between local practitioners, medical staff, and patients and their families are also often closer than those in urban settings.

There are scenarios where rural surgeons will have to treat members of the community that are within their social circle. Additionally, a Fellow may need to manage staff members, such as nurses, who may know the individual going in for emergency surgery. Boundaries surrounding these professional interactions can be complex and have the potential for both positive and negative effects on a surgeon's mental health and wellbeing.

There are fewer healthcare personnel in rural settings and rural Fellows may be sole practitioners within a particular area of expertise. There may be no surgical technicians in the area, meaning the surgeon will have more responsibility during an operation. Additionally, healthcare personnel may also have multiple roles (e.g., GP anaesthetists) that can impact on the team's ability to safely treat or manage some patient conditions. The impact of any individual is likely to be greater in a small team, which may start to take its toll on an individual.

This can also have a flow-on effect as there may be a lack of staff available to replace a surgeon or Trainee if they travel away from the rural setting. It should be noted that this also has its benefits, as there was a greater opportunity to learn new skills in the surgeon's specialty, as well as in leadership and administration. These skills are desirable in both rural and urban settings.

Despite the unique challenges, RACS spoke with many rural surgeons throughout the research process, and everyone spoke highly of their place of work. They highlighted that they have a real opportunity to make a change for the better in their local community and form strong personal and professional relationships with members of their healthcare team.

EQUITY IN SURGERY

Call for Abstracts Now Open

RACS 91ST ANNUAL SCIENTIFIC CONGRESS

1 – 5 May 2023

Adelaide Convention Centre,
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Royal Australasian College of Surgeons

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RACS 91ST ANNUAL SCIENTIFIC CONGRESS

1 – 5 May 2023

Adelaide Convention Centre, Adelaide, Australia

ABSTRACT SUBMISSIONS

ABSTRACT SUBMISSION WILL BE ENTIRELY BY ELECTRONIC MEANS.

This is accessed from the Annual Scientific Congress website: asc.surgeons.org by clicking on Abstract Submissions.

Several points require emphasis:

1. Authors of research papers who wish to have their abstracts considered for inclusion in the scientific programs at the ASC must submit their abstract electronically via the online abstract submission form having regard to the closing dates in the Call for Abstracts, the provisional program and on the abstract submission site. **Abstracts submitted after the closing date will not be considered.**
2. The title should be brief and explicit.
3. Research papers should follow the format: Purpose, Methodology, Results and Conclusion. Non-scientific papers, for example, Education, History, Military, Medico-legal, may understandably depart from the above. Surgical History authors are advised to check some additional advice on the Surgical History page of the College website.
4. Excluding title, authors (full given first name and family name) and institution, the abstract must not exceed 1,750 characters and spaces (approximately 250 words). In Microsoft Word, this count can be determined from the 'Review' menu. Any references must be included in this allowance. If you exceed this limit, the excess text will NOT be captured in the submission or appear in the Australian and New Zealand Journal of Surgery.
5. Abbreviations should be used only in common terms. For uncommon terms, the abbreviation should be given in brackets after the first full use of the word.
6. Presentations (slide and video) will only have electronic PowerPoint support. Audio visual instructions will be included in correspondence sent to all successful authors.
7. Authors submitting research papers have a choice of two sections under which their abstract can be considered. Submissions are invited to any of the specialtie s or special interest groups participating in the program except cross-discipline.
8. A 100-word CV is required from each presenter to facilitate their introduction by the chair.
9. The timing (presentation and discussion) of all papers and posters is at the discretion of each Section Convener. Notification of the timing of presentations will appear in correspondence sent to all successful authors.
10. Tables, diagrams, graphs, etc. CANNOT be accepted in the abstract submission. This is due to the limitations of the computer software program.
11. Authors must be registrants at the Congress to present, and for their abstract to appear in the publications, on the website or Virtual Congress.

RESEARCH PRIZES

Please indicate on the abstract submission site if you want your abstract considered for a research prize. Each abstract may only be submitted for one prize and it is the author's responsibility to ensure they conform to any preconditions (e.g. only open to trainees). Section Conveners will select the best abstracts for presentation to be adjudicated. The awarding of a prize is at the discretion of the adjudication panel.

BEST CLINICAL RESEARCH PAPER PRIZE

- The Professor Mark Smithers Award for clinical research for oesophagogastric or bariatric surgery
- Grantley Gill Breast Surgery Research Prize
- Cardiothoracic Surgery
- Colorectal Surgery: The Mark Killingback prize for the best paper from a Trainee or Fellow within five years of gaining the FRACS
- Endocrine Surgery: The Tom Reeve Prize – Trainees
- General Surgery
- Global Health
- HPB Surgery
- Indigenous Health
- Medico-legal
- Military Surgery
- Neurosurgery
- Otolaryngology Head & Neck Surgery
- Paediatric Surgery
- Pain Medicine & Surgery
- Plastic & Reconstructive Surgery
- Rural Surgery
- Surgical Oncology
- Transplantation Surgery
- Trauma Surgery (Damian McMahon Prize for Trainees)

BEST NON-CLINICAL PAPER PRIZE

- The Leslie Nathanson Award for translational research and/or innovation in the field of oesophago gastric or hepato-pancreato-biliary surgery
- Quality and Safety in Surgical Practice
- Surgical Leaders
- Jenepher Martin Surgical Education Research Prize
- Surgical History
- Women in Surgery

BEST PAPER PRIZE

- ANZ Chapter of the ACS Scientific Forum Best Paper Prize (for clinical and non-clinical)

The submitting author of an abstract will ALWAYS receive email confirmation of receipt of the abstract into the submission site. If you do not receive a confirmation email within 24 hours, it may mean the abstract has not been received. In this instance, please email the ASC team at the Royal Australasian College of Surgeons to determine why a confirmation email has not been received. E: asc.registration@surgeons.org

IMPORTANT INFORMATION

TO SUBMIT AN ABSTRACT GO TO asc.surgeons.org AND CLICK ON 'ABSTRACT SUBMISSIONS'.

THE CLOSING DATE FOR ALL SCIENTIFIC PAPER ABSTRACT SUBMISSIONS IS 8:00AM FRIDAY 27 JANUARY 2023.

PLEASE NOTE THAT PAPER OR FACSIMILE COPIES WILL NOT BE ACCEPTED, NOR WILL ABSTRACTS BE SUBMITTED BY COLLEGE STAFF ON BEHALF OF AUTHORS. If there are any difficulties regarding this process please contact the ASC team for assistance.

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SCIENTIFIC POSTERS

All posters will be presented electronically during the Congress and will be available for viewing on plasma screens in the industry exhibition. Posters will be placed on the Virtual Congress in addition to the abstract.

IMPORTANT DATES

Abstract Submission opens	October 2022
Closure of Abstracts	8:00AM Friday 27 January 2023
Closure of Early Registration	Sunday 19 March 2023

RACS ASC 2023 SECTION CONVENERS AND VISITORS

Correct at time of preparation (September 2022). May be subject to change.

Section	Convener	ASC Visitor	City/Country
Bariatric Surgery	Dr Jacob Chisholm		
Breast Surgery	Dr Janne Bingham Dr Subhita Prasannan	Associate Professor Shelley Potter Professor Cicero Urban Associate Professor Oluwadamilola "Lola" Fayanju	Bristol, UK Curitiba, Brazil Philadelphia, USA
Cardiothoracic Surgery	Professor Jayme Bennetts Dr Greg Rice	Professor Chris Malaisrie Dr Joseph Phillips	Chicago, USA Lebanon, USA
Colorectal Surgery	Dr Tiong Cheng Sia Associate Professor Tarik Sammour	Dr Miranda Kusters Dr James Ngu Chi Yong	Amsterdam, the Netherlands Singapore
Endocrine Surgery	Dr Andrew Kiu Dr Leong Tiong	Dr Jessica Gosnell Dr Abdullah Noor Hisham	San Francisco, USA Putrajaya, Malaysia
General Surgery	Dr George Barreto Dr Chris Lauder	Professor Kjetil Søreide	Stavanger, Norway
Global Health	Dr Mark Moore Professor Suren Krishnan	Dr Kiki Maoate Dr Ifereimi Waqainabete	Christchurch Suva, Fiji
HPB Surgery	Dr Eu Ling Neo Dr John Chen		
Indigenous Health	Professor Kelvin Kong Dr Maxine Ronald		
Medico-legal	Dr Orso Osti	Associate Professor David Cherry	Adelaide
Military Surgery	Dr Abhilash Chandra Associate Professor Brendon Coventry	Colonel Wylan Peterson	Corpus Christi, USA
Neurosurgery	Dr Catherine Cartwright Associate Professor Andrew Zacest	Professor James Rutka	Toronto, Canada

