SurgicalNews

Volume 21 | Issue 04

Spotlight on | Page 27
Advocacy during COVID-19

Spotlight on | Page 11
Global health and
Indigenous health

Royal Australasian
College of Surgeons

SurgicalNews Volume 21 | Issue 04 surgeons.org

RACS leadership

Spotlight on

Global and Indigenous health

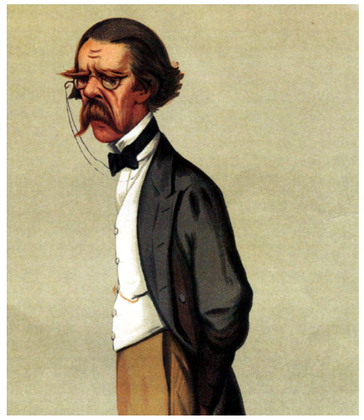
Historical

Research

Spotlight on

Advocacy during COVID-19

Articles of interest



FSC www.fsc.org MIX Paper from responsible sources FSC® C007821

The Royal Australasian College of Surgeons supports green printing initiatives. *Surgical News* has been printed on FSC certified paper using vegetable based inks by Printgraphics Printgreen under ISO 14001 environmental certification. *Surgical News* is fully recyclable.

Correspondence and letters to the editor for Surgical News should be sent to: surgical.news@surgeons.org
Editor: Abderazzaq Noor
T: +61 3 9249 1200 | F: +61 3 9249 1219
Contributing writer: Sharon Lapkin
www.surgeons.org
ISSN 1443-9603 (Print)/ISSN 1443-9565 (Online).

Cover image:
A Ni-Van mother and her child receive care in Port Vila, Vanuatu by a Pacific Islands Program (PIP) visiting medical team. The PIP is funded by the Australian Government through DFAT. Photographer: Darren James

President's perspective

I finished my last president's perspective just a few months ago stating that I was "cautiously optimistic that we will soon see the other side of COVID-19". Unfortunately, my hope was misplaced, and the last two months have demonstrated that a lot can change in a short space of time.

At the time of writing, in much of Australia and New Zealand socialising and travel is being encouraged. In Victoria severe restrictions have been announced and limits on elective surgical procedures reintroduced.

On behalf of all Fellows may I pass on our best wishes and support to our Victorian colleagues. The current situation has caused additional anxiety and stress for many, and I encourage you all to continue working together and to seek support services when you need them. However, I am optimistic that we will again be able to get this outbreak under control and begin planning for the post-COVID-19 medical workforce. There have been, and there will continue to be, many important lessons for us to learn that will inform future decision-making.

An example of this is the rapid increase in telehealth consultations across Australia since the pandemic began. In our submission to the consultation on stage 5 for specialist items for telehealth, which was drawn up in close consultation with our Rural Surgery Section, we strongly advocated for the lifting of some restrictions in the Medical Benefit Schedule to increase services to patients during COVID-19, and further safeguard the health and safety of our health practitioners.

Undoubtedly, even once we have safely navigated our way through the current challenges, advancing and integrating telehealth into health service delivery will remain a high priority. I believe it is essential that the College is ready for this, and that we can provide effective representation on what we believe the future of telehealth should look like.

While I have heard anecdotal reports from many of you, I am keen to develop a better understanding and a more rigorous evidence base to assist us in our advocacy efforts.

RACS has, therefore, partnered with John Hunter Hospital and the Hunter Medical Research Institute Newcastle to assess the uptake of telehealth by surgeons and patients across Australia. We will do this via a survey seeking your input. I encourage you to take the short amount of time needed to complete this important survey, as your feedback will be crucial in determining our position.

In other news, we continue to advocate on the protection of the title of 'surgeon'. Professor Mark Ashton, one of our Councillors and a past president of the Australian Society of Plastic Surgeons, has written eloquently on this topic in this issue of *Surgical News*. I have added my voice to it in an opinion piece and we will continue to do everything we can to highlight the dangerous trend of people using the title 'surgeon' and performing surgery despite not having completed the accredited training.

After a decision by the COAG Health Council in November last year to look at restricting the title of 'surgeon', the Victorian Department of Health and Human Services (DHHS) has been tasked with undertaking a regulatory impact statement in relation to this potential change.

RACS has spoken with DHHS and has been informed that the department will release a 'consultation draft' to stakeholders before the end of 2020. We plan to put forward a strong position in collaboration with our specialty societies, and I will endeavour to keep you informed.

New Zealand, and a number of states and territories, will be holding their government elections in the second half of 2020. Before every state, territory and national election we provide an opportunity for political parties to outline their policy positions on key issues. We then distribute the responses to the membership and the wider community.

In the past there have been many examples where RACS has been able to secure firm commitments from political parties prior to an election. For example, in the last Northern Territory election we had a written guarantee from the soon-to-be-elected government that they would end the Territory's unrestricted speed policy. Following the election, one of the government's first actions was to reintroduce maximum speed limits on the Stuart Highway.

Trauma prevention will remain a priority in the lead up to this Northern Territory election, particularly in relation to ensuring that the strong and highly successful alcohol harm reduction legislation that has been implemented over the past four years remains in place.

Ahead of New Zealand's general election on 19 September 2020, RACS' statement explores political parties' commitment to the development of a single Electronic Health Record, and also requests for greater certainty around the improvement of the hospital infrastructure to meet the needs of New Zealanders over the next 10 years.

In the Australian Capital Territory (ACT), the College has used its election statement to advocate for much needed upgrades to the ACT's education and training facilities. In addition to this, the statement refers to the findings of the Independent Review into the Workplace Culture within ACT Public Health Spaces. To date, none of the recommendations of the review have been implemented, despite it being released in early 2019.

Queensland will be the last of the jurisdictions to hold an election this year when they go to the polls at the end of October. The main issue the state committee intends to raise is the delivery of surgical services, especially in regional and rural areas – in particular the local 'Support Our Surgical Services' program. This encourages a greater focus on engagement with surgeons, trauma care and a number of specifically targeted programs to improve patient safety and surgical outcomes.

As part of the RACS response to COVID-19 we stopped the printed hard copy of *Surgical News* and have been sending out an electronic version.

Many have expressed their disappointment and miss the hard copy. We will be recommencing the previous practice, although if you would prefer not to receive the posted hard copy please notify the editorial team via surgical.news@surgeons.org

Stay well and stay safe. ■

Mr Tony Sparnon
President

The One College Transformation: our first 12 months

In the last few issues of *Surgical News* we have provided updates on the One College Transformation – an infrastructure enhancement initiative that will make your interactions with the College easier and more personalised.

Our vision is of a robust, integrated RACS governance, management and infrastructure, one that supports all Fellows and provides greater opportunities to be involved in, and feel part of, the capability the College offers the Fellowship, aspiring Fellows and the surgical profession.

The Transformation team had their efforts disrupted to an extent due to COVID-19 and its accompanying restrictions. Considering this, their achievements over the first 12 months are even more impressive. While some projects were pushed to the back burner for the time being, the team found innovative ways to progress the Transformation program's objectives while working remotely.

Their work, under the oversight of former vice president Richard Perry, has placed us in good stead for the next stage of the program.

I will provide an update on the program's first 12 months and outline what you can expect in the next phase of the program.

Technology

We are making the College's systems and ways of working more efficient and responsive. Our technology infrastructure is ageing and dated, providing us with the opportunity to create a more receptive and enabling organisation – one that continually strives to help you achieve your best.

The One College Transformation program gave us a strong digital footing when the COVID-19 pandemic caused College staff to work remotely. We were able to quickly implement Microsoft products, such as Microsoft Teams, which allowed staff to communicate and collaborate effectively.

We upgraded our phone system, replacing our ageing and unsupported telephony system. Our new system has improved features, such as enhanced conferencing and collaboration facilities that will be linked to our new audiovisual systems, supporting a modern way of working.

We also enhanced the College website, moving to a more stable, flexible, scalable and secure platform. The roadmap of this upgrade offers the ability to personalise users' experiences based on the data we hold.

Governance

The Governance stream of the One College Transformation program sets the parameters for decisive action by streamlining decision-making and enabling new opportunities for more members to participate in College business.

We are re-examining the opportunities through which Fellows can engage with the College, beyond committees. We want to streamline our governance model, ensuring committees and approval pathways are fit for purpose.

This will reduce our administrative overhead, allowing us to be focused on outcomes, giving our members more value, and better supporting the strategic priorities of the College.

Under Richard's leadership, with Councillor support from Annette Holian as Chair of Global Health, and executive support from Emily Wooden, the Global Health Governance Structure was revised. The new structure now consists of the International Engagement Committee, the Global Health Section and the Global Health Programs Steering Group, each with specific functions and objectives.

Corporate committees were also rationalised, with the Resources Committee and the Risk Management and Audit Committee merged into a dedicated Finance, Audit and Risk Management Committee of Council.

We are also reviewing our policy framework. Simplifying the categories of documents that govern College operations will clarify responsibilities, minimise risk and free up Council to focus on the strategic work of the College. Governance documents will be easier to find, understand and apply. There will be one source of truth, rather than different versions and conflicting rules.

People and Culture

The People and Culture stream is charged with leading a College-wide cultural change by inspiring a positive and future-ready mindset, and enabling a more collaborative and flexible workplace.

Our experience during COVID-19 demonstrated the appetite and enormous capacity of our staff to adapt to new and more flexible ways of working. Post-COVID-19 we envisage that staff will retain many of the positive elements of flexible working to increase levels of employee wellbeing and member engagement.

To drive collaboration and engagement we have launched our new intranet Pulse, which has quickly become an essential platform to share important information among staff.

We are working on many new initiatives to support a positive workplace culture. These include new learning and development initiatives, a refreshed reward and recognition program, plus a focus on diversity in our recruitment activities.

By maintaining a focus on employee wellbeing and engagement, our members will ultimately benefit.

What's coming next

We have a lot more exciting work that will continue to improve how you engage with the College. This includes projects such as eHub, a new membership portal that will replace the current ePortfolio. eHub will personalise content and provide you with a 360 degree view of your information and overall journey with RACS.

Our new website will also offer personalisation opportunities and room for upgrades in the future. Our audiovisual system upgrade will enhance the College's collaboration across different teams and office locations, making it easier to run meetings remotely – ultimately, reducing the need for travel.

Come on board with us as we seek to support and advance your needs in today's rapidly changing world.

You are welcome to send feedback and suggestions to the One College Transformation program team: 1CT@surgeons.org. I look forward to providing you with regular updates on the progress of the program. ■

Associate Professor
Julie Mundy
Vice President

Celebrating the art of surgery – in a time of disruption

It was a great disappointment to everyone when we had to cancel the Annual Scientific Congress (ASC) in 2020. However, unprecedented times call for unprecedented measures and it was pleasing to see that the lockdown instituted across our two countries led to a flattening of the COVID-19 curve, and in New Zealand and some Australian states and territories complete eradication.

COVID-19 is undoubtedly the biggest disruptor that our community has experienced in our lifetime. It has not only caused an unbelievable number of deaths around the world, it has made us rethink the way we interact with each other, the way we work and the way we socialise.

Our community responses in trying to contain the virus have made us consider, as a society, what it is we value, and how we can best protect and support the vulnerable among us. Lockdown has taken us from being almost unbearably busy and forced us to be quiet. Restrictions on elective operating make us consider what it means to be a surgeon, and who we are if we are not operating.

As the College reflected on the broad impact of COVID-19 on our surgical community it seemed our planned theme, 'Celebrating the art of surgery', was just as relevant as it was in planning for 2020.

To survive the changes personally, and as a Fellowship, we have had to find creative ways to adapt our practices, support our patients and provide care to our communities. We have had to reconsider how and where we deliver care. We have constantly needed to be agile and adapt – as the landscape changed, sometimes daily. We had to rely on the art of what we do, not just the science of what we do. We have had to 'Celebrate the art of surgery – in a time of disruption'.

It was with great confidence and optimism in June that we started to plan for an even bigger and better ASC back in Melbourne for 2021. However, within a few weeks the number of COVID-19 cases in Melbourne started to rise exponentially. Our plans needed to change again, reminding us what a disruptor this virus is and how agile we need to be.

Just as we have had to adapt our practices and our personal lives to this COVID-19 disruption, we have had to adapt the ASC. The ASC 2021 will be completely different to any we have ever held. While we will attempt to have an on-site presence in Melbourne, it is almost assured now that we will not be able to have 2500 people in one place.

Therefore, we are looking to set up 'hubs' around Melbourne and in other metro and regional centres, where smaller groups can get together and participate in sessions virtually. RACS is looking forward to welcoming presentations from our colleagues and friends at Royal College of Surgeons Edinburgh and, even more so, we hope to welcome them in person.

While we hope we will be able to travel in a New Zealand-Australia 'bubble' there is no assurance that borders will be open, so we need to prepare for our international speakers to contribute virtually. It may be that all our speakers will need to present virtually.

We need to re-examine how many days we offer, as we are all now aware of the new phenomenon of Zoom fatigue. We will need to look at how we can recreate the networking and catch-up opportunities we all enjoy, and what the cost of the congress should be.

There is much to be done and we will try our best to keep you informed as we work through these issues. We look forward to 'seeing' you somehow, in some way, in May, as we celebrate the art of what we do, and how we have dealt with, and are dealing with, a time of disruption. ■

Professor Wendy Brown
2021 ASC Convener

Associate Professor Sebastian King
2021 ASC Scientific Convener

Spotlight on

Global and Indigenous health

Our vision is that safe surgical and anaesthetic care is available and accessible to everyone. Through partnerships with South East Asia and Pacific neighbours, our global health program provides specialist medical education, training, capacity development and medical aid to 15 countries in the Asia-Pacific region. RACS Global Health aims to support the national health care systems to develop so they can provide quality medical services into the future.

We recognise that improving the health of our Indigenous populations in Australia and Aotearora/New Zealand is a public health priority. Achieving this requires addressing the determinants of health and improving the health care that Indigenous people receive in culturally appropriate ways.

The photo shows Ni-Van surgeon Dr Trevor Cullwick (left) and Dr John Batten (right) conducting an operation on a patient during an Australian government funded visit to Vanuatu as part of the RACS managed Pacific Islands Program (PIP). Photographer: Darren James

Working towards transformative change

Indigenous Health Committee Chair Dr Maxine Ronald talks about the committee's work to improve surgical health equity for Indigenous communities, and surgical training for Indigenous doctors.

In 2018, Dr Maxine Ronald became the first Māori Councillor on the Royal Australasian College of Surgeons (RACS) Council. In doing so, she also became the first female Māori Councillor to sit on the Council in its 93-year history.

Dr Ronald is now also Chair of RACS Indigenous Health Committee (IHC) and, along with eight other Australian and New Zealand surgeons, is seeking to address the inequities of healthcare in Indigenous communities across the two countries. The committee also works to improve access to training and provide appropriate support for Indigenous Trainees and surgeons.

After graduating with an MB ChB from Auckland University in 2005, Dr Ronald completed a Colorectal/Acute Surgical Unit Fellowship in 2013, and an Oncoplastic Breast Fellowship in 2014 – both at Perth hospitals. As a general surgeon she became more involved in Indigenous health issues and noted there was a "significant acceleration of the Indigenous profile at RACS". There were "a lot more sponsors and engagement promoting surgery as a career for Indigenous doctors", she said.

Indigenous doctors have probably not seen surgery as a safe place to work, Dr Ronald added, pointing out that "most of us who have trained recently will have experienced racism as Trainees".

RACS recently approved the inclusion of cultural competency and cultural safety in the core training competencies for all Trainees across all specialties. "It's a significant and massive thing because we'll be teaching surgeons to interact, not only with Indigenous surgeons, but with Indigenous patients and their families in ways that are culturally safe," Dr Ronald said.

The way that healthcare is delivered to Indigenous people may look different to non-Indigenous people, but it will achieve the same outcomes, she said, emphasising that Indigenous models of health are broader than just disease. "Hopefully, it will provide a signal to Indigenous doctors, who might be considering surgery as a career, that it's a real and substantial commitment from RACS to support Indigenous surgeons."

It's essential that Indigenous people are involved in decision-making from the beginning, Dr Ronald explained. "Too often we're asked for an opinion at the end when a lot of decisions have already been made. Then it's frustrating because it seems like a tick-box exercise, as though we're just being asked for an opinion," she said.

"Indigenous people need to be at the table from the beginning making decisions on their own behalf."

One of the most important relationships in Māori culture is Tuakana–Teina, Dr Ronald said. "It's important to have these mentoring connections to the people you work with and those relationships are key." Five years ago, there were so few Indigenous people in surgery that "we didn't have the critical mass to be able to do it – or perhaps just in small ways, but it's difficult when you have to spread yourself so thin", she said.

These days there are more Indigenous Trainees and surgeons across Australia and New Zealand, as well as "non-Indigenous people who are supportive of equity so we're hoping we can build on creating those connections", she added.

One of the aims of the IHC is to increase the Indigenous workforce. For this to happen, specialty training programs and surgical professions need to be more attractive to Indigenous doctors, so they see surgery as a safe haven in which to train. There also "needs to be strong mentorship and strong support for Indigenous Trainees", she added.

Evidence has shown that, over time, affirmative admission programs that provide strong support through training to undergraduate medical students have the most success, Dr Ronald explained.

"It is important that RACS aims for transformative change with real and tangible outcomes and improvements in both surgical health equity for Indigenous communities and surgical training for Indigenous doctors," Dr Ronald said.

As Chair of the IHC, there is a lot of ongoing work to be done, and "an opportunity to create real change", she added. The "size of the task can seem daunting," but the support within RACS is both exciting and encouraging. ■

Indigenous Health Committee launches new initiatives

It's shaping up to be a busy year for the committee with the launch of a new advisory group for Indigenous Australian surgeons among multiple other projects.

The Royal Australasian College of Surgeons (RACS) Indigenous Health Committee (IHC) has launched a number of initiatives to support Indigenous Trainees and surgeons, and Aboriginal and Torres Strait Islander peoples.

The Mina Health Advisory Group

The contemporary iteration of the IHC, which was co-founded in 2008 by Associate Professor Kelvin Kong along with Professor Russell Gruen, Mr Jonathan Koea and Mr Patrick Alley, has created a new advisory group to promote the trajectory of Aboriginal and Torres Strait Islander peoples. Like its counterpart, the Māori Health Advisory Group, the Mina Health Advisory Group will function under the auspices of the IHC.

Mina translates as 'knowledge' and is from the language of the Gathang people on the New South Wales mid-north coast, the language nation of Associate Professor Kong. The Mina Health Advisory Group incorporates wisdom and experience from RACS members who have been involved in the IHC. It is an avenue for providing advice on the development and implementation of key Aboriginal and Torres Strait Islander peoples' health initiatives and projects, as well as content in RACS position statements and policies.

The group will meet regularly to discuss the strategies and progress of the Aboriginal and Torres Strait Islander Reconciliation Action Plan.

National taskforce for monitoring ear health

Indigenous children in Australia have the highest rate of ear disease in the world. The World Health Organization (WHO) has identified it as a "public health crisis" – a term WHO usually reserves for crises in developing countries.

The IHC recognises the disparity in ear disease among Aboriginal and Torres Strait Islander peoples and is supporting measures to help advocate for action. The Ear Health for Life consortium, which is supported by RACS, is a national approach to hearing health and represents a multidisciplinary and intersectorial group of interested professionals striving for equity.

Surgical Pathway project

There have been great advances and interest in surgery among Aboriginal and Torres Strait Islander doctors. The Surgical Pathway project is an adjunct to help accelerate and capture this interest. With the overall objective of reaching parity of Aboriginal and Torres Strait Islander surgeons, the IHC working group has identified three initial aims. The first is to increase the number of Surgical Education and Training (SET) applications submitted by Aboriginal and Torres Strait Islander junior doctors; the second is to increase the number of successful SET applications; and the third is to increase the number of Indigenous Trainees successfully completing SET.

The team is looking forward to working with the Australian Indigenous Doctors' Association (AIDA) to help develop pathways to help. The project's target group will include Indigenous high school students, medical students, existing professionals and junior doctors. The IHC will develop engagement strategies that encompass the full spectrum of potential surgeons, and the Royal Darwin Hospital (RDH) is collaborating with the working group to develop a pilot model. Associate Professor Kong and IHC committee member Dr Stephanie Weidlich, who is a general surgeon at the RDH, are assisting with surgical advice.

Funded by the Australian Government Department of Health through the Specialist Training Program (STP).

The new RACS Health and Safety Course

A new course recently approved by RACS will include cultural competency and cultural safety in the core training competencies for all Trainees across all specialties. The training will assist surgeons in their interactions with Indigenous surgeons and their patients and families.

The course is to be undertaken by Fellows, Trainees, Specialist International Medical Graduates and junior doctors. It is accredited for Category 4 Continuing Professional Development 'reflective practice', and is available on the Aboriginal and Torres Strait Islander eLearning webpage.

Funded by the Australian Government Department of Health through the Specialist Training Program (STP).

RACS Reconciliation Action Plan

The Reconciliation Action Plan (RAP) is a workplace framework that provides four sequential stages enabling the College to contribute to reconciliation. RACS recently commenced the second stage, 'Innovate', which is overseen by the IHC, RACS Council and Reconciliation Australia.

The RAPs undertaken by RACS serve two purposes: they reflect both the College's administrative role in developing strategic health policies, as well as its role in supporting surgeons on their journey to reconciliation. ■

Read more about the new RAP on page 16.

Updating surgical standards

The Royal Australasian College of Surgeons is proud to present the third edition of the Surgical Competence and Performance Guide. We have revised the guide to reflect the standards we hold as a profession and our commitment to the community to deliver high-quality, patient-centred surgical care.

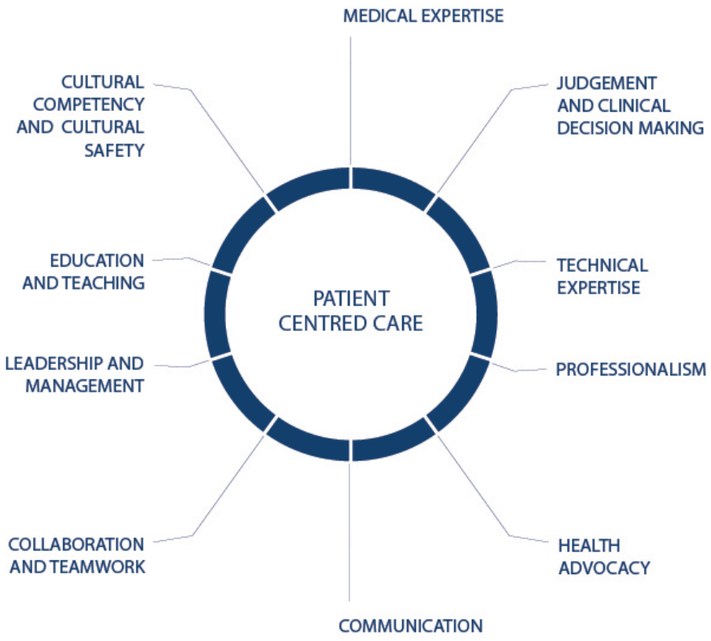
The guide provides a framework to aid the assessment and development of surgeons across all areas of surgical practice.

