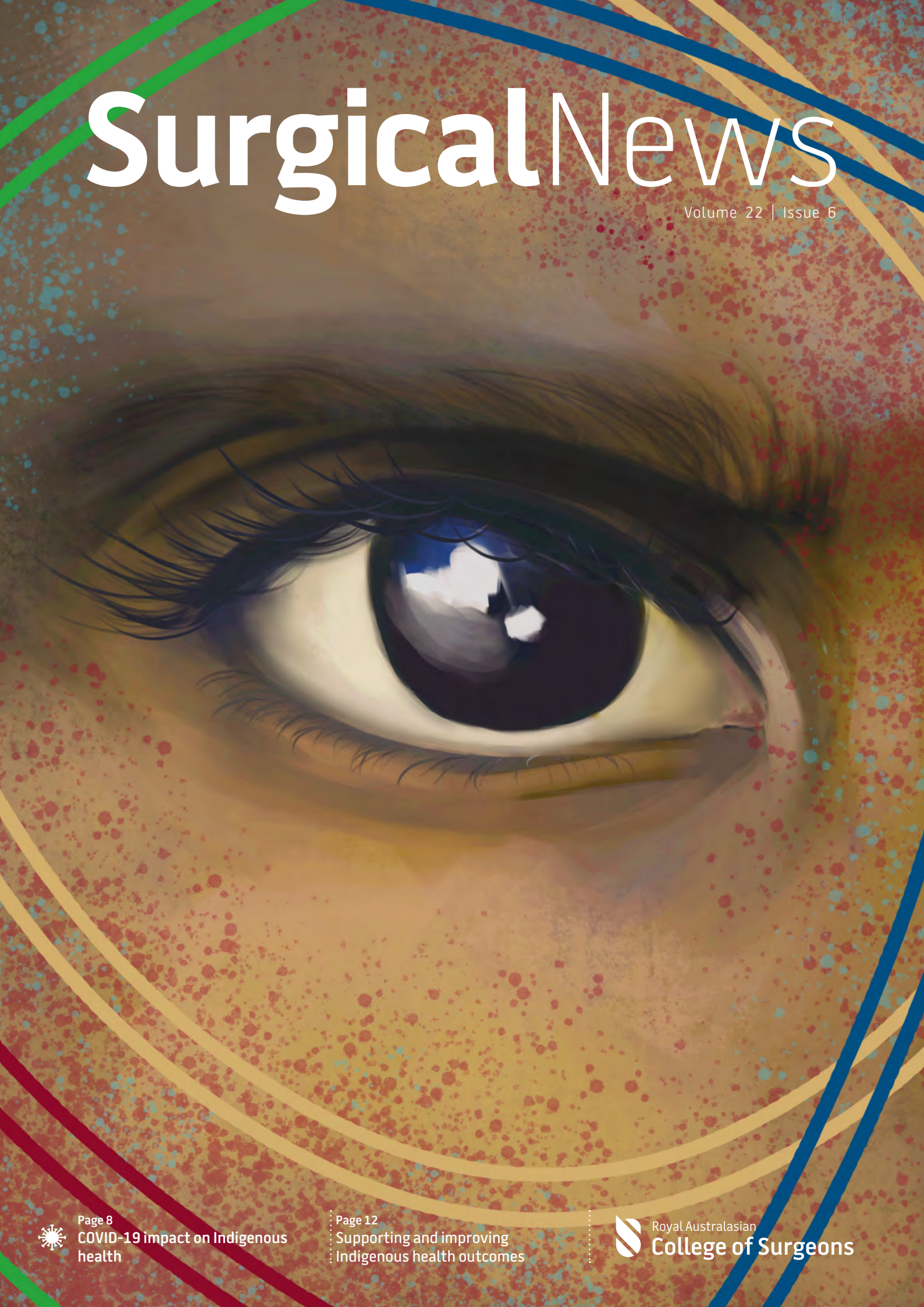
SurgicalNews

Volume 22 | Issue 6



Page 8
COVID-19 impact on Indigenous health

Page 12
Supporting and improving Indigenous health outcomes

Royal Australasian College of Surgeons

Leading support in your times of need – it's why more doctors choose Avant

When the moment arrives, how confident are you in the quality of support you'll receive? Avant offers unrivalled protection.

Award-winning defence

A 270-strong* team including Australia's largest health law firm recognised for their expertise, providing members with on-the-ground support in six states and territories.

Industry-leading insights

With half of Australian doctors as members, we handle more calls and cases. This wealth of insights and experience helps us determine the best approach for your matter, to achieve a positive outcome.

Expert advice and risk management

Prevention is better than cure. That's why members have access to our medico-legal experts, 24/7 in emergencies, risk advisers and high-quality educational resources.

Experience the Avant difference.

1800 128 268 avant.org.au/practitioners

Avant mutual
by doctors for doctors

RACS leadership

Spotlight on

Indigenous health

Historical

Research

Advocacy

Articles of interest

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
Publications Lead: Saleha Singh
Designer: Amy Tanner

Contributing writers: Rachel Corkery, Shima Ibuki and Fleur Morrison.
www.surgeons.org
ISSN 1443-9603 (Print)/ISSN 1443-9565 (Online).

Cover image: Sumaya Harare

President's perspective

It is hard to believe that the year is almost over. It has been a tumultuous and eventful one, framed by the ongoing pandemic. It is pleasing to see so many communities in Australia and Aotearoa New Zealand coming out of lockdowns.

Despite this positive step forward, we are faced with the challenges brought about by the pandemic that have impacted negatively on the health of our communities. For example, in Victoria, we have had elective surgery restrictions imposed intermittently over the last 18 months, resulting in a growing waiting list for elective surgery in both the public and private sectors. We believe that the current stabilisation of the COVID-19 situation with high vaccination rates, fall in the number of COVID-19 cases, and the gradual reduction in hospital in-patient ICU cases presents an ideal window of opportunity for government to restore surgery to full capacity.

We called on the Victorian government to address this issue urgently and we are pleased to say that elective surgery capacity was increased to 75 per cent and hopefully full capacity by the time this magazine goes to print.

This successful outcome is the result of the great efforts of surgical directors, Victorian chairs of colleges and specialty associations, and the Victorian perioperative consultative council comprising of surgeons and anaesthetists.

I would like to thank our Fellows, Trainees, Specialist International Graduates, staff at the College and our patients for soldiering on in the face of so many challenges.

I also extend my gratitude to the many who went out of their way to support their communities. If there is one positive we can carry forward, it is the spirit of generosity that has been so evident in the last two years of the pandemic.

One of the challenges we faced during the year was running our Fellowship examinations. The Fellowship Clinical and Viva examinations took place for seven surgical specialties with 151 candidates in Australia and Aotearoa New Zealand between 5 and 7 November 2021. The examinations were delivered in a hybrid model across 23 venues involving a mix of in-person and remote examiners and observers.

This was a particularly challenging examination to deliver due to the constantly changing COVID-19 restrictions. Exam participants had to be COVID tested, wear N95 masks, and eye protection. Some of the changing circumstances meant that we had to cancel the plastic surgery exam in Auckland because of border closures.

An enormous amount of work went into ensuring that the exams were conducted successfully with as many candidates as possible able to sit for them. More than 170 examiners, 30 local coordinators and 50 RACS staff and volunteers delivered the exam over the weekend. I thank everyone involved. It was an example of true collaboration between our staff, specialty societies, the Court of Examiners and many volunteers working together to achieve a successful event.

There are so many people who provide their time generously to the College from managing examinations, working in the Asia-Pacific to support healthcare to contributing their ideas through College committees and Council. We would not be able to run many of our activities without their valuable support. The pro bono contribution of Fellows has been, and continues to be, one of the College's most valued assets and resources.

My thanks also to our Fellows who participated in the Council elections. I encourage you to communicate with your specialty elected Councillors, and indeed with any of us on how you can engage with and support your College. Congratulations to the re-elected councillors and new Councillor, Professor Deborah Bailey.

I also take this opportunity to congratulate our new Fellows. I wish you every success as you embark on this new phase of your surgical journey. I encourage you to take time to learn more about your College and reach out to us where you need assistance.

As we look forward to 2022, the RACS Council has been busy working on our strategy. We will have more to share on this when it is finalised. One of the key pillars of the strategy is the focus on supporting Indigenous health, so I am pleased to see a *Surgical News* issue that is dedicated to highlighting the many initiatives and people who work so hard in this area.

Improving the health of Māori and Aboriginal and Torres Strait Islander people is a national priority in both our countries. Despite government initiatives, health and social inequities persist between Indigenous and non-Indigenous communities.

To address this, the College made Indigenous health a priority by incorporating it in our strategic planning. We want to address the health inequities of the Aboriginal, Torres Strait Islander and Māori populations of Australia and New Zealand. Our goal is to achieve this by increasing the number of Indigenous Trainees , building workforce capabilities, and increasing services to better meet the health needs of these communities in culturally appropriate ways. More information on our approach is detailed in our Indigenous health position paper, which can be found on our website.

I believe that we have to learn more about our Indigenous communities in order to be more effective surgeons. We have some courses in this area available at RACS.

I recently attended an interesting one-day course at the University of Otago's Māori Indigenous Health Institute (MIHI). The course was organised by Professor Suzanne Pitama, a highly respected child psychologist. The course supports health practitioners to feel informed and confident in the development of Māori competencies, with a special focus on the application of the Hui Process (a framework to enhance the doctor-patient relationship with Māori) and the Meihana Model, a framework that facilitates the fusion of clinical and cultural competencies to better serve Māori within mental health service delivery.

Dr Maxine Ronald and Professor Yin Paradies also conducted a course on Indigenous Health Cultural Safety for the chairs of Surgical Training programs in October. We will include more Indigenous healthcare education in surgical training as part of the RACS Cultural Competence and Cultural Safety Competency.

We also welcome announcement by Ahpra and the Medical Board of Australia to conduct an external review of patient safety issues in the cosmetic surgery sector. For far too long we've had a system that allows anyone with a medical degree to call themselves a surgeon. It is time to close the loopholes that bring harm to patients.

I am pleased to end my message with my warmest congratulations to Dr Annette Holian on her recent appointment as the president of the Australian Orthopaedic Association. As a woman president, this appointment also gives me much pride to see the increasing diversity in our surgical profession. I wish Annette every success in her endeavours and remain committed to supporting her and other women in their leadership journeys.

May the holiday season end the present year on a cheerful note and make way for a fresh and bright New Year.

Dr Sally Langley
President

Vice president's perspective

Another year is rapidly coming to an end and despite the accompanying challenges and disruptions, I hope that you and your families are safe and well.

It is heartwarming to see Australia and Aotearoa New Zealand emerging from difficult circumstances and into a sense of normality as vaccination rates increase and a decrease in the severity of COVID-19 cases.

I would like to highlight a few thoughts in this message to you.

We recently conducted an evaluation of the short-term outcomes of the RACS Building Respect and Improving Patient Safety initiative. The evaluation focused on program governance and oversight, awareness of standards of respectful behaviour, and identifying program deficiencies. This would not have been possible without the contribution of our Fellows, Trainees and Specialist International Medical Graduates (SIMGs) whose insights will be invaluable in formulating the upcoming Action Plan. RACS extends its gratitude to all who contributed.

The evaluation found that more than 90 per cent of members support our work in this area, the leadership role that RACS has taken and the commitment to improve the culture in the surgical workplace. This aligns with community awareness and expectations of the need to improve workplace behaviour, which is increasingly part of workplace policies.

Almost all (99 per cent) Fellows, Trainees and Specialist International Medical Graduates (SIMGs) believe in the need to demonstrate respectful behaviours, and 96 per cent recognise the need to address unacceptable behaviour in colleagues and peers. However, there is a knowledge and behaviour gap as while knowledge of respectful behaviours is widespread, and attitudes are changing, 'calling it out' is a challenge for many. We recognise that behaviour change is a long-term goal, but many of us need more confidence to act when witnessing or experiencing poor behaviour.

There is another extremely important relationship, that I would like to highlight: that of between Fellows and staff. Council has guided the evolving governance structures and it is important to explain the implications for Fellows and staff.

Your Board represents members and delegates the responsibility to progress board set strategic direction to board-related committees. Many committees are predominantly operational and are critically reliant upon the diligence, support, and high-level expertise of RACS staff. Our staff are the engine room of our strategy delivery, and my experience of board governance reflects the importance of the team in developing and maintaining relevance for our members, and more importantly to our community. A recently held workshop, facilitated by an industry expert external reviewer provided an update of appropriate governance of RACS, our roles and how to best add value.

Fellows must lead by example in acceptable standards of behaviour and interactions with Trainees, SIMGs, other healthcare workers and RACS staff. I have observed the lack of appreciation of power differentials that exist in these relationships and perhaps it is time to recognise the effect this has upon those with whom we interact. Being aware of nuances such as these is a sign of respect. I am saddened by reports of poor behaviour by Fellows towards staff, and we need to appreciate the negative impacts of this behaviour on their function and physical wellbeing.

I highly commend College staff who, despite the difficulties imposed by the pandemic, have performed above expectations, for the benefit of the College. RACS staff are highly trained and qualified professionals, experts in their field and employed to progress College goals and aspirations. RACS staff are the ether for the College's success.

We recently achieved the Department of Foreign Affairs and Trade (DFAT) basic accreditation and aim for full accreditation, which will create new funding opportunities. As we continue to meet the evolving regulations and standards of DFAT, we need to ensure compliance with DFAT and institutional donor requirements to attract funding for our growing programs in the Asia-Pacific region.

A recent independently facilitated donor-mapping activity involved Fellows and staff as part of a strategy to grow programs and diversify funding sources. RACS has a highly skilled team with more than 100 years of development expertise, which we Fellows can harness for a brighter future. Together, we can make this happen.

As we look into the future, it is increasingly important for RACS to explore surgeons' growing interest in robotic assisted surgery with implications for training, standards and accreditation. Surgery delivery is changing as are the barriers to adoption of robots such as cost and availability. I have little doubt that in the future, Trainees and surgeons will become increasingly technology dependent. RACS has a responsibility to develop our members with the necessary skill sets for the digital future. We are working with the Australian Medical Robotics Academy in Melbourne to explore future relationships.

On other Council matters, the proposed name change for the College was mentioned in my message in the October 2021 issue of *Surgical News*. A working party scoped a proposed College name and recommended to the Council to put this forward to members. The working group identified two viable alternative names:

- Royal College of Surgeons of Australia and Aotearoa New Zealand (RCSAANZ)
- Royal Australian and Aotearoa New Zealand College of Surgeons (RAANZCS)

Most working group members favoured the second name as it was closest to the current name. Options featuring 'ANZAC' were avoided given the military connotation. Council approved a vote of members on the proposed name change. This will be conducted via (electronic) postal ballot in 2022. More information will be provided in due course.

Council also recently decided to transition our well-regarded member magazine, *Surgical News*, to a digital format in the second half of 2022. There is a growing expectation that as the world embraces digital platforms, our offerings should join the ever-increasing list of publications adopting a digital platform. We currently receive a hard copy and a flip book version but plan to move to a fully digital version hosted on a microsite within the RACS website.

A paper-based version will be available upon request. This change is in tandem with the recent decision to go digital with the *ANZ Journal of Surgery*.

Finally, I warmly congratulate Dr Annette Holian, an esteemed member of Council, on her election to president of the Australian Orthopaedic Association (AOA). I have known Annette for a long time, and she is popular, focussed and diligent. Annette has proven to be a wonderful leader and will continue to bring immense value to AOA.

I wish you all a relaxing and safe holiday season – a welcome chance to enjoy family and friends, and a happy, successful and enjoyable 2022.

Dr Lawrence Malisano
Vice President

news in brief

College of Surgeons welcomes review of cosmetic surgery

RACS President, Dr Sally Langley, said that Australians rightly expect all surgical procedures to be performed to the highest possible standards and meet nationally established surgical standards.

"We call on the enquiry to focus on the transparency of training. Any surgery entails risk, and it is critical that the enquiry establishes clear guidelines into the training required to conduct surgery. The practices of some health practitioners have caused significant harm to patients.

"We also welcome the Health Ministers' commitment to national consultation on changing the national law to protect the title of 'surgeon'. We have been advocating for a long time that only those registered in specialties that undergo Australian Medical Council (AMC) accredited training program, which includes a significant surgical component, should be allowed to use 'surgeon' in their titles," Dr Langley added.

A smarter way of working

Congratulations to RACS Fellow Dr Jillian Tomlinson on being a successful recipient of Telstra Health's inaugural 2021 Brilliant Women in Digital Health awards!

Dr Tomlinson believes digital health initiatives allow all to work smarter, not harder. She was recognised for her contributions in encouraging medical specialists to adopt digital technologies.

Her extensive contributions to digital health include formerly chairing the Australian Health Digital Agency's Specialist Toolkit Steering Group, instigating the Australian Medical Associations Digital Health Committee and collaborating with government groups, regulators, and professional organisations to deliver digital health implementation projects improving safety and quality in Australian health care.

Leading the way

The Australian's annual *Research Magazine* acknowledges the best researchers and research institutions across Australia, in 250 individual fields of research.

RACS congratulates the following Fellows for being listed in Australia's top 250 researchers in 2021:

- Professor Zsolt Balogh
- Professor Paul Bannon
- Professor Jeffrey V Rosenfeld
- Professor Anand Deva
- Professor Jonathon Golledge
- Professor Declan Murphy
- Professor Richard Harvey
- Professor Julian Feller

Talent discovery and research analytics firm League of Scholars in conjunction with *The Australian*, comprehensively measured online data about Australia's research output, leading to the identification of the best researchers and best research institutions in each field, based on the excellence of their research and the impact it has in discovery and scholarship.

The End of Life Choice Act 2019

The *End of Life Choice Act* 2019 (the Act), came into effect in Aotearoa New Zealand on 7 November 2021. The introduction of assisted dying means that a person with a terminal illness who meets the eligibility criteria can request medication to relieve their suffering and end their life.

The Medical Council wrote to RACS highlighting that some doctors may not be familiar with the requirements of the new Act, and may be unsure of the implications, whether or not they are willing to participate in medically assisted dying.

In response, the Medical Council has prepared a resource document (https://bit.ly/3FBSweM) to assist doctors as they seek to understand and apply some of the key provisions in the Act.

The Ministry of Health has also created e-learning modules (https://bit.ly/3nGlDHG) about assisted dying services. There are three 20-minute modules, which they encourage all medical practitioners to complete.

2022 membership renewal

Your 2022 College membership fee renewal notice is now available for review. Payment is due by 1 January 2022.

Please visit the member portal to view the schedule of fees and subscription category options or to renew your membership.

Made for doctors and their families

“I switched to Doctors’ Health Fund because it was the only fund created for doctors and their families.

We recently expanded our family, and it gives me assurance that they are all covered under the policy.”

Dr Wilson Petrushnko
General Surgeon
Doctors’ Health Fund member since 2015

Choose the cover that’s right for you and your family.

Speak to our expert Member Services Team today.

1800 226 126

doctorshealthfund.com.au

doctors health fund

Avant mutual

DHF 324_ 11/21

First Australian languages

Before colonisation took full effect, there were between 290 to 350 Aboriginal language nations in Australia. When considering different dialects in each language, the number of languages spoken are estimated at 500.

Similar to cultures such as the Vikings, which relied on the verbal transmission of history and culture, Aboriginal peoples' history and cultural practices were transmitted through songs and ceremony.

Each Aboriginal language nation had its geographical region, language, cultural beliefs, laws, and political systems. In some regions, sophisticated hand-sign languages were also developed.

Although geographical boundaries separated language nations, they were connected by trade and exchange of information. Songs were sung during the journey capturing details of the trade routes connecting neighboring nations, including information on landmarks and directions, backgrounds to ceremonies, and details of the locations of water and food sources—known as song lines.

Twenty eight Aboriginal languages are still spoken today. Due to trade between language nations and marriage, it was common for Aboriginal people to be multilingual and speak up to three or more languages.

Just as lawyers and doctors have their technical language, Aboriginal medicine people also had technical words to describe medicines created using various plants. Sadly, where languages have disappeared, so too has essential knowledge of plant use and medicine making.

In some language nations, such as the Warlpiri people, when a family member dies, the women of the family enter a vow of silence, which can last between three to 12 months. During that time, sophisticated sign language is used to communicate.

RACS use of Aboriginal words

Mina – means 'knowledge' in the language of Gathang-speaking nation. It is also the language nation of Australia's first Aboriginal surgeon Professor Kelvin Kong, a founding member of the RACS Indigenous Health Committee and an Indigenous health advocate and champion.

The 'Mina Advisory Group', is used to denote the English translation 'Aboriginal and Torres Strait Islander Knowledge Advisory Group'.

Common words that originate from Aboriginal words:

Yakka – means physically draining work. It comes from the word 'yaga', meaning 'work' in the Yagara language of the Brisbane area.

Cooee – originates from the Dharug language of Aboriginal Australians in the Sydney area. It means 'come here' and has now become widely used in Australia as a call over distances.

Other well-known Aboriginal words include:

Ballarat
Bilby
Bunyip
Coolabah
Dingo
Galah
Jarrah
Koala
Kookaburra
Quoll
Wallaby
Wallaroo
Waratah
Wombat
Billabong
Min-min lights (ground-level lights of uncertain origin sometimes seen in remote rural Australia)

To find out more visit:

https://bit.ly/3DVgOjt
https://bit.ly/3nKLOgp

An advocate for better Indigenous health

Combining science with helping people is Mikayla Couch's mantra

Dr Mikayla Couch is a proud Bundjalung woman and an Obstetrics and Gynaecology registrar currently working at Lismore Base Hospital in New South Wales. Dr Couch appears regularly in social and web media advocating for better Indigenous health. She has an Instagram page, and her podcast will be launching in December.

Dr Couch wanted to study surgery from a young age because she wanted to combine science with helping people, particularly in her own community. Her grandmother developed breast cancer at age 75, and refused to go to hospital. "So many of my people are terrified of hospitals. They are regarded as places full of white people where you go to die," Dr Couch said. "Maybe if there had been an Indigenous doctor available to help my nan, she would have received treatment for her cancer."

Dr Couch is a recipient of the RACS ASC Award, which provided funding so she could attend the 2015 College's Annual Scientific Congress (ASC) as a final year medical student. The Award was invaluable because it enabled her to network and meet with many surgeons, attend educational programs, and it helped to demystify the activities of the College. It helped build Dr Couch's confidence in pursuing a surgical career. When she explained her history and commitment to improving the health of Aboriginal Australians to other attendees and speakers, she recalls being met with interest and encouragement.

Dr Couch became an unaccredited Neurosurgical Trainee at the Royal Prince Alfred Hospital in Sydney, but left after three months due to burnout, despite supportive supervisors who tried to dissuade her from leaving. She had two car accidents within a week due to falling asleep at the wheel. "The hours were insane. For example, I was rostered on for 21 days straight with one weekend off and then I worked another six weeks straight with one day off. We have to keep talking about this until it changes."

Dr Couch believes that unaccredited Trainees have been left behind and lack the workplace protection available to others. It's a gap that she is concerned will discourage other Indigenous doctors from become surgeons. "I would love to come back to surgery one day," Dr Couch said, "it's my dream."

While Australia is doing well in terms of policy development around improving Indigenous Australians' health, in reality there are still many barriers that prevent people from accessing and receiving quality medical care. "I really like the Closing the Gap framework," Dr Couch said, "but we need more action until Indigenous people have the same longevity in life expectancy and the same standards in living, employment and education as non-Indigenous people."

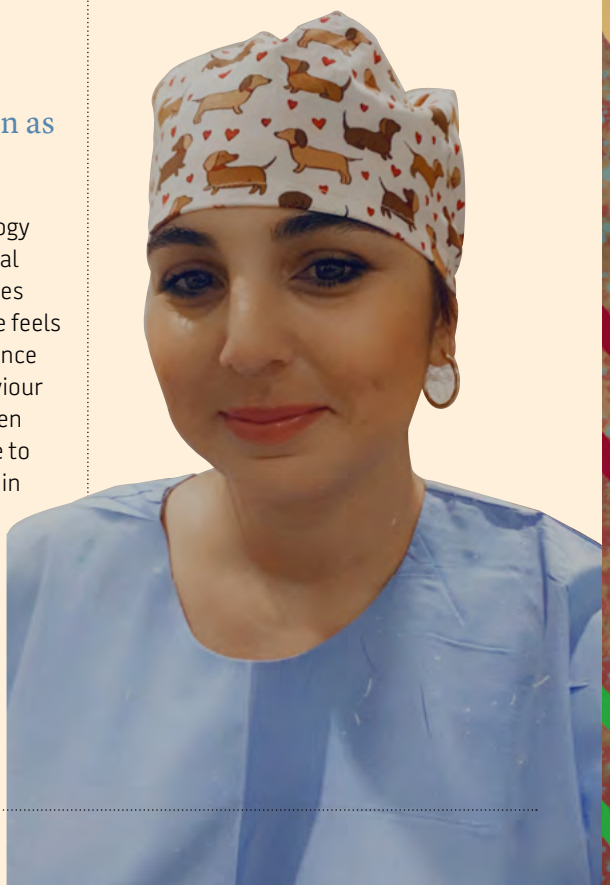
> ... "we need more action until Indigenous people have the same longevity in life expectancy and the same standards in living, employment and education as non-Indigenous people."

Moving to Obstetrics and Gynaecology meant she could keep up her surgical skills and learn new skills. Colleagues often turn to her for advice, and she feels her presence has an informal influence in encouraging more positive behaviour around Aboriginal patients. She often encourages other Aboriginal people to study medicine and pursue careers in health.

Dr Couch thinks most surgeons want to help, but they're not sure how to go about it. They can join the Australian Indigenous Doctors' Association (AIDA) as an associate member, attend conferences, and access training and educational material. Dr Couch acknowledges the generous support given by RACS to AIDA's conferences in encouraging Indigenous doctors to consider training as surgeons.

In the meantime, Dr Couch is excited and looking forward to the launch of her podcast, which will be called BLA.C.K Medicine (the 'c' is emphasised as an act of reclaim; it represents colonisation). Dr Couch hopes the 30-minute episodes will have a broad audience with guests such as Dr Justin Cain, a Gomeroi and Yuin man and a Vascular Surgery unaccredited registrar, and Professor Kelvin Kong, a proud Worimi man, the first Aboriginal surgeon in Australia, and an Otolaryngologist, Head and Neck surgeon. She hopes RACS will talk about their outreach program and the work being done to encourage Indigenous surgeons.

If you would like to keep in touch with Dr Couch and her work, follow her on Instagram: https://www.instagram.com/dr.aboriginal.woman/



Supporting and improving Indigenous health outcomes

RACS supports the implementation of the new *Cultural Competence and Cultural Safety* competency

RACS is one of the first medical colleges to identify the need to introduce a dedicated Cultural Competence and Cultural Safety Competency.

This new competency was developed in collaboration with the Indigenous Health Committee and Indigenous surgeons in Australia and Aotearoa New Zealand.

It was introduced to support improvement of Indigenous health outcomes and guide members on how to provide culturally safe care.