Section	Convener	ASC Visitor	City/Country
Otolaryngology Head & Neck Surgery	Dr Andrew Foreman	Dr Eric Moore	Rochester, USA
Paediatric Surgery	Dr Sanjeev Khurana	Professor Mark Davenport	London, UK
Pain Medicine & Surgery	Associate Professor Andrew Zacest	Professor Kim Burchiel	Portland, USA
Plastic and Reconstructive Surgery	Dr Nicholas Marshall Dr Vani Prasad Atluri	Dr Edward Buchel Dr Lay-Hooi Lim	Winnipeg, Canada Penang, Malaysia
Quality & Safety in Surgical Practice	Dr Andrew Luck Dr Iain Skinner		
Rural Surgery	Dr Chetan Pradhan Associate Professor Mahiban Thomas	Dr Jesudian Gnanaraj	Tiruchirappalli, India
Senior Surgeons Program	Associate Professor Rob Atkinson	Dr Cherie Holmes	New Hampshire, USA
Surgical Education	Dr Gavin Nimon Dr Robert Whitfield Associate Professor Peter Smitham	Dr Lisa Hadfield-Law	Charlbury, UK
Surgical History	Dr Richard Hamilton Dr Philip Game	Associate Professor Susan Neuhaus	Adelaide
Surgical Leaders	Dr Trevor Collinson Dr Markus Trochsler	Professor Simon Paterson-Brown	Edingburh, UK
Surgical Oncology	Dr Richard Smith Dr Robert Whitfield	Dr Myles Smith	London, UK
Trainee Association	Dr Angie Arnold Dr Hoang Ha		
Transplantation Surgery	Dr Santosh Olakkengil	Dr Philip Thomas	McAllen, USA
Trauma Surgery	Dr Shivangi Jog Associate Professor Joseph Dawson	Dr Martin Griffiths	London, UK
Upper GI Surgery	Dr Conrad Stranz Dr Harsh Kanhere	Dr Suzanne Gisbertz	Amsterdam, the Netherlands
Women in Surgery Program	Dr Catherine Cartwright Dr Sonja Latzel		
Younger Fellows Program	Dr Philip Britten-Jones		

*Please check the website **asc.surgeons.org** for the most up to date information.*

A surgeon's experience of natural disaster

Dr Sally Butchers is a general surgeon based in the flood ravaged town of Lismore in New South Wales.

"It's been particularly tough for the whole community including the medical services," she said. "We lost five weeks of elective surgery due to increased emergency surgery related to the floods, and on top of that we are now dealing with staff shortages due to COVID-19."

Dr Butchers described the causes of the cumulative strain on health services as hospitals and staff have had to adapt in emergency situations.

Both private and public hospitals in Lismore lost power and had to fall back on generators. Patients in Ballina Hospital were evacuated to makeshift evacuation centres. Patients from towns that were cut off by water were transported by helicopter. Casino Hospital became the designated COVID-19 response hospital for evacuees.

"Everyone in the community was doing all they could," Dr Butchers said. "Our head of department was ferrying drugs and equipment to various evacuation centres. Some of us were doing triage with GPs. Our Trainees helped at the evacuation centres as well."

Hospitals were faced with the dilemma of releasing people who have nowhere to go because their homes had been destroyed.

Dr Butchers had two weeks' break when she extended her leave to attend the Provincial Surgeons Annual Scientific Conference held in Mackay.

"It was amazing to be able to get away—even though you have to work so hard to get away—and then you work equally hard to catch up when you return. But it enabled me to come back with a different perspective, which helped to handle the frustrations around what we're experiencing.

"It would have been interesting to see what services like Australian Medical Assistance Teams (AUSMAT) could have achieved if they had been deployed," she said. "Our capacity to treat people was limited because we didn't have spaces and equipment to care for people nor did we have accommodation for emergency staff. I would like to see the emergency infrastructure requirements addressed better in disaster zones."

> Dr Butchers said there is good recognition by many heads of department around the dangers of burnout and the need for staff to be able to take time off to prevent or alleviate exhaustion. Like many colleagues across the country working in hospitals that continue to be impacted by COVID-19, Dr Butchers has not had a proper break for a long time.

The emotional toll has been high. It's difficult for Dr Butchers to see her community suffering such devastation, particularly when it was that sense of community that attracted her to Lismore to live and work as a surgeon, and where she is feels so much connection.

In 2019 Dr Butchers coordinated the Lismore Dance for Cancer fundraiser. It included a wide range of activities benefiting local businesses and creating opportunities for people to come together for fun. More recently the junior doctors and medical staff raised and donated money to flood victims.

"Surgeons are people who like to fix things." Dr Butchers said, "So it's really hard when we want to fix the problem, but we can't, because there are issues outside our control."

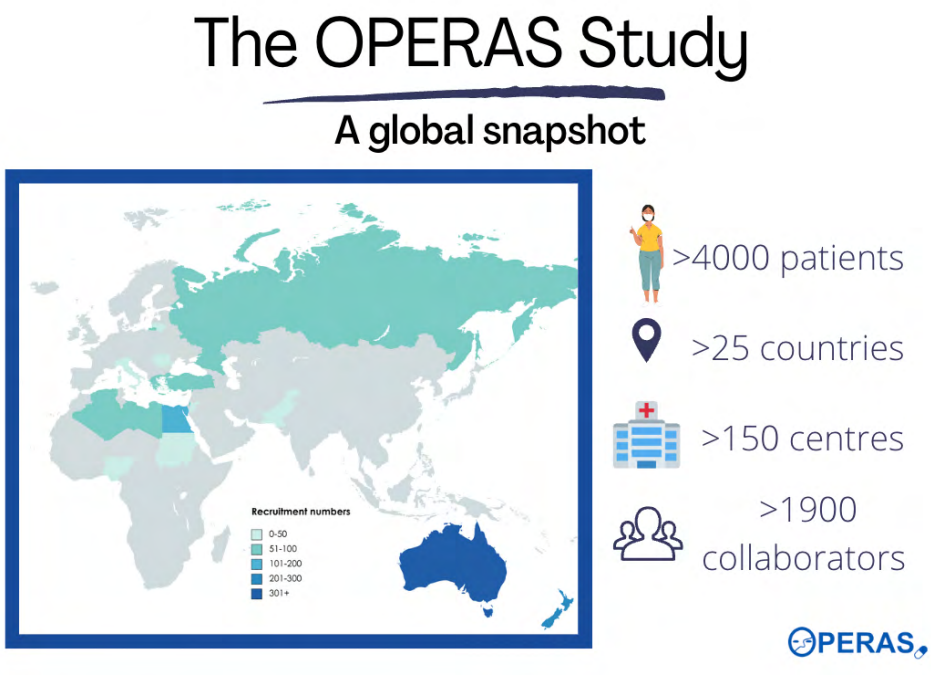
Dr Butchers' sense of community extends to other professional participation. She has been the chair of the Rural Section of RACS and a member of the New South Wales State Committee. She is currently the president of General Surgeons Australia and a member of the Rural Health Equity Steering Committee.

"I don't feel any impediments to me being part of the medical community even though I am separated by distance," Dr Butchers said. "Since COVID-19 it's been even easier meeting online with colleagues."

Dr Sally Butchers

Teaching as a RACS instructor on Early Management of Severe Trauma and Management of Surgical Emergencies (MOSES) courses gives Dr Butchers great satisfaction passing on the skills and structured approach she learned as a junior doctor. She feels privileged being able to meet, teach and also learn from her students who attend from other faculties and says it helps her refresh her skills.

She hopes that over time more surgeons and medical staff will be persuaded to move into regional Australia. "Everyone deserves to have access to surgical services as close to home as possible and—natural disasters aside—the community and the lifestyle I have here is incredible. I couldn't recommend it highly enough."



Update on OPERAS

The RACS Clinical Trials Australia and New Zealand (CTANZ) conducted an interview with the Trial Steering Committee on the OPERAS program.

The Opioid PrEscRiptions and Usage After Surgery (OPERAS) is the first Australian and Aotearoa New Zealand medical student designed and led international study by the Trials and Audits in Surgery by Medical Students in Australia and New Zealand (TASMAN) Collaborative.

Any changes to clinical practice should be underpinned and supported by robust clinical data. This is achieved through research driven by well-designed studies that emphasise patient recruitment from large and diverse populations.

The OPERAS collaboration exemplifies how such data required to drive changes in clinical practice can be attained. It represents the culmination of diligent and meticulous planning across 18 months by the research arm of the Australasian Students Surgical Association (ASSA) and the TASMAN Collaborative.

ASSA, through the TASMAN network, brings together university medical school surgical students groups, and impressively developed and delivered their first Australian and Aotearoa New Zealand student designed and led international study.

The primary aim of OPERAS is to quantify the amount of opiate medication prescribed at hospital discharge after surgery and identify the proportion of opiate medication consumed by patients by seven days post-discharge.

Secondary aims include describing variation in prescribing and consumption of opioids across specialties, quantifying the impact of opioid prescriptions on patient-reported outcomes, identifying risk factors for opioid consumption and over-prescription, and identifying the duration of opioid use after discharge.