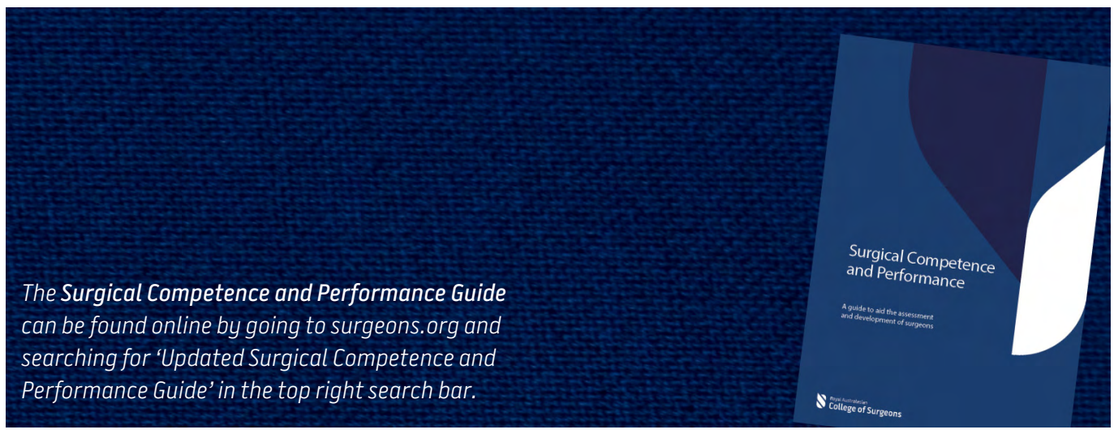
In delivering safe, effective and timely surgical services, patient-centred care is central to the Surgical Competence and Performance Framework. The introduction of a tenth competency – cultural competence and cultural safety – prioritises the importance of understanding the individual, social and cultural needs of our patients to ensure they are the focus of our interactions.

Underpinned by the principle of shared decision making, this competency challenges surgeons to use the privileged position they hold within society to address health inequities and improve health outcomes with an emphasis on working in partnership with our Indigenous peoples in Australia and New Zealand.

The updates in the revised guide include additional emphasis on patient-centred care and shared decision making, addressing discrimination, bullying and sexual harassment, and highlight the surgeon's role in supporting health care sustainability.

All Fellows are encouraged to familiarise themselves with the updated surgical competencies. If you have any questions or feedback please contact the Professional Standards team at Professional.Standards@surgeons.org ■





*The **Surgical Competence and Performance Guide** can be found online by going to surgeons.org and searching for 'Updated Surgical Competence and Performance Guide' in the top right search bar.*

Māori scholarship helps Trainee to give back

Dr Lance Buckthought was able to enrich his own surgical skills, as well as give back to the community with his Māori SET Trainee One Year Scholarship.

The New Zealand Society of Otolaryngology, Head and Neck Surgery (NZSOHNS) is a close-knit surgical community where everyone knows each other by name, and that suits Dr Lance Buckthought (pictured).

Otolaryngology, also known as ear, nose and throat (ENT), is a popular and sought-after specialty in New Zealand, with 117 active members and 23 Trainees. Each year, only two or three applicants are selected for the Surgical Education Training (SET) program from a cohort of about 15 applicants. Dr Buckthought was one of those successful applicants and, in 2019, he was also awarded the Royal Australasian College of Surgeons (RACS) Māori SET Trainee One Year Scholarship.

"Te Ao Māori (the Māori world) is a big part of my life," he said. "The scholarship gave me the means to attend conferences, courses and continue with my mentoring and teaching of Māori students and junior doctors." Dr Buckthought also runs workshops for Māori medical students and, along with Dr Rebecca Garland, is conducting qualitative research into the impact of middle ear disease on Māori patients in Aotearoa.

After completing a Bachelor of Science in Anatomy in 2007, followed by a Bachelor of Medicine and Bachelor of Surgery at the University of Otago in 2012, Dr Buckthought moved to Wellington to complete his internship, and then became a surgical registrar. He is currently in his second year of SET (Otolaryngology and Head and Neck Surgery) and is working at Wellington Hospital.

Having just obtained ethics approval for his study on middle ear disease, Dr Buckthought expects to have the study up and running soon. "The project will take about one year", he said, "and it will contribute to the literature on middle ear disease in New Zealand.

"Too often we see tamariki (young) Māori referred to our service after years of being labelled as troublemakers in the classroom. However, the reason they are falling behind their peers is due to middle ear fluid causing hearing loss," he said. "They get referred so late." His aim is to increase awareness around otitis media with effusion, and encourage earlier detection and referral to ENT.

As well as an interest in Māori health, Dr Buckthought has a subspecialty interest in head and neck surgery, and hopes to do a Fellowship overseas. However, he emphasised that he would like to return to Wellington to practise as a specialist.

Mentoring is an important part of Māori culture, Dr Buckthought said. "In medical school, hospitals and primary care there aren't many Māori around and it's very important to have someone you can talk to who has walked the path before you ... then it's your responsibility to help the younger ones coming through." Currently, Dr Buckthought has several Māori mentors of his own that he turns to for advice. When he completes his training, he, too, will become a mentor.

"Māori medical students need to have Māori role models who work as surgeons," Dr Buckthought said. "If you have someone in that position who you can identify with and relate to – who takes down those barriers, you can see yourself getting there."

RACS Indigenous Health Committee awards the Māori SET Trainee One Year Scholarship each year, and Dr Buckthought said he was "very grateful" for the assistance he had received. "It's fantastic to see that Hauora Māori is recognised as a priority by the College,"

he said. "We know that increasing the number of Māori doctors and surgeons results in better outcomes for our Māori patients."

Going forward, he has no doubt that the Māori medical workforce will continue to expand, and noted that there are some great young Māori surgeons coming through.

Dr Buckthought also has an interest in adventure sport and has competed in freediving – the highly disciplined form of deep-sea diving without any breathing apparatus. "I thrive on adventure as well as surgery," he said. "I spend much of my free time out at sea spearfishing. Being out in the water or exploring New Zealand's incredible back country is how I relax and keep focused." ■

For more information on what RACS scholarships, fellowships and grants are offered please see the RACS website www.surgeons.org/scholarships or contact the Scholarship and Grant Coordinator at scholarships@surgeons.org

For more information on setting up a scholarship, fellowship or grant of your own, please contact the Foundation for Surgery at foundation@surgeons.org or +61 3 9249 1110.

Introducing the Innovate Reconciliation Action Plan

The Royal Australasian College of Surgeons (RACS) recognises and acknowledges Aboriginal and Torres Strait Islander people as the traditional custodians of Australia and pays respect to their continuing connection to culture, land, sea, community and family. RACS is proud to be part of the reconciliation journey and embraces our obligation as a peak bi-national health organisation to make meaningful ongoing commitments.

There have been significant gains toward addressing Indigenous health, including the decision for the Indigenous Health Committee (IHC) to report directly to RACS Council. This means Indigenous health is now a standing item on Council agenda; the IHC will be chaired by a Councillor; and the addition of 'Competence and Cultural Safety Competency' will be included in the core training competencies for all Trainees (for more see page 14). The IHC has also approved the formation of the Aboriginal and Torres Strait Islander Advisory Group, known as Mina, which will provide advice, guidance and feedback on the development and implementation of key Aboriginal and Torres Strait Islander health initiatives, projects and policies.

But we are a long way from achieving health equity. The College acknowledges that historical inequalities in social and economic status currently experienced by Aboriginal and Torres Strait Islander people, caused through the colonisation process, contribute significantly to poorer health outcomes, particularly decreased life expectancy. The College recognises that Aboriginal and Torres Strait Islander people are over-represented in every way in the determinants of poor health. To make significant change, RACS will need to acknowledge and address the legacy of colonisation processes and the resultant racism and privilege at curricular and institutional levels.

Our 'Innovate' Reconciliation Action Plan (RAP) provides the mechanism to do so. Implementing the Innovate RAP will strengthen our approach to driving reconciliation through our business activities, services and programs and develop mutually beneficial relationships with Aboriginal and Torres Strait Islander stakeholders.

RACS will prioritise Indigenous health, building the workforce and increasing services to better meet the health needs of Aboriginal and Torres Strait Islander people and Māori.

Our vision for reconciliation

Our vision for reconciliation is for no health discrepancies to exist between the Aboriginal and Torres Strait Islander people and non-Indigenous populations of Australia. Our aims are:

- The rate of infant mortality should not differ.
- There should be no significant discrepancy in life expectancy.
- The overall rates of disease and sickness should not differ significantly.
- The rates of injury should not differ significantly.
- There should be equity of access to medical and allied health services, including primary care, surgical and other hospital care, as well as after hospital care.
- There should be improvements in the social determinants of health to enable equity in health outcomes.

RACS has committed to:

Building relationships

Collaboration and relationships are key to joint strategies and partnerships that achieve significant outcomes in Australia's First Nations people's health. RACS recommends that Indigenous healthcare policies, projects and research from all institutions, specialty societies and organisations are developed in collaboration with Australia's First Nations people to ensure they are culturally relevant and delivered in an understandable and useful way.

Building respect

The College is committed to contributing to improving health inequities. To achieve this, it is necessary to acknowledge and respect Aboriginal and Torres Strait Islander cultures, communities and histories. Respect through consultation, recognition and celebration contributes to developing respectful, supportive relationships and reflects cultural and community values.

Building opportunities

Social and economic factors are strong determinants of the wellness of the individual and their community. These factors are compounded in Australia's First Nations populations by the multigenerational grief, loss and trauma associated with colonisation, the Stolen Generations, many layers of racism, discrimination and cultural dislocation. The College recognises that 'closing the gap' is imperative if disparities in life expectancy are to be addressed. ■

To learn more about the actions RACS is taking read the full RAP here.

Developing the Innovate RAP

The new Innovate RAP was an interesting strategic document to develop due to the unique structure of RACS. On the one hand, the RACS organisation, itself, has over 200 administrative staff. On the other hand, there is the surgical profession and community RACS serves. The challenge was to bring the two groups together on the reconciliation journey, and to make the RAP relevant to both.

To accommodate this, the RAP was developed to support and facilitate internal organisational reconciliation initiatives such as National Aborigines and Islanders Day Observance Committee Week (NAIDOC) activities, employment of Aboriginal and Torres Strait Islander staff and procurement of Aboriginal and Torres Strait Islander services. It was also developed to support RACS members wanting to make contributions directly, or indirectly, to improving Aboriginal and Torres Strait Islander health and community engagement by better equipping surgeons with cultural resource tools and knowledge.

The Indigenous motif design was created to symbolise RACS' commitment to help 'close the gap' in Aboriginal and Torres Strait Islander health across Australia. It features two snakes winding around the winged staff, symbolising medicine, and can also be seen as Rainbow Serpents entwined together, carving out the land, creating our rivers and mountains. The white dotted pathways descend from the mountains, flow through the rivers and ascend back to the skies re-forming as rainbows, the spirit of the Serpent. The two snakes winding around the winged staff also symbolise Aboriginal and Torres Strait Islander and non-Indigenous people coming together. The heights of the rainbow symbolise greater professional equity as well as improved health, social and economic wellbeing for all Aboriginal and Torres Strait Islander people and communities across Australia.

The motif was developed by Marcus Lee. Born and raised in Darwin, he is a descendant of the Karajarri people and is proud of his Aboriginal heritage.

Breast reconstruction rates much lower for Māori and Pasifika patients

Smoking and being overweight is preventing a disproportionately large number of Māori and Pasifika breast cancer patients from being eligible for breast reconstruction after a mastectomy, potentially resulting in lower quality of life and poorer psychological wellbeing.

These were the findings of research carried out by Royal Australasian College of Surgeons (RACS) Fellows Dr Jenny Wagener and Dr Michelle Locke and research assistant Dr Jessica Allan.

They undertook a retrospective review of patients diagnosed with breast cancer beween 1 January and 31 December 2017, at Counties Manukau District Health Board (CMDHB). Of the 177 patients treated with mastectomy, 26 (15 per cent) received Post-Mastectomy Breast Reconstruction (PMBR).

Thirty-four per cent of patients receiving mastectomy were of Māori or Pacific ethnicity, but only a third of these met the eligibility criteria for PMBR at CMDHB of having body mass index of less than 35 and being non-smokers. Only one Māori woman and no Pasifika women received PMBR at CMDHB in 2017. In contrast, European women made up 50 per cent of all mastectomies, but received 77 per cent of all PMBR.

Dr Michelle Locke, one of six plastic and reconstructive surgeons who specialise in breast reconstruction at CMDHB, said she was surprised by the very low breast reconstruction rate generally, but, in particular, the extremely low rate among Māori and Pasifika patients. “Patient-reported quality-of-life outcome scores are broadly higher for women who have a breast reconstruction than those who don’t, so I’d like to see the rate doubled at least,” she said.

Dr Locke has talked with her colleagues about the resarch findings and what could be done to improve the PMBR rates for Māori and Pasifika women. “We could raise the Body Mass Index (BMI) criteria for Māori and Pasifika to, say, 40, instead of 35, but the thing that would probably make the biggest difference is getting more Māori women to quit smoking, as that is preventing a lot more people from being eligible”.

Dr Locke said smoking cessation programs, such as the Living Smokefree program at CMDHB, which has a strong focus on Māori and Pasifika, work well for delayed reconstruction. The program includes free nicotine replacement therapy and has an 80 per cent quit rate.

“Getting smoking rates down would make a big difference, but it’s challenging for immediate reconstruction – which involves patients stopping smoking as soon as they are diagnosed – because that requires quitting smoking by going cold turkey, as we need them off nicotine completely. That’s very hard for many people.”

More could perhaps be done to make people aware of the option of breast reconstruction. Encouraging conversation around breast reconstruction has been found to be a strong predictor of patients undergoing reconstruction.

The research found that fewer than 40 per cent (69/177) of patients undergoing mastectomy had documentation of discussion of PMBR in their preoperative notes. The authors believe this low rate may reflect the surgeon’s knowledge of eligibility criteria – that is, BMI less than 35 and non smoking.

“International best practice is that every woman who’s diagnosed with breast cancer and who will be treated with mastectomy should have breast reconstruction discussed with them,” Dr Locke said.

“In theory, this is a great idea but firstly, it is hard to ensure this happens for every patient and secondly, a cancer diagnosis is so shattering on its own. To throw breast reconstruction into the mix would be just too overwhelming for some patients.”

Socio-economic factors may also play a role in the differing PMBR rates. “In a population that is more socio-economically disadvantaged and already faces additional delays in cancer treatment, it is highly possible that PMBR poses too great an additional cost in terms of transport, time off work and recovery for Māori and Pasifika women.

“The existence of such barriers may be reflected in the higher rates of non-attendance or declining of breast cancer surgery in Māori and Pasifika patients in this study when compared with other ethnicities.” ■

Oceania University of Medicine names renowned surgeon as Dean for Australia

Oceania University of Medicine (OUM) has appointed Air Vice-Marshal (Retired) Frederick Anthony ‘Hugh’ Bartholomeusz, OAM RFD FRACS as Professor and Dean for Australia. Professor Bartholomeusz is a renowned military physician and plastic surgeon.

Brisbane native Professor Bartholomeusz earned his medical degree from the University of Queensland.

Professor Bartholomeusz was first commissioned into the Royal Australian Air Force Reserve (RAAF) in 1972. He performed clinical duties at RAAF Base Amberley and 3 Combat Support Hospital RAAF Base Richmond, concurrently with his numerous community and teaching hospital positions. He was appointed Director General Air Force Health Reserves and promoted to Air Commodore in 2007. In November 2011, he was promoted to Air Vice-Marshal, serving as the Surgeon General, Australian Defence Force Reserves until 2015.

He has served in many national and international capacities in the Australian Air Force Cadets, eventually becoming World President of the International Air Cadet Exchange Association and Chairman of the Australian Air Force Cadets National Council from 2014 to 2019.

Professor Bartholomeusz obtained his Fellowship of the Royal Australasian College of Surgeons in 1984, and has been a clinical teacher at the University of Queensland since 1985. He was appointed Associate Professor in 2013. At both Ipswich General and Greenslopes Private hospitals, he managed placements and taught medical students from the University of Queensland, Griffith University and overseas medical schools. He was also Clinical Supervisor for interns, junior medical officers, and principal house officers. Professor Bartholomeusz was in private plastic surgery practice in Brisbane and the West Moreton region from 1985 until June 2020. He recently retired from his role as the senior plastic surgeon at Greenslopes Private Hospital.

Professor Bartholomeusz was elected to the Executive of the International Association of Ambulatory Surgery, has been Chairman of the Australian Day Surgery Council, and is a past president of the Australian Society of Plastic Surgeons. He is a section editor of the *Australasian Journal of Plastic Surgery* and has participated in Interplast Australia surgical services and training programs in Fiji.

“I look forward to working with Oceania University of Medicine’s non-traditional medical students and many adult learners who are eager to learn and are focused on the prize – earning their medical degrees,” said Professor Bartholomeusz. “A majority of these students remain practising healthcare professionals during their

preclinical studies, juggling work, families and studies, to answer a call many had, even as children, to become doctors. I am eager to work with them and help them reach that goal.”

One of Professor Bartholomeusz’s first tasks, and a primary role as Dean, is to strengthen relationships with Australian hospitals to arrange and facilitate clinical rotations for OUM students.

He will also work with the Australian Medical Council and the Australian Health Practitioner Regulatory Agency to explore internship opportunities for OUM’s Australian graduates.

For more information visit www.oum.edu.ws ■

Preventing ear disease and hearing loss in Tonga

Dr Sepiuta Lopati is working to introduce screening and early intervention for childhood ear disease in her home country.

Imagine 172 islands floating in the turquoise water of the Pacific where, every year from July to October, hundreds of humpback whales swim 6000 kilometres from Antarctica to give birth and mate. It's a remarkable cycle that sees whale calves born where they were conceived the previous year, and Tonga is one of the few places in the world where humans can swim with these giant, gentle creatures.

This is Dr Sepiuta Lopati's heritage. But like most Pacific Islanders wanting to study medicine, she had to travel to the Fiji School of Medicine to complete her training. After graduating in 2003, she returned to Tonga to complete her internship and was provided with three specialty choices: radiology, pathology or ENT (ear, nose and throat). She chose the latter, she said, because "at that time there was only one ENT surgeon in the whole of Tonga," although since then others have come onboard to provide medical care for the population of 110,000 people.

Ear disease is a common problem in Tonga, especially in children, and that is one of the focuses of Dr Lopati's work. It's not easy, she said, because "there's little awareness or education about ear health", and the only time the medical staff are able to educate parents or collect data is when the families come into the clinic.

The most common ear problems in children in Tonga are acute and chronic otitis media, wax build-up in children's ears and associated hearing problems. Although these health problems are widespread throughout the outer islands, Dr Lopati said she is unable to focus solely on treating ear disease in her daily practice because she is required to look after all three components of ENT.

There's no ENT training in Fiji for Tongan surgeons, and this leaves Dr Lopati to learn from visiting teams of ENT surgeons from Australia and other countries. "If we have difficult cases and need a team to come to Tonga, we contact the Royal Australasian College of Surgeons (RACS)," she said. "We collect all the patients and the team stays for a week and operates. They also give us training and that way we learn more advanced surgical skills," she explained.

RACS Global Health has been supporting Pacific Island countries through the Pacific Islands Program (PIP) since 1995. It is funded by the Australian Government through the Department of Foreign Affairs and Trade (DFAT).

When the PIP commenced, it was almost exclusively clinical service delivery.

Above left: Dr Sepiuta Lopati. Above: Dr Lopati with government ministers and RACS ENT specialty coordinator on World Hearing Day in Tonga.

Today, activities focus on workforce planning, continuing professional development and clinical governance. RACS Global Health works closely with Pacific Island Ministries of Health, facilitating their ownership of the PIP goals for their specific country priorities.

In addition to further training through visiting teams, Dr Lopati travels to countries, such as Australia, to undertake advanced surgical training. She was recently in Australia studying for her Master of Surgery – Research degree at the University of Melbourne, where her supervisor was Professor Stephen O'Leary, the William Gibson Chair of Otolaryngology.

Dr Lopati's masters research included three weeks of collecting data on ear disease and hearing loss from about 600 children in Tonga. It is the first survey of its kind to include children from the rural area of Tongatapu, and Dr Lopati and her University of Melbourne colleagues hope their study will identify the extent of the problem and contribute to ongoing health service planning in Tonga.

In July she completed her masters and headed back to Tonga to continue her surgical work. Dr Lopati's hopes for the future include integrating a primary hearing health service into the existing system in Tonga so that early diagnosis of ear disease in children, screening and awareness education are part of the ongoing medical program.

Waiting for children to present at the clinic at Vaiola Hospital is not ideal, she said. "The kids have to come by boat and some of them have had very complicated ear problems."

On 3 March this year, Dr Lopati was involved in organising Tonga's first World Hearing Day. Representatives from Australia, New Zealand and China attended, as well as the Tongan Minister for Health.

To coincide with this event, RACS Global Health, under the Australian NGO Corporation Program (ANCP) grant from the Australian government (DFAT), was able to support the procurement, delivery and training of a number of pieces of vital ENT medical equipment to assist efforts in combating ear disease in the Tongan population. It was a tremendous day that involved an awareness program about ear health with attendance by the local medical community who, no doubt, were very impressed by Dr Lopati's work in the prevention of ear disease and hearing loss in their country. ■

Education courses update

Education at Royal Australasian College of Surgeons is aiming to recommence from September 2020, for both prevocational and professional development courses. Some previously scheduled courses may not go ahead; however, our Education Services teams are working hard to run as many courses as possible. If you are registered for a course, the program coordinator will be in touch to confirm details. Course registrations will open on Friday 14 August. For more information, visit the RACS courses coronavirus (COVID-19) FAQs in our COVID-19 information hub.

Educator Studio Sessions – Webinars

Each month, the Academy of Surgical Educators presents a comprehensive schedule of education events curated to support surgical educators.

The Educator Studio Sessions deliver topics relevant to, and beyond, the surgical education sphere to help to raise the profile of educators. They provide insight, a platform for discussions and an opportunity to learn from experts.

Register for webinars here.

