SurgicalNews

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Royal Australasian College of Surgeons

Leadership team

Spotlight on

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Illustration by Ness Flett

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President's perspective

On 10 September we celebrated R U OK? Day. The profile of this day has progressively grown, but this year it was more important than ever, following all that has occurred in 2020.

Although R U OK? Day has passed for another year, the importance of the message remains. Looking after ourselves and our colleagues is essential for our health and wellbeing. If you feel like something's not quite the same with someone you know, trust your instincts and take the time to ask them, 'Are you OK?'

I would like to take this opportunity to remind you of the assistance that the Royal Australasian College of Surgeons (RACS) offers to its members. The RACS Support Program delivered by Converge International is available to all Fellows, Trainees, Specialist International Medical Graduates, Global Health volunteers and our immediate families. The service offers up to four free sessions a year and provides confidential support and counselling for any work or personal issues. To find out more, go to surgeons.org and click 'About' in the header, then the 'Surgeons' Wellbeing' tile.

The surgeons' wellbeing webpage has practical tips, advice and resources for taking care of our mental and physical health. This page also has links and contact details for various external support agencies.

Many of us have hobbies that we use to aid our personal wellbeing, and I know that art is a particularly important pursuit for many of our members.

On that note, I am very excited that plans are now well underway for the 2021 Annual Scientific Congress (ASC), which is based on the theme 'Celebrating the Art of Surgery – in a Time of Disruption.'

We are pleased that the Royal College of Surgeons of Edinburgh will join as co-host, and I would like to extend a warm welcome to you all to join us.

The ASC, which will be centred in Melbourne from 10-14 May 2021, is the largest multi-disciplinary surgical meeting held in the southern hemisphere. We usually have more than 2500 participants attending the Congress, but this may not be possible in 2021.

In order to keep the wellbeing of all attendees at the centre of everything we do, we are planning to run the Congress in a hybrid format, with virtual activities and events together and also a physical event in Melbourne, and other places around the country.

May 2021 is a long way away, and there is nothing more I'd like than to have you gathering in Melbourne in person. If that is not possible, I look forward to you joining us virtually. We will be sharing more information with you soon, so please look out for our call for registration and submission of abstracts. In the meantime, save the dates of 10-14 May 2021 in your diary.

In other news, I was very pleased by the goodwill and fellowship demonstrated at a meeting with the Australian Deputy Chief Medical Officer (DCMO), Dr Nick Coatsworth, and surgical specialty society presidents and representatives.

During the productive discussion, concerns were raised about a range of issues related to personal protective equipment (PPE); the inadequate availability of PPE, particularly in the private setting; the timeliness of PPE supply; the widespread variation in the type and quality of PPE; and the fitting of masks to ensure an appropriate seal.

The DCMO assured us that the Commonwealth Government was aware of these concerns and is working to ensure we have onshore production. He noted that the long-awaited local manufacturing of masks would alleviate many of the problems of insufficient variety of N95 masks and should allow more certainty in the future.

We also discussed the need for a more comprehensive approach to determining elective surgery categories beyond the simplistic three-category system, which is commonly used. The DCMO was very receptive to an alternative approach and I acknowledge the work that the Australian Society of Plastic Surgeons and the Victorian chairs of specialty societies and Colleges are doing in developing a fairer process, which RACS will be advocating to the state authorities.

I am pleased to report that RACS has been invited to be a member of the National COVID-19 Clinical Evidence Taskforce, the group of peak health professional bodies across Australia, whose members provide clinical care to people with COVID-19.

This is particularly important as the Australian Health Minister has announced a new partnership between the Infection Control Expert Group (ICEG) and the National COVID-19 Clinical Evidence Taskforce to ensure a safer environment for physicians, surgeons, Trainees and other health workers. The partnership will bring together leading experts in infectious diseases and infection control, and a range of other specialists to review the high volume of emerging evidence and develop key recommendations for clinical settings. It will provide up-to-date advice about the rapidly changing evidence base and its implementation on the ground in the health and aged-care settings are ongoing challenges during the COVID-19 pandemic.

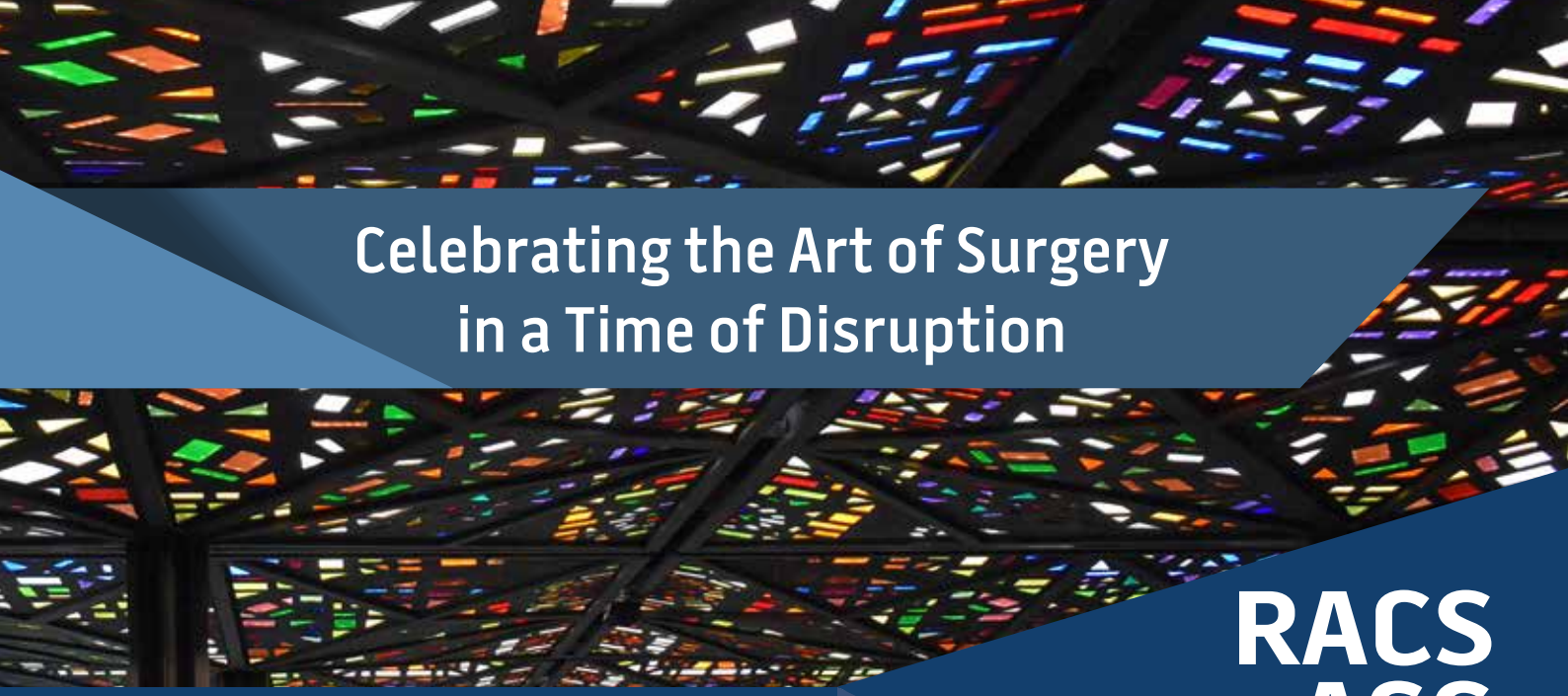
In a joint statement with the Royal Australasian College of Physicians (RACP), RACS has welcomed these additional measures from the Commonwealth to improve the safety of healthcare workers.

Thank you to everyone who took the time to complete the RACS telehealth survey. We received 690 responses from surgeons, which provided us with high-quality data. This will be vital in guiding our advocacy efforts and representations to government on this issue. Professor Mark Frydenberg, who chairs our newly formed Sustainability in Health Care Working Group, has written an article on page 11 in this edition with more information about the survey results.

Lastly, I was delighted to recently attend an award ceremony for one of my South Australian colleagues, Dr Michelle Lodge. Despite COVID-19 restrictions limiting numbers, it was lovely to be able to gather in person and to see Dr Lodge honoured with the RACS Outstanding Service to the Community Award.

Michelle has done remarkable work in advancing the treatment of children suffering complications of meningococcal sepsis (more information is provided on page 43). It is these sorts of contributions to our community, which I know are made by many Fellows across Australia and New Zealand, that makes me so proud to be part of our profession and this College. ■

Mr Tony Sparnon
President



Celebrating the Art of Surgery in a Time of Disruption

RACS ASC 2021

RACS 89TH ANNUAL SCIENTIFIC CONGRESS

IN COLLABORATION WITH THE ROYAL COLLEGE OF SURGEONS OF EDINBURGH

Monday 10 May to Friday 14 May 2021
Melbourne Convention and Exhibition Centre
Melbourne, Australia

ABSTRACT SUBMISSION

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 Tuesday 26 January 2021.

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

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

SCIENTIFIC POSTERS

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

Royal Australasian College of Surgeons

IN COLLABORATION WITH
THE ROYAL COLLEGE OF SURGEONS OF EDINBURGH

IMPORTANT DATES

Abstract submissions open	October 2020
Closure of abstracts	Tuesday 26 January 2021
Closure of early registration	Sunday 14 March 2021

#RACS21 asc.surgeons.org

ABSTRACT SUBMISSION WILL BE ENTIRELY BY ELECTRONIC MEANS

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

Several points require emphasis:

1. Authors of research papers who wish to have their abstracts considered for inclusion in the scientific programs at the Annual Scientific Congress must submit their abstract electronically via the Congress website having regard to the closing dates in the call for abstracts, the provisional program and on the abstract submission site. **Abstracts submitted after the closing date will not be considered.**
2. The title should be brief and explicit.
3. Research papers should follow the format: Purpose, Method, Results and Conclusion. Non-scientific papers, for example, Education, History, Military, Medico-legal, may understandably depart from the above.
4. Excluding title, authors (full given first name and family name) and institution, the abstract must not exceed 1750 characters and spaces (approximately 250 words). In Microsoft Word, this count can be determined from the 'Review' menu. Any references must be included in this allowance. If you exceed this limit, the excess text will NOT appear in the Australian and New Zealand Journal of Surgery.
5. Abbreviations should be used only for common terms. For uncommon terms, the abbreviation should be given in brackets after the first full use of the word.
6. Presentations (slide and video) will only have electronic PowerPoint support. Audio visual instructions will be included in correspondence sent to all successful authors.
7. Authors submitting research papers have a choice of two sections under which their abstract can be considered. Submissions are invited to any of the specialties or special interest groups participating in the program except cross-discipline.
8. A 50-word CV is required from each presenter to facilitate their introduction by the Chair.
9. The timing (presentation and discussion) of all papers is at the discretion of each Section Convener. Notification of the timing of presentations will appear in correspondence sent to all successful authors.
10. Tables, diagrams, graphs, etc CANNOT be accepted in the abstract submission. This is due to the limitations of the computer software program.
11. Authors must be registrants at the Congress to present, and for their abstract to appear in the publications, on the website or the Virtual Congress.
12. Please ensure you indicate on the abstract submission site whether you wish to be considered for:

BEST RESEARCH PAPER PRIZE *(Correct at time of release.)*

- Bariatric Surgery
- Breast Surgery
- Burn Surgery
- Cardiothoracic Surgery
- Colorectal Surgery (The Mark Killingback Prize for the best paper from a Trainee or Fellow within five years of gaining the FRACS)
- Craniomaxillofacial Surgery
- Endocrine Surgery (The Tom Reeve Paper Prize – Trainees)
- General Surgery
- Global Health
- Hand Surgery
- Hepatobiliary Surgery
- Medico-Legal
- Military Surgery
- Neurosurgery
- Orthopaedic Surgery
- Otolaryngology Head & Neck Surgery
- Paediatric Surgery
- Pain Medicine & Surgery
- Plastic & Reconstructive Surgery
- Quality and Safety in Surgical Practice
- Rural Surgery
- Surgical Directors
- Surgical Education
- Surgical History
- Surgical Oncology
- Transplantation Surgery
- Trauma Surgery (The Damian McMahon Prize for Trainees)
- Upper GI Surgery
- Urology
- Vascular Surgery

The submitting author of an abstract will **ALWAYS** receive email confirmation of receipt of the abstract into the submission site.

If you do not receive a confirmation email within 24 hours it may mean the abstract has not been received.

In this circumstance, please email Binh Nguyen at the Royal Australasian College of Surgeons to determine why a confirmation email has not been received.

E: binh.nguyen@surgeons.org

Planning for 2021 ASC powers on

Celebrating the Art of Surgery – in a Time of Disruption

As we in Victoria grind our way towards the end of 2020, we have good news to report on progress towards the Annual Scientific Congress (ASC) 2021 in Melbourne with the theme, 'Celebrating the Art of Surgery – in a Time of Disruption'. The change of theme will allow us to reflect on the events of the year: How well have we responded to the pandemic, what changes need to be made to our health systems as a result, and how do we deal with the concomitant challenges?

We are excited to announce that Professor Brendan Murphy has agreed to deliver the 2021 Syme Oration in Melbourne. The Oration is designed to welcome and provide inspiration to new Fellows as they prepare for practice. As Australia's immediate past chief medical officer, Professor Murphy will, no doubt, have many insights into the pandemic response, and offer advice on how we, as surgeons, can think about our working lives in the context of public health.

The Council plenary will be another highlight of the 2021 Congress. COVID-19 has altered many aspects of our society. The plenary, titled 'The Art of Communication in a Crisis', will demonstrate what our leaders have learnt from this pandemic. We have invited an impressive array of speakers, including our Treasurer, the Hon. Josh Frydenberg and Professor Mike Griffin, representing the Royal College of Surgeons of Edinburgh. Professor Griffin will also deliver the President's Lecture and will speak on the experience of COVID-19 in the United Kingdom.

In addition to impressive educational programs and inspirational speakers at the ASC, you told us that meeting and networking with friends and colleagues is the highlight, so we are planning to maximise the opportunities to mingle. While we remain unsure of the extent to which we will be constrained in May next year (and safety and wellbeing will be paramount), we plan to present the Congress in a hybrid format with a physical component to proceed in Melbourne. For New Zealand and interstate members of the RACS, you can register to attend the ASC at an interstate or regional hub.

Our New Zealand and state committees, along with management teams, are working hard to build prospects for Fellows, Trainees and Specialist International Medical Graduates to attend the ASC closer to home. As with the standard ASC, you can select and tailor your attendance from a wide range of specific programs or sessions of interest. Our gracious international faculty will participate live, or with pre-recorded presentations, and join for panel discussions to interact and take questions from the audience whenever they can.

With the virtual environment, we are in a unique position to engage a larger scale of international speakers than ever before.

As the leading advocate for surgical education, RACS supports and promotes the ongoing research, development and maintenance of expertise to complement surgical practice.

Call for abstracts for ASC 2021 opens in October and we encourage you to submit and showcase your innovation to the surgical community. Details for abstract submissions are on the ASC website: asc.surgeons.org.

A provisional program with more information will be released in November. In the meantime, we will keep you updated regularly, and remember to follow the ASC (#RACS21) on social media as well.

We look forward to meeting with you in May. ■

Dr Liz McLeod FRACS

ASC Coordinator

Thriving in the regions

The COVID-19 pandemic has disrupted everybody's lives, causing immeasurable loss of human life and devastating many livelihoods.

The pandemic has been a great equaliser for those in the rural, regional and remote locations. Geographic proximity is no longer a barrier to participating in meetings, conferences, webinars, training and networking events. Greater adoption of technology has been a valuable tool for inclusion.

As a result, working and living in rural and regional areas has become a more attractive prospect for many people, including doctors. Early indications suggest there will be an influx of new residents to these areas as a long-term result of the pandemic.[1] The idyllic lifestyle in a vast and natural setting can be combined with working in close-knit communities, while seeing a varied case mix of patients with a high degree of autonomy. Many find it rewarding to contribute to better equity in access to healthcare.[2,3]

It is important to retain our surgical colleagues in the rural and regional areas. Sustaining wellness is key to recruiting and retaining a thriving and viable surgical workforce. Longer working hours and onerous on-call requirements have been highlighted as major factors for distress experienced by our rural medical colleagues.[2,4] Receiving adequate workplace support is vital to maintaining wellbeing. Supportive professional networks, adequate resources and infrastructure, as well as links with larger centres will boost the successful retention of rural practitioners.[5] These factors feature prominently in the Rural Surgery Section's 'Retain for Rural' strategic paper as we advocate for more equitable access to surgical services for these under-served communities.

The local healthcare system must be structured to ensure that practising surgeons work and thrive in safe and supportive environments. We encourage the formalisation of networks between metropolitan and rural hospitals to allow for the sharing of staff, peer support, on-call rostering and increasing opportunities for continuing professional development (CPD). This is recognised in the Royal Australasian College of Surgeons' (RACS) Safe Working Hours position paper.[6]

Rural-focused urban specialists (RuFUS) can play a pivotal role by providing clinical leadership to rural centres. This can include telehealth, outreach, mentoring and coaching local surgical teams, and coordinating dual metropolitan/rural appointments, transfer protocols and pathways.

Rural surgeons often face financial barriers to access professional development opportunities. To reduce these barriers, the Rural Surgery Fellowships for Provincial Surgeons is a travelling grant offered to Fellows in rural, regional and remote settings to undertake CPD away from their practice.[7] The Australian Department of Health also offers a similar funding initiative. The Support for Rural Specialists in Australia (SRSA) program aims to provide rural and remote specialists with professional connection and CPD that's not directly available in their local area.[8]

In order to thrive at work, good mental health is a priority. The challenges faced by surgeons in rural and remote locations can be different to those experienced in an urban setting. The negative impacts from climate change and natural disasters, such as bushfires, can take a major toll psychologically and physically. We strongly encourage Fellows, Trainees and Specialist International Medical Graduates to contact the RACS Support Program, which is provided in partnership with Converge International.

Practitioners in the rural and remote areas can also make use of the confidential Bush Support Services telephone service. Finally, we encourage you to contact the RACS Rural Surgery Section to let us know about your local challenges or successes in your area. This will allow us to advocate and help where possible or share successes for the benefit of all. ■

Dr Bridget Clancy FRACS

Chair

Rural Surgery Section

Resources and contact information

- RACS Support Program in partnership with Converge International can be accessed here or telephone 1300 687 327 in Australia or 0800 666 367 in New Zealand
- Bush Support Services: Toll-free telephone 1800 805 391, 24 hours a day
- Email the RACS Rural Surgery Section: rural@surgeons.org

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New sustainability working groups active on many fronts

Health sector must clean up its act

As countries and continents locked down to contain the spread of COVID-19, remarkable pictures began to emerge of marine life visibly swimming through the usually murky waters of Venice. Elsewhere in the world, clear skies suddenly broke through in cities usually blanketed by smog and pollution haze.

While COVID-19 has caused devastation for individuals, health systems and economies across the globe, it has conversely led to a noticeable improvement in the quality of our environment. In May, the Commonwealth Scientific and Industrial Research Organisation (CSIRO) predicted that global emissions would reduce by 7.5 per cent in 2020, compared with 2019, if countries remained in varying levels of lockdown until the end of the year.

While the reduction in emissions has been possibly the only beneficial side effect of this pandemic, clearly we cannot rely on the temporary effects of a major health and economic catastrophe to meet our international agreements on climate change. Nor would we ever want to!

Instead we must develop and implement the appropriate long-term policy measures right across our society. In our own backyard, health care is a major contributor to environmental damage. It is estimated health care is responsible for 7 per cent of greenhouse gas emissions, with hospitals contributing two thirds of that. It is a matter of human life: the World Health Organization estimates pollution causes 4.2 million deaths per year.

Hospitals are also major users of energy and water and generate large amounts of waste. A single 700-bed hospital generates more than 1.5 million tonnes of waste per year, 25 per cent of that from theatres, with 77 per cent ending in landfill. The magnitude across Australia and New Zealand is hard to comprehend.

As surgeons, we can do much to change this.

With greater need for personal protective equipment (PPE) during COVID-19, this waste production is now likely an underestimate. Gloves made of latex rubber are not eco-friendly. While many surgical masks are made of polypropylene, which provide some protection from bacteria, they are still plastic-based and liquid-resistant with a long afterlife once discarded. When they spill over from landfill, they end up in the ocean. It is estimated that by 2050 there will be more plastic in the ocean than fish.

The Lancet Commission on Climate and Health has previously called for the healthcare community to take a leadership role in advocating for emissions reductions, and to critically examine its own activities with respect to the effects on human and environmental health.

As an organisation, the Royal Australasian College of Surgeons (RACS) supported these calls and, in 2018, the College developed a position paper on the Environmental Impact of Surgical Practice. Earlier this year we formed the Environmental Sustainability in Surgical Practice Working Group (ESSPWG), and I am pleased to say we have achieved some early successes in our attempts to strengthen our advocacy work and profile in this area.

In April, the ESSPWG coordinated an important submission to the Commonwealth Royal Commission into Natural Disaster Arrangements (the Bushfire Royal Commission). I was then asked by the Royal Commission to participate in a videoconference consultation where I elaborated on our submission. The Commission subsequently released an issues paper for further comment, to which we provided another submission, highlighting issues such as the health impacts of bushfire smoke.

In July, we responded to the Australian Government's consultation 'Australia's Foreign Affairs, Defence and Trade policy in a post-pandemic world'. In our response we highlighted the risks to our region of failing to adopt stronger environmental policies and the consequences of failing to manufacture products for our own needs, such as PPE and ventilators.

Most recently, we expressed our support for a letter sent to the Australian Prime Minister, co-signed by 10 specialist medical Colleges and organisations. The letter praised the Australian government for its handling of the COVID-19 emergency and urged a similarly proportional response to the climate change emergency. Government has a central role to play. For example, in the United Kingdom, the Climate Change

We must develop and implement the appropriate long-term policy measures

Act 2008, has not only resulted in a reduction of emissions, but strategies implemented are currently saving $160 million per year.