After extensive project planning and preparation, the study launched in April 2022 and now, four months later, more than 4000 patients have been enrolled by 155 participating institutions across 26 countries.

These impressive results have been achieved by a large data collection team—coordinated by the Trial Steering Committee that includes Aya Basam (Monash University), Lorane Gaborit (Australian National University), Chris Varghese (University of Auckland) and William Xu (University of Auckland).

We asked Trial Steering Committee (TSC) representatives Aya, Chris, William and Lorane to elaborate on the study.

CTANZ: What was the impetus for TASMAN to launch and undertake this study?

TSC: Emerging pilot data from New South Wales corroborates a body of literature suggesting opioids are over-prescribed following common general surgical procedures. Given the context of a global opioid crisis, we thought it would be important to capture a global snapshot of current prescribing practices and patient reported outcomes after discharge to inform future guidelines and optimise opioid prescribing practice.

Without the real-world data on opioid prescription, actual consumption of prescribed opioids and records of the expectations of patients, it is difficult to change practice and mitigate opioid-related harm, while also ensuring adequate post-discharge analgesia for patients.

CTANZ: What do you hope to achieve for yourself and your collaborators?

TSC: The goals of OPERAS parallels that of the TASMAN Collaborative, and we hope to deliver valuable data to impact clinical practice and ultimately improve outcomes for our patients.

As a student and Trainee-led collaborative, our secondary goals are to upskill and foster a rich research skillset among early career researchers across Australia and Aotearoa New Zealand in an accessible and meaningful way.

CTANZ: What challenges did you encounter and how did you solve the problem?

TSC: OPERAS is a global project with 155 centres participating from 26 countries. It has taken a lot of teamwork, camaraderie and support to facilitate such a large study, which includes navigating the heterogenous research approval landscapes around the world.

We were able to do this because of the diversity in collaborator skillsets and familiarity with collaborative research. This meant we could troubleshoot individual problems and facilitate maximum global engagement.

CTANZ: What did you learn about yourself and what skills did you acquire from being an organiser of this study?

TSC: From its conception, OPERAS has ultimately been a test of our ability to remain oriented to the fundamental goals of the study, including the goals of TASMAN, while navigating the responsibilities of managing such a large study with so many moving parts.

The ability to efficiently prioritise and allocate tasks has been crucial to this endeavour. It has allowed us to maintain communication with the different parties involved in OPERAS, while remaining a cohesive central team with a shared understanding of where the study is headed.

We have gained a deeper insight into the intricacies of running a global study. In the collaborative environment we developed our problem solving skills and worked as a team by troubleshooting the difficulties that have arisen over the course of the study.

CTANZ: How did you manage your time between studies, training and driving the project in your role as team leaders?

TSC: It's always a challenge to manage research during your medical career. The secret lies in the name—collaboration. Such large scale studies cannot be managed by an individual—having a hardworking team willing to chip in is crucial to a successful study outcome.

A collaborative study is made up of numerous spinning plates and it takes a team to keep the plates spinning. Regular meetings meant we were able to keep abreast of where everyone was at and have a high-level overview of the progress being made among the different parts of the project.

From an organisational perspective, the key drivers of success from a time management point of view were assigning key roles and responsibilities, empowering people to take ownership of tasks, playing to individuals' strengths, and facilitating shared responsibilities. Appreciating the ebbs and flows of the academic year—where individuals are busy and when people have more capacity—was integral to making sure all members of the steering committee were supported.

CTANZ: With the benefit of hindsight, what advice would you give yourself if you had to start this study again from scratch?

TSC: There are a couple of key lessons that we have learned, which we would relay to our past selves. First, seek critical feedback as early as possible at every opportunity, especially from as many external sources as possible. This would have alerted us to recognise some points for improvement sooner and reduced the logistical burden of implementing these improvements further down the track.

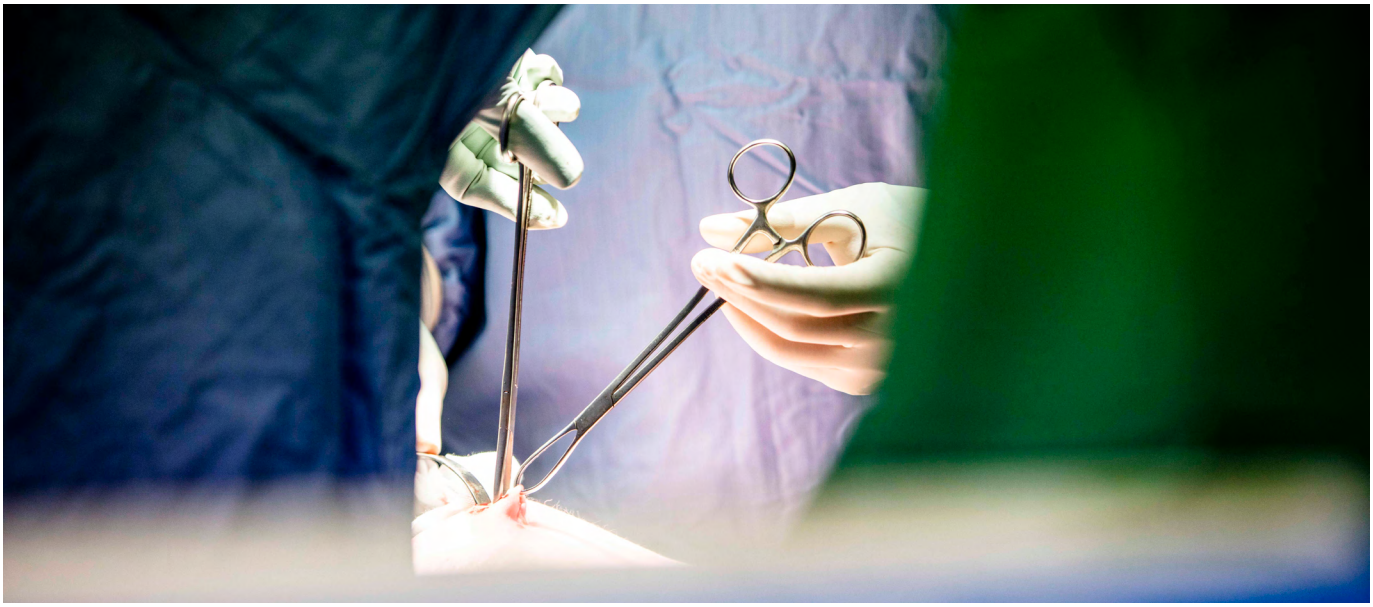
Second, ensure that the entire study team is unified in its goals and direction from day one, and carry that overarching aim through the entire study. Making sure you have a clear timeline from the start will help safeguard that key milestones are met and momentum is maintained.

Finally, being aware of the immense value of collaborating with other established regional networks to further drive study dissemination, recruitment, approvals, and delivery. Earlier identification of network leads would have been beneficial to extend the reach of OPERAS, and to build the relationship between TASMAN and these networks.

The OPERAS study guided by a medical student/JMO-led Trial Steering Committee includes 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).

University of Newcastle, the Maurice and Phyllis Paykel Trust, and the Hunter Medical Research Institute in NSW, provided project sponsorship, financial aid, professional support services and database capability. Kristy Atherton (University of Newcastle), 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) provided supervision and specialist clinical and trial expertise to the Trial Steering Committee.

Contributors: Aya Basam, Lorane Gaborit, Chris Varghese, William Xu.



Surgical mortality audits: close the loop

The Australian and New Zealand Audit of Surgical Mortality (ANZASM) has implemented a new process to help close the loop on preventable clinical management issues (PCMIs). It is important to outline this new process and highlight its benefits relating to second-line assessment (SLA) reports.

ANZASM facilitates the independent review of in-hospital surgical mortality data. Importantly, ANZASM is a quality assurance activity covered by Commonwealth Qualified Privilege (QP) under Part VC of the Health Insurance Act 1973 (gazetted 24 April 2022). All ANZASM processes are covered under QP and are non-punitive.

ANZASM's new process involves the treating surgeon completing a PCMI form. When an audit assessor identifies a PCMI, the treating surgeon receives a PCMI form along with the assessor's feedback.

The PCMI form asks the following questions:

- Was this case discussed at a hospital morbidity and mortality meeting?
- Have any changes or improvements been implemented from reviewing this case?
- What hospital-based changes or improvements have resulted from these implementations?
- Have you changed or improved your surgical practice or care?
- Were the peer-review assessments informative?
- Was the peer-review feedback a good source of information to improve surgical care?
- Has peer-review helped you to reflect critically on your practice?

Submission of completed PCMI forms may count towards the 'Peer Review - Performance of Self' component of RACS continuing professional development program.