Course	Start Date	Speaker
A surgeon reflecting on insight	Thursday 27 August 2020	Dr Neil Price
Developing a spine surgery training program using EPAs	Wednesday 23 September 2020	Dr Bryan Ashman

Nursing webinars in the Pacific

The Royal Australasian College of Surgeons' Global Health programs all saw a significant change in operations and programming due to COVID-19 travel and quarantine restrictions. The Pacific Island Program (PIP), which typically mobilises between 40–50 medical teams across 11 Pacific Island countries each year, had to cease the travel of all volunteers. It is funded by the Australian Government through the Department of Foreign Affairs and Trade (DFAT).

In order to continue supporting Pacific countries during this difficult time, the programs pivoted to online and remote support activities. Online nursing forums, which have been held in cooperation with the Pacific Community (SPC) and members of the Australian College of Perioperative Nurses (ACORN) are a key source of information and support for nurses across the Pacific regarding COVID-19 preparedness and training.

Mabel Taoi is project coordinator for the Clinical Services Program at SPC's Public Health Division, and she has 11 years experience engaging with Pacific Island countries. She spoke about the exciting achievement for nursing in the region at the first Pacific Heads of Nursing and Midwifery meeting in February 2020.

Fortunately, the meeting was held just before the closure of borders due to COVID-19. "In hindsight," Ms Taoi said, "the meeting was strategically timed, as it strengthened the nursing leadership networks before the COVID-19 pandemic that followed immediately after."

Sally Sutherland-Fraser was also at the February meeting. She met with Ms Taoi, ACORN Chief Executive Officer (CEO) Rebecca East; Ruth Melville, Past President of ACORN and the Ambassador for the Pacific and Papua New Guinea for the International Federation of Perioperative Nurses (IFPN); and the new Australian Government Chief Nursing and Midwifery Officer, Allison McMillan.

The group was concerned about the pandemic unfolding internationally and agreed it was an opportunity to link Pacific nurses with the nurses in Australia, Ms Sutherland-Fraser said. "As COVID-19 escalated we kept talking to Ms Taoi about accessing more training, trying to think what we could do."

RACS was already using the webinar forum format for other training, and it seemed like a natural fit for the collaboration and connection initiated at the first Pacific Heads of Nursing and Midwifery meeting.

The selection of topics for the webinars emerged in a number of ways. From surveys undertaken after the first 'talanoa' (open discussion) session implemented by SPC, during the online chat discussions, through email responses and via feedback from previous sessions.

Topics covered include the appropriate use of personal protective equipment, infection prevention and control, environmental cleaning, cleaning and reprocessing of equipment, airway management and patient care in relation to managing COVID-19.

The forums are hosted by RACS and facilitated by SPC with panellists such as Fellows and members of ACORN, the Australian College of Peri-Anaesthesia Nurses (ACPAN) and the Royal Melbourne Intensive Care Unit. They are organised by Margaret Leong, the SPC Infection Prevention and Control Advisor.

Pacific nurses are very involved in the format and content of these online sessions through nominating topics and presenting to their fellow nursing colleagues across the Pacific on cases, processes and trainings that have been put in place to ensure COVID-19 readiness across their hospitals.

"Principles are important," Ms Sutherland-Fraser said. "We need to respect the knowledge and wisdom that comes from the Pacific. They know best how the information needs to be applied in their settings and their cultural context. We make sure there's a lot of time for discussion and focus on what's available for them to use."

Ms Sutherland-Fraser said that Ms Taoi was acutely aware of the need to tailor the information presented to the different contexts of the nurses dialling in, and has organised Pacific nurses to present on their experiences with COVID-19.

"It's important for nurses logging in to see the knowledge doesn't exist solely outside the boundaries of their countries. They just need to seek it out and make those connections."

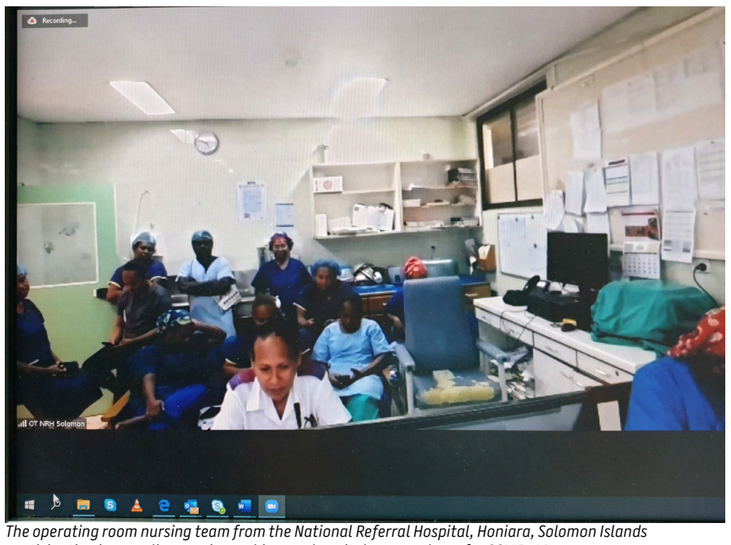
For each forum there have been between 20–40 dial-ins from five to ten Pacific Island nations. Each dial-in can have up to eight nurses on the line. Ms Taoi estimated there have been a total of 50–60 nurses logging in for each webinar.

"The engagement is brilliant and it's great to see the support and the networking," Ms Sutherland-Fraser said. "It's a huge geographical zone and there could be a country of 100 nurses who are now connected to thousands of nurses because of these forums."

Five forums have been conducted so far and it is anticipated that this new model of remote training and exchange will continue beyond the COVID-19 pandemic. As Ms Taoi said, "These virtual engagements are likely the 'new norm' for the future."

SPC, as an organisation, will continue to find new and innovative ways to effectively reach out to the nurses in the Pacific and provide them with opportunities for meeting, learning and networking to stay connected within the Pacific Island countries and the world.

The benefit goes two ways, Ms Sutherland-Fraser added. All participation is completely voluntary with presenters giving their own time. "Everyone wants to provide the support they can and everyone comes away with a new insight into the challenges for nurses working with limited resource settings." The Pacific nurses participating "are adaptable, creative and a great inspiration to me." ■



The operating room nursing team from the National Referral Hospital, Honiara, Solomon Islands participating in an online nursing webinar on hospital preparedness for COVID-19

2021 John Corboy Medal – call for nominations

Have you worked with an outstanding Trainee who you think should be recognised?

The prestigious John Corboy Medal is awarded annually to a Trainee who demonstrates the characteristics for which John was admired. The award is made to a candidate who shows some or all of the following qualities:

- Outstanding leadership
- Selfless service
- Tenacity
- Service to Trainees of the College.

These qualities must be demonstrated in either the performance of their duties, service to the surgical community, the manner of and approach to the fulfilment of their surgical training and/or by their commitment to, and involvement with, the community of surgical Trainees.

Nominations for the 2021 award close on Friday, 28 August 2020. Nomination of a candidate for the award may be made by either a Fellow or another Trainee. Please email racsta@surgeons.org to request a nomination form.

Further information about the John Corboy Medal can be found here.

Meaningful medicine at its best

Twenty-five years ago Professor Herwig Drobetz, then a medical student in Austria, attended a presentation by a surgeon who had returned from an assignment with international humanitarian aid organisation Médecins Sans Frontières (MSF), also known as Doctors Without Borders.

Professor Drobetz was so captivated that he decided instantly that he wanted to be part of the movement that he describes as "meaningful and immediate medicine". He trained as a specialist trauma surgeon in Austria and moved to Queensland for a Fellowship before finally establishing roots in Mackay as an orthopaedic surgeon.

Fast-forward to 2018, and that life-long dream came into fruition when Professor Drobetz was matched to work with MSF in Hassakeh, in north-eastern Syria. "Every day in Syria we saw patients with gunshot wounds and severe burns and victims of landmines. Working alongside a general surgeon, we focused mainly on acute surgery for life-threatening injuries," he said.

During his second and third stints with MSF, this time in Gaza, the surgical approach was different. The project focused on surgical and post-operative care, including rehabilitation and mental health support, for people who were injured during the Great March of Return protests in 2018 and 2019. Thousands of protestors were shot – mostly in the legs – resulting in chronic wounds, fractures, bone defects and infections.

It was well outside his comfort zone: "It's highly specialised surgery. Reconstructive work on lower extremities with chronic infections is not easy and you have to be quite specialised for that."

He applied the techniques and procedures he would back home, with some improvisation.

"We started introducing the Masquelet technique in Gaza – an elegant way to deal with bone defects in a low resource setting, making later bone grafting much easier. Although the technique is regularly used in Australia and many other countries, it was not available in Gaza. We had to overcome a few hurdles, for example we had no intraoperative imaging (relying solely on vision) and difficulty getting bone cement into Gaza. Stable fixation was also difficult as we didn't have access to plates or nails, just external fixators."

"In my hospital back home in Lismore, northern New South Wales, I am doing about five Masquelet cases per year; whereas, in Gaza there are about 4000 patients who could benefit from it. This is just one step, however, and you then need to cover that bone with muscle flaps with input from the plastic surgeon," he said. "The biggest challenge in Gaza is that you have thousands of patients who need sophisticated reconstructive procedures on their lower extremities, and there's not enough surgeons trained to do that," Professor Drobetz explained.

For anyone considering a placement with MSF, Professor Drobetz said, "I was quite apprehensive about whether I had the skills to deal with the unknown, but I prepared by reading papers, books and attending several courses focused on surgery in low-income and resource-poor settings. You can expect to be working outside your comfort zone, but you quickly learn how to do a lot with nothing and it is extremely rewarding.

"You really go back to basics and learn how to improvise under pressure. The best part about it are the experiences you form with the local surgeons – I've made wonderful friends both in Syria and Gaza as a result."

Regardless of where you go, the most important thing is to make your contribution sustainable, said Professor Drobetz. "Do not sign up with the intent to do sophisticated surgeries because you're only there for eight weeks.

"Instead focus on training so that you have staff on the ground who can continue to manage the patient follow-up. There needs to be continuity of care and informed follow-up.

"Going with a well-established organisation like MSF is extremely crucial because they have a big network of support to help you through it. It is meaningful medicine at its best!" ■

Médecins Sans Frontières, or Doctors Without Borders, is urgently recruiting general, paediatric, plastic and orthopaedic surgeons available to work in the field for up to eight weeks.

For more information visit www.msf.org.au or contact SydneyFieldHRRecruitment@sydney.msf.org

Spotlight on

Advocacy during COVID-19

The Royal Australasian College of Surgeons is committed to adopting informed and principled positions on issues of public health.

We have a proud tradition of effecting positive change in health care and the broader community by regularly advocating for positions across a number of different mediums. This includes through media, public campaigns, negotiating directly or by providing written submissions to governments.

Advocacy update

Read on for a list of some of our recent advocacy work.

Pregnancy warning labels for alcoholic beverages

The College is pleased to share that alcohol bottles will need to display a prominent warning label outlining the dangers of drinking while pregnant.

This will become mandatory across Australia and New Zealand following a decision by the governments of both countries in July.

New Zealand and Australia, which have a joint food regulation system and share food standards for labelling, currently have voluntary labelling of alcoholic beverages with health warnings about not drinking alcohol while pregnant.

Following this decision, manufacturers will now have three years to implement a standard pregnancy warning on alcoholic beverages. For bottles larger than 200 millilitres, the standard labels will have black, white and red text stating "PREGNANCY WARNING: Alcohol can cause lifelong harm to your baby."

Smaller bottles will need to display the pictogram, which will be required to print a picture that also uses the black, white and red colour scheme.

RACS firmly believes the alcohol warning labels will significantly improve community awareness of the risks of drinking alcohol throughout pregnancy, and will result in fewer babies born with fetal alcohol spectrum disorder in years to come.

We would like to thank the Trauma Committee and the many Fellows who have contributed to our advocacy efforts against the harmful effects of alcohol and illicit drugs over many years.

RACS congratulates the Australian and New Zealand governments for taking strong leadership in this area, despite vocal opposition from the alcohol industry. We also acknowledge the hard work of the Foundation for Alcohol Research and Education (FARE) and other like-minded organisations, as well as the many practitioners and researchers who campaigned for this reform.

Health arrangements in natural disasters

In April, RACS made a submission to the Royal Commission into National Natural Disaster Arrangements. The Commission subsequently released an issues paper for public comment. The issues paper explores some of the health and mental health arrangements in relation to natural disasters in Australia. It provides an overview of Australia's health care arrangements and discusses the role of primary care providers, the health effects of bushfire smoke, and whether there is a need for greater research into any particular health effects of natural disasters.

The paper poses six questions on which the Commission invited comments and submissions from the community, and particularly encourages health care providers, health policy departments and agencies, researchers, emergency coordinators and practitioners to provide their views.

RACS sent a submission to the Commission in June, in which we expanded our initial submission from April. The response also made additional recommendations in relation to research priorities and communication strategies. The full submission is available on the RACS website.

First meeting of the new RACS Advocacy Working Groups

In the first week of June, both the Sustainability in Health Care Working Group (SIHCWG), led by Chair, Professor Mark Frydenberg, and the Environmental Sustainability in Surgical Practice Working Group (ESSPWG), led by Professor David Fletcher, held their inaugural meetings via videoconference. Members of each working group were asked to rank their priorities prior to each meeting, which formed the basis for the following set of collective priorities for each group.

SIHCWG priorities

1. Cost of surgery and out-of-pocket expenses
2. Outcomes data
3. Private health insurance sustainability

ESSPWG priorities

1. Reduce rubbish produced in operating theatres by reusing, recycling and reducing excess use of disposables. Influence hospital procurement programs by developing College guidelines (similar to 'Greening the OR').
2. Develop advisory role within the Therapeutic Goods Administration to approve the more environmentally responsible medical devices and equipment.
3. Advocate to state, territory and federal governments on sustainability.
4. Advocacy to governments on the health implications of climate change, both alone and in conjunction with other Colleges.

In addition to the above priorities, a key focus of the ESSPWG will be to continue to review and update the College's Position Paper on 'Reduce, Reuse, Recycle, Rethink, Research' to provide more specific guidelines (as developed by Australian and New Zealand College of Anaesthetists).

The Working Group also discussed a recent submission to the Australian Prime Minister from medical professionals titled 'Climate Change Statement Australian Health Professionals (Post Covid 19 Health Recovery)'. The Working Group expressed its support for this submission.

The SIHCWG agreed to develop a list of three or four key policy and advocacy projects to work on for the remainder of the year. In addition to this, the Working Group will also take the lead in promoting telehealth advocacy as well as responding to the Council of Australian Governments and Victorian Health Department Protection of Title consultation.

The terms of reference for both working groups allow extra members from both inside and outside RACS to be co-opted for specific issues.

They also encourage extensive involvement with specialist societies and associations, and various other RACS committees, such as the Rural Surgery Section, the Surgical Oncology Section, and the New Zealand Board and state and territory committees. ■

Fires, floods and COVID-19: the Shoalhaven Hospital Group

Bushfires of summer 2019–2020

As the whole of the east coast of Australia burned in the summer of 2019–20 there were important lessons learned for the New South Wales rural region.

The fires were so ferocious and quick that hospital staff left their duties at the hospital to defend their home and businesses. Those going home were often difficult to follow and contact, and their roles had to be filled from within the hospital.

The fires forced a stop on elective surgery and only the emergency cases proceeded. Patients and some staff were unable to attend the lists because of roadblocks, lack of petrol and severe fire conditions. The safety of the surgical staff was the most important priority.

Those practitioners who did not have young children were used as the front-line while those with young families were kept out of the region. Aside from ensuring their safety, this allowed them to be a little more rested and to relieve their senior colleagues when the emergency was over.

The most senior nursing staff member moved to casualty and a local nursing member was immediately appointed second bed manager (BM), the most senior administrator on site.

One duty of the second BM was to try to contact all staff who had left to go home to ensure they were safe. They also assisted the senior administrator in organising a roster that was based on geographic location of the staff rather than seniority. This led to problems of skill mix within specialised areas such as theatres, the intensive care unit (ICU) and casualty.

Another role of the second BM was to communicate with the two evacuation centres that were established for the population escaping the fires. Only patients were allowed in the hospital, thus a member of staff became the liaison between the hospital with the evacuation centres to communicate between the patients and their relatives and visitors.

We have now re-established the practice, begun during the fires of 2001, of distributing and replenishing special boxes to general practitioners and evacuation centres. These contained supplies to help treat burns, eye injuries and dehydration, as well as the phone numbers of the heads of the departments at the Shoalhaven Hospital.

Because of the intensity of the fires and their proximity to the town there was a loss of the phone towers leaving us without telecommunication – there were hours when we were unable to use any phone system. We had a staff member equipped with a satellite phone situated in a tent outside an evacuation centre, so we could keep in contact. On one occasion the whole surgical team stayed in one house very close to the hospital and, as the on-call surgeon, I went and got them when they were needed for theatre. While difficult, it certainly functioned as a team-building exercise.

On New Year's Eve the staff hosted their families in the tearoom and the education room of theatres for safety reasons. While all fast food outlets were closed, only one supermarket was open and most food products were gone, we managed to accumulate enough food for the whole team and their families, and we were able to enjoy the entry of the New Year together in the theatre.

Floods

Within three months of the fires a huge deluge hit the area, and access was destroyed for a second time. Again, the surgery list was restricted to emergency cases but, thankfully, all team members could be used. The roads were blocked again, so once more the geography of the staff was vital to provide a service.

Accommodation was provided in town and often shared with colleagues because of the changeable nature of the road closures.

COVID-19

The *Ruby Princess* ship docking in Port Kembla presented Illawarra with an education on treating this coronavirus in an at-risk population.

I personally saw and appreciated some changes that will be of ongoing advantage to our hospital and Illawarra Shoalhaven Local Health District.

The signage around the hospital was made much clearer, initially around visiting hours and the location of the COVID-19 testing clinic. Public access was restricted to three doors and had an immediate benefit for those testing temperatures, but also in providing information about hospital wards and activities. This could be applied in future to stop the public from becoming lost or accidentally finding their way into areas not intended for general use. Another measure that should be maintained is the practice of greeting each employee every day, taking their temperature and asking about their wellbeing.

The transition zone in the undercroft, which provided showers to those arriving and leaving the hospital precinct, was an excellent addition to the staff services and should also be continued.

The storage cabin positioned in the car parking area near Shoalhaven Aged and Geriatric Unit became a vital addition for the storage of personal protective equipment (PPE), which is still a concern. It has become an ongoing necessity for the hospital.

Zoning the hospital into COVID-19 and non-COVID-19 areas was established very early. We planned for surge capacity, relocating the cardiac care unit (CCU) into the back of recovery and using the old surgical ward (now known as COVID Medical) as a surge facility. The separation of the air conditioning between COVID Medical and the Maternity Ward provided a sense of security for both wards. It demonstrated the necessity of separation (ie: separate air conditioning, sewerage, electrical and platform networking systems) when building wards in the future. All hospital staff were advised to wear surgical scrubs, and each ward was given supplies of clothing and a place to change. This will be of obvious future benefit.

One issue was an unchanged system for door access within the hospital, which led to the loss of PPE. Card access would resolve this problem. Another was the difficulty in accessing WIFI across the hospital and the lack of cameras on hospital computers, which made videoconferencing impossible.

The lack of one electronic patient platform across the hospital has made a lot of education and increasing skill mix and in hospital communication more difficult.

The focus on day patients-only was, and will continue to be, a great source of pressure on the short-stay and day-only teams. In the future, our capacity will need to be increased significantly to keep up with the demand.

I had the advantage of seeing the workings of the hospital from both a Head of Department (HOD) role and as an acting Director of Medical Services (DMS). I was impressed by the immediate move by General Manager, Mr Craig Hamer, to establish a number of advisory groups, and how the senior members of the hospital family came together. I include in this the senior leadership group in Wollongong, as it became vital that there was a direct line of communication and action from the executive to all hospital administrators, line managers and HODs.

The HODs COVID-19 meeting was an excellent forum for discussion and dissemination of ideas and information. The interaction between medical, administrative, ancillary and nursing leadership was the reason The Shoalhaven Hospital Group (David Berry Hospital, Shoalhaven Hospital and Milton-Ulladulla Hospital) was able to act as one and, I believe, stay ahead of the developing situation. These meetings are useful under any circumstances and will certainly help in any future emergencies.

The resident medical officers were allocated to a single bedroom and single bathroom for their accommodation to avoid losing multiple doctors if one doctor became ill. Meanwhile the provision of food to the staff, especially on long 12-hour shifts, was lacking, and was not helped by the closure of many outlets in the town at an earlier hour than normal. Interestingly, we saw that same problem during the fires. This is something to address for the future.

We appreciated the trust placed in us by the senior management. This was demonstrated when we cancelled elective surgery well ahead of the directions of the state or federal health departments. I am grateful to all my colleagues who have been working tirelessly: Rae Phillips and Glenn Ball to satisfy the needs of the health department with emergency and elective surgery; Dr Timothy Skyring and Kate Fish as co-directors for surgery; the theatre nursing staff who were a vital cog, including acting Nurse Manager, Luke Royston, and acting Educator, Amy Barrett, who were thrown into the fray; Dr Joanne Moore for the anaesthetic department rostering and the ubiquitous guidance of Dr Sumati Joshi; Leanne McTavish, who took on the difficulty of establishing a nursing roster for theatre, recovery, ICU and COVID-19 intubation; the continued guidance and advocacy of Operations Manager Karon Stalgis; the vital and ongoing advice from my colleague Dr Anna Leavy, a retired anaesthetist and former DMS at Shoalhaven Hospital; Drs Warren Bruce, Robert Gillies, Stafford Hughes and Anthony Fitzpatrick in anaesthetics who provided teaching and counsel; Dr Izham Cheong in the role of Skype guru and educator; Kate from ancillary services and the wonderful assistants in administration who were constantly helping the luddites. Meanwhile, the daily information sheet from Craig Hamer and the letter from Chief Executive Officer Margot Mains were keenly read and provided essential updates that sometimes changed every few hours.

The citizens of the Shoalhaven local government area were very pleased to hear of the progress made in their local hospitals. They were happy to take up the option of using telehealth. This is a development that should be maintained, with efforts aimed at the older population for easier access to such a service.

We must now utilise the experiences gained by the fires, the floods and the pandemic in how to run the hospital for dual streams of care. The flow of staff and patients through the hospital must be ordered and deliberate to maintain safety for all. There must be clinics utilising telemedicine and plexi-glass facilities to protect clerical and medical staff.

Cohorting and provision of pods within hospitals are essential for ongoing care with COVID-19 and into the future, especially when planning new medical facilities.

One of the most important aspects is to maintain the new skills learned by nurses who are from other parts of the hospital or are from retirement in ICU. Their hard-earned skills must be updated regularly, for example, through a regular rotation through ICU or CCU. Additionally, the use of simulation exercises is necessary for all areas of the hospital and disaster planning should be carried out every six months and can be tailored to any emerging situation.

