SurgicalNews

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Royal Australasian
College of Surgeons

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Articles of interest

Aboriginal and Torres Strait Islander people are advised this content contains images of deceased persons on page 26.

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President's perspective

As we come to the end of this very long year I think it is important to acknowledge the challenges that have been thrown at us in 2020, and the efforts of so many people who have helped us to deal with them.

The year 2019 ended in tragic circumstances with the Whakaari/White Island volcanic eruption in New Zealand and then we had devastating bushfires that raged across large parts of Australia and carried on well into 2020.

As I have said previously, these tragedies often bring communities together and I was so proud to see the surgical community contributing to this effort by caring selflessly for the many injured in both countries. The small group of burn surgeons and their well-trained teams in both Australia and New Zealand were assisted by many others and did an unbelievable job. The Australian and New Zealand Burn Association must be congratulated on their excellent Emergency Management of Severe Burns Course, which has trained so many to be prepared.

In regard to the bushfires, the Royal Australasian College of Surgeons (RACS) made two submissions to the Royal Commission tasked with examining this disaster. Professor David Fletcher, Chair of RACS' newly formed Environmental Sustainability in Surgical Practice Working Group, was asked to participate in a videoconference consultation where he discussed our submission.

The final report from the Royal Commission was released on 30 October 2020, and provided 80 recommendations covering a range of different areas. I was pleased to see that the College's submission was referenced in the report. Several of the issues we raised were addressed in the recommendations.

Part of the responsibility of the Royal Commission was to examine our preparedness for any natural disasters

and to guide future emergency responses. I hope the recommendations will lead to targeted improvements and meaningful insights and learnings about how we can best prepare and respond when the next natural disaster occurs. Thank you to everyone who was involved in preparing RACS' submission.

As the state of emergency escalated in Australia, news of the outbreak of COVID-19 first began to filter through. At that stage no one quite comprehended what this would mean for our two countries and the rest of the world, but within weeks the urgency of the situation was clearly apparent.

From the outset of the pandemic, our priority was the health and safety of our Fellows, Trainees, Specialist International Medical Graduates (SIMGs) and staff. We followed a set of overarching principles to guide our decision-making. We agreed that we would act in the best interests of patient care and the community, and in consultation with our stakeholders and the healthcare systems in which we work. We wanted to make sure that we acted consistently, transparently and fairly across all our training and educational programs.

While these actions were necessary, I know that they were also terribly disruptive for many. I empathise with those who were impacted, particularly our Trainees and those whose livelihoods were affected. I would like to extend my gratitude to everyone for your understanding and support. The work performed and support shown by the specialty societies, the New Zealand National Board, and state and territory committees have allowed RACS to be seen as 'One College' and our views appreciated and actively sought by the national and state governments.

Despite the challenges, I was delighted that we were still able to deliver the Fellowship Examination. Holding an exam in over 50 venues in five different time zones for 290 candidates involving 250 examiners is an extraordinary achievement that most colleges would not contemplate attempting. Thank you to everyone who made this possible: our examiners, specialty societies, staff throughout Australia and New Zealand, and, most importantly, thank you to our candidates for their patience. Earlier in the year, it looked highly unlikely that these examinations would go ahead, and it is a credit to so many that they were delivered successfully.

While much of our advocacy efforts in 2020 have focused on navigating our way through COVID-19, we have not lost sight of our other priorities. We continued to advocate strongly in areas such as road trauma and rural health, among others.

Another issue that emerged with greater prominence due to COVID-19 was telehealth. In Australia, the College was a strong supporter of the temporary telehealth Medicare Benefits Schedule item numbers and has been writing to, and speaking with, the office of the Australian Federal Minister for Health and the Commonwealth Department of Health to advocate for their extension until March 2021.

We have been advised that over the next few months the Australian Government will be looking at the future of telehealth and we plan to continue to engage, and advocate strongly for a long-term role for telehealth in our health system.

COVID-19 and the Black Lives Matter protests shone a spotlight on health issues and racial injustice around the world. There has also been an increase in domestic violence, child abuse and health inequalities, which have been highlighted during the pandemic. As the virus took hold in the United States and the United Kingdom, health authorities quickly noticed that people from racial and ethnic minorities were at increased risk of getting COVID-19 and experiencing severe illness. This is partly due to higher rates of existing health conditions such as heart and lung diseases, which are strongly associated with more severe outcomes from COVID-19. Similar risk factors also put Māori and Indigenous Australians at high risk.

Post-pandemic, we must learn from these experiences and review how we do everything, rather than going back to the old ways. On a bi-national level we need to continue advocating for our position on changes to health governance and care, including telehealth, as well as maintaining our work on health equity. At RACS we may have to rethink the need to hold all meetings in person in Melbourne, the future format of exams and courses, the format for the Annual Scientific Congress and how and where staff work in the future, especially as we plan to redevelop the Spring Street building in Melbourne.