The aim of this process is to determine how and if ANZASM's peer-review feedback is improving processes, patient care and surgical practice generally. PCMI data will be aggregated and de-identified to help inform recommendations for quality improvement initiatives. The aggregated, de-identified data will be reported to relevant health departments, demonstrating the role of peer-review feedback and the impact it has on improving patient care. The PCMI process also gives surgeons the opportunity to identify and change processes to ensure that the identified PCMI does not occur in the future.

In the following SLA audit report, the second-line assessor highlights two PCMIs. The response from the treating surgeon to these PCMIs follows the report.

Management delay in a patient with sub-capital fracture of the femur

Case summary

An 89-year-old male was brought to the emergency department (ED) by ambulance services and admitted to hospital after an unwitnessed fall two days before. He was unable to recall the fall event. There was evidence of delirium, dehydration, urinary incontinence, and poor hygiene. He also had multiple skin tears and abrasions. He was unable to follow commands. His medical history included visual impairment of unknown duration. He had a history of multiple falls and had presented eight months earlier after a fall.

Clinical examination included contracture of all four limbs. The right lower limb was warm to touch and erythematous. There was bilateral pitting ankle oedema.

Chest X-ray and CT scan of the brain and cervical spine were performed in the ED to rule out intracranial pathology, cervical spine fracture, sepsis, cellulitis and acute kidney injury. The ED notes state the patient was 'not tender over the pelvis, leg and greater trochanter'. The pelvic X-ray was reported as 'rotated'. The radiology

report of the X-ray of the pelvis and left hip documents that the left hip joint was 'end-located'. The patient was rotated, significantly limiting evaluation of the left hip on the frontal view. While no definite displacement was identified, CT should have been considered if there is ongoing clinical concern.

The patient was admitted to the medical ward. On the day of admission, the orthopaedic consultation did not mention the pelvis or left hip. The consultation concentrated on the forearm laceration. A formal washout of the forearm wound was planned.

On day one post-admission, an orthopaedic review had the patient booked for surgical debridement. The anaesthetic review noted the patient was high-risk for general anaesthesia.

On day three post-admission, surgery was planned for when the patient was medically optimised. After orthopaedic review, it was considered the patient was not medically ready for surgery. Physiotherapy review determined the patient had pain in his hips with turns. His confusion meant he was unable to mobilise without assistance. Medical and physiotherapy reviews highlighted concerns regarding external rotation of the left hip. The X-ray performed in the ED was poor quality for assessment of the left hip. X-ray of the right hip showed no abnormalities. Sacral and left hip pressure injuries were noted. The patient was unable to internally rotate the left hip and there was tenderness on attempt at hip flexion.

On day seven post-admission, X-ray of the left hip showed an impacted fracture of the femoral neck on the left with surrounding soft tissue swelling. There was no mention in the medical records of this X-ray being reviewed until day 10 post-admission.

On day 10 post-admission, the physiotherapy review stated that the X-ray was reviewed on the radiology reporting system but not reported due to the long weekend: 'X-ray reports impacted fracture left femoral neck. For orthopaedic review.'

The orthopaedic review on day 10 post-admission stated: 'This will be discussed with consultant. Patient will likely require hemiarthroplasty.' Hemiarthroplasty of the left hip was performed on day 11 post-admission.

On day 19 post-admission, the patient was transferred to palliative care for symptom management and end-of-life care in the context of progression of his underlying disease (delirium, loss of vision, urinary incontinence). He passed away the next day.

The main issues from this case include:

- lack of consultant assessment
  - of pelvic X-rays performed on the day of admission
  - of pelvic X-rays performed on day seven post-admission
  - of pelvic X-rays for three days after they were performed
- communication between the orthopaedic and general medicine teams.

Clinical lesson

This case highlights the importance of communication between the medical team and the orthopaedic team. Criteria for hip fracture management are well documented and best outcomes follow early diagnosis with appropriate management.

The treating surgeon's responses to ANZASM's new PCMI process is outlined below, relating to the SLA report above.

The treating surgeon was sent a PCMI form, which noted two PCMIs:

1. communication between the orthopaedic and general medicine teams
2. delay to surgery

The response of the treating surgeon was as follows (reproduced with permission):

'It was discussed at length at the Morbidity and Mortality meeting. It was also noted that a thorough review by the initial treating medical officer would have indicated a review and consultation with a senior doctor and that would have been beneficial in this instance. A formal hospital review was undertaken. We also noted the communication issue between orthopaedic and general medicine teams, leading to a delay in surgery.'

The treating surgeon further commented:

'We had highlighted the time pressures experienced by junior staff in assessing acute trauma patients. We have subsequently requested, through senior management streams, that we employ a further medical officer such that workload pressures are less of an issue and there is sufficient time to see and assess acute patients more thoroughly so cases such as this are not missed, as a full history, review, examination and review of X-rays can be undertaken in the form of a full secondary survey.

We also keep a list of patients under other or medical teams who have required a 'consult' from orthopaedics on the daily orthopaedic handover list. These patients and their imaging results are now reviewed each morning by the post-take orthopaedic consultant on call. Any outstanding issues then remain on this handover sheet until actioned and the patient no longer requires orthopaedic review or is discharged.

This case highlighted to each consultant and junior the importance of reviewing the patient holistically and reviewing all imaging, even if it is not specifically handed over by other practitioners. The handover process has been changed to reflect this.

In this particular case, we were able to review and reflect on similar areas where patient care could have been improved. It is useful to have a peer review confirm findings and identify areas for improvement.'

This SLA report and the completion of the accompanying PCMI form clearly demonstrate the impact the audit has on improving patient care and processes.

Although the PCMI form is neither mandatory nor punitive, the audit encourages all surgeons to complete and submit their PCMI forms. Completed forms contain valuable insights and information.

Professor Guy Maddern, Chair, ANZASM

Tristate ASM: Associate Professor Mary Theophilus, Dr Cathy Ferguson and Dr Paul Bumbak

Annual scientific meetings - highlights

August was a busy month for many RACS state and territory offices, with several jurisdictions hosting their local annual scientific meetings (ASM). These meetings typically include a variety of high-quality presentations relevant to surgeons, irrespective of specialty. Equally important is the opportunity for participants to network with colleagues—often in pleasant surroundings.

The College would like to thank the local chair conveners and staff who put a significant amount of effort into sorting through abstracts, lining up speakers of interest, finding sponsorship and ensuring the events ran smoothly.

Below is a brief summary of the scientific meetings that were held across Australia.

South Australia, Western Australia, Northern Territory tristate ASM

'Artificial Intelligence in Surgery - Superpower or Peril'? was the theme, as surgeons from South Australia, Western Australia, and the Northern Territory gathered in the Barossa Valley for the tristate scientific meeting.

At the event, which took place from 25 to 27 August, RACS South Australia chair, Associate Professor Amal Amou-Hamden's presentation provided a unique opportunity to explore the current use of artificial intelligence (AI) in surgery. This included the future of its integration in surgical practice, as well as an analysis of what has been learned from the implementation of past innovations.

A common theme over the two days was that AI and other computer-aided technologies are transforming our surgical practice by augmenting human intelligence. This has the potential to replace the traditional human techniques in many surgical disciplines. However, as well as being revolutionary, change of this magnitude can also be disruptive and daunting, and there are many pitfalls that must be considered as part of this change process.

Highlights of the conference included:

- A presentation from South Australia's chief scientist, Professor Caroline McMillen AO, discussing Machine Learning and advanced technological applications.

- The Sir Henry Windsor Lecture delivered by inspirational surgeon Emeritus Professor Bill Gibson AO. Emeritus Professor Gibson is the founder and past director of The Sydney Cochlear Implant Centres (SCIC)—recently rebranded as Nextsense Cochlear Implant Centres. His moving presentation received a standing ovation and there were very few dry eyes left in the house.

- An exploration of the links between AI in surgery and local industry, particularly the wine industry for which the region is famous.

- The Sir Henry Newland Award, which was presented at the conference dinner to distinguished South Australian surgeon, Dr Tim Proudman.

ACT ASM

Artificial intelligence was also a strong theme throughout the ACT scientific meeting, which centred around the theme of 'Role of the Surgeon into the Future'. In addition to this, the conference also explored the sub-themes of environmental stewardship and our climate change responsibilities within a clinical realm.

Throughout the day delegates examined the carbon footprint of the health sector in Australia, which accounts for seven per

Tristate ASM: Professor Deborah Bailey, Mrs Jaqui Sparnon and Dr Rebecca Cooksey

Tristate ASM: Dr Michael Cusack, CMO, SA Health

Tristate ASM: Associate Professor Amal Abou-Hamden with Maggie Beer

Dr Sally Langley opening the ACT ASM

Dr Phillip Whiley presenting at ACT ASM

Dr Sharon Chih Lin Lee presenting at the ACT ASM

Dr Michelle Atkinson, orthopeadic surgeon and RACS NSW Chair presenting at the ACT ASM

ACT ASM co-convenors Dr Sandra Krishnan and Dr Adrian Fernandez

cent of our nationwide carbon emissions. It is estimated that hospitals contribute half of this and more specifically, the operating theatre generates up to 30 per cent of an institution's waste. While this poses many challenges, the presenters throughout the day highlighted the opportunities this also poses to change behaviours and shape policies in surgical practice.