As with the bushfires, placement of doctors, nurses and ancillary staff into safe accommodation early in the pandemic was essential. To avoid telecommunications issues, accommodation for senior staff when on call should be available on site. Food for after-hours duty is also needed.

We should note the importance of keeping senior staff available for different and variable roles within the hospital. Keeping senior staff for counsel, education and hospital leads are vital. This year we have coped with fires, floods and now the pandemic; no holidays have been taken for many months and the staff need to be protected from exhaustion. ■

Professor Martin Jones
FRACS
Head of Surgery,
Shoalhaven Hospital Group

Telehealth in the bush

It is well recognised that rural communities have poorer access to surgeons and surgical care. Thirty per cent of Australians live in rural, regional and remote areas, as defined by the geographical classification system Modified Monash Model (MMM 2-7). However, only 12 per cent of surgeons live and work rurally. A further 18 per cent of urban specialists provide intermittent rural outreach services.

The 2018 Royal Australasian College of Surgeons (RACS) census showed that for five of the nine surgical specialties, less than 5 per cent of surgeons were based outside cities.[1] Tertiary care is centralised in the capital cities and, as a result, many patients and their families must travel great distances, sometimes more than 24 hours, to access surgical care.

Using telehealth has reduced the barriers to delivering care in geographically challenging settings. It has become essential to these rural communities, as it provides convenience to families, reduces outreach clinics and supports rural health professionals. Although telehealth will not replace face-to-face consultations, it plays a significant role in continuity of care.

While the benefits of telehealth are acknowledged, surgeons and other consultant specialists have only had access to Medicare reimbursement for video-consultation services provided to patients from 1 July 2011.[2] The Medicare Benefits Schedule (MBS) item 99 can be billed with an existing specialist consultation item (either 104 or 105) for video-consultations and increases the base schedule fee for the consultation item by 50 per cent. Co-claiming these telehealth MBS items has been exclusive to those surgeons and patients in 'telehealth eligible areas', which are determined by the Australian Standard Geographical Classification Remoteness Area classifications. MBS benefits are only available for services provided to patients who are not admitted and when patient and surgeon are at least 15 kilometres apart.

These arrangements can have unintended impacts on accessibility and efficiencies. The removal of the requirement that the patient is not an admitted patient would allow surgeons to provide consultations to patients in public hospitals (emergency departments and wards) when specialists are unable to travel to these hospitals.

It could be applicable to scenarios where there is a cessation of outreach clinics, reduced on-call due to no surgery happening, or if the local surgeon is in self-isolation. Telehealth for in-patients in public and private hospitals would be beneficial as it could allow patients to be recommended for a referral to rural hospitals, which can be closer to home.

We advocated for improved access to specialist services for all patients on MBS, by removing requirements on in-patient admission in a recent submission to the Australian Deputy Chief Medical Officer, Professor Michael Kidd, and the Australian Federal Department of Health. This was in response to their consultation on stage 5 for specialist MBS telehealth items.[3] Telehealth would also allow subspecialist surgeons (with narrow scopes of practice) to readily support their rural generalist (broad scope of practice) surgical colleagues and general practitioners.

Internet access in regional and rural areas is not equitable, as observed in some areas in Western Australia, where it is almost non-existent. National Broadband Network (NBN) or 5G connectivity is crucial to allow for telehealth and teleradiology.

Geographically linked rebates for phone telehealth, where video services are not supported on current internet capability, and using free video calling apps could be avenues to overcome technological gaps.

Social distancing and quarantine rules, as well as the lack of personal protective equipment, amid the COVID-19 pandemic has highlighted the importance of telehealth as an adjunct for provision of care.

Prior to the introduction of the temporary COVID-19 telehealth MBS items, audio-only consultations were not recognised as telehealth and, thus, did not attract an MBS benefit. The rapid adoption of telehealth in the urban areas has seen swift changes in government policies and regulations related to Medicare reimbursements, NBN connectivity and infrastructure improvements. We hope to see this momentum translate into improvements in the telehealth experience for those in the rural, regional and remote areas.

RACS held a couple of webinars on telehealth and digital prescribing in June and July. The presentations demonstrated how surgeons can perform telehealth consultations and highlighted a new research proposal to understand patients' telehealth experience within surgical practice. You can listen to a recording by searching for 'RACSurgeons' on Youtube. ■

REFERENCES

1. Royal Australasian College of Surgeons. 2018 Surgical Workforce Census Summary Report [Internet]. 2019. Available from: https://www.surgeons.org/resources/reports-guidelines-publications/workforce-activities-reports.
2. Australian Government (2011). Health Insurance (Telehealth Services) Determination 2011 of the Health Insurance Act 1973, Federal Register of Legislative Instruments F2011L00954, 23 May 2011.
3. Royal Australasian College of Surgeons. RACS Submission to Consultation on stage 5 for specialist items for telehealth [Internet]. 2020. Available from: https://umbraco.surgeons.org/media/5202/20200407_141515_sub_racs_doh_consultation-specialist-telehealth-items_fin.pdf.

The COVID-19 experience in North-West Tasmania

On Friday 3 April 2020 two cases of COVID-19 were reported at the North West Regional Hospital in Tasmania. The positive cases were returned travellers who had been on the *Ruby Princess* cruise ship. The next day a third case of COVID-19 was reported.

Over the following week a further 21 cases of COVID-19 were identified in medical staff and patients. Cases were identified in the public hospital, the private hospital, among theatre staff, ward staff, outpatient clinics and in pathology.

Such was the rapid spread of the virus through the hospital and medical workplace that by 12 April, (nine days after the first cases were identified) the public and private hospital were closed. The number of staff and health workers placed into quarantine reached 1300.

The military was called in to run the emergency department for the North-West of the state. By 21 April, 114 people had contracted COVID-19. Of these, 73 were hospital staff members, of which 33 were medical staff. Twenty-two patients and 19 household contacts made up the remaining cases.

North-West Tasmania had become the epicentre of the COVID-19 virus in Australia at the time. Health workers and patients at the North-West regional public hospitals had become infected with the virus. The virus had crossed the road, spreading from the public to the private hospital, from the emergency department to theatre, the wards and the outpatient clinic. The north-west of the state progressed into a lockdown, with 5000 people going into quarantine.

The Launceston General Hospital (LGH) was now responsible for an extra 100,000 people. It faced a scenario where all patients coming from the North-West were possibly infected with the virus.

Wards at the LGH quickly transformed into 'blue wards' (for at-risk or infected patients), theatre access was greatly restricted, and the hospital struggled with bed access. To cope with this onslaught, the private hospitals in Launceston came to the assistance of the LGH and essentially became an extension of the public hospital.

The surgical and medical community divided into 'green' and 'blue' teams. Five emergency theatres were run per day in the private hospital for 'green' (unlikely to be infected) patients.

Care was provided for approximately 370 emergency and Category 1 cases (public and private) over a six-week period. Surgery and medical care was performed through the private hospital in a safe and efficient manner.

Meanwhile, the LGH theatre complex turned into a demanding and stressful 'donning and doffing blue zone', providing surgical and medical care for at-risk or infected patients.

This was a great example of how, when faced with a crisis, the medical and surgical community came together. It was a strong demonstration of teamwork, dedication and community spirit in working through the pandemic.

No health workers have died from the virus as yet, although sadly some are yet to return to work. Twelve people in the North-West of Tasmania have died from COVID-19.

The Tasmanian government subsequently commissioned a report into the outbreak.

Factors that may have enhanced person-to-person transmission in this setting were:

- Staff attending and continuing to work while experiencing respiratory symptoms
- Workplace activities such as regular staff gatherings with people in confined spaces
- Incomplete or delayed identification of close contacts of confirmed COVD-19 cases for immediate isolation to limit further transmission
- High levels of staff mobility between different healthcare facilities
- Transfer of undiagnosed infectious or incubating patients between healthcare facilities

Recommendations to mitigate risk in Tasmanian Health Service settings included:

- Strengthening the culture of safety regarding infection control practices, including optimising standard and transmission-based precautions.
- Implementing procedural changes to strengthen social distancing in the hospital workplace (e.g. meal breaks, meetings, ward rounds, handovers and other work-related activities).
- Addressing the drivers of presenteeism and implementing processes to prevent this including screening all people, including staff, for symptoms on entry to the workplace.

Hopefully the lessons learned in Tasmania can be applied to other health regions as cases of COVID-19 continue to emerge. ■

Mr David Penn FRACS
Chair, Tasmanian Board

Why the title ‘surgeon’ matters

The Australian Society of Plastic Surgeons is working with the Royal Australasian College of Surgeons (RACS) to protect the use of the title of ‘surgeon’. While some may dismiss this as a turf war between plastic surgeons and cosmetic practitioners who use the title, this initiative is regrettably necessary because of an important public health issue that directly impacts patient safety.

Unfortunately, in recent years there have been a disturbing number of surgical patients who have suffered major complications at the hands of doctors with no formal Australian Medical Council (AMC)-accredited specialist surgical training. Yet they advertise themselves as fully trained ‘cosmetic surgeons’. Many of their patients mistakenly believed the person performing their procedure was a fully trained and accredited surgeon. The consequences of this have been significant – in some cases devastating.

Some of these commercial operators are propelled by social media and aggressive marketing, and their techniques make it difficult for consumers to discriminate between providers, which is increasingly compromised by the lack of protection around the use of the title ‘surgeon’.

Too often, people, insecure about their appearance, are persuaded that a surgical procedure will resolve their discomfort without fully understanding the associated risks. When confronted with advertising or websites promoting ‘cosmetic surgeons’ most, not unreasonably, assume that the title refers to the appropriate level of officially sanctioned training and assessment typically associated with those called a ‘surgeon’. In other words, it is assumed that these practitioners have the same skills as a specialist bearing the letters ‘FRACS’ after their name.

The decision to undergo cosmetic surgery, and the research into the risks and techniques employed, tends to be undertaken on the internet and through social media. General practitioners or other appropriately skilled medical advisers are rarely involved in the patient’s decision to seek and undergo cosmetic surgery. Frequently, patients research surgeons and the operations in isolation, and believe what they read on the internet. Many of the cosmetic surgeon websites and social media posts are deliberately confusing. They falsely augment the level and complexity of the individual’s surgical training, and are designed to mirror official AMC-accredited training bodies in their language, the use of titles, and through the use of letters after the practitioner’s name. In many cases it is impossible to differentiate between the official AMC-accredited body and the imitation.

We believe this ability of practitioners with no AMC-accredited training in surgical practice to call themselves ‘cosmetic surgeons’ is a dangerous loophole in our health regulation that all too frequently leads to serious misjudgements by vulnerable members of our society. This needs to change.

The term ‘cosmetic surgeon’ is not a recognised title within the Australian Health Practitioner Regulation Agency (AHPRA) and despite APHRA legislating that “it is important that the use of a title does not lead a consumer to believe the practitioner holds specialist registration or an endorsement they do not hold”, there is no restriction on the title ‘cosmetic surgeon’: any doctor can use it, irrespective of their level of training.

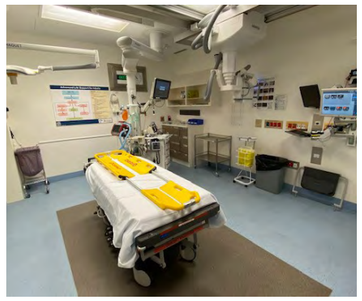
The New South Wales Parliamentary Report into Cosmetic Surgery recommended banning the use of the title ‘cosmetic surgeon’ to eliminate consumer confusion. Australian state and territory governments are now considering restricting the use of the title ‘surgeon’ to only those with an AMC accredited surgical training qualification, such as FRACS.

This would provide transparency about the level of training that a particular medical practitioner has undertaken and would enable a patient unfamiliar with medical terminology or AMC processes to accurately assess their proposed surgeon’s qualifications and training.

We believe that it is not unreasonable for a patient to expect that the person operating on them and calling themselves a ‘surgeon’ is, in fact, a surgeon, in the same way that their brain surgeon is a neurosurgeon, their heart surgeon is a cardiothoracic surgeon, or their hip is being replaced by an orthopaedic surgeon. In each of these examples the surgeon is AMC accredited, and their level of training is clear, transparent and able to be objectively benchmarked against a predetermined government standard. ■

Professor Mark Ashton
MBBS MD FRACS
Specialist Plastic Surgeon
RACS Specialty Elected Councillor
Past President, Australian Society of Plastic Surgeons

Trauma surgery during COVID-19: a South Australian perspective



When COVID-19 took hold, South Australia, much like the rest of Australia and New Zealand, shut down rapidly. Consequently, we were fortunate that we experienced no COVID-19 positive patients in our trauma department.

Although elective surgery was shut down, we, as trauma surgeons and emergency surgeons, maintained full staffing and emergency services. We trained to fit protective clothing to ensure that we minimised any risk of contamination.

This included being trapped in the operating theatre post-operatively, allowing the air conditioning to clear the virus before we could scrub and leave the operating theatre. For patients who were high risk, aerosol producers such as laparoscopy with smoke producing procedures like diathermy, smoke evacuation using an N-98 filter on an inflation port was used.

The Emergency Department and anaesthetists realised that if there was a COVID-19 positive patient, all drugs in the drug cart in the theatre, or in the resuscitation room, would have to be thrown away after a drug cart drawer was open for use. This would equate to thousands of dollars of drugs being thrown away.

As a result, the Emergency Department and the anaesthetists made up small packs of commonly used drugs, which would result in enormous cost savings.

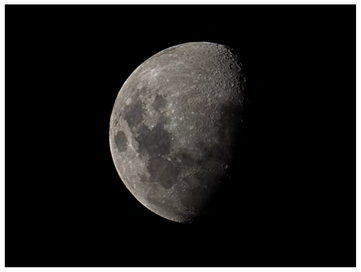
While this period has been very difficult for many, it has, nonetheless, allowed us to make many interesting observations. In many ways the lockdown demonstrated that trauma is a social disease that does not occur in lockdown, namely issues such as drink-driving or bad driving.

We noted an approximately 80 per cent reduction in trauma during the COVID-19 lockdown. We had feared there would be significant increases in self harm, as well as domestic violence incidents requiring admission to surgical trauma. Thankfully, neither of these occurred.

It was also noticeable that non-surgical conditions, like abdominal pain and pelvic pain, almost disappeared from the emergency departments during the lockdown.

Our trauma surgery teaching to junior staff continued during the lockdown with social distancing where we could not conduct a normal teaching session. I used Microsoft Teams to great effect, so I could continue to provide teaching to the juniors, which otherwise would not have happened because of social distancing.

As trauma surgeons we found that our main danger was from dying of lack of work during this period. Obviously, with more time on my hands, I significantly improved my photographic skills! ■



Mr Peter Bautz FRACS

Above photographs by Mr Peter Bautz

Reduction in childhood trauma during lockdown in New Zealand

On 11 March 2020, the World Health Organization declared coronavirus disease 2019 (COVID-19) a pandemic.[1] On 25 March 2020, New Zealand declared a state of national emergency and a lockdown known as 'Alert Level 4'. People were instructed to stay at home except for essential movement, recreational activity was limited to local areas, travel around the country was severely limited, all gatherings were cancelled, public venues closed, businesses except essential services closed, schools and universities closed and healthcare services reprioritised.[2]

No event had led to such restrictions on daily life in New Zealand since the Great Influenza Epidemic of 1918–1920.[3] Most parents and virtually all children stayed home. Traffic on the roads was minimal. Could such restrictions on families be the ultimate in injury prevention and lead to a reduction in trauma admissions? At the end of the lockdown, we looked at how paediatric trauma patterns had changed at our centre.

Starship Child Health is New Zealand's only designated paediatric major trauma centre, and it admits approximately 1000 trauma patients annually. We interrogated the children's trauma registry for admissions from 26 March 2020 until 27 April 2020, the period of the lockdown, and compared these to the same date range from the years 2016 to 2019.

We found that the total trauma admissions during the lockdown were at a five-year low. There were 57 trauma admissions (four major trauma) during the lockdown compared to an average of 85 (six major trauma) during the same period in previous years. Incoming transfers from around New Zealand were reduced, consistent with a nationwide effect.

The lockdown coincided with a period of relatively warm, fine weather in New Zealand that, in our experience, would increase trauma rates. Instead, trauma rates decreased across all aetiologies except for bicycle trauma, which increased fivefold to a five-year high. The percentage of children injured on bicycles during this period was 19 per cent compared to an average of 3.6 per cent in previous years. To understand the reasons behind the changes will require further analysis, but it is probably linked to reduced traffic on suburban streets and increased supervision of children at home.

Some may interpret the jump in bike trauma as an injury prevention problem to be addressed. Others may feel warmed to see children able to cycle the streets again like in previous times. The nature of bike injuries were mostly minor, predominantly limb and soft tissue injuries (although we saw one handlebar injury to the abdomen resulting in subserosal bruises on the colon but no perforation).

Our figures were too small to show a significant reduction in road trauma; however, data from the New Zealand's Midland Trauma System showed that in the first two weeks of the lockdown, motor vehicle crashes dropped to almost one quarter compared to the two weeks prior.[4]

Injury prevention was not the only winner from lockdowns around the world. Air pollution levels decreased by 20 per cent across countries affected by the pandemic, with potential benefits on paediatric asthma and the global air pollution health crisis.[5] Carbon dioxide emissions also decreased.[6] Now is a good time to reflect on how we can approach, not only injury prevention, but also the wider issues of health and the environment in a new and meaningful way. ■

Summarised from an article by James K. Hamill, PhD, FRACS and Matthew C. Sawyer, DipHE, MN, CAISS, published in the ANZ Journal of Surgery *as an Early View perspective on 14 June 2020. The full article can be read here.*

REFERENCES

1. Nature. Coronavirus: the first three months as it happened. 2020. [Cited 5 May 2020.] Available from URL: https://www.nature.com/articles/d41586-020-00154-w
2. New Zealand Government COVID-19 alert system. Unite against COVID-19. 2020. [Cited 5 May 2020.] Available from URL: https://covid19.govt.nz/alert-system/covid-19-alert-system/
3. Summers JA, Wilson N, Baker MG, Gottfredsson M. The influenza pandemic of 1918–1919 in two remote island nations: Iceland and New Zealand. N. Z. Med. J. 2013; 126: 8.
4. Christey G, Amey J, Campbell A, Smith A. Variation in volumes and characteristics of trauma patients admitted to a level one trauma centre during national level 4 lockdown for COVID-19 in New Zealand. N. Z. Med. J. 2020; 133: 81–8.
5. Venter ZS, Aunan K, Chowdhury S, Lelieveld J. COVID-19 lockdowns cause global air pollution declines with implications for public health risk. medRxiv 2020. https://doi.org/10.1101/2020.04.10.20060673
6. Molintas DT. Analysis of coronavirus and carbon emissions. 2020. [Cited 7 May 2020.] Available from URL: https://mpra.ub.uni-muenchen.de/98858/

Prominent Darwin surgeon retires

Associate Professor and RACS Censor-in-Chief, Dr Phillip Carson, retires from active surgery

In late-June, the medical community in Darwin came together to farewell Associate Professor Phillip Carson (pictured, below) as he retired from active surgery. A much-admired and popular general surgeon, Phill, as he prefers to be called, first arrived at the Royal Darwin Hospital (RDH) in 1981. Evidently, he'd been trying to retire for two years, and whether he couldn't leave a job that needed him or they wouldn't let him go – he had made the decision.

Dr Stephanie Weidlich, who, herself, arrived at the RDH as a General Surgery Fellow almost 10 years ago, described him as a mentor and friend.

"Phill has taught me many things," she told the guests. "How to give one's heart; how to treat another's heart; and how to hold and pump a dying bloody heart in my own hand."

Dr Weidlich was one of many colleagues and friends who gathered to celebrate Phill's "extraordinary career and life".

They fondly recalled his great mentorship, inspirational teaching and friendship. Video tributes from registrars who couldn't travel from interstate, due to COVID-19, were played. Phill's wife, local general practitioner Dr Bronwyn Carson, was there along with those of their six children who could make it.

The Northern Territory (NT) Health Minister, the Honourable Natasha Fyles, also attended. She presented Associate Professor Carson with a plaque on behalf of the government, thanking him for his longstanding service to the people of the NT.

Phill originally intended to become a general practitioner. He wanted to work in "a small remote place" and in his second year out of university he went to Alice Springs to follow up on that plan. Serendipitously, he ran into Dr John Hawkins, a specialist medical officer operating there "initially, entirely by himself". He'd been there for many years and performed the entire range of surgery, "very well, very modestly and very competently", Phill said. "I found him inspirational."

Sadly, Dr Hawkins died that same year. He was awarded an MBE after his death, and Alice Springs Rotary created the John Hawkins Memorial Scholarship in his honour.

Thanks to Dr Hawkins, the seed was planted and Phill became Mr Steven Baddeley's first orthopaedic registrar at the RDH. Then a year later, he returned to Adelaide for further training, and a Fellowship that took him to the UK. By 1990, he was ready to commence a career in General Surgery and moved back to Darwin as a specialist. He's been there ever since and loves "the community, the challenge and satisfaction of the work, and the feeling that you're actually contributing and making a difference".

Associate Professor Carson has been at the surgical end of some tragic events. He was at work the day after the Bali bombings in 2002, when 60 badly injured patients had been airlifted to Darwin. "We acted as a forward hospital, which is how they put it in military terms when you're one back from the front line," he explained. "The people with the worst burns were triaged over those first days and flown to burns units across the country." Full of praise for the team, Phill said they put their well-practised disaster plan into place and "responded magnificently".

In 2008, in another incident, Associate Professor Carson operated on the East Timorese president José Ramos-Horta, who had been shot in an assassination attempt and airlifted to Darwin. The president recovered after a number of operations and five weeks in hospital.

Crocodile attacks in the NT are infrequent, but cause significant damage to humans when they occur. Over the years, Phill has operated on numerous victims of these attacks, but he pointed out that interpersonal violence and road accidents in the NT are two-and-a-half times the rate of the rest of the country, and perhaps more deserving of media attention.

Recent data from the Australian Bureau of Statistics shows that the NT has the highest victimisation rate for selected family and domestic violence-related offences in Australia. In 2018, Associate Professor Carson was appointed a member of the NT Liquor Commission and this is one of the ways he has been working to reduce alcohol-fuelled violence and accidents in the NT.

While a little reticent about media attention, Phill wasn't able to escape the ABC's request for his participation in a story about his first crocodile attack victim in 1990. Lena Pangquee had been camping with her family when a four-metre crocodile charged through their tent and grabbed her in its jaws. Her son Peter wrestled with the crocodile, poking its eyes with his fingers until it fled. Then Peter and his father got Lena to hospital where Phill performed two operations to repair a series of rib fractures and resected her damaged liver. Every day for 27 years, Lena thought about the surgeon who saved her life.