There is still much more for the College to do, and I will continue to keep you updated on our progress. I encourage anyone who would like to know more about our work in this area, or who would like to become involved, to contact the College's Advocacy team at racs.advocacy@surgeons.org. We are particularly interested in local strategies that have reduced the impact on the environment.

The 'new normal' has become somewhat of a catchphrase throughout the pandemic. I am hopeful that when we finally emerge on the other side, our new normal will involve greener industries, cleaner energy and reduced waste. I am excited to see how we as a College can contribute to this.

Professor David Fletcher FRACS

Chair
Surgical Directors Section
Past chair
Professional Development

Fellows value telehealth

Before the pandemic only 11 per cent of Fellows utilised telehealth regularly, but with its rapid uptake since March a significant majority see its value, with more than 87 per cent saying they would consider continuing to use it once social distancing restrictions are eased.

More than 93 per cent of surgery patients are satisfied with the quality of their telehealth consultations, and more than 97 per cent agree that their surgeon was able to answer their questions clearly and satisfactorily.

These point-in-time statistics come from two ongoing surveys of Australia-based surgeons and surgery patients that, at the time of writing, have more than 600 and 700 respondents, respectively. The survey project is being driven by the Sustainability in Health Care Working Group, which made it a priority at its first meeting in June this year, and is being jointly developed with researchers at Hunter New England Local Health District. In addition, RACS' research team, RAAS-ASERNIPS, is looking at the findings of previous Australian and international studies of telehealth.

The working group decided to undertake this project as we believe that the data gathered, as well as being useful to discussions around telehealth in clinical practice, has the potential to be persuasive with Australian governments as they consider funding arrangements for telehealth beyond the pandemic. RACS has already engaged with various levels of government in relation to this work and we will continue to do so in coming months as the data is analysed.

The working group plans to take a similar strategic approach – combining rigorous evidence with targeted government engagement over the long-term – to all its priority advocacy issues.

For example, a similar approach is being taken in relation to protecting the title of 'surgeon', an issue that the working group has also made an advocacy priority. Last November, the Council of Australian Governments Health Council agreed to a process to decide which medical professionals should be permitted to use the title 'surgeon'. Under the auspices of the working group, RACS staff are monitoring this process closely, engaging with government, and coordinating with speciality societies and state committees in order to ensure the position we put to government is strong and evidence-based.

As Chair of the working group I have also taken the lead in RACS' engagement with the Australian National COVID-19 Clinical Evidence Taskforce. Following internal consultation, I was recently nominated as the RACS representative on the taskforce's Guidelines Leadership Group and its Steering Committee. The Taskforce plays a key role in Australia's COVID-19 response, undertaking continuous evidence surveillance to identify and rapidly synthesise emerging research in order to provide national, evidence-based guidelines for the clinical care of people with COVID-19. A RACS voice on the taskforce will be a valuable two-way conduit for evidence relating to the management of COVID-19 patients relevant to surgeons.

It has only been a few months, but I genuinely believe that the model of an active group of Fellows with a dedicated focus on strategic policy and advocacy is already showing its value. ■

Professor Mark Frydenberg AM MBBS FRACS GAICD

Chair
Sustainability in Healthcare Working Group
Chair
Research & Academic Surgery

RACS weighs in on elections across Australia

Status quo remains in the Northern Territory

Despite a reduced majority, the Gunner Government has been comfortably returned for a second term in the Northern Territory (NT) following the 22 August territory election.

Before this election, Royal Australasian College of Surgeons (RACS) identified a series of questions for each party to consider and respond to, which were focused around four main priorities. These priorities were infrastructure and resourcing investment, addressing climate change, reducing alcohol-related harm, and reducing the rate and impacts of family and domestic violence.

The state Government's response outlined a range of policy proposals across each of these areas. Crucially, for NT surgeons, this included a commitment to keeping the highly successful alcohol harm reduction legislation that has significantly reduced the number of violent alcohol-fuelled assaults across the territory.

The Hon. Natasha Fyles has been returned as the Minister for Health. We congratulate Ms Fyles on her re-election, and we hope to continue the productive working relationship that we have developed with her over the past four years.

We also look forward to meeting with Mr Bill Yan, the Opposition Health Spokesperson.

The full RACS NT election statement can be found on our website, as can responses from the Government and the Opposition.

While the election may be over, the key issues for NT surgeons remain, and we will continue to advocate strongly in these areas. Over the next four years the committee will work with both the Government and Opposition to progress issues of public health that affect so many in our community.

Mr Mahiban Thomas, Chair Northern Territory Committee

Greater regional support and quad bike action among the priorities in lead up to Queensland election

As Queensland prepares for its state election, the RACS state committee has sent an election statement to all major political parties, requesting they detail plans for how they will lead the COVID-19 recovery and, in particular, how they will support regional and rural services.

"In contemplating and planning a recovery strategy for surgical services, Queensland Health should not merely return to the status quo, but should take the opportunity to develop a 'new normal', with new models of care, and to grow meaningful partnerships between tertiary hospitals and remote, rural and regional facilities to better serve patients' needs," RACS Queensland Chair Professor Deborah Bailey said.

"The Government has previously backed a Support our Surgical Services (SOSS) program aimed at strengthening and safeguarding the provision of specialist surgical services by supporting staff in rural, regional and remote hospitals across Queensland.

"The pandemic has highlighted the need to find better ways of integrating isolated areas, improving equity and access to care and allowing patients to receive care closer to their homes. Despite the tough economic circumstances, now more than ever is the time to invest in programs such as SOSS."

The election statement also highlighted a recent report from the Australian Competition and Consumer Commission, showing that quad bike deaths have almost doubled in Australia in the first six months of 2020 compared with the same time in 2019 (14 deaths compared to eight in 2019).

In particular, the report singled out Queensland's unenviable record of having a much higher fatality rate than any other jurisdiction. Since 2011, the state has accounted for almost a third of all quad bike deaths nationally and, alarmingly, half of Australia's quad bike deaths in 2020 have occurred in Queensland.

RACS Queensland Trauma Committee Chair Dr Matthew Hope said it was important the new national standards help reduce deaths and injuries, but emphasised that the next government must play a key role in ensuring ongoing policy development and educational awareness campaigns reach the community.

Dr Hope said that "2020 has been a horror year for Queensland. While the newly introduced laws will go some way to reducing the risks, they are being phased in over a two-year period and many of the changes are more than 12 months away. Furthermore, the changes do not apply to older quad bikes already in operation, so we need to make it very clear just how dangerous these quad bikes are."

"We know that quad bike accidents tend to affect regional communities in much higher numbers, so we would like to see leadership from our next government in promoting public awareness in regional communities, particularly the dangers that adult-sized quad bikes pose to children," Dr Hope added.

"Kids and quad bikes are a toxic mix. Protecting them from the inherent instability of adult-sized quad bikes and achieving compliance with manufacturers' warnings against the carriage of children will remain a significant challenge while the reforms take time to be implemented," Dr Hope said. "We cannot continue on our current trajectory. That is why we are looking

for all political parties to demonstrate leadership in this area and to detail their plans to eliminate these types of tragic incidents in Queensland."

Australian Capital Territory election priorities included the SPIRE hospital building, workplace culture and alcohol related harm

In October we wrote to all contesting political parties in the Australian Capital Territory (ACT) seeking responses to a number of critical issues for ACT surgeons.

Among the concerns raised was that the new SPIRE building to be constructed as part of the Canberra Hospital expansion risks being too small.

RACS ACT Chair Professor Paul Smith said that it was important all political parties were aware of clinical concerns, and given the opportunity to address them before the election on 17 October 2020.

Professor Smith noted there were predictions from clinicians that the proposed building would not be big enough and that there would not be enough operating theatres for the required number of operations by the time of completion.

The current plans didn't indicate how emergency situations in other parts of the hospital (i.e. maternity ward) would have direct access to the new building and emergency operating theatres.

Professor Smith welcomed the state Government's investment in the health system but stressed the importance of future-proofing the proposed SPIRE building so that it could support the ACT's steadily growing population.

RACS ACT has been advocating for some time for the ACT Government to commit to providing a permanent space that would encompass state-of-the-art facilities for all medical professions. It would be used for education, training and practising skills and would put ACT on the map as a desired place for Trainees to come and stay following transition into Fellowship.

The concerns about SPIRE were raised as part of the RACS ACT Committee's election statement, which had been sent to all political parties. In total, RACS requested that each political party provide responses to 19 key questions.

Another key issue outlined in the statement was the need to improve the culture within the ACT health system. This followed the release of the Independent Review into the Workplace Culture within ACT Public Health Services in 2019. The findings of the review identified several cultural issues within the ACT health system and made 20 recommendations for improvement.

Professor Smith also used the election statement to urge the next ACT government to take a tougher stance on alcohol harm minimisation policies. He noted that a 2019 alcohol policy scorecard awarded the ACT a 'Fail' for policy efforts to reduce alcohol-related harm, and called for stronger leadership and a clear strategy to reduce the effects of alcohol-related harm across the state. ■

Lessons from Victoria's second wave

As a regional surgeon and director of surgery in the middle of Victoria's second wave of coronavirus, I am learning new things about this pandemic on an almost daily basis, but I am also aware that surgical colleagues around the country are looking on from outside, with only a partial understanding of where we are.

Australia's 'first wave' of COVID-19 was met with a united front. Rapid wind-back of elective surgery was followed by the transfer of public elective surgery into private hospitals under national agreements. Plans were made for the large-scale expansion of intensive care unit (ICU) capacity and staff were redeployed to deal with an overwhelming surge of COVID-19 patients. Yet our first wave wasn't really a 'wave' at all if we consider the global picture. It was a relatively well-confined outbreak, mainly limited to returned overseas travellers and dealt with by quarantine and border restriction.

History and science together are formidable predictors of the future. What might we have learnt from them this time? Perhaps that a pandemic virus such as this will have many waves or that, however optimistic we are, a vaccine takes some time to develop, or that our hospital and healthcare infrastructure is poorly designed to resist an airborne viral attack.

As the first wave faded, rather than learn from history and science, we let out a sigh of relief and planned a return to normal. The talk was of a 'surgical blitz' to catch up: hospitals, especially in the private sector, quickly ramped back up to full capacity. We let our guard down.

My advice? Use time wisely. Many healthcare facilities are old and unsuited to care for infectious patients. Patients who truly require urgent or emergency surgery will suffer if it is delayed, and yet there was no detailed or staged plan for how this work might continue.

In Victoria, our model of surgical care has surgeons working at many different hospitals – sometimes covering large areas of the state – and that brings its own complexities during a pandemic.

Some of the questions that have arisen include preoperative COVID-19 testing of surgical patients, appropriate personal protective equipment (PPE) for a range of surgical scenarios, the risks posed by a mobile health workforce, and the role of fit-testing, which varies in its uptake nationally.

In the midst of a major outbreak, it is clear that none of these systemwide problems have easy fixes. My recommendation is to make the most of the gaps between the waves. Use that time to redesign the services and facilities to cope better and more safely with a subsequent wave of COVID-19, rather than constantly trying to catch up mid-wave.

If this requires a reduction in bed numbers, better ventilation, new employment models or operating lists that look very different, that may be a cost worth paying. If this requires financial investment upfront, the current position in Victoria suggests this would be money well spent.

> My strongest conviction, however, is that, as surgeons, we need to be front and centre of decision-making that affects surgery.

While our colleagues in infectious diseases and public health medicine rightly stand at the forefront of the current pandemic, their expertise is not in the surgical field. We need to open the lines of communication and make recommendations early on from the surgical specialties to government. The recommendations should be based on the best evidence available. We should also be prepared to shut down quickly and early if there are outbreaks – and then be ready to recommence surgery as soon as it is safe to do so. Above all, prepare now – it will be time well spent. ■

Mr Matthew Hadfield FRACS

Chair, RACS Victorian State Committee

Working at the coalface of a global pandemic

During stage four lockdown in Victoria, we speak to four surgeons and Trainees about their experiences during the COVID-19 pandemic.

Dr Sarah Cain

As a Neurosurgery registrar at the Royal Melbourne Hospital (RMH), Dr Sarah Cain has been at the coalface in the fight against COVID-19.

The second wave of COVID-19 across metropolitan Melbourne brought high numbers and substantial changes to Dr Cain's work routine.

"The main impact as a Neurosurgery Trainee was performing urgent operations in COVID-19 theatres. All trauma patients were classified as suspected COVID-19 (SCOVID) and, therefore, required a negative pressure theatre with full precautions," Dr Cain explained.

"I performed a number of urgent craniotomies under these conditions and, although it was challenging at first, our anaesthetics team and entire theatre staff refined the process to ensure our safety without delaying urgent surgeries for our patients."

The onset of COVID-19 also brought updates to the way shift changes are conducted. "We do a handover via Zoom and we have reduced our numbers on ward rounds to abide by social distancing rules," Dr Cain said. "The Zoom platform has also been adapted by The Neurosurgical Society of Australia to ensure our formal teaching continues and that we meet our mandatory training requirements."

Dr Cain said she takes measures not to let COVID-19 restrictions hamper her interactions with patients. "I don't think that's changed for me. I am as close to my patients now as I normally am because I think that's an important part of looking after the patient. As registrars, we examine all our patients every day, twice a day. We're still doing that with appropriate personal protective equipment (PPE)." It also helps that patients are masked where medically appropriate, she added.

Both the emergency department and the level nine infectious disease ward at the RMH are classified as 'hot,' Dr Cain said. This classification also applies to screening wards where patients go when their COVID tests are pending. "The staff who man these wards need to be commended for their ongoing commitment to patient care," she said.

In terms of PPE, "The RMH has been excellent," Dr Cain said. "We've had everything that's required, from face shields to N95 masks to gowns. The Neurosurgery ward (4 south) was a hot ward for just over a month, which means we had to be in full PPE every day, and we had an adequate supply. Our 4 south nursing staff and junior doctors showed tremendous teamwork throughout this time and I feel proud to be part of such a collegiate team headed by Professor Kate Drummond."

Those staff who are not in COVID hot wards must still wear face shields and masks throughout the day. "It's annoying, but we are accustomed to it," Dr Cain said. "We do neurosurgical operations that go on for hours wearing masks and our operating loupes, so we're used to being in these things for long periods of time."

The peak of the second wave was particularly challenging for Dr Cain because she was going home at the end of her shift to her young child. However, her family put strict protocols in place to protect them from infection. Changing clothes at the door, which went straight into the washing machine, and then showering before greeting any family members became part of her daily regimen. "My downtime at home playing with my daughter was my time out and precious to me," she said.

Dr Cain said she had confidence in the RMH's COVID-19 protocols and ample supply of PPE. "For me, personally, ▶

and my colleagues, our main focus and concern was our patients and ensuring we were able to make sure they're looked after like we normally do," she said.

"Despite all the protocols and PPE supplied to us, I know a number of colleagues who have sadly contracted COVID19. Thankfully, they all have recovered."

Dr Cain believes that "the new COVID-19 normal will have us facing this virus long term, and I have confidence we can adapt and rise to the challenge".

Dr Benjamin Hunn

For Dr Benjamin Hunn, an unregistered Neurosurgery registrar, the impact of COVID-19 created a significant change in his workload at the Royal Melbourne Hospital (RMH), and the two hospitals that RMH covers – Sunshine Hospital and Western Hospital in Footscray.

"Initially we reduced our cases to emergency cases only. As part of this, half our registrars were kept home and we worked two weeks on and two weeks off," he explained.

While he found it rewarding to be doing more registrar-level emergency operating, it presented a more complex work environment.

"We had some cases of COVID-19 on the neurosurgical ward, and so there was a period of a few weeks in which we had to wear full PPE and take these on and off in specified areas."

All patients in the ward were isolated from each other and the nursing staff did "an exceptional job", Dr Hunn said. Eventually, the COVID-19 patients were discharged and the neurological ward returned to a new normal.

There is a designated COVID-19 emergency theatre at RMH where COVID-19 patients are taken to be operated on, and these theatres were also used for urgent cases where there is no time to wait for a COVID-19 test result.

"This poses difficulties in communication from a locked theatre to the outside when we need instruments or need to organise scans," Dr Hunn said. "On the weekend, or at night, it is also difficult to be on call when you're operating from a COVID-19 theatre."

Regarding the establishment of a new normal in hospitals, Dr Hunn said he believed it would become an everyday reality. "It will also be interesting to see if all the COVID-19 measures have a run-on effect in reducing other hospital-acquired infections like c. diff [*clostridioides difficile*]," he said.

Dr Hunn, who has an MBBS and BMedSc from the University of Tasmania, and a Doctor of Philosophy from the University of Oxford in the UK, has been studying for exams throughout the strict lockdown in Melbourne. Despite the disruption and challenges of the pandemic, he managed to find time to study, and added that the lockdown had minimised everyday distractions and allowed him to focus on work and study.

Regarding Trainee exams, Dr Hunn said the Royal Australasian College of Surgeons has done a "great job in balancing the needs for Trainees to complete exams and progress, with the need to prevent further spread of COVID-19".

The experience of working in hot wards and operating theatres gave Dr Hunn the opportunity to witness the dedication of nursing staff firsthand. As a result, he would like to see a fund established to support the nurses who have contracted COVID-19 in the course of their daily work. Something along the lines of the Victorian Government's Traffic Accident Commission or the National Disability Insurance Scheme, he said.

"Some of the nursing staff on our ward who contracted COVID have ongoing complications associated with their infection, including cardiac and pulmonary issues."

Dr Carolyn Vasey

Colorectal surgeon Dr Carolyn Vasey operates at Ballarat Health Services and St John of God Hospital in Ballarat, in regional Victoria. She consults across the road at The Specialist Centre Ballarat.

The impact of COVID-19 on Dr Vasey's surgical work has been "relatively spared", she said. She does a lot of cancer work, and the cancer throughput hasn't been hit as hard as a lot of other surgery, she explained.

"During the first wave, there was an arrangement between the private sector and the public sector so that, in Ballarat, we were able to do Category 1 urgent surgery on public patients in the private hospital."

"It was convenient for patients because our public and private hospitals are co-located and patients could be wheeled across a footbridge between the two hospitals," Dr Vasey continued, adding that it was nice to see the private and public sector working together to get the job done.

But as time went on, a backlog developed in non-emergency elective surgery due to several reasons including "all of the isolation and screening that had to go on with the usual respiratory presentations", Dr Vasey said. "This delayed a lot of medical care, which meant that surgical beds were very difficult to come by."

Dr Carolyn Vasey

As a result, they ended up doing a lot of work in the private sector in the first wave and, thankfully, the second wave has been much better because people have had more time to work out their systems.

The pressure on beds remains high Dr Vasey said, "in part because people are

using one room and waiting a number of days to get their swabs back before they can go into shared care wards – and that slows everything down".

Ballarat Health Services also transformed the surgical ward into the COVID-19 ward because it had the most single rooms. Surgical nurses were the first to be trained in personal protective equipment and everything COVID-19-related, Dr Vasey said, so general surgical patients ended up being 'boarders' on other wards.

The inability of patients to receive postoperative support from friends and family has also been a challenge. "It's very hard to get into hospitals at the moment. Even staff have to answer questions, register and get their temperature checked," Dr Vasey explained. This means patients don't have access to the normal supports in terms of family and friends.

COVID-19 protocols can also create a challenge in interactions with patients, Dr Vasey said. "It's very difficult, as a caregiver, not to be able to show compassion in your care because of restrictions that are beyond your control," she explained. "If you're dealing with someone who's got metastatic cancer and has just been given that information, then not being able to have the people they love support them is hard."

Dr Vasey explained that she'd "had a few family meetings on Skype but, certainly, there's a human factor that can't be conveyed over the internet – and I think that's what people are craving".

COVID-19 has had a significant impact on Dr Vasey's life out of work as well. Her husband is an infectious diseases physician in Ballarat. With two small children at home and the sharp increase in her husband's clinical workload it means "a whole team of people" have been required to support them at home while they go to work.

Dr Jessie Cole

A registrar in General Surgery at Ballarat Health Services since August, it's the second time Dr Jessie Cole has worked at Ballarat Health.

"I find it a very friendly environment," she said, of the public hospital in the provincial city 100 kilometres from Melbourne.

One of the COVID-19 challenges facing Dr Cole are the visitor restrictions for patients. "Our patients might have cancer or some other condition that makes it one of the worst times in their lives, and they find it very difficult when they can't have their partner, or their children, come to visit them because of COVID-19," she explained.

COVID-19 has generated a reduction in the number of elective surgeries at Ballarat Health, "but we have continued to do our most urgent cases, including our bowel cancer cases. Those in need of cancer surgery have been treated in the normal time frame," she said. "But there are people with less urgent conditions, such as a hernia, who will have waited longer than usual for their surgery."

Dr Jessie Cole

The biggest change to Dr Cole's practice has been in her outpatient clinics. "We still had to speak to the same number of patients in the clinic," she said. "But the way we organised it had to change very quickly." Now the majority of consultations are done via telephone. Surprisingly, she explained, "while we thought it might be easier to talk with a patient over the phone, it actually entailed the same amount of work, if not more, because we had to get accustomed to the new system."

There was also "a bit of anxiety associated with not being able to see patients face-to-face, making sure you're giving the right advice and doing the right follow-up for those patients just through a phone call", Dr Cole said.

Interacting with patients and other staff through a mask and face visor "can also take away some of your ability to communicate", she added. "This has been an adjustment because it's actually a physical barrier over your face. I think this can sometimes impair your ability to project empathy to patients and communicate with those who are hearing impaired."

Safety procedures implemented at Ballarat Health Services include a temperature check on entry and the requirement to sign in every time staff enter for work. "Tea rooms and physical spaces where people can talk and socialise have been highly regulated as well," she said, "and we have to log in when we sit in the tearoom and interact with people".

"I feel physically safe at work," Dr Cole said. "We take precautions and I'm also very fortunate in that I've spent the year working in regional hospitals, where the COVID-19 counts are lower. I think we have good safe systems in place, so I feel safer here than perhaps some of my colleagues in the city."