The new competency was introduced in June 2020 and is available on: https://bit.ly/3CMpuHs

Having a dedicated Cultural Competence and Cultural Safety Competency framework highlights to RACS members the importance of improving Indigenous health outcomes by providing appropriate culturally safe care to Aboriginal, Torres Strait Islander people and Māori. It also highlights the need to provide culturally safe care to all Indigenous patients, families, communities and colleagues.

Developing the Professional Skills Framework

The implementation of the new Cultural Competence and Cultural Safety Competency is supported by the Professional Skills Framework. This framework was developed in collaboration with the Indigenous Health Committee and Indigenous experts in Australia and Aoteraroa New Zealand and will provide a framework for everyone in the College implementing the new competency. The framework identifies learning outcomes across the three stages of surgical training, including statements identifying what a Trainee should know and be able to do in early, mid and late SET.

The final draft of the framework was presented to the Board of Surgical Education Training (BSET) on 15 October 2021, and will be presented to the Specialty Training Boards for review. The next stage of the framework development will include an appropriate Assessment Framework to support specialty boards and trainers implementing the newly identified Learning Objectives.

Training our Fellows to implement the new competency

To support the implementation of the new competency, RACS has been developing and delivering a range of professional development courses for our members. The Indigenous Health team has also been developing and providing a range of training across all sectors of RACS, including targeted professional development for training boards, Cultural Safety and Indigenous health sessions—through Indigenous providers and the new Aboriginal and Torres Strait Islander courses—and the Maori Indigenous Health Institute (MIHI) training with the University of Otago in Aotearoa New Zealand.

The most appropriate training was identified by BSET and the Specialty Training Boards to support the implementation of the new competency and the Professional Skills Framework. This training commenced with BSET on 14 October and the Board of Vascular Surgery on 22 October. Training will be delivered to other Boards in early 2022.

AIDA Aboriginal and Torres Strait Islander health in clinical practice

The first AIDA Aboriginal and Torres Strait Islander Health in Clinical Practice (ATSIHICP) session was held in Brisbane on 17 July with a broad range of RACS Queensland Fellows attending. The session was delivered by Associate Professor Shannon Springer and Dr Ngaree Blow (pictured above left) at the RACS Queensland office.

The session provided RACS Fellows an opportunity to learn more about connection to country and how holistic health perspectives are different to

Western biomedical approaches. They also learned about how racism is impacting Indigenous Health outcomes and considered what they can do differently in their practice to address these disparities.

The RACS Fellows participated in a yarning circle with the facilitators to talk about what they are going to implement in their practice.

Lindy Jeffree, a neurosurgeon from Queensland said, "It was a fascinating and enjoyable interactive session that synthesised the challenges faced by Aboriginal and Torres Strait peoples within our health system. We learnt the strategies that non-Indigenous doctors can use to improve the clinical experience. The stories and examples of how to provide culturally safe clinical encounters left me inspired to improve recognition, access, and outcomes for my Aboriginal and Torres Strait Islander patients and colleagues."

Associate Professor Bernard C.S. Whitfield said, "The AIDA session in Brisbane significantly enhanced my understanding of 'sorry business' and its implications."

Professor Yin Paradies' Indigenous Health and Cultural Safety sessions in Australia

RACS has also developed and delivered a customised online Indigenous Health and Cultural Safety session delivered by Professor Yin Paradies. These were delivered to the Melbourne Fellows on 9 October and to the Sydney Fellows on 6 November.

Professor Paradies is an Aboriginal-Asian-Anglo Australian of the Wakaya people from the Gulf of Carpentaria. He is also the Chair in Race Relations at Deakin University and is developing this training.

Professor Paradies said, "Providing optimal healthcare requires an understanding of colonisation, the nature of health disparities, aspects of Indigenous culture, and effective approaches to addressing the detrimental impacts of racism and privilege in medical contexts. Surgeons have found this in-depth exploration of cultural safety engaging and influential in relation to their ongoing practice."

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

Training for trainers in Aotearoa New Zealand

RACS has collaborated with the Hui Process/Meihana Model to deliver the MIHI course customised for surgeons.

The course entails a range of components, including online learning, onsite learning, and assessment modules. The topics will explore the context of Hauora Māori and include Te Roe within a clinical setting and understanding the context for studying Māori health. Orientation to the Hui Process and Meihana Model and its application can help reduce clinical bias and improve health literacy along with the role of Whakateres.

The objective of the course is to support health practitioners to feel informed and confident in the development of Hauora Māori competencies, specifically focusing on the Hui Process and Meihana Model. The different components of the training are:

- onsite training seminar in Christchurch, including team-based learning activities to orientate learners to the Hui Process and Meihana Model
- simulated patient sessions to practice application of Hui Process and Meihana Model to clinical practice
- face-to-face courses assisting learners to apply these models within their clinical practice alongside Māori patients and/or whānau. These models promote positive engagement, appropriate care and treatment, and health advocacy that support Māori health equity.

Learners will receive feedback about their progress through assessment modules, which require them to demonstrate their ability to use the Hui Process and Meihana Model in clinical practice. They also complete a case assignment involving a virtual patient case that allows them to demonstrate how they apply the Hui Process/Meihana Model.

If the learner chooses to continue their learning past Assessment 1, they can complete another written assignment. This involves interviewing a Māori patient with whom they are working and completing the assignment.

eLearning training (Aborginal and Torres Strait Islanders)

To support delivery of the new competency Fellows, SIMGs, Trainees, and JDocs can undertake the Aboriginal and Torres Strait Islander eLearning courses. These courses have been specifically developed with the requirements of surgeons in mind. They were designed and developed in collaboration with a range of Aboriginal and Torres Strait Islander partners to ensure they provide an authentic Indigenous perspective.

More information on the courses and access to them is available through the RACS Indigenous Health webpage (https://bit.ly/3HPmvSC). These courses are designed to be completed over an extended period and are broken down into self-contained 30-minute self-contained modules. Members will be issued a certificate on completion of the full course along with 10 hours of CPD for the new Cultural Competence and Cultural Safety Competency. The courses can be used each year towards the CPD requirements for the Learning Plan related to the new competency.

To support delivery of the eLearning courses the RACS library has purchased access to a range of online and hard copy books highlighted in the courses for members to use. The RACS library page provides access to the Informit – Indigenous Database along with a range of suggested articles, books and other relevant resources for Australia and Aotearoa New Zealand. If you would like access to other books or resources, please contact the RACS Library.

Next steps

The focus for 2022 will be on finalising the Assessment Framework and implementing the Professional Skills Curriculum into the specialty Board curriculum documents. The Indigenous Health team will provide support for training our members, inclusion of questions in the surgical education training entry process, and the curriculum documents. The RACS Indigenous Health team will work closely with BSET and the Boards to ensure they have the support to implement the competency in a culturally safe way.

If you need assistance please contact the RACS Indigenous Health team on indigenous.health@surgeons.org

This program is funded by the Australian Government Department of Health through the Specialist Training Program (STP).

Matariki - the Maori New Year - declared a public holiday in Aotearoa New Zealand

Matariki refers to a large cluster of stars, also known as the Pleiades

Aotearoa New Zealand is preparing for an annual celebration of Matariki with the recent government announcement of a Māori new year public holiday.

Matariki, the Māori new year, is a season when people, culture, language and the spirit of those beneath the stars of Matariki are celebrated.

Also known as the constellation of Pleiades, Matariki is a star cluster that first appears in the night sky above Aotearoa during mid-winter.

It is a time to remember those who have passed throughout the year and reflect on ancestral knowledge to guide us into how we can live our lives today.

When Matariki will appear is knowledge that comes from the maramataka—a calendar informed by the moon, the stars, and our natural environment. Within it navigation, planting, fishing, and many other practices are determined by thousands of years of observation, recording and practice.

According to the maramataka, Matariki brings the old lunar year to a close and marks the beginning of the new year.

This highlights the importance the nation places on Indigenous knowledge and is demonstrating, in a very real way, how Aotearoa New Zealand can engage with mātauranga Māori (Māori knowledge systems)".*

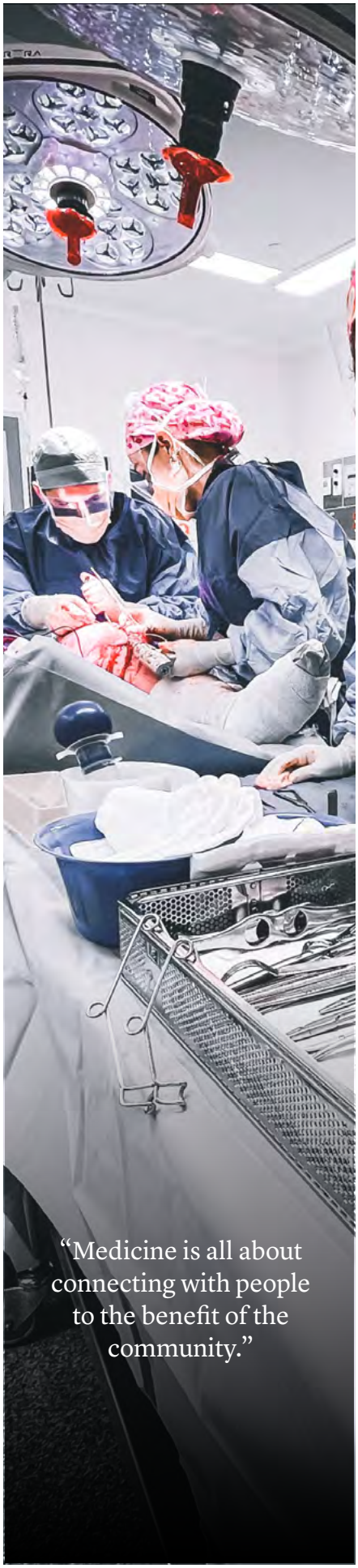
The New Zealand government has introduced the Matariki Public Holiday Bill to Parliament. The Te Pire mō te Hararei Tūmatanui o Te Kāhui o Matariki /Te Kāhui o Matariki Public Holiday Bill is only the fifth dual language Bill to be introduced to the New Zealand Parliament. The first public holiday to celebrate Matariki will be on Friday 24 June 2022.

Matariki is an abbreviation of 'Ngā Mata o te Ariki Tāwhirimātea' (The Eyes of the God Tāwhirimātea) and refers to a large cluster of stars, also known as the Pleiades.

The predawn rising of Matariki in the mid-winter sky marks the changing of the seasons and the beginning of the Māori new year. A Matariki public holiday will be our first public holiday that recognises Te Ao Māori. This day signifies:

- Remembrance – honouring those we have lost since the last rising of Matariki
- Celebrating the present – gathering together to give thanks for what we have
- Looking to the future – looking forward to the promise of a new year.

*Wikitera, K. A. (2021, P1).



Community is at the heart of Indigenous surgical Trainee's work

Dr Rachel Farrelly had a very different upbringing to many of her peers in medical school.

The orthopedic surgery Trainee grew up on a farm outside the country town of Orange in New South Wales, where she was homeschooled.

While that background might not have been the typical pathway towards a career in surgery, Dr Farrelly believes it will be an asset when she becomes Australia's first female Indigenous orthopedic surgeon.

"Moving to Sydney to study medicine was daunting and initially, I didn't really feel like I belonged there. Most of the other medical students were from schools in Sydney, and I was from a small country town," she says.

"But growing up in the country gave me an ability to communicate and build rapport with patients, and that is one of my strengths. I can talk in a straightforward manner and understand the complex backgrounds of patients."

Dr Farrelly believes that along with procedural skills, communication is key to success as a surgeon.

"Medicine is all about connecting with people to the benefit of the community. The procedural side of things is valuable, but if that's all you're interested in, you might as well be studying veterinary medicine."

The Royal Australasian College of Surgeons (RACS) has outlined the role communication plays in health care and its importance in the care provided to Indigenous communities in its *RACS Indigenous Health Position Paper*. It recognises the importance of a holistic view of health—encompassing wider aspects like family, community, kinship networks and connection to land, culture, traditions, waterways, and other resources.

RACS also aims to support more First Nations people from Australia and Aotearoa New Zealand to follow in Dr Farrelly's footsteps into a career in surgery.

Along with being a trailblazer in the Indigenous community, Dr Farrelly is the first in her family to attend university. However, it was her father who, recognising her interest in helping people in Orange, first suggested she consider a career in medicine.

She had only encountered medical professionals through her brother, who grew up with a disability and her grandmother who suffered from oesophageal cancer.

"I didn't grow up wanting to be a surgeon. The medical profession was quite foreign to me at the time and I didn't take much notice of it."

After her father had planted the idea of studying medicine in her mind, she spoke to a family friend who was a general practitioner. She was advised about the rigour of the training and the steps towards becoming a doctor.

At university, Dr Farrelly was drawn to anatomy for its practicality. She finished at the top of the class in the subject, with another student.

She feels great satisfaction in being able to make a difference to patients through her career in the orthopedic specialty.

"I enjoy that in six weeks to three months, I can help someone go from being incapacitated to being able to walk out the door."

Her advice for other Indigenous women interested in a career in medicine is to foster relationships with those who can provide advice and encouragement during what can be a challenging journey.

"The way I progressed was by building relationships. Our history and culture are very word-of-mouth and relationship based. My advice is to reach out to teachers and friends to get an understanding of what is involved, and to learn about the steps you need to take to get you where you want to be.

"You need to be very dedicated because during training you have to work hard and don't always get to do some of the ordinary things like chilling out at a pub. Instead, you'll be at the library studying."

However, for Dr Farrelly—who would like to inspire Indigenous women to follow her into surgery— the benefits of a career in surgery are far-reaching.

"Trying to help my people is one of my drivers and to be a role model is also important to me. Our experience of health care has often been negative, and if I can change that I will be very happy," she says.

Audits of surgical mortality data identifies common surgical themes in Indigenous communities

In 2021, an estimated 33 per cent of Indigenous Australians (292,100) live in New South Wales, 28 per cent (246,300) live in Queensland, and 9 per cent (79,571) live in the Northern Territory. However, the Northern Territory has the highest proportion of Indigenous residents (31 per cent – 79,600 people).[1] Similarly, the proportion of the population who identify as Indigenous is generally higher in more remote areas.[1] In Australia, Aboriginal and Torres Strait Islander people experience poorer health outcomes compared to non-Indigenous people.[2]

In January 2011, the Australian and New Zealand Audit of Surgical Mortality (ANZASM) included Aboriginal and Torres Strait Islander status in the data it was collecting on in-hospital patient mortality. The Northern Territory Audit of Surgical Mortality (NTASM) and the Queensland Audit of Surgical Mortality (QASM) have the most comprehensive datasets in this regard. NTASM and QASM reviewed 28 per cent and 34 per cent (respectively) of all Indigenous cases notified to ANZASM from 2015–2020. Recommendations regarding Aboriginal and Torres Strait Islander patients have been included in annual reports for ANZASM, NTASM and QASM.[3–5]

These reports have identified common themes when compared with non-Indigenous patients. Aboriginal and Torres Strait Islander patients who die in hospital under the care of a surgeon:

- are at least 19 years younger
- were more likely to be transferred to another hospital
- were more likely to be admitted to a public hospital
- were twice as likely to have three or more co-morbidities per patient (co-morbidities were typically renal disease, diabetes, and hepatic disease)
- were more likely to have fluid balance issues when in hospital
- were more likely to have acquired an infection before admission to hospital.

The NTASM has published data showing surgical care is equitable for both Aboriginal and Torres Strait Islander and non-Indigenous patients.[6]

QASM's 2021 annual report[7] includes data from 2015 – 2020 and shows all Aboriginal and Torres Strait Islander patients admitted under vascular or paediatric surgeons received an operation. Aboriginal and Torres Strait Islander patients admitted under a neurosurgeon were 20 per cent more likely to have an operation than were non-Indigenous patients. Fewer Aboriginal and Torres Strait Islander patients were admitted under orthopaedic surgeons than non-Indigenous patients.

Aboriginal and Torres Strait Islander patients who had an operation, compared to non-Indigenous patients, were nearly twice as likely to die following vascular or cardiovascular operations.

ANZASM will continue to review and report on the differences between Aboriginal and Torres Strait Islander and non-Indigenous patients.

Aboriginal and Torres Strait Islander patients could benefit from a model of care that includes early recognition of health decline at primary care centres and early transfer for appropriate surgical intervention. These approaches could lead to better outcomes for these patients.

In 2020, RACS published an Indigenous Health Position Paper that reaffirms the College's commitment to improving health outcomes for Aboriginal and Torres Strait Islander people.[8] In 2020, RACS updated its surgical competence and performance guide to include a 10th competency: *Cultural competence and cultural safety.*[0]

The following case study spotlights the surgical journey of an Indigenous patient, revealing challenges and asking relevant questions.

References:

1. Australian Institute of Health and Welfare. Profile of Indigenous Australians [Internet]. Canberra: AIHW. 2021 [accessed 15 October 2021]. Available from: https://bit.ly/3kxCiLC
2. Australian Institute of Health and Welfare. Cardiovascular disease, diabetes and chronic kidney disease—Australian facts: Aboriginal and Torres Strait Islander people. Cardiovascular, diabetes and chronic kidney disease series no. 5. Cat. no. CDK 5. Canberra: AIHW. 2015 [accessed 16 August 2021]. Available from: https://bit.ly/3qCMfv3
3. Royal Australasian College of Surgeons. Australian and New Zealand Audit of Surgical Mortality National Report. 2016. Available from: https://bit.ly/3cfcob3
4. Royal Australasian College of Surgeons. Northern Territory Audit of Surgical Mortality Annual Report (July 2010–June 2020). 2021. Available from: https://bit.ly/3ne7CAM
5. Royal Australasian College of Surgeons. Queensland Audit of Surgical Mortality (QASM) Report (2007–2016). 2018. Available from: https://bit.ly/2YKrG4k
6. Treacy PJ, North JB, Rey-Conde T, Allen J, Ware RS. Outcomes from the Northern Territory Audit of Surgical Mortality: Aboriginal deaths. ANZ Journal of Surgery. 2014;85(Numbers 1/2):11–15. Available from: https://bit.ly/3kWXc7l
7. Royal Australasian College of Surgeons. Queensland Audit of Surgical Mortality (QASM) Report (2015–2020). 2021. Available from: https://issuu.com/maxgecko/docs/4043_qasm_annual_report_2020_final
8. Royal Australasian College of Surgeons. Indigenous Health Position Paper June 2020. Available from: https://bit.ly/3kC241e
9. Royal Australasian College of Surgeons. Updated Surgical Competence and Performance Guide February 2020. Available from: https://bit.ly/30mMyzH

Case summary

An Indigenous patient in his 60s presented to hospital in the evening and was admitted medically with cellulitis. He had multiple comorbidities including congestive heart failure, ischaemic cardiomyopathy, alcoholic liver cirrhosis with varices, atrial fibrillation, gout and stage IV chronic kidney disease. He had previously had a coronary artery bypass graft and had a defibrillator in-situ. Intravenous antibiotics were started.

The following day, he was referred to the surgical department in a state of septic shock with an erythematous and swollen right leg. Necrotising fasciitis was suspected, and he was resuscitated.

He was sent to theatre; however, surgery was delayed for one hour when the anaesthetist was called to another urgent case. His 15-minute surgery included a right ankle and lower leg debridement with excision of <1% of the wound area. The appearance was not typical for necrotising fasciitis. Shortly after surgery, he arrested in theatre. Cardiopulmonary resuscitation was performed, and he was transferred to the intensive care unit (ICU).

He required high inotropic support and developed refractory acidosis (pH 7.34 progressing to 7.23 then to 7.0, with lactate 2.7 to 3.9 to 6 mg/dL). It was decided among the surgical consultant, ICU consultant and family members to palliate the patient.

Discussion

This patient was admitted with and died from overwhelming sepsis due to a *Serratia marcescens* infection in the leg. *Serratia marcescens* is an uncommon but known cause of skin and soft tissue infections and necrotising fasciitis. It is unusual for overwhelming sepsis to result from an infection such as cellulitis (in the absence of necrosis).

His leg was swollen and erythematous, but at surgery there was 'merely cellulitis' and no necrosis found.

Is it possible there was a site of necrosis in the leg that was not identified at surgery? Could there have been necrotising fasciitis deeper or higher up in the leg, or even osteomyelitis?

This case highlights the need for early identification of such infections.

Is it possible that if the patient was admitted under a surgical team the path to surgery would have commenced sooner (perhaps on the day of admission)?

Given the severity of this bacterium's pathogenicity and the poor health reserves of the patient, it is likely the path to death was predetermined even before admission.

Clinical and cultural lessons

Surgeons, doctors, and other healthcare providers are faced with multiple challenges, including societal and cultural differences, when managing Indigenous patients' healthcare.

It is possible that there were other significant factors that could have contributed to this patient's comorbidities, including:

- the patient's ability to access appropriate primary healthcare
- the patient's education level
- the influence of environmental factors that may have contributed to the development of some of the patient's comorbidities.

It is important for surgeons to review Indigenous patients holistically and understand that disease development may not rest solely on the patient.

A Surgical Audit eLearning module has been added to the RACS professional development activities (eLearning course and resources). The module has been developed in a collaboration between ANZASM and the RACS Professional Development department. It is available to all surgeons and takes about 40 minutes to complete.

The eLearning module will provide training around the sensitivity of reporting surgical mortalities and the logistics of using the Fellows Interface. This is delivered in four practical sections:

1. The Audit of Surgical Mortality
2. The audit process
3. The Fellows Interface
4. Feedback and evaluation.

The course will provide an adaptable teaching and learning platform for a broad range of users from different regions, specialities and career stages to access information and gain CPD points (by completing the course assessment and award of certificate).

The eLearning module is anticipated to 'go live' in early 2022.

Indigenous program grants

Indigenous program grants – building careers in surgery to support Indigenous health

Together with the Indigenous Health Committee, RACS is committed to increasing the participation of Aboriginal, Torres Strait Islander and Māori doctors in a surgical career by providing education, training and research opportunities. By prioritising Indigenous Health, building the surgical workforce and increasing services, we can better meet the health needs of Māori, and Aboriginal and/or Torres Strait Islander peoples.

The following grants open for application in January 2022 for Aboriginal, Torres Strait Islander and Māori junior doctors and final year medical students with an interest in surgery.

Indigenous Program Grants on offer for junior doctors and final year medical students

ASC Award
Registration, airfares, travel, and accommodation costs up to $5000 (multiple grants)

The grant supports final year medical students and doctors interested in surgery to attend RACS Annual Scientific Congress in May 2022.

Who can apply?

Aboriginal, Torres Strait Islander and Māori junior doctors and final year medical students.

ASC Peer Support Award
Registration, airfares, travel, and accommodation costs up to $5000 (multiple grants)

This grant supports final year medical students and doctors interested in surgery to attend the RACS Annual Scientific Congress in May 2022.

Who can apply?

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

Davison Family Grant
$2,500

This grant supports doctors who have the potential to inspire and attract similar young people to the field of surgery and who, without financial assistance, may be unable to contemplate a career in surgery.

Who can apply?

Aboriginal and Torres Strait Islander junior doctors wishing to undertake postgraduate surgical training.

Career Enhancement Grant Junior doctors
$5,000 (multiple grants)

This grant supports junior doctors to acquire knowledge and skills that will strengthen their surgical career pathway.

Who can apply?

Aboriginal, Torres Strait Islander and Māori junior doctors.

Career Enhancement Grant - Medical students
$2,000 (multiple grants)

This grant supports final year medical students who are interested in pursuing a surgical career.

Who can apply?

Aboriginal, Torres Strait Islander and Māori final year medical students.

Applications are open via surgeons.org/scholarships from 17 January to 16 February 2022.

Further information:
Tricia Quek, Learning and Development Grants coordinator
E: scholarships@surgeons.org.
www.surgeons.org/scholarships

Building rapport with patients is key to success for new Indigenous surgeon

A childhood split between Australia and South Africa provided Dr Andrew Martin with an appreciation of difference. He brings this to his work as an Ear, Nose and Throat (ENT) surgeon.

Dr Martin lived in South Africa between the ages of nine and 14 during a tumultuous time in the country's history, towards the end of apartheid and the beginning of Nelson Mandela's presidency.

"It was very confronting to see what was happening in South Africa. But being an Indigenous Australian gave me sympathy for what people were going through," he says.

As a new Fellow with RACS, Dr Martin attributes his understanding of the value of cultural sensitivity to this experience, combined with his Indigenous heritage, and his time living and travelling internationally.

RACS is working to ensure more Indigenous Australians have the opportunity to become Fellows. RACS launched its Indigenous Surgical Pathway Program Australia in August 2021 to increase Aboriginal and Torres Strait Islander surgeons in the workforce.

Dr Martin says his journey towards Fellowship has been long and challenging but rewarding.

> "Training is a very long journey, so you have to really enjoy the journey and not be too obsessed with the result."

Before moving to South Africa, he spent his younger years in Benalla in the north of Victoria.

He attended high school in Frankston, Melbourne, and enrolled in Pharmacy at Monash University, where he completed an honours year researching medicinal chemistry.

However, his ultimate ambition was to become a surgeon and he embarked on a four-year post graduate degree in Medicine at the University of Queensland.

He completed his surgical training in Aotearoa New Zealand, where he lived for seven years. This year he moved back to Australia to start his Fellowship in Head and Neck Surgery.

Dr Martin says that the hard work of surgical training is part of a journey that is satisfying not just in its destination, but also in itself.

"Overall, I think it's a hugely positive experience, with a number of stressors and challenges along the way. There are a lot of hurdles to jump over with training and exams, and life can throw you curve balls that are not always timed to fit in with your plan.

"Training is a very long journey, so you have to really enjoy it and not be too obsessed with the result. I made a lot of great friends and mentors in training—this is what made for an awesome experience."

Dr Martin encountered a hurdle of a different kind during the year, when he and his family contracted COVID-19 and he found himself isolating at home with his wife and three children.

Fortunately, he and his wife had been vaccinated and the family only suffered mild symptoms. But it did mean that Dr Martin was responsible for some homeschooling of his young children.

"It was definitely a challenge!" he says.

Spending time with his family and his love of the natural world, ignited amid the bounteous wildlife of Africa, provide him with respite from the stress of his job.

He considers his birdwatching hobby to be an obsession, something he was able to indulge in during a trip to northern Spain following an Ear Surgery course and while training in New Zealand.

Dr Martin also gets great satisfaction from helping a wide range of patients—an element of his specialty that originally attracted him to pursue a career in ENT surgery.

"What I love about ENT is the variety of people you treat, from babies to older

people. I also see a variety of conditions, from hearing problems to cancer or sinus surgery. I get great satisfaction from the whole patient experience—from seeing people in the clinic, operating on them and their follow up. It gives me a buzz when I see people who have achieved a good result."

In his surgery career, Dr Martin believes communication is more than half of the job and that building a successful relationship with patients is crucial to the role.

"The most important thing is to try to understand and bond with those who have a different background. Learning some phrases or words from their language and having a broad understanding of their cultural norms helps you develop a rapport with them. But essentially, it is always important to treat each person as an individual."

eLearning courses

As part of the new Surgical Competence and Performance Framework, RACS has acknowledged the importance of surgeons being culturally competent and culturally safe. This is reflected in the new dedicated 10th Cultural Competence and Cultural Safety Competency. This competency includes points related to improving Indigenous Health outcomes, providing culturally competent and safe care, fostering respectful relationships, and promoting inclusive and safe workplaces.