"I've always wanted to meet him and shake his hand and say 'thank you'," she told the ABC. Filmed in 2018, for the ABC's 7.30 Report, the reunion showed 83-year-old Lena and Phill greeting each other and embracing. Afterwards, Lena told the reporter "I can close that now because he is not just a name to me ... he gave me back my life."

Regarded as a champion of generalism within surgery, Associate Professor Carson is said to have instructed many surgeons at the RDH on how to perform difficult procedures. His patience as a teacher is renowned. But it's not just his expertise in General Surgery that has earned him respect; it's his advocacy as well.

"Within each surgical specialty, it's important that a large number of surgeons at least maintain competence for the whole range of their specialty," he said. "If you go to smaller places like Alice Springs or Broome, the surgeons can not only cover the issues in General Surgery, but the elements of all the other specialities," he explained. "People, ideally, are treated as close to home as possible. It's not possible to reproduce a whole range of subspecialty units in a smaller place."

Second, Associate Professor Carson said, "The population is getting older and many people have multiple illnesses at the same time." So, in the large city hospitals, it's important to have generalists – or people with a generalist mindset, "who can look after the patient with multiple things going on at the same time," he said. "Or, at least be able to diagnose what's wrong and help organise their care among all the subspecialties." This helps minimise the problems that arise when patients go from one specialist to another for different illnesses. "It's not efficient and they can get lost amongst the huge team."

His advice to surgeons is to treat patients as a whole person, and know enough about them to be able to diagnose and seek appropriate help, rather than just saying 'This is not my area'.

Indigenous health is a priority for Associate Professor Carson. Forty per cent of patients at the RDH are Aboriginal and Torres Strait Islander peoples and his work at the Royal Australasian College of Surgeons (RACS), where he is Censor-in-Chief and Chair of the Education Board, means that his decades of rich personal experience inform his board and governance work.

"There are now many role models for Māori surgeons, but few for aspirant Aboriginal and Torres Strait Islander surgeons." he said. "So Indigenous young people can look and say 'You know that's possible. I can be a surgeon because that person is a surgeon.'" In Australia, we're not there yet, he added, other than Associate Professor Kelvin Kong and Dr David Murray, who are "exceptional role models and inspiring Indigenous Australians".

It's important to recognise that we're not overcoming disadvantage by lowering standards, Associate Professor Carson said. "It's about recognising the 10 competencies, not just school grades, but the life experience people bring," and he stressed the importance of supporting Indigenous people once they're in training because "people's lives can be complex with family connections and trauma and illness".

Phill is an Associate Professor of Surgery at Flinders Northern Territory Medical Program, which is part of Flinders University. Teaching a new generation of surgeons, including Indigenous Australian surgeons, is part of his plan for the future.

On his hopes for the future he said: "I was motivated by many people in surgical services, and I hope I've inspired others to reach across barriers of culture and distance and adopt a mindset of providing excellent, accessible surgical care to the entire populations of our countries, not just those who can readily access inner-city hospitals." ■

Above: Dr Bronwyn Carson, Dr Stephanie Weidlich and Associate Professor Phillip Carson with his farewell gift, a totem pole from Yirrkala.

The two of us

Meet father-son vascular surgeons Dr Bernard and Dr Victor Bourke

Dr Bernard Bourke MBBS, FRACS, DDU

In 1986, Dr Bernie Bourke founded Gosford (Central Coast) Vascular services. In so doing, he brought Vascular surgery and diagnostic vascular ultrasound to the Central Coast in New South Wales for the first time.

Over the following 10 years, he was the only vascular surgeon on the Central Coast, and built up his surgical practice while attending to many other responsibilities. Personal audit was one of those tasks and, despite the time involved, he maintained a steadfast audit routine.

"I think it's important to monitor your results and have them externally looked at. I did that by publishing papers because there was nobody I could go to audit meetings with," Dr Bourke said. "I wanted to satisfy myself that I was maintaining standards." Years later in 2010, together with Dr Barry Beiles, he was instrumental in establishing the Australasian Vascular Audit – which is officially endorsed by the Royal Australasian College of Surgeons (RACS) and a necessary requirement of membership to the Australian & New Zealand Society for Vascular Surgery (ANZSVS).

Dr Bourke, who is a past-president of ANZSVS (2016–2018), is also an advocate of ongoing surgical education. He attributes this passion to his time as a medical student under Professor Graham Coupland at Royal North Shore Hospital. "One Sunday morning he made a special point of calling me to help him and his senior colleague, Emeritus Professor Tom Reeve, with a nasty major neck artery laceration sustained by a large sliver of glass in a young girl. He made me feel part of the team even as a medical student," he said. "That single case demonstrated to me the value of teamwork and humility."

Years later, Dr Bourke became Professor Coupland's registrar and that same inspirational philosophy contributed to his own love of teaching. He went on to complete a Fellowship in General Surgery, followed by three years at Charing Hospital in London learning Vascular surgery under Professor Roger Greenhalgh.

In 2015, Dr Bourke's son, Dr Victor Bourke, commenced practising at Central Coast Vascular. "There are a number of father and sons in Vascular surgery, but I think we are the only two who work together," he said. Proud of his son's achievements, he added, "He's done it all himself; he's a great observer."

The two vascular surgeons "occasionally see, treat and operate on selected patients together," Dr Bourke said. "This is done in an open and transparent way to the patient and anyone else involved in their treatment. We often discuss each other's patients, which is mutually beneficial, and the patients are very comfortable with it and reassured, it seems."

Victor picked up the University of New South Wales Foundation Year Graduates Medal for leadership and fellowship in his final year, and did "extremely well" in the RACS Surgical Education Training (SET) for Vascular surgery, Dr Bourke said. "The RACS' vascular training is recognised worldwide as probably the best in the world," and "we learn from each ▶

other in practice," he added. "Like any surgeons, we each have our own specialties within a specialty, and it's not only the mutual exchange of technical skills, but the development of an approach to management of increasingly complex cases in patients with challenging comorbidities.

"Victor and I never really talked about him being a doctor until two weeks before his Higher School Certificate (HSC) when he suddenly announced he'd like to do medicine if he could," Dr Bourke said. "From school to medical student to surgery and Vascular surgery, we really didn't discuss things at all until the very last minute when he had, in fact, made up his own mind anyway." It was "more a case of judicious encouragement".

When his three children were young, Dr Bourke often took them to the hospital on weekends to accompany him on ward rounds. Perhaps this played a part in Victor deciding to study medicine, and his brother, Dr Michael Bourke, completing a PhD and working in medical research and teaching, he suggested.

These days, Dr Bourke noted, his four-year-old granddaughter likes to wear a stethoscope "so it's conceivable she could become a third-generation vascular surgeon – and I will only be about 96 when she commences surgery, so I should be still operating."

Dr Victor Bourke MBBS (Hons), BSc Med (Hons), BA (Lit), MS, FRACS

For Dr Victor Bourke, studying medicine was a last-minute decision. He was interested in law, but decided instead to undertake a seven-year combined arts/medicine program at the University of New South Wales.

While growing up, he occasionally would ask his dad, Dr Bernard Bourke, what he did for work. "We would talk about carotid surgery and aneurysms and bypasses," he said.

"It was not uncommon to find a carotid endarterectomy specimen in formalin on the breakfast table, and I would hear the phone ring at odd hours during the night.

"I think dad enjoyed seeing me think about a surgical problem for the first time when I was young. He would ask me how I would fix an aneurysm," Dr Bourke said. "I remember being engaged by trying to visualise what was going on, and come up with a solution. I've seen him do the same with his medical students."

Part of Dr Bourke's combined degree took him to Dublin for six months on an exchange program. There he studied the Irish poets, Shakespeare and 20th-century American literature. Medicine wasn't far away, though, and during that time he also worked as a phlebotomist.

A pivotal moment for Dr Bourke came at the Prince of Wales Hospital in Sydney. A medical student at the time, he was in theatre with the late Associate Professor Bryan Yeo, who was "looking down a cholangioscope with pure, child-like joy," he said. "He passed the scope to me and I could see bile stones hurtling toward the lens, like asteroids in orbit. It was amazing." Associate Professor Yeo, a lover of tennis, also pointed out that "surgery is about moving your feet", and this lesson has stayed with Dr Bourke "to this day, particularly in open surgery".

As a resident, Dr Bourke assisted surgeons on his days off and in 2011 took a year off his Surgical Education Training (SET) to undertake a Master of Surgery (Vascular) at the University of Sydney. During that time, he assisted vascular surgeons in the private system.

Working now with his father at Central Coast Vascular, he describes him as "a very flexible thinker", who has made introducing new surgical techniques to the Central Coast possible and very rewarding.

Over the past five years, the two have introduced new techniques that are supported by evidence and subjected to audit. These have included endovascular thoracic aneurysm repair, intravascular ultrasound, endovascular treatment of mesenteric aneurysmal disease, mechanical thrombolysis, endovascular deep venous reconstruction, treatment of pelvic venous incompetence and rotational atherectomy.

"Working together is one of the greatest pleasures I've had as a doctor," Dr Bourke said. "It is atypical, I suppose, but I think there are benefits, to the patients – first and foremost – and professionally.

"When we started working together, I was already fully trained as a vascular surgeon," Dr Bourke said. The registrars around Gosford can get confused by the name "Dr Bourke", he explained, and "I believe they call us Big Bourke and Little Bourke for the sake of clarity."

The two have developed a hybrid technique for para-renal aneurysm repair using a Teflon collar "that is useful in both open abdominal aneurysm repair and as a hybrid procedure where we use it to make a landing zone/neck before placing an endograft," Dr Bourke said. "I'm always surprised by dad's energy levels," he added. "I will be exhausted after a long day of open cases and he often seems unfazed and ready for the next challenge."

Dr Bourke's wife, Lina, is about to give birth to their first son. "If he wishes to become a surgeon there could be an opening when Bernie retires in about 30 years or so," he said. Lina, who is a General Practitioner, has assisted Dr Bourke once or twice. "I met my wife when I was a registrar at St George Hospital and she was a student," he said. "She fainted during a varicose vein operation I was doing."

Something else Dr Bourke is looking forward to seeing, as well as his new son, is a father–daughter or mother–daughter combination in Vascular surgery. "One of these days," he remarked. ■

Calling it out

It's time to stand up for the culture we want to be part of

There is growing international recognition that bystander action supports colleagues by effectively addressing bullying and harassment, including sexual harassment.

A culture of calling it out has been found to foster a patient safety culture and works best when backed up by a constructive complaints handling process and transparent complaints data. This is RACS' approach.

In research from the United States, "bystander-intervention training" is cited as the "most promising alternative" to dealing with these issues, along with transparency in publishing incidence report numbers and a constructive non-adversarial approach to managing complaints.

There has long been evidence in the health sector of the effectiveness of timely and constructive peer-to-peer, 'cup of coffee' conversations that offer feedback. The well-established and respected Vanderbilt model uses this approach, which has shaped RACS' program of work, evidenced most clearly under the banner of 'operating with respect'.

Speaking up or 'calling it out' involves timely, non-judgemental peer-to-peer conversations that have been shown to encourage reflection about our personal behaviours and individual responses in times of stress, fatigue and uncertainty. This process of reflection triggers personal behaviour change.

RACS encourages all surgeons who have taken part in the Operating with Respect face-to-face training to put the skills they have learned into practice.

There are increasing calls for bystanders to speak up in all walks of life, most recently in the legal profession. This follows evidence that other approaches, including legislation, have not solved the problems they were designed to address.

According to barrister and Women Lawyers Association New South Wales President, Larissa Andelman, despite the long-term existence of anti-discrimination laws in Australia, "the number of complaints and the incidents of sexual harassment haven't reduced".[1]

She has called for "another way of doing things", because the model of requiring victims of sexual harassment to report "just hasn't worked". Her solution is bystander provisions, or calling it out, which shifts responsibility to report away from the victim and towards all team members, to share responsibility to "not walk by standards that we consider to be unfair, wrong, unlawful or unsafe".

The recently published *Respect@Work: Sexual Harassment National Inquiry Report* by the Australian Human Rights Commission concluded that Australia now lags behind other countries in preventing and responding to sexual harassment.[2]

But as Commissioner Kate Jenkins points out in the Commission's final report, "Workplace sexual harassment is not inevitable. It is not acceptable. It is preventable."

The report notes that "throughout the Inquiry, the Commission heard of the need to shift from the current reactive, complaints-based approach to one that requires positive actions from employers and a focus on prevention".

RACS encourages all Fellows, Trainees and Specialist International Medical Graduates (SIMGs) to speak up for the culture we want to be part of. When we all refuse to accept the unacceptable and call out behaviours that are not acceptable by providing feedback to our colleagues and peers, we help to create a culture of respect.

Many senior Fellows have now participated in RACS' Operating With Respect face-to-face course. It gives surgeons the skills they need to have peer-to-peer conversations, by encouraging self-reflection. If you've done the course, think about downloading or revisiting the Speak Up app to freshen up your skills, re-hear suggestions for self-care and self-regulation, and be reminded of tips for initiating peer-to peer conversations. Since 2016, RACS has steadily been addressing discrimination, bullying and sexual harassment in surgery. Having identified a serious problem, the College has educated, trained and raised awareness of these issues among Fellows, Trainees and SIMGs. Huge numbers of surgeons have been actively involved, leading the profession in different ways to help build a culture of respect.

The RACS Action Plan: Building Respect, Improving Patient Safety is the cornerstone of this work. Through it, RACS has been widely recognised across the health sector, and beyond, as a pioneer, committed to shifting cultural norms and making a real difference to the culture of surgery and the behaviour of surgeons. ■

Read the Action Plan: Building Respect, Improving Patient Safety here.

"Peer-to-peer conversations are collegial and non-judgemental and aim to encourage self-reflection and behaviour change. They are an established and effective tool that help build a culture of respect and impact on patient safety."
—Professor David Fletcher,
Chair, Surgical Directors Section
Past Chair, Professional Development

Download the app by searching for 'RACS Speak Up' on Apple iTunes or Google Play.

REFERENCES

1. Doraisamy, J. The need for bystander provisions [Internet]. Lawyers Weekly [cited 2020 Jul 28]. Available from: https://www-lawyersweekly-com-au.cdn.ampproject.org/c/s/www.lawyersweekly.com.au/biglaw/26043-bystander-provisions-needed-because-requiring-victims-to-report-hasn-t-worked/amp
2. Australian Human Rights Commission. Respect@Work: Sexual Harassment National Inquiry Report [Internet]. Sydney (NSW): Australian Human Rights Commission; 2020 [updated 2020 Nov 5; cited 2020 Jul 28]. Available from:https://humanrights.gov.au/our-work/sex-discrimination/publications/respectwork-sexual-harassment-national-inquiry-report-2020

Giving to change lives

Dr Peter Little and Mrs Ruth Little create a lasting legacy for education and research through the Foundation for Surgery.

There's a proverb about giving that goes like this: "If you have much, give of your wealth; if you have little, give your heart."

For retired general surgeon Dr Peter Little and his wife, Ruth, who died last year, it seems they gave and are still giving both. Throughout their life together they gave continually to those in need with focused intent and great love.

"It's good to give back," Dr Little said. "I couldn't have studied medicine without a lot of support from outside, and various scholarships. I also wouldn't have had the career I had, which I thoroughly enjoyed, without the education and support of the Royal Australasian College of Surgeons (RACS)."

In Dr Little's view, planning their legacies wasn't about simply assigning and leaving assets, but rather about looking at who really needs help. In his and Ruth's case there were no immediate family. Sadly, his daughter, a gifted and successful architect, died 10 years ago. So he and Ruth made plans to honour her by creating a scholarship in her name at her former university for a student "who otherwise couldn't afford to be there". Similar needs-based awards were created in legacies to Ruth's old school and the University of Melbourne.

After giving to charities and causes around the world throughout their working lives, Dr Little and Ruth had plans to visit some of their international charity projects in their retirement. However, Ruth was diagnosed with colorectal cancer and needed to undergo ongoing chemotherapy and radiotherapy. "Our plans for international charity work all went out the window," he said. "She carried on with what she could on her laptop, but we were stuck at home. It was a terrible diagnosis and we knew it was incurable."

Aside from restricting her ability to travel, ongoing treatment for cancer didn't slow Ruth down. Dr Little became her caregiver for the next five years as they continued to run their philanthropic interests. Ruth had to stop doing her field work and resign from some international committees, but "carried on right up to the end, working at home," Dr Little said. "And she accomplished an awful lot right up to her last three weeks. She arranged our affairs and legacies in great detail and with a lot of thought."

Ruth was a trained midwife and a director of neo-natal intensive care until she became practice manager and cancer support nurse at her husband's practice. When she was diagnosed with cancer, she made the decision to keep her illness quiet. She was well-known in the surgical community and was concerned people may treat her as if she were sick – which would have interfered with her charity work. "Ruth wanted to carry on as much as she could," Dr Little said. "It was such a large part of her life."

Dr Little had dealt with colorectal cancer early in his career, and "had no illusions about where they stood."

As a general surgeon, he had an interest in emergency and trauma work, but in later years worked in laparoscopic and breast surgery. He did a training rotation at PANCH (Preston & Northcote Community Hospital) in Melbourne, and enjoyed it so much he returned as a consultant and moved with it when it was relocated to the Northern Hospital in Epping in 1998.

Part of Dr Little and Ruth's legacy will be the creation of a scholarship to be administered by the RACS Foundation of Surgery. It will be a broad scholarship available to a Fellow or Trainee in any specialty, to be used for either research or professional development. It can be awarded to more than one applicant, and carried forward more than one year.

"I think the idea of a lasting scholarship is better than an outright gift," Dr Little said. The Foundation of Surgery can invest the money and use the income to award the scholarship.

"The Foundation has an excellent record of investment and stewardship of such legacies and are given wide discretion by ours."

The scholarship intentions were finalised during Ruth's lifetime so she could see it, and Dr Little said they were both very proud to be able to assist surgeons, like he was once helped on his journey to surgery. ■

Royal Australasian College of Surgeons
Foundation for Surgery

Your legacy

Each of us finds different ways to make our mark on the world. A legacy fund through the Foundation for Surgery is a gift that will always be remembered.

There are two very special ways you can make an extraordinary difference, transform lives and advance your area of speciality or passion:

1. Establish a named perpetual scholarship to see the results of your philanthropy in your lifetime.

2. Leave a bequest – of any size – in your Will and change lives in the future

For more information on establishing your legacy, please contact the Foundation for Surgery at foundation@surgeons.org or call +61 3 9249 1110 today.

Introducing the new Chair of the New Zealand National Board

Philippa Mercer, a general surgeon based in Christchurch, is the new Chair of the New Zealand National Board of the Royal Australasian College of Surgeons (RACS).

Philippa is looking forward to working with New Zealand Fellows, Trainees and Specialist International Medical Graduates, her National Board colleagues, RACS staff, and a range of health agencies and organisations to promote New Zealand surgeons and surgery, cultural change, diversity and inclusion.

"I fully support the mahi (Māori word for work) that's under way to make our surgical profession in Aotearoa/New Zealand more culturally competent and safe.

"The inequitable health outcomes for Māori are totally unacceptable. Through Te Rautaki Māori, our recently adopted Māori health strategy, I'm confident that we can make real progress in terms of attracting more Māori into surgical careers and, equally importantly, building a culturally safe surgical workforce so all patients receive the care they deserve.

"Surgeons need to come from a diverse background and be well trained in communication skills, surgical skills, and be prepared to adapt and continue to learn throughout their career.

"One thing I have found invaluable throughout my career is staying on the acute roster. The range of patients and their conditions helps you maintain your skills, and means you work with a variety of medical and surgical colleagues across many specialties."

As a medical student, Philippa was attracted to surgery because the surgical runs were the most enjoyable. "The great aspect of General Surgery is that it covers a wide range of elective and emergency surgery while also allowing for subspecialisation. Every hospital needs general surgeons. General Surgery enables me to be involved with my patients' care pre-, peri- and postoperatively. Often, especially for cancer patients, you have contact, through regular follow ups, with the patient for years. I find that very satisfying."

Philippa is especially interested in promoting more mentoring among the surgical profession. "Surgical Trainees and newly qualified surgeons need support from their experienced colleagues and it's very satisfying for those who are mentoring to be able to give back some of the skills and knowledge they have acquired during their career. As a more senior surgeon you learn from your Trainees and younger colleagues."

As well as her work at Christchurch Hospital, Philippa has two private practices in the city – a breast surgery practice and a general and endocrine surgery practice.

When Philippa isn't working, she enjoys spending quality time in her home, repaired, finally after the 2011 Christchurch earthquake, with her husband and their two springer spaniels. She also likes roaming the Port Hills and beaches, or relaxing at their holiday home in Golden Bay near the top of the South Island. ■

The canon of plastic surgery: embodying art and beauty Part I

OPUS LXIV

The word ‘canon’ has a meaning referring, as a general rule, to the establishment of principles of artistic, musical, aesthetic and scientific development. Even Beethoven once sent a thank you letter, a canon, which was a composition with a repeat melody – his simple way of offering gratitude to his medical practitioner in Vienna for services rendered.

In Plastic and Reconstructive surgery, we surgically mould, fashion and repair abnormalities from early life and beyond. The correction of deformities, injuries and malignancies are the basis of our reconstructive art. Innovation is essential for any such ongoing surgical change, embracing a wide spectrum of surgical applications. The Canon of Plastic Surgery implies an ever-changing focus, seeking perfection with research resulting from the refinement of techniques.

In the mid-1970s, in the early days of my reconstructive career, my mentor in London, Professor Gerald ‘Charlie’ Westbury, of the Westminster (of melanoma and head and neck fame) came to visit us in Melbourne. We managed to see the microsurgical research facilities at St. Vincent’s Hospital on the invitation of the late Bernard ‘Bernie’ O’Brien. Charlie observed “this would have been one of the most advanced microsurgical laboratories in the world!” It continues to the present day, combining research and clinical applications. This reflects Bernie’s commitment to his surgical craft. He was also a keen world traveller visiting many units of international prominence. Following a visit to the American microsurgeon Dr Thomas Krizek, Bernie returned to Melbourne to do the same procedure of a microsurgical re-attachment of a dog’s abdominal wall. He was one of the few in the world to achieve this.

Bernie’s lab was also involved in refining surgical instruments and microsurgical sutures. A nylon suture is a delicate item. It is finer than a human hair with a diameter of 0.05 millimetres. Interestingly, the needle is attached to the suture by a technique of dipping the thread into molten steel before being polished into a sharp pointed round bodied repair unit. This item, I recall, once featured on the front page of *The Age* in the mid-1970s.

Bernie was a public relations expert, always looking for research funds. Microsurgical instrument development was also part of this costly exercise. The Microsurgical Research Centre, renamed the Bernard O’Brien Institute of Microsurgery, reflected the principles of research with clinical applications that continues to the present day. It is now headed by Ramin Shayan who replaced Professor Wayne Morrison AM, Bernie’s protege.