Regarding a new normal, Dr Cole said she thought face-to-face interaction would be an important part of surgical practice in the future because online services can't be fully replicated. Smaller meeting sizes and not focusing meetings around shared food were also important considerations.

"Hospitals need to develop a culture of being very safe, and making sure protective equipment is freely available is a part of that," Dr Cole said. "A new normal is developing and it is being driven by staff looking after themselves. I hope it will include a lot greater awareness about not coming to work if you're unwell." ■

Spotlight on

Wellbeing

Your wellbeing matters

Our profession is focused on improving the health of others, but this can sometimes come at the cost of not looking after our own health. Being healthy means more than just the absence of ill-health. It encompasses our mental, physical and social wellbeing. It enables us to practise effectively throughout our career and thrive in all aspects of life.

Read on to find out more about wellbeing and the ways we can support you.

Wellbeing Working Group: how do you look after your wellbeing?

The Royal Australasian College of Surgeons (RACS) Wellbeing Working Group is reviewing the College's support offerings for surgeon wellbeing, and exploring opportunities for collaboration in support of doctors' health and wellbeing. The group was established in November 2019 and is represented by members from RACS, the Australasian College for Emergency Medicine (ACEM), Australian and New Zealand College of Anaesthetists (ANZCA), Royal Australian and New Zealand College of Obstetrics and Gynaecologists (RANZCOG) and the Royal Australian and New Zealand College of Psychiatrists (RANZCP).

The working group consists of Chair Ms Ruth Bollard (Victoria), Dr Eric Levi (Victoria), Mr Phil Truskett (New South Wales), Mr Pat Alley (New Zealand), Mr Tony Dunin (Victoria), Miss Kate Martin (Victoria), Dr Aoife Rice (RACS Trainees' Association representative), Dr Scott Ma (ANZCA), Dr Simon Judkins (ACEM), Dr Paul Howat (RANZCOG), Dr Kym Jenkins (RANZCP and Chair, Committee of Presidents of Medical Colleges), Dr Margaret Kay (FRACGP and Medical Director, Queensland Doctors' Health Program) and Associate Professor Marie Bismark (FRACP and Head of the University of Melbourne's Law and Public Health Group).

The group has met three times in 2020 to share strategies, initiatives and programs that support doctors' wellbeing across the colleges involved. The group has also reviewed a range of new wellbeing resources launched during the pandemic.

The Wellbeing Working Group is developing a Doctors' Wellbeing Charter to demonstrate a unified approach and support advocacy across our colleges. The charter will describe the roles individuals, medical colleges and workplaces all play in advancing doctors' wellbeing. It is important that doctors thrive in all aspects of life, not only in medicine, and this will be a key principle for the charter.

Another collaborative effort is establishing a shared approach to data collection on doctors' wellbeing. Currently, data collected by each medical college varies in focus (e.g. individual wellbeing, workplace health, impairment). The group is reviewing tools to assist with measuring wellbeing and investigating ways to achieve a consistent approach.

I welcome feedback from the membership on how RACS can better support its members' wellbeing across all stages of surgical careers. Please email fsc@surgeons.org to get involved, and read on to find out more about how some of our members look after their wellbeing.

Ms Ruth Bollard FRACS
Chair, RACS Wellbeing Working Group

Ms Ruth Bollard

I attended an Australasian Doctors' Health Network event last year and was struck by the great work in doctor wellbeing that was happening. I was the only surgeon in the audience and believed that we all had a lot to learn from each other, so we came up with the idea of a doctors' charter on wellbeing as a collaborative approach between the colleges. By creating this RACS working group with expert membership from other colleges we will have a stronger political voice to advocate for our own health.

Mental health and wellbeing are linked to tolerance and resilience, and we know it is also related to patient outcomes. Wellbeing covers how we perform in all our 10 RACS Competencies and is, therefore, vital for us to be the best and most complete surgeon that we all want to be for our patients, colleagues and staff.

If someone is hesitant about seeking help, I would tell them that a problem shared is a problem halved. Everyone needs help at some point in their life and it can be as simple as off-loading with a trusted friend. You need to put your own oxygen mask on before you can help others.

Dr Scott Ma

I'm an anaesthetist and have been involved in the development of the Australia and New Zealand College of Anaesthetists' health and wellbeing framework. When the opportunity to join the RACS Wellbeing Working Group came up, I felt it was a great way to collaborate with RACS and to share what we have learnt along the way. It has been so insightful to work with members from a number of specialist medical colleges, understanding what challenges they have faced and the common issues we share.

I have watched with interest the way that the Operating with Respect movement has evolved and become an essential part of RACS' culture. To truly live these principles, you need to learn how to first respect yourself. This means understanding that you are as important as your colleagues and patients and that the way you look after yourself will flow on to the way you value and respect others.

We all understand the importance of preventative healthcare for our patients when it comes to things like heart disease and cancer, but we find it difficult to extrapolate that to ourselves or to our emotional and psychological wellbeing. We need to remind ourselves, that we are not infallible and our capability to care relies on understanding our vulnerabilities.

You would expect a marathon runner to prepare themselves physically, mentally and psychologically before a race, so why should a surgeon be any different? When you are considering on embarking on a procedure for a patient when you're not in top condition, put yourself in your patient's shoes and ask yourself if you would be happy with a surgeon who is not at their best.

Miss Kate Martin

As surgeons, we are familiar with the pressure of always needing to perform at our best, at work and at home. We also know very well that if we are not in good health, everything can be that little bit (or a lot) harder. The healthier we are mentally and physically, the better we perform and the happier we are.

Throughout my career I found myself supporting colleagues, and I realised I was facing the same challenges as they were. I turned to resources outside of the workplace such as friends, family, colleagues and a psychologist to help nurture my wellbeing.

I took an interest in what our College was doing to support surgeon wellbeing. Joining the Wellbeing Working Group gave me an opportunity to contribute to a more user-friendly process by bringing my own experiences to the table. I also see it as an opportunity to understand how others are promoting wellbeing within the medical workforce.

The most useful strategy I have found to prioritise my wellbeing is to take time to step away both physically and emotionally. This does not need to be for long periods, but rather having times in the day or week or month to slow down, take a breath, and look at things from a different perspective.

In my own experience, seeking the help of a psychologist has had great benefits for me both professionally and emotionally. If someone is particularly hesitant to do this, I would ask them what they would advise if it was someone else in their shoes – a trainee or a colleague, a parent, a spouse, a sibling, or a child?

I would like to break down the stigma associated with seeking help. I think all surgeons should proactively consider seeking the services of a psychologist rather than waiting for a crisis. It may be someone who specialises in leadership coaching, or it may be someone with whom you can discuss wellbeing specifically. I regard my psychologist as a personal trainer for my mind. Elite athletes have sports psychologists, so the same should be true for high-performing professionals who carry a significant responsibility in the decisions we make most days of the week.

Mr Eric Levi

I joined the Wellbeing Working Group because I wanted to discover how we can better support our colleagues.

The most important asset in any surgery is yourself. Wellbeing is a matter of surgeon safety and patient safety. Technical brilliance might determine the height of your career, but your wellbeing will determine its longevity, impact and the satisfaction it brings.

We need to smash the stigma around mental health. Seeking help is not a sign of weakness – seeking help shows insight and strength of character. Your family, colleagues and patients need you at your best. Seek both formal and informal support.

Wellbeing looks different to every surgeon. I encourage surgeons to find out what wellbeing looks like to you. ■

Some suggestions from the group to nurture your wellbeing

Exercise outdoors, do some online yoga, unwind before bedtime, go swimming, spend time with family and friends, support your colleagues, spend time with work friends away from work, find some quiet time, journal, write, go for a walk, listen to music, watch a movie, do something you love, take up a new hobby and notice the reasons you have to be grateful.

Finding mindfulness

Mr Tony Dunin talks about the practice of Mindfulness Based Stress Reduction and how it changed his life.

Twelve years ago, at the peak of his surgical career, orthopaedic surgeon Mr Tony Dunin realised he wasn't doing well. He describes it now as feeling "a bit empty" and subject to different stresses, all of which he put down to external factors having a disproportionate impact on his life.

"I looked at trying to change the external environment," he said. "I stopped doing trauma surgery and reduced my hours." However, as Mr Dunin explained, any impact proved minimal because he "hadn't addressed the issues within".

Then he experienced an acute stress response when, returning jetlagged from an overseas conference, he found an administrative bungle had occurred in his absence, along with a distressing personal incident. "Up until then I had experienced a general feeling of dissatisfaction," he said, "but it tipped over into 'acute overwhelm' with this quick succession of events".

Mr Dunin took some time off work and wisely sought the counsel of his general practitioner (GP). And after speaking to his GP he felt an enormous relief – just because he had spoken to someone about his vulnerability. He began searching for something that would provide "a greater depth to understanding" why he was "feeling so exhausted and finding things so burdensome". He explored different forms of meditation but wasn't able to find any that were supported by scientific validation.

Eventually, Mr Dunin came across a program known as Mindfulness Based Stress Reduction (MBSR). The founder, Emeritus Professor of Medicine Jon Kabat-Zinn from Boston, had a background in science and had researched the effect of MBSR on pain, anxiety and brain function. So Mr Dunin commenced an eight-week MBSR course in Melbourne. What followed was life changing.

The course involves 26 hours of face-to-face learning, as well as practice at home each day. This was no small task, but research shows that this is the time needed to make a meaningful and lifelong change.

"We start off with focused attention training through awareness of the breath, physical sensations and sound," Mr Dunin said. "Then by week five or six, we start exploring thoughts and our relationship to thoughts and emotions and that's where things start to get really interesting."

"As doctors we preference our intellect," Mr Dunin explained. "We preference our thoughts and we think we are our thoughts. With mindfulness, we come to realise that they are just passing mental events and this can be very liberating. We are no longer at the mercy of painful thoughts."

"Doctors are constantly striving, and what we don't realise is that we are giving ourselves a hard time. We have a harsh internal critic and that is unhelpful. What I learnt was to be kind to myself, to accept my vulnerability and accept my own imperfections," Mr Dunin said.

Mr Dunin sees as helpful the three areas of emotional regulation as described by Professor of Clinical Psychology Paul Gilbert, who was the founder of compassion-focused therapy. These are the drive system, threat system and soothing system.

"Our drive system gets us out of bed and pushes us towards achievements," Mr Dunin explained. "This is important but, too often, can get out of control. Our threat system protects us from danger, but our fear of medical errors can make us hypervigilant. Our soothing system is our capacity to take care of ourselves and has been undervalued. This is where mindfulness is helpful. We don't tolerate our imperfections, mistakes or complications and we take them onboard as personal faults, rather than recognising that we are human, we are all imperfect."

In a 2009 study, Michael Krasner and his colleagues set out to determine whether the wellbeing, psychological distress, and burnout of primary care physicians and their capacity to relate to patients could be improved by an intensive program in mindfulness, communication and self-awareness.[1] Seventy primary care physicians attended eight weekly two-and-a-half hour sessions, and a seven-hour session followed by a maintenance phase.

Results showed that the physicians participating in the program experienced significant improvements in wellbeing, including diminished burnout and improved mood, as well as 'positive changes in empathy and psychosocial beliefs'. Krasner et al concluded that 'participation in a mindful communication program was associated with short-term and sustained improvements in wellbeing and attitudes associated with patient-centred care.'

In 2013, in the *ANZ Journal of Surgery*, Dr Antonio Fernando et al set out a case for surgeons to consider mindfulness as an 'alternate mind state or way of being' as opposed to the 'typical stressed and untrained state that predisposes physicians and surgeons to fatigue and burnout'.[2] Mindfulness is a way of looking at stress calmly, Dr Fernando wrote. It's 'not a way out of daily troubles but instead a "way in".' While it requires

practice, learning it is not difficult and it will be beneficial 'for both surgeons and their patients' he added.

Mr Dunin was part of a team of researchers from the University of Melbourne and St Vincent's Hospital who looked at the effectiveness of MBSR in improving post-surgical pain and function in patients who had undergone a total joint arthroplasty (TJA).[3] This randomised control trial examined participants scheduled for TJA who had a wellbeing score of less than 40, and were suffering from psychological distress. The trial found that at 12 months post-surgery, the MBSR group showed statistically significant and meaningful improvements in pain and function, compared to the treatment-as-usual group.

Mr Dunin was a senior consultant at St Vincent's Hospital for 32 years. He continues to consult privately at Knox Orthopaedic Group and is a qualified MBSR teacher at the Melbourne Centre for Mindfulness.

Earlier in his career, as a junior surgeon in 1986, he completed an orthopaedic Fellowship under Professor Emile Letournel, renowned for his management of pelvic and acetabular fractures. Letournel's ground-breaking surgical work earned him a Legion d'Honeur from President Mitterrand of France in 1988, and the rare honour of having his image printed on a French postage stamp.

During his Fellowship with Professor Letournel, Mr Dunin learnt the anterior minimally invasive approach for hip replacement. He brought this approach back to Australia, but was unable to perform the operation for several years until a customised operating table became available in the country.

Now regarded as a pioneer of the anterior approach for hip replacement in Australia, Mr Dunin has performed more than 1600 hip replacements using this method and teaches it to orthopaedic surgeons across Australia, New Zealand and internationally. He has served on the Executive of the Australian Orthopaedic Association (AOA), was chair of the AOA Victorian branch, and is a principal supervisor of an AOA-approved clinical Fellowship.

Through his surgical career and mindfulness training Mr Dunin has found it rewarding to be able to help other doctors deal with the challenges of a career in medicine. He teaches mindfulness regularly to doctors, as well as the wider community. He is now embracing the new experience of teaching online during COVID-19.

In March 2020, Mr Dunin and his wife Jo Dunin, a qualified mindfulness teacher, along with Dr Linda Kader, a psychiatrist at the Royal Melbourne Hospital, offered sessions for doctors online on Saturday mornings during the first wave of COVID-19, with up to 100 medical professionals in attendance. "This was in response to high levels of anxiety and stress among doctors in Australia and New Zealand" he said, and "coming together gave many doctors relief in feeling they were not alone."

At a personal level, Mr Dunin said that mindfulness has taught him to be more satisfied with less, not to burn the candle at both ends and to live a simpler life.

On a professional level, there have been two big gamechangers, he said. Where he previously found consulting burdensome, he now finds it an opportunity to relate to a fellow human being.

> "Every person who walks through the door has their own story and their own experience. Seeing it this way, I become more engaged and connected. I always thought I had to fix people. I now realise that listening and being present to the patient is so important to them and, at the same time, rewarding for me."

"The second big change is that during surgery, I'm much more in the present," he said. "When things are difficult or when there is an interoperative problem I'm able to acknowledge that, pause, take a breadth, regroup, move slowly and make wise choices about how to overcome the problem. Technically, it's made me a better surgeon, as well as a better doctor and hopefully a better human being." ■

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Supporting colleagues: the conversation beyond ‘R U OK?’

On 10 September 2020 the College joined organisations throughout Australia to celebrate and promote R U OK? Day. It’s a national day of action when we are reminded that every day is the day to ask, ‘Are you OK?’ if someone you know is struggling with life’s ups and downs.

Looking after ourselves and our colleagues is essential for our health and wellbeing. If you feel like something’s not quite the same with someone you know – there’s something going on in their life or you notice a change in what they’re saying or doing – trust your instincts and take the time to ask them, ‘Are you OK?’

The important theme for the day this year was ‘There’s more to say after R U OK?’ This is a reminder that when we reach out and show concern for the people around us, we need to make time to listen, encourage action and be willing to follow up at a later time.

Helping a colleague can be as simple as having an open and honest conversation.

Here are some tips to navigate it.

Be prepared

You will need to be in a good head space for a meaningful conversation, and ensure you start the conversation at a time and place that’s appropriate for both of you. Things to consider include choosing a relatively private space, making sure that you’ve picked the right moment for your colleague and that you have enough time to see the conversation through, especially if the answer is, ‘No, I’m not, actually.’

How to start the conversation

Start by mentioning the specific things you have noticed in your colleague that have concerned you. For example, ‘You seem less chatty than usual. How are you going?’

Listen without judgement

Take the time to actively listen to what your colleague is saying and resist the temptation to interrupt or rush the conversation. If they do open up, encourage them to talk more by asking questions like, ‘How are you feeling about that?’ or, ‘How long have you felt that way?’

Encourage action

In addition to encouraging your colleague to engage in self-care activities and to have a general practitioner, it’s important to emphasise the value of accessing support services early on. There are a range of confidential and free professional services available to RACS Trainees, Specialist International Medical Graduates and Fellows, including the RACS Support Program, the Doctors Health Network throughout Australia and New Zealand and Drs4Drs.

Check in

After your initial conversation, stay in touch and check in on your colleague. This additional support can really make a difference.

Visit R U OK for more resources including videos and conversation starters, or the RACS Surgeons’ Wellbeing webpage. ■

For urgent support contact the following services, 24 hours a day:
- *Beyond Blue (AU) 1300 22 36 46*
- *Lifeline (AU) 13 11 14*
- *Lifeline (NZ) 0800 54 33 54.*

Find out more about the RACS Support Program here.

Do you have a GP? Surgeons need doctors too

We are all familiar with that age-old adage, 'Physician, heal thyself'. As surgeons we have a responsibility to put the best interests of our patients first, but to do this we must prioritise our own wellbeing. It is vital that we promote a culture that recognises the importance of looking after ourselves.

The College strongly encourages Trainees, Specialist International Medical Graduates and Fellows to have their own general practitioner (GP) for regular check-ups. In the 2018 Surgical Workforce Census, approximately one in four Fellows reported it had been more than two years since their last general check-up, and 8.5 per cent of Fellows reported doing their own health check-up.

Dr Kym Jenkins, a psychiatrist and member of the Royal Australasian College of Surgeons Wellbeing Working Group and Chair of the Committee of Presidents of Medical Colleges, encourages all medical professionals to have a GP.

"None of us in the medical profession should be our own doctor – we all need and deserve good independent and objective medical advice."

"A good GP will get to know you as a person and be able to take a holistic approach to your health needs," said Dr Jenkins. "It's not only important to have your own GP, it is important to have a GP with whom you feel comfortable enough to share some of your innermost thoughts and anxieties."

Choosing your GP can be a very personal decision and we all tend to look for different qualities or a certain style.

Dr Jenkins shared some tips on how to choose the right GP for yourself. Look for a GP who:

- is comfortable treating members of the medical profession
- appreciates that it's hard making the transition from caregiver to care-receiver
- allocates additional consulting time when necessary
- treats you like a patient and not a colleague (for example, arranges your follow-up and explains things as if you have no prior knowledge).

"Finding a GP who suits you is a personal choice and you may need to try several GPs before you find one who suits you," Dr Jenkins advised. "There are a growing number of GPs who have a keen interest in helping their colleagues and who have undergone specific training to be GPs for other doctors," she continued.

Dr Jenkins, who previously served as the Medical Director for the Victorian Doctors Health Program, recommended that surgeons contact their local Doctors' Health Advisory Service, as they can refer you to GPs who have a specific interest in this area.

Your GP is also a confidential source of support. Anything you share will remain confidential unless your doctor is obliged to report under mandatory reporting laws set out by the Medical Council of New Zealand (MCNZ) or the Australian Health Practitioner Regulation Agency (AHPRA). "Feeling stressed, depressed or having a mental illness are certainly not, in themselves, grounds for mandatory reporting," said Dr Jenkins.

Let's make our own health a priority. Make regular visits to your GP part of maintaining your wellbeing. ■

Learn more about the Do You Have A GP? campaign on our website.

Trainees talk wellbeing

Recently, some members of the Royal Australasian College of Surgeons Trainees' Association (RACSTA) executive committee had an informal discussion about how we look after our mental health and wellbeing. It turns out we all have broadly similar approaches: we look to our support networks to nourish us and in return we commit to spending quality time with our friends and family. Ring-fencing time for sports and hobbies outside work and prioritising these pursuits is also an important strategy to keep us balanced. We need reminders that we are not invincible and that life exists outside of surgical training.

James Churchill,
Chair, RACSTA Committee

I find that the biggest challenge to wellbeing as a surgical Trainee comes from an under-appreciation of the importance of self-care. Too often we see our own physical and mental health priorities relegated somewhere below that of our surgical training goals and that of our patients, but good Trainees are healthy Trainees and healthy patients need healthy doctors.

For me, an unexpected side effect of the COVID-19 pandemic has been an acute focus on assessing my own health on a daily basis. Being asked the question, "Are you feeling OK?" each morning at the temperature check station on arrival at work (and with the subsequent six or so further checks during each working day) has allowed me to reflect on the little things that I do to stay balanced in the face of a busy job, competing time demands and professional challenges.

For some time, I have valued taking half an hour each Sunday night to plan the coming week and determine priorities through the perspectives of training, personal, professional and family life. This year, I have found that taking 10 quiet minutes at the end of each day to process the day's events has been valuable, and I have realised it's rare that this time would be any more productive if spent doing anything else.

My dentist appointments have become non-negotiable, which I'm sure has been good for me, even if not apparent at the time. My GP now remembers who I am and I know I can chat with him if I need some advice. I have happily been reminded by my colleagues that, for the benefit of my own health, nobody is irreplaceable at work for a couple of hours.

Aoife Rice,
Support and advocacy portfolio, RACSTA representative, Wellbeing Working Group

The vigorous requirements of surgical training, when combined with the general demands of life and adulthood, mean that keeping my mind healthy and looking after my personal wellness can be low on the priority list. The support of my friends and family is immeasurable, while regular gym sessions give the endorphin release and fitness levels required for general wellbeing.

However, the number one contributor to my overall wellness is my dog, Larry! Larry the labradoodle is always happy to see me and greets me at the end of a long day like my return is the happiest event of his whole life.

Regardless of how tired I feel, Larry enjoys a walk and the sight of his tail wagging as he pounds the pavements is restorative. He's also a great listener, gazing at me with his serious face and his head cocked attentively. Our conversations are judgement-free and, although I can't speak for Larry, they certainly help me feel better!

I would encourage anyone who feels they are struggling to speak to someone they know and trust. I know not everyone has a companion as awesome as Larry, but I've never regretted chatting to a friend over coffee and putting the world to rights. Try it, and hopefully you can enjoy the benefits too!