In addition to the already high calibre of speakers, the line-up was further strengthened with the last-minute addition to the program of Senator David Pocock. He was elected in May as the first independent senator representing the ACT, where he ran on a largely pro-climate agenda. His presence at the meeting demonstrated a strong commitment to working with local surgeons and medical professionals to deliver practical solutions for health and the environment.

The 2022 meeting was a both an in-person and hybrid event as COVID-19 disruptions emerged. The event was well supported by the local membership with total participation over the day reaching 80 in person, with 31 delegates attending the event virtually.

Tasmanian ASM

On Saturday 13 August 2022, the Tasmanian RACS State Committee hosted their ASM at Aura in Hobart.

The theme of this year's meeting was the 'Humanitarian Surgeon'. We heard from exceptional speakers who gave their insight into providing surgical care in countries that have very limited resources. Clinical Professor Nitin Verma presented on the East Timor Humanitarian Service Provision and Dr Adam Mahoney spoke about the humanitarian experience with a military focus.

Dr Billie Saykao gave an overview on the work she does with Care for Africa (with her counterpart Diana Butler zooming in from Tanzania at 4.00am) and Dr Gausihi Sivarajah shared stories of her incredible work in the South Pacific.

The meeting allowed the participants to consider the possible opportunities for humanitarian work and share their own experiences with their colleagues. The day was a huge success and on close of the meeting, participants reconvened at the Tasman Hotel, for a Foundation for Surgery dinner, raising much needed funds for the foundation.

Images (from top): Dr Adam Mahoney and Dr Billie Saykao.

The easiest way you can support safe surgery today: share your thoughts!

Your views are important to us.

You would have received a survey in your mailbox. The survey will only take a few minutes to complete, but will help make a lifetime of difference. So please, complete and return it using the reply-paid envelope, and show your support for accessible, safe, and quality surgical care today.

Your feedback will help us improve and work harder than ever toward critical Indigenous health, global health, and research projects, now and into the future.

For more information on the Foundation for Surgery, please visit surgeons.org/foundation-for-surgery or email our team at foundation@surgeons.org.

Advocacy at RACS

RACS has a strong history of advocacy across Australia and Aotearoa New Zealand.

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

MBS Review Advisory Committee - Surgical Assistant Working Group Draft Report

RACS has welcomed the opportunity to provide comment on the Surgical Assistant Working Group Draft Final Report. Our comments included:

- Surgeons are best placed to determine who can surgically assist with reference on the complexity of the procedure, the assistant's level of competence and available local workforce.
- RACS recommends that non-medical surgical assistants, with the appropriate training and experience, can be used in settings where there is a limited pool of medically trained surgical assistants, especially in the rural, regional and remote settings. Non-medical surgical assistants are registered nurses, perioperative nurse surgical assistants and nurse practitioners, who have appropriate training and experience in surgical assisting.
- Expanding MBS eligibility to non-medical surgical assistants, with appropriate training and experience is important to equity for rural patients and rural surgeons' financial sustainability.
- Current highly experienced, rural, non-medical surgical assistants can be recognised by a legacy clause as part of the MBS eligibility. Any formal Masters' qualification should not be onerous for rural health services to support their nurses through.
- RACS is best placed to define what constitutes adequate past experience and adequate training for a nurse surgical assistant. This should be determined before implementation of any MBS changes.
- RACS can play a significant role in developing training, accreditation and credentialing of non-medical surgical assistance education programs with funding from government.

Medibank meeting

RACS met with Medibank Private to discuss ongoing topical issues. It was noted that Private Healthcare Australia are calling for an urgent review of the process by which private hospitals are accredited and declared eligible to receive health fund benefits considering allegations in the media about inferior quality and safety in the cosmetic surgery sector. This would impact the health funds' obligation to pay claims with a Medicare Benefits item number that occur in these facilities– regardless of the quality, safety and appropriateness of the services performed.

Concurrently, Ahpra have proposed an 'endorsement' pathway for practitioners seeking to perform cosmetic procedures. Medibank Private continues to advance the proposal for a joint data project with RACS. They seek an initial in-principal support to sign a memorandum of understanding between RACS and Medibank to undertake a data discovery project to review Medibank data where RACS would provide clinical insights.

Canberra meetings

We met with the Department of Health (Health Resourcing, Medical Benefits DIV, MBD Private Health Industry Branch, and PSD National Health Reform Branch), Australian Private Hospitals Association, Consumer Health Forum, and Office of the Minister for International Development and the Pacific.

We also met with the Office of the Federal Assistant Minister for Rural Health and engaged with several other relevant ministerial offices. These meetings were introductory and future meetings will be arranged where necessary.

Environmental Sustainability in Surgical Practice Working Party (ESSPWP)

The ESSPWP met on 12 September. The meeting was attended by RACS CEO John Biviano, RACS Project Manager Travis Dawe, and representatives from Lovell Chen, the architects behind the Melbourne office renovation project. The architects provided a presentation to the group which included sustainability elements that have been incorporated as part of the design.

ESSPWP webinar, 15 September

The Environmental Sustainability in Surgical Practice Working Party (ESSPWP) webinar featured a presentation delivered by Dr Chantelle Rizan, an ENT research fellow at University Hospitals Sussex NHS Foundation Trust. Listen to the recording here: tinyurl.com/4mnfveef

Anti-Racism Working Party

The RACS Anti-Racism Working Party will meet in November with the goal of completing a draft position paper, which highlights on what RACS should do in the advent of alleged racist conduct and consequent reforms and rehabilitation.

We have also been consulting with our Building Respect, Improving Patient Safety Initiative team to help inform our approach.

Letters to Medtronic and Johnson and Johnson

The Environmental Sustainability in Surgical Practice Working Party (ESSPWP) wrote to Medtronic and Johnson and Johnson (J&J) seeking information on the carbon footprint of their stapling products.

The ESSPWP plans to follow Medtronic's advice and write to the Medical Technology Association of Australia.

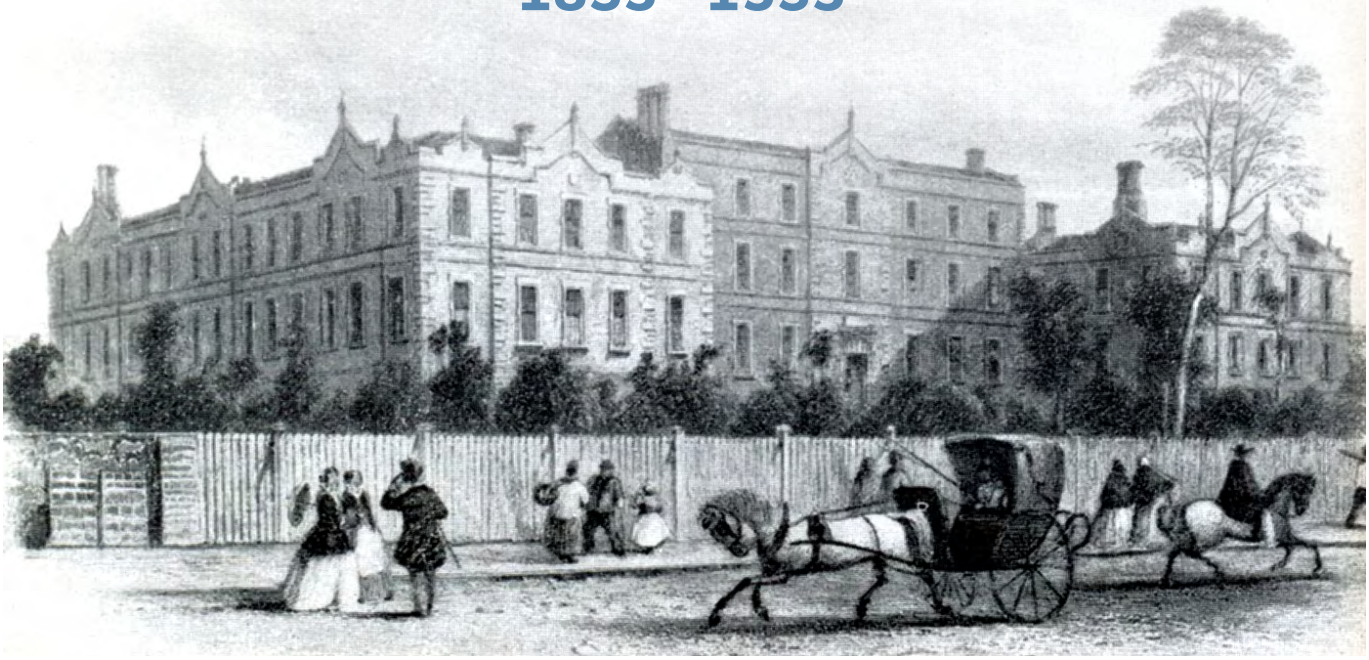
The ESSPWP also received a response from J&J, who facilitated a meeting between their international subsidiary Ethicon and RACS to discuss shared areas of interest regarding sustainability.