To support delivery of the new competency, Fellows, SIMGs, Trainees and JDocs can undertake the Aboriginal and Torres Strait Islander eLearning courses. These courses have been developed with the surgeons' requirements in mind, and designed and developed in collaboration with Indigenous partners to ensure they provided an authentic Indigenous perspective.

More information about the courses and how to access to them is available through the RACS Indigenous Health webpage section (https://bit.ly/3l354nD).

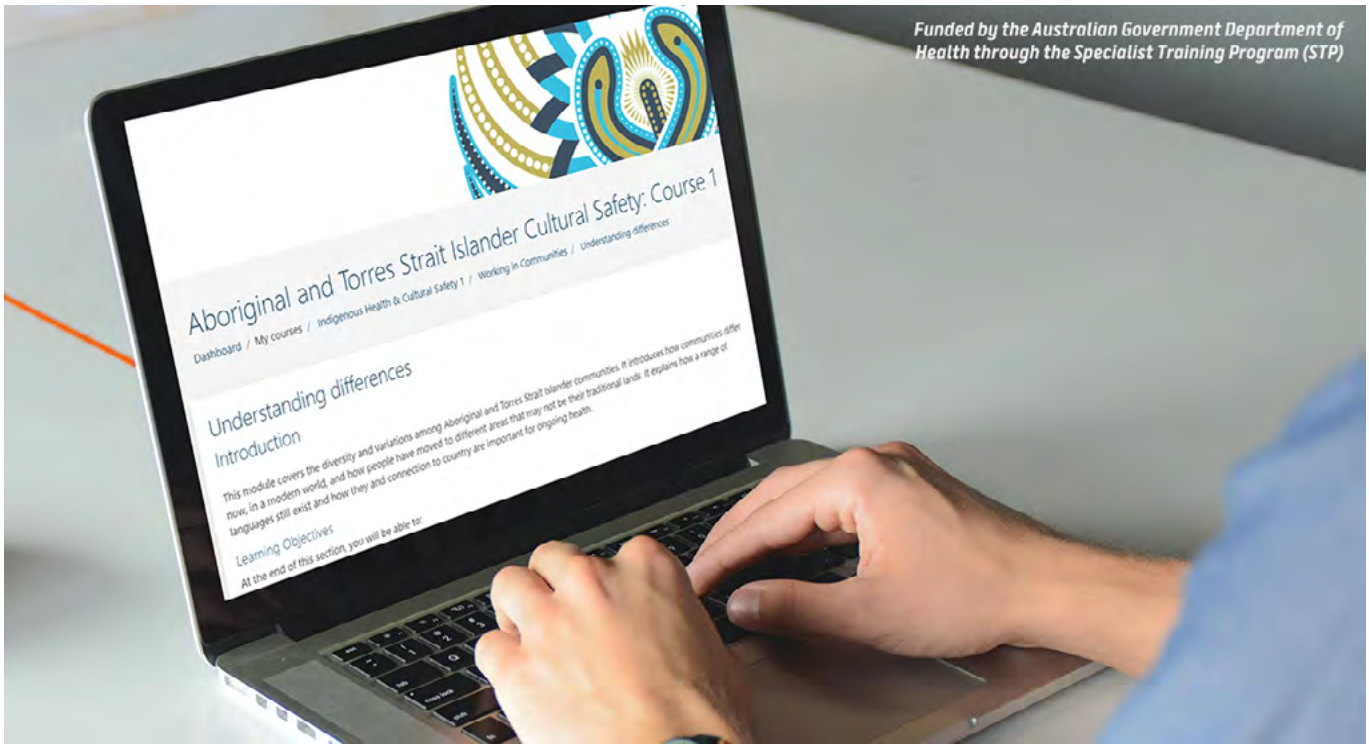
The courses are designed to be completed in self-contained 30-minute modules, and members will be issued a certificate on completing the full course along with 10 hours of CPD for the new Cultural Competence and Cultural Safety Competency. The courses can be used each year towards the CPD requirements for the Learning Plan related to the new competency.

These courses have been specifically designed to introduce members to life prior to colonisation—the process and impact of historical and modern-day colonisation. The courses also provide a range of information about supporting working in communities, effective communication, men's and women's business, and the impact racism has on health outcomes. The final section of the course is focused on healthcare outcome challenges and options to improve delivery.

To support delivery of the eLearning courses the RACS library has purchased access to a range of online and hard-copy books for members to use, and these are linked into the course pages. The RACS library page provides access to the Informit—Indigenous database along with a range of suggested articles, books, and other relevant resources for Australia and New Zealand.

For more information please contact the RACS Indigenous Health team.

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



Indigenous surgical mentorship

Supporting surgeons wishing to mentor Indigenous surgical Trainees

Mentoring has been identified as an important learning and development strategy for surgeons. Research has shown that having a mentor supports the achievement of personal and professional goals and improves motivation, engagement and work performance. RACS advocates for mentoring at all stages of a surgeon's education and throughout their career.

Outside of formal programs, most mentor relationships develop organically; we seek guidance from those we share values with. Considering the importance of culture and country, it 'makes sense' that Indigenous junior doctors will seek out Indigenous senior doctors as mentors. Such a fit can not be assumed and it is important to realise that Indigenous junior doctors will require and need to seek a diversity of mentors.

The paucity of First Nation Australian surgeons also mandates the need for our non-Indigenous Fellows to have a genuine engagement to help recruit and mentor Indigenous Trainees. We are fortunate that many willing and able non-Indigenous Fellows want to help us achieve parity in the surgical workforce.

First Nation Australians are faced with unique challenges which most Australians never encounter. Mentors need to be mindful of these challenges and develop the necessary skills to support our juniors. We need the tools to be strong advocates when Aboriginal and Torres Strait Islander juniors are faced with racism, and when advocating for targeted Indigenous surgical recruitment.

We collaborated with the Australian Indigenous Leadership Centre (AILC) to develop a two-day workshop for Indigenous Surgical Mentorship training. The aim is to deliver to non-Indigenous Fellows skills in mentorship designed to foster the careers of aspiring First Nation Australian surgeons.

This builds on the 10th competency e-learning courses, with the aim to take us from being 'educated', towards gaining

a greater awareness of the barriers faced and a better understanding of what the First Australians bring to the surgical workforce.

Mentoring models and leadership concepts are explored with emphasis on cultural diversity and the complexities of mentoring in a cross-cultural context.

Scenario driven small group discussions and self-reflective exercises draw out cultural responsiveness, elicit ethical and professional considerations, and challenge stereotypes and world views.

A successful pilot workshop on mentorship was held in October in Darwin. Anticipating COVID-19 interstate travel limitations—recognising that we and our juniors work as part of the 'whole of hospital' team and harnessing the breadth of experience in Indigenous health of local clinicians—we adapted to our circumstances.

Participants included local representatives from surgery, medical administration, intensive care as well as general and emergency medicine. We trialled a hybrid Zoom delivery, which allowed RACS staff members and JDocs in Melbourne and Aotearoa New Zealand to participate.

This workshop is the next step to harnessing the good intent of our Fellows and enables us to work together in elevating the voices of our Indigenous colleagues.

Participants who attended the pilot workshop said:

"… this workshop allows for an open and frank discussion in a safe space. It is insightful and very useful as we move towards supporting an increased Indigenous specialist workforce…"

"… was as interactive as it was informative; Timmy Duggan (AILC) was a master at guiding the group through communication activities and the importance of mentorship…"

"….this workshop gives a much needed perspective on the experience and cultural capital of Indigenous Trainees. In doing so, it helps the mainly non-Indigenous senior doctors to see the difficulties they may face, and cause, in trying to be an effective mentor. It does this in a non-confrontational way, allowing personal realisation to drive the learning..."

We look forward to offering the Indigenous Surgical Mentorship Workshop to RACS Fellows throughout 2022.

Keep an eye on the RACS website and social media for upcoming dates. For more information contact us at IndigenousHealth@surgeons.org

This program is funded by the Australian Government Department of Health through the Specialist Training Program (STP).

Surgeons call for greater COVID-19 protection for Indigenous communities

The end of COVID-19 lockdowns, the easing of restrictions and the reopening of borders is a cause for relief and joy for many Australians and New Zealanders. But not everyone is celebrating.

Surgeons from the Royal Australasian College of Surgeons (RACS) are concerned about the impact of widespread COVID-19 infections on Indigenous communities once restrictions are lifted.

They warn that without putting in place safeguards against the spread of the virus and increasing vaccination rates, reopening of borders and lifting of restrictions could have devastating consequences for Australia's Indigenous and Aotearoa's Māori populations.

Australia's first Indigenous surgeon and Macquarie University Professor Kelvin Kong says vaccination is a key step to protecting Indigenous communities, but multiple cultural and economic barriers mean vaccination rates remain low.

In September, the *ABC* reported that the vaccination rate among Indigenous Australians was 20 per cent lower than the national average.

Professor Kong believes a major factor driving lower vaccination rates in these communities is the delivery method of the vaccination program. This is further confounded by a historical wariness of the government resulting from generational disadvantage and prejudice.

"A long, convoluted history of racism and unconscious bias has meant that when the government says you have to do something, you have a wariness of that advice. This is especially the case among older members of the Indigenous community.

"We can only overcome this distrust and fear by communicating effectively—the best chance of success in convincing the mob lies in asking them what their concerns are and dispelling their fears."

Professor Kong says another driver of the slow uptake of vaccinations is the misinformation widely available and propagated via social media, which has created unnecessary fears pertaining to vaccination, such as supposed adverse effects on fertility and side effects of vaccines.

Compounding this issue is a lack of access to trusted medical information. He says that while ensuring a greater Indigenous presence in the health system would be a positive step in creating a greater sense of trust, it is crucial that services themselves address barriers to access.

"If you own a shoe shop and no one comes and buys your shoes, you're not going to blame people for not coming to you. You're going to adjust what you do. If we have 20 per cent of people not attending their appointments and they're all Indigenous, we need to ask ourselves what we're doing wrong.

"The public health response to COVID-19 in Australia and Aotearoa New Zealand was fantastic, but it revealed disparities quite starkly. There have been huge differences in vaccination rates between affluent areas compared with disadvantaged communities. It shows we need to be serious about removing the barriers to health care. Surgeons are in a unique position to be able to speak up."

For orthopedic surgeon John Mutu-Grigg, the issue of protecting Indigenous communities is close to home. He is concerned about the impact of COVID-19 on his tribe living in far north Aotearoa, and other similar rural Māori communities across the country.

He agrees with Professor Kong that lifting vaccination rates is crucial to stopping

the spread of the virus among these vulnerable communities.

"For a long time, we were able to hold off COVID-19 in Aotearoa, but now we know that the idea of remaining COVID-free forever is fanciful," Dr Mutu-Grigg says.

"We now understand that we will all become exposed to the virus and it will become a disease of the unvaccinated."

In mid-late October, only 48 per cent of young Māori had received their first vaccine, compared with 80 per cent of white New Zealanders.

At the time, *The Guardian* reported that the outbreak had disproportionately affected Indigenous New Zealanders. While Māori make up just 16.5 per cent of the overall population, Māori had made up almost half (46 per cent) of cases over the previous two weeks.

Dr Mutu-Grigg says there are two main reasons why vaccination was low among Māori communities.

"For some people, it is a matter of access. The area where my family lives is a long way from any vaccination clinics, and there are many people who would struggle to access vaccinations. They might not have a car, or petrol to get them to a clinic.

"Then there are those who are slightly hesitant who might be mistrustful of the government, due to the intergenerational disadvantage, but who might be responsive to incentives."

He says government and administrative errors had also played a role in the low vaccination rates among Māori, with the age brackets for the rollout penalising a community with a shorter life expectancy.

"By rolling out the vaccine to the elderly, the first phase missed Māori almost completely," Dr Mutu-Grigg says.

"The Māori population is a much younger cohort than the non-Māori, therefore Māori by proportion have only very recently had the opportunity to become vaccinated."

This failure is particularly damaging for people often living in poor and crowded housing conditions, and which is at increased risk of comorbidities such as diabetes, heart disease and stroke.

In addition, there has been a delay in the distribution of funding allocated by the government to vaccinate rural Māori communities.

Dr Mutu-Grigg is calling on the government to act quickly to enable health workers to access the funding to provide access to information and vaccination to his Maori tribe.

"It's all about timing and now that the virus has arrived in New Zealand and it's here to stay, we need to act quickly.

"I'm definitely worried because a lot of people are going to die, and that's the reality. It's so avoidable and we're doing our best to encourage and support Māori to get vaccinated, and if only it wasn't for the road blocks, it would be that much better."

Retired paediatric surgeon Alan Woodward says the government also has a role to play in preventing COVID-19 from spreading among Indigenous communities in Australia.

Dr Woodward worked at the Royal Darwin Hospital for 30 years and witnessed the effects of poor and crowded housing on the transmission of infectious disease, resulting in long-term health problems.

He says that poor and crowded housing, where 10 people were living in a house suitable for two or three, were a breeding ground for illness, causing Indigenous children to suffer from streptococcal disease, rheumatic fever, and glomerulonephritis—diseases that have all but disappeared in places with adequate housing.

"These diseases were circulating in cities like Melbourne in the 1950s, but when housing improved, they disappeared. They are still rife in the Indigenous communities. It's extremely frustrating."

The housing conditions that allow these diseases to spread will also accelerate the spread of COVID-19 in these areas.

Combined with the pre-existing conditions disproportionately suffered by Indigenous Australians, Dr Woodward believes the introduction of COVID-19 into these areas is a recipe for disaster.

"For Indigenous people in the Northern Territory, the opening up of Australia's borders is a potential nightmare," Dr Alan Woodward.

"For Indigenous people in the Northern Territory, the opening up of Australia's borders is a potential nightmare."

He says that, along with providing culturally-sensitive information about vaccination, housing conditions must improve before the virus starts to circulate in Indigenous communities.

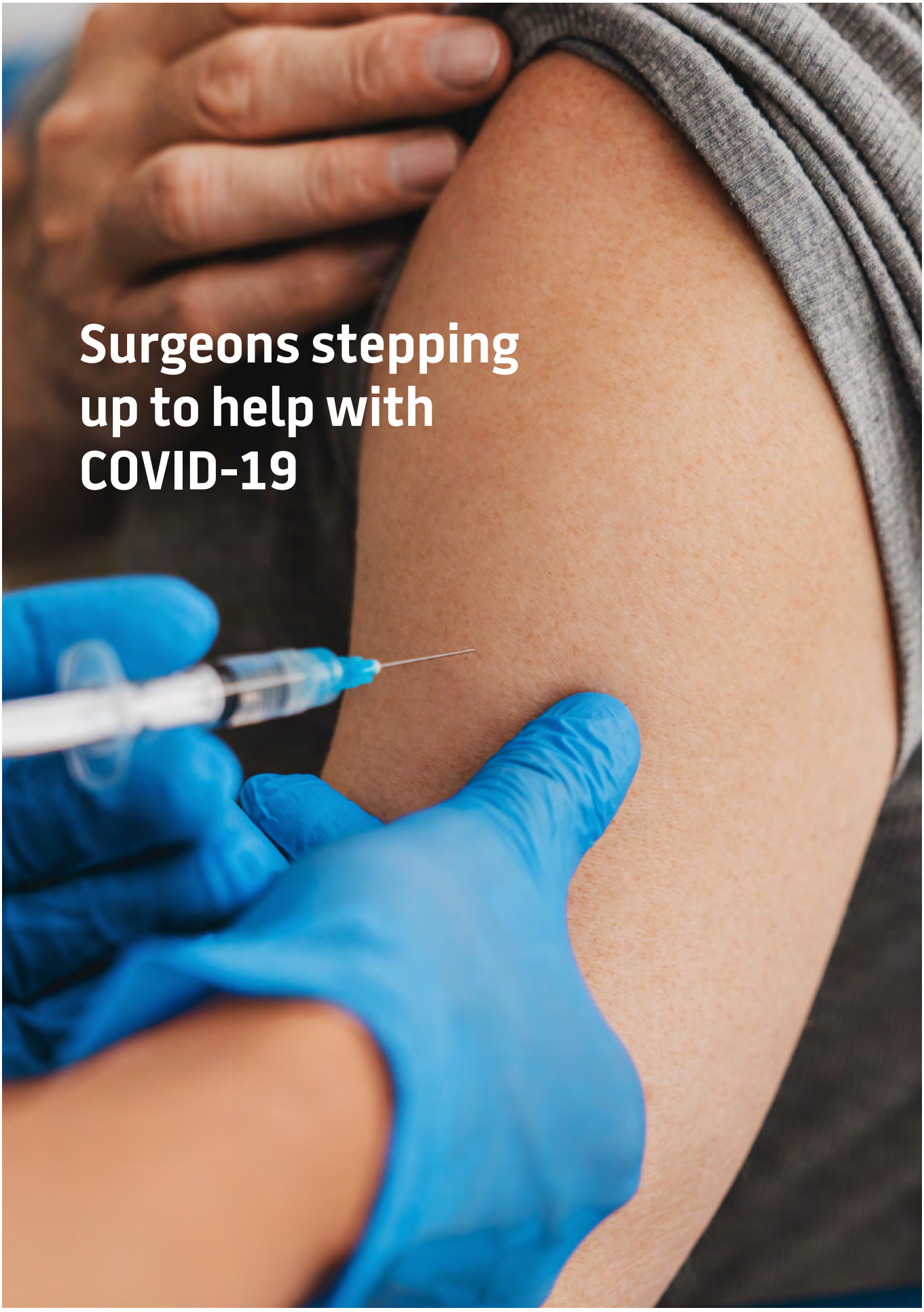
"Housing can make a huge difference in the transmission of infectious diseases like COVID-19. In Wilcannia, the government provided caravans and mobile homes in areas where housing was inadequate, and the number of infections turned around immediately."

His vision is for RACS to bring together the government, architects, public servants and Indigenous leaders to find a solution to poor housing conditions in these communities.

"While surgeons might not be directly involved with housing, it would not be the first time we have driven change in an area outside our own," he says.

"When road trauma deaths ran out of control 1960 – 70 the RACS acted as the catalyst to bring together government, car manufacturers and the Australian Road Research Board to enact mandatory seat belt legislation.

"There is a similar opportunity today for RACS to act as a catalyst to bring together the relevant groups to improve Indigenous housing and reduce the spread of infectious disease," Dr Woodward said.



Surgeons stepping up to help with COVID-19

Dr Pat Alley

In retirement, Pat Alley's life is incredibly busy. He is a councillor of the Auckland University of Technology and sits on their Research Ethics Committee. With many years' experience of caring for doctors with health needs, he remains a willing member of the RACS Wellness group. He is a treatment injury advisor for New Zealand's Accident Compensation Scheme and is assisting with the development of a digital record for New Zealand's rich lode of medical history.

It was no surprise then, that when an appeal was made for additional resources to assist with COVID-19 vaccinations, that Dr Alley responded. He completed the 25 hours online course with the Immunisation Advisory Centre (IMAC) and in April, and began immunising healthcare staff at the North Shore Hospital, where he had worked for many years, being a founding member of the Department of General Surgery.

"I enjoyed seeing many of my old colleagues. After we finished, there were 92 per cent fully vaccinated, two per cent further waiting for their second vaccination, and a small minority who refused," Dr Alley said.

Dr Alley answered another call to assist with community vaccinations, and from the end of April, has been working at a large vaccination centre twice a week. The clinic has completed more than 100,000 injections and on busy days, completes 1,600 to 1,700 injections a day.

The work has been no less interesting and rewarding for Dr Alley than his previous surgical work. "It's still an interaction and a procedure. Vaccinations are a microcosm of a surgical procedure, still requiring a large supportive team, technology, patient consent, patient interaction and aftercare."

Dr Alley said he enjoys educating the public about the necessities of being vaccinated, including talking to vaccine hesitant people, who often present due to family or work pressure. By the end of the conversation, he said, most are reassured and happier about receiving the vaccination.

Dr Alley explained that at full capacity, the clinic operates with approximately 70 people. "The public might not appreciate the whole process," he said. "In addition to vaccinators, there are many staff directing people to the appropriate areas, administration and registration, aftercare and a large group making up the vaccines as the Pfizer vaccine needs careful handling and preparation."

He enjoys this team approach. "At the beginning of the day, we review the previous day, cover any news, and listen to anecdotes and feedback. I'm moderately fluent in Te Reo Māori (Māori language), so I lead a karakia. Some people call it a prayer, but I regard karakia as a mission statement for the day. It acknowledges respecting and looking after each other, being inspired by our history and celebrating our successes."

At the time of interview, the New Zealand population was just under 80 per cent first dose and around 50 per cent double dosed. To date, Dr Alley has administered more than 3,200 vaccinations and is looking forward to continuing to add to that number.

"I would encourage all retired surgeons to do the same," he said. "Helping to vaccinate the New Zealand population has been immensely satisfying and rewarding. Furthermore, it relieves the nursing workforce who may be better utilised in specialist inpatient roles."

Dr Ahmad Aly is a Specialist Upper Gastrointestinal Surgeon and the Head of Upper GI Surgery at the Austin Hospital in Melbourne. He has been educating and supporting local leaders in marginalised areas to encourage their communities get vaccinated against COVID-19.

Dr Ahmad Aly

Most COVID -19 patients requiring ICU beds at the Austin live in the City of Hume, north of the CBD. Hume has high rates of socioeconomic disadvantage, diverse cultural communities which include people from Turkey, India, Iraq and Lebanon, and many essential workers who work in trades like transport and labour.

Paul Johnson, Head of the North Eastern Public Health Unit, contacted Dr Aly to see if he had any ideas that could help to turn around low vaccination numbers. After speaking to community representatives, Dr Aly understood that people were not vaccinating due to a combination of several barriers. One barrier was a lack of vaccine delivery infrastructure, which meant people were relying on local doctors and pharmacies, many of which were becoming Tier One exposure sites and having to close.

Dr Aly decided to convene a meeting that brought together community leaders, governments, and health providers.

The meetings, chaired by Dr Aly, helped form an integrated response between government and community workers. For example, the supply of Pfizer over Astra Zeneca was adjusted to maximise uptake, and vaccination clinics were set up in local locations like mosques and community centres. Health providers realised the message around the importance of vaccinating had to come directly from community leaders, who were trusted and respected. ▶

"I was able to see the situation from a medical perspective and I could combine this with an understanding of the cultural issues," Dr Aly said.

Dr Aly recorded a video of COVID-19 patients in the ICU with the help of Dr Stephen Warrillow, the Director of ICU at The Austin. The video was made to contextualise the issue emotively. It was a direct, tailored appeal and it worked. Many community leaders realised their community would continue to suffer if vaccination levels were not increased.

"At the time we made the video, the first dose vaccination rate was 39 per cent. Four weeks later, it was 90 per cent. What this shows is that these communities were not simply vaccine recalcitrant, we needed to implement a community-based strategy with appropriate government support. Not surprisingly, issues like COVID-19 affect marginalised and disadvantaged communities disproportionately. The key is local people and local actions and working with communities so they can help themselves."

Orthopaedic spinal surgeon John Cunningham is another surgeon who has been assisting with the urgent drive to vaccinate the population. When elective surgeries in the public system were put on hold, Dr Cunningham and his colleagues discussed how they could contribute to addressing the issues surrounding COVID-19.

"David Love came up with the idea to do something positive and asked the question: why don't we vaccinate? Especially since that's the key to getting out of this: to help the population get vaccinated as quickly as possible."

After completing the straightforward vaccination training, Dr Cunningham has been working at the clinic at the Royal Melbourne Hospital. He has been vaccinating during the time he would otherwise spend doing elective surgery, which has been put on hold, in the public health system.

"It's a way of ensuring resources aren't wasted," he said. "Why not put that time that would otherwise be wasted, for the greater good?"

He feels great satisfaction in the number of people he is helping. "In one session I can get through about 15-20 people. That

Dr John Cunningham

is the number of people I have helped to take out of the equation of being unvaccinated. Every single vaccination is pushing us towards the end of this pandemic."

Dr Cunningham has appreciated the opportunity to engage with a wide range of people in the vaccination booth. "Many people are quite knowledgeable about the benefits of the vaccine and the process around vaccination. They have read resources online and by the time they see me, they have answered most of the questions they would otherwise have had."

Dr Cunningham said that for a procedure that is remarkably safe, it was disheartening that there was also fear surrounding it. This observation is familiar to Dr Cunningham, who was awarded an Order of Australia in 2016 for his services to medicine and his work around promoting the importance and benefits of immunisation.

"There's a basic human instinct to be frightened of new things—that is sensible. But in this instance, people need to ask themselves, am I being rational or am I listening to some primitive instinct?"

Dr Cunningham believes there will be other opportunities for surgeons like himself to continue to help. "As restrictions ease, the public are looking forward to enjoying life more normally, but we in the healthcare sector are bracing ourselves for a scenario where, if predictions are right, hospitals will be overwhelmed with patients," he said.

Dr Cunningham has a message for his colleagues: "I would encourage all surgeons to think about ways they can continue to help while elective surgeries are furloughed. If there's a time for us to think resourcefully about how we can contribute, this is the time."

Dr Cunningham worked as general resident medical officer in a COVID-19 ward in a private hospital and hopes there will be an opportunity to do this again.

"I hope that in years to come surgeons like myself will look back and feel satisfied that we helped, in our small way, to navigate a way out of this."

Introducing the ANZ Hernia Society

ANZ Hernia, a new society, is inviting general surgeons to be involved in its forthcoming election of office bearers.

Hernia is a common and major health issue in Australia and New Zealand. Approximately 60,000 patients have hernia surgery annually at a cost of more than $350 million. Despite the use of prosthetic mesh in most ventral and incisional hernia repairs, the long-term recurrence rate remains unacceptably high. While complication rates (chronic pain, recurrence, infection) for common hernia procedures are low—given the large number of procedures performed—a substantial number of patients suffer with chronic disabilities.

With increased media exposure and legal proceedings arising from uro-gynaecological mesh implants, patients are concerned about the use of mesh in hernia repair. This has highlighted the low quality of evidence available on safety, effectiveness, and morbidity of meshes, including concerns about governance and post-insertion surveillance. The result—a significant loss in consumer confidence. Consequently, the Therapeutic Goods Association (TGA), has recently reclassified mesh in line with EU recommendations—mandating strict criteria before registration of mesh for human use and a rigorous process to monitor post insertion surveillance.

Currently, hernia surgery is undergoing substantial change. Many new techniques are being introduced, including advanced Abdominal Wall Reconstruction (AWR) procedures, robotics, and new prostheses, all of which require evaluation.

Attempts at forming a dedicated hernia craft group within Australia have largely been stillborn. However, a few surgeons continued to work on a more formal structure and formed the ANZ Hernia in Australia. The working group has established strong connections with the American Core Health collaborative, TGA, Safety Commission and the AWR Surgeons community. Endorsed by the College and supported by surgeons from both countries, the ANZ Hernia Society aims to

foster improved education, training, and clinical and basic scientific research. It will also maintain a nationwide database of hernia outcomes, administer a mesh registry, and importantly advocate on behalf of surgeons for more equitable reimbursement to reflect the time and effort involved in complex procedures.