At this centre, international plastic surgeons gathered from the four corners of the globe (a Judean reference to when the earth was presumed to be flat and the four points of the square represented the corners of the flat ‘globe’). They learned their art and their skills and feature in the ‘rogues gallery’ on the first floor. This is a photographic summary of many local and international personalities who have contributed to our specialty. Yes, there have been personality clashes. Let’s not forget that Napoleon’s surgeon Dominique Jean Larrey is reputed to have observed, “deep injuries cause deep scars”. Besides the clinical implications, there was an underlying psychological overtone as well, reflecting vindictive antagonism.

Perfection is in the realm of the almighty, as they say. However, perfection even has some earthly proponents. Polykleitos, whose name means ‘much renowned’, was considered the most important sculptor in ancient Greece. He created a new approach called the *Kanon*, which advocated aesthetic balance formulated on a mathematical background to accomplish artistic perfection in sculptured results.

Plato observed it is possible to express beauty mathematically, exemplified in Euler’s equation $e^{i\pi} + 1 = 0$, something I cannot fathom conceptually. Euler is regarded as the mathematical equivalent of a Mozart. Plato went on to say “the mixture of beauty in mathematics may help to explain the Universe”. In plastic surgery measurement and design are part of our basic fundamentals – measure twice and cut once. We used Gillies blue ink to mark out surgical sites before the texta took over.

The four pillars of wisdom who influenced my surgical career

Over two essays I will list four people who epitomise the characteristics of our reconstructive art and explain how they influenced my own career: I call them my Four Pillars of Wisdom.

Sir William Manchester

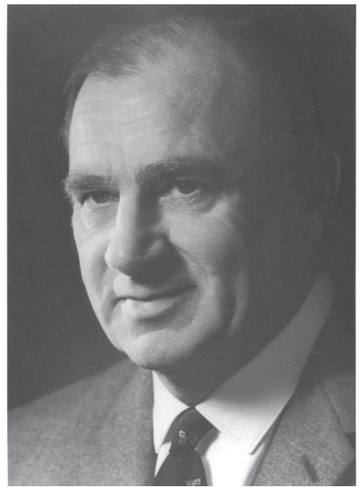
Here I will introduce the first two.

My New Zealand link

My colleagues across the Tasman, Earle Brown and Michael Klaassen, are compiling a book on Sir William ‘Bill’ Manchester (‘Perfection, the life and times of Sir William Manchester’). He was my first mentor. He had a reputation for seeking perfection in everything he did, as in the title of the upcoming publication. The book will be launched in Auckland in the early 2021.

When I presented at the international Plastic Surgery Congress in Madrid in 1972, Bill Manchester chaired the session. There I gave my inaugural presentation on the angiotome vascular concept for flap reconstructions – marking flaps confined to dermatomal precincts. This simplified design means any neural component must have an accompanying vascular supply, even without defining random perforators.

This technique protects lymphatic and somatic components left in the surrounding tissues when the perforators are not skeletonised. Kinking is avoided. At the conclusion of the talk, chatting over morning tea, Bill said to me, “Felix, I don’t know where you are coming from but continue to develop this interesting concept.” At the time I was a Bernard Sunley research Fellow at the Royal College of Surgeons in London. Over 30 years, these ideas have metamorphosed into the Keystone Perforator Island Flap, which are aligned within the dermatomes with fascial support.

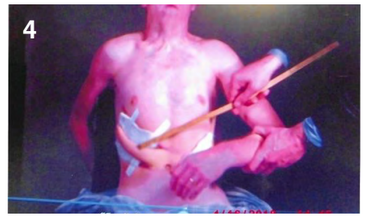


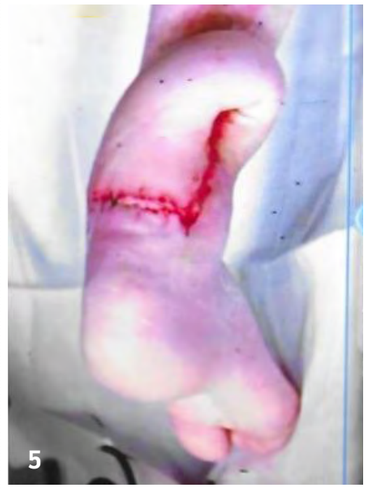
Sir Benjamin Rank

I gleaned the word “angiotome” from *Dorland’s Illustrated Medical Dictionary* during those London days, referring to a vascularised segment, and when based on nerve supply as patterned in the dermatome, the word ‘angiotome’ becomes applicable.

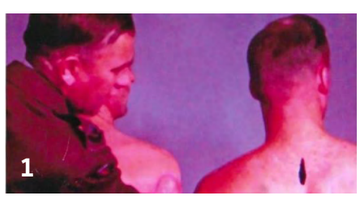
Bill’s encouragement for my research has been rewarding and he gave it the green light. He had an analytical mind and a heart that sought perfection. He must have taken a page out of Voltaire’s writing, which declared, “Perfection is the enemy of good.”

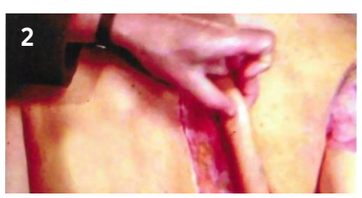
Sir Benjamin ‘Benny’ Rank was my Melbourne link and an encyclopedic wonder of the reconstructive art. At the Victorian Plastic Surgery Unit (VPSU) at PANCH (Preston & Northcote Community Hospital), the consultants from the major teaching hospitals in Melbourne voluntarily gave their sessional time to operate on public cases, as a contribution to our plastic surgical teaching - including me. The VPSU was Benny’s baby. When we learn a range of techniques from various positive personalities, we pick the pearls best suited to our own way of operating to achieve an element of perfection. Benny had the mind of a disciplinarian and one learned to never arrive late. He had a heart of gold, yet a desire to achieve the best possible patient outcome. This was preeminent in his surgical ethos. He also taught me the art of politics – how to deal with hospital administrators. He was my primary mentor, the doyen of plastic surgery in Australia at that time, and he invited me to join the Melbourne scene to continue his stewardship. ■

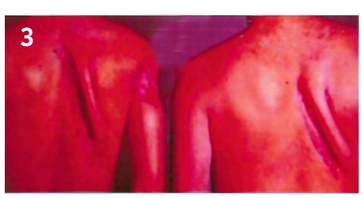




Associate Professor
Felix Behan







Images on page one and two:

1: Shows Major Rank in his military uniform marking out the design for detachment of a Gillies tubed pedicle from the right scapular region before it is staged and transferred to another distal site.

2: Checking the viability and directional flow of the tube before transfer, linking fourth to the eighth intercostal perforators.

3: The healed tube pedicle over the right scapular before detachment.

4: Further staged reconstruction with attachment to the abdominal wall via the wrist.

5: Shows the reconstruction of the tube pedicle after multiple procedures waltzed down from the back to the groin via the arm before definitively attached over the exposed tendo-achilles of the right ankle.

Electronic prescriptions gaining momentum

On 6 May 2020, Australia transmitted its first electronic prescription in primary care – end to end, from the doctor to the patient – using a digital token via an encrypted digital exchange to be dispensed by the pharmacist, and then PBS claimed through Services Australia at the other end.

The March–April 2020 edition of *Surgical News*[1] previously reported that implementation of electronic prescriptions was underway. Acceleration of the implementation of electronic prescriptions to support the associated telehealth medicine initiatives was announced on 11 March as part of the Australian Government's COVID-19 National Health Plan. The goal was to enable electronic prescribing in general practice and dispensing of electronic prescriptions in community pharmacy, within 8 weeks.

Electronic prescribing is the process by which a prescription is electronically generated by a prescriber using software which conforms to technical requirements as published by the Australian Digital Health Agency[2] (the Agency). Following changes to Commonwealth PBS regulations, all state and territories have now made regulatory changes to recognise the form of the electronic prescription as a legal alternative to a paper prescription. Electronic prescribing is not mandatory, and patients and prescribers will be able to choose either an electronic or paper prescription.

Staged and managed implementation

The Agency and the Department of Health, in conjunction with clinical software providers, are now evaluating electronic prescribing in a number of 'electronic prescribing communities of interest'[3] around Australia.

"These communities of interest have been established to ensure any technical or workflow issues can be addressed on a smaller scale before broader national roll-out, and is part of the standard beta-testing evaluation that software providers would normally undertake,' said Mr Andrew Matthews, Director of Medicines Safety at the Agency.

'What makes the evaluation more complex is that it is not the test of one software product but the connection through four products associated with prescribing, prescription exchange, dispensing and subsequent PBS claim.' Successful transmissions of real, legal electronic prescriptions are happening now. At the time of writing there were over 30 established communities of interest.

Get ready for electronic prescriptions

The technical solution provides two models for electronic prescriptions.

Token:

A token is received as a QR code on a patient's mobile phone by SMS (or by email). When scanned, the token unlocks the electronic prescription from a secure, encrypted, cloud-based prescription delivery service.

Active Script List (ASL):

An ASL displays a list of a patient's active prescriptions available to be dispensed, to those health professionals who the patient has consented to view their ASL. Scanning a token is not required, and patients can manage and view their own prescriptions via an App.

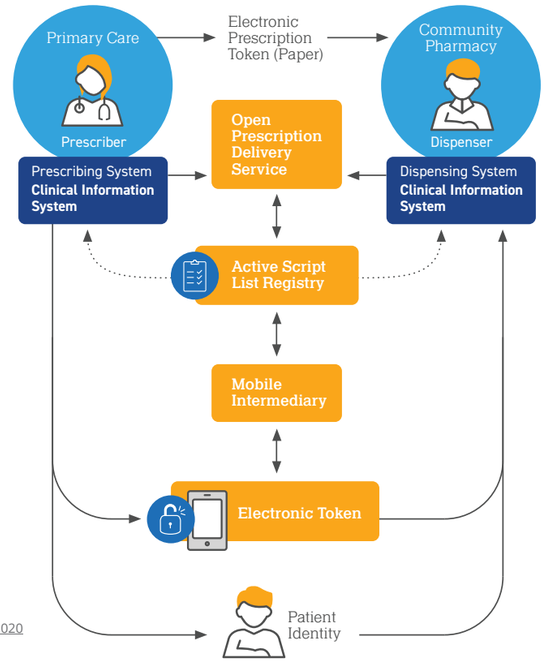
Only the Token Model is to be introduced nationally first (August – September) with the Active Script List model to be available late 2020.

Providers of practice management and prescribing software are progressing changes to their products to ensure conformance against the electronic prescribing technical requirements; those products participating in communities of interest are already declared conformant[4]. Surgeons will need to use a conformant product to generate electronic prescriptions.

To learn more, the Agency's electronic prescriptions eLearning courses for both prescribers and dispensers are now available. The eLearning courses are free and accessible at training.digitalhealth.gov.au.

Find out more on how to get ready for electronic prescriptions here.

Figure 1: Technical framework for electronic prescribing - Token and Active Script List models.



[1] Electronic prescribing implementation underway: RACS Surgical News 21(2) pg. 50 March-April 2020
[2] Electronic prescribing: Developer Centre, Australian Digital Health Agency
[3] Electronic prescribing – implementation via communities of interest
[4] Electronic prescribing conformance register

More information about electronic prescribing is available at digitalhealth.gov.au

More information about electronic prescribing as part of the COVID-19 National Health Plan is available at health.gov.au

Supervisors of training: the unsung heroes

Supervisors of training play a critical role in the training of future surgeons and are highly regarded by the Royal Australasian College of Surgeons (RACS) and the Specialty Training Boards. Yet there is a perception that this role is thankless and unrecognised. We need to do something about this perception as it is far from the truth.

The role of surgical supervisor has evolved over the years. The demands of the role have increased and supervisors are expected to be leaders, educators, trainers, assessors and mentors. Training programs have likewise developed with a move towards competency-based training and workplace-based assessments. These innovations have resulted in increased requirements for clear documentation, feedback to Trainees and assessment of Trainee performance.

Many surgeons become a supervisor to 'give back' to their profession and to contribute to the training of our future surgeons, just as others did for them. RACS appreciates this dedication, but also recognises that support for these people is necessary. To quote one supervisor, "I found myself in the role with very little training, save for a few email attachments, as to the expectations of the position."

In recognition of the importance of the surgical supervisor role and the need to provide support to our valued supervisors, the RACS Education Portfolio is undertaking a supervision project. This project has the endorsement and support of both the Education Board and the Council.

There are four pillars to the project:

1. Advocacy: RACS recognises the need to advocate for the resources required to support supervisors in undertaking their role. We will be looking at ways to achieve this.
2. Recognition and valuing: RACS is reviewing ways to recognise the value we place on this vital role and taking into consideration the suggestions that have been made by supervisors.
3. Identification of competencies: many supervisors have asked for clarification about the competencies required of a supervisor and RACS is currently working on identifying these clearly.
4. Support: A dedicated supervisor portal is being developed to make it easy for our supervisors to access resources to support them in their role. The portal will provide access to:
   - relevant policies and procedures
   - professional development to assist supervisors in achieving the competencies in the supervisor framework
   - templates to use in the role
   - contact people within RACS to answer questions.

In addition, a recent survey of supervisors highlighted some excellent suggestions for resources that our supervisors would like to see in place to support them. Many indicated that they would like a mentoring program, or some way to connect with other supervisors, to learn from their experiences. Facilitating these connections will assist our regional and remote supervisors, along with those new to the role. The project will be looking at how best to facilitate provision of these resource suggestions.

We are keen to hear from our supervisors about other ways we can support you. We will be keeping you up to date on the progress of the supervision project and will be providing you with an opportunity to provide us with your feedback and suggestions. We encourage you to work with us to achieve these valuable outcomes.

To all the supervisors reading this article, we thank you for your ongoing work. We see you as the pillars of the surgical training program and a precious resource. You are significant contributors to the ongoing wellbeing of our populations. We value what you do and we are committed to improving our support for you in this important role. ■

Professor Phillip Carson
Censor-in-Chief

New Western Australian office

Excitement is building as fit-out work progresses at the Royal Australasian College of Surgeons (RACS) new office in Perth, located on the ground floor at 216 Stirling Highway, Claremont in Western Australia (WA).

Boasting a range of in-house space for training courses and workshops, as well as a broad array of meeting rooms to increase engagement with Fellows, Trainees and Specialist International Medical Graduates, the new office is scheduled to be complete and ready for relocation in early September 2020.

The office premises will have the following spaces available:

Meeting room	Maximum capacity
Boardroom	20
Meeting room 1	6
Meeting room 2	14
Training room 1	30
Training room 2	30
Training rooms combined	70

Please note that due to COVID-19 social distancing requirements, capacity numbers will be impacted and will be reduced accordingly from the maximum capacity numbers above. Please contact the WA office from September onwards to find out the adjusted capacity numbers.

RACS WA is looking forward to utilising this new space and we encourage those in WA to take advantage of the facilities.

Contact RACS WA:
college.wa@surgeons.org
+61 8 6389 8600

Sir Henry Thompson, the versatile Victorian

The surgeons of *Vanity Fair* part three

Sir Henry Thompson was *Vanity Fair*'s 85th 'Man of the Day' on 1 August 1874: his accompanying caricature by Carlo Pellegrini, 'Ape', was captioned *Cremation*. The accompanying notes helpfully note that, "he has more recently advocated cremation as a better method of disposing of the dead than that now in vogue".

The likeness captured, matching a firsthand description in 1878, "as a distinguished slender middle-aged man with hair untouched with grey, great bushy eyebrows bristling over dark brown eyes, a full moustache, and a lithe active frame."

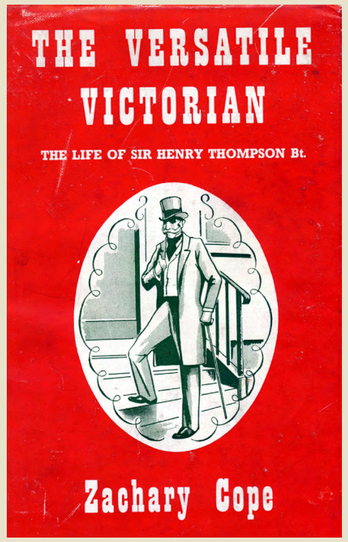
Sir Henry Thompson Vanity Fair *caricature,* Cremation *by Carlo Pellegrini 'Ape'.*

Thompson was born at Framlingham, Suffolk, on 6 August 1820. He was the son of a nonconformist, a businessman with rather narrow convictions, who objected to his son studying medicine because he thought the necessary studies might pervert his religious faith. Henry was thus engaged in commercial activities until he was 27 years old; his health steadily deteriorated until his father eventually allowed him to enter medicine. In October 1846, he visited the University College in London, which had been founded in 1826 as a secular alternative to Oxford and Cambridge, and, in January 1847, commenced his medical career there.

He never went to a public school and received all his education privately; however, Thompson's general knowledge suffered little from this and he had a good grounding in the classics and a considerable amount of elementary science. He was the only boy in the family and for 10 years the only child.

His mother, Susannah Medley, was the eldest daughter of Samuel Medley, artist, and Thompson inherited his artistic capabilities, finding during his medical studies his ability to draw useful. He later found painting to be a great relief from his surgical work. Over time he had no less than 13 paintings hung at the Royal Academy.

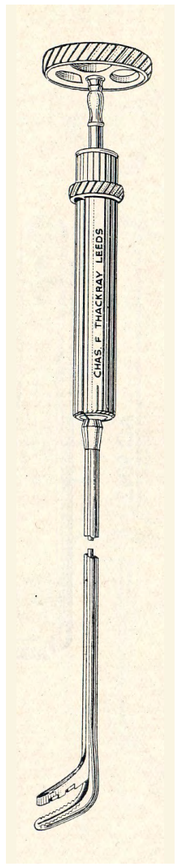
He won the gold medal in anatomy in 1849 and surgery in 1851, gaining the Membership of the Royal College of Surgeons (MRCS) in 1850, M.B. Lond. in 1853 and Fellowship of the Royal College of Surgeons (FRCS) later that year.

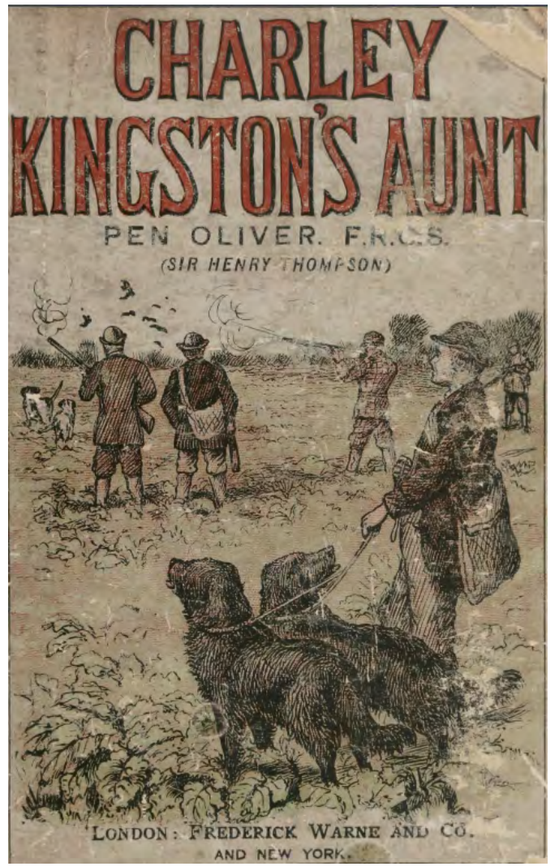


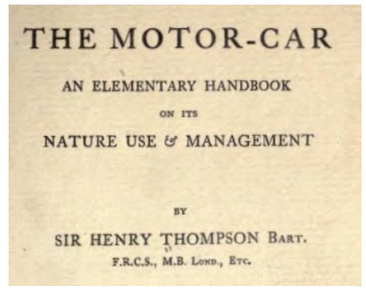
The Versatile Victorian *by Zachary Cope dustjacket.*

In February 1850, he met Kate Loder, a brilliant young pianist, and before long Thompson realised that he had found someone he could both love and admire. They married in December 1851.

Thompson then noticed that the Royal College of Surgeons was offering the Jacksonian Prize for the best essay on 'Stricture', and that all manuscripts, drawings or pathological specimens were required by 31 December 1852. Thompson spent most of the first year of his marriage preparing material to submit for the prize, ultimately proving successful in April 1853 when he received his cheque for 20 guineas (£21) from the president. This work was published as *The Pathology and Treatment of Stricture of the Urethra*.







Above l-r: Thompson's modified lithotrite 1860s, Thompson's first novel 1885; Motoring handbook written by 82-year-old Thompson.

Urological progress owes most to the French. In 1824, Jean Civiale created a urological service in Paris, where Thompson was to study, later modifying Civiale's lithotrite and bringing the operation of lithotrity to perfection. He pioneered a revival in suprapubic cystotomy and was the very first to remove a growth from the urinary bladder. Though Thompson practised general surgery for a short time he soon limited his work to urinary surgery and became the first specialist in urinary diseases in England.

Vanity Fair opined, "with a hardhead, a great love of the positive and an equal distrust of the speculative, he naturally devoted himself to the carving branch of the healing art … addressing himself more especially to the study of some of the most despised organs of the human frame."

He was self-confident. "Sir," he once said to a patient as he lay on the couch, "you have a stone in the bladder".

"That is impossible," replied the patient. "I have been assured by a very rising surgeon that there is nothing of the kind present."

"Sir, I have risen," was Thompson's crushing reply.

For the greater part of his life Thompson was a keen traveller, and as his practice flourished he began a series of continental holidays. This tradition continued for 30 years with 26 such holidays during that time, in addition to professional visits made to patients in Belgium, France and Italy.