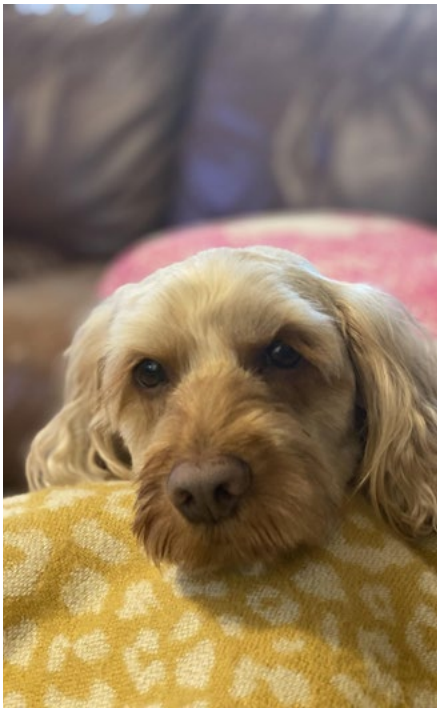
Linda Tang
Training portfolio

At a time of high stress, I echo the sentiments of my fellow committee members about taking time for self-care and wellbeing.

A COVID-19 era hot topic has been exercise for mental health and wellbeing for all surgical Trainees, and I have a new appreciation for this as part of my surgical Trainee armamentarium.

As I am currently working in Orange I have had the luxury of a socially distanced hike up Mount Canobolas (mind the snakes!) or a run around the lake. In addition, most studios now offer yoga and pilates classes via Zoom. ■

Left: the view from Mount Canobolas, New South Wales.
Below: Larry with his listening ears on.



Building resilient surgeons

Surgeons are already under stress but recently bushfires, the White Island eruption and now COVID-19 have made things only more difficult. Now more than ever surgeons need to build greater levels of resilience and need systems and support frameworks to enable them.

There is a strong body of research that has identified the core components in building resilience and wellbeing, and this is captured in the evidence-based STRONG model.

S: strengthen relationships

Strong and supportive relationships are the number one predictor of wellbeing. Cultivating and investing in healthy relationships is a core resilient behaviour. Having colleagues who will cover, swap on-call or scrub in on a difficult case is vital in a high-pressure job, especially when balancing this with family and other commitments.

High levels of social support have been associated with improved psychological and physiological health: benefits include a reduction in stress-related illness, increased self-confidence and improved problem-solving. Humans, and that includes surgeons, are wired for connection.[1] This enables them to be more productive and engaged, and have more energy available for themselves, their patients and colleagues.

T: take control

There will be things that go wrong in a surgeon's working life. At the best of times, healthcare organisations and patients are complex, ever changing and unpredictable. When faced with additional high-pressure situations, such as COVID-19, it is easy to succumb to feelings of being overwhelmed and lacking control.

A person's experience of the world is shaped by their perceptions and interpretations of events. Those with an internal locus of control believe that their actions affect their outcomes. People with an external locus, on the other hand, are more likely to see circumstances as largely steered by external forces, over which they have little or no control.[2]

Research has shown that those with an internal locus of control experience greater levels of success and are much happier at work.[3,4] A feeling of control, or mastery of one's own destiny, is one of the strongest drivers of wellbeing, performance and capacity to cope with life's challenges. Identifying the areas where actions and behaviour can have a real impact will ultimately be of benefit to the surgeon, as well as to colleagues and patients.

R: recharge and restore

For busy surgeons, the pace and demands of working life can be frenetic and surgeons can often find themselves operating in a high arousal zone. However, the lack of a recovery period might be holding surgeons back from being resilient and effective in high-pressure situations. Moreover, there is a direct correlation between lack of recovery and increased risk to health and safety.[5]

Building resilience at work is about identifying suitable internal and external recovery periods. Internal recovery refers to the shorter periods of relaxation that take place within the workday, such as seizing a moment during the day to pause, breathe deeply, engage with a colleague or take a short brisk walk.[6,7]

External recovery refers to actions that take place outside of work, such as in the time between workdays and during downtime periods. These periods give the brain a break from high mental arousal states and can incorporate activities such as connecting with loved ones, a mindfulness practice, exercising or engaging in a favourite hobby.[8,9]

O: optimise mindset

Believing that positive outcomes are possible during times of struggle can be difficult. The surgical brain is trained to spot weaknesses, problems or risks and is generally not as well equipped when it comes to identifying positives in a situation.[10,11]

Realistic optimistic thinking is a skill that can be learned, one that enables a surgeon to choose helpful ways to interpret life's challenges and setbacks.

Realistic optimistic thinking is a skill that can be learned, one that enables a surgeon to choose helpful ways to interpret life's challenges and setbacks.

People who have an optimistic explanatory style tend to look first for what is right, and hold a belief that, in the majority of cases, things will work out for the best. This is what psychologists refer to as grounded, or rational, optimism. Optimists believe that adverse events are local (contained) and temporary (they will pass or get better).[12]

Those with a more pessimistic explanatory style are likely to see an adverse event as all-encompassing and permanent. This tends to take thinking into a downwards spiral, which negatively impacts levels of confidence and motivation, fostered by a belief that one's behaviour, or the behaviour of others, does not matter.

Becoming more aware of one's thinking and its impact on emotions and subsequent actions is key to cultivating an optimistic mindset. When negative thinking occurs, it is useful to instead focus on the advantages or opportunities presented by a situation, as well as which elements are within one's control.

N: nurture: nourish, move and rest

Physical health underlies every other aspect of life, not just what you do and what you are capable of achieving, but how you think and feel as well. Effective resilience-building habits lie in choices about food, exercise and sleep, particularly when under pressure.

Making healthy food choices, sleeping well and moving regularly throughout the day contribute to building vital energy and long-term physical wellbeing.

Both exercise and food choices have been shown to have benefits to mental state and neurocognition.[13,14] Even brief physical efforts in the working day such as standing up, stretching, taking the stairs and replacing traditional meetings with walking meetings can have cumulative benefits.[15]

The effects of fatigue and sleep deprivation on performance are well known. Lowered judgement and decision-making, diminished situational awareness and lowered emotional control have been linked to preventable errors.[16] Making sleep a priority and aiming for the recommended seven to nine hours a day will contribute to enhanced cognitive functioning, sustained energy, stable mood and better immune functioning.[17]

G: grow and develop

Challenging and stretching oneself in new and unknown situations can enable adaptation and growth, which contributes to wellbeing.

It has been shown that people's area of greatest potential and growth lies within their areas of unique strength, rather than in correcting weaknesses. Typically, using one's strengths leads to increased feelings of engagement and immersion in work, and greater authenticity, as well as feeling energised and fulfilled. Being able to articulate and apply strengths empowers individuals, boosts self-confidence and leads to higher levels of performance.[18]

A key resilience factor is growth from adversity. Surgeons can learn to cultivate growth in themselves by choosing how they construct meaning from times of hardship. In recalling a time that was really challenging, surgeons can facilitate a growth mindset by looking for new perspectives, gratitude or a sense of meaning that might have been gained.

Surgeons are currently facing challenges not foreseen in their training. By fusing together evidence-based elements that contribute to resilience and wellbeing, surgeons can apply the science of human flourishing to their own lives to strengthen themselves, the people around them and ultimately benefit their patients. ■

Professor Andrew Hill FRACS

Ruth Robertson Msc

This is a condensed version of the article 'Building resilience in the face of adversity: the STRONG surgeon' from the ANZ Journal of Surgery. *It can be accessed at https://doi.org/10.1111/ans.16199*

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Embracing flexible training

Surgical directors are finding creative ways to increase flexibility in surgical training while maintaining standards and progression towards Fellowship for Trainees.

Surgeons with experience in flexible training are finding that the wellbeing of the whole surgical team can be boosted when a flexible post is created. One benefit for the team is reduced unscheduled overtime, and Trainees can benefit directly by gaining more control and flexibility over their work and personal lives, while maintaining training progression.

Research by the Royal Australasian College of Surgeons (RACS) has found that inflexibility in surgical training is a disincentive to many graduating medical students when selecting their specialist career. Flexible training is less than full-time training and can be relevant for all Trainees, regardless of gender. It increases diversity in the surgical workforce by enabling Trainees to pursue wider interests while training, and by increasing the appeal of surgical training to more candidates.

There are two basic models of flexible training currently in place and working effectively in Australia and New Zealand: job share of a full-time training post, and stand-alone part-time roles. There are many variations of these two arrangements and new models may be developed that also work well.

According to most consultants and Trainees with experience of flexible training, the arrangement can work well for most of the people involved. The keys are commitment and planning.

"It is possible, and it can be done within an existing budget envelope. It's safe for patients and it's great for paediatric Trainees," said Professor Deborah Bailey, paediatric surgeon and Chair of RACS Queensland State Committee.

Professor Bailey said the big issues with flexible training are consistency, continuity and competency progression, all of which are achievable.

"You have to build a role that Trainees will succeed in. Supervisors may need to be a bit more focused on their teaching and may need to adjust their timetable a bit to make it work," Professor Bailey continued.

For Trainees, flexible training can mean the difference between staying in the profession and leaving surgery for another form of medical practice. It can also make it possible for Trainees to continue training while pursuing other opportunities that broaden life experiences.

"Usually, those seeking flexible training opportunities are highly organised, committed to the success of the role and keen to support the productivity of the surgical unit," said Dr Joanne Dale, a colorectal surgeon from Queensland.

The College's support for flexible training is evident in strong policy, mandated reporting by training boards to the Board of Surgical Education and Training (BSET) on both supply and demand for flexible roles, and a commitment to including flexible training in accreditation processes. All RACS Speciality Training Boards (STBs) support flexible training, which is reflected in their individual training regulations.

To promote flexible training and encourage take-up across the profession, we have published new resources on our website, including a toolkit with tips for establishing flexible roles and a series of interviews with surgeons and Trainees who have experienced it personally. The resources share the expertise and experience of many of the Trainees and Fellows who have already made flexible training a reality in Australia and New Zealand.

Flexible training advocates say the reason a Trainee is interested in flexible training shouldn't matter. Mr Robert Whitfield, a member of RACS' South Australian training committee, doesn't ask why someone wants to train part-time.

"It shouldn't make any difference. It's sometimes, but not only, for work–life balance. It can be for the Trainee to pursue research, music, sport – it shouldn't matter. We need to understand there are a range of different motivations, and flexible training increases diversity, which is good for our profession," Mr Whitfield said.

He encourages anyone thinking about establishing a flexible role to look at the volume and caseload of the unit. The role has to be real and it has to provide value to the hospital.

RACS supports flexible surgical training as a legitimate training option that is viable for Trainees and surgical units and supports diversity in surgery. While flexible training can only be delivered in partnership with hospitals that host accredited training posts, a 2018 survey found 75 per cent of hospitals said they could provide flexible training.

"It's a reputational thing," Mr Whitfield said. "We don't want to be seen as old white guy dinosaurs who can't embrace something modern and flexible for the workplace. We want to be seen in a different way. We need to walk the walk, not just talk the talk." ■

For more information about flexible training, resources for establishing less than full-time roles and interviews here .

Spotlight on Preparation for Practice: doctors' health and wellbeing

The final webinar in the Victorian State Committee's series Preparation for Practice was held in August and focused on doctors' health and wellbeing.

This series, normally held as a two-day workshop in Melbourne, was presented this time as a series of 12 webinars throughout June, July and August for our Younger Fellows.

The final webinar was moderated by Mr Patrick Lo FRACS and Dr Mariolyn Raj FRACS. Long Nguyen, an educator at the Victorian Doctors Health Program (VDHP), spoke about stress, burnout and the confidential doctor-to-doctor support provided by the VDHP.

Long spoke about the importance of doctors needing their own GPs (even GPs need their own GPs) and building a life outside medicine and surgery. He also emphasised the need for surgeons and doctors to stay connected to each other. Keep an eye out for your colleagues even if they look as if they are coping well, and check in on them.

Life coach Melo Calarco spoke on mental health, self-care and mindfulness. Calarco, an experienced life coach, suggested a few self-care tips that doctors can take on even in the midst of their busy schedules.

What can you do to build your physical energy?

- Healthy nutrition
- Regular exercise
- Adequate sleep

What can you do to build your mental energy?

- Take regular renewal breaks
- Engage in mental stimulation (outside of work)
- Practise regular meditation to deactivate your stress response

Calarco suggested making one of these practices your 'non-negotiable' and sticking to it! Even better, tell a friend or colleague what your non-negotiable self-care practice is so they can hold you accountable.

Calarco is also an advocate for mindfulness and suggested taking part in either formal or non-formal mindfulness. Both types of practices will train your mind to pay attention to tasks, allow you to be more present and enjoy life more fully. While formal practice can consist of a 10-minute seated, guided mindfulness practice, the informal option might be a simple way for busy surgeons to introduce mindfulness into their daily routine.

Pick an activity you do every day, such as walking, cooking, o eating, and decide to do it mindfully. Be present for the duration of that activity – it's as simple as that.

Benefits of mindfulness

1. React less to stress
2. Manage anxiety
3. Enhance your performance
4. Improve your immune function and wellbeing
5. Increase your mental focus and clarity
6. Improve your sleep pattern

We understand that, as surgeons, it might feel like your schedule is not your own sometimes, if not all the time. As Mr Lo said, it can be very daunting when you first start out, because you feel like you need to work all the time, otherwise your progress is affected. Mr Lo added that, "If I knew then what I know now, I would have made the time for myself."

Dr Raj spoke from her experience as well. "A career in surgery is a marathon, not a sprint, so it's really important to make sure that you're fuelling yourself appropriately to last the marathon." ■

Head to our YouTube channel to watch the recording of the webinar.

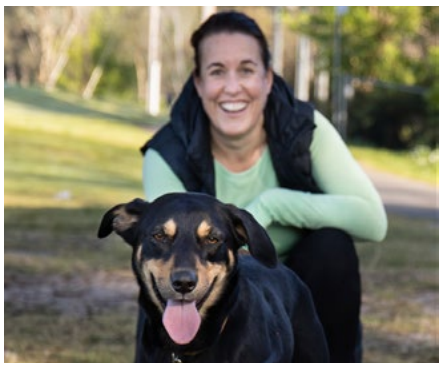
Lockdown dispatches from around the College

Surgical News reached out to our members and staff to ask them what they've been doing during lockdown to help them cope and manage. Read on to find out about new hobbies, big changes and more.

Dr Michelle Locke, plastic and reconstructive surgeon, Auckland

During lockdown all my hockey games and trainings were cancelled and the gym was closed, so it was back to basics for me to keep up my fitness. I went running in my local area, rediscovering beautiful Cornwall Park (One Tree Hill) in Auckland. Even better, my eldest daughter, Charlotte (10 years old), often biked alongside me, so we got in some quality mother–daughter time too.

Sophie Lukeis, Executive General Manager, People and Culture, Melbourne



I start each day with a run with my new kelpie, Daisy, on the nearby golf course. Studies tell us that being in nature has a measurable and positive impact on our wellbeing. The greenery, fresh air and endorphins released after chasing my extremely fast dog help me get through this tough time. I am really going to miss the golf course when it opens back up!

Here is a photo of us after we'd just finished running (hence no mask!).

Associate Professor Payal Mukherjee, otolaryngology head and neck surgeon, Sydney

I submitted and have now passed my PhD, as a result of the lockdown. My PhD was on the translation of personalised medicine and 3D technologies in ear surgery (Otology).

It took me three-and-a-half years to complete it, which I did on top of my clinical work. This meant I've been doing 80 plus hours a week. On top of this, COVID-19 presented interesting challenges as a parent, such as supporting online education – but it also allowed my daughter and I to be students together. It's such a relief to have it all behind me. I feel extremely relieved and really delighted.

Mr Li Hsee, trauma and acute care surgeon, Auckland

New Zealand lockdown was a trying time that presented a lot of uncertainty at all levels. With that comes a lot of responsibility. I would like to recognise the team, including clinicians who were on the frontline, and also support staff, communication teams, cleaners – all of whom had to practise in a different way to the norm. Some were working from home and balancing family commitments, others in full personal protective equipment to ensure the health and safety of our patients and staff.

From a surgical clinical leadership perspective, my role was to ensure our service was up-to-date with the latest COVID-19 guidelines. We changed the way we managed emergency General Surgery from a systems perspective and looked at how treatment protocols were modified. In addition, there were many Zoom meetings and ongoing participation in international webinars on COVID-19.

For those of us in the hospital, we were aware of the potential risks that we faced and brought home to our own personal 'bubbles'. While it was uncertain, nothing gives me greater pride than to witness the teamwork and camaraderie of the individuals who make our health system work. ■

Dr Vaish Thiru, surgical resident, Melbourne

During these bizarre times I have found solace in expressing myself through writing.

our bruised city sleeps but we lie awake
for freedom and air; we burn and we ache
the walls are closing in, for you and for me
this is the end of modern-day bourgeoisie

there is a dread filled fog that fills the air
and sometimes it's all a little much to bear
we wake with a heaviness, a collective pain
a yearning for the smell of fresh cut grass in the rain

we hide our numbness behind our masks,
and we're doing 'just fine' if anybody asks,
but there is a solace amidst this era of restrain;
that is - our unified actions are undeniably humane

we watch as our social structures flail and fall
signalling an aquarian rebirth for all
showing it doesn't matter how much you are worth
we are one and the same, in death and in birth

for only a virus could topple the economy
and force us all to sacrifice our autonomy
but we do it all because we are united
the thread of humanity pulls and guides us

it was about time that we all needed reminding
that underneath our differences lies a deeper binding
a global recognition of the sanctity of life,
and the need for human connection to hold you through strife

so, whilst we're here in this unnatural state
let's take this time to explore and create
for even if we're stuck somewhere stale and small
another world awaits, with no ceiling, no wall

because freedom is nothing but a state of mind
it is a rapture of the molecular kind
so, take a seat and close your eyes
let those feelings surface and crystallize

feel your lungs expand and feel your heart beat
inside feel your energy, your glow and your heat
inhale and escape, release your mind
watch your thoughts as they spark, burn and unwind

dream in colours you've never seen before
dream in silence or in song or uproar
explore the depth of your consciousness sea
learn who you are and who you wish to be

find the peace that lies within your core
find the things that you are grateful for
I know it feels like there is no end in sight
but we need the darkness to appreciate the light

so be kind to yourself, and let yourself feel
the last few months have been dark and surreal
but we'll come out of this with a renewed empathy
and a strengthened love for the collective humanity

Education activities

RACS has recommenced education activities for both prevocational and professional development courses. The Education Services teams are working hard to run as many courses as possible. However, some previously scheduled courses may not go ahead. If you are registered for a course, the program coordinator will be in touch to confirm details. For more information, see our Frequently Asked Questions page, which can be accessed by clicking on the COVID-19 information hub banner on surgeons.org.

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

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

Face-to face courses

Course	Date	Region
Process communication model seminar 1	Friday 30 October-Sunday 1 November 2020	Adelaide, South Australia
Operating with respect	Friday 16 October 2020	Wellington, New Zealand
	Saturday 7 November 2020	Sydney, New South Wales
	Saturday 14 November 2020	Perth, Western Australia
Bioethics forum	Saturday 14 November 2020	Sydney New South Wales

Online courses

Course	Date	Time
Leading out of drama	Tuesday 24 November, Thursday 26 November, Tuesday 1 December and Thursday3 December 2020	6.00pm AEST, four 90-minute sessions Note: participants are required to attend all four sessions to attain a completion certificate and CPD points.

The six pillars of wellbeing

Six pillars to build resilience and help you thrive

Research shows if you do something from each of these six pillars every day, it will help you feel good, function well and bounce back from stress.

Doing just one thing from each pillar every day is a way to look after your future self. Over time you should feel more positive, resilient and be able to get the most out of life. They may be small daily actions, but they can lead to big improvements in wellbeing.

Pillar one: chill

Chill is all about reducing stress. It's what you do to calm your mind, relax your body, and switch off your fight-or-flight response.

Did you know? You can't be relaxed and stressed at the same time. Chilling tells your fight-or-flight response it's safe to relax.

Pillar two: do

Do is all about learning: the things you do to keep your brain active and stay creative.

Did you know? When you set a goal of learning something new it helps to take small steps and notice progress along the way. This strengthens brain networks that expect positive outcomes, so you'll feel more optimistic and better about yourself.

Pillar three: connect

Connect is all about connecting with, and helping, others. It's the things you do to strengthen relationships, socialise, give back and volunteer.

Did you know? Connecting boosts feel-good brain chemicals oxytocin, serotonin and dopamine. Acts of kindness and helping others are associated with feeling happier and more satisfied with life.

Pillar four: move

Move is all about keeping physically active. It's the things you do to move your body in a way that feels good.

Did you know? Keeping active improves physical health, but it's also a way to raise your spirits. If you're not used to doing lots of exercise, just moving a little bit can be enough to lift your mood.

Pillar five: celebrate

Celebrate is all about taking time to celebrate and appreciate you, when you do things to notice the positive, be kind to yourself and feel good about yourself.

Did you know? Evidence indicates that taking time to think kind thoughts about yourself leads to greater happiness and being better equipped to cope with stressful situations.

Pillar six: enjoy

Enjoy is all about having things to look forward to. What you do for pleasure and fun is a way to practise self-care.

Did you know? Making time for pleasure, fun and laughter can help boost feel-good brain chemicals, such as serotonin and endorphins. This can help you feel more upbeat for the rest of the day and more resilient in the face of stress. ■

This article is from Mentemia, a digital platform that helps people improve their daily mental wellbeing through science-backed tools and expert content. The College has partnered with Mentemia to provide staff with access to Mentemia as part of our existing suite of wellbeing tools.

Surgeons' wellbeing: resources and support

Wellbeing is important, not only for us, but also for our patients and the teams we work with.

The Royal Australasian College of Surgeons (RACS) advances surgeon wellbeing through education, support and advocacy on issues that affect your training and consultant experience. These include unprofessional behaviours, diversity, flexible work and safe hours. We know that workplaces can have a significant impact on our wellbeing.