Currently the office bearers of the steering committee are self-selected and includes Dr Chris Hensman, Dr Alex Karatassas, Dr Ken Loi, Dr David Wardill, Dr Su Mei Hoh, Dr Harsha Chandraratna, Dr Ross Roberts, Dr Anita Jacombs, and Dr Rodney Jacobs. “We plan to hold elections January-February 2022 for a committee of 10—president, vice president, secretary, treasurer, education, and research chairpersons. Surgeons will be able to email their nomination to our secretariat and website,” Dr Jacobs said.

In 2019, ANZ Hernia co-hosted the Adelaide Hernia meeting along with the ANZAWR 2020 and ANZAWR 2021 virtual meetings held in conjunction with the AWR Surgeons from India. A third meeting, ANZAWR III, focussing on mitigating the risks in hernia surgery, took place in late November. The group has already commenced a journal club, been involved in several recent publications in Hernia and the ANZJS, initiated several research projects, and is looking to develop dedicated training posts in hernia surgery.

ANZ Hernia have been closely involved in the soon to be published RACS rapid review of the safety of mesh, have established links with MD Epinet, a device epidemiology organisation based in the US and along with a local firm, Data Dissect, have established the ANZ Hernia

Clinical Quality Registry (CQR). It will oversee the registry to track hernia and mesh outcomes in Australia and New Zealand. The CQR pilot program, endorsed by Australian Safety and Efficacy Register of New Interventioanl Procedure (ASERNIP), the TGA and the Abdominal Core Health Quality Collaborative (AHSQC), will go live in South Australia in November, and will be rolled out Australasia wide over the next couple of years. It will provide a unique platform incorporating a novel learning system to allow both surveillance of implants and monitor the efficacy of various methods of hernia repair.

ANZ Hernia will play an important role in maintaining standards with its oversight and governance functions. As an independent, bi-national craft group, it will facilitate communication with the College, government, industry, and consumer groups. It gives hernia surgery a greater voice and a focus to lobby for more equitable reimbursement to reflect the time and effort involved in complex procedures. “By engaging with government and consumers, ANZ Hernia will endeavour to restore consumer confidence in mesh mediated hernia repair,” Dr Jacobs said.

ANZ Hernia is inviting all general surgeons to be involved in ANZ Hernia and the ANZ Hernia Quality Registry. The forthcoming election of office bearers is your chance to participate in the development of this new society.

Email: secretariat@anzhernia.org

IMAGES (from left)
Dr Rodney Jacobs and Dr Ken Loi

RACS volunteers provide critical support in Fiji

Specialist medical volunteers provide urgent clinical support to two hospitals in Fiji during the COVID-19 crisis

In August 2021, the Department of Foreign Affairs and Trade (DFAT) contacted RACS Global Health to determine if RACS could assist the Fiji Ministry of Health by deploying a specialist medical team through its Pacific Island Program (PIP).

The Ministry of Health specifically requested intensivists, anaesthetists, Intensive Care Unit (ICU) nurses, and Infection, Prevention and Control (IPC) nurses. The request was to provide COVID surge support to the Colonial War Memorial Hospital (CWMH) in Suva and the Lautoka Hospital in Ba Province. These health facilities and their healthcare workers were hit hard by the outbreak. The staff needed support and respite as the COVID-19 surge had not waned for months and many had been infected.

The RACS Global Health team worked tirelessly behind the scenes to ensure the deployment was managed safely and effectively. This was the first volunteer team RACS has deployed since the onset of the pandemic. The Global Health team assisted in relieving the administrative burden on the volunteers as there was a very tight timeframe to onboard the volunteers before they flew out to Fiji.

Within four weeks of receiving the initial request from DFAT, RACS had assembled a team of medical volunteers consisting of anaesthetists and ICU and IPC nurses to fly to Fiji to assist the country as it was recovering from a protracted COVID-19 outbreak. DFAT also provided extensive logistical support to RACS and the volunteers which contributed to the success of this deployment.

Dr Ned Douglas led the CWMH team consisting of Priscilla Singh (IPC nurse), Lucy Malcolm (ICU nurse) and Dr Elizabeth Bennett (Intensivist). Dr Megan Walmsley was the Lautoka team leader and was joined by Mackenzie Finnis (ICU nurse). The teams provided direct clinical services and clinical training and mentoring to respond to the needs of the clinical teams at these two hospitals.

On their return to Australia in October and during their two weeks quarantine in Brisbane, RACS spoke with Dr Megan Walmsley, Mackenzie Finnis, Lucy Malcolm, and Priscilla Singh about their experiences in Fiji.

Dr Megan Walmsley is an existing RACS volunteer who works at the Royal Darwin Hospital in the Northern Territory. In 2017 she volunteered in Fiji as part of the ASA Sereima Bale Pacific Fellowship program.

Having previously worked with two anaesthetic colleagues from Fiji, Megan had first-hand knowledge of the situation there.

"I knew the extent of stress the hospital [staff] were in at Lautoka Hospital," Megan said. "I worked with the anaesthetic registrars in the COVID-19 theatre; supported anaesthetic registrars and consultants in the non-COVID-19 theatre—ranging from a six-month-old neurosurgical case to obstetric cases to adult trauma. I also held tutorials and exam preparation classes for registrars; conducted department Continuing Medical Education (CME) sessions; and held day-long workshops at the sub-divisional hospitals of Nadi and Ba on how to recognise a deteriorating patient."

Megan returned to Australia richer from her experience. "I learnt about resilience, teamwork, and flexibility from our Pacific colleagues," she said. "They have done an amazing job in challenging circumstances with very limited resources."

The Fiji trip was Mackenzie Finnis' second opportunity to volunteer. As an ICU nurse in an adult setting, her current role is as a nurse educator in Brisbane. She says there is something special in being able to share her skills, which is why she put up her hand when the call to volunteer came up.

"By the time we reached Fiji, the procedures on how to deal with COVID-19 had already been laid down," she said. "When I arrived, the team was seeing one or two presentations a day in the ICU for COVID-19 and non-COVID related issues. The cases were easing because of their great vaccination efforts."

"I provided nursing-focussed education and training in both the COVID and non-COVID ICUs. I had a good team of doctors and medical staff who were keen to learn about equipment and management of ventilators. I spent some time on direct patient care as the ICU was returning to non-COVID related activities."

Mackenzie also spoke about how privileged we are in Australia with our healthcare system, especially with the ICU equipment and resources, which Fiji hospitals are lacking. For example, most ICUs in Australia run arterial blood gases every four hours which is standard procedure, to check the ventilation of a patient. "In Lautoka, the ICU didn't have [equipment to run arterial blood gases] until recently. When I was there an acutely unwell patient would have only one blood gas during the day. I realised there are many assessments we could still perform

without those blood monitoring systems. It's good reminder that as healthcare professionals we do the best we can for our patients," she said.

Lucy Malcom, an ICU nurse at the Northern Beaches Hospital in Sydney volunteered at the Colonial War Memorial Hospital. When she arrived in Suva, the city was coming out of its worst wave of the COVID-19 Delta variant.

Lucy explained that her first week was spent getting to know the staff and understanding how she would be able to assist them. The nursing staff were keen to learn about the best practices on how to look after COVID-19 patients, so Lucy spent three days a week during her deployment teaching face-to-face, along with conducting online classes in the evenings.

"The hospital had two ICU wings, the larger one for COVID-19 patients, and the smaller for non-COVID patients," Lucy said. "It was interesting to work in a healthcare system that was quite under-resourced. I realise how fortunate we are in Australia to have a robust system."

"The equipment that the hospital team was using had been donated by Australia. So, I manipulated my teaching and practices accordingly."

Priscilla Singh was born in the CWMH, Suva, and wanted to volunteer as she saw this as her way of giving back to her birth country.

Priscilla wears many hats in her day job in Melbourne. She is an IPC clinical nurse at St. John of God Hospital, Berwick; an Immunisation nurse for the City of Greater Dandenong; and a casual midwife in the public health sector. While in Fiji, she trained the medical team in IPC measures, including donning and doffing; mentoring and educating on COVID-safe measures, environmental cleaning, including waste management; auditing; handling hospital acquired MRSA infections; and vaccinations. She also presented in the local health clinics and to the Fiji Emergency Medical Assistance Team.

Like her colleagues, Priscilla is grateful for the Australia healthcare system, which makes her job in Melbourne easier. She continues to share her knowledge widely with the CWMH team and has maintained contact with the staff on the ground, supporting them in whatever way possible.

The Fiji volunteering experience was a life-changing experience for the RACS volunteers and something they would like to do again.

For Megan, "it would be a great opportunity to continue to work with, support and continue to build relationships with the amazing anaesthesia teams in the Pacific."

Mackenzie said, it was the "most rewarding experience for me in Fiji. Despite working late hours with minimum equipment, the team was welcoming and supportive. I felt their smiles through their masks and the commonalities as healthcare professionals."

Lucy learnt about resilience, hope, and making the best of any situation. "I will volunteer in a heartbeat. I learnt to work through adversity from my Fiji colleagues."

Priscilla will go back again as a volunteer, provided "there are no more hotel quarantines."

How to apply

If you wish to apply to become a RACS Global Health Specialist Volunteer, please email volunteer@surgeons.org along with your:

- Current CV
- Copy of qualifications
- Registration Certificate with AHPRA or the Medical Council of New Zealand

Find out more about RACS Global Health programs on our website.

Australian Aid

COVID-19 induced anosmia and Smell Retraining Therapy

Our fifth sense, often relegated to a mere mention at medical school has risen to prominence in the pandemic, ironically through its disappearance.

Anosmia has several causes, the most common of which are viral infections, such as colds or flu and now COVID-19. Any obstruction of the journey of scents to the roof of the nose, such as allergic rhinitis, nasal polyps, or tumors can cause this too. So can head trauma and anterior skull base fracture through the cribriform plate, exposure to pesticides and solvents, cocaine inhalation, smoking and poor air quality. Of course, radiotherapy to the head and neck and normal ageing can cause anosmia too. It is important to exclude more serious etiologies such as brain tumors, Parkinsonism and Alzheimer's disease.

But for those with permanent loss of smell, the effects can be devastating. It can impact on their personal safety by being unable to detect a gas leak or a fire. There is extensive evidence linking anosmia to both depression and decreased quality of life—with people unable to appreciate flavours, enjoy their food, or detect if it is rancid. They may even miss a soiled nappy!

During the pandemic, restrictions and lockdowns often delayed thorough examinations and investigations that would exclude serious problems in patients.

The prime real estate area of concern is in the roof of the nose under the cribriform plate. That is where the olfactory fibers reside. This tiny area of mucosa, 5cm^2, is where smell is primarily detected and vulnerable to attack. The mucosa is rich in ACE 2 receptors for which SARS-CoV-2 virus has an avid appetite, hence its ability to affect smell.

Up to 70 per cent of people with COVID-19 disease have developed anosmia. In many, this is their only symptom, and has led to the suggestion that anosmia could be a 'biomarker' for COVID-19 disease.

In a study of 1,420 European COVID-19 patients published in the *J Int Medicine*, Sept 2020, anosmia (70.2 per cent) was only marginally second to headache (70.3 per cent) as the commonest presenting symptoms in mild to moderate COVID-19 disease. A meta-analysis of 3,563 COVID-19 + patients published in *Rhinology* Oct 2020, the prevalence of smell and taste loss was 47 per cent. It was more common (67 per cent) in mild to moderate COVID-19 symptomatic patients than severe cases (31 per cent). Outcomes show smell recovery is either complete in a few days, or slowly over one to three months. The majority recover by six months.

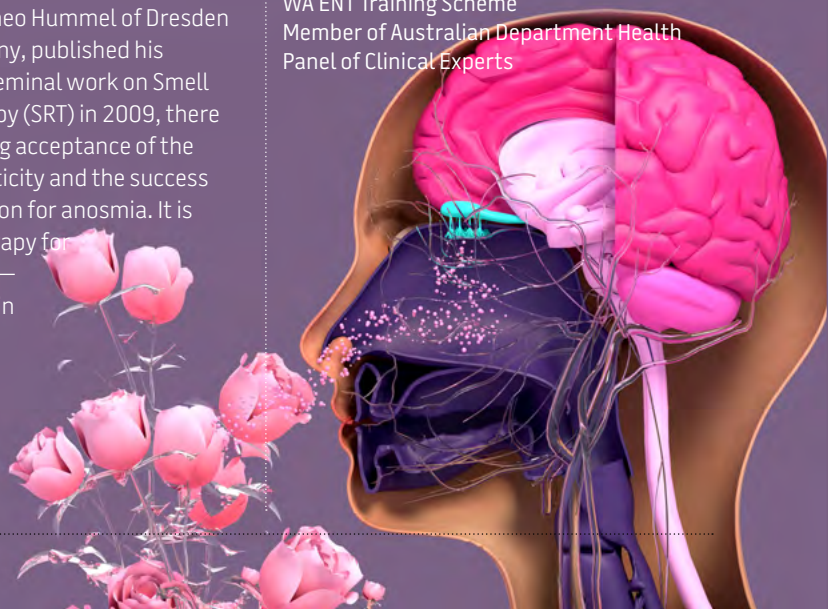
Since Professor Theo Hummel of Dresden University, Germany, published his evidence-based seminal work on Smell Re-training Therapy (SRT) in 2009, there has been a growing acceptance of the brain's neuroplasticity and the success of early intervention for anosmia. It is akin to physiotherapy for our smell centers—exercising our brain in the process. It calls on our brain cells' memory to generate expectation of odour molecules.

Originally, Professor Hummel used four basic smells, lime (fruity), cloves (spicy), eucalyptus (resinous) and rose (floral). Nowadays if four different and familiar odours are used, it doesn't appear to decrease the effect. Essential or aromatherapy oils such as lemon, sandalwood, cinnamon, and peppermint are popular.

The two key aspects are to perform the re-training twice daily for about 20 seconds, for four months or until recovery, and to be mindful and focused during the task. This is done simply by opening each jar separately and taking gentle 'bunny' sniffs for 20 seconds while concentrating on what you are trying to smell. Then continuing with the next fragrance.

Once serious pathologies causing anosmia have been excluded, SRT can empower patients. They can make their own home-made inexpensive kits and don't need pricey commercial kits.

Dr Peter Friedland
Department of Otolaryngology-Head Neck Skull Base Surgery, Sir Charles Gairdner Hospital
Associate Professor in School of Medicine, University of Western Australia
Professor in School of Medicine, Notre Dame University
Chair, Royal Australian College of Surgeons WA ENT Training Scheme
Member of Australian Department Health Panel of Clinical Experts



ANZ Journal of Surgery: a farewell to print

As previously outlined in an editorial published in the June 2021 issue of the Journal[1], there will be a transition to exclusive online publication of the *ANZ Journal of Surgery* in 2022. So, the final issue of the *Journal* has now been printed and distributed.

Since 1931, there has been an uninterrupted publication of 91 volumes containing a total of 636 issues, initially at three issues per year rising to a peak of 12 issues per year, and now at 10 issues per year. There have been six different cover designs over this period.

There will be significant sustainability and environmental benefits associated with a wholly digital publication. Currently 16 million pages are printed annually and 85,000 copies, each wrapped in plastic, and shipped to readers from the printers. In addition, our publisher, Wiley, has committed to planting a tree for every print copy saved.

Many readers already access current or archived articles in each issue of the journal online at the Royal Australasian College of Surgeons (RACS) website www.surgeons.org via the library, both in HTML and PDF formats. This will not change. Access may also be achieved through hospital, university, or other institutional subscriptions. Wiley is currently exploring the possibility of publishing each full issue as a PDF or as a flipbook.

Regular email alerts containing issue highlights will be provided. An electronic table of contents (eTOC) for each issue will continue to be available through the RACS library. Fellows, Trainees and specialist international medical graduates can set up an individual customised alert by visiting the Wiley Online website (https://onlinelibrary.wiley.com/). The Journal may also be read on the Wiley App available from the App Store or Google Store. Follow the Journal on Twitter @anzjsurg.

It is hoped that the transition to an exclusive digital format will be smooth.

The *Journal* will continue to publish high quality articles for all surgery and for those with specialty interests. An improved article submission system will soon be introduced, and the overall efficiency of article publication will be enhanced. The incorporation of videos, photo galleries and sound bites to complement written submissions will be encouraged. Additional refinements are under consideration to further optimise the contributor and reader experience.

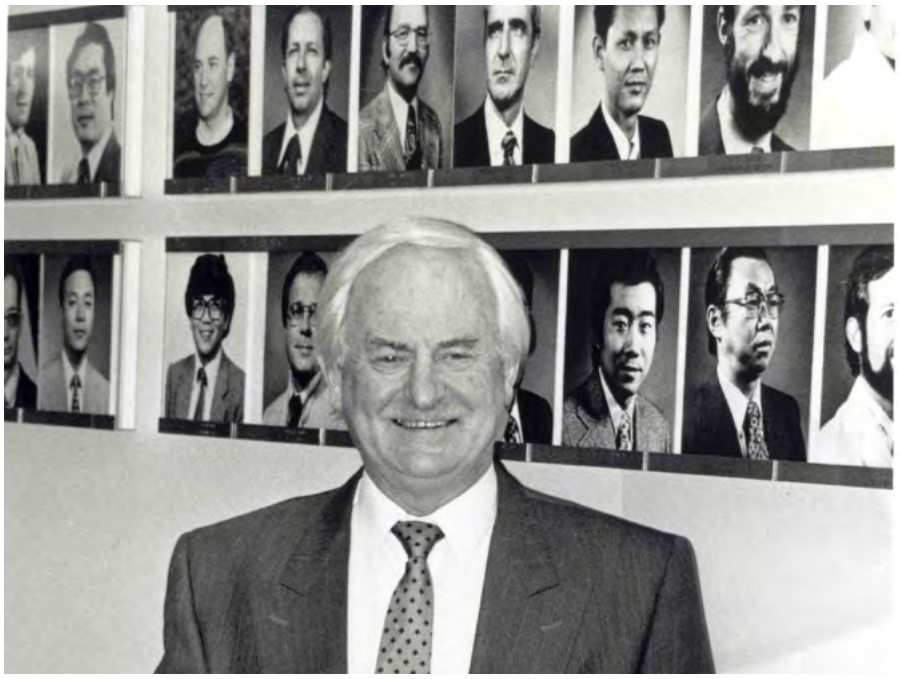
Please retain your final issue as a collector's item for posterity.

Julian A. Smith, MBMS, MSurgEd, FRACS
Editor-in-Chief
Department of Surgery, Monash University, Melbourne, Victoria, Australia

Reference
1. Smith JA, Malisano LP. ANZ Journal of Surgery: soon to make the shift from print to digital publishing. ANZ J Surg 2021;91:1051.

Publish or perish?

Working together: the surgical Mentor and the surgical Trainee



In 1961 Professor Ian Aird of London, wrote, *The Making of a Surgeon*: the 15 chapters encompassed historical aspects, attributes requisite in a surgeon, the registrar, and surgical training abroad, *inter alia*.

Chapter 7, *The Registrar*, notes: 'the proper duties of a registrar are to assist at major operations, to perform lesser operations under the direction of his seniors, to make sure that full and accurate notes are kept about patients, to be concerned particularly with pre-operative and post-operative care, to extend his reading, and if possible, to begin to engage, also under suitable direction, in the work of a research team'.

This advice had been foreshadowed in an editorial of the November 1950 *ANZ Journal of Surgery*, when Sir Hugh Devine, former President of the Australasian College, wrote on *Surgical judgement*: 'It is judgement even more than skill that makes a truly successful surgeon. At the outset of surgical training the student is required to absorb a mass of accepted knowledge, and then as time goes on, the surgeon begins to exchange memorising for reasoning habits of mind.

'Under the influence of those who have attained a position in the profession, which entitles them to hand on the torch of knowledge, the way of wisdom and judgement becomes apparent to the surgical trainee'.

In June 1985, on being conferred with the Honorary Fellowship of the Royal College of Surgeons in Ireland, Bernard O'Brien FRACS delivered an address, *The Challenge of Surgery*.

His comments included these words, with reference to the desirable characteristics of a surgeon: 'Young surgical trainees and surgeons need intellectual as well as technical skills. It is my passionate belief that early in a surgical career one should be intellectually challenged in depth, and I do not mean the day-to-day intellectual challenges that arise in diagnosis and patient management, but a deep study of a specific area.

'This may be, for instance, an analysis of results in the clinical field. It can consist of a research project, either clinical or experimental, which may lead to a publication or even a thesis for a senior degree.'

O'Brien had instituted the Microsurgery Foundation at St Vincent's Hospital Melbourne in 1970, which led to the establishment of the Microsurgery Research Centre. Research Fellowships were established, which attracted high quality Trainees from around the world, many of whom returned to their own country and established themselves as international leaders in the field of microsurgery.

Following O'Brien's early death in 1993, an obituary written by Professor Wayne Morrison, outlined his friend's lifetime achievements—from his appointment at St Vincent's where with the support of Dick Bennett, Professor of Surgery, O'Brien gained access to a disused mortuary. He immediately commenced animal research into microvascular repair techniques, histological evaluation of repair and injury, and the unique development of microsurgical instrumentation, which led to some of the earliest publications in this field.

Initially using his own money, O'Brien soon gained NHMRC research funding, and this support continued almost uninterrupted until his death. In May 1975, the Sunday Press Magazine in Melbourne featured a prominent article titled, *Miracles, we do now: raising money, takes longer*. Essentially it was an article designed to garner financial resources for the research unit at St Vincent's. This was just one of the great skills of Bernard O'Brien—the ability to inspire support, financial and otherwise, for his interests.

The article detailed that there were four full-time surgical research fellows, and eight part-time surgeons and that St Vincent's had the largest microsurgical research unit in the world. I chanced to be

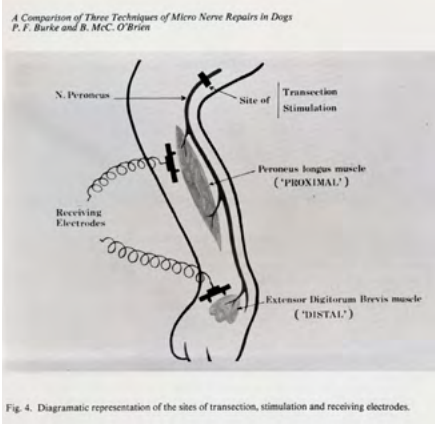
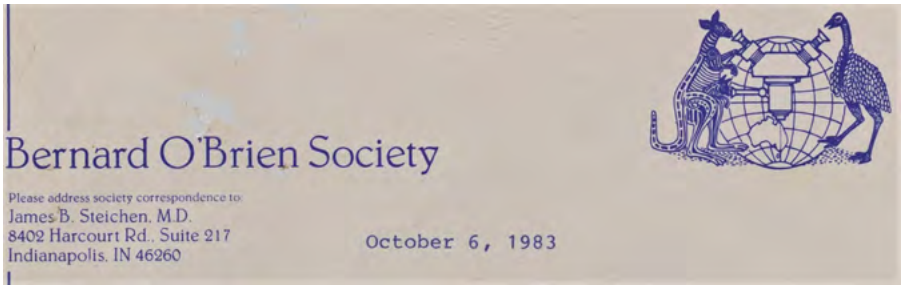


Fig. 4. Diagramatic representation of the sites of transection, stimulation and receiving electrodes.


Bernard O'Brien Society

Please address society correspondence to:
James B. Steichen, M.D.
8402 Harcourt Rd., Suite 217
Indianapolis, IN 46260

October 6, 1983

photographed in the research laboratory for that fund-raising publicity.

In years past, many Australasian surgeons travelled abroad to complete their surgical training. Now the tables had turned, and surgeons were coming to Australia for clinical training and microsurgical research opportunities: Bernard O'Brien had 'reversed the tide'.

Over time, 100 candidates from more than 20 different countries completed Fellowships of one year or longer. Research output became prodigious leading to more than 300 publications, innumerable chapters and two books.

Such was the enthusiastic influence of Bernard O'Brien that the Bernard O'Brien Society was established—the first official meeting being held on 20 June 1983 in New York City. This was held during the Seventh Symposium of the International Society of Reconstructive Microsurgery, and 15 members of the society attended. The Secretary, James B Steichen MD of Indianapolis, noted that 60 letters were sent in April of that year to all potential members of the Bernard O'Brien Society.

Thus, it came to pass—*en route* to Fellowship, and working for a year in 1972 as a Graduate Research Assistant in the Department of Surgery, St Vincent's Hospital Melbourne—that one came to be involved in both clinical research on deep vein thrombosis and laboratory research in the developing field of microsurgical repair. Not only did the Trainee undertake all the microsurgical procedures, but was also required to record, detail and write-up any account recording the research undertaken: these were exciting times.

Personal research work resulted in the publication of a paper *A comparison of three techniques of Micro Nerve Repairs in Dogs*, P F Burke and B McC O'Brien, Melbourne, published in June 1978 in The Hand, Journal of the British Society for Surgery of the Hand.

The paper noted that although peripheral nerve repairs had been practised since the 19th century, the advent of the operating microscope, combined with improved suture materials had resulted in increased experimental and clinical work on nerve repairs.

Accordingly, it was decided to conduct an evaluation of the role of the epineurium in peripheral nerve repairs, and simultaneously, to compare the overall results of nerve repairs performed in different ways.

The common peroneal nerve in the dog was selected as it was easily accessible and had few but relatively large funiculi. The experiments were designed to compare the motor re-innervation of both the peroneus longus muscle and the extensor digitorum brevis muscle of the limb selected.

Careful review of return of function of the common peroneal nerve, following microsurgical epineurial, funicular and combined epineurial/funicular repairs in a series of dogs revealed that no one method was superior to the others, as assessed by electromyography and histology.

The simple epineurial repair offered an equal chance of recovery as a more complicated repair, providing fine sutures and microscopic techniques were used. In this experiment, the one exception to this general conclusion was, that at the greater distances, a funicular/epineurial repair was more likely to provide better results.

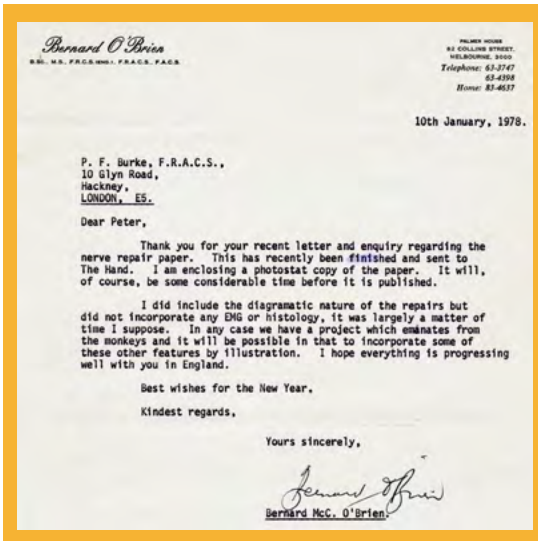
The surgery had been undertaken in 1972 –73, the electromyographic and histopathological results analysed at the University of Melbourne, results statistically analysed, a draft paper prepared, and the junior author then undertaking further studies in London, continued correspondence with his mentor, enabling final completion of the paper.

The entire process, incorporating the observation of the management skills of one's mentor in organising, funding, and furthering research activities, coupled with subsequent guidance in the preparation of a paper to a standard acceptable for publication, aided immeasurably in the transition from trainee to trainer. A most successful collaboration.