United Kingdom Health Alliance on Climate Change

Dr Ken Loi and Dr Ben Dunne represented RACS on the United Kingdom Health Alliance on Climate Change (UKHACC) Green Surgery Oversight Committee. Representatives included several college groups across England and Scotland, the USA and Canada.

The purpose of the larger steering group is to direct a smaller working group to produce an evidence-based guide to being more environmentally sustainable in surgery.

Victoria, a remarkable century:
1835 - 1935



The first Britons to discover Port Phillip were the crew of the Lady Nelson, commanded by John Murray, which entered the bay on 15 February 1802. Murray called the body of water, Port King, after the Governor of New South Wales, Philip Gidley King. On 4 September 1805, King himself formally renamed the bay, Port Phillip, in honour of his predecessor, Arthur Phillip.

Port Phillip was then left mostly undisturbed until June 1835, when settlers from Van Diemen's Land—from 1 January 1856 renamed as Tasmania—led by John Batman and John Pascoe Fawkner, established Melbourne on the lower reaches of the Yarra River. Melbourne is distinguished from the other Australian state capitals in that it was founded, unofficially, by individual enterprise. Once Batman, Fawkner, and others had established the settlement in 1835, the government in Sydney had to accept the fact.

In 1836, Captain William Lonsdale, the first administrator of the Port Phillip District, arrived and in March 1837 the new settlement was given its present name, Melbourne, honouring the then British Prime Minister, William Lamb, Viscount Melbourne. By 1841, the population was more than 20,000. However, its first main surge in growth came in the early 1850s following the discovery of gold near Bendigo and Ballarat, less than 100 miles away.

In three years, the population of Melbourne increased fourfold to 80,000.

In 1839, there were six medical practitioners in Victoria: four in Melbourne, one in Geelong and one in Portland. By 1841, 18 physicians and surgeons lived in Melbourne; in 1865 there were nearly 400 of whom 64 were members of the Medical Society of Victoria. Of the medical graduates in the colony most received their training in the United Kingdom: not all were practising medicine. Many migrated to Victoria in the middle of the 19th century, some coming to look for gold, others seeking a cure for their tuberculosis.

For the first five decades of European settlement in Australia, medical care for convicts and free settlers was provided by the salaried Colonial Medical Service. After the mid-19th century, as population and wealth grew, there was significant professional development based on private practice.

With the rapid increase in population, the need for doctors could not be met by casual migration, and medical schools in Australia became a necessity. The University of Melbourne began teaching medical students in 1862, Sydney in 1863, and Adelaide in 1885. The importance of this initiative was confirmed in February 1927, when of the 41 founders of the College of Surgeons of Australasia, eight of the 10 Victorian signatories, were graduates of the Melbourne Medical School.

The Melbourne Hospital was established as a charitable institution and its foundation stone was laid on 20 March 1846, at the corner of Swanston and Lonsdale Streets. Even in its first years the hospital was not financed wholly by the voluntary gifts of charitable citizens; colonial governments gave it considerable financial aid.

The earliest rules of the hospital said that contributors, in return for their donations, had the right to elect the men who held responsible office. A contributor of £2 each year became a governor, and a donor of £1 annually was called a subscriber. The first six honorary physicians and surgeons to the hospital were appointed without an election, as there were only six applicants.

Doctors in Melbourne realised that practice in the crowded wards of the hospital would give them a richness of experience, which they could not hope to encounter in private practice and would help them become better practitioners. Appointment at the hospital was widely regarded as the best evidence of the doctor's worth, and it helped greatly to build a lucrative private practice.

Accordingly, the practice of soliciting votes became customary: in the press, in handbills, in clubs and by door-to-door canvassing. Candidates for honorary medical office tried to persuade subscribers to vote for them. The struggle for places at the hospital became even more intense later in the 19th century. Controversy led to the Medical Society of Victoria asserting that printed solicitations 'should be as brief and devoid of puff as possible'.

Sir Thomas Fitzgerald said of the system in 1900: 'the mode of electing staff … most seriously embitters our relations with one another'. William Gillbee, after 22 years of service, when he was still a highly skilful surgeon, was defeated in the elections of 1875. Two of the most active Listerians, TM Girdlestone and JH Webb, were removed by subscribers in 1887 and 1891 respectively, when both were active and capable practitioners.

Surgeon William Moore had been an opponent of the electoral system since the 1880s, when he first held office at the hospital. Finally, in 1910 he led a successful campaign for electoral reform, ensuring that the term of medical officers to inpatients be extended from four to at least 15 years. He also suggested that new members of the inpatient staff be chosen, in order of seniority, from the physicians and surgeons to outpatients—the choice was not to lie with subscribers. The only hospitals in Melbourne before 1900 were charitable ones, apart from a few highly expensive private nursing homes.

In 1879, the fees charged by the profession were too high for a large proportion of the population. Private practitioners who accepted the recommendation of the Medical Society charged half a guinea for advice given during the day in their own rooms or within a mile of their residence. They charged an extra guinea for each mile travelled to a patient's home. For consultation at the request of another doctor, two guineas; for setting a fracture: five to 20 guineas; for a major amputation or treatment of hernia: 25-50 guineas.

William Moore's life provides a glimpse into surgical practice of the time. Born in Milton, Brisbane in 1859, the son of a Baptist minister, he had an exemplary path through secondary school. He passed the Senior Public Examination of the University of Sydney before 1876, and then entered the Melbourne Medical School topping his final year in 1883. And just two years later qualified for the MD (Melb) and MS (Melb).

He was immediately appointed to the Melbourne Hospital where he undertook his life's work. His contributions to the Intercolonial Medical Journal of Australia were numerous, including reports on

hydatid disease, popliteal aneurysm, and the performance of prostatectomy under spinal anaesthesia. He championed the introduction of Listerism, especially as it related to safe abdominal surgery.

In 1899, some of his papers were collected and published in a small book entitled *Plastic Surgery*, a term not commonly used until after WWI. His dissections for malignant glands of the neck and for malignant breasts were described as 'works of art', beautifully undertaken.

He was one of the few surgeons with his own hospital and Milton House, was a busy place. His fame was Australia-wide, and he treated many cases sent to him from Queensland and Western Australia; Professor Archibald Watson referred many cases from Adelaide.

Moore was one of the Foundation Fellows of our College in February 1927 and one of three Victorians appointed to the first Credentials Committee—George Syme and Hamilton Russell being the others.

His death from an 'accidental infection', in late 1927, sadly robbed him of the opportunity to attend the opening of our College building in 1935, the year of Victoria's Centenary.

Dr Peter F Burke
FRCS FRACS DHMSA

Images (clockwise from top-left to top-right): Melbourne Hospital 1862; RACS opening of building 4 March 1935; William Moore 1903; John Pascoe Fawkner and natives (Melbourne 1835 Artist William Strutt, Parliament of Victoria).

The medicinal value of gin and tonic and associated royal patronage

I was entertaining some Jesuits from Newman College recently when we had a gustatory meal (as the French say multiple tastes and varieties appropriate for my new status of acquired bachelorhood) and the topic of gin and tonic surfaced in lubricating the conversation. One of this erudite community, Father Dan Madigan, said, "Do you know it is called the Jesuit bark because the missionaries in Peru found the Peruvian Indians consumed the bark of the Chinona tree as a preventative measure against malarial infection?"

Thanks to Father Antonio de la Calancha, who discovered a quinine source in the bark and took it to Europe to the scientific community where it was found that the content of quinine was the important anti-malarial factor. Who would have thought the missionary society of Jesus would have developed into the gin and tonic craze that has spread around the world—from the exclusive clubs in Europe and elsewhere, to the mess camps of the forces as a protection against this infection.

With the emergence of the industrial revolution in England in the 1870s the British empire had a controlling influence over one fifth of the world's dominions, which explains the influence and spread of gin and tonic.

The origin of the word gin – two sources: The Benedictine monks of Salerno, Italy included a recipe for a tonic wine using juniper berries, that grey green conifer berry that adds a taste to the gin. But the Dutch too had a hand in the gin origin as they produced a spirit called Genever. William of Orange on becoming king of England after marrying Mary Queen

of Scots, brought gin from Holland to England where the word Genever became gin.

Cleverly, he put a tax on the French brandies and gave tax breaks for gin spirits produced from corn in stills in focal areas like Southwick. This began the gin craze, which developed into a social problem. Why? The price of gin was cheaper to produce than beer and this accounts for its excess consumption, which Hogarth illustrated in his two cartoons (a sketch as a preamble for a painting) reflecting society's decay.