Your wellbeing

There are things you can do to maintain your wellbeing:

- Practise self-care and continually evaluate what works best to allow you to thrive. This includes basic needs such as sleep, exercise, nutrition, hydration, regular breaks and leave. It can also mean setting boundaries and engaging in enriching activities that bring joy and purpose such as learning, giving, engaging in hobbies, having a spiritual practice and social connections.
- Foster a network of support that includes colleagues, family and friends to seek out in difficult times.
- Show compassion to colleagues and encourage them to seek help if you have concerns.
- Have a general practitioner and regular check-ups. For more on why surgeons need GPs see page 25.

Support services

Our profession can be challenging, and we are living in uncertain times. See the following confidential options if you need a safe place to talk.

- RACS Support Program: Delivered by Converge International, RACS Support Program provides 24/7 support and four free sessions a year for Trainees, Specialist International Medical Graduates, Fellows, Global Health volunteers and immediate family.
- Australasian Doctors Health Network: 24/7 support by doctors.
- Drs4Drs: 24/7 support by doctors.

Doctors' wellbeing resources

There are a range of doctors' wellbeing resources available, including new resources launched during the pandemic.

Apps:

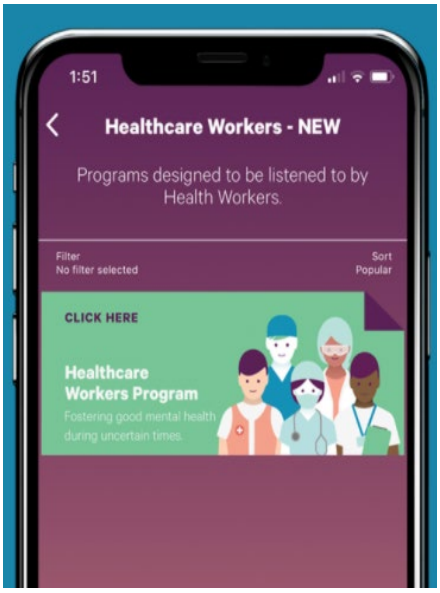
- TEN for Healthcare Workers and Smiling Mind Healthcare Worker Program.

Podcasts:

- AHPRA's Taking Care and RACS Post Op podcast can be found wherever you get your podcasts.

Online:

- RACS Five to Thrive is a self-care micro activity.
- Drs4Drs produces a Five Minute Guides to Staying Well.
- Pandemic Kindness Movement offers wellbeing resources curated by clinicians.
- The Black Dog Institute Online Clinic can be found here.
- Keeping the Doctor Alive is a self-care guidebook for medical practitioners.
- Every Doctor: Healthier Doctors = Healthier Patients is an eBook for medical practitioners.



Visit the Surgeons Wellbeing and Resources webpages for a full list of resources and support options. ■

Paying it forward: meet supervisor Mrs Toni Wilson

Tell us a bit about yourself

I am a paediatric surgeon at Capital & Coast District Health Board (CCDHB) in Wellington, New Zealand.

I got my FRACS in General Surgery in 1991, which was endorsed in Paediatrics in 1994. I did most of my training in Auckland, but when I finished there were no consultant jobs in Australasia. It was difficult for us to move as my husband was a lawyer, so I embroidered and did various locums around the country and had two children.

Almost 16 years ago I got a position in Wellington, so the family moved and we have been very happy here ever since. I am now Clinical Leader.

When did you become a supervisor?

I have been in charge of registrars since I started at CCDHB, although we have only had one trainee for the last five years.

Why did you become a supervisor?

I wanted to help trainees wherever I possibly could. In my training days, trainee assessments were not usually discussed with the trainee, so it was common to have no idea of how your bosses had assessed you. Fortunately, that has changed now.

What do you like about the role?

I have always enjoyed 'growing' young surgeons, so I have been happy to be the supervisor for training in Wellington. I view the job as a privilege, as I can help the next generation of skilled surgeons achieve their best.

As the paediatric training scheme is competency-based it involves a lot of interaction, which means that you spend a lot of time with your trainee. All my colleagues enjoy teaching and training so that makes my life as a supervisor easier. Where there have been problems, it is a matter of working through them in a constructive manner.

Anyone coming to the role of supervisor should fully embrace the position. I find the relationship that I have with the trainee a very satisfying one.

What qualities are important for a good supervisor?

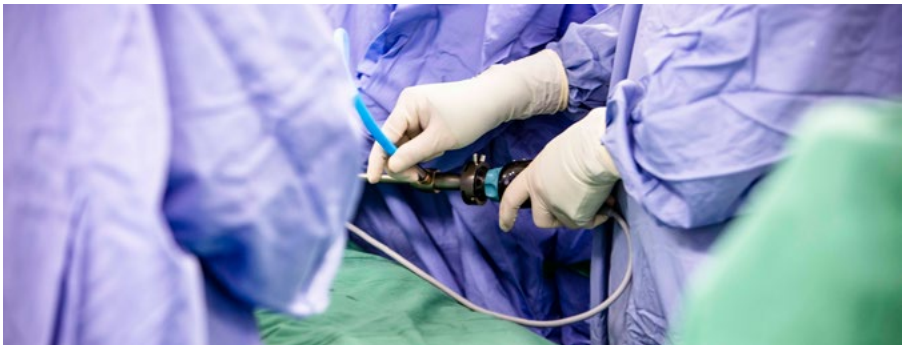
Honesty and trust are an important foundation for the trainee/supervisor relationship. I have always tried to be as honest as possible while being kind and supportive. And there are times when you have to be prepared to go into battle with your management to advocate on behalf of your trainee.

I believe in the concept of 'paying it forward', which means recognising the talent and skill of house surgeons and registrars and encouraging them to help them grow.

Our training system is complex and often daunting for those unfamiliar with it, so people need help to navigate it in the best way possible. I take any opportunity to help trainees to advance their career.

What is your top tip for trainees?

I tell the trainees that it is important to find a mentor and that often it is best if that person is another specialty. The choice of a mentor is a very personal one and it is different to the relationship between a supervisor and a trainee. Trainees need both.



What support do you think supervisors need?

Paediatric Surgery had a trainers' weekend retreat for the first time last year and it was a valuable opportunity to discuss training with those on the board, to educate trainers and to meet other registrar supervisors. It was deferred this year but hopefully it will continue once the pandemic settles.

The Royal Australasian College of Surgeons (RACS) Education department has developed specific webpages to make it easy for supervisors to access resources to help them in their role. This is a great initiative and I look forward to seeing additions to the resources as they are developed. I'd encourage other supervisors to look at these webpages. ■

LAUNCHING THE SURGICAL SUPERVISOR HUB

In a recent survey RACS supervisors indicated that they wanted better access to resources to help them in their roles. We are now launching a dedicated webpage for all supervisors. The new Supervisor Support Hub provides links to:

- relevant policies and procedures,
- the supervisor standards and surgical competencies
- current journal articles which will be updated quarterly
- links to Specialty Training Boards and Societies
- links to relevant Professional Development courses
- the Academy of Surgical Educators
- useful contacts across the College.

Access the Supervisor Support Hub here. Feedback on the webpages is welcomed, as we want to ensure that it is a useful site for our supervisors. If you would like to provide any feedback, please email Supervisor.Hub@surgeons.org

Damian McMahon Trauma Research Travel Grant recipient 2020: Mr Enoch Wong

The Damian McMahon Trauma Research Travel Grant was established in 2014 to commemorate the life of a true advocate for the care of the injured. The prize is awarded for the best trauma paper presented at the Royal Australasian College of Surgeons (RACS) Annual Scientific Congress (ASC) by an eligible entrant, who is then invited to present their paper at the Advanced Trauma Life Support (ATLS) Region XVI meeting later in the year. With the cancellation of the 2020 ASC, the Damian McMahon prize was moved to a virtual platform in line with the ATLS Region XVI meeting, which is scheduled to be held online in November.

Of the 21 papers accepted for an oral presentation as part of the Trauma program of the ASC this year, 11 eligible residents, Trainees and junior Fellows accepted the invitation to present as part of the Damian McMahon Trauma Research Paper Competition on Saturday 29 August. The event was chaired by Dr John Crozier, Chair of the Trauma Committee, and presentations covered a broad range of topics including rib fixation, venous thromboembolism (VTE), solid organ injury, tracheostomy tube function, nail gun injury, imaging in obstetric trauma, concussion and ocular trauma.

The presenters were assessed for the quality of their abstract, a clear aim or hypothesis and methodology, accuracy of results presented, discussion and conclusions, originality, relevance, response to questions and presentation style.

The best paper was awarded to Mr Enoch Wong (pictured above), for his paper 'Use of the Canadian C-spine rule in blunt trauma significantly reduces the number of cervical spine images performed whilst maintaining sensitivity'. This study, performed in a metropolitan non-trauma centre, included over 800 patients in a prospective analysis of the use of CT scanning after the introduction of a cervical spine injury algorithm using this established clinical rule. The study was able to demonstrate a 30 per cent decrease in the use of CT imaging, while maintaining sensitivity to detect any injuries with the introduction of the algorithm. The rate of cervical spine injury was calculated to be five per cent. Only one patient was identified as having a missed injury and this patient did not undergo CT imaging initially despite meeting the criteria as per the algorithm. The study design was simple and utilised appropriate statistical methodology.

A notable commendation was given to Dr Angelika Na from the National Critical Care and Trauma Response Centre in Darwin, for her paper 'CT imaging for patients post-hanging'. Her study revealed that the frequency of adequate imaging in this important group of patients was somewhat less than what would be expected, and concluded that appropriate imaging should be clinically considered given the potentially significant sequelae of missed injury. She was applauded for her work on intentional self-harm, a mechanism of injury that is all too common in communities across Australia and New Zealand.

With 51 attendees online, including the four judges Dr Dieter Weber, Dr John Crozier, Professor Zsolt Balogh and Associate Professor Jeremy Hsu, as well as Helen, Damian's widow, the 2020 Damian McMahon Trauma Research Paper Competition can be considered a notable success. The quality of research and interest in trauma among our members signals a bright future for trauma surgery and the care of our injured patients. I'm sure Dammo would have been very chuffed. ■

Miss Kate Martin FRACS

Trauma Program Convenor, RACS ASC 2020, 2021

Find out more about the Damian McMahon Trauma Research Travel Grant here.

Kiwi surgeons' wish list for the general election

A comprehensive pandemic health recovery plan, a single electronic health record for all New Zealanders, and less reinventing of wheels are on surgeons' wish list for the October 17 general election.

The sight of elderly patients being transported on stretcher beds from their rest home into Burwood Hospital during the COVID-19 lockdown in April was spine-chilling for those of us who work in health care. Was this just the beginning of a deluge? How would our hospitals cope? Fortunately our fears were not realised and New Zealand has continued, so far, to avoid the horrendous situations faced by other countries as they respond to the COVID-19 pandemic.

The management of our response to COVID-19 has been extremely effective, but we are paying a huge price for that and not just economically. Thousands of people have had planned procedures delayed and, while the government has put in more funding to enable hospitals to catch up, infrastructure and staffing limitations mean that many patients are still experiencing long and painful delays.

Given that the infectious cases are still coming into the country from people arriving home, there is no vaccine for COVID-19, and that epidemiologists say we should expect similar pandemics will occur every 10 years, we continue to have serious concerns about our ability to meet the challenges of this and future pandemics.

Singapore, for instance, learnt many good lessons from the SARS outbreak in the early 2000s and the systems it has put in place since then have paid off during COVID-19. We would like the next government to oversee the development and implementation of a comprehensive health recovery plan that enables, for example, planned operations to continue wherever possible.

We would also like the next government to take the idea of a single electronic health system out of the 'too hard' basket. It's difficult to believe that in 2020, about 30 years after information technology began to be adopted in New

Zealand, we still do not have a single Electronic Health Record (EHR) system here.

Currently, for example, if I want the treatment history of a patient who has moved from Auckland to Christchurch, where I practise, I will need to find out which hospital(s) my patient has been treated at, then trawl through scanned records, images and test results. Compare this with most patients who have lived in the South Island all their lives. With a click or two of a mouse I can get a comprehensive picture of their health status, consultations, medications, treatments and procedures.

Having a connected electronic patient record also means that if a drug is recalled urgently, it is easy and fast to identify and inform people who are currently on that medication and arrange for an alternative.

A study of Pennsylvanian hospitals, relatively early adopters of an EHR system, found that between 2005-2012 there was a 30 per cent reduction in adverse medication events, a 27 per cent decrease in aggregated adverse patient safety events, and a 25 per cent drop in complications following tests, treatments or procedures.

Plans for a single EHR have been proposed and talked about in New Zealand for at least 10 years. We wish the next government would make it happen.

Every dollar spent on our increasingly demanding health system is precious so it is concerning that, despite national procurement strategies and legislation to encourage District Health Boards (DHBs) to work more collaboratively, there still seem to be a lot of wheels being reinvented around the country.

This was particularly evident during the national response to COVID-19 as each DHB created its own interpretation of national directives issued by the Ministry of Health. For example, the allocaton of personal protective equipment and the prioritisation of patients' needs varied not only from DHB to DHB, but from hospital to hospital and even from ward to ward. Valuable – and expensive – time and resources are being taken away from where they are needed most. We support calls made recently by the Health and Disability System Review Panel for more collaborative DHBs, and for more consistency among them when it comes to basic operational issues that don't need unique solutions. We hope the next government will adopt the panel's recommendations in this regard.

These are some of the challenges that we would like the next New Zealand government to tackle. The firm foundations are in place, they just need to be built on. ■

Philippa Mercer FRACS
Chair, RACS New Zealand National Board

Study finds inequities in New Zealand General Surgery training

Female General Surgery Trainees in New Zealand perform fewer operations with meaningful autonomy than their male counterparts, a retrospective study has found.

The findings of the study were published recently in *JAMA Surgery*. The study, conducted from December 2012 to December 2017, examined all endoscopic, major and minor procedures performed by all New Zealand General Surgery Trainees in every training hospital in New Zealand. It found, after accounting for differences among Trainees, hospital type, number of female and male surgeon mentors at each hospital, and Trainee seniority, female Trainees performed fewer cases with meaningful autonomy compared with male Trainees. Meaningful autonomy was defined as cases where the Trainee was the primary operator without the surgeon mentor scrubbed for the case.

Being given appropriate autonomy is an important aspect of surgical training, said the study's authors. They wrote that 'Trainees who are able to act autonomously learn better and may achieve superior performance through the development of a range of technical and non-technical skills. Ideally, surgical training programs should be designed for Trainees to gradually gain more responsibility and autonomy in preparation for independent practice.'

The authors concluded there was a need for pragmatic solutions to address this bias and further investigations on mechanisms contributing to discrepancies.

Associate Professor Elizabeth Dennett, a Wellington-based colorectal surgeon and one of the authors of the study, said no aspects of the findings surprised her. "There's an old surgical maxim: see one, do one, teach one. And there used to be a joke with female Trainees: see a hundred, do a hundred, then maybe teach one.

> "Women generally tend to be more reticent about their abilities and promoting their abilities. Society doesn't encourage women to put themselves forward."

Associate Professor Dennett added that "If they do, they're labelled as bolshy or premenstrual; whereas, men are just being affirmative."

There is also a 'chicken and egg' phenomenon at play. "A female Trainee may be very competent but reticent about putting herself forward to be in charge of an operation, the supervisor may perceive this as a lack of confidence and decide to take over the operation, which makes the Trainee feel she isn't competent."

The pressure on hospitals around service delivery and reducing their waiting lists could also be contributing to the problem, Associate Professor Dennett said. Supervisors may feel they don't have time to enable Trainees to perform operations autonomously. "I know there are some hospitals where they identify particular operating lists as teaching lists. The lists are organised in such a way that there is no pressure about time."

One possible solution was for supervisors to have more meaningful one-to-one conversations with Trainees at the start of their rotations to talk with them about what they've done so far and what they'd like to do.

"I hope that people will read the research findings, start thinking about them and reflect on what's happening within their own specialties," Associate Professor Dennett said.

If similar studies were carried out in other specialties she would expect the findings to be much the same. "However, some specialties, such as ENT [Ear, nose and throat, or Otolaryngology Head and Neck], have a large number of female surgeons and Trainees and have had for quite some time so I would be surprised if we saw similar results there.

"Ultimately, society needs to change. Women need to acknowledge that they are just as good as men and, in fact, in some areas we are distinctly better," Associate Professor Dennett continued.

"In general, female Trainees pay far more attention to detail, are far more concerned about following up and make sure stuff's done, and are more committed to giving patients time." ■

The original investigation was published under the title 'Assessment of Autonomy in Operative Procedures Among Female and Male New Zealand General Surgery Trainees' online at jamasurgery.com. To read the full article contact the Library and ask for doi: 10.1001/jamasurg.2020.3021.

Momentous achievement sees vital equipment delivered to PNG

In the midst of a pandemic, people from across the country came together to make the impossible happen.

A remarkable effort was coordinated in mid-September to deliver advanced paediatric life support training equipment to Royal Australian College of Surgeons' (RACS) Global Health program partners in Papua New Guinea (PNG).

The equipment, procured through RACS' Global Health program and funded by the Department of Foreign Affairs and Trade (DFAT), has everything needed to deliver comprehensive training for all types of paediatric emergencies. In preparation for inevitable real-life emergencies they will train with neonate, infant, child and adolescent mannequins. This kit will be utilised through a new local training program, funded by the DFAT Australian NGO Cooperation Program.

With Australia's international borders closed and little hope of transporting the large cargo in a manageable and affordable manner, a strategy was developed that saw 16 large tubs of medical equipment piggybacking a Royal Australian Air Force (RAAF) mission into PNG.

RACS' Global Health Medical Equipment Coordinator, Gill Pye, worked with the Acting Director of Corridor Operations at DFAT, Krystal Millar, to establish a safe passage to PNG through the humanitarian corridor.

The Essential Services and Humanitarian Corridor was established in March 2020

Above: the APLS kits being packed; bottom left: the kits being loaded for delivery.

by the Australian Government to ensure the continued supply of essential services and medical and testing equipment to the Pacific and Timor-Leste.

To date, the corridor, which is operated by DFAT, has been used to provide 33 tonnes of personal protective equipment, COVID-19 testing equipment, medical supplies and other humanitarian goods to 13 countries and territories. More than 150 flights have transported equipment and supplies, and DFAT has also utilised commercial shipping routes for passage to countries not permitting incoming flights.

DFAT utilises commercial transport options in the first instance. However, it draws on Australian Defence Force (ADF) assets when there is a scheduled route happening, and this was the mode used to transport the RACS equipment to PNG.

The incidence of childhood deaths in PNG is a significant concern. Chair of Global Health and orthopaedic surgeon Dr Annette Holian said they only know the number of children who arrive to hospital, as many people live in isolated rural communities where affordable modes of transport are a challenge. "Of those who get to hospital the death rate is around 10 per cent," she said.

Children in PNG are presenting to hospital quite late and, unless they live nearby, it can be difficult to get there, Dr Holian said. "There are often delays in the decision to go to hospital, delays in getting to the hospital and then whether they're at the right hospital for the needs of the child."

What exacerbates the risk is that "kids can get sick and then very sick very fast", Dr Holian said. "They can deteriorate quickly and unless you recognise the signs that they're deteriorating, you can lose them very quickly."

With assistance from RACS Global Health and Advanced Paediatric Life Support (APLS) Australia, local APLS instructors in PNG will train 324 healthcare workers to deliver emergency treatment for children from neonates through to teenagers. Some participants will go on to become APLS instructors themselves.

Acting Medical Director of the Port Moresby General Hospital Dr Kone Sobi is a paediatrician who became interested in the APLS course when he was training at Westmead Children's Hospital in Sydney. He travelled to Melbourne to complete the APLS instructor course before returning to PNG.

"We started this training in Advanced Paediatric Life Support in PNG in December 2018," he said. "Since then we've run several courses including a generic instructor course." They've also produced about 70 graduates since then – doctors and nurses who have been able to put their clinical skills to good use in the hospital setting.

"It's really about the first couple of minutes attending to very sick and seriously injured children who present in the hospital setting," Dr Sobi said. "Our doctors and nurses will be trained to attend to a series of complications with a stepwise, systematic approach."

"We were so grateful for the first APLS kit," Dr Sobi added, "and now this second kit is going to take our training to a whole new level".

For Dr Holian, who was an APLS instructor, the delivery of the APLS kit is a milestone on the way to PNG's self-sufficiency and a contribution that will assist them in that journey.

Her own relationship with PNG began in 1996, when she was a volunteer surgeon there. She met ADF people responding to a disaster in the region and decided to join the RAAF. Now an RAAF Group Captain, Dr Holian has been deployed to war zones five times, including three trips to Afghanistan. "I've seen PNG come a long way, but still recognise the need to partner with them to the next level," she said.

There's a lot of pre-course learning to do in the APLS course, and the face-to-face part of it is focused on skills and discussion groups.

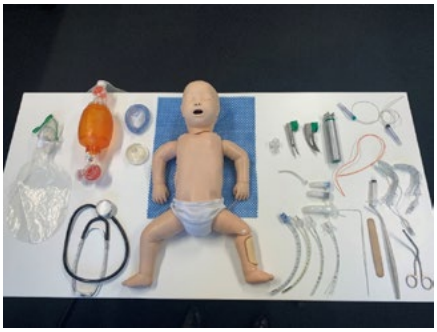
While COVID-19 has shifted what Global Health can do, it has also fast-tracked some of the processes that were under consideration. "We were shifting towards doing more online support and education," Dr Holian said. "Historically, a number of medical teams would go in and provide care," but RACS Global Health is now looking at coordinated capacity building and ways it can expand clinical teaching online.