Mr Peter F Burke
FRCS FRACS DHMSA

Images (from far left)

Bernard O'Brien and Research Fellows at his Foundation; Scheme of assessment of micro nerve repairs in dogs; Bernard O'Brien Society letterhead; 1978 letter confirming project completion; The author, centre foreground, operating in Research Foundation.


Bernard O'Brien
B.Sc., M.S., F.R.C.S.(Edin.), F.R.A.C.S., F.A.C.S.

Palmer House
92 Collins Street,
Melbourne, 3000
Telephone: 63-3747
63-4398
Home: 83-4637

10th January, 1978.

P. F. Burke, F.R.A.C.S.,
10 Glyn Road,
Hackney,
LONDON, E5.

Dear Peter,

Thank you for your recent letter and enquiry regarding the nerve repair paper. This has recently been finished and sent to The Hand. I am enclosing a photostat copy of the paper. It will, of course, be some considerable time before it is published.

I did include the diagramatic nature of the repairs but did not incorporate any EMG or histology, it was largely a matter of time I suppose. In any case we have a project which emanates from the monkeys and it will be possible in that to incorporate some of these other features by illustration. I hope everything is progressing well with you in England.

Best wishes for the New Year.

Kindest regards,

Yours sincerely,

Bernard McC. O'Brien.

The changing landscape of surgical education - the role of near-peer teaching

Should more be done to educate and support medical students as they undertake new roles?

There is an axiom within surgery – see one, do one, teach one. This apprenticeship model has existed since the beginning, and to its credit has trained pioneering surgeons who have pushed the limits of medicine to new heights. However, over time, medical curriculums have expanded to include professional development, 'soft' skills, research, ethics, and practical skills. As a result, there is limited exposure during medical school to surgical subspecialties. Even when students are lucky enough to undertake clinical rotations on subspecialty terms, there is more seeing, less doing, and hardly any time for teaching.

Every year more than 3,500 medical students graduate in Australia and come January more than 1,000 new interns enter the hospital system in NSW alone. The transition from medical student to junior doctor has long been considered a significant—albeit a stressful rite of passage.

My first week of internship went past in a blur of bewilderment, anxiety, and a constant feeling of inadequacy. As the months progressed, I attempted to navigate this steep learning curve, trying to lessen the discrepancy between my capabilities and the expectations of hospital staff and patients. It was this experience that prompted me to question if more could be done to educate and support medical students as they undertake their new roles.

I am currently a General Surgery SET Trainee, balancing my learning with the teaching of those junior to me. My passion for teaching arose during medical school and has culminated in the organisation of numerous state and national medical conferences. Attendance was open to anyone interested and topics ranged from trauma, surgical skills, and leadership to global health. While lectures from keynote speakers and consultants were always a drawcard, the backbone of these conferences was undoubtedly the junior doctors. Recognising the benefits of near-peer teaching for both students and teachers, they volunteered their valuable weekends to facilitate small session tutorials and practical workshops. With limited available time in medical curriculums and formal teaching programs, I believe that educational courses and conferences play a valuable part in training and should be widely available to all students and junior doctors.

The research I presented at the RACS ASC 2021 was conducted as part of my Master of Surgery thesis. The feedback I received from both attendees and volunteers during my earlier conferences served as the basis for my project, which examined the benefits of a near-peer teaching program in acute surgery.

The participants for this research were penultimate year medical students, who participated in a pilot one-day teaching program. The program consisted of a small group didactic teaching and interactive practical sessions led by junior doctor volunteers. While the content was reviewed by the university faculty , the facilitators were given a free rein on how they wished to run their sessions. The surgical topics were chosen based on the final year curriculum and in consultation with a small focus group of interns and residents.

When analysing the results, I was not only interested in the outcomes of the teaching program, but also the reasons for attendance, their subspecialty exposure, and views on surgery as a specialty.

None of the students reported having undertaken a prior ENT clinical placement. Also, despite being held towards the end of the term and near exams, the most frequently reported reasons for attendance were to increase knowledge, improve practical skills, and prepare for internship.

Before attending the program, students rated their confidence levels as low globally. Improvements in scores for knowledge-based assessments were noted in all three topics, and self-reported confidence scores increased by 100 per cent. All the participants found the teaching program was relevant to internship and recommended its inclusion in their curriculum. Students found the near-peer teachers to be knowledgeable on the topics taught, highlighting the usefulness of feedback received.

There is now greater awareness of the impact of preparedness on patient outcomes and junior doctor mental health. Like myself, many interns find their first few months of work stressful, with high personal expectations and concern about their competency in emergencies as commonly reported reasons. Universities have introduced pre-internship rotations to help students negotiate the transition to being junior doctors. Our research findings provide further evidence that a near-peer education program designed and conducted by junior doctors is an efficient, cost-effective way of improving the knowledge and confidence levels of senior medical students in acute surgery.

The benefits of near-peer teaching, simulation and repetitive practice within medicine are well known. While COVID-19 has changed the landscape of how we come together to share knowledge and ideas, the virtues of lifelong learning remain the same.

I hope that this teaching program—and others like it—will improve intern readiness and patient safety by giving interns the tools they need to manage acute surgical emergencies before their first day.

Dr Wendy Liu, Winner of the Surgical Education Research Prize Article

Professional development 2022

Selected 2022 Professional Development courses are now open for registration.

For more information on courses and to register, visit surgeons.org/ lifelong-learning

For any queries, please email the Professional Development department at PDactivities@surgeons.org

Overwhelming support for respectful behaviour

A five-year evaluation finds 99 per cent of RACS Fellows, Trainees and SIMGs support respect in surgery

According to the findings of a five-year evaluation, the RACS community overwhelmingly supports the College's work to build respect in surgery.

Almost all Fellows, Trainees and SIMGs (99 per cent) believe they need to demonstrate respectful behaviours, and 96 per cent recognise the need to address unacceptable behaviour in colleagues and peers.

The evaluation examined perceptions of RACS implementation of its *Action Plan: Building respect, improving patient safety*. More than 90 per cent support RACS work, leadership, and commitment to working in partnership to improve the culture of surgery.

The evaluation looked at 'expected' changes in awareness, knowledge, skills and attitudes to discrimination, bullying and sexual harassment. Some data was collected on behaviour change 'to inform further planning and to create a baseline for future evaluations'.

The evaluation found that RACS has strong credibility among external stakeholders and college members for its commitment and leadership. Fellows, Trainees and SIMGs also backed the ongoing relevance of this work, as well as its focus on improving surgical education and fostering cross-sector collaborations to build respect in surgery.

RACS commitment to building diversity was widely supported, along with an ongoing focus on improving surgical education. Issues around supervision remain challenging—supervisors reported feeling unsupported and fearful of legal challenges, and Trainees reported concerns about lack of transparent and actionable feedback.

The report identifies the devolved structure of surgical training delivery as a barrier to implementing profession-wide initiatives to improve training and support cultural change. It found that 'behaviour, a long-term goal of the Action Plan, is already beginning to change towards the desired outcomes. As expected, there is a gap between knowledge and behaviour, with variations in people's level of confidence to take action when witnessing or experiencing an incident.'

The 2021 evaluation results will inform RACS next five years work to build a culture of respect in surgery.

A separate prevalence study—also conducted in mid-2021—looked at reported rates of unprofessional behaviours.

The results of the 2015 and 2021 prevalence studies are not directly comparable. The 2015 study detailed participants' total experience of discrimination, bullying and sexual harassment over their working lifetimes. The 2021 study tracked reports of these kinds of unprofessional behaviour in the last 12 months.

The nature of unprofessional behaviour reported in 2021 has changed. There are fewer reports of yelling, shouting, aggression, or physical abuse and more on belittling behaviour, career constraints, humiliating comments, or being undermined.

The nature of reported sexual harassment is more nuanced in 2021, with fewer reports of sexual propositioning and inappropriate physical contact. There is an increase in reports of sexually explicit or offensive jokes and comments about appearance or sexual orientation. There is more reporting of sexual harassment by men and Trainees.

There is support for RACS to focus on increasing diversity in the profession and an opportunity for the College to communicate its revised approach to complaints management more widely.

Knowledge of respectful behaviours is widespread, and attitudes are changing, but 'calling it out' remains challenging and behaviour change is a long-term goal.

RACS President, Dr Sally Langley, said wider community attitudes over the same period have shifted as a result of #metoo and vigorous public dialogue in Australia in 2021.

"We are proud of the work we have done to build respect in surgery and just as importantly, that the overwhelming majority of surgeons support our focus and commitment," Dr Langley said.

"We know that cultural change takes time and is a shared goal across the health sector. This evaluation tells us we are on track, that RACS leadership is valued. It shows that we need to stay on course in our work to build a safe and respectful culture in surgery. This is good for our patients, our teams, and ourselves," she added.

Domestic violence - A surgeon's perspective

Healthcare providers are often the first professional point of contact for victims of domestic violence

As a surgeon I see many cases of domestic violence. Unfortunately, it has become one of the most urgent social and public health issues of our time. People of all walks of life are affected by domestic violence—irrespective of gender, postcode, demographic, creed, or ethnicity.

According to the Australian Bureau of Statistics, females in Australia are three times more likely to experience at least one incident of physical and/or sexual violence by a current and/or past domestic partner compared to males (17 per cent compared to 6.1 per cent).

Shockingly, 79 per cent of females in Australia are more likely to die during a domestic violence related assault with the man being the main perpetrator. We also know that according to the Australian Institute of Health and Welfare, certain communities are at greater risk of domestic violence. These include females who are Aboriginal, Torres Strait Islander (ATSI) or Māori, young, pregnant, disabled, and/or experiencing financial hardship, or are adults who faced domestic violence as children.

Domestic violence is a major contributing risk factor to mental and physical ill health, and homelessness. It contributes to the highest burden of disease in females aged 25 to 44 years (higher than other well-known risk factors such as smoking or alcohol). Among Māori and ATSI populations, domestic violence is estimated to contribute five times more to the burden of disease compared to the non-Indigenous[1].

Healthcare providers are often the first professional point of contact for victims of domestic violence. As most incidents of domestic violence go unreported in healthcare settings it is not possible to measure the true extent of the problem.

While general practitioners are more likely to see the chronic and insidious side of domestic violence, health practitioners in emergency and hospital settings are more likely to treat acute trauma and more severe injuries. Surgeons, especially those specialising in trauma, general surgery, otolaryngology head and neck, orthopaedics, vascular, obstetrics and gynaecology, neurosurgery, plastic and reconstructive, oral and maxillofacial are best placed to assess the patient's risk of serious harm to life. They can also provide links to relevant support services.

I always recommend that treating practitioners should take note when a clinical history relayed by the patient victim is inconsistent with the injuries sustained. Less severe injuries such as a tympanic membrane perforation or chronic pain, are not likely to be present at hospitals, but they may be seen in an outpatient setting or as a concurrent second injury during a hospital admission.

Sadly, many healthcare workers who manage the lives of others may do so under stress of their own experience of domestic violence in the workplace. Any healthcare worker experiencing domestic violence should be able to work and train in a compassionate supportive environment. Factors preventing disclosure of violence may include a fear of shame, fear of being labelled with a psychological disability such as depression, fear of being considered a burden on the team, or fear of negative impact on career progression. Further, a perpetrator may even use these fears and potential negative impact on career as a tool to further control and abuse the victim. A victim or their children may also be under duress while at work and these risks may increase if the perpetrator is also employed at the same hospital.

It takes significant courage for victims to disclose and seek support from their predicament. Culturally diverse and older victims are unlikely to disclose abuse because of the cultural and societal mindset that domestic violence is a private matter. Victims often find it easier to seek help from medical practitioners due to the relationship of trust, compared to others such as the police. While there are varied opinions on universal screening for domestic violence or targeted screening of at-risk groups in healthcare settings, the treating practitioner should be extra vigilant when assessing a patient with injuries that may have been inflicted from domestic abuse.[2]

Treating practitioners should be sensitive that from a victim's point of view, any disclosure made must be balanced against the risk of further threat to their safety and the safety of any children, if their perpetrator found out about such a disclosure. This may happen if disclosure starts a cascade of system action that, even though well intentioned, in the end does not adequately protect the victim and their children.

It is important that healthcare workers approach the matter in a non-judgemental manner displaying respect and confidentiality, validating the victim's disclosure. The role of the treating practitioner is to not only care for the immediate injury, but also to

sensitively provide information and identify resources in their hospital and in the wider community which can support victims. If suspicious, the treating practitioner should respectfully probe and prioritise their safety and confidentiality. However, there may be instances where the patient will choose not to accept it nor take immediate action. If domestic abuse is disclosed, practitioners should inquire about the safety of the victim.

I would also recommend that documentation of domestic violence in the patient's medical record are kept confidential. It should include any health complaints, clinical observations of symptoms, behaviours, and physical injuries. Practitioners should counsel the patient and refer them to domestic and family violence support services.

Lastly, everyone and every organisation can play a role in raising awareness of the evils of domestic violence. I am proud that my college – the Royal Australasian College of Surgeons has been actively raising awareness of domestic violence and its key issues as well as mandating training for the surgical workforce through the well-respected Building Respect, Improving Patient Safety initiative, which aims to build a culture of respect in the surgical workforce. More organisations should develop and implement similar programs.

By Associate Professor Payal Mukherjee MBBS, FRACS, Phd, MS Adult & Paediatric ENT Surgeon

Otologist, Cochlear Implant & Skull Base Surgeon, Chair RACS NSW Committee and Clinical Associate Professor - University of Sydney

This article was initially published in a longer format in the *ANZ Journal of Surgery* under the names of Associate Professor Payal Mukherjee and Elaine Tieu, Senior Policy Officer at RACS.

References

1 Ayre J, Lum On M, Webster K, Gourley M, Moon L. Examination of the burden of disease of intimate partner violence against women in 2011: Final report. Sydney: ANROWS; 2016.
2 O'Doherty L, Hegarty K, Ramsay J, Davidson LL, Feder G, Taft A. Screening women for intimate partner violence in healthcare settings. Cochrane Database Syst Rev.

Advocacy update

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

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

Some of the advocacy work the College has undertaken in the last quarter of the year includes:

Consultation on draft report from Rural Surgery Section Aotearoa New Zealand Regional and Rural Health Equity Workshop

On Saturday 4 September, Dr Nicola Hill, RACS Councillor, with the Rural Surgery Section Committee, convened an online workshop to discuss Aotearoa New Zealand facing rural health equity strategies. The main topics captured included:

- leveraging the relationship with the Ministry of Health to influence the implementation of massive changes to occur in the health system post-District Health Board dismantling
- highlighting the importance of Māori health and adopt principles outlined in the RACS Māori Health Action Plan
- gaining consensus on an agreed definition for regional and rural in Aotearoa New Zealand
- improving SIMG relations with RACS and surgical colleagues
- establishing an annual forum dedicated to regional and rural Aotearoa New Zealand matters in collaboration with other medical colleges
- exploring the concept of Hub and Node training networks.

A draft report summarising the key concepts, themes and recommendations arising from the workshop has been prepared and is currently under consultation.

Health Policy and Advocacy Committee update

In the four months since RACS' Health Policy and Advocacy Committee's (HPAC) inception, it has been involved in nearly 40 projects—big and small—throughout the College. These range from quick and fast advice to major submission writing. There have also been around 20 external stakeholder meetings.

The last HPAC meeting was held on 27 September 2021. Besides HPAC, others who attended were the Executive General Manager of Fellowship Engagement Division, the Policy and Advocacy Team, and the RACS CEO. Invited guests included the President, Executive Director for Surgical Affairs, Manager of State and Territory Engagement, and Research Audit and Academic Surgery General Manager. Dr John Crozier is now the Professional Standard Committee (PSC) and Trauma Committee Representative on HPAC, with Deputy Chair Professor David Fletcher the HPAC representative on the PSC.

AEHA Priority Plan released

In 2017, RACS became a proud signatory to the Australian Consensus Framework for Ethical Collaboration (ACF) in the healthcare sector, now known as the Australian Ethical Health Alliance (AEHA). It is a collaboration of professional bodies, industry organisations, hospitals and health service associations, regulators, and patient and advocacy groups who have come together to tackle ethical issues within the health sector. The group is government-supported but sector-led voluntary initiative, which started with five signatories (RACS included) and has subsequently grown to more than 70.

Since February 2021, the AEHA Steering Committee has been developing a strategic direction for the Alliance. RACS recently reviewed the draft Strategic Plan and provided a submission, which is available on the RACS website.

In early October, the AEHA launched the AEHA Priority Plan 2022-2024. The plan determines the organisation's strategic objectives and includes three key areas of focus:

- advocacy and awareness
- embedding ethics
- organisation sustainability.

RANZCR range of Practice Position paper

The Royal Australian and New Zealand College of Radiologists (RANZCR) shared an initial version of a Specialist Interventional Radiology and Interventional Neuroradiology Range of Practice position paper for comment.

In our response, RACS raised a number of concerns in relation to the mention of 'ward-based care' and 'outpatient management', as well as 'non-interventional management of congenital and acquired diseases', in relation to the range of practice for these subspecialties.

RACS noted that, 'Interventional radiologists are not involved in the primary clinical assessment and primary decision-making regarding patients' care, as they are not trained in the biology, natural history and therapeutic options for all conditions.' RACS also stated that, 'Interventional radiologists should always work as part of a multidisciplinary team (MDT), and provide a service based on MDT plans.'

Want to know more about RACS advocacy?

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

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

RACS advocating for appropriate reform to Prostheses List

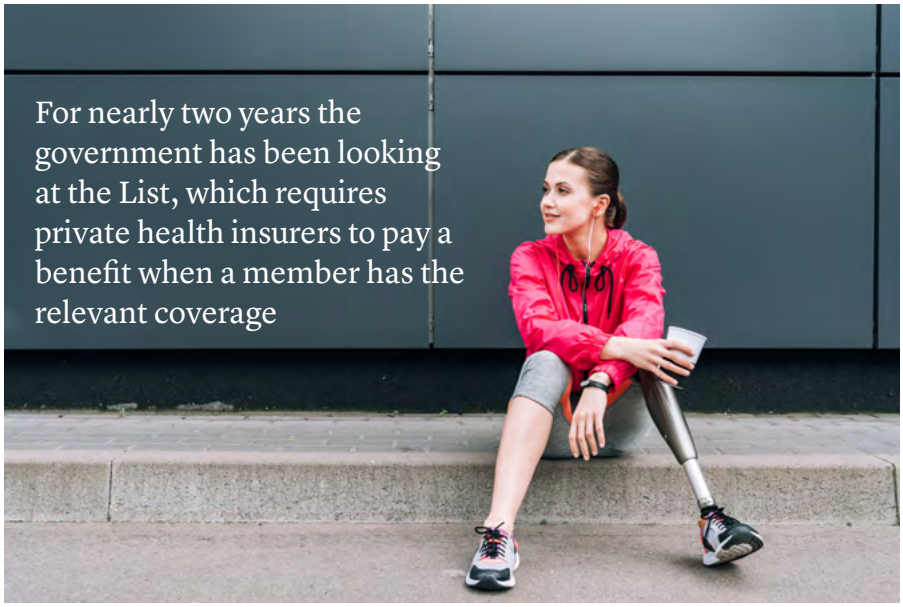
For more than a year RACS has been engaging with the Federal Government regarding proposed reforms to the Prostheses List—writing to the Minister for Health, advocating directly to the Department of Health and Ministerial office, and responding to consultations with detailed submissions in collaboration with a number of surgical societies.

As many will be aware over the last 18 months or more, the government has been looking at reforming the Prostheses List—the list of medical devices for which private health insurers are required to pay a benefit when a member has the relevant coverage.

Earlier this year a government options paper proposed the replacement of the Prostheses List (PL) with a Diagnoses Related Group-type (DRG) funding model. Led by Professor Mark Frydenberg, Chair of the Health Policy and Advocacy Committee (HPAC), RACS submitted a response to a government consultation, which was critical of this approach. RACS was concerned that with a DRG model, funding would be capped with the prosthetic cost incorporated within the DRG. There would then potentially be an incentive to choose prosthetic items which were cheaper but less appropriate to a given patient's care.

With RACS and other stakeholders opposed to the DRG model, the government eventually decided against pursuing this approach. Instead, it is pursuing changes focused around 'better defining the Prostheses List purpose, definitions, and scope'.

This approach has also provoked concerns, as it has the effect that many general use surgical items will be removed from the Prostheses List. A consultation paper released in August stated that such items, 'would continue to be funded through other mechanisms, such as contracts between insurers and hospitals.' However, these 'other mechanisms' were not detailed. HPAC again took the lead in developing RACS response, drawing heavily on the views of surgical societies and associations.



For nearly two years the government has been looking at the List, which requires private health insurers to pay a benefit when a member has the relevant coverage

Because of the types of items expected to be removed from the list, certain subspecialties may be affected more than others. For example, citing specific impacts on their Fellows, General Surgeons Australia (GSA), and allied groups such as Australian and New Zealand Oesophageal and Gastric Surgery Association (ANZGOSA), and the Australian and New Zealand Metabolic and Obesity Surgery Society (ANZMOSS) made strong submissions, which RACS endorsed.

GSA's submission noted that many items required for general surgery are bundled under 'general miscellaneous' category on the Prostheses List, 'most of which have been flagged for removal'.

To quote GSA, 'removal of these items does not recognise their essential nature in specialised general surgery practice, compromises patient safety, and also means that Specialist General Surgeons would no longer be able to choose the product that is required for particular operations.'

With the first items slated for removal from March 2022, RACS plans to continue to engage with the government to advocate for reforms, which reduce costs, while ensuring patients continue to have access to the medical devices best suited to their particular clinical circumstances.

In the event the changes go ahead, RACS' position is that it would be appropriate for access to, and use of, devices removed from the Prostheses List to be independently monitored, with a focus on the views of clinicians. Should monitoring find that clinicians believe their clinical choices have been significantly impacted, then it is RACS' view that the changes should be revisited.

Capacity building in Samoa

The Primary Trauma Care Training courses aim to build capacity and establish local faculty that can be run by local providers

A training workshop to equip medical staff with knowledge and skills in Primary Trauma Care (PTC) was held in Samoa on 28 and 29 September 2021, with another planned for early February 2022.

This was the fifth Primary Trauma Care training (PTC) held in Samoa since 2016. The Royal Australasian College of Surgeons (RACS) partners with the Australian College of Emergency Medicine (ACEM) and the Pacific Ministries of Health to coordinate and fund the delivery of these trainings across several Pacific Island countries under the Department of Foreign Affairs and Trade (DFAT) funded Pacific Island Program (PIP).

The courses are designed to build the capacity and establish local faculty. The trainings can then be run independently by local providers.

Dr Sione, one of the senior PTC faculty said, "It is our aim to develop our younger leaders to take over and sustain the PTC training in the future. We are grateful to have had the support to run the instructor's course and two PTC courses in Upolu and Savaii for our frontline staff with prioritisation for Trainee interns and rural staff in district hospitals and health centres."

Six PTC faculty attended the instructor refresher training. They all assisted the senior trainers to deliver the two-day course to 20 participants, including nurses, interns, and registrars. Dr Sione said the training was well received and that they felt much more confident in their skills to manage trauma patients.

Trauma is gradually becoming a large cause of death and disability in many countries, especially in the developing world.

Dr Sione said, "Low- and middle-income countries like Samoa often have difficulties with the early management of patients with trauma injuries as they have to travel great distances to receive care. This means by the time patients get to the hospital they haven't had a proper assessment or any initial management procedures. This is often due to low numbers of health professionals with appropriate training."

The World Health Organisation's Global Burden of Disease points out that 1.3 million people die each year due to road traffic injuries. Global Burden of Disease is defined by the WHO as 'impact of a health problem on an area measured by financial cost, mortality, morbidity, or other factors'.

In the most recent audit (2014), 730 trauma patients* were admitted to Tupua Tamasese Meaole Hospital in Apia, Samoa. Out of the total, 11 per cent were related to road traffic accidents, 43 per cent to falls, and about half of the total cases were related to assault injuries, natural disasters, and suicides.

There is a great demand for trauma management and the need for ongoing training of medical professionals and first responders—police, paramedics etc.—in providing effective assessments and timely appropriate management in limited resource environments.

Dr Sione and his team plan to run a second course in February 2022 and are also working with the National University of Samoa to provide the course to students at the School of Medicine.

**Source: Ms. Lora Su'a of medical records*

Image: Dr. Sione Pifeleti (Photo: Vaitogi A. Matafeo)

RACS hosts the first post COVID-19 global health forum

RACS Global Health is proud to have hosted a preliminary online session of the first post-COVID-19 all colleges, societies and organisations in a global health forum recently.

This important forum is a unique coming together of Australian and Aotearoa New Zealand colleges, specialist medical colleges and international partners including government, hospitals, and non-government representatives.

RACS Global Health had initially hoped to hold the forum as a singular in-person event on 20 September. This was unfortunately disrupted by Melbourne's most recent lockdown due to COVID-19 community transmission and the closing of state and international borders.

The disruption however, as it often has, provided a useful opportunity to bring together a smaller group of colleagues and peers to revive an important goal of this group prior to the COVID-19 pandemic. This included the development of a draft mutually-agreed terms of reference, or ways of working for this critical gathering of global health professionals.

Facilitated by external, independent consultants, the discussions captured a range of priorities, goals and objectives of the various participating colleges, societies and organisations to help form the basis of broader discussions at the larger, in-person forum in February.

During this meeting, RACS Global Health and participating organisations had the privilege to hear from some of our partners in the Pacific, including the Honourable Dr Ifereimi Waqainabete, the Minister of Health in Fiji and Ms Selina Motofaga, Clinical Services Adviser at Pacific Community-SPC also in Fiji. The two special guests discussed the challenges faced by Fiji and Pacific Island nations as a result of COVID-19, and how this vital group of peers can work to support locally led efforts to improve surgical and other health outcomes in the Pacific communities.

RACS Global Health will soon distribute a 'save the date' notice and agenda for the second part of the forum, to be held in early February 2022. The Global Health Forum looks forward to welcoming our colleagues and peers in person from across Australia, Aotearoa New Zealand, and hopefully the wider region at our offices in Melbourne.

Notice of error

Royal Australasian College of Surgeons

ANZSVS

19 October 2021

Editors of Surgical News
Via email: surgical.news@surgeons.org

To Whom it May Concern,

I'm writing to advise of an error in a recent article titled "Making flexible surgical training accessible for everyone" printed in Surgical News, Volume 22, Issue 4, pages 40 to 41.

In the fourth paragraph, the article erroneously included Vascular Surgery in a group of specialities that are '...yet to offer part-time (job share or stand-alone) positions to their Trainees...'. The truth is that the Vascular Surgery Board made provisions for part-time training inn 2017, and a part-time post has been accredited since 2018.

I am requesting that this fact is acknowledged, and a correction is printed in the next edition.

Kind Regards,

Mr Peter Charalabidis, FRACS
Chair, Board of Vascular Surgery

COVID-19 plays havoc on cancer patients' surgery

The alarming number of cancer patients missing potentially life-saving operations

One in seven cancer patients around the world have missed out on potentially life-saving operations during COVID-19 lockdowns, a new study reveals.