Now where did the medicinal tonic come from? Schweppes in Geneva produced the world's first carbonated beverages, which led to soft drinks and tonic water as a natural consequence—developed in 1783 to balance the bitterness of the Chinona bark. Clinically, it was named a tonic, like the English gentry taking the waters at Bath, hence the clinical appellation of a tonic.

The plastic surgical team at St George's and Westminster where I worked under Ian Wilson, taught me the art of drinking gin and tonic. He once said, "Son, if you cannot handle three, you're a beginner."

This was also characteristic of the Chelsea set, where he lived—off the Kings Road.

Visiting Ian frequently, I saw Sean Connery regularly perambulating along the commercial boulevard. Once I was invited to the actor John Mills' house in Richmond, and being of the same ilk, gin and tonics flowed lavishly, often more thirst-quenching than champagne on those hot summer days. Incidentally, Ian Wilson had repaired John Mills' hand who was forever grateful and always invited Ian's theatre staff to his parties.

Now the additional royal patronage: the Queen Mother surfaces following in the wake of William of Orange. I have included the illustration of flowers outside Clarence House and a Beefeater bottle —possibly her favourite—and thanks to the SBS Food Show on royal recipes her gin aperitifs featured prominently.

Queen Elizabeth II's beloved mother wasn't afraid to imbibe and started her daily drinking routine before lunch.

Now her Savoy links were interesting.

Often when she had royal commitments later in the afternoon, the chief steward at The Savoy Hotel (illustrated)—on a phone call from the driver—would have a covered glass with ice, with the ratio of two parts Dubonnet and one part gin. This would come out wrapped with lace on a silver tray and the Queen Mother would return to Clarence House at 5.45pm with the driver taking a sluggish—if not longer route home—prolonging her enjoyment before pre-dinner gin martinis at Clarence House commencing at 6pm.

Thanks to that SBS program more facts emerged of the Queen Mother's gin drinking preferences. Once when Queen Elizabeth was having lunch with the Queen Mother in the early part of her career, she said to her daughter, "I would go light on the drinks darling, because you have to govern this afternoon".

You can see I have been tainted by the gin and tonic fraternity in London, but I do prefer my own recipe using the zest of the lemon (thanks to Rick Stein) containing pectin, D-limonene, antioxidants which targets cholesterol. Then I separate the vesicles of lemon juice and individually place them in the glass—giving a long tasty libation, with the clinking of ice in the Georgian glass—adding auditory satisfaction to the drinking experience.

The senior plastic surgeons in Melbourne in the mid-to-late 70s and 80s—Benny Rank, John Hueston, Don Marshall, and John Snell entertained visiting international plastic surgeons at the Melbourne Club. I was invited to join the Melbourne Club by David Kennedy, one of its former presidents—who was my patient—and who said, "Felix you would be a great member here, you're a raconteur with a Hemmingway style of telling stories." But my response was tardy, and the opportunity slipped away and the Groucho Marx quote about exclusive clubs came to mind —yes, "I am a Marxist of the Groucho variety."

A few of these important international plastic surgeon entities spring to mind— William Kerr Lindsay, from Canada, Graham Lister from Kleinert's unit in Louisville, Ian Jackson from the Mayo Clinic and Jack Moustardé of Canniesburn. However, John Hueston was top of the surgical tree from an international recognition point of view. His reputation on the American hand surgical scene was complemented by his European contacts, including Skoog who was the Nordic expert on Dupuytren's—the Viking disease.

The Vikings rowed in their flat bottom boats across the North Sea and the focus of their strength when rowing and the ulnar side of the hand was their power grip—the site for Dupuytren's development. And upon landing in England, Ireland and Scotland, subsequently Celtic immigrants created a focus of Dupuytren's development in Chicago and the Antipodes. This gave John Hueston his local focus, thanks to Archie MacIndoe eventually writing a textbook on Dupuytren's—one of the first—over a weekend.

John also organised an international hand surgical meeting in Melbourne in the late 70s in association with Owen Cole and entertainment at the Melbourne Club (with G and Ts) was part of the social program. I cannot forget the video presentation of John doing a Dupuytren's fasciectomy procedure. It was a clever piece of marksmanship he had the video played on fast forward. The audience were floored by his surgical wizardry and superb surgical technique from the Antipodes. On becoming his assistant doing Dupuytren's in 1974, I asked him how he performed so quickly, and he whispered, "Felix, don't tell anyone but I got them to put the projector on fast forward."

At a political level Michael Long entertained surgical groups at the club asking them to work out a response to the Kennett government plan of amalgamating Melbourne hospitals in a hub and spoke health design. Michael was the political organiser, trying to maintain the status quo to ensure the continuing excellence and independence of Melbourne hospitals including Essendon. I trained at PANCH Hospital and the VPSU unit under Benny Rank, this is now only a memory as Epping is the new PANCH hospital and the old one a Convention Centre. Benny's bronze from the VPSU has now gone to Mercy Private.

I recall the gin and tonics that summer day under the sycamore tree in that exclusive backyard of the Melbourne Club with the envious community from the surrounding buildings looking down at us before we returned to the dining room where the oyster course of 13 was the baker's dozen and it made me recall Oscar Wilde's quote from *The Importance of Being Earnest* on "the privileged class enjoying their privileges".

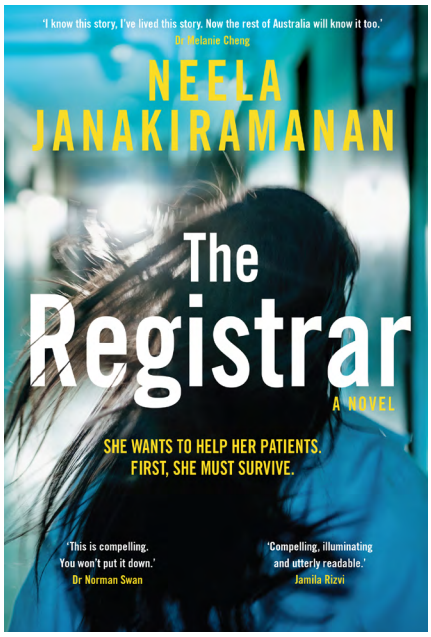
But the best quote is from Winston Churchill observing: 'The gin and tonic has saved more Englishmen's lives, and minds, than all the doctors in the Empire'.

PS: In view of the recent death of Queen Elizabeth II, it is opportune that having spent most of this article on the Royal Family, we therefore offer this as a memorial to the Queen Mother and her daughter.

Associate Professor
Felix Behan

Images: Hogarths illustration of Beer Street (left) and Gin Street as a Point of Social Criticism (right); Madras Club, India; The Beaufort Bar, Savoy Hotel, London.

Good reads



The Registrar, Dr Neela Janakiramanan

Dr Neela Janakiramanan's debut novel tells the gripping story of Emma Swann, a young registrar on her surgical journey at the prestigious Mount teaching hospital.

While we know the story is fiction, Dr Janakiramanan paints a realistic picture of the frenetic pace of the registrar experiencing long days, little sleep and the many ups and downs of life in a busy hospital.

The novel shines a light on the life of the main protagonist, Emma as a surgical Trainee because that's what she knows best and says that many of the incidents and scenarios are applicable to junior doctors of hospital-based specialties and training programs.

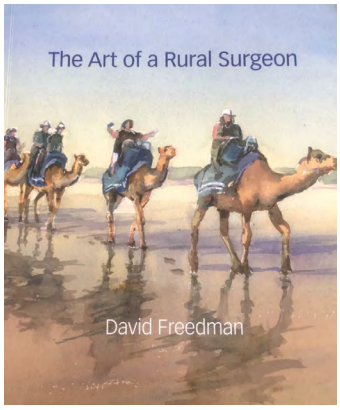
Emma is an engaging character and you will find yourself immersed in her story, getting upset with her when her tough father pushes her, empathising with her as she supports her brother (also on a pathway to a surgical career and tries to commit suicide), and hoping her marriage with the supportive Shamsi works out.

But Emma also offers hope. When asked what should be done by Professor Bones, one of the hospital's senior people, she says, "You could be nicer to everyone … We all could be, but you are at the top of the system. Anger's for us at the bottom. You could see people for what they have to offer, not what you think they do wrong. You could listen to our anger, for a change, and make things better."

The book ends with Emma skipping out into the sunny evening and you get a sense that this is one registrar who will fight for a brighter and happier future.

The Registrar is available at all leading bookstores throughout Australia and Aotearoa New Zealand, as an e-book, and from online retailers.

Dr Neela Janakiramanan, a FRACS, is a reconstructive plastic surgeon with expertise in complex hand and wrist surgery. She has wide experience working in the public and private health sector. She is a seasoned public speaker and advocate on issues including health equity, gender equity, and diversity and inclusion.



The Art of a Rural Surgeon, David Freedman

David Freedman has donated *The Art of a Rural Surgeon* and *Plein Air Painting: general principles and tips for beginners*, to the RACS library.