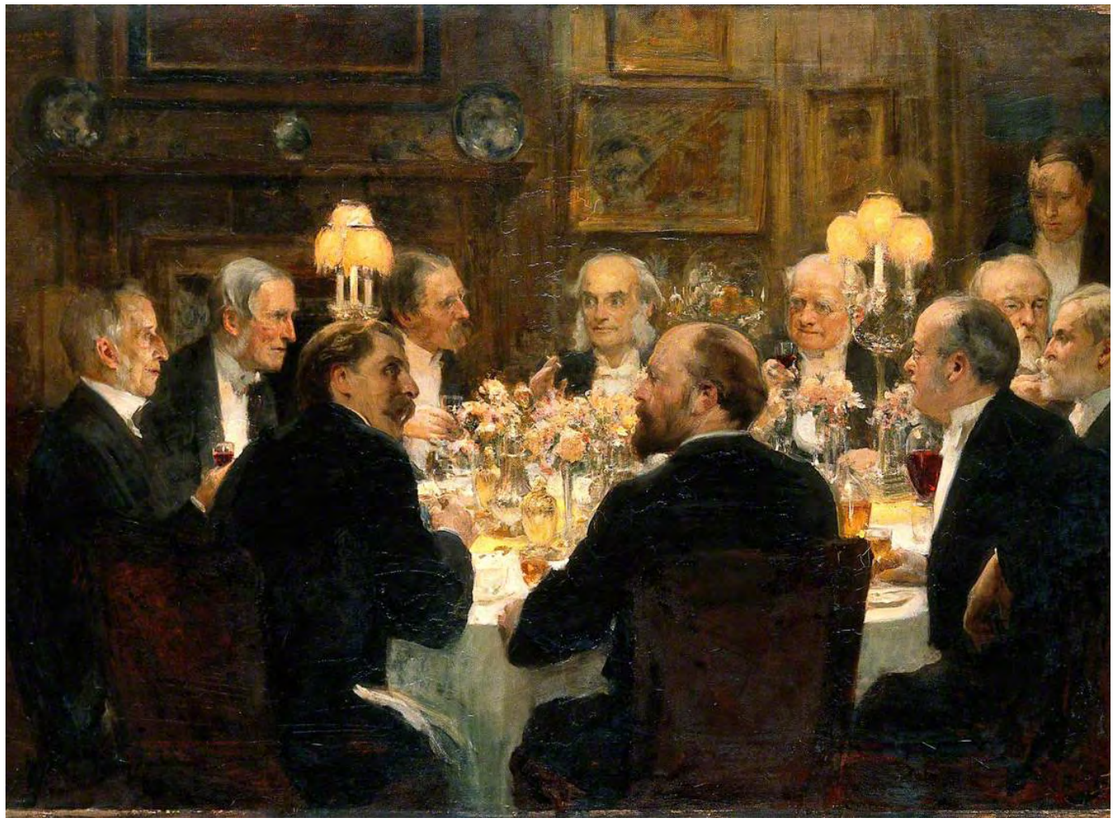
Thompson was a prolific writer from his youth onwards. He published no less than 22 books, comprising surgical texts related to diseases of the lower urinary tract, as well as cremation, Qing dynasty porcelain. He also published *Moderate Drinking*, *Food and Feeding* and, in 1902, *The Motor-Car: an elementary handbook on its nature, use & management*.

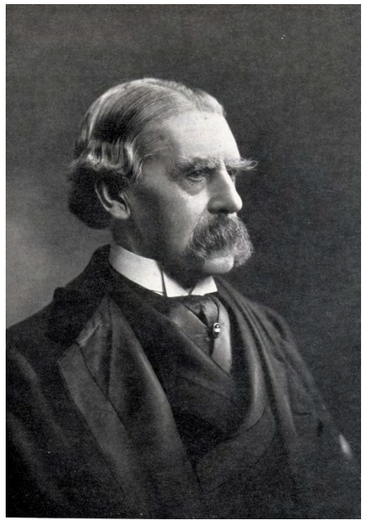
Regarding cremation he wrote, "I had long believed that cremation was in theory the quickest and safest mode of reducing the dead body to its original elements – the end attained slowly and not without danger to the living, by burial in earth."

Thompson also wrote novels under the pseudonym of 'Pen Oliver'. His first novel, *Charley Kingston's Aunt*, was published in 1885, achieving 15 editions in 18 months. Charley Kingston was a medical student who, while dissecting, thought the face of the subject was familiar. He suddenly realised, "Good heavens the old aunt!" The subject was his wealthy aunt who had gone to America a few years previously and having returned, lost her memory after a stroke. She died in the Marylebone Infirmary, friendless. Charley sees that his aunt is buried decently and, in so doing, obtains a considerable share of the money she left!

In 1880, Thompson purchased Hurstside, a property near Hampton Court Palace, both as a country retreat and to commence poultry farming and market gardening. By 1883, the *Live Stock Journal* declared his poultry yard as the best in England, only for Thompson to abandon the whole enterprise the following year. The reason was that poultry shows were judged on the external characters of birds, not as table produce.

His interest in astronomy led him to build an observatory there in 1886, utilising part of the poultry house. Once again, his enthusiasm waned, and by 1889 he disposed of the installation "and all the valuable contents at a considerable sacrifice". Nevertheless, in 1897, he ▶





Above from top: Octave dinner scene, from left, facing one: Quain, Paget and Thompson; Thompson at 80 years old.

presented the Royal Observatory at Greenwich with a large photographic telescope at a cost of more than £5000.

Thompson had been knighted in 1867 and as the *Encyclopaedia Britannica* noted he received a baronetcy in 1899, "probably not unconnected with the presentation." At age 70 he took up photography instead of sketching, utilising a special twin camera equipped with special lenses.

He was famous for his 'Octaves', dinners for eight male guests, which began in 1872 and continued until 1904, the last one occurring shortly before his death. Thompson took it upon himself to bring together men of different professions, men engaged in art, literature and politics, at small and well-selected parties. To be invited was a distinction. There were eight courses and eight wines, the meal commencing at 8pm, where seated at a round or oval table the group could, if needed, discuss a single topic of conversation when one naturally arose.

He was a typical Victorian with vigorous intellectual activity and a capacity for intense hard work, rendering him always inquisitive and curious. His many diverse interests were well summarised in the *Punch* magazine in 1881.

Thompson died peacefully, aged 83, three days after his last motor drive, at his London home. His body was cremated at Golders Green crematorium. He left one son and two daughters, predeceasing his wife. His death notice in *The Times* occupied three and a half columns, reflecting the replete life of a very versatile gentleman. ■

Mr Peter F. Burke
FRACS

IMAGE REFERENCES

Page 50: Pellegrini C. New York. Vanity Fair; 1874. Public Domain. Henry Thompson caricature 'Cremation' caricature.
Page 51: Thompson H. Charley Kingston's Aunt: A Study of Medical Life and Experience. London. F. Warne and Co.; 1893. Dustjacket of book; Thompson H. The Motor-Car: An Elementary Handbook on its Nature Use and Management. London. F. Warne and Co.; 1902. Title page
Page 52: Solomon JS. An Octave for Mr Ernest Hart at Sir Henry Thompson's House. London. Wellcome Library; 1897. Licensed under Creative Commons CC BY (3.0. Unported); Millais JE. Sir Henry Thompson Bt. London. Tate; 1881. Licensed under Creative Commons CC-BY-NC-ND (3.0 Unported).

Medicine and law: two professions, one common language?

This topic was raised by a distinguished surgeon at a meeting of the Australian Medico-Legal College in Sydney, in December 2018.

Despite inclination towards an affirmative reply, his decision was not definitive. My views are in definite opposition. While this is an intriguing philosophical and ethical topic, I base my view as negative due to the vastly different ethics, duties and interests of the two professions. My impressions are formed by reading and experiences.

The duties of physicians were set out in the early 16th century by the great humanist Erasmus of Rotterdam (1466–1536). Erasmus was the son of a priest in Brabant and he received an extensive education, mostly ecclesiastical.

Ordained but excused from preaching due to ill health, Erasmus wrote on theology, philology, education, history, politics and morality. His exceptional ideas were collected in 24 volumes that can still be found in today's university libraries.

This humanist remained aloof from all church reformers seeking his support, as well as separated from all monarchs and pontiffs seeking his advice. He remained faithful, and protected the institution of the Church, stating, "do not condemn the church for a few monks being murderers."

His views on healers were expressed in his 'Oration in praise of the art of medicine' (1518), dedicated to his physician. In it he enumerated the well-known duties of a physician:

1. Erasmus reminded the reader of the physician's duty to save lives, or at least ameliorate suffering, irrespective of any other interest. "The majesty of civil law and the authority of the common law are voluntarily submitted to the medical one, and that medicine has a role of an independent authority assisting theological and judicial deliberation." He stated that health outcomes are determined partly by birth (i.e. DNA?) and also mentioned exercise, nutrition and even housing as factors.
2. Erasmus reminded physicians of the need to keep up with medical developments, and apply them with diligence, being aware of "new strains of diseases" and "daily hazards", that is to say, the requirement for continuous study.
3. Erasmus stated that a duty of the physician is to be a friend to the patient, while also expecting financial reward. He said, "does not a man who by his professional skill holds imminent death at bay, who restores life when it has been suddenly assailed by disease, forever deserves to be treated as if he were some beneficial propitious being?"

These duties are enshrined within the rules of the Royal Australasian College of Surgeons and the Australian Medical Association, and to these all doctors must comply.

In opposition I present Niccolò Machiavelli (1469–1527), a contemporary intellectual who was a notary to the Florentine government, diplomat, writer and historian.

His name became acknowledged in the dictionary as Machiavellian: "placing expediency above political morality, and countenancing the use of craft and deceit in order to maintain the authority and effect the purposes of the ruler."

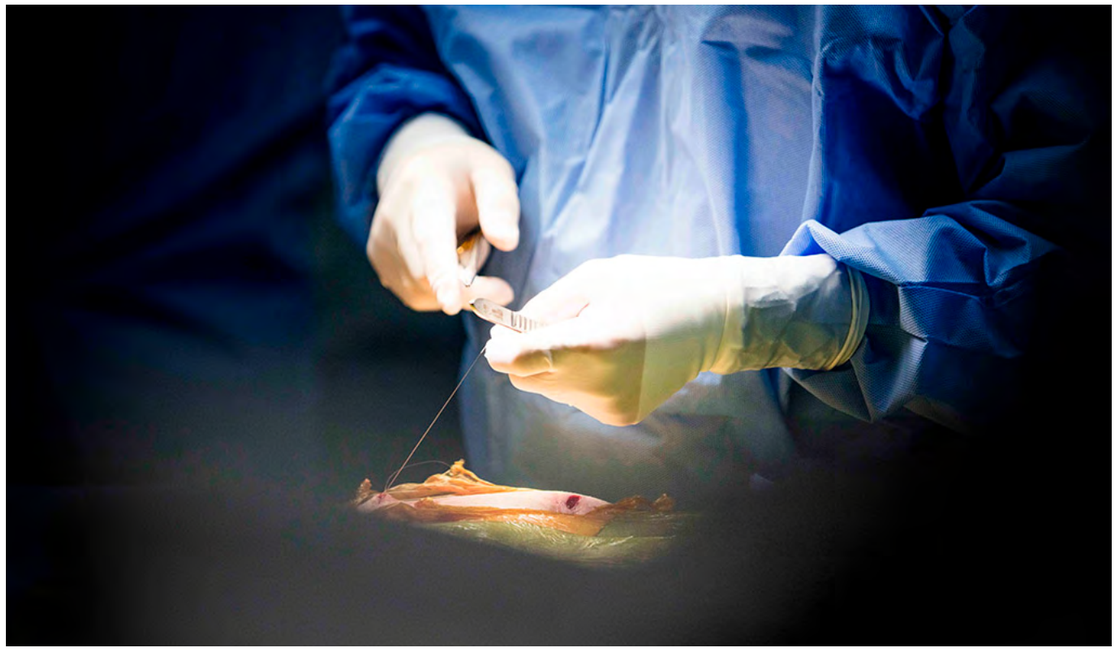
From my own experience I quote three examples:

1. In consulting a patient for medico-legal purposes, the patient attended with no X-rays, at the advice of his legal representative. This was done so as "not to confuse the doctor". Was the lawyer afraid that the doctor might reinterpret the report supporting the patient's claim and find a different diagnosis?
2. A patient with a forearm fracture and a slight deviation had refused in writing the surgical reposition offered, and was accordingly treated conservatively. Nonetheless, several months later she was operated on by another surgeon. The unhappy patient turned to a lawyer who suggested sueing both surgeons. The case was settled with minuscule reward for the patient, and a double reward for the lawyer acting against the two surgeons, against the wishes of both surgeons involved.
3. The third example is perhaps the most morally condemnable one. A 27-year-old suffered a steering wheel compression, with signs of myocardial infarct. He was taken to hospital unconscious and was diagnosed with ventricular fibrillation. He was fully resuscitated, a stent was inserted and he was looking for work a year later. When he sought legal advice, he was advised to sue the hospital that saved his life.

Recalling these three cases, one may question how these two professions, with such different ethical values and interests, can have a common language? ■

Dr George M Weisz, FRACS
Adjunct Associate Professor, School of Humanities UNE and Adjunct Senior Lecturer, School of Humanities, UNSW

Surgical oncology: cancer surgeons and cancer surgeons



Surgical oncology is an area of specialisation that is often misunderstood by the general public and sometimes the medical profession itself. Surgical oncologists can be from any surgical subspecialty and are involved in cancer care through clinical practice, research, advocacy and education.

Surgical oncologists are frequently the first specialist a patient sees after a cancer diagnosis. They can manage a large multidisciplinary, team but are often perceived as a technician directed by others.

RACS' Surgical Oncology Section aims to raise awareness of the role of surgeons in cancer care, advocate on their behalf and, through innovation and research, improve cancer outcomes.

The RACS Surgical Oncology Section celebrates its 21st birthday this year with a new committee. Chair Associate Professor Michael Hughes said that having a solid foundation in place puts the section in a strong position to make a real difference.

Associate Professor Hughes is proud that the section pulls together members from most specialties and subspecialties, as is reflected in the committee. The vision of the section is a clear one: to represent, support and advance cancer surgery and cancer surgeons across Australia and New Zealand.

Having a space to collaborate affords the section a united voice with which to advocate on general issues surrounding cancer care more effectively, and to improve visibility for surgical oncology and outcomes for patients.

The section provides an opportunity for interdisciplinary discussion and sharing of ideas that may not otherwise occur. Associate Professor Hughes explains how general surgeons with expertise, in areas such as skin cancer, can engage with Fellows in Plastic and Reconstructive surgery.

The collaboration and sharing of ideas are not limited to between Australian and New Zealand specialties but extend internationally, recognising that through connection with others, real understanding and action can be achieved.

Surgical Oncology Section membership is open to all Fellows, Trainees and Specialist International Medical Graduates on the pathway to Fellowship.

Join now by logging into the RACS website, selecting the Portfolio followed by your Profile tab. Go to the 'Sections' tab and select Surgical Oncology or email the secretariat: surgical.oncology@surgeons.org ■

Case note review

Careful consideration of clinical details is essential for determining the overall benefit of a lesser procedure in a septic elderly patient.

Case details:
An 83-year-old female presented to a peripheral hospital after falling from a toilet seat at home. She had multiple comorbidities including cardiovascular disease, diabetes and obesity. She had previously undergone a left total hip replacement, which used a long stem femoral component, cerclage wires and a greater trochanteric plate. X-rays performed on admission showed a dislocated hip replacement and loosening and dislodgement of a cup cage construct.

Five days after presentation she was diagnosed as having Staphylococcus aureus bacteraemia. End-of-life care was discussed with the family at the peripheral hospital, but 16 days after her fall the patient was transferred to a tertiary hospital for ongoing care.

After appropriate investigation and planning she was taken to theatre for a one-stage washout, debridement and revision of the total hip replacement. The infected components (cup cage construct, wires, greater trochanteric plate and femoral head but not stem) were removed and the acetabulum stabilised using a Trabecular MetalTM augment.

After the procedure, the patient had a prolonged period of hypotension and was transferred to the intensive care unit (ICU) for inotropic support. She was in ICU for seven days with extensive efforts made to improve her condition.

On day 11 post-surgery, she had a gastrointestinal bleed. By day 20, she was described as having peripheral shut down. The patient died on day 22 post-surgery.

Assessment of the medical records revealed extensive anaesthetic assessment and preparation before the major operation was undertaken at the tertiary hospital. The operation was performed in the middle of the day with a consultant surgeon and anaesthetist involved. The operation was performed within three hours and proceeded without incident.

Clinical lessons:
A question was raised regarding the decision to perform a revision total hip replacement in an elderly patient with septicaemia. A lesser procedure of drainage and debridement pending clinical improvement before a one- or two-stage revision may have led to a different outcome.

There were some important decisions to be made in the care of this patient, who previously had extensive revision surgery to her left hip. She presented with an infection and a dislocated hip with a dislodged cup cage construct. She was appropriately investigated and treated to reduce the effects of the bacteraemia. A one-stage procedure was decided on when she was not toxic.

There was no occasion where a simple washout would have provided sufficient benefit to this patient. To have washed out the hip and left her with a dislocated prosthesis would have prolonged her suffering and was unlikely to have improved her chance of survival. In these circumstances, the decision to perform a one-stage washout, debridement and revision was appropriate.

The surgery was performed at an appropriate time, by senior staff, in an expeditious manner to give this patient the best chance of survival.

Although there may be a role for a simple washout in sick, toxic patients with prosthetic infections, in this case, the decision to proceed with a one-stage revision was appropriate. ■

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

RECOMMENDED READING

Argenson JN, Arndt M, Babis G, et al. Hip and Knee Section, Treatment, Debridement and Retention of Implant: Proceedings of International Consensus on Orthopedic Infections. J Arthroplasty. 2019;34(2S): S399-S419. doi: 10.1016/j.arth.2018.09.025

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

COVIDSurg global collaborative

International surgical collaborative research during the COVID-19 pandemic

COVID-19 has caused all sorts of tragedies and disrupted every aspect of normal life across the globe since it emerged in late 2019. Its easy transmission from person-to-person and its high rates of morbidity and mortality compared to most other viruses have caused well-documented disruption to medical and surgical services in many countries.

One of the most difficult problems facing health services was that, as a new pathogen, there was no data on which to base decisions and strategies. The speed of the spread of the disease overwhelmed some health care services, even in wealthy and well-resourced countries like Spain, Italy and parts of the United States. Almost everywhere else services were reorganised quickly, and with a degree of (understandable) over-reaction or planning for worst-case scenarios. What data existed was anecdotal, and tended to be catastrophic in nature, feeding the responses of responsible politicians, health care service managers and health care professionals.

In response to the need for better data, the National Institute for Health Research (NIHR) Global Surgery Unit at Birmingham University, United Kingdom, organised the COVIDSurg Collaborative to collect and analyse data from surgeons around the world. NIHR Global Surgery is one of the many successful research collaboratives based in the United Kingdom which have developed this method of involving multiple centres in parallel to collect large data sets quickly.

Surgeons across Australia and New Zealand joined this project at the outset, and have continued to develop it throughout the pandemic. The Clinical Trials Network of Australia and New Zealand (CTANZ) is the RACS group that has coordinated this work. CTANZ is charged with developing networks among surgically oriented medical students, Trainees and Fellows of the college. In three years this group has developed rapidly, and is now coordinating student projects across Australia and New Zealand – including IMAGINE, RECON and COMPASS. More recently, CTANZ has rolled out registrar-based projects including the SUNRRISE randomised clinical trial, as well as Australian and New Zealand contributions to large scale international prospective audit projects, including COVIDSurg.

The COVIDSurg project is collating the outcomes of surgery on SARS-CoV-2 infected patients, as well as the impact of the COVID-19 pandemic and the pandemic response on cancer surgery. This is the largest collaborative study ever conducted in surgery, with data now collected from more than 700 hospitals in 70 countries, including outcome data from over 24,000 patients. This project has already produced two papers in high impact journals (*The Lancet* and *British Journal of Surgery (BJS)*) with more to come.

The papers produced have allowed the group to estimate the effect of COVID-19 service changes on cancellations and waiting times, and on the actual mortality rates that result from operating on people who are infected or become infected with SARS-CoV-2 soon after their surgery.

The Cancellations paper[1] in the *BJS* achieved widespread coverage in the general media in Australia and raised awareness of the impact of the recent slowdown in elective activity, and the projected medium-term impact on services going forwards as we all try to catch up as the pandemic recedes. In Australia, the modelling suggested a backlog of up to 400,000 cases have been deferred and need to be rescheduled.

The Morbidity and Mortality paper in *The Lancet*[2] shows the impact that COVID-19 has on surgical outcomes. The short-term outcomes for 1128 patients in 24 countries was reported, showing an overall mortality of 23.8 per cent. The cohort included 22.3 per cent 'minor' procedures, and 74 per cent of the procedures were emergency operations. This very high mortality in a large case series will inform decision-makers and surgeons globally about the risks of surgery in the COVID-19 era.

The success of the data collection, rapid analysis and presentation of clinically and organisationally relevant results has powerfully demonstrated the validity of this collaborative approach to surgical research, and the ability of trainee collaboratives to pivot quickly and respond to the rapidly changing scenarios we are encountering across the COVID-19 pandemic. CTANZ will ensure not only that COVID-19-related research continues in this way, but also that the growth in specialty, registrar and student/junior trainee networks is maintained. ■

For more information contact CTANZ@surgeons.org

Dr Peter Pockney FRACS

Dr Daniel Cox

Dr Philip Townend FRACS

Professor David Watson FRACS

REFERENCES

1. COVIDSurg Collaborative. Elective surgery cancellations due to the COVID-19 pandemic: global predictive modelling to inform surgical recovery plans: https://doi.org/10.1002/bjs.11746
2. COVIDSurg collaborative, Mortality and pulmonary complications in patients undergoing surgery with perioperative SARS-CoV-2 infection: an international cohort study. The Lancet, Accepted ahead of print, May 2020

Name change for international medical graduates

The Board of Council and the Executive team have approved that international medical graduates on a specialist pathway should be renamed Specialist International Medical Graduates (SIMGs). The name change, including for the committee responsible for the governance of the program, will align the Royal Australasian College of Surgeons with the Medical Board of Australia and many other specialist medical colleges' terminology. The term will be used for all SIMGs including those on a vocational pathway to registration in New Zealand.

Spotlight on our surgical societies

Urological Society working to support members during COVID-19

President of the Urological Society of Australia and New Zealand, Mr Stephen Mark, talks to *Surgical News* about the challenges ahead.

In these uncertain times, Mr Stephen Mark, President of Urological Society of Australia and New Zealand (USANZ) is doing the regular work of a president. But he's also keeping an eye on the COVID-19 pandemic to ascertain the level of support USANZ members might need.

"So much has changed, but the most important thing for us, as a professional organisation, is to remain relevant to our members, and that requires us to be flexible and supportive," he said.

COVID-19 has placed a lot of USANZ's plans and objectives in limbo, Mr Mark explained, and the current focus of the society is "much more of a supportive role facilitating changes in the way things are done". Supporting members with their phone and video consults, electronic platforms and non-person educational platforms are a priority, he said.

Mr Mark, who graduated from the University of Otago with a Bachelor of Medicine and a Bachelor of Surgery in 1983, completed two Fellowships – one in reconstructive and urodynamic Urology at Duke University in the United States of America, and the second in Paediatrics and paediatric Urology at Bristol Children's Hospital in the United Kingdom.

Today, he is one of nine urological surgeons working at what is believed to be the longest continuously running private specialist medical practice in New Zealand. Urology Associates, a highly qualified and experienced team of consultants, was established in 1982.

USANZ had 515 full members and 103 Trainees across the two countries in 2019, and the society is aiming to train enough surgeons to meet future needs.