Planned cancer surgery was affected by lockdowns regardless of the local COVID-19 rates at that time, with patients in lower income countries at highest risk of missing their surgery.

While lockdowns have been essential in protecting the general public from spreading infection, they have had collateral impact on care for patients with other health conditions. In one of the first studies that have measured these effects directly, researchers showed that lockdowns led to significant delays to cancer surgery and potentially more cancer deaths. These could have been prevented if operations had gone ahead on time.

Researchers are calling for major global reorganisation during the recovery from the pandemic to provide protected elective surgical pathways and critical care beds that will allow surgery to continue safely, as well as investment in 'surge' capacity for future public health emergencies.

They believe that 'ring-fenced' intensive care beds would support patients with other health conditions and those with advanced disease (who are at the highest risk from delays) to undergo timely surgery. In parallel, long-term investment in staffing and infrastructure for emergency care would mitigate against disruption of elective services.

Led by experts at the University of Birmingham, almost 5,000 surgeons and anaesthetists from around the world, including Fellows and Trainees from the Royal Australasian College of Surgeons, worked together as part of the NIHR-funded COVIDSurg Collaborative to analyse data from the 15 most common solid cancer types in 20,000 patients across 466 hospitals in 61 countries. The team published its findings in The Lancet Oncology.

The researchers compared cancellations and delays before cancer surgery during lockdowns to those during times with light restrictions only. During full lockdowns, one in seven patients (15 per cent) did not receive their planned operation after a median of 5.3 months from diagnosis—all with a COVID-19 related reason for non-operation. However, during light restriction periods, the non-operation rate was very low (0.6 per cent).

Patients awaiting surgery for more than six weeks during full lockdown were significantly less likely to have their planned cancer surgery. Frail patients, those with advanced cancer and those waiting surgery in lower-middle income countries were all less likely have the cancer operation they urgently needed.

Co-lead author and Royal Australasian College of Surgeons surgical Trainee

Dr Nagendra Dudi-Venkata, University of Adelaide, commented: "Our research reveals the collateral impact of lockdowns on patients awaiting cancer surgery during the pandemic. While lockdowns are critical to saving lives and reducing the spread of the virus, ensuring capacity for safe elective cancer surgery should be part of every country's plan to ensure continued health across the whole population.

"In order to prevent further harm during current and future lockdowns, we must make the systems around elective surgery more resilient – protecting elective surgery beds and operating theatre space, and properly resourcing 'surge' capacity for periods of high demand on the hospital, whether that is COVID, the flu or other public health emergencies."

Co-lead author and Royal Australasian College of Surgeons Fellow, Associate Professor Tarik Sammour, from the University of Adelaide, added: "The most vulnerable patients to lockdown effects were those in lower income countries, where capacity issues that were present before the pandemic were worsened during lockdown restrictions. Patients in these environments were at highest risk of cancellation, despite being younger and having fewer co-morbidities.

"While we only followed patients that underwent a delay for a short period of time, evidence from other research suggests that these patients may be at higher risk of recurrence. To help mitigate against this, surgeons and cancer doctors should consider closer follow-up for patients that were subject to delays before surgery."

Researchers analysed data from adult patients suffering from cancer types including colorectal, oesophageal, gastric, head and neck, thoracic, liver, pancreatic, prostate, bladder, renal, gynaecological, breast, soft-tissue sarcoma, bony sarcoma, and intracranial malignancies.

The team believes that this data can help inform governments when making decisions about whether to prolong or reduce restrictions.

Country-level lockdowns have a direct impact on hospital procedures and planning, as health systems change to reflect stringent government policies restricting movement. They found that full and moderate lockdowns independently increased the likelihood of non-operation after adjustment for local COVID-19 case notification rates.

Royal Australasian College of Surgeons' Professor David Watson said he welcomed this latest in a series of high-quality, high-impact research outputs from the NIHR-funded COVIDSurg Collaborative.

"We are proud of how our Clinical Trials Network of Australia and New Zealand swiftly joined this collaborative and adapted to help colleagues around the world study the impacts of the global COVID-19 pandemic. These findings will help build the evidence base for how surgical services can 'build back better' and, working with the World Health Organization and national coordinating bodies including the Royal Australasian College of Surgeons, develop guidance for global surgery."

Collaborative research upskills surgical trainees

Aotearoa New Zealand Trainee-led study finds patient age and Māori ethnicity significantly associated with re-presentation to hospital following thoracic trauma

The student- and Trainee-led collaborative research model is an effective strategy to efficiently run multicentre studies while meaningfully upskilling Trainees. The benefits of collaborative research include decreased research waste and the inclusion of a larger number of patients in less time. This can permit greater generalisability and improve the impact of studies, while fostering a network of like-minded researchers.

Multiple Trainee-led collaborative networks have been developed across Aotearoa New Zealand (AoNZ) and Australia. Trainee-led networks benefit from medical students being taught practical research skills by senior registrars, which promotes future engagement in research. It gives Trainees the opportunity to learn skills that include data collection, data analysis, research ethics, manuscript writing, publishing, and leadership.

The first AoNZ trainee-led collaborative research network, Surgical Trainees Research Audit and Trials Aotearoa (STRATA) was founded in 2018. It followed the success of medical students and trainees in AoNZ contributing to international collaborative studies. The creation of STRATA was supported by the RACS Clinical Trials Network Australia and New Zealand (CTANZ) and Northland District Health Board (NDHB), AoNZ. The first STRATA study, *RURAL*, was successfully coordinated between 2019 and 2020. The second study, RiBZ (Rib Fractures in Blunt Thoracic Trauma: New Zealand Management and Outcomes), was completed in mid-2021. The third study, CHOLENZ, is actively collecting data across 16 AoNZ hospitals and has recruited more than 700 patients who have had a cholecystectomy.

The RiBZ study is a national prospective multicentre observational cohort ▶

study supported by NDHB, AoNZ and guided by Associate Professor Christopher Harmston (CTANZ Surgical Specialty Lead). Patients admitted between 1 December 2020 and 28 February 2021 with isolated thoracic trauma and radiologically proven rib fracture(s) were included.

The primary outcomes of interest were the rates of pneumonia, 30-day re-presentation and mortality. Thirty-seven collaborators across 14 AoNZ hospitals collected data on 407 patients. The mean age was 57.4 years—28 per cent were female, 15 per cent Māori and 85 per cent non-Māori.

The median number of rib fractures was four. The rate of pneumonia, re-presentation and mortality were 11 per cent, 8 per cent and 2 per cent , respectively. Logistic regression found that age at admission (OR 1.03 95 per cent CI 1.005-1.051) and Māori ethnicity (OR 2.75 95 per cent CI 1.077-7.045) were significantly associated with re-presentation to hospital. Surgical stabilisation of rib fractures was performed in 2 per cent of patients and 23 per cent of patients received a regional anaesthetic block.

This Trainee-led collaborative study describes key clinical outcomes for patients with rib fractures across AoNZ. The moderate pneumonia rate of 11 per cent is likely amendable to reduction with quality improvement initiatives. Consideration should be given to further improving and resourcing the access across AoNZ to regional analgesia and surgical stabilisation of rib fracture, given their low utilisation. Māori patients were 2.75 times more likely to re-present to hospital than non-Māori patients. This disparity has been reported across various presentations. Rumball-Smith et al suggested that differential treatment within the health system was a likely contributing factor to higher re-presentation rates in Māori patients[1-3]. Priority should be given to providing equitable care for Māori patients sustaining trauma and further research is required in this area.

This study was made possible by the enthusiasm and hard work of collaborators across AoNZ, the guidance of our mentors, and the support from CTANZ and NDHB. These last few years have been the start of AoNZ's collaborative Tainee-led network journey—a journey that is just beginning.

Dr Matthew McGuinness (CTANZ Working Party Trainee Lead) on behalf of RiBZ Trainee Collaborative and STRATA

1. Rumball-Smith J, Sarfati D, Hider P, Blakely T. Ethnic disparities in the quality of hospital care in New Zealand, as measured by 30-day rate of unplanned readmission/death. Int J Qual Health Care. 2013;25(3):248-54.
2. Robinson T, Kerse N. Medical readmissions amongst older New Zealanders: a descriptive analysis. N Z Med J. 2012;125(1367):24-34.
3. Seibt S, Gilchrist CA, Reed PW, Best EJ, Harnden A, Camargo CA, et al. Hospital readmissions with acute infectious diseases in New Zealand children ← 2 years of age. BMC Pediatr. 2018;18(1):98.

IMAGE

First row - Teresa Vanderboor, Maria KR Brand, Andrew D. MacCormick, Niki Kau, Rebecca Teague, Brodie Elliott, Kevin Henshall

Second row - Deborah Wright, Lauren Bidois, Choo Hang Khoo, Omar Mohyieldin, Jaques Marnewick, Sean Affonso, Olivia Lengyel

Third row - Top row (Left to right): Chris Harmstom, Chris Varghese, Nelson Song, Rebecca Coats, Gordon Speed and Fiona Thomas

Collaborators without photos: Pam Fitzpatrick, Carsten Stracke, Rory Miller, Claire Hitchcock, Cheyaanthan Haran, David Vernon, Harsh Singh, Zoe Clifford, Bena Law, Caroline Knudsen, Monique Mahadik, Clare Swanson, Cindy Xin Yi Ou, Grant Christey, Benjamin Nuttall, Ramanen Sugunesegran, Valerie August

When will Australia's regulator start protecting patients?

ASAPS demands immediate action from AHPRA over use of the title of 'cosmetic surgeon'

Leading professional body, the Australasian Society of Aesthetic Plastic Surgeons (ASAPS) is pressuring AHPRA, Australia's health regulator, to take immediate action and ban the use of the title 'cosmetic surgeon' by those who are not in fact specialist surgeons.

In Australia, the Australian Medical Council (AMC) is the benchmark that provides a nationally consistent standard of care that patients can rely on for specialist treatment. It decides what specialist training is accredited, recognised and safe. AMC accreditation provides independent oversight of both standards of specialist education and ongoing compliance with ongoing professional education. Only practitioners who have successfully completed Australian Medical Council accredited training can use legitimate approved specialist surgical titles. However, most practitioners who use the title 'cosmetic surgeon' are not registered surgical specialists. This is currently allowed by AHPRA.

The use of the title of 'cosmetic surgeon' is a free for all—it can be used by any medical practitioner without AHPRA registration as a specialist surgeon and without Australian Medical Council-accredited surgical training. It means doctors with no more than a basic medical degree can call themselves a 'cosmetic surgeon'. A recent survey has shown that 81 per cent of Australians agree that the title 'cosmetic surgeon' implies that the doctor is a registered specialist surgeon. There is therefore a real issue as to whether patients understand that their surgeries are not in fact being carried out by a specialist accredited surgeon.

Robert Sheen, President of the Australasian Society of Aesthetic Plastic Surgeons (ASAPS) says, "The issue here is one of transparency. Transparency is central to patients making informed choices about their healthcare provider.

"There are practitioners who self-label as cosmetic surgeons yet do not have specialist surgical registration, and do not reveal this important detail to their existing or prospective patients.

"It is AHPRA's job to regulate anyone who would perform procedures on a patient. Part of that regulation should be to enforce transparency and honesty about titles that clearly communicate assumed levels of education and expertise.

"The National Law that already exists even mandates transparency in Section 118: 'to protect members of the public to ensure they are not misled'.

"The terms 'cosmetic surgeon' and 'plastic surgeon' are used interchangeably, and people wrongly assume both titles reflect the same level of expertise. The difference is this: only practitioners who have completed an additional 8 – 12 years of AMC accredited specialist plastic surgical training, beyond their medical degree, can lawfully call themselves a registered specialist plastic surgeon. Whereas the title 'cosmetic surgeon' is a free-for-all. It is not backed up by AMC accredited training."

In November 2019, Australian State and Federal Health Ministers voted unanimously to restrict the use of 'surgeon', including by those using the title 'cosmetic surgeon' without the other appropriate specific training, in order to prevent causing confusion among members of the public. However, practitioners carry on every day using the term 'cosmetic surgeon' when they are not specialist surgeons.

Action needs to be taken immediately to rectify these issues in order to protect patients and ensure that they understand the qualifications of the medical practitioner carrying out their surgery.

We are pleased to see that, at the time of printing, a review of cosmetic surgery has been announced by Ahpra and the Medical Board of Australia.

Dr Bal Krishan honoured with RACS Rural Surgeons Award

Inspirational surgeon and Fellow of the Royal Australasian College of Surgeons (RACS), Dr Bal Krishan was recently presented with the RACS Rural Surgeons Award in recognition of his long and distinguished service to rural surgery.

While COVID-19 lockdowns across NSW meant the award was unable to be presented at the Australian Society of Otolaryngology Head Neck Surgery Annual Scientific Meeting, RACS Councillor and Wagga Wagga local, Associate Professor Kerin Fielding was on hand to present the award to Dr Krishan.

"The Award recognises surgeons with a dedicated history of service to rural surgery. Without them the standard of surgical care in that community would have been less than society expects," AssociateProfessor Fielding said.

A citation for the award was provided by RACS Rural Surgery Chair Dr Bridget Clancy, who paid tribute to Dr Krishan's tireless service over many years.

"Born in India, Dr Krishan came to Australia in 1963 and he obtained his Diploma in Otorhinolaryngology in ENT in 1966. He underwent further training and obtained his FRACS in 1967. He trained in Victoria and had postings in Royal Melbourne, Royal Victorian Eye and Ear, St Vincent's, Royal Adelaide, Whyalla, Port Augusta, and Port Lincoln," Dr Clancy said.

"He worked in country practice for more than 50 years and covered a large area as a solo ENT including visits through the Royal Flying Doctors. He tried to retire twice but had to return as there was no service in the region.

"A supporter of higher education in regional Australia, Dr Krishan donated to the Charles Sturt University Foundation Trust in 2008. This donation enabled the creation of the Dr Bal Krishan scholarship for Indigenous students enrolled full-time in a course on Wagga Wagga campus.

"As a rural ENT myself, I have got to know Dr Krishan over the years. He has attended all ASOHNS annual scientific meetings except in 1984 when there was an airport dispute and in 2002 due to family illness. It is with great pleasure that we present Dr Bal Krishan with this very well-deserved award."

Accepting the award Dr Krishan said that he was humbled to receive it and said, "I was just a country work horse surgeon that hung around in rural areas for 53 years, and for 37 years I was on call 24/7. I am very grateful to receive the rural surgeons award and that the College has decided to recognise me in this way."

IMAGE

Associate Professor Kerin Fielding with Dr Bal Krishan

Trauma surgeons welcome crackdown on quad bikes as important first step

RACS has publicly welcomed mandated design changes to new quad bikes and urged further reform to the industry

The new standards, which came into effect on 11 October, require new and imported second-hand general use quad bikes to be fitted with an operator protection device (OPD), or have one integrated into their design, and to meet minimum requirements for stability.

The changes follow recommendations from Australian Competition and Consumer Commission (ACCC) in 2019. These were made in response to 136 people dying in quad bike accidents in the eight years prior, 60 per cent of which the ACCC attributed to rollovers.

RACS spokesperson and long-term advocate against the harms of quad bikes, Professor Warwick Teague, said that the changes were much needed and long overdue.

"The new changes could not have come fast enough, and lives will be saved thanks to their introduction. Since the time of the 2019 announcement, Australia experienced its highest annual death toll in 2020 with 24 quad bike fatalities. So far this year, a further six fatalities have been recorded."

Dr Teague said that while he applauded the new changes it was important that the public understood the inherent risks involved with older quad bikes, particularly when children are involved.

"These changes do not apply to second-hand quad bikes unless they are being imported. Quad bikes are the leading cause of death and injury on Australian farms, and there are still so many of these older models being sold and ridden across Australia. I urge governments to implement measures to address the dangers posed by the legacy fleet.

"Furthermore, at this stage, youth and sports quad bikes do not have to be fitted with an OPD due to the lack of testing of after-market OPDs designed for these categories. This is despite children being overrepresented in the number of quad bike fatalities.

"Rather than see this type of testing occur, I would like to see a complete ban placed on children riding quad bikes of any size. Sadly, kids and quad bikes are a toxic mix and I do not believe there is any safe way for children to ride these dangerous machines."

Younger Fellows and later year Trainees meet for a leadership presentation

RACS ACT dipped a toe into the water on 28 October to hold a face to face gathering for our Younger Fellows, and those in their later Trainee years, at QT Hotel, Canberra.

It was a great night with all the appropriate capacity limits and social distancing requirements adhered to.

Twenty-one people attended the dinner and a presentation on leadership delivered by Dr Ailene Fitzgerald, Director ACT Trauma Service.

The event was sponsored by Avant Mutual and The National Capital Private Hospital.

Promoting respect in surgery – Addressing microaggressions

Microaggressions are subtle, everyday putdowns experienced by people in marginalised groups, which causes poorer health care for our patients and weariness and burnout in our colleagues.

Over the last six years, the RACS Operating with Respect program has worked to address discrimination, bullying and sexual harassment in Surgery in New Zealand and Australia.

However, creating work environments that are high functioning, respectful and safe for staff and patients require more than 'just' dealing with overtly unacceptable behaviour—we need to recognise and address microaggressions too.

What are microaggressions?

Microaggressions—a term proposed in 1970 by Pierce[1] and expanded by Sue DW, Capodiluo CM, Torino GC et al. in 2007[2]—are defined as: 'everyday, verbal or nonverbal or environmental, … putdowns, … that can be intentional or unintentional, … that communicate hostile, derogatory or negative messages, … towards marginalised group members (female, people of colour, LGBTQI, disabled, and religious).'

Microaggressions are not called micro because they do no harm, but because they are subtle and commonplace. From an outsider's perspective the behaviour may seem trivial, but it does not feel trivial to the recipient. For people in marginalised groups there is often the 'pile on principle'[4] where the 'insult burden' accumulates over a person's lifetime leading to substantial harm—like a mosquito bite, which is annoying if it occurs infrequently, but life-changing if it occurs multiple times every day[5]. Experiencing microaggressions has been associated with mental health problems including depression and anxiety[6] and increased physician burnout[14].

Types of microaggressions

Four types of microaggressions have been described (Table 1)[2].

TYPE	DEFINITION	EXAMPLE
Microassaults	Verbal or nonverbal acts of discrimination that convey to the receiver that they are of lesser worth	Not acknowledging anything that female registrars share in group discussion while acknowledging male registrars' thoughts
Microinsults	Rude, insensitive comments/behaviours that belittle a person based on their identity	Mistaking the Black registrar as a cleaner and asking them to clean the room
Microinvalidations	Behaviours that nullify or deny someone's lived experiences	Calling someone oversensitive when they say a patient's comments about their sexuality hurt
Environmental microaggressions	When the above three are reflected in our culture	Having no breast-feeding rooms in a workplace that says it is family-friendly

Table 1: Microaggression types

Effects of microaggressions

Adverse effects on both mental and physical health of students, patients and health care staff have been reported. More than 60 per cent of medical students from minority groups experience at least one microaggression a week[7], with associated higher depression scores and increased medical school withdrawal. Health care delivery to marginalised groups also may be directly impacted—for example, Black children presenting to the Emergency Department receive less adequate analgesia for the same surgical condition[8], increased general anaesthesia for caesarean section in Black and Hispanic patients[9], and less frequent recommendations for cervical cancer screening, rectal examinations, and smoking cessation for Black patients[10]. This 'casual' discrimination not only impacts patient care, but also diminishes patient trust in the health service. For example, 18 per cent of LGBTQ adults say they avoid health care because they believe they will experience discrimination[11].

Health professionals experience microaggressions at work from a variety of sources. Three quarters of female orthopaedic surgeons said they experienced microaggressions during their training and more than 90 per cent at work[12]—most commonly from patients and their families (60 per cent), male surgeons (59 per cent), and female support staff (56 per cent). Trainee to trainee microaggressions are also common[13].

Addressing microaggressions

The first step in addressing microaggressions is to acknowledge that they occur, and that we are all capable of unintentionally microaggressing. Options for self-evaluating our tendency to microaggress, include completing the online Harvard Implicit Association Test https://bit.ly/30Umo75 or spending time in reflection of one's day and interactions (Asking oneself whether interactions with people from marginalised groups were different to those from the dominant group). If we realise, we have microaggressed we should apologise—even if our intention was not to offend—just as we would apologise to a patient who we harmed unintentionally[15].

When we see microaggressions displayed by others, we need to be an 'upstander'—someone who acknowledges the microaggression and intervenes to minimise damage and recurrence[16].

There are several ways to do this (see Table 2) and these can also be used by the recipient of microaggression.

Another way to help people who experience microaggressions is to acknowledge their experiences. Mentors or support groups from the same marginalised group may be helpful. We also need to be vigilant and pro-active in making our environments more inclusive—ensuring diversity in who we honour in pictures on the wall, in leadership teams, in invited speakers for conferences, and reviewing our promotion practices and outcomes to maximise equity. ▶

METHOD	APPROACH	EXAMPLES
'Open the Front Door'[17]	**O**bservation – factual **T**hink – about what you observed **F**eel – emotion generated **D**esire – desired outcome	When you said, "JS you don't look gay" **(O)**, I think that JS looked offended **(T)**. I felt sad as this wasn't very inclusive **(F)**, and I was wondering if you should apologise to JS **(D)**.
ACTION[18]	**A**sk clarifying questions **C**uriosity not judgment **T**ell what you observed – factual **I**mpact exploration – effect on others **O**wn your own thoughts and feelings re: impact **N**ext steps – desired action	I notice that when the Black person entered the lift you pulled your purse close to you. Was that the case? **(ACT)**. This can make Black people feel they are a criminal **(I)**, which we know they are not **(O)**. Maybe this is something you could reflect on **(N)**.
XYZ[19]	I feel **X** when **Y** because of **Z**	I felt devalued when you said today that I "should not be a surgeon because I should be at home looking after my children" because I know you would not say that to any of the male registrars.
GRIT[20]	**G**ather your thoughts – pause – don't respond out of anger **R**estate – the microaggression comment/action **I**nquire – their meaning by the statement **T**alk it out – impact on others	On the ward round when you presented JS you said this "retarded patient". **(R)** Please help me understand what you mean by that statement. **(I)** In my experience this is not the terminology we use for an intellectually handicap patient and could cause offense **(T)**.
"Smallest possible firepower"[21]	Give your take Didn't hear Didn't understand Re-state role and purpose Non-verbal interventions	That's not ok Sorry, didn't quite hear you, could you repeat that? Sorry, I don't understand, could you explain? I'm the resident and I'm here to ask for advice. A quizzical look A pause in activity Moving between the aggressor and recipient – 'Oh sorry, I need that pen …'

Table 2: Ways to respond to microaggressions

Summary

Microaggressions are subtle, everyday putdowns experienced by people in marginalised groups. This causes poorer health care for our patients, and weariness and burnout in our colleagues. Increased awareness of, and sensitivity to, microaggression will allow us to change our own personal attitudes and environment and to intervene in a positive way when we see microaggression occurring.

Authors: Jenny Wagener, General Surgeon, and the Chair with Anne Leditschke, Richard Turner, Julian Smith, Cathy Ferguson, and Marcus Stoodley - RACS Operating with Respect Committee

References

1. Pierce, C. Offensive mechanisms. The Black seventies Boston, MA: Porter Sargent. (1970). 265– 282.
2. Sue DW, Capodiluo CM, Torino GC et al. Racial microaggressions in everyday life, implications for clinical practice. Am Psychol. 2007; 62(4): 271-286.
3. Sue DW, Wing D. Microaggression in everyday life: Race, Gender and Sexual orientation, (2010) Wiley and Sons.
4. Cullen M. Microaggressions: A campus climate conversation webinar. Little Falls. NJ, Paperclip communication (2015, September 30) as told in Belich M, J. Leadership and Development. Cont Educ Nurs. 2015; 46 (11):487-488.
5. DeBenedetics C et al. Microaggression in radiology. J Am Coll of Radiology. 2019; 16 (9): 1218-1219 and "How microaggressions can be like mosquito bites". Higginton, John. https://vimeo.com/425345011
6. Cruz D, Rodriguez Y, Mastropaolo C. Perceived microaggressions in health care: A measurement study. PLOS one. 2019; Feb: 1-11. Doi.org/10.1371/journal.pone.0211620.
7. Anderson N et al, The association of microaggressions with depressive symptoms and institutional satisfaction among a national cohort of medical students. J Gen Intern Med. 2021; April 30. Doi 10.1007/s11606-021-06786-6.
8. Goyal MK, Kuppermann N, Cleary SD et al. Racial disparities in pain management of children with appendicitis in emergency departments. JAMA Pediatr. 2015; 169: 996-1002.
9. Butwick AJ, Blumnfeld YJ, Brookfield KF et al. Racial and ethnic disparities in mode of anaesthesia for caesarean delivery. Anesth Analg. 2016; 122:472-479.
10. Franks P, Fiscella K, Meldrum S. Racial disparities in the content of primary care office visits. J Gen Int Med. 2005; 20: 599-603.
11. Casey LS, Reisner SL, Findling MG et al. Discrimination in the United States: Experience of lesbian, gay, bisexual, transgender and queer Americans. Health Service Research.2019; 54 Suppl 2:1454-1466.
12. Samora JB, Denning J, Haralabatos S et al. Do women experience microaggression in Orthopedic surgery? Current state and future directions from survey of women Orthopaedists. Current Orthopedic Practice 2020; 31 (5): 503- 507.
13. Alimi Y, Bevilacqua LA, Snyder RA et al. Microaggressions and implicit bias in surgical training: An undocumented but pervasive phenomenon. Annals of Surgery. 2021: April. Doi 10.1097/SLA.0000000000004917.
14. Sudo NT, Guaderrama NM, Honsberger P et al. Prevalence and nature of sexist and racial/ ethnic microaggressions against surgeons and anesthesiologists. JAMA surgery. 2021; 156 (5) e210265; 1-10; doi:10.1001/jamasurg.2021.0265.
15. Trueland J. How you can tackle casual racism and microaggression in the NHS, Nursing Management, 2020, 27 (5) 14-17.
16. Ehie O, Muse I, Hill L et al. Professionalism: microaggression in the health care setting. Current Opinion Anaesth. 2021; 34 (2) 131-136. Doi: 10.1097/ACO.0000000000000966
17. Roy P. Strategies for microresistances and ally development. Available at: https://www.diversitynetwork.org/blogpost/1437725/273902/Strategies-forMicroresistances–Ally-Development. Accessed September 2019
18. Cheung F, Ganote C, Souza T. Microaggression and microresistance: Supporting and empowering students. In Faculty Focus. Special report 2016 Diversity and inclusion in the college classroom, Magna publication: 15-17 http://www.facultyfocus.com/free-reports/diversity-and-inclusion-in-the-college-classroom/
19. Ganote C. Creating welcoming and inclusive classrooms: a workshop for part-time faculty. Available at: https://www.unomaha.edu/facultysupport/teaching-excellence/microaggressions-adjunct.pdf. Accessed September 29, 2021.
20. Warner NS, Njathi-Ori CW, O'Brien EK. The GRIT (Gather, Restate, Inquire, Talk it out) Framework for addressing microaggressions. JAMA surgery 2020, 155 (2) 178-179.
21. Liang, R. Speaking up immediately – Use the smallest possible firepower to achieve the aim. https://twitter.com/liangrhea/status/1443121447396773888?s=21 Accessed September 29, 2021.