The 121 page book includes 120 of Dr Freedman's painting and traces his journey in surgery and painting. This book is available here: https://davidfreedmanart.com.au/products/the-art-of-a-rural-surgeon

Plein Air Painting: General Principles and Tips for Beginners: https://www.booktopia.com.au/plein-air-painting-david-freedman/book/9780987535184.html

Earlier this year, Dr Freedman donated his book *Australia's Birds* to the RACS library.

The Painted Surgeon, Ezhuth Aani

This is a gripping story about a vascular surgeon's fightback after being caught in a medical intrigue.

The story is set in an imaginary country and the politics of the medical world will keep you riveted.

Written by Dr Anantha Ramanathan, a vascular surgeon, under the pen name Ezhuth Aani (pen in Tamil) this is the sixth book written by him since 2013.

This book is available from the RACS library and also here: Aani, Ezhuth: 9780998505022:

Available on amazon.com

The Queensland State Committee is proud to present the

Preparation for Practice Workshop – Queensland

Avant Mutual Office
Level 18/345 Queen Street, Brisbane City QLD
Saturday 5 and Sunday 6 November 2022

Purpose

The two-day workshop will provide Younger Fellows, final year Trainees and practice managers information on practical skills, tips and advice for setting up private practice. The focus is on practicality and experience provided by fellow surgeons, consultant speakers and industry. Participants will also have the chance to speak to Fellows who have experience in starting up private practice.

As a part of this workshop, we will also host a dinner at Navala located at the Riverside Centre, 123 Eagle St, Brisbane City for all registrants and partners on Saturday 5, 2022 at 6:30pm.

Who should attend?

Younger Fellows and final year Trainees from all specialties who are considering setting up private practice will benefit from attending this two-day workshop. Practice managers and partners are also welcomed to register (note: priority will be given to RACS members).

What will you learn?

Understand matters involved for setting up private practice
Acquire strategies and tools for practice operations
Develop practice framework and improve practice performance.

CPD for Fellows

This educational activity has been approved in the RACS CPD program. Fellows who participate can claim one point per hour in Maintenance of Knowledge and Skills.

Cost

$350 (RACS members)
$395 (non-members)

REGISTER ONLINE NOW
https://bit.ly/3zHC9vQ

Enquiries

E: courtney.rhone@surgeons.org T: 0402 736 732

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In memoriam

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

The College has received notification of the passing of the following Fellows since 10 June 2022.

Dr Edward (Ted) Michael Schutz

Dr Frank Yam Wang Kwok

Dr John Milton Saunders

Dr Remo L Cantamessa

Professor Brian Fowell Buxton

Associate Professor Joseph Epstein

Dr Kingsley Wallis Mills

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 John Hargraves Hodgson FRACS
General Surgeon
1 September 1924 - 12 September 2021

John was born in Lane Cove—the firstborn child of John Hargraves and Edith Mary Hodgson (nee Jacobs).

He undertook a Bachelor of Medicine and Bachelor of Surgery (MBBS) course at Sydney University in 1942. An important part of his university degree was the time spent in training at Sydney Hospital, as was belonging to the Sydney University Rugby Union team.

John graduated from Sydney University in 1947, and his first medical posting was in Tamworth. He also worked at the Launceston General Hospital and for Tasmanian Government Health.

He travelled to London in 1952 to study for a fellowship at the Royal College of Surgeons (FRCS) and completed his primary exams in Edinburgh and finals in London.

He lived in England between 1952 and 1958. He worked for a year at the Royal Portsmouth Hospital, six months in Bath Hospital, as well working and studying at the Orthopaedic Hospital in Oxford, Nuneaton, and Tooting Beck Hospitals.

On his return to Australia, John joined the Pennant Hills Medical Practice of Clyde and Harold Davis, later known as Hampden Clinic. He worked in this surgery through his professional life—serving families and the community with dedication and personal care for many years. Testament to John's care as a doctor are the many words of gratitude and appreciation flowing through to the family since his passing.

John retired in 1991 and continued to involve himself in the community, as well as tapping into his creative side.

He lived in service to his profession, community, family, and God—passing away at the grand age of 97 years.

Dr John William McKenzie Upjohn OAM
MBBS, FRACS, FRCS (Eng)
General Surgeon
31 March 1931 – 1 August 2022

John was born to William and Norma Upjohn. His brother David had cerebral palsy and died at the age of 14—a tragedy that made him sensitive to those less fortunate and perhaps influenced his decision to study medicine.

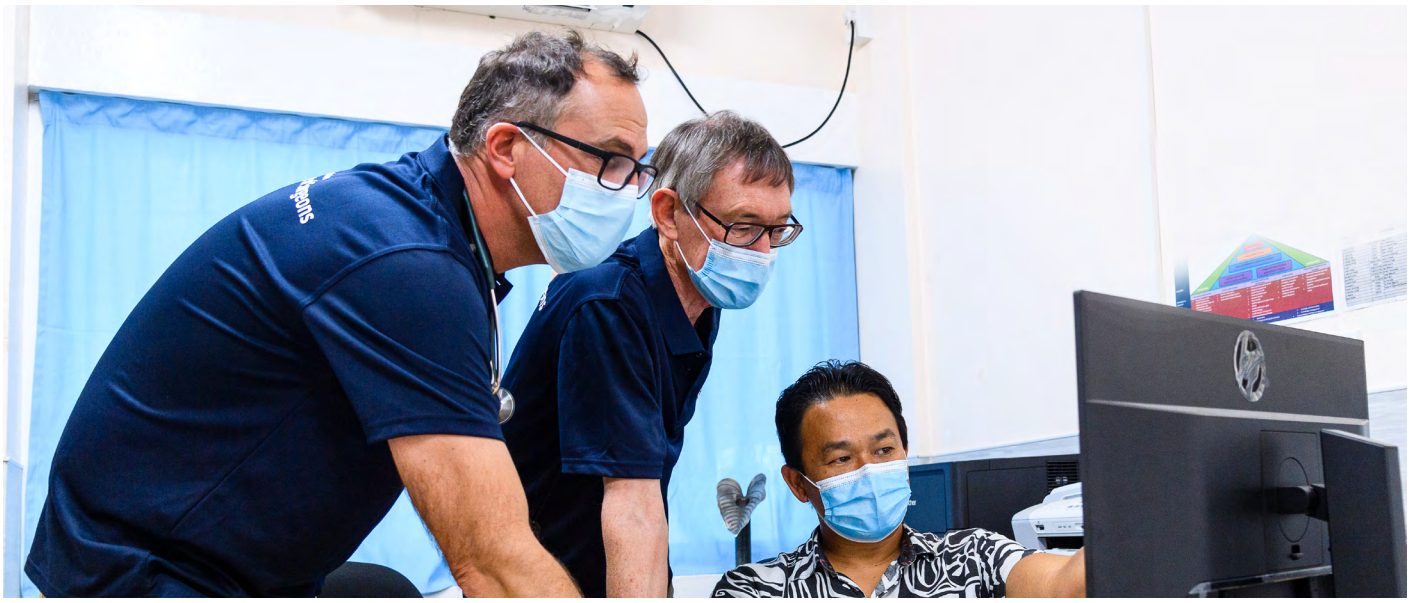
John matriculated from Melbourne Grammar and at the young age of 16 and studied medicine at the Melbourne University, Mildura campus.

On graduating he pursued post-graduate training at the Royal Melbourne Hospital where he worked under many of the local doyens of surgery before heading to England, in 1958, for three years.

John gained his fellowship of the Royal College of Surgeons (England) and gathered General Surgical experience at the Wittington, Barnet General, Peppard and St Helier hospitals.

He held several honorary assistant surgeon positions at numerous city teaching hospitals. In 1969, he was appointed assistant surgeon to Dr John Fethers at PANCH, and in 1988, he was the acting Head of Unit for nearly two years. John worked tirelessly at PANCH in this unit until his retirement in 1996.

John's loyal service also extended to the Metropolitan Fire Brigade (MFB) where he served as brigade medical officer for more than 30 years. His life-long service to the MFB and medicine was recognised in 2003 when he was awarded the Order of Australia Medal (OAM).



Royal Australasian College of Surgeons
Foundation for Surgery

Thank you for your extraordinary compassion and generous support to the Foundation for Surgery in August and September.

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Editor's note

The online newsletter headline in issue 4 of *Surgical News* incorrectly represented Dr Rennie Qin's work. It stated that: Surgical Trainee, Dr Rennie Qin, is using her medical knowledge to uphold Indigenous health principles and better Māori health. Her work is improving the health of people in Pacific Island countries rather than Māori health.

"There is no health without mental health; mental health is too important to be left to the professionals alone, and mental health is everyone's business."

— VIKRAM PATEL, PSYCHIATRIST, RESEARCHER AND CO-FOUNDER AND FORMER DIRECTOR OF THE CENTRE FOR GLOBAL MENTAL HEALTH, LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE

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