"The patient population is ageing and the opportunities for urological treatment are expanding," Mr Mark said. "The current workforce of consultant urologist ratio to population is really not sustainable."

While COVID-19 will affect the plans of Trainees and Specialist International Medical Graduates (SIMGs) in the short term, Mr Mark made the point that Trainees graduate into a global employment environment. "A number of them shift internationally, and we have SIMGs who shift internationally back to us," he said.

"Historically, the surgical workforce was trained for local needs but, I think, now we're realising that, despite the pandemic, we do live in a mobile global environment. On the basis of that, a number of our Trainees will be expected to subsequently travel to and live overseas; and a number of SIMGs will have the understanding that they want to live and work in Australia and New Zealand."

USANZ is making great strides in attracting female medical students to Urology. In 2019, 30 per cent of new Trainees were female and, in 2020, a new group for female urology surgeons was established. Dr Anita Clarke and Dr Lydia Johns Putra organised and initiated Surgical Women in Australia and New Zealand Urology (SWANZU). Terms of reference are being developed that will see the SWANZU group operating within USANZ.

"We're very supportive of female Trainees," Mr Mark said.

"We're promoting flexible training and raising the visibility of women in leadership roles within Urology."

In recent years, Urology has expanded into female Urology, including urinary incontinence and pelvic floor disfunction, and there are more and more opportunities in that area. As well, an increasing number of female Trainees are undertaking all aspects of Urology, and "we promote and support that", Mr Mark said.

The society is also focusing on encouraging Māori, Aboriginal and Torres Strait Islander medical graduates to apply for the Urology training program. Within the training program, USANZ encourages Māori graduates to apply, Mr Mark said, so there's a degree of positive influence and some movement in the actual application process.

Most urologists have more than one active area of subspecialisation. According to Mr Mark, they've either trained specifically in their Fellowship for a subspecialty, or focused on it with a higher level of expertise during their career.

"There's a breadth of opportunity within Urology that fulfils the interests of a large number of surgical staff," he said. "That's why surgeons remain enthusiastic and interested in their subspecialty.

There's a degree of evolution and the rapid change of culture and advancements translate into patient care, which allows us to maintain an interested group of innovative people within Australia, New Zealand and internationally."

USANZ has also recently completed a comprehensive update of its training curriculum. A dedicated committee "recognised that for a modern education system we need a defined curriculum with an exam that's aligned with examining the curriculum", Mr Mark said.

The result is an examination process that is both clinically relevant and flexible in the COVID-19 environment. The examination can be done without patients, so it can be run in any location. "On the basis of that, the examination process is not only aligned to the curriculum, but can also be run in a standardised fashion to ensure the assessment process is fair and equitable."

Regarding the short-term future, Mr Mark said USANZ was aware the College had activities and events scheduled that "have to be managed in an unstable environment. We want them to recognise the importance of a strong society and strong College – both providing relevant member benefits in this difficult environment.

"The College needs to hear from the societies that we have strength working together and we need to support each other and our members through this challenging time." ■

Historical timeline of the Urological Society of Australia and New Zealand

1910s	**1914**	Sydney urologist, Dr Samuel Henry Harris appointed first full-time specialist urologist in Australasia.
1920s	**1927**	Dr Harris published his version of the Fryer technique for suprapubic prostatectomy.
1930s	**1935**	Dr Harris embarked on a tour to Europe where he demonstrated the Fryer technique in London, Edinburgh and Vienna.
	1935	Nine full-time urologists formed the Sydney Urological Association.
	1937	The Urological Society of Australasia was formed. Dr Harris was due to become the foundation president but, unfortunately, he died of pneumonia in December 1936.
1940s	**1944**	The first annual meeting with a scientific program was held in Sydney.
	1944–1947	The year before incorporation the society had a membership of 42 full members.
	1948	The society was incorporated.
1950s	**1958**	The rotation of annual scientific meetings among cities in Australian states and territories and New Zealand commenced.
1960s	**1963**	Dr Lorna Sisely, an Associate Member and the first woman to join the society attended an annual scientific meeting hosted in Canberra.
1970s	**1976**	RACS specialist surgical training committees became Surgical Boards and the Board of Urology.
1980s	**1987**	Gail Hill was appointed as the society's secretary.
1990s	**1999**	After being a tenant of RACS in Albion Street, Sydney, the society moved to premises in Edgecliff, Sydney.
2000s	**2002**	A full-time CEO was appointed.
	2006	The name was changed to the Urological Society of Australia and New Zealand.
	2008	The society began administering the Surgical Education and Training (SET) program through RACS.

Source: Wilde, S. 1999. A History of the Urological Society of Australasia, Hyland House: Melbourne.

From the library: choosing the right content alert options

The Royal Australasian College of Surgeons (RACS) Library provides a range of quality self-service online resources such as databases, e-journals and e-books, and also has a number of content alert options to choose from.

eTOC

The eTOC service offers email delivery of the latest table of content alerts. There are 15 specialty or topic-based sets, with each containing a selection of key or popular e-journals. Sets available are:

- *ANZ Journal of Surgery*
- *Cardiothoracic Surgery*
- *General Surgery – Breast Surgery*
- *General Surgery – Colorectal Surgery*
- *General Surgery – Endocrine Surgery*
- *General Surgery – Gastric & Oesophageal Surgery*
- *Neurosurgery*
- *Orthopaedic Surgery*
- *Otolaryngology Head and Neck Surgery*
- *Paediatric Surgery*
- *Plastic & Reconstructive Surgery*
- *Urology*
- *Vascular Surgery*
- *Medical Education*
- *Trauma*

Signing up to one or more sets means that regular emails will be delivered with the latest tables of contents for the included journals. Articles of interest can be clicked on, and the full text easily accessed, read and saved. More details and sign-up can be found here.

Read by QxMD

This allows for a customised service. It will push out eTOCs for any journals to which RACS subscribes, or will alert you to new articles on subjects of choice, giving full text access. Read by QxMD will operate on mobile devices, laptops and desktops. Further information can be found here.

If just one or two journals are required, please contact library staff and they can use login options at the publishers' sites to set-up emailed alerts that can easily be forwarded on. Please note that the links in these alerts do not provide full text access to individual articles and that the journal issue would need to be accessed via the Library website for full text.

MEDLINE and Embase

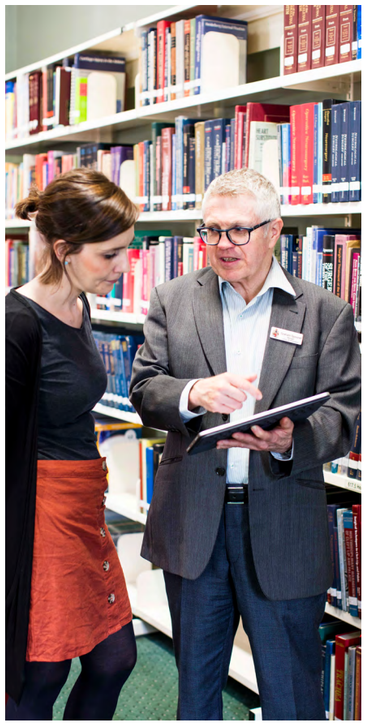
The MEDLINE and Embase bibliographic databases offer powerful alerting options. Library staff already provide a popular literature/database search service for members. However, in addition to obtaining results that provide citations from the database that are current at a point in time, there are options within these databases to save the search strategies so they are re-run on a regular basis to identify any new citations that meet the search criteria.

When requesting a search, just indicate in the notes field that the search should be saved as an alert and how frequently it should be run (e.g. weekly, monthly, etc). Otherwise, simply email the College library@surgeons.org or phone us on +61 3 9249 1271 to discuss your saved search requirements.

If you want to keep searches or alerts, or just come back to them later, there is the facility to create your own Ovid account. Ask library staff for help, if required. Database search results also include easy linking to full-text (when it is available) or to an online journal request form to order articles not held in RACS' collections. ■

Useful links and information

- Sign up for eTOC at surgeons.org/library/etocs.
- Read by QxMD can be found under surgeons.org/library/apps.
- MEDLINE and Embase can be requested by contacting the Library.
- Library contact: college.library@surgeons.org +61 3 9249 1271



In memoriam

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

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

Mr Robert Dykes (NZ)

Mr John Coutts (NZ)

Dr Andrew Sutherland AM (SA)

Informing RACS

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

ACT: college.act@surgeons.org

NSW: college.nsw@surgeons.org

NZ: college.nz@surgeons.org

QLD: college.qld@surgeons.org

SA: college.sa@surgeons.org

TAS: college.tas@surgeons.org

VIC: college.vic@surgeons.org

WA: college.wa@surgeons.org

NT: college.nt@surgeons.org

Andrew D'Arcy Sutherland AM FRACS

Orthopaedic surgeon

14 May 1943–20 March 2020

Andrew D'Arcy Sutherland was born in Adelaide in 1943. His father, D'Arcy, was an accomplished Cardiothoracic Surgeon who pioneered open-heart surgery in Australia and no doubt had strong influence on Andrew (as well as his other son Peter) to pursue a career in surgery and medical leadership. The most revealing example of this effect was Andrew's own election to President of the Royal Australasian College of Surgeons (RACS) in 2007 – the first father/son combination with D'Arcy also President 29 years earlier.

Andrew grew up in Adelaide with his siblings Elizabeth and Peter. He excelled at St Peter's College and whilst being offered the opportunity to stay on for an extra year in school leadership, he chose to enter university with the lure of a more liberal lifestyle and associated distractions. His desire to enjoy life while working hard was obviously cemented early in his career.

Following Medical School and some early years as a doctor, Andrew ventured to Canada for five years, then the UK, to complete his training in Orthopaedic Surgery. He returned to Australia and was readily employed at the Royal Adelaide Hospital and the Adelaide Children's Hospital, where his advanced new skills were welcomed. He supported Sir Dennis Paterson and dedicated his clinical practice to the care of children, particularly those with fractures, those suffering the effects of cerebral palsy (then called spasticity) and scoliosis. He chaired the Board of the Spastic Centres of South Australia, was a founding member of the Australian Paediatric Orthopaedic Society and a strong contributor to various societies.

Generations of Australians had their lives improved by Andrew. His expertise in communication, clinical care and persistent quest for improvement in outcomes for patients were witnessed daily. A conservative surgeon who made operations seem easy, unhurried, and performed with finesse. He had a wonderful style of communicating, being able to listen to opinions, debate in good spirit and provide formal advice no matter how difficult the situation. He nurtured and cared for junior colleagues from all specialties, encouraging the importance of professional behaviour above self-interest or personal gain.

He was an adept administrator, always willing to hear the various opinions and then statesmanlike in providing formal advice, even when faced with difficult decisions.

He was Head of Orthopaedic Surgery at the Women's and Children's Hospital (South Australia) for 10 years and then Chief of Surgery. He worked in close collaboration with the nursing staff for whom he was the strongest medical advocate for their importance in the healing of children.

Andrew had a distinguished career in representing surgeons, not only his orthopaedic colleagues through the Australian Orthopaedic Association, but all surgeons with the Royal Australasian College of Surgeons.

He served as a RACS examiner on the Orthopaedic Court from 1988–1996, including four years as senior examiner. He was a member of RACS Council from 1998–2008, holding many official roles including Chairman of the Court of Examiners 2002–2003, Honorary Treasurer 2003–2007 and he was the first Orthopaedic surgeon to be elected President 2007–2008.

Associate Professor Peter Cundy FRACS and Mr Tony Sparnon FRACS

For the full obituary please visit our website.

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

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

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

All costs for the Foundation for Surgery fundraising are provided for by the College so that 100 per cent of your donation can achieve its maximum benefit in the community.

100% of your donation assists in addressing critical surgical need

REGISTERED CHARITY

To find out more, please join us at www.surgeons.org/foundation

Gold/Platinum

Prof Ian Gough
Anonymous donor
Mr John Kearney
The Kimberley Foundation
Mr Brian Morgan
The Wilkinson Foundation

Silver

Dr Susan Adams
Mr William Armstrong
Dr Michelle Atkinson
Prof Bruce Barraclough
Mr Peter Barrie
Mr Andrew Bean
Anonymous donor
Anonymous donor
Ms Mara Bennett
Mr Graeme Brown
Mr Lee Brown
Mr Wei Chang
Dr Susan Chapman
Mr John Chew
Mrs Margaret Chiam
Dr Joan Cosgrove
Prof Ross Crawford
Mr Terence Darby
D'Extinguished Surgical Club
Mr Douglas Druitt
Anonymous donor
Prof Kingsley Faulkner
Mr Bruce French
Prof Mark Frydenberg
Dr Anthony Green
Mr Bruce Hall
Ms Karen Hill
Dr Geoffrey Hirst
Anonymous donor
Inner Wheel District 54
Mr Bal Krishan
Dr Christine Lai
Mr Patrick Lo
Mr Ken Loi
Anonymous donor
Dr Katherine Martin
Mr Gerard McCafferty
Anonymous donor
Mr Glenn McCulloch
Mr Michael McFarlane
Prof David Morgan
Assoc Prof Julie Mundy
Mr Philip Nase
Anonymous donor
Mr Frederick Niesche
Assoc Prof Chris Perry
Mr William Poate
Dr Timothy Porter
Mr David Price
Mr John Ralph
Rotary Club of Kew
Anonymous donor
Prof John Royle
Anonymous donor
Mr Anthony Shakeshaft
Dr Brindha Shivalingam
Prof Julian Smith
Prof Russell Stitz
Mr Ming Tong
Mr Michael Troy
Mr Harry Tsigaras
Mr Stephen Tudge
Dr Rosslyn Walker
Ms Hilary Wallace
Dr Jefferson Webster
Dr Gregory Witherow
Mr Ivan Yaksich

Bronze

Mr Barrie Aarons
Dr Renata Abraszko
Mr Ian Allison
Ms Nicole Allsopp
Dr Matilda Anderson
Mr Robert Anderson
Dr Nagy Andrawis
Anonymous donor
Mr Ronald Baker
Dr Graeme Barber
Mr Arshad Barmare
Miss Ginny Barro
Dr Borjana Barth
Anonymous donor
Mr Peter Bath
Assoc Prof Robert Bauze
Anonymous donor
Mr Dalmiro Bellio
Dr Maria-Pia Bernardi
Prof Michael Besser
Conjoint Prof Andrew Bezzina
Mr Ratnakar Bhattacharyya
Mr John Biviano
Dr Frances Booth
Mr Laszlo Borbely
Anonymous donor
Dr Graeme Brazenor
Miss Ingra Bringmann
Dr Andrew Broadhurst
Anonymous donor
Mr Peter Brown
Mr Michael Bruce
Mr John Callander
Mr Donald Cameron
Dr Claire Campbell
Prof Abraham Campero
Mr Robert Carey
Mr Lawrence Carroll
Mr Ross Cartmill
Mr Anthony Cass
Mr William Castleden
Dr Douglas Cavaye
Mr Simon Chan
Mr Sean Chan
Dr Abdul Chaudhry
Dr Bernard Cheung
Mr Mark Chia
Dr Colin Chilvers
Mr Anwar Choudhary
Prof Wui Chung
Anonymous donor
Anonymous donor
Mr Harvey Coates
Dr Neil Cochrane
Anonymous donor
Mr David Cottier
Mr Murray Cox
Mr John Cox
Mr Trevor Crofts
Dr Richard Curran
Dr Peter D'Alessandro
Mr David Davidson
Mr Michael Davies
Assoc Prof Alan De Costa
Dr Nalaka De Silva
Anonymous donor
Mr Terence Devine
Assoc Prof Peter Devitt
Anonymous donor
Mr James Drummond
Mr Anthony Dunin
Anonymous donor
Mr Barry Edwards
Mr David Elder
Mr Peter Endrey-Walder
Mr Gregory Etherington
Ms Ruth Evans
Assoc Prof Hamish Ewing
Prof David Fletcher
Mr John Fliegner
Ms Patricia Foster
Anonymous donor
Mr Andrew Gatenby
Mr Wylie Gibbons
Mr Michael Gillespie
Dr Rowan Gillies
Mr Jeremy Goad
Prof Glen Gole
Mr Anthony Goodman
Mr Paul Goodman
Mr Michael Gordon
Dr John Graham
Mr Angus Gray
Anonymous donor
Mr John Groome
Mr Peter Grossberg
Mr Hettiarachchige Gunawardane
Dr Indunil Gunawardena
Mr Dennis Gyomber
Dr Mark Haber
Dr Joshua Hammerschlag
Anonymous donor
Mr John Hanrahan
Mr James Harbison
Prof Philip Hardcastle
Mr Gerard Hardisty
Mr Christopher Haw
Mr Ian Hayes
Mr Brian Haymet
Prof Michael Henderson
Mr Alastair Hepburn
Mr Soon Ho
Mr Raymond Hollings
Anonymous donor
Mr Peter Holman
Mr George Hopkins
Dr Zhen Hou
Mr Roland Hunt
Assoc Prof Nabeel Ibrahim
Dr Hany Ibrahim
Mr Shing Ip
Mr Cyrus Irani
Mr Justin James
Prof Glyn Jamieson
Mr Narayanan Jayachandran
Mr Warren Johnson
Mr Jamie Kearsley
Mr Srisonghan Khamhing
Mr Sikander Khan
Mr Noel Kinny
Dr Milos Kolarik
Mr Andreas Kreis
Mr Chris Krousoratis
Dr Julian Lane
Mr Mikko Larsen
Mr Matthew Lawrence
Dr James Ledgard
Mr Yuk Lee
Mr Tristan Leech
Mr John Leeton
Dr Elizabeth Lewis
Mr Tony Lewis
Mr Eugene Lim
Mr Robert Lindsay
Mrs Elizabeth Livingstone
Mr Robert Loane
Ms Rosaleen Love
Mr Kenneth MacGowan
Dr David MacIntosh
Mr Arun Mahajani
Dr Sheanna Maine
Mr Waisani Mar
Mr Keith Markwick
Mr David Marshall
Mr Nicholas Marshall
Dr Peter Martin
Dr Julia Matheson
Mr Phillip Mathews
Mr Richard Maxwell
Mr Bernard McCusker
Mr Robert McDonald
Anonymous donor
Dr David McLeod
Dr Timothy McMeniman
Mr Matthew McNamara
Mr Roger Mee
Mrs Mary & Ms Spiros Michalas
Mr Campbell Miles
Mr Bruce Miller
Mr David Millons
Mr Rodney Mitchell
Mr Ian Mitchell
Mr William Mooney (Snr) OAM
Anonymous donor
Mrs Terri Mulhearn
Mr Donald Murphy
Anonymous donor
Mr Stephen Nicholls
Mr James Nield
Mr Simon Nieuwesteeg
Mr Ikram Nizam
Dr Fritha Noonan
The Nordstrand Family
Anonymous donor
Mr Robert North
Prof Helen O'Connell
Ms Nancy Odgers
Dr Jill O'Donnell
Mr Stanley O'Loughlin
Mr Barry O'Loughlin
Dr Junius Packiyanathan
Dr Tony Palasovski
Anonymous donor
Dr Girish Pande
Anonymous donor
Dr Bhavik Patel
Dr Roger Paterson
Mr Stephen Pearson
Dr Kesley Pedler
Mr Anthony Perks
Dr Joel Petit
Dr Turab Pishori
Mr Donald Pitchford
Emeritus Prof Adrian Polglase
Mr Francis Prendergast
Dr Kimberley Prince
Mr Stephen Purchas
Mr John Quain
Dr Yasantha Rajapakse
Miss Meera Raju
Prof Tindivanam Ramanujam
Mr Christopher Rance
Mr Peter Randle
Assoc Prof Prem Rashid
Dr Ian Rebello
Mrs Jessica Redwood
Dr Mifanwy Reece
Emeritus Prof Thomas Reeve
Mr Thomas Roberts
Mr Andrew Roberts
Mr Francis Robertson
Anonymous donor
Dr Sebastian Rodrigues
Mr Paul Rosen
Mr Harry Ross
Prof Alastair Rothwell
Dr Emmanouel Roussos
Dr Olivia Ruskin
Dr Christine Russell
Dr Roderick Ryan
Mr John Saalfeld
Dr Adnan Safdar
Dr Alexander Saxby
Anonymous donor
Assoc Prof Margaret Schnitzler
Anonymous donor
Anonymous donor
Mr Ragheb Sidhom
Ms Meta Smith
Dr Kylie Snook
Mr David Speakman
Mr David Stary
Dr James Stephenson
Dr Anthony Stroud
Mr Malcolm Stuart
Mr Unis Suliman
Mr Alistair Swanton
Mr John Tharion
Dr Michelle Thomas
Prof Robert Thomas
Mr Graeme Thompson
Mr Andrew Thompson
Mr Francis Tomlinson
Ms Julie Tsembis
Dr Khrisna Tumali
Dr Melinda Van Oosterum
Prof Richard Vaughan
Assoc Prof David Veivers
Mr Ivan Velasquez
Prof David Vickers
Dr Pauline Waites
Mr Henry Walsh
Mr John Walters
Anonymous donor
Ms Susan Wardle
Dr Agnes Warren
Miss Clare Warren
Mr Richard Watson
Anonymous donor
Wetzig Maisha Fund
Anonymous donor
Anonymous donor
Mr Gerard Wilkinson
Mr John Williams
Mr Thomas Wilson
Mrs Heather Winneke
Mr Enoch Wong
Mr Kwok-Kee Wong
Mr Brian Wood
Dr James Wynne
Mr Edward Yeboah
Mr Philip Yeung
Mr Michael Zacharia

"A psychologically healthy workplace fosters employee health and wellbeing while enhancing organizational performance and productivity,"

Sodexo 2017 Global Workplace Trends

Flexible workplaces are happy workplaces

Speak in total confidence to a Converge International consultant.
Australia 1300 our eap (1300 687 327) **New Zealand** 0800 666 367
International +613 8620 5300 or **visit** convergeinternational.com.au

Converge international

Australia's most trusted hospital and private practice transcription provider

WEB-BASED
Dictate and receive reports from anywhere at any time

ACCURATE
Sub-specialty typists with over 99.5% accuracy

SECURE
Data securely stored at an accredited and endorsed State Government Data Centre

QUICK
24-hour turnaround time

GUARANTEED
cost savings and process efficiencies

FREE APP
Apple IOS/ Android App
Securely upload to our server

IMPROVE
patient care and reduce secretarial overload

ISO 9001:2015 Registered AUS/QMS/JAS-C0045/1117

JAS-ANZ www.jas-anz.org/register

An ISO 9001:2015 Quality Certified Company

Download our app now for your free no obligation trial OR Call our friendly staff anytime

1300 768 476 (Australia)
0800 884 323 (New Zealand)

Professional Transcription Solutions www.etranscriptions.com.au • info@etranscriptions.com.au