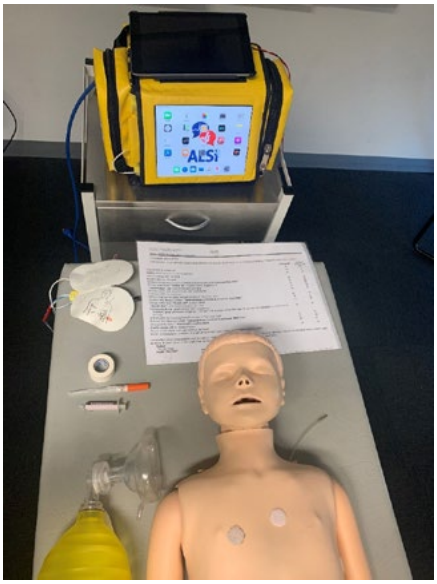
The possibilities of telehealth, for example, are worth investigation, Dr Holian said, because "If you can do telehealth for isolated communities that puts a lot more people in contact with surgeons and getting surgical advice without having to physically be there."

Despite the havoc caused by the pandemic, "COVID-19 has provided enormous opportunities for us to do things in new and better ways," Dr Holian said.

Delays getting sick people to hospital can result in their death on or after arrival, and this creates an impression in resource-poor populations that hospitals are associated with death, Dr Holian explained. "This makes people reluctant to engage with health because they see it as a place where people who are about to die go."

The delivery of the APLS advanced paediatric life support training equipment was an important coordinated component of the partnership between Australia and PNG, one that respects their national right to determine what support they need and when. ■





Above: some of the contents of the APLS kits, including infant airways equipment and defibrilation setup.

Australian Aid

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Royal Australasian College of Surgeons

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surgeons.memberadvantage.com.au

For more information,
email info@memberadvantage.com.au or call 1300 853 352.

Congratulations Dr Michelle Lodge

RACS President Dr Tony Sparnon with Dr Michelle Lodge at the ceremony.

On Thursday 13 August, Dr Michelle Lodge was presented with an Outstanding Service to the Community award in a small surprise ceremony at the Royal Australasian College of Surgeons (RACS) South Australia (SA) office.

The award was presented by RACS SA Chair, Mr David King, in recognition of the role Dr Lodge has played in the management and advancement in care for children with meningococcal septicaemia.

This rare, but potentially devastating infection, progresses rapidly and can be extremely difficult to diagnose. If children survive the initial septic storm associated with meningococcal septicaemia they are typically left with extensive skin and soft tissue loss, which is commonly associated with digit or limb loss.

Mr Bernard Carney, who nominated Dr Lodge for the award, spoke at the ceremony about her diligent management of these complex cases, which included over 60 operations on one child.

He also highlighted Dr Lodge's significant advocacy for the meningococcal B vaccine to be provided free to children, which was approved in South Australia in 2018.

"As a result of powerful presentations made by Michelle to medical grant rounds and the SA Chapter of the Australasian Society of Infectious Diseases, the medical and economic rationale for the meningococcal B vaccine was made. This request had previously been consistently denied by state authorities," Mr Carney said. "Michelle's presentations revealed to other professionals the extreme nature of the surgical problems confronted by the surgeons, nursing staff, patients and their families for the first time."

"Many physicians in our hospital [The Women's and Children's Hospital] commented that they had no idea of the management struggles associated with the patients, and the cause was taken up by the hospital at the highest level," Mr Carney continued.

"Michelle has also played a key role in national advocacy and was a signatory to a letter sent to the Federal Minister of Health asking for the Meningococcal B vaccine to be part of the national childhood immunisation schedule."

RACS President, Dr Tony Sparnon, also attended and spoke at the ceremony, where he paid tribute to Dr Lodge's tireless work ethic and humble nature.

"Michelle is the ultimate quiet achiever, and not the sort of person who would seek or want to be recognised in this way. It is important that we do so though, as she has done so much for the community and our profession," Dr Sparnon said.

"She is not only an outstanding plastic paediatric surgeon, but she is widely respected and admired by all of her colleagues, and those whose lives she touches with her compassion and her care.

This award was created to recognise surgeons with a dedicated history of service to their local community, without whom the standard of surgical care in that community would have been less than society expects. I cannot think of anyone who embodies these values more than Michelle." ■

New Fellows enjoy rural placement opportunities

Dr Priya Nandoskar and Dr Michael Basedow commence pilot program in Cairns and Darwin.

Two new Fellows are thriving in their placements at the Royal Darwin Hospital and Cairns Hospital, through the New Fellow Rural Placement Pilot.

The purpose of the pilot, funded by the Australian Government Department of Health's Specialist Training Program (STP), is to provide a New Fellow (within the first two years of practice post-Fellowship) with a comprehensive, high-quality experience in a rural location that will help them consolidate their skills and encourage them to consider working in a rural setting long term.

On 1 April 2020, Dr Michael Basedow and Dr Priya Nandoskar commenced the pilot in Cairns and Darwin, respectively. Dr Basedow was keen on working in the North Queensland Tropics; meanwhile, Priya travelled north from South Australia after guidance from her mentor, Royal Australasian College of Surgeons Councillor Dr Christine Lai.

Dr Basedow (over page) began his medical career at the University of Queensland then he focused in working in developing areas, with some experience on Bamaga, at the tip of Cape York, and in Vietnam. He also had quite a few experiences during education and training in regional and tropical parts of Queensland.

Cairns is a popular gateway for tourism in tropical North Queensland, with the Great Barrier Reef, the Daintree Rainforest and Port Douglas relatively close by. "I've always been an admirer of Australia's outdoor beauty," Dr Basedow said, "and when I think about it, I get to live in a place that most people consider a tourist destination."

However, for people living in Cairns, accessing the same level of health care as those living in urban centres is challenging. Cairns has a significant Aboriginal and Torres Strait Islander population, as well as people living in rural communities who often present with complex and interesting cases that require surgical attention.

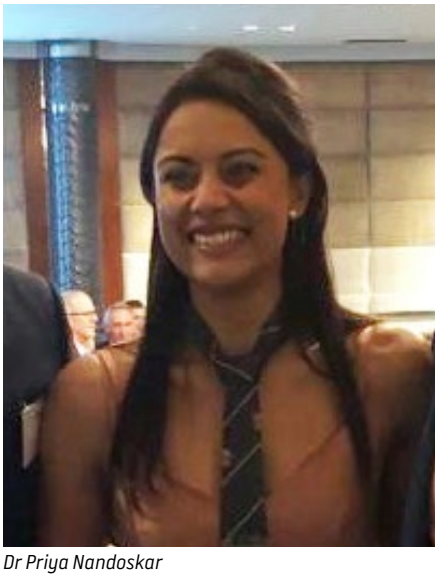
Additionally, due to the city's geographical location and proximity to island nations, tropical diseases that are not seen elsewhere in Australia are present in the region. This makes work for Dr Basedow fascinating. He advocates for the New Fellow Rural Placement as a way of both attracting surgeons to work in rural areas, and providing professional development opportunities that are complex and interesting.

Remote medicine and outreach to the Torres Strait Islands has enriched Dr Basedow's experience as a surgeon. He has welcomed the opportunity to work remotely on Thursday Island. In one instance, Dr Basedow arrived by plane to find a young male with acute apendicitis. Rather than moving him to another location, Dr Basedow was able to perform the surgery immediately.

Dr Basedow hopes the impact of the program on the community will be a positive one. He is hopeful it will encourage new surgeons to spend at least a few years in rural Australia, serving the community. Dr Basedow also hopes that those surgeons will gain a greater understanding of what can be done in these settings and that they'll come back in the long run.

In the Northern Territory (NT), the story is similar for Dr Nandoskar (right). While Darwin is the capital city of the NT, it is also considered a rural location. To the Australian public, Darwin is the tourism gateway to Kakadu National Park, and Australia's WWII history, while a ride on the Ghan Train can quickly find you in Alice Springs and Uluru. For people living in Darwin, the Royal Darwin Hospital is their major health service. In fact, it is the primary health service for the NT, and as the Katherine region is home to a significant Aboriginal population, this presents Dr Nandoskar with opportunities to do outreach services and learn more about Indigenous health. During her placement, she is tutoring an Indigenous student on a weekly basis though Flinders University.

Dr Nandoskar's interest in surgery was sparked when her friend fractured a hand during basketball at school. While concerned for her friend, she found that, instead of experiencing horror like everyone else, she was curious. This curiosity continued through medical school, where Dr Nandoskar was interested in the practical solutions in medicine and wound management. Most of her training was in Victoria, through the Geelong network, which gave her a taste of rural surgical experience.



Dr Priya Nandoskar

Dr Michael Basedow

Earlier in 2020, Dr Nandoskar was considering an overseas Fellowship to gain new skills and experiences. When COVID-19 restrictions were applied to Australia, she decided to stay in the country and participate in the placement on advice from Dr Lai.

By April 2020, she was recruited to the Royal Darwin Hospital. "Since I arrived, it has been the best weather," Dr Nandoskar boasted about Darwin. Despite her original plans to go overseas, Dr Nandoskar has had a great experience. In the future, she is hoping to work at least part time as a rural surgeon.

Dr Nandoskar advocates for the pilot. "I certainly think this is a fantastic idea for anyone considering a rural career. The support is great, the surgeons look after one another and the case mix is very interesting," she said. In a rural setting like Darwin, the training environment offers much more one-on-one supervision and mentoring, and this is helpful to those wanting to develop skills for rural surgery.

"I'm sort of the step between the Trainees and the true supervisors, the consultants," Dr Nandoskar said. This dual position offers her support from senior clinicians while gaining experience in supervising juniors.

Both surgeons believe the pilot is an excellent opportunity for anyone considering careers in rural surgery. The broad exposure to subspecialties, Indigenous health, interesting cases and community support in and out of work is a real advantage to working in rural Australia.

In 2019, RACS received 17 Expressions of Interest from hospitals around Australia, and we hope this interest continues to grow. As this is a pilot, it will not continue in the 2021 clinical year. Once the pilot has been thoroughly evaluated, the Department of Health will decide about the future of the program based on reporting and evaluation from RACS. ■

The New Fellow Rural Placement is funded by the Specialist Training Program (STP), an initiative of the Australian Commonwealth Department of Health.

Putting you at the centre: the One College Transformation

How we are advancing your needs

In the last issue of *Surgical News*, we provided an update on the progress made by the One College Transformation team over their first 12 months. To help us support the implementation of the program,we developed a narrative for the College and provided key messages for the main transformation streams – Technology, People and Culture and Governance. Following are a few key messages that clearly illustrate the intent of the transformation program and outline the benefits you can expect.

We're transforming the ways you engage with the College and putting you at the centre of the experience

Over the next few years we will be transforming and improving the technology, learning and development, governance and service delivery of the College to meet modern expectations of the surgical profession. Our new member management system will enable you to access information and services, move between platforms more intuitively and provide better personalisation to address your needs.

We are enhancing our current Portfolio system in stages with the tools offered by Microsoft Dynamics 365. This will provide significant benefits such as reliable storage and updating profile information and preferences. The new eHub will offer an efficient method of capturing your interactions with the College, including registrations, events and exams – all these interactions will be stored on one platform.

Most importantly, eHub will establish the 'golden record' or a single view of your profile across the College. The 'golden record' will be the single source of truth, providing us with a record of your activities that, in turn, will enable us to provide more personalised services, such as suggesting courses you might be interested in, given your specialty.

We're reducing inefficiency to improve value for you and have a shared purpose to see this through

We are making sure our staff are trained and equipped to support you by ensuring each interaction adds value.

We have established a digital workplace initiative to promote collaboration across the College and enhance business processes by reducing manual work, enabling College staff to better cater to your needs.

The introduction of technology, such as SharePoint Online, Microsoft Teams, Planner and One Drive will improve productivity and relationships between our staff and you, our members. Microsoft Teams, in particular, will give us new ways of working, of which the College has already had a steep learning curve, given the quick escalation of the COVID-19 pandemic.

We need your contribution to shape surgery's future

We need more diverse voices that represent the different specialties, locations and practices of surgery. We are working to exceed the diversity targets in our committees so we can hear from more people. We are also making sure the committee member selection process is transparent.

We are moving to a contemporary model of governance and removing internal roadblocks for approvals. We are putting in place clearer and shorter approval pathways for recommendations. This will minimise duplication and delays and help get committees' recommendations heard and actioned by the Council, reducing the waiting time for new initiatives to be carried out and, ultimately, benefiting the surgical community. Shorter council agendas will ensure important issues are heard and decided on in a timely manner.

We need our Fellows, Specialist International Medical Graduates and Trainees to be involved in and contribute to the transformation program. This transformation is making the College more open and inclusive, giving you many new opportunities to engage and make an impact. We will let you know how you can participate in pilot reviews for the 1CT program. If you have any questions, please email 1CT@surgeons.org. ■

Evidence for surgery in a COVID-19 world

In April 2020, to support surgeons in Australia and New Zealand, the Royal Australasian College of Surgeons (RACS) produced evidence-based guidance on topics of relevance to surgeons during the COVID-19 pandemic.

COVID-19 has forced surgical services to evolve. During the initial peak activity of COVID-19 (March 2020), a reduction in surgical services was imposed to restrict operations to only those most urgent. Many published recommendations to guide surgical practice during the pandemic have been based on expert opinion. There is a clear need for recommendations to guide surgical practice to be based on high-quality evidence.

RACS initiated a review of the safety of laparoscopic surgery following the March release of the 'Updated Intercollegiate General Surgery Guidance on COVID-19' from United Kingdom Colleges. This document recommended that laparoscopic surgery should be avoided. However, our review[1] did not support this position, stating that, 'There is no current evidence that laparoscopy presents a greater risk to the surgical team in the operating room than open surgery, with respect to viruses, but it is important to maintain a level of caution due to the possibility of aerosolisation.'

Other recommendations supported limited use of lower energy devices and for all procedures to use an appropriate capture device to reduce exposure to surgical plume. For laparoscopic surgery, advice was for desufflation of pneumoperitoneum to be performed via an appropriate suction device attached to a high-efficiency particulate air filter. During surgery, all bodily tissues and fluids should be treated as a potential source of COVID-19.

Personal protective equipment (PPE) was reviewed in the surgical setting[2], not only to ensure the safety of operating theatre staff, but also to ensure efficient use of resources. At the early stages of the pandemic, there was concern about supplies of PPE. The guidance developed from the rapid review reinforced the minimum threshold for PPE use by healthcare workers in the treatment of COVID-19 patients. Appropriate PPE is essential, given the virus' transmission capabilities. Surgical staff should wear full PPE, including a surgical P2/N95 respirator, and eye and head protection during operations on patients with confirmed COVID-19, in addition to surgical emergencies and aerosol-generating procedures where the patient has not been confirmed as COVID-19 negative. Staff must have formal training in the use of PPE, and should be supervised by a colleague during donning and doffing. Patients with suspected or confirmed COVID-19 should wear a surgical mask during transfer to and from theatre.

Surgical triage was considered important, especially at the early stage of the pandemic, to guide the selection of cases that could be conducted with safety. In April 2020, a working group produced recommendations from the rapid review of existing guidelines,[3] stating that urgent surgery should continue throughout the pandemic, with a staged return of elective surgery aligning with a decrease in COVID-19 caseload.

Preparation for a potential future surge in COVID-19 cases was considered crucial, and was borne out by the subsequent Victorian experience. A case-by-case assessment of the need for surgery should incorporate the patient's health, risk of COVID-19, and the supply of hospital resources. Multidisciplinary care and initial assessments by senior consultants should be implemented wherever possible. An 'Advised Schema for Elective Surgery Triage' was also developed to address situations where elective surgery was appropriate. A staged approach was suggested to enable a careful expansion of elective surgery, which, if COVID-19 escalated could be rolled back relatively quickly.

The initial literature searches for these three rapid reviews have been repeated weekly since early in 2020, as part of a medical student's (Joshua Kovoor) Honours thesis. This has enabled updated literature to be included in revised rapid reviews. Interestingly, despite the large amount of evidence produced there have been no significant changes to the original recommendations.

Recently, RACS was included as a member of the National COVID-19 taskforce, and we are working with the Living Evidence Consortium, which supports the committees of the taskforce. Professor Mark Frydenberg is the RACS representative on this group and he will report more on this in the next issue of *Surgical News*. ■

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

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Sir William MacCormac (1836-1901) Knight Bachelor, Baronet

The surgeons of *Vanity Fair* part four

In the *Vanity Fair* issue on 1 October 1896, Sir William MacCormac was presented as 'Man of the Day' No. 660. The accompanying caricature by 'Spy', Leslie Ward, was captioned as 'Gun Shot Wounds'. It confirms that MacCormac was a big man, standing over 6 feet 3 inches. *Vanity Fair* described him as one 'who has lately achieved the summit of his professional ambition by being improved into President of the Royal College of Surgeons of England'.

Vanity Fair continued, 'he is a bluff, handsome man of very few words, though he can speak sarcastically, as many a student knows. Altogether, he is an exceedingly agreeable fellow with a good heart, many friends, and (possibly) no enemies.'

Sir William was an Ulsterman, born in Belfast on 7 January 1836, who died in Bath on 4 December 1901. He was the elder son of Henry MacCormac, Professor of Medicine at Queens College Belfast and spent half his life in Northern Ireland and the latter half in London.

As a schoolboy, MacCormac was in no way distinguished. He was educated at the Belfast Institution, which he left at 15 years of age to enter Queen's University Belfast in October 1851. He gained scholarships during his first two years as a student of Engineering before turning to the Arts, graduating with a Bachelor's degree in 1855, and Masters in 1858. In 1857, he was admitted MD (Belfast), and also attained the Membership of the Royal College of Surgeons (RCS, England). After graduation he studied surgery in Berlin and made lasting friendships with Bernhard von Langenbeck and Theodor Billroth. In 1859, he became a resident at Belfast General Hospital and undertook postgraduate training in London and Dublin. MacCormac obtained the Fellowship of the Royal Colleges of Surgeons (FRCS, Ireland) in 1864, and was then elected as consultant surgeon to that hospital from 1864 until he left in 1870.

In 1861, he had abducted and married Katherine Maria Charters, an heiress of Belfast, the union being opposed by both families. She subsequently survived him, but there were no children of the devoted marriage.

On 19 July 1870, the Franco-Prussian war broke out and this was to change MacCormac's life forever. Seeking a challenge, MacCormac attended a public meeting in London on 4 August 1870, when the British National Society for Aid to the Sick and Wounded in War, finally reconstituted as the British Red Cross Society in 1905, was formed. The Geneva Convention had been signed on 22 August 1864, allowing for the organisation of neutral battlefield hospitals and ambulance corps. The new British Society assisted in providing aid to both warring armies under the protection of the Red Cross emblem, designed as the inverse of the Swiss flag in honour of one of the movement's Swiss founders, Jean-Henri Dunant.

The MacCormacs immediately made their way to Paris. Katherine remained there, while William ultimately served as Surgeon-in-Chief of the Anglo-American Ambulance at Sedan. In 1870, the word 'ambulance' had the double meaning of a wagon or carriage designed to transport wounded patients, and also that of an improvised field hospital.

Napoleon III's ill-advised declaration of war resulted in France suffering its first major defeats in early August and, by 2 September 1870, Napoleon had surrendered to the Prussian forces, following the Battle of Sedan.

Ironically, MacCormac's arrival at the Sedan Railway Station coincided with Napoleon III's arrival, the latter being taken prisoner. MacCormac later wrote: 'in place, therefore, of our going to the front, the front came to us'.

MacCormac was now responsible for a 384-bed hospital on the battle field of Sedan. He noted 'during the first fortnight I performed with one or two exceptions, all the operations'. For 15 days he had no time to remove his boots. His *Notes and Recollections of an Ambulance Surgeon*, published in 1871, was translated into

many languages. MacCormac became a household name among the military surgeons of Europe. *Vanity Fair* observed 'When any Prince or other person of note is hit on a moor or in a cover, by the unhandy gun, he is always called in.'

Returning to London in 1871, MacCormac was admitted FRCS *ad eundem*, a rare distinction, and became Assistant Surgeon at St Thomas's Hospital. In later years, he would drive there in a smart brougham with scarlet wheels, drawn by a fine pair of black horses. This love of display endeared him to the students and his diary revealed that wine, cigars and stable were his largest expenses. In time he became the most decorated surgeon of his generation; however, his very many medals lay without any order in a drawer at his home.

He contributed largely to the success of the Seventh International Congress of Medicine held in London in 1881. The meeting lasted over a week and met all over London in various hospitals, museums and colleges. At a time of massive advances in medical practice, those most involved were there: Rudolf Virchow, Louis Pasteur, Sir William Osler, Robert Koch and Joseph Lister, to name but a few. As part of the social program, Baroness Burdett-Coutts held a garden party at her Highgate home for the most eminent Congress participants. The occasion was recorded in a group portrait (above) now in the Wellcome Collection, London.

There were 3181 registered participants and the official languages were English, French and German. At the time, MacCormac was the General Secretary and then Editor of the *Transactions* – of which no less than 2500 pages were printed in the languages of the respective speakers. For these services, he was knighted at the age of 45. MacCormac's knowledge of foreign languages and foreign doctors, as well as his organising ability, and with his Irish bonhomie, were unique.

At the RCS, MacCormac was elected a Member of Council in 1883, and to the Court of Examiners in 1887. He served as president over the years 1896-1900, on the last occasion specifically to direct the centenary of the College in March 1900. However, as he was serving in South Africa as government consulting surgeon to the Field Force, celebrations were postponed until July. This was MacCormac's final military involvement. He celebrated his 65th birthday in South Africa; nevertheless, he undertook some front-line surgery at Colenso, working in two tents with two operating tables in each. MacCormac disliked Field Marshal Herbert Kitchener, never forgiving him for his remark, 'You want pills, I want bullets, and bullets come first.'

On MacCormac's return to London in April, the RCS centenary occupied him. In July he presented Edward, Prince of Wales, with the first Honorary Fellowship of the College. (In 1978, when your author was presented with his hard-earned FRCS diploma, the Patron of our own College, Charles, the current Prince of Wales, was awarded his Honorary FRCS.) Besides the degree-giving, there were Conversaziones, a grand banquet, a Presidential address of Welcome and a reception at the Mansion House. In the College library, museum and council room, exhibitions were held of portraits, busts, and manuscripts illustrative of the history of the College.

The last year of MacCormac's life was compromised by controversies. He felt bitterly about how much of the country had been misled by those who decried the work of the Army Medical Service and who knew little of war. MacCormac's final illness came in a matter of weeks, with the onset of back pain and insomnia. He agreed to travel to Bath to 'take the waters', only to die suddenly at 66 years of age. ■

Mr Peter F. Burke
FRACS

Images l-r:

Swiss ambulance evacuating wounded French. 1871. Edouard Castres (1838-1902); Baroness Burdett-Coutt's garden party, August 1881, MacCormac centre rear; the Baroness second to his left; Gun Shot Wounds. Spy. 1 Oct 1896.

IMAGE REFERENCES

1. Unknown author, William MacCormac, 1st Baronet. Public Domain.
2. Leslie Ward, Caricature of Sir W MacCormac, Vanity Fair, 1896. Public Domain.
3. Edouard Castres, Swiss Ambulance Evacuating Wounded. 1871. Public Domain.
4. Tilt AP, Baroness Burdett-Coutt's Garden Party at Holly Lodge, Highgate. 1882. Licensed under Creative Commons CC BY 4.0.

Surgical research in a pandemic world: obstacles and opportunities

The College's new key initiative to support the development of trainee-led research collaboratives through the Clinical Trials Network Australia and New Zealand (CTANZ) has exceeded expectations.

Since its inception just a few years ago, we have seen an increasing number of networks established. CTANZ has grown and now spans the geographic breadth of Australia and New Zealand. Its engagement includes many of the surgical specialities such as General Surgery, Vascular, Paediatric, and Plastic and Reconstructive surgeries. Importantly, these collaboratives are now delivering outcomes from large scale studies that inform our surgical practice.

However, this has not been without challenges and, along with the rest of the surgical community, the COVID-19 pandemic has affected the functioning of trainee collaboratives this year. From late-March, travel between countries, states and regions largely stopped and the surgical community has now moved into a virtual world. In addition, non-urgent surgery in Australia and New Zealand was largely cancelled from late-March until May/June. Parts of our countries are now again experiencing reduced surgical activity due to the impact of a second wave of COVID-19.

Travel restrictions combined with less actual surgery had the potential to seriously disrupt trainee research collaboratives and surgical training in general. CTANZ was directly affected, with a scheduled face-to-face meeting cancelled in early April. We also lost the ability to meet during the College Annual Scientific Congress in May, and at the upcoming Annual Academic Surgery Conference.

Surgical research has been put on hold in many other countries, including the United Kingdom (UK) where surgical trials were stopped after February. Our UK colleagues are sanguine, as they look forward to restarting clinical research in the UK in this challenging environment.

Despite these challenges, 2020 has presented unique opportunities and ultimately revealed itself to be a year of significant growth. Nascent international collaboratives have developed as CTANZ adopted Zoom technology to meet more frequently and continue ongoing planning.

CTANZ is supporting the SUNRRISE trial through regional General Surgery networks in the five mainland Australian states. SUNRRISE is a UK-led randomised trial of negative pressure wound dressing, compared to standard dressing in patients undergoing emergency abdominal surgery. In Australia, it is funded by the Medical Research Futures Fund.

The trial commenced last year in the UK. Approximately 400 participants were recruited by February, but no further activity was possible from March. The trial commenced in Australia in January 2020, and because the impact of COVID-19 was less severe, the trial was able to continue with more than 200 patients recruited in six months. This recruitment rate, which is well above what was anticipated, has ensured the success of this international collaboration. CTANZ now anticipates contributing nearly half of the total patient cohort for the study, around 400 participants.

Opportunities specific to COVID-19 have also arisen. CTANZ networks across Australia and New Zealand have contributed to large international cohort studies informing pandemic health care decisions and surgical practice worldwide.

The initial COVIDsurg study confirmed a high mortality risk for patients undergoing even minor surgery under general anaesthesia when infected with COVID-19 during the perioperative period.[1] COVIDsurg-Cancer determined the impact of COVID-19 on cancer treatment outcomes. It demonstrated better outcomes when surgery was undertaken in hospitals not impacted by COVID-19.[2] We are proud to report that 94 surgeons and trainees from our region contributed to this study and are cited co-authors in the *Journal of Clinical Oncology* publication.

Other COVID-19-related international studies include CholeCOVID, which evaluates the impact of COVID on surgery for gallstone disease, and 'COVIDsurg Week', a large international study that is evaluating surgery worldwide, with recruitment expected to exceed 50,000. 'COVIDsurg Week' is well supported across Australia and New Zealand and, importantly, the UK Global Surg group has requested that CTANZ/RACS becomes the Oceania and South-East Asia recruitment hub for the 'COVIDsurg Week' study. Devolvement of responsibility to CTANZ has been taken as a show of confidence and an acknowledgement of the contribution that RACS Fellows, trainees, junior doctors and medical students have made to previous COVIDSurg global studies.

Paradoxically, COVID-19 has been both an impediment but also a catalyst to grow trainee-led research collaboratives, and it is heartening to see the enthusiasm of our trainees, who are actively participating in a series of significant, practice-changing international studies. CTANZ is achieving one of its chief aims, which is to provide the foundation for future growth and development of trainee research capacity across Australia and New Zealand.

We call on College Fellows to lend their support to trainees by recognising the value and power of these research collaboratives, and encouraging the future contributions to this exciting collaborative research endeavour. ■

Professor David Watson
FRACS
Clinical director, CTANZ

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The canon of plastic surgery: embodying art and beauty

Part II

OPUS LXV

Professor Donald Marshall

Part I of this essay featured in Volume 21 Issue 4–2020 of *Surgical News*. I discussed my New Zealand associate, the late Bill Manchester, and Benny Rank, who introduced me to Plastic and Reconstructive Surgery in Melbourne.

The other two players in this quartet are Don Marshall (above) and John Hueston (rightt).

The late Don Marshall was Benny's protégé, and he had plastic surgery in the palm of his hand in Melbourne, if not Australia (yes, I came from Brisbane), over a period of almost 50 years. He was selected by the 'master' to carry the mantle.

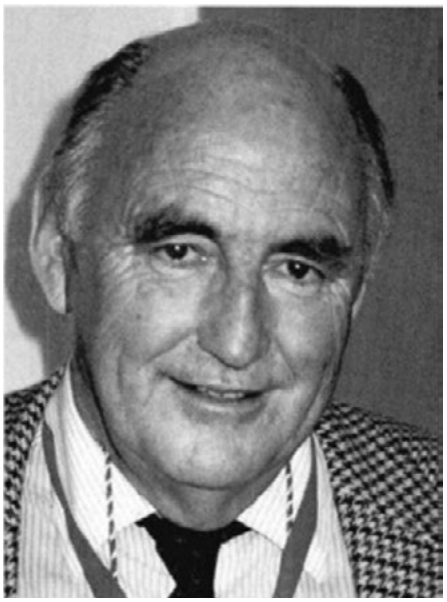
Don's career in plastic surgery was outstanding, with a fine surgical aptitude seeking perfection. I can still recall Don repeating such words in those months before passing, when he recalled certain operations, "How could I have done this better?" – his *modus operandi*. It was Don who taught me refinement in the surgical sphere. Don had the mind of a philosopher with a heart of gold – *un bel esprit*.

The final person in this quartet, and the one with the greatest influence on me, was the late John Hueston. His consulting rooms were next to mine, and the pattern of his working commitment was easy to recall. He had the largest plastic surgical practice in Australia, and Tom Robbins recently showed me an audit of his surgical bookings, which could only be described as monumental.

I can recall meeting John outside his rooms in Royal Parade one Friday afternoon. I had just completed what I though was an 'arduous' list at the Western Hospital and was complaining to John about my surgical commitments. He said, "Try this: I finished four rhinoplasties by midday." Yes, I paled in comparison.

His surgical program would be all-day lists, on Tuesdays from 7.30am to late in the evenings, interspersed with emergencies. This pattern was repeated on Fridays, and even overflowed onto Saturdays. He had the international reputation of surgical excellence seeking perfection and followed in the footsteps of his English mentor, Sir Archibald McIndoe.

It was McIndoe who advised John to capitalise on the Dupuytren's contracture procedure to compete with Tord Skoog from Uppsala in Sweden. The 'Viking disease' was so named because of the contractual development in the ulna half of the hand, developed from the Vikings' prodigious rowing activity of their



Mr John Hueston

flat-bottomed boats. They came across the North Sea and spread their 'Nordic' disease through Europe. Brian Collopy recounted recently to me that he was John's registrar at the Repat Hospital in 1960-1961, and did the photography for John's book on Dupuytren's disease in 1963, over a weekend of manic activity. It was one of the first in the world.

Clearly John inspired people with his work philosophy, combining technical proficiency and surgical innovation. His operation of integumentectomy for disseminated cutaneous melanoma was one such item.

He would editorialise in international surgical journals, and he was an insomniac, working from daylight to dusk. He did ward rounds at his private clinic at the Cotham even at dawn, to

The Royal Melbourne Hospital, circa 50s-60s.

the understandable annoyance of the night staff. On many a Saturday morning, I would see his Citroën parked in Royal Parade, presumably attending to correspondence organised by Lorraine, his personal assistant of many years. Here is a little 'silky' note; she threaded the silk sutures onto his needles before the emergence of the nylon phase. My Saturday mornings were far more relaxed: after going to the Victoria Market for baguettes and buying French patisseries from Les Halles, I would return home to watch the French news with my wife, Mariette.

One of the best stories of John's international prominence in Dupuytren's disease needs retelling before it is lost in the archives, not forgetting, surgical memoirs are really the back stairs to history. It was at the time of the introduction of Medicare when an international financier had complications from poor surgical attempts for his Dupuytren's disease in Europe. John Hueston's name was known internationally, and so a trip was organised to Australia for surgical correction.

However, the Department of Immigration was concerned he was coming to get a free Medicare procedure – this was corrected when it was revealed his wealth was such that he could buy out Medicare financially. The procedure was successful and the patient was photographed leaving Tullamarine with an almost normally extended hand, fully extolling John's surgical talents.

Another international snippet from the 90s tells of an Italian professor of hand surgery in Milan, who gave a presentation about the seven cases of Dupuytren's he had treated in the last seven years. At this meeting, the chairman of the session remarked how grateful they were to have the world's expert, John Hueston, in the audience. John later remarked, "Felix, I could not help myself and told the open forum that in the week before I left Australia, I did seven Dupuytren's procedures." Not seven years, but seven days experience for John.

At another international hand meeting in Melbourne in the late 70s, John showed a video of his fasciectomy technique. Either by instrumentation or by oversight, the technician played it on semi-fast forward. The audience was stunned at the 'speed' of John's surgical execution.

Another surgical story worth repeating occurred when John was part of the Army team working with the American forces in the Korean Peninsula in the 1950s. (He was in transit to London for postgraduate studies.) The late Don reminded me of this story that John retold on his return. On one particular occasion after operating for up to 12 hours, as was his want, he 'blew a fuse'. The incessant noises of the howitzers outside the hospital precinct were enough to produce this emotional outburst. An American colonel casually walking by heard the conflagration. He popped his head into the operating theatre tent and, on hearing the reasons for the outburst, said "John, if they stop both you and I become prisoners-of-war, like *M*A*S*H*!"

Besides seeking perfection in surgery, John adored the fine arts; he even obtained a post-graduate Fine Arts degree, and wrote a thesis about the eminent sculptor, Rodin. This mirrors the introduction to these two essays highlighting the link between classical form, sculpture and the Fine Arts.

John spent the final period of his life in France, living in Aix-en-Provence at St Saturnin. Tom Robins, his long-term associate in Royal Parade, may have been the last Australian plastic surgeon to visit him before he passed.

Tom would share his clinics and enjoyed John's encouragement in writing papers ranging from fingertip repairs to breast reconstruction. Tom revealed in the final letter he received from John that he had written a cryptic statement. 'After you visited me, when we said goodbye Tom, it was raining here (tears).' How portentous!

John had an incisive mind, a brilliant memory and a heart committed to his profession. He taught me the art of dedication in Plastic and Reconstructive Surgery. He refined my techniques in the Dupuytren's fasciectomy, which I gleaned from those Tuesday visits to the Cotham Clinic for months on end. He was a real-life video teacher – there is nothing like watching Rick Stein's television food show to demonstrate how to master a French recipe. (Even at my maturing age now, Springers International is about to sign contracts for a video series on how to perform the Keystone technique.)

The recollections here really portray, for me, a debt of honour to the personalities who have helped me in my surgical journey. Yes, there have been highs and lows, peaks and troughs, successes and setbacks, compliments and reprimands. Yet dedication to the patient's welfare has been my salvation – something I gleaned from John Hueston.

To these 'four pillars of wisdom' (paraphrasing T.E. Lawrence) I will be forever indebted. I must add, that my late wife, Mariette, was a vital link in this chain of maturing development. She was my guiding force emotionally and psychologically. She added the touch of Gallicism from their idiomatic way of thinking and acted as a 'wise owl' – *un hibou*. She was my perennial confidante.

As Berlioz said, '*Il faut casser le noyau pour avoir l'amande*' – it is necessary to break the nut to enjoy the almond. Really, thank you, Benny, for introducing me to the Melbourne surgical scene. ■

Associate Professor
Felix Behan

Spotlight on our surgical societies

ANZSCTS: Moving steadily through 2020

ANZSCTS President Mr Aubrey Almeida talks about the society's plans and challenges.

President of the Australian & New Zealand Society of Cardiac and Thoracic Surgeons (ANZSCTS) Mr Aubrey Almeida (above) is keeping a watchful eye on the ANZSCTS community as he leads the society through the COVID-19 pandemic.

With 252 members, including 132 Australian Fellows and 24 New Zealand Fellows, it's proving to be a challenging year with the cancellation of the annual scientific meeting and the transition of meetings and teaching to online platforms.

Elective surgery has been cancelled or limited in varying degrees across Australasia and, in April, the World Health Organization declared that the presence of underlying cardiovascular disease confers the highest mortality with COVID-19.

Helping Trainees through COVID-19

While everybody is finding it tough, Mr Almeida is especially concerned about ANZSCTS Trainees who are separated from their families. Trainees in Melbourne, who have families in New South Wales, those in Sydney with family in Perth, and Trainees from Australia who are in New Zealand and vice versa, he said.

"We have a Trainee representative on our Executive and they've done a great job of running regular Zoom catchups and a WhatsApp group," he added. But COVID-19 has brought something else to the society's attention, he explained. It's that "we really need to improve support for Trainees when they get to their new posts without their families and friends. They're in a new hospital with a whole lot of challenges and I think that's something we need to address."

The ANZSCTS Executive is currently discussing the idea of allocating mentors to Trainees, separate from current supervisor training, Mr Almeida said. While still in the early stages they're keen to set up a support network to help Trainees navigate their new landscape.

"One of the great things about Cardiothoracic Surgery is that it's a relatively young specialty," Mr Almeida said. There's a lot of innovation and change happening, as well as "disruptive technology in terms of transcatheter valve implantation, both in the aortic valve and the mitral valve. It's an area where a lot of younger surgeons are gaining experience and the training program needs to evolve to incorporate that."

An important focus for the society is to engage with younger people, and from Mr Almeida's perspective "the earlier the better because often they're the people with the best ideas". Clearly, he's succeeded, as 39 of the 41 Trainees have decided to also be members of the society.

Advocating for the patient in an age of specialty overlap

One of the current challenges for Cardiothoracic Surgery is that it overlaps with other medical specialties quite considerably. For example, there's a large overlap with cardiology, Mr Almeida explained, and this has created challenges in the treatment of coronary artery disease where stenting has become a popular alternative to coronary artery bypass surgery.

It's important that cardiothoracic surgeons advocate for patients and help them decide the best treatment option. For a patient who would have traditionally been having open cardiac surgery, but will now be having transcatheter aortic implantation (TAVI), "make sure that the indications are appropriate for each patient", Mr Almeida said. "Make sure the surgeons are involved in the multidisciplinary team meetings, that people are well-trained and that surgeons are part of the treatment modality."

Avoiding major surgery can be an attractive option for patients, especially if it can be done with what appears a safer and faster operation with a small, or no, incision. "But we have to make sure we're clear on the science and the evidence behind it," Mr Almeida said. "That people have an understanding of the true advantages and disadvantages. Sometimes the patients' initial emotive response may not be the right one."

Trying to achieve long-term survival of five, 10 or 20 years, rather than short-term results that look good at three months or a year, should be the aim, Mr Almeida said. At the same time "We don't want to be wedded to old treatment modalities that aren't as good as new treatment modalities."

Transitioning to consultancy

An upcoming focus for the society is looking at how it can assist Fellows in their first couple of years of consultancy. Transitioning from Fellowship to consultant practice with all the associated responsibilities can be very challenging, Mr Almeida said.

The society conducted a survey a couple of years ago around the transition, and is looking at writing a paper on processes that can help surgeons on this professional journey.

"The margins for error are very small and it's a great specialty because we get to make a huge difference, but these are life and death decisions," Mr Almeida said. "It's a tough thing to expect someone to just suddenly go from a supported position to an unsupported one."

Almost every referral requires an operation, he added, and that means that "if we see a patient, by and large, we will end up operating on them ... In our specialty, every operation is, by other standards, a high-risk operation."

As far as Cardiothoracic Surgery goes, it's a really difficult specialty, Mr Almeida added, "and the way to do it well is to support each other". This is why, he pointed out, there's a lot of self-evaluation and continuously looking at ways to improve processes and better support colleagues.

The ANZSCTS cardiac surgery database

ANZSCTS established the database in Victoria in 2000. By 2006, it had developed into a national database that collected and analysed data related to cardiac surgeries across Australia and New Zealand. Currently, there is collected data from 153,944 surgeries.

There are 26 public and 30 private hospitals contributing to the database, and 15,500 cardiac surgeries performed each year.

The society sees the collection and monitoring of data as best practice. The surgical performance data is shared with the cardiac surgical community in the hope that it will lead to discussion and improved outcomes, both individually and nationally.

"We take the audit, assessment and evaluation very seriously," Mr Almeida said. "But equally, we make sure that evaluating things doesn't necessarily equate to being critical of individuals ... it's about trying to get that balance right and striving to do better."

Women in surgery

Like many other specialities, women are under-represented in Cardiothoracic Surgery. Of the 41 Trainees, 11 of them are woman, and Mr Almeida is keen to increase this number.

A forum had been organised for the now-cancelled 2020 scientific meeting with female Trainees, and there were hopes that discussions would lead to ideas and plans about how to make the specialty more accessible to women.

Cardiothoracic Surgery has had some outstanding women surgeons, Mr Almeida said, but it's not enough to "hold up successful women as a sign we're doing a good job of gender equality because we're not".

"One of the things we wanted to discuss was how do we make Cardiothoracic Surgery accessible to people who don't want to work 120 hours a week," he explained. "I think it's wrong to presume that anybody of any gender wants to be hired in a stereotypical way."

Mr Almeida said he believed that while the average male cardiothoracic surgeon will have a successful career, the equivalent female surgeon has to work harder to achieve the same success. "We have to try and make it fair for everybody," he said. "Gender equality isn't just about allowing the best people to be best. It's allowing everybody to have an equal chance."

Working with the College

ANZSCTS has a good relationship with the Royal Australasian College of Surgeons (RACS), Mr Almeida said, but one area that's been a little difficult is "understanding who's responsible for what". However, he says, "I think the College is taking really good steps to address that" and "we're looking closely at how we can best work together to address our goals".

For a small specialty, there's a significant overlap of members who are, or have been, in executive positions on the society and also in positions at the College. These professional contributions benefit Cardiothoracic Surgery as well as the wider RACS community.

Associate Professor Julie Mundy is RACS Vice-President and a strong member of the society, Professor Julian Smith was president of ANZSCTS and also on RACS Council, and Mr Almeida is on the training board and an examiner for the Fellowship exam. ■

Case note review

Communication is the key to rational decision-making

Reviews of important surgical procedures help us improve outcomes. This is a case study selected by the ANZASM Committee for your information.

Background

An 89-year-old woman presented to hospital with symptomatic heart failure and constipation. Significantly, she had a history of rheumatic fever and, in 2005, had undergone a tissue mitral valve replacement and tricuspid annuloplasty. In recent years, she had developed structural deterioration of her bioprosthetic valve, which presented itself as increasing mitral stenosis. The degree of stenosis was now graded as severe. Although said to be living at home independently, she was becoming increasingly symptomatic with poor quality of life.

Sequence of events

The patient presented to a large regional public hospital with exertional dyspnoea and neck pain. A diagnosis of heart failure and constipation was made. After initial assessment the patient was transferred to a private hospital under the care of her usual cardiologist. The main underlying diagnosis was severe bioprosthetic mitral stenosis. She was treated symptomatically with aperients and changes to her heart failure medications with minimal improvement.

The regional centre could offer no further treatment options, and a consultant-to-consultant referral was made to a cardiologist at a large tertiary referral hospital for consideration of further valvular intervention.

Following referral, the patient underwent a re-evaluation and the diagnosis of severe prosthetic mitral valve stenosis was confirmed, together with significant tricuspid regurgitation, severe right ventricular dysfunction, severe pulmonary hypertension, and grade 2 (out of 4) aortic regurgitation with aortic sclerosis.

Other issues listed in the referral letter included possible angina, hypertension, atrial fibrillation on oral anticoagulant, a dual chamber permanent pacemaker, renal insufficiency with a glomerular filtration rate (GFR) of 35, bronchiectasis, osteoporosis and gastro-oesophageal reflux.

The question of further surgical intervention was raised, and a surgical opinion was sought. The reviewing surgeon felt the option of redo surgery was out of the question as the risk was unacceptably high. Percutaneous valve replacement via a valve-in-valve technique was considered by the medical team, and the patient was reviewed by the structural heart team.

The patient was placed on the pathway for a percutaneous valve replacement. The high risk of the procedure was explained and stressed to the patient and family. The patient insisted she proceed with the procedure as her symptoms were unacceptable to her.