Living the dream: Paediatric surgery and work-life balance

Dr Annie Roberts shares how she found her way into paediatric surgery and strikes the subtle balance between life with a young family and work

Dr Annie Roberts is a Paediatric surgeon at the Women's and Children's Hospital (nicknamed the Women's and Kids') in Adelaide. After starting out as a scientist, she fell in love with surgery, made the leap across to surgical training, and joined the ranks as a Fellow of the Royal Australasian College of Surgeons (RACS) in 2017.

Now, a fully-fledged Paediatric surgeon and a mum of two young children, Dr Roberts is working out the optimal balance between personal life and surgery, where everything appears to come together, and both family and work thrive.

Dr Roberts started out with a Bachelor of Science (Biomedical Science) majoring in human genetics and human physiology from the University of Adelaide, and time spent with the Clinical Genetics team inspired her to be a clinical geneticist. While in medical school, having never wanted to be a surgeon, her deep interest in surgery started to unfold. "One of the surgical registrars, who was pregnant and had a young child whom she was immensely proud of, let me drain an abscess, and it was phenomenal. I was really excited and it changed my mind about surgery."

Dr Roberts says she enjoys working at a public hospital because she can teach registrars. "I'm still close enough to training that I can help them navigate their way and avoid the mistakes I made in my own training. I'll still miss some of the nuances they're facing, but I try to support them as well as I can."

What Dr Roberts likes most about Paediatric Surgery is "... that I'm not just looking after a single patient. I'm caring for a whole family. I'm guiding them through one of the worst things that can happen in a family's life [their child needing surgery] and helping them understand what we're doing and why we're doing it."

A drawback of the specialty, for Dr Roberts, is bringing work stress home. "You never walk away easily. Even when you're not at work, you think about what's happening there, probably more so since I've had my own children."

Dr Roberts' message to new surgeons about the work-life dance is: "Anything is possible, as long as you work out how your support network can help make it happen with you." She suggests getting very organised at home, outsourcing house cleaning , and being prepared to lower standards for a while. "At home, embrace that everything doesn't have to be perfect and nothing has to happen instantly."

> "I'm really proud of recent changes around flexible, inclusive training, and acknowledgement of our lives outside work."

We asked Dr Roberts what advice she'd give to someone considering becoming a surgeon. "Look at surgeons who are about to retire and work out if their job is something you'd be prepared to do—with no sleep if you have a young family, and all the pressures of home. Work out how the job would fit around the rest of your life and what else you want from your life. If you can confidently say you see it all fit, then you should go for it. But if you have any hesitation, think carefully because it's a huge undertaking."

Dr Roberts feels in her element in paediatric surgery and is pleased to see improvements to attitudes around work-life balance in her profession. "I'm really proud of the recent changes around flexible, inclusive training, and acknowledgement of our lives outside work. I feel we've made huge progress in the last 15 years, although I think we still have far to go."

Reading: lots of kids' books, case reports on congenital lung lesions, books on navigating parenting

Listening: parenting and surgical podcasts, online surgical conferences, Phillip Adams on Late Night Live (ABC RN podcast), Adelaide Symphony Orchestra (Dr Roberts was a violinist pre-kids), Play School songs

Watching: nothing, no time for television at this point in my life

Dr Tony Sparnon presented with the Sir Henry Newland Award

Former president Tony Sparnon honoured with a prestigious award

On 22 October 2021, former RACS president Dr Tony Sparnon was presented with the Sir Henry Newland Award, in front of family and friends at the South Australian Annual Dinner.

The award is named after Sir Henry Newland and is awarded in recognition of the extraordinary contribution a surgeon has made to the surgical community in South Australia over a number of years.

Sir Henry is remembered for the extensive and honorary service he provided to the South Australian, Australian, and international surgical communities throughout his lifetime. His accolades include being recognised for his services during WW 1 with the Distinguished Service Order in 1917, and later being appointed CBE in 1919.

Following WW1, Dr Newland was one of the original founders of RACS. He served as the College President from 1929 to 1934, and as Chairman of the RACS State Committee in South Australia from 1939 to 1942. In Sir Henry's honour the award recognises a surgeon who has provided distinguished service to surgery in the state.

Friend and former recipient of the award Mr Glenn McCulloch nominated Dr Sparnon for the award, and provided a citation, which was read out at the dinner. Dr McCulloch described Dr Sparnon as a thoroughly deserving recipient, who embodies all the values the award seeks to recognise.

"Tony has been a longstanding mentor to many—if not all—in the paediatric surgical and burns community in South Australia. His wit, good humour, wisdom and humility in the service of fellow workers , patients and their families have served to set the tenor of the burns unit at the Adelaide Women's and Children's Hospital, and hopefully the effects of this will be felt for many years to come.

"He has been a shining example of how to care and support nursing and medical staff from the most junior student to fellow colleagues.

"In particular, in the realm of burns surgery, Tony has been a longstanding member of the Australia New Zealand Burns Association and has been involved at all levels of teaching and curriculum development for the association's Emergency Management of Severe Burns course both in Australia and throughout the Asia-Pacific. For this he has been awarded life membership of Australian and New Zealand Burn Association."

Many of the state's paediatric and burns surgery contingent were present at the event. In his acceptance speech, Dr Sparnon described the relationships he had developed throughout his time as a surgeon as the most rewarding aspect of his career.

"My highlights have been the interaction with the Fellowship and in particular my paediatric surgical colleagues, the members of the Burns team, and all the diverse Fellows and leaders from all specialties.

"This has been true throughout my career and was particularly evident early last year in my time as President, when I was so proud of how our profession came together as one during difficult times early in the COVID-19 pandemic."

Throughout his time on Council and during his tenure as president, Dr Sparnon was a strong advocate for diversity and inclusion in surgery. He particularly championed issues such as parental leave entitlements for Trainees and the removal of gendered titles in surgery.

Dr Sparnon encouraged others to never lose sight of the enormous honour that is bestowed on surgeons upon receipt of their Fellowship, and to always ensure that surgery reflects the communities in which they serve.

"When we receive the FRACS we inherit a level of public trust due to the enduring values of generations of surgeons who have preceded us. We must continue to earn this trust by ensuring RACS has a culture, which is inclusive, diverse with gender equity and has zero tolerance to harassment, bullying and racism."

The presentation of the Sir Henry Newland award was the final part of a highly successful dinner, which was held at the National Wine Centre. Another highlight from the evening was the annual Anstey Giles lecture, which was delivered by the 2020 Australian of the Year, ophthalmologist Dr James Muecke.

In his speech Dr Muecke provided an enlightening and somewhat confronting insight into the growing worldwide epidemic that is Type 2 diabetes, and the toxic impact that sugar and unrefined carbohydrates are having on our health and the world.

The RP Jepson Medal and Justin Miller prize papers were held at the South Australia State Office, with the winners announced later in the evening during the dinner. Congratulations to Dr Ravi

Vissapragada, who won the Justin Miller Prize for his presentation *Cost-utility analysis of limiting endoscopic surveillance to long-segment non-dysplastic Barrett's oesophagus*. Congratulations also to Dr Ahmed Bassiouni, who won the RP Jepson Medal for his presentation *The global transcriptomic signature in sinonasal tissues reveals roles for tissue type and chronic rhinosinusitis disease phenotype*.

Work is already underway for preparing next year's annual dinner, which will also be the conference dinner for the South Australia/Western Australia /Northern Territory Annual Scientific Meeting. The event will be held in the stunning surrounds of the Barossa Valley. Stay tuned for more information about the Annual Scientific Meeting, including how to register, in future issues of *Surgical News*.

IMAGES (from left)

Dr Tony Sparnon (left) and RACS South Australia Chair Dr David King; Dr James Muecke (left) and RACS South Australia Chair Dr David King

RACS road trauma advocacy update

RACS has long recognised that road trauma is a serious public health problem of epidemic proportions. Nearly 1,200 people are killed each year on Australian roads, and almost 40,000 are seriously injured. We regularly advocate on issues of road safety, and the last two months has been a busy time for the RACS Trauma Committee. Some of our advocacy efforts include:

Joint Select Committee on Road Safety

In August, RACS made a submission to the Australian Parliament's Joint Select Committee on road safety. Following this, members of the Trauma Committee were invited to provide evidence to the joint committee at a public hearing on 7 October.

At the hearing, the Trauma Committee members advocated for:

- improved data reporting
- Australia-wide adoption of 30 km/h speed limits for schools and high pedestrian activity zones
- point to point speed cameras for all vehicles.

A recording of the hearing is available on the Australian Parliamentary website (https://bit.ly/3CX6p5K).

WHO kicks off a decade of action for Road Safety

In August 2020, the UN General Assembly adopted resolution 74/299 (https://undocs.org/en/A/RES/74/299) *Improving global road safety*, proclaiming the Decade of Action for Road Safety 2021 – 2030, with the ambitious target of preventing at least 50 per cent of road traffic deaths and injuries by 2030.

Following this the WHO and the UN Regional Commissions, in cooperation with other partners in the UN Road Safety Collaboration, began developing a plan of action for the decade for consideration by member states and other stakeholders.

RACS wrote to the Australian Deputy Prime Minister, the Hon. Barnaby Joyce and the Health Minister, the Hon. Greg Hunt. Our letters endorsed the WHO/UN Global Plan and encouraged the government to commit to implementing the recommendations of the plan.

The letters are available on the RACS website. The 2021 – 2030 plan and announcement of the plan are both available on the WHO website: https://bit.ly/3HS2Wc1

South Australian Road Safety Strategy to 2031

The South Australian State Committee and the State Trauma Committee recently co-signed a submission in response to the government's draft South *Australian Road Safety Strategy to 2031*.

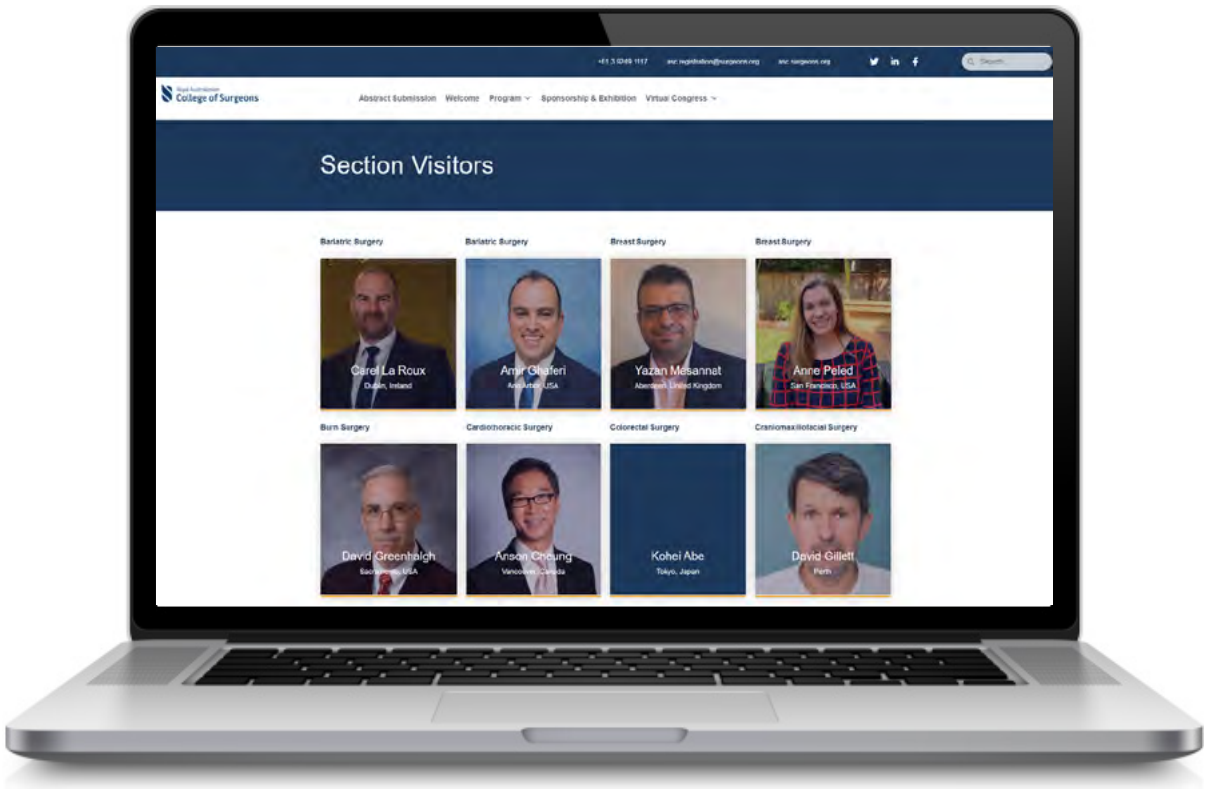
This was the second time the South Australia government has consulted on the draft strategy, and RACS submission reiterated the points that we made in our initial submission earlier this year. The College's response is available on the RACS website.

RACS ASC 2022

Monday 2 May to Friday 6 May

Brisbane Convention & Exhibition Centre
Brisbane, Queensland, Australia

Sustainability in the Dispersed Workplace



The asc.surgeons.org website has had an upgrade. Visit the website to view information about abstract submissions, registration, program updates, along with viewing all of our invited section visitors.

Registrations for the RACS ASC 2022 will open in December 2021.

Royal Australasian College of Surgeons

asc.surgeons.org #RACS22

CALL FOR ABSTRACTS

IMPORTANT DATES

Abstract submission opens	Now open
Closure of abstracts	8:00am Thursday 27 January 2022
Closure of early registration	Sunday 20 March 2022

ABSTRACT SUBMISSION WILL BE ENTIRELY BY ELECTRONIC MEANS.
This is accessed from the Annual Scientific Congress website by clicking on Abstract Submission.

Please ensure that you indicate on the abstract submission site whether you wish to be considered for the following paper prizes:

BEST RESEARCH PAPER PRIZE

- Bariatric Surgery
- Breast Surgery
- Burn Surgery
- Cardiothoracic Surgery
- Colorectal Surgery *(The Mark Killingback Research Paper Prize for Younger Fellows & Trainees)*
- Craniomaxillofacial Surgery
- Endocrine Surgery *(The Tom Reeve Paper Prize – Trainees)*
- General Surgery
- Global Health
- Hand Surgery
- Hepatobiliary Surgery *(The David Fletcher Research Paper Prize)*
- Indigenous Health
- Military Surgery
- Orthopaedic Surgery
- Otolaryngology Head & Neck Surgery
- Paediatric Surgery
- Pain Medicine & Surgery
- Rural Surgery
- Surgical Oncology
- Transplantation Surgery
- Trauma Surgery *(The Damian McMahon Research Paper Prize for Trainees)*
- Upper GI Surgery *(The Mark Smithers Research Paper Prize)*
- Vascular Surgery

BEST NON-CLINICAL PAPER PRIZE

- ANZ Chapter of the ACS Scientific Forum *(Best Paper Prize)*
- Bariatric Hepatobiliary and Upper GI Surgery: The Les Nathanson Translational Research Prize *(For research that has been conducted as part of a higher degree and relates to the fields of HPB, UGI or Bariatric Surgery)*
- Endocrine Surgery *(The Best Basic Science Paper Prize)*
- Medico-legal
- Quality and Safety in Surgical Practice
- Surgical Directors
- Surgical Education
- Surgical History
- Women in Surgery

IMPORTANT INFORMATION

To submit an abstract go to asc.surgeons.org and click on 'Abstract Submission'.
The closing date for all scientific paper abstract submissions is 8:00am Thursday 27 January 2022.

Please note that paper or facsimile copies will not be accepted, nor will abstracts be submitted by College staff on behalf of authors or industry partners.

If there are any difficulties regarding this process please contact Binh Nguyen for assistance.
T: +61 3 9249 1279
E: binh.nguyen@surgeons.org

VISIT ASC.SURGEONS.ORG FOR MORE INFORMATION

Dr Ned Ninnear – 2020 RACS Brendan Dooley and Gordon Trinca Research Scholarship recipient

Dr Ned Kinnear is a urology Trainee and the recipient of the 2020 RACS Brendan Dooley and Gordon Trinca Research Scholarship.

In 2019, Dr Kinnear was part way through his PhD researching different models of emergency surgical care in Australian public hospitals. He was encouraged by his supervisors at the University of Adelaide to apply for the scholarship, which supports research into the prevention and treatment of trauma injuries in Australia and Aotearoa New Zealand.

Supported by the scholarship, Dr Kinnear took leave to focus on research. Key questions were the extent of uptake of the Acute Surgical Unit (ASU) model, staff satisfaction, and the effect on safe working hours. To answer these, Dr Kinnear contacted 120 medium to large Australian public hospital treating emergency surgery and trauma patients, spending eight hours every day for six weeks on the phone.

"There is no national register of how hospitals manage these patients, so there was no data around how popular the ASU model was, what the benefits were, or barriers to implementation. I wanted to capture perspectives from both surgeons and registrars at each hospital," Dr Kinnear said.

> ... there was no data around how popular the ASU model was, what the benefits were, or barriers to implementation

Dr Kinnear discovered that the adoption was higher than expected. "The new ASU model continues to soar in popularity since the first Australian unit started in 2005. Today, more than two thirds of the Australian public hospitals have adopted it or a hybrid model."

Surgeons and registrars working within the ASU model had higher satisfaction, because they felt it delivered better outcomes for patients and staff. It was less disruptive than managing emergency surgery on an ad-hoc basis alongside elective surgery and it reduced the instances where surgical staff worked after-hours or prolonged on-call.

"The ASU model helps to combat exceptionally long shifts and reduce delays to emergency patients, or elective patients being cancelled to accommodate more critical surgeries."

But the ASU model doesn't fit all hospitals, Dr Kinnear said.

"There is a threshold. Justifying an ASU model requires a sufficient number of surgeons and steady intake of emergency cases."

> "Justifying an ASU model requires a sufficient number of surgeons and steady intake of emergency cases."

Dr Kinnear was surprised to discover a connection with the late Dr Dooley and the late Dr Trinca, both of whom helped to introduce legislation to reduce road trauma such as seat belts in cars and helmets for motorcycles.

"I never had the chance to meet Dr Brendan Dooley or Dr Gordon Trinca, but I feel a connection to them," Dr Kinnear said. "I spent a lot of time here in Melbourne with Associate Professor David Webb, who was taught pathology by Gordon Trinca and played golf with Brendan Dooley. David Webb was delighted when he heard I had been awarded the scholarship."

Dr Kinnear reflected on the scholarship and the two surgeons it honours. Their scholarship is helpful in enabling dedicated, passionate research," Dr Kinnear said. "I am so grateful that I was able to devote my full-time attention without the need to work part-time to support myself."

For Dr Kinnear it's important that the legacy of both of Brendan Dooley and Gordon Trinca, who made huge advances in road trauma research, and changes to legislation to improve road safety, are perpetuated. The scholarship helps to encourage focussed research and commemorates the importance of what they both achieved.

Dr Kinnear concluded, "I would like to express my thanks to my supervisors: Associate Professor Tarik Sammour, Dr Christopher Dobbins, Dr James Moore and Dr Derek Hennessey. I feel that with their help and with the assistance of the scholarship, I have contributed useful research to the field. I plan to continue researching because I enjoy it, although maybe with fewer telephone-intensive projects!"

Academy of Surgical Educators year in review

Educational events

Educator Studio Sessions
Educational events at RACS continued to be affected by COVID-19. However, the Academy of Surgical Educators (ASE) Educator Studio Sessions (ESS), continued to grow in popularity in 2021. ASE has conducted nine ESS featuring various presenters, including guest speakers from the Graduate Program presenting on their theses. Our most popular sessions were on Narcissism—with presentations from Dr Riccardo Caniato in March and Dr Bryan Ashman in August. We have had more than 1,000 register for ESS in 2021.

COVID-19 and professional development courses
Due to COVID-19 having a significant impact on PD courses through 2020-21, the Professional Development team took this opportunity to explore the prospects in the online space, and how we could deliver PD courses virtually. In 2021, we piloted several new and revised courses with a commitment to focus more on Supervisors' training.

The *Induction for Surgical Supervisors and Trainers* course is designed to provide Supervisors and SET Trainers with an introduction to their roles and responsibilities, and to support them in providing high-quality education and training to RACS Trainees. The course was launched early 2021 and four courses have been successfully completed.

Keeping Trainees on Track and Difficult Conversations with Underperforming Trainees both underwent review in 2021 and piloted in October-November with positive responses from participants. The Foundation Skills for Surgical Educators (FSSE) course is mandatory and given the restrictions with face-to-face learning, it was decided to offer this online. This makes the course more accessible to regional and remote surgeons. The online course was piloted in October and ran for six weeks.

Our 2022 professional development program is being regularly reviewed, and we are adapting the delivery and schedule of our courses to continue supporting your learning. For more information go to: http://www.surgeons.org/lifelong-learning

Rewards and recognition

Educator of Merit
The Academy recognises the contributions of SET Supervisors/SIMG Supervisors and Facilitators/Instructors via the ASE Recognition Awards. The recipients of the Educators of Merit for 2021 were:

Category: SET Supervisor/SIMG Supervisor of the Year Awards:
- ACT: Dr Christopher Roberts, FRACS
- NSW: Associate Professor Kerin Fielding, FRACS
- NT: Dr Suresh Mahendran, FRACS
- SA: Professor Jeganath Krishnan, FRACS
- VIC: Dr Igor Konstantinov, FRACS
- WA: Dr Wysun Wong, FRACS
- AoNZ: Dr Simon Harper, FRACS
- AoNZ: Dr Marianne Lill, FRACS

(Note: No nominations were received for Tasmania and Queensland)

Category: Facilitator/Instructor of the Year Award
Associate Professor Andrew Kurmis

The Educator of Merit winners will be presented with their awards at the local STANZ office events (where possible). The Academy also recognises the length of service of SET Supervisors, SIMG Supervisors and PD Facilitators through the Educator of Commitment Award. The list of awardees is available in this issue .

Each year the Academy of Surgical Educators recognises a SET Supervisor/SIMG Supervisor of the Year. This is awarded in each state or territory of Australia and New Zealand, where an appropriate candidate has been nominated. Do you have a supervisor you want to recognise? Nominations for 2022 Educator of Merit awards will open in March 2022. More details will be available in the January/February issue of *Surgical News.*

We support supervisors through the Academy of Surgical Educators (ASE). The Academy's purpose is to help support and develop all who are interested in surgical education. Academy membership is open to all supervisors and is free. Find out more at: https://www.surgeons.org/Fellows/for-educators-trainers/academy-of-surgical-educators

IMAGE
Andrew Kurmis receiving award.

Surgical Workforce Census: Key insights

A Surgical Workforce Census is conducted every two years to guide workforce planning and advocacy. The Census collects valuable data on work patterns, wellbeing, and future work intentions for Fellows.

The 2020 Surgical Workforce Census achieved a response rate of 24 per cent (n=1563) and respondents were representative of the wider Fellowship when considering specialty, age ranges, sex, and location. Key insights include:

Work hours and patterns

Full-time Fellows worked an average of 47.1 hours per week in 2020 compared to 50 hours in 2018, 51 hours in 2016, and 53 hours in 2014. This is a small but consistent decrease in average hours worked per week reported over the past six years.

Full-time Fellows would prefer to work on average three hours less per week, with surgeons in the 50-59 years age group reporting the most hours worked per week (Figure 1).

Public and private employment

Fifty three percent of respondents reported working in both public and private practice. During 2020, Fellows in private practice reported working longer hours in consulting work than their public counterparts. Time spent on procedural work was similar, however Fellows in the public sector spent more time on administration. In the public sector, one in 10 Fellows worked more than the recommended emergency on-call period of 1:4.

Private billing

Australian Fellows in private practice were asked what they consider to be a fair professional fee. Almost 30 per cent reported that the AMA fee is about right, with a further 11 per cent reporting that higher than the private health insurance amount, but less than the AMA was fair. This is similar to 2018 results.

Rural and regional practice

Approximately 22 per cent of Australian Fellows reported working solely in rural or regional locations. For Aotearoa New Zealand Fellows, approximately 19 per cent reported only working outside major cities. Fellows who worked in rural or regional locations only reported working on average 43.7 hours per week, slightly less that the overall result of 47.1 hours.

Approximately 13 per cent of respondents engaged in outreach services monthly and six per cent reported working working in outreach services weekly, including both metropolitan and regionally-based Fellows. Most Fellows indicated no intention to change their future work hours in rural or regional settings.

Wellbeing

Administrative regulation and processes continue to rate as a high to extreme source of stress, and in 2020 rated higher than COVID-19. Fellows rated COVID-19 most frequently as a little to moderate source of stress (Figure 2).

Surgeon wellbeing is a RACS priority and it is pleasing to see that most participants (72 per cent) reported having a health check-up in the last two years. The number of Fellows who reported undertaking their own health checks continues to slowly decline (7.6 per cent, down from 8.5 per cent in 2018 and 10 per cent in 2016). Nine percent of Fellows reported seeking professional assistance for stress or mental health issues in the last two years.

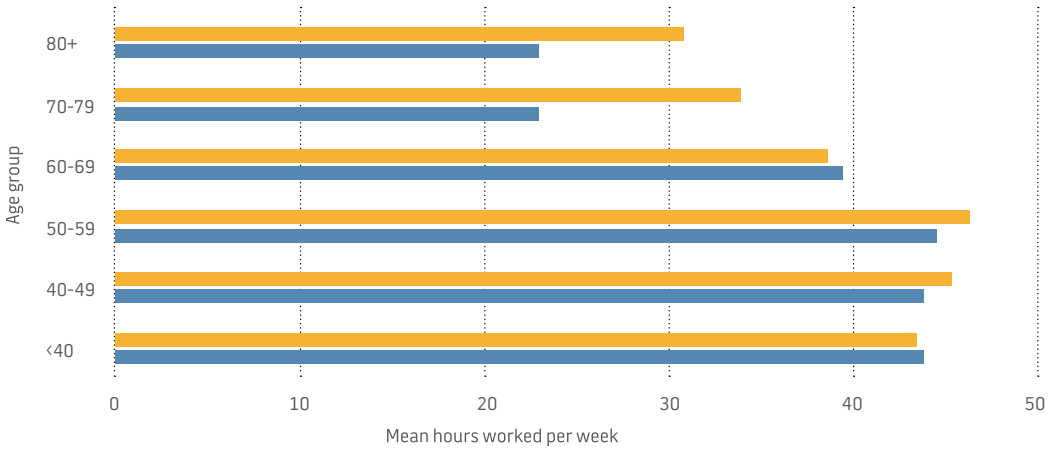


Figure 1: Fellow mean hours worked per week by age group

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; retired Fellows; unemployed or parental leave.