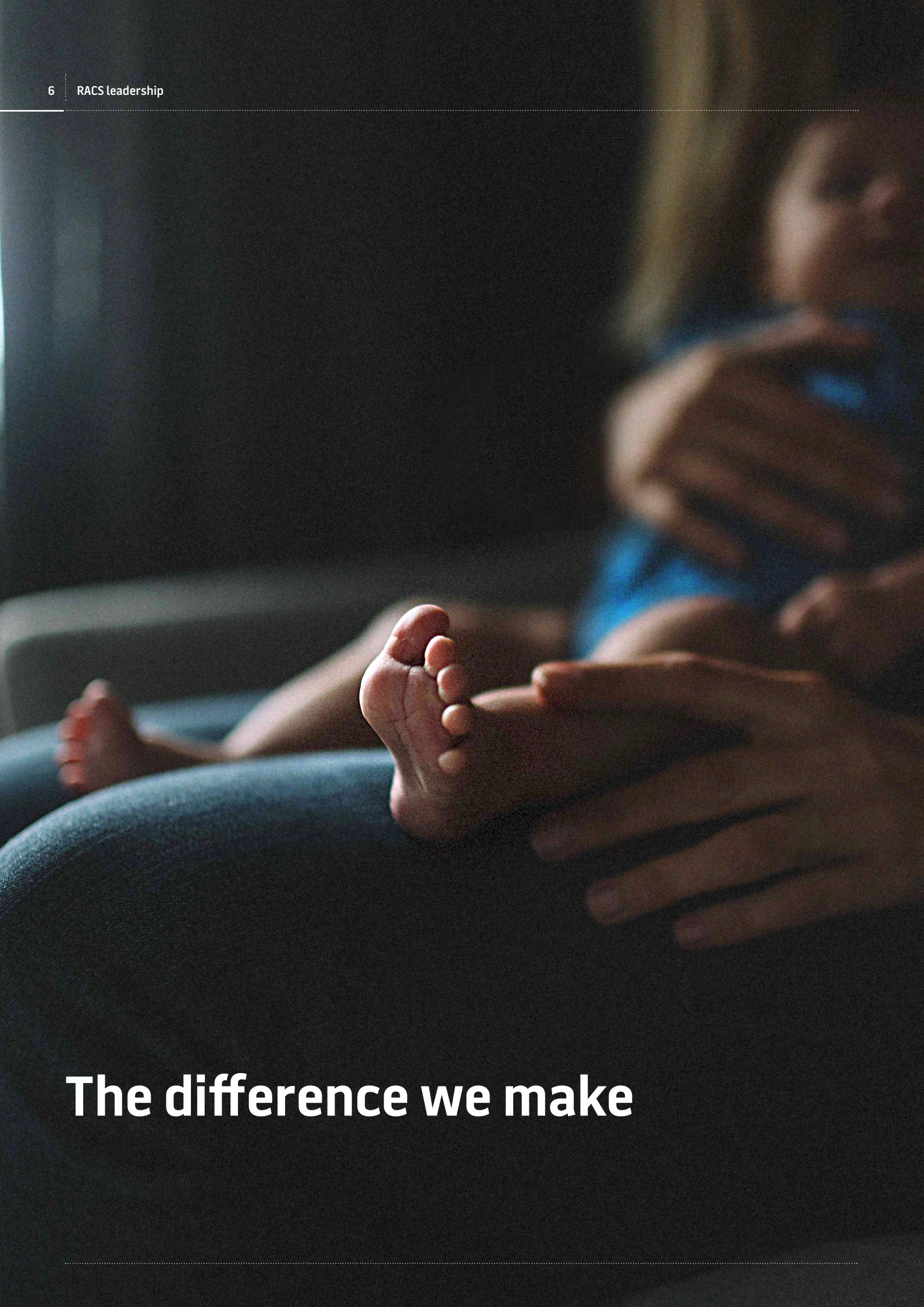
It has been a year of grief and many hard decisions have been made, but it has also been a year that has made us reflect on what we can do better as surgeons and as a society. At the time of publishing this article, the situation in Australia and New Zealand is improving but others around the world are very much in the grip of the pandemic. I have communicated with the colleges in India, United States, Sri Lanka, Edinburgh, England and Ireland passing on our best wishes and support.

While none of us can predict what 2021 will bring, we hope that we will continue to foster the spirit of resilience and camaraderie that has seen us through 2020. ■

Mr Tony Sparnon
President

COVID-19 financial impact

We are acutely aware of the importance of supporting our members who may be experiencing financial difficulty due to the significant impacts of COVID-19. Please keep an eye out for further advice on annual fee reduction options available to our members for the forthcoming 2021 subscription year.



The difference we make

"What counts in life is not the mere fact that