The procedure was scheduled and was carried out by cardiology with no surgical input. However, the procedure, although described as technically satisfactory by the cardiology team, was complicated by ventricular fibrillation and cardiac tamponade. An attempt at a percutaneous pericardial drain was made by the cardiology team and a subxiphoid approach quickly followed. A partial lower sternotomy was made by a surgical team summoned to the hybrid theatre by the cardiac arrest call. Although the pericardial collection was ultimately drained, a decision was made against further intervention. All resuscitation and active measures ceased.

Areas of good practice

The note keeping in both the regional centre and the tertiary referral centre was generally very good. The entries were contemporaneous, informative, and to the point. The sequence of events was able to be followed.

Areas of practice questioned

The issue of whether a complex intervention in an 89-year-old patient was appropriate was never raised. Providing medical management only does not appear to have been considered. The question of what long-term functional improvement could have been expected in a patient of such an advanced age does not appear to have ever been addressed.

Attention was focused on the prosthetic mitral stenosis but no attention was paid to the correct heart issues.

The Cardiac Society of Australia and New Zealand (CSANZ) and the Australian and New Zealand Society of Cardiac and Thoracic Surgeons (ANZSCTS) have a position paper on percutaneous valves.[1] In addition to specifying the credentials

and technical aspects required for individuals and institutions to perform the procedure, the two societies place emphasis on each institution establishing a 'heart team' to independently review patients being considered for a percutaneous valve. The aim is to ensure the suitability of the procedure for each patient.

Patients should be fully investigated then presented at a meeting of the heart team before a recommendation is reached as to the most appropriate management, whether it be surgical valve replacement, percutaneous valve replacement, or ongoing medical management only.

In addition, if a patient is accepted for percutaneous intervention, possible emergency surgical intervention in the case of misadventure needs to be documented. The surgical team must be made aware of the date and time of the procedure to ensure immediate availability of a surgical team and operating theatre.

In this case, the patient was reviewed by the heart team registrar and other members of the team; however, there is no documentation of the case being formally presented at a heart team meeting. There is no documentation of the consensus opinion regarding further management, or the course of action in the event of procedural misadventure.

The surgeons who operated on the patient were alerted to a problem by the emergency bell ringing in the hybrid theatre and were told the patient was for active management.

Due to a combination of factors, the end result was expected.

Summary

This case reflects poor patient selection for intervention of any type, failure of cardiology teams to follow protocol, and failure to communicate with the surgical team called to help unprepared.

This case presents governance issues and would benefit from a root cause analysis, if one has not already been done. ■

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

REFERENCE

1. Walters DL, Webster M, Pasupati S, Walton A, Muller D, Stewart J, Williams M, MacIsaac A, Scalia G, Wilson M, El Gamel A, Clarke A, Bennetts J, Bannon P. Position statement for the operator and institutional requirements for a transcatheter aortic valve implantation (TAVI) program. Heart, Lung and Circulation 2015 March 01;24(3):219–223.

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

Responsible approach to alcohol policy

The Royal Australasian College of Surgeons (RACS) has developed a Responsible Approach to Alcohol policy. This new policy mirrors our public advocacy work of highlighting the harm that alcohol can cause in the community, and to the health of individuals.

Our workforce is unique in that it comprises paid employees and surgeons who offer their services pro-bono. It is essential for anyone representing the College to uphold the highest standards of behaviour when performing any service, whether paid or unpaid, within the workplace or at events, including after work hours.

Please read the policy at tinyurl.com/y2ctl8r5 to find out more about our duty of care as an employer and our approach to events and business meetings. ■

Infringements of the Geneva Convention on Australian prisoners

The 1929 Geneva Convention on the Treatment of Prisoners of War stipulated that all prisoners 'should at all times be humanely treated'. It states that prisoners should be employed in accordance to their physical fitness – that the duration of daily work should not exceed that of the local population employed in the same type of work, and that 24 full hours of rest ought to be allowed every Sunday.

The Convention also demands that sufficient food rations and water be supplied to all prisoners. Importantly, it states that 'prisoners of war shall have no direct connection with the operation of the war' and they should not be employed in 'unhealthy or dangerous work'. The Convention demands that sick prisoners suffering from specific diseases such as an enlarged liver caused by malaria, and by inference from other infectious diseases, be repatriated.

A recent search in the National Archives of Australia shows that in 1941, on the island of Crete, the German Army perpetrated war crimes against a group of Australian soldiers, while a German physician committed crimes against humanity.

The war on Crete began with a surprise paratrooper attack by the Germans on 20 May 1941. The resistance by the Australians and New Zealanders was ferocious, and there were 600 Australian deaths and 220 Australians injured. Ultimately, there was a German victory and occupation that lasted until 1944.

The first infringement of the Geneva Convention occurred when Australian prisoners were employed in construction work at the aerodrome, and later at other military facilities, with insufficient food supply.

The second infringement occurred once the war turned against the Axis powers, when just over 1000 prisoners were transported to forced labour camps in Germany (stalags). They stayed there until May 1945, working under severe conditions in unhygienic surroundings.

These are revealed in the testimony of Private George, SA, given in 1942 to the Australian Military Authorities. He had been captured by the Germans in June 1941 on the island of Crete, and forced to work in the construction of military facilities. He worked 10 hours each day until he escaped in July 1941. He was re-captured, court-martialled and condemned to hard construction labour near the Rethymno General Hospital, renamed the German Military Hospital.

He reported that the rations were "one meal a day (one slice of bread and cooked beans) and half a pint of water, twice a day".

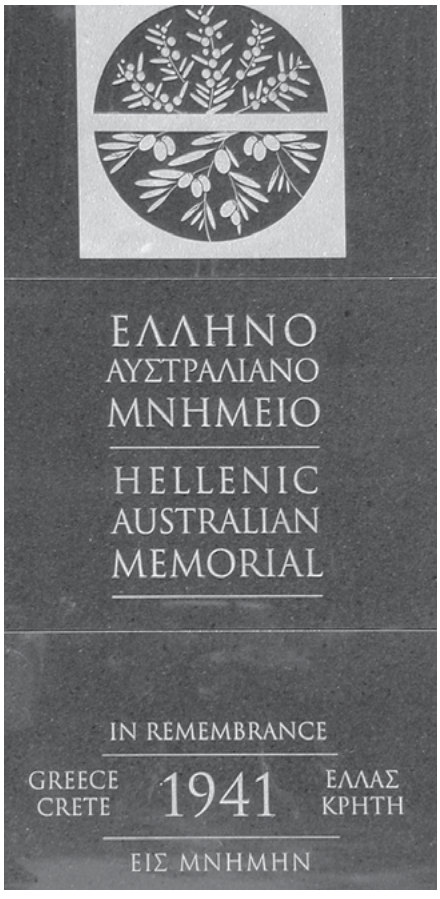
The third and most serious of the infringements were the crimes against humanity perpetrated by a German doctor in Crete.

The physician selected five young Australian prisoners from the construction site. They were physically examined, had blood and urine tests conducted and X-rays performed. The soldiers were declared 'sick', despite no physical complaints, and were admitted to the hospital ward, which was full of very unwell German soldiers.

Private George, one of the Australians stated, "the doctor … withdrew blood from a German patient and immediately injected it into my vein in my arm … Within the space of 24 hours, all became very sick." On day 10, further blood was injected, "on this occasion in the buttocks … all were very sick".

The Australians protested. "We all knew that we were being used for experimental purposes and objected," Private George reported. Subsequently, they were released and returned to their camp. Private George finally managed to escape and returned to Australia via Egypt.

Who was the German physician at the Cretan hospital? The presence of Dr Friedrich Meythaler in Crete, and his subsequent publications, are congruent with the Australian soldier's testimony.



Dr Meythaler was a renowned bacteriologist with numerous prewar publications on the liver and infectious diseases, and later in his career on diabetes and insulin related malfunctions.

Dr Meythaler was born in 1898. He studied medicine at the eminent universities of Heidelberg and Munich and graduated in 1922. He joined the Sturmabteilung, the Nazi paramilitary wing, early in the new regime in 1933, and his career progressed rapidly. He was named an associate professor in 1939.

The war took him to Crete as a staff physician, dealing with infectious diseases affecting the invading forces. Hepatitis was one of the endemic diseases in the Mediterranean area, and an area of interest to the doctor. The German soldiers in the hospital were jaundiced, and Dr Meythaler was looking for proof of transmission of hepatitis. Accordingly, he investigated and published an article in a German medical journal in 1942, revealing that "I carried out on Crete transmission experiments from person to person through transfer of blood … in three of the experimental subjects … distinct liver enlargement was observed."

Dr Meythaler was professionally promoted to full professorship at the Nuremberg University Hospital in 1942. In1947, he became Director of Medicine in the Nuremberg Hospital, and at neighbouring Erlangen University. There is no record of him being tried for any infringement of human rights.

This Nazi physician was guilty of crimes against humanity for non-consensual medical experimentations. The doctor forfeited his Hippocratic obligations and caused the suffering of human beings. He should have been charged with crimes against humanity, as defined by the Nuremberg Trials in 1947.

This reported case is considered the first documented medical experiment on an Australian prisoner of war. ■

Dr George M Weisz, FRACS

2020 Surgical Workforce Census

Look out for your email invitation to be part of the 2020 RACS Surgical Workforce Census in November.

The Surgical Workforce Census is conducted every two years, collecting important data to inform advocacy and workforce planning. Key data collected includes work patterns (employment status, hours worked, private/ public mix), characteristics of the rural and regional workforce, health and wellbeing, contribution to the SET Program and future work intentions, including retirement.

All active and Fellows who live in Australia and New Zealand will receive an invitation to complete the census using the email address registered with the College. All Fellows who participate will go into a draw to win a $500 gift card. Your participation is vital to help shape the future of surgery. Email workforce@surgeons.org for further information.

Library collections: beyond books

Way back when I started my library career librarians did really 'collect' and build 'collections'. Mostly, it was actual books, but library services were starting to move into cassettes or video cassettes before CDs and DVDs also found their way onto the shelves. Academic library shelves were filled with journals, with binders doing a good job of turning individual issues into bound volumes that required more and more shelf space.

These days, librarians still put much of their time into building collections to anticipate and meet their patrons' study, work and leisure needs. However, building a collection in 2020 involves many different processes. Most of the traditional print publishers, such as Elsevier, Springer, Wiley and Oxford have turned their hand to making their titles available online. So, now, rather than buying a print copy of a journal, binding it and keeping it on the shelves, librarians need to basically 'rent' access to content available in larger and larger databases.

Our library clients work and research in a number of specialties and subspecialties, so part of the collection development process is to do our best to ensure all these areas are covered. The specialty pages on the library website provide listings and links to key and popular e-resources. Suggestions for additions to these pages are always welcome.

Like many libraries, the Royal Australasian College of Surgeons (RACS) library builds its collection by combining large packages offered by journal publishers with a range of subscriptions to individual e-journal or e-book titles. When putting together these packages many publishers include non-print, multimedia materials.

Multimedia content

- ClinicalKey

Extensive e-journal and e-book online collections can be found at www-clinicalkey-com-au.ezproxy.surgeons.org, with options to browse procedure videos, use the Presentation Maker with images, or access ClinicalKey Patient Education materials.

- Access Surgery and Access Medicine

These resources can be found at: https://accesssurgery-mhmedical-com.ezproxy.surgeons.org/ and https://accessmedicine-mhmedical-com.ezproxy.surgeons.org/ respectively. They include videos, patient education handouts and selected episodes from the 'Behind the Knife' surgical education podcast. ▶

- An@tomedia

This program, accessed at anatomediaonline.com.ezproxy.surgeons.org/, covers anatomy from multiple perspectives and is useful for anatomy studies at both undergraduate and postgraduate level.

- Acland's Video Atlas of Human Anatomy

This learning aid presents images of the real human body in three dimensions at aclandanatomy-com.ezproxy.surgeons.org/.

Searching and accessing content

While there are many quality e-resources available, the library has licensed access to a number of reputable databases, search tools and apps that make it easier to find relevant material. Talk to library staff about which ones could work for you.

A Recommend a Resource form is available online at surveymonkey.com/r/FQTDXDD to request that the library investigates obtaining a new e-resource for the collection.

Other online forms make it easy to order a journal article, which we may scan from the print journal archive, request from another library or use a commercial service to obtain. This is a very popular and well-used service that is available at no cost to RACS member. Loans of books from other libraries are available as well. Library staff can also undertake expert searches and deliver results by email. Both these options are requested via forms on the library webpage.

All these services are normally provided with a quick turnaround time, but please get in touch for a discussion with the team if you have more urgent or unusual needs. ■

Graham Spooner
Manager, Library and Information

Meet the library team

The RACS library team are all highly experienced in the health libraries field, with extensive knowledge and expertise in information organisation and retrieval.

Manager **Graham Spooner** has worked for a long time in the College library environment, with 19 years at the College of Nursing before joining RACS. His interests include trialling and evaluating new tools and systems that can make information-seeking simpler and more efficient.

Graham Spooner is retiring after seven years of dedicated service at RACS. We wish him all the best.

Kirsten Burkitt (Electronic Services Librarian) has been at RACS for almost 19 years and looks after the online library. She maintains resources so they are accessible through the A–Z Title Listing, Summon, and the Specialty resources pages. She also troubleshoots any problems that arise.

Librarian **Kelly Phillips** has worked for RACS for 12 years. The main focus of her shared role (three days per week) is to source all journal article requests and perform literature searches for RACS members. **Judy Czuchnowski** has worked in hospital and other health-related libraries for decades. She currently shares the job with Kelly, working two days per week.

All in all, combining a very experienced and expert team with a well-resourced collection of e-resources, tools and apps is the perfect recipe for a high-quality service for the members and staff of RACS. If you're not already taking advantage, why not start now?

The easiest way you can support safe surgery today: tell us what you think!

Your views are important to us. You would have recently received your survey in your letterbox. The survey takes most people several minutes to complete, but it can make a lifetime of difference.

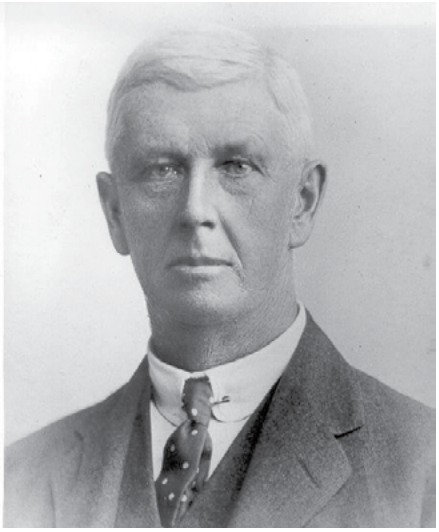
So please complete it and return it using the reply paid envelope provided and show your support for accessible safe and quality surgical care today.

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

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

Royal Australasian College of Surgeons
Foundation for Surgery

100 years ago



The 11th Australasian Medical Congress was held in Brisbane in October 1920. At the session of the Surgical Section it was proposed that a surgical association be established in Australia and New Zealand, with the aims of raising and maintaining surgical standards and accrediting surgeons by means of Fellowship.

The proposer was Louis Barnett, Professor of Surgery at the University of Otago. Barnett favoured a system like the one developed by the recently founded American College of Surgeons (1912). (This American bias may be the reason Barnett was referred to in the proceedings as Professor at the University of Chicago.) In the event, Barnett was unable to travel to Brisbane to present his proposal, and so the eminent Melbourne surgeon R. Hamilton Russell did it for him. Balcombe Quick seconded the motion.

Debate on the motion followed. Almost immediately an amendment was proposed by R. Gordon Craig:

'That, with a view to the advancement of the science and art of teaching surgery in Australasia, the members of this Section favour the formation of a section of surgery in each Branch of the British Medical Association in Australia and New Zealand.'

Debate then turned to this amendment, and it became a discussion about the authority and influence of the British Medical Association (BMA), to which all the delegates belonged. It effectively stymied Barnett's idea of an independent organisation open to all surgeons.

George Syme expressed deep concern about the suitability of such an association as proposed by Barnett. Henry Newland called Barnett's proposal 'a dagger in the heart of the BMA'. Hugh Devine lamented that the debate had become an argument about the BMA, rather than about improving surgical standards. Ralph Worrall noted that American and Australian situations varied considerably, and there should be no attempt to follow an American model.

The discussion became somewhat acrimonious, but eventually 'Dr Craig's amendment was carried by a large majority.' Barnett's proposal had failed, but the seed had been planted, and over the next few years it took root. Nearly all those involved in the discussion at the Congress became Founders of the College.

Syme was knighted in 1924, was a signatory to the Foundation Letter in 1925, and was elected first president of the College in 1927. Newland was knighted in 1928, and became second president of the College on the death of Sir George Syme in 1929. Barnett was knighted in 1927, and became fourth president in 1937. Devine, the real driving force behind the formation of the College, became its fifth president in 1939. He had been knighted in 1936. Hamilton Russell became the first censor-in-chief.

In 1931, Gordon Craig bequeathed the sum of £60,000 (about $2.4 million today) to establish the Library. But in 1920, this was all in the future. ■

Top left: Dr. R Hamilton Russell. Above: Professor Louis Barnett

In memoriam

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

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

Kenneth Brearley (VIC)

Ronald Bruce Davey (SA)

Barry Partridge (NZ)

Informing RACS

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

ACT: college.act@surgeons.org

NSW: college.nsw@surgeons.org

NZ: college.nz@surgeons.org

QLD: college.qld@surgeons.org

SA: college.sa@surgeons.org

TAS: college.tas@surgeons.org

VIC: college.vic@surgeons.org

WA: college.wa@surgeons.org

NT: college.nt@surgeons.org

Ronald Bruce Davey OAM FRCSEd FRACS

Paediatric surgeon

21 October 1931-22 June 2020

Bruce Davey, as he was known, died on Monday 22 June 2020 after a long period of illness. Despite this his faculties and determination remained to the very end.

Bruce was born in Newcastle, New South Wales, on 22 October 1931. After secondary education at Newcastle High School (1944-48) he attended Sydney University, graduating MBBS in 1955. He then served as resident medical officer at Sydney Hospital in 1955, Royal Hobart Hospital in 1956 and Royal Alexandra Hospital for Children, Camperdown in 1957 under senior paediatric surgeon Douglas Cohen. On Cohen's advice, Bruce travelled to the United Kingdom, achieving his Fellowship of the Royal College of Surgeons in General Surgery in Edinburgh in 1960. After four years in general surgical positions, Bruce was appointed as registrar to Peter Paul Rickham at Alder Hay Children's Hospital, Liverpool.

1963 saw Bruce back in Australia as deputy superintendent at the Royal Hobart Hospital. Towards the end of this appointment, Bruce 'transported' a patient to the Royal Children's Hospital (RCH) in Melbourne, where he met the revered Douglas Stephens AO. As a result of that meeting Bruce was appointed senior surgical registrar at the RCH in 1964. In the first six months of that appointment Bruce worked with Murray Clark, Peter Jones and Alan Wakefield, which clearly fostered his future interest in Paediatric surgery and, in particular, in the treatment of burns.

J.K. Freeman FRACS

Kenneth Stewart Brearley FRACS FRCSEng FRCSEd

General Surgeon

3 December 1928-16 July 2020

Ken Brearley started life in Hampton (Melbourne) where he attended both Hampton Primary and Hampton High schools before winning a scholarship for Years 9-12 at Scotch College, which was quite some distance away. In 1948, having won a place into Medicine at the University of Melbourne in the highly competitive years immediately after World War II, Ken was sent to Mildura, in regional Victoria. In 1947 the University of Melbourne had established a campus outside of Melbourne to accommodate the huge influx of students enrolling as servicemen returned. The whole first year of Medical studies took place in the former Royal Australian Air Force station, the so-called 'Mildura experiment'.

Ken graduated in 1952 and was awarded the Proxime Accessit Jamieson Prize in Surgery. His residency years were spent at the Royal Melbourne Hospital and then, typical of the era, a year was spent in the University of Melbourne School of Anatomy in preparation for the Fellowship exams, which were duly successfully negotiated.

In 1955 he set sail overseas to gain surgical experience in the United Kingdom. By this time he had married a nurse from the Royal Melbourne Hospital. His first appointment was at the Royal Postgraduate Medical School in Hammersmith Hospital in London, where his first child was born, and then north to the Leeds General Infirmary, Yorkshire, where his second child was born. At Leeds he spent a rewarding time working with both Professor John Goligher, a pioneer in colorectal surgery, and Mr Henry Shucksmith, a general surgeon who became prominent in the newly emerging specialty of Vascular surgery.

Hamish Ewing, David Butterfield, Boon Hong with assistance from his daughter, Amanda Woodard.

For the full obituary please visit our website.

We are gravely concerned that due to the COVID-19 pandemic, the health inequities already experienced in Aboriginal and Torres Strait Islander communities will become exacerbated.

Now, more than ever, it is time to show our support for Indigenous health.

A very special thanks to all those who have completed and/or gave in the recent **supporter survey**.

Your feedback will help us improve and work harder than ever to increase access to safe and quality surgical care. Thank you.

Gold/Silver

Mr Douglas Allan
Mr Peter Dryburgh
Dr Catherine Ferguson
Rotary Club of Glenferrie
Mr Arend Merrie
Mr Martin Rees
Dr Tapukitea Taumoepeau

Bronze

Miss Meera Raju
Dr Hamish Alexander
Mr Paul Anderson
Mr Peter Annear
Mr Michael Barnes
Miss Ginny Barro
Mr Laszlo Borbely
Miss Ingra Bringmann
Mr David Brougham
Prof Ian Campbell
Mr Michael Caughey
Mr Jin Cho
Mr Anthony Ciccocioppo
Mr Thomas Clements
Mr Harvey Coates
Mr David Cottier
Mr Alan Crosthwaite
Mr James Davidson
Prof Kumud Dhital
Mr Peter Dobson
Mr Falah El-Haddawi
Dr Kirsten Finucane
Mr Colin Fitzpatrick
Mr Adrian Flemming
Mr John Flood
Mr William Gilkison
Prof William Gillespie
Prof Glen Gole
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