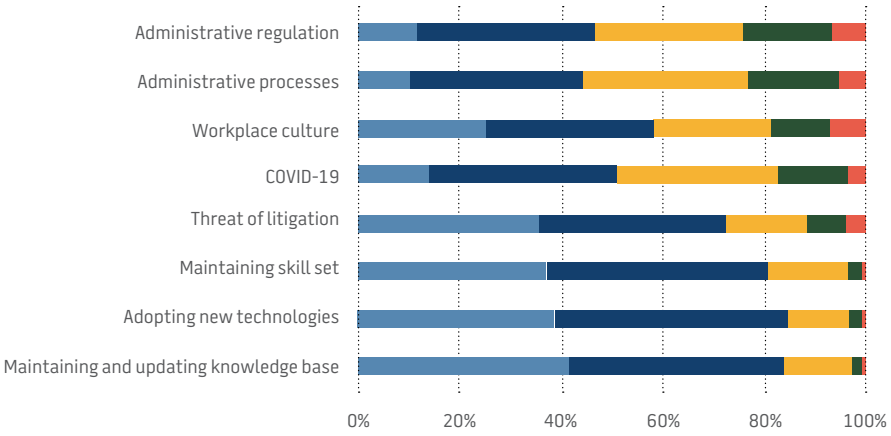


Figure 2: Sources of Fellows' self-rated stress levels

Exclusions: Fellows not currently living in Australia or Aotearoa New Zealand; retired Fellows and Fellows who selected not applicable to me responses.

Future work intentions

Fellows aged between 40 and 69 years intend on reducing their preferred weekly work hours gradually over the next 10 years, with no major differences between female and male Fellows.

More than 40 per cent of Fellows aged 50 years and over plan to retire from all forms of paid work within the next 10 years, a key issue that RACS needs to plan for to meet workforce needs.

Thank you to all Fellows who participated in the Census. The 2020 Surgical Workforce Census Report is available on the Workforce and Activities Reports webpage.

Dr Christine Lai
Chair, Fellowship Services Committee

The power of escapism

OP – LXXI (71)

Escapism has been my salvation during a period of COVID-19 confinement when locked down under the government regulations.

I have an acronym for COVID-19 (I love abbreviations) – Convergence of Various Infectious Dynamics.

And why this word confinement – it is the French word for quarantine. I also communicate regularly with my colleagues—with witticisms and wisecracks—enjoying laughter as much as many coffees. Let us not forget what Mary Poole said, 'He who laughs, lasts'.

Also, my solitude is channelled into the world of cooking besides writing and listening to classical music. And my endogenous hormones Dopamine, Oxytocin, Serotonin and Endorphins dose me up.

Cooking is a marriage of cuisines and cultures and I have explored this to the hilt, thanks to the SBS Food channel usually with Rick Stein. I now make a variety of recipes—bouillabaisse, gazpacho, boeuf en croute—and I leave my former boiled eggs talent for the potato salad.

At our home in Royal Parade, my late wife Mariette was the chef supreme—producing good countryside French cuisine. Once while making a steak Diane she needed cognac. Incidentally, steak Diane came from the mythological Greek figure Diane, the goddess of hunting, and the meat was usually game. In the French sauce tradition, one combines the caramelised base with cream, brandy, Dijon mustard, and Worcestershire sauce. I only had a bottle of Courvoisier cognac, which she used to make the impressive flambé, and what an effect! My subconscious criticism of this extravagance was allayed by her response, “the best food must have the best ingredients”.

While watching the TV cooking shows I have become educated by various chefs, enjoying the ‘look and learn’ process and then emulating them. It occurred to me that this technique should also be adopted in surgical teaching to convey words of wisdom. David Kaufman, an ophthalmologist, is also a firm believer in this concept, and we both tried to get Don Marshall’s expertise recorded for posterity, but he passed on.

Current online tutorials combine PowerPoint and video voiceover to convey the wisdom and experience of the operator. On my return from London in ‘74, I physically shadowed John Hueston’s weekly Dupuytren’s list, watching the expert. Regretfully, the only record is my memory. In my last international lecture in Paris—showing the applications I learnt from John and the development of the modified Keystone principle in Dupuytren’s management—the lead European author discussed John Hueston’s worldwide contribution, a world figure even from the Antipodes. John, also a Francophile, and I became good friends (I am sure it was Mariette’s appeal and not mine) and got to know each other well. One of his final words were, “Felix, I am now retired and can use the scissors for the parsley”. John formerly had the largest plastic surgical practice in Australia—covering oncology, hand and aesthetic surgery.

Rick Stein, my culinary mentor, in his Far Eastern tour recently went to Hanoi and stayed in Graham Greene’s room in the French Hotel Metropole (illustrated). He remarked, that Greene possibly finished his novel, The Man from Havana here and offered verbatim Graham Greene’s quote on escapism – ‘Writing is a form of therapy; and those that do not compose, nor write nor paint are not exposed to this form of escapism to help manage our madness and melancholia’.

Greene was a literary maestro graduating from Oxford, shortlisted for the Nobel Prize, and sub-editor of The Times. His escapism were his novels

The French Hotel Metropole in Hanoi

and if I had not watched the Rick Stein show, I would have missed out on his Vietnamese curry and his vignette on Graham Greene.

Regarding PowerPoint video publishing, a la Rick Stein, this idea was recently adopted by the Australasian Journal of Plastic Surgery, to impart wisdom, knowledge and experience in a video format. It was a Mark Ashton initiative instructing others in the section: ***How I do It***. This teaching style could herald a future hallmark in medical publication.

Recently, I was invited to contribute a chapter in the latest edition of Blondeel’s book on Perforator Flaps. Geoffrey Hallock, a co-author, subsequently commented after my request for a video input, “Felix … video showing how to design and execute this Keystone flap is really the important part. Most millennials want to see how to do it, rather than read where the only image would be what they can fantasise within their own brain ”.

In this final phase of my surgical career doing medico-legal work, I will find time to complete a number of unfinished symphonies for the younger brigade to reveal some tricks of the trade on video with voiceover.

Music is another distraction well phrased by Tolstoy: “Music is another shorthand of emotion.” My conscious hours, including those hours of the insomniac, are bathed in musical harmony. And, let us not forget that tempo in a piece of music with 70bpm

matches our own heart rate and a bond develops. All compositions focus on rhythm, melody and harmony with the tempo accelerating the movement and increasing our enjoyment. Some examples are unrivalled – Albinoni's Adagio in G, the fast tempo of Offenbach's Gaité Parisienne and his Can Can, the multiple high Cs of Pavarotti singing Donazetti's Lucia di Lammermoor, or the The Lark Ascending by Ralph Vaughan Williams (incidentally his daughter was a Radiotherapist with us in London in my Westminster days in the 70s).

Great philosophers also loved music and Albert Schweitzer also said, "I have two means of refuge from this misery of life on earth—my music and my cats". John Cocteau was more practical when he said, "I have a home but the cat is its soul".

I am fortunate to have Mariette's cat Sisi as a memory of times past.

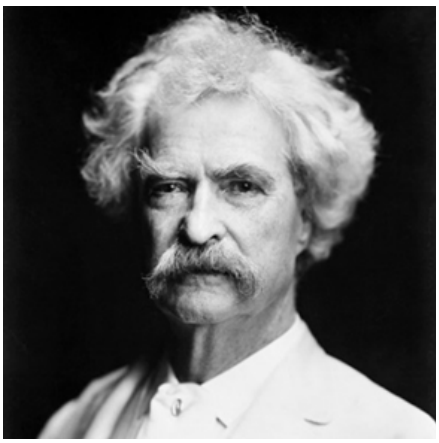
As Graham Greene said, writing is one of the best forms of escapism and I amplify my writings with humour. David Kaufman continues in a similar vein and recently sent me the word – paraprosdokians (yes, I had to look it up). This is a figure of speech but with a twist in the tale (tail).

Dorothy Parker (illustrated), the classic wit of the 20th century, is one of my favourite American writers. Along with Groucho Marx she would play verbal ping pong at lunch regularly at the Algonquin Hotel (illustrated) in New York in the 1920s, knocking the establishment.

Parker once said, "There's a hell of a distance between wise-cracking and wit. Wit has truth in it; wise cracking is simply verbal calisthenics". One of her funniest quotes relates to a

neurosurgical procedure when she said, "I prefer the bottle in front of me rather than the frontal lobotomy". Another one of her quotes about an irritating personality who said, "I cannot bear fools" and Dorothy replied, "Apparently your mother could".

Another favourite author is Mark Twain (illustrated), a pseudonym for Samuel Clemens. He had to write under this nom de plume as a journalist in the deep South where the emotions of the Civil War were still bubbling. Why did he use Twain? It is the 12 feet watermark on the Mississippi steamboat for water depth clearance.



In one of his many erudite synoptic statements on life, Mark Twain said, "Politicians and diapers must be changed often, and for the same reason". He continued, "Never argue with stupid people, they drag you down to their level then 'beat' you with their experience" – of stupidity! Could we have witnessed this in the recent COVID-19 demonstrations about civil rights, transgressions and mandated vaccinations where the anti-vaxxers and the extreme right reflect current trends of flawed thinking and rejecting medical science? However, Twain's quote about newspapers is eminently pertinent, "If you do not read newspapers you are uninformed, if you do read them, you are misinformed". The word misinformation has travelled a long way since the 1890s into the modern day press.

Now for a Papal divergence. On Pope John XXIII's election to the Papacy in 1953, a journalist at his press conference asked, "How many people work at the Vatican?" and the Pope responded,

"About half". Some of his other sayings were, "What unites us, is much greater than what divides us", and the COVID-19 demonstrations are dividing our society—even neglecting the wisdom of medical science and the value of vaccinations. I cannot help referencing the Wakefield articles in ***The Lancet***, retracted in 2010 because of fraudulent and inaccurate scientific publication. This eventually became the genesis of the anti-vax brigade.

So, you can see how I have survived COVID-19, summed up by Vergil in a nutshell:

"We as humans are always dragged along by our distractions."

Associate Professor
Felix Behan

2022 Scholarships and Grants Program

We are immensely proud that RACS is now the second-largest philanthropic funder of surgical research and education worldwide.

This would not be possible without our many Fellows, donors, and sponsors.

In March 2021, Fellows, Trainees, SET applicants, and other health professionals from Australia and Aotearoa New Zealand were encouraged to apply for the 2022 Research Scholarships, valued at more than $2.5 million.

I commend all who applied and encourage those who were unsuccessful in this round to re-apply in 2022. To those who were awarded a scholarship – congratulations! I wish you well with your upcoming scholarship activity and look forward to sharing news of your outcomes with colleagues, donors, and sponsors.

I also wish to thank the ANZSGC and all Fellows and invited expert selection panel members who dedicated considerable time and energy to assessing applications in a thorough and highly competitive selection process.

The success of the Scholarships and Grants program is measured not only from the benefits brought to Fellows, Trainees, SET applicants and other health professionals, but most importantly, from their scholarship and grant outcomes that contribute to the highest levels of surgical care for our patients.

2022 Research Scholarship Recipients
Scholarship tenure is one year unless otherwise indicated.

John Mitchell Crouch Fellowship

Value: $150,000

Associate Professor Carlo Pulitano (NSW)

Specialty: General Surgery

Associate Professor Carlo Pulitano is an academic general and transplant surgeon based in Sydney. He intends to develop a normothermic liver perfusion system that autoregulates multiple core physiological functions. He also intends to investigate prolonged ex-vivo perfusion—a platform for reconditioning poor-quality livers.

Senior Lecturer Fellowship

Value: $132,000 per annum including 50 per cent procured externally
Tenure: Up to two years

Dr Kheng-Seong Ng (NSW)

Speciality: General Surgery

Topic: Health service utilisation and outcomes of patients with non-malignant colorectal disease: Exploring the role of virtual healthcare to improve patient outcomes

Tour de Cure Cancer Research Scholarship

Value: $100,000 per annum

Dr Tony Pang (NSW)

Speciality: General Surgery

Topic: Development of an ex vivo vascularised organoid model of pancreatic cancer metastasis

John Loewenthal Project Grant

Value: $100,000 per annum
Tenure: Up to two years

Professor Jonathan Clark (NSW)

Specialty: Otolaryngology, Head and Neck Surgery

Topic: Craniomaxillofacial Prosthetic and Advanced Reconstructive Translation Surgery (CMF-PARTS)

James Ramsay Project Grant

Value: $88,000 per annum
Tenure: Up to two years

Dr Simon Tsao (VIC)

Specialty: General Surgery

Topic: Portable circulating tumour cell analysis for personalised breast cancer care

Surgeon Scientist Scholarship

Value: $77,000 per annum
Tenure: Up to three years

Dr Lachlan Batty (VIC)

Speciality: Orthopaedic Surgery

Topic: Biochemical predictors of osteoarthritis following anterior cruciate ligament reconstruction

Margorie Hooper Scholarship

Value: $75,000

Dr Nicholas Smith (SA)

Specialty: Plastic and Reconstructive Surgery

Funding to undertake hand and wrist Fellowship program with Dr Jeff Ecker in Perth, WA

Catherine Marie Enright Kelly Memorial Research Scholarship

Value: $66,000

Dr Angus Hann (QLD)

Speciality: General Surgery

Topic: Exploring the hepatic niche, which promotes survival, function, and retention of infused regulatory T cells in human liver allografts

Eric Bishop Research Scholarship

Value: $66,000

Dr Krishanth Naidu (ACT)

Speciality: General Surgery

Topic: Computed tomography assessment of residual vascular pedicle length following colon and rectal cancer surgery: A marker of extent of lymphadenectomy and surgical quality?

Foundation for Surgery Research Fellowship

Value: $66,000 per annum
Tenure: Up to three years

Dr Joseph Kong (VIC)

Speciality: General Surgery

Topic: Novel therapeutic precision analysis in advanced and recurrent rectal cancers

Foundation for Surgery Research Scholarship

Value: $66,000

Dr Yi Ma (VIC)

Specialty: General Surgery

Topic: Determining the antitumoral effect of cannabinoids on pancreatic ductal adenocarcinoma through cell-line and murine models

Herbert and Gloria Kees Research Scholarship

Value: $66,000

Dr Adam Frankel (QLD)

Speciality: General Surgery

Topic: Understanding and improving the surgical care of special patient cohorts with gastro-oesophageal reflux disease

Dr Amanda Nikolic (VIC)

Speciality: General Surgery

Topic: Do synbiotics reduce infections in foregut surgery? A randomised controlled trial.

MAIC-RACS Trauma Research Scholarship

Value: $66,000

Dr Noha Ferrah (VIC)

Speciality: General Surgery

Topic: Management and models of care of older trauma patients

New Zealand Research Scholarship

Value: $66,000

Dr Sean Seo (NZ)

Specialty: General

Topic: Body surface mapping of colon. Development and validation of a tool for assessment of colonic function and recovery.

Paul Mackay Bolton Scholarship for Cancer Research

Value: $66,000 per annum
Tenure: Up to two years

Dr David Liu (VIC)

Speciality: General Surgery

Topic: Survival and Patterns of Care in the Era of FLOT-based chemotherapy for gastric cancer (SPACE-FLOT): An international multicentre cohort study

Dr Tamara Vu (VIC)

Speciality: General Surgery

Topic: Radio-labelled Girentuximab as a theranostic agent in metastatic colorectal cancer

Peter King Research Scholarship

Value: $66,000

Dr Yiu Ming Ho (QLD)

Specialty: General Surgery

Topic: The cost of colonoscopy surveillance: a Queensland study

Reg Worcester Research Scholarship

Value: $66,000
Tenure: Up to three years

Dr Leonard Shan (VIC)

Speciality: Vascular Surgery

Topic: The patient-reported outcomes and economic evaluation of arterial vascular surgery – The case in chronic limb-threatening ischaemia

Sir Roy McCaughey Surgical Fellowship

Value: $66,000
Tenure: Up to three years

Dr Leonard Shan (VIC)

Speciality: Vascular Surgery

Dr Sam Emmanuel (NSW)

Speciality: Cardiothoracic Surgery

Topic: The importance of pulsatility in modern mechanical circulatory support devices

Ian and Ruth Gough Surgical Education Scholarship

Value: $15,000

Dr Jessica Ng (QLD)

Specialty: General Surgery

Topic: Improving the effectiveness of laparoscopic simulation training in surgical registrars

Brendan Dooley/Gordon Trinca Trauma Research Scholarship

Value: $14,000

Associate Professor Jeremy Hsu (NSW)

Specialty: General Surgery

Topic: Mixed reality technique to identify fractured ribs in Surgical Stabilisation of Rib Fractures (SSRF) with HololensTM – a feasibility study

Academy of Surgical Educators Research Scholarship

Value: $10,000

Dr Tracey Barnes (NZ)

Specialty: General Surgery

Project: An innovative approach to providing operating theatre experience for clinical medical students in a contactless environment

Small Project Grant

Value: $10,000

Dr Sina Babazadeh (VIC)

Specialty: Orthopaedic Surgery

Project: Improving the diagnosis and management of prosthetic joint infections

Dr Daniel Cox (VIC)

Specialty: General Surgery

Project: Determining the contributors of plasma mitochondrial-derived cell-free DNA in patients following liver transplantation and their effects on outcomes

Dr James Dimou (VIC)

Specialty: Neurosurgery

Project: Development of a brain tumour organoid biobank for individually tailoring therapeutic targeting in newly diagnosed and recurrent glioblastoma

Dr Weranja Ranasinghe (NSW)

Specialty: Urology

Project: Development of targeted therapy for ductal prostate cancer metastases

Applications for RACS Scholarships and Grants Program's 2023 Research Scholarships round open in March 2022.

Please visit https://bit.ly/3p1U9fo to read about the Scholarships and Grants Program and view scholarships and grants.

Dr Sarah Coll
Chair
ANZSGC

Royal Australasian College of Surgeons
Foundation for Surgery

What will your legacy be?

The health and wellbeing of future generations depends on the research and training we do now. Thanks to you, over the past 40 years, the Foundation for Surgery has helped fund some of the most exciting research conducted in Australia and New Zealand.

But we still have a long way to go and it will take more than just one lifetime.

Each of us find different ways to leave our mark on the world. A Legacy Fund is a gift that will always be remembered.

There are two very special ways you can leave an ongoing legacy through the Foundation for Surgery:

1. **Leave a bequest** - of any size - to make an extraordinary difference, change lives and advance your area of passion or specialty.

2. **Establish your own named perpetual scholarship** – you can establish your own scholarship to change lives and see the results of your philanthropy in your lifetime.

If you are considering your legacy, the Foundation for Surgery team would love to hear from you. Please contact them on +61 3 9249 1110 or foundation@surgeons.org today.

Summer shopping made breezy.

Summer is here, and that means more time outdoors, more time with family and friends... maybe even a fresh new wardrobe to take you there! And with Christmas just around the corner, now is the time to flex your Member Advantage to save time and money on trusted brands:

- Save on summer shopping with eGift Cards from MYER, BCF, Freedom Furniture, Dymocks, Sephora and many more
- Refresh your home with commercial pricing at The Good Guys
- Shop new season style with coupon discounts for a wide range of fashion, leisure and lifestyle brands
- Celebrate and save at over 10,000 pubs and bars
- Keep the family entertained with discounted movie tickets, theme park entry and attractions

Plus so much more! Login today and make summer shopping a breeze!

Visit your member benefits area on the Surgeons Website and click Member Advantage to start using your benefits.

For more information:
racsau@memberadvantage.com.au
1300 853 352

Royal Australasian College of Surgeons

Member Advantage

Appreciating our educators

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

EDUCATORS WHO HAVE SERVED NINE YEARS

SET Supervisor
Dr Ollapallil Jacob
Dr David Koong
Assoc Prof Vincent Lam
Dr Hugh Lukins
Dr Sarah Martin
Dr Quentin Ralph
Dr Michael Chin
Dr Francesco Piscioneri
Dr Renata Bazina
Dr Henry Dowson
Assoc Prof Frank Miller
Dr Michael Edger
Dr Stephen Pearson
Prof Stephen O'Leary
Dr Ian Jacobson
Dr David Pohl
Dr Michel Neeff
Dr Simon Dempsey
Dr Scott Ferris
Dr Elias Moisidis
Dr John Preston
Dr Jonathan Masters
Dr Graham Coombes
Dr Ravi Huilgol
Dr Mathew Sebastian

SIMG Supervisor
Prof Ruurd Jaarsma

EDUCATORS WHO HAVE SERVED SIX YEARS

SET Supervisor
Dr Yishay Orr
Dr Sheen Peeceeyen
Dr Sean Galvin
Assoc Prof Navin Niles
Dr Christos Apostolou
Dr Grace Lim
Prof Richard Turner
Dr Christian Sutherland
Dr Julian Choi
Dr Corinne Ooi
Dr Sanjeeva Kariyawasam
Dr Susan Taylor
Dr Peter Stiven
Dr Jeremy Rossaak
Dr Jane Strang
Dr Mark Dexter
Dr Jacob Fairhall
Dr Simon John
Dr Ananthababu Sadasivan
Dr Timothy Makeham
Dr Piera Taylor
Dr Faruque Riffat
Dr Brent McMonagle
Dr Halil Ozdemir
Dr David Hall
Dr Angus Alexander
Dr Shane O'Neill
Dr Michael McCleave
Dr Cheng Lo
Dr Terrence Creagh
Assoc Prof Peter Chin
Dr Kevin Bax
Dr Mischel Neill
Dr Philippe Wolanski
Dr Jen San (Jason) Lee
Dr Rohan Hall
Dr Kathryn McLeod

PD Facilitator
Dr Marion Andrew
Dr Adrian Anthony

Dr Rex (Hin) Chan
Dr Gowan Creamer
Dr Andrew Malcolm
Dr Phil Morreau
Dr Ros Pochin

SIMG Supervisor
Dr Patrick Bade

EDUCATORS WHO HAVE SERVED THREE YEARS

SET Supervisor
Dr Christopher Cole
Dr Pankaj Saxena
Dr Johannes Stroebel
Dr Keshav Bhattarai
Dr Igor Konstantinov
Dr Eric Slimani
Dr Saad Al Mahaidi
Dr Anubhav Mittal
Dr Christopher Lehane
Dr Michael Donovan
Dr Pranavan Palamuthusingam
Dr Angela Robson
Dr Peter Hodgkinson
Dr James Roberts
Dr Robert Pucius
Dr Chon Hann Liew
Dr Sarah Abbott
Dr James Tietjens
Dr Alexander Lengyel
Dr Amal Abou-Hamden
Dr Neil ThoDron
Assoc Prof Nirmal Patel
Dr Graeme Crossland
Dr Paul Paddle
Dr Richard Kennedy
Dr Stewart Lee
Dr Darin Bilish
Dr Roy Craig
Dr Lyndon Bradley
Dr Salil Pandit
Dr Pierre Navarre
Dr Carolyn Russell
Dr John Atkinson
Dr Zet-Sheng (Michael) Ee
Assoc Prof Sebastian King
Dr Michael Kernohan
Dr Paul Belt
Dr Alexandra Turner
Dr Jonathan Heather
Dr Fiona Smithers
Dr Mohan Arianayagam
Dr Clair Whelan
Dr Michael Holmes
Dr Johannes Goosen
Dr Daniel Lenaghan
Dr Alister Jones
Dr Jill O'Donnell
Dr Carsen Ritter

PD Facilitator
Assoc Prof Andrew Davidson
Dr Mark Hamilton
Dr Joseph Lizzio
Dr Andrew Luck
Dr Juanita Muller
Dr Stuart Philip

SIMG Supervisor
Dr Henry Duncan

Dr Peter Woodland
Dr Isolde Hertess
Assoc Prof Gary Morgan
Assoc Prof Christopher Young
Dr Anthony McDonald
Dr Andrew Mitchell
Dr Brendan Mooney
Dr Harsh Kanhere
Dr Benjamin Parkinson

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

Royal Australasian College of Surgeons
Foundation for Surgery

Thank you for your extraordinary compassion and generous support to the Foundation for Surgery in October and November.

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

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

Gold

Dr Richard Jonas

Silver

Dr Rupert Atkinson
Dr Harvey Coates
Dr Peter Dryburgh
Dr Hamish Foster
Dr Bruce French
Dr Daniel Goldbloom
Dr Sanjay Kalgutkar
Dr Fred Leditschke
Dr Gregory Mitchell
Prof Julian Smith
Dr Gregory Witherow
Dr Ivan Yaksich

Bronze

Dr Jacqueline Allen
Dr Vinna An
Dr David Anderson
Dr Hari Priya Bandi
Mr Laszlo Borbely
Dr John Boulas
Dr Peter Boys
Dr Graeme Brazenor
Dr Ingra Bringmann
Dr Timothy Brown
Assoc Prof Anthony Buzzard
Assoc Prof Richard Cade
Dr Venu Chalasani
Dr Carolyn Chew
Prof Ronald Chin
Dr Yvonne Chow
Prof Jonathan Clark
Dr Graeme Clarke
Dr Andrew Clout
Dr David Colledge
Dr Raymond Cook
Dr David Cottier
Dr Richard Coutts
Dr John Cox
Dr Ian Curley
Dr Edwin Dorman
Dr Mark Doudle
Mr Gregory Eckersleey
Dr Kirsten Finucane
Dr Philip Fisher
Dr David Flint
Dr Wallace Foster
Dr Harry Frydenberg
Dr Shanu Gambhir
Dr John Groome
Dr Dennis Gyomber
Dr Reema Hadi
Dr Terence Hammond
Dr John Harris
Dr Timothy Heath
Dr Hayley Herbert
Prof Andrew Holland
Dr Matthew Hope
Prof Anthony House
Dr Kevin Huang
Prof David Hunter-Smith
Dr Scott Ingram
Dr Corinne Jones
Dr Craig Jurisevic
Dr Stuart Kennedy
Assoc Prof Sebastian King
Dr Sally Langley
Dr Matthew Lawrence
Dr Tristan Leech
Dr Scott Leslie
Mr K Lever
Mr Tony Lewis
Dr David Lieu
Dr Peter Loder
Dr Timothy Love
Dr Patricia MacFarlane
Dr Ravi Mahajani
Dr Richard Masters
Dr Mary McCaskill
Dr Samuel McGinness
Dr Lorcan McGonagle
Dr Richard McMullin
Dr Peter Mutch
Dr Mark Newman
Ms Nancy Odgers
Dr Olubukola Oloruntoba
Dr Sarah Olson
Dr Anthony Parker
Dr Bruce Peat
Dr Trung Pham
Dr Allan Pollack
Dr Angelo Preketes
Dr Morgan Prince
Dr Harald Puhalla
Ds Tam Quinn
Assoc Prof Prem Rashid
Dr Ian Rebello
Dr Hayder Ridha
Dr Francis Robertson
Dr James Roberts-Thomson
Dr Naveen Salutagi
Dr Anaimattam Santhanam
Dr Philip Sharp
Dr Sean Stevens
Dr Siew-Piau Tan
Dr Richard Theile
Dr Francis Tomlinson
Mr Simon Tratt
Prof Owen Ung
The Victorian Urological Nurses Society
Dr Sindy Vrancic
Dr Roger Wale
Dr Stephanie Weidlich
Mr Gerard Wilkinson
Dr Anthony Wilson
Prof Henry Woo
Assoc Prof Gavin Wright

Anonymous Donors

We wish to acknowledge and thank the two Gold, four Silver and 12 Bronze anonymous donors for their incredible generosity and support.

Your support has helped us improve and work harder than ever to increase access to safe surgical care, now and into the future.

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

100% of your donation assists in addressing critical surgical need

REGISTERED CHARITY

Tailored Medical Indemnity Insurance for Specialists

Scan Me

New customer offer
2 months free

Call **1300 834 683** Visit **tego.com.au** Email **clientsupport@tego.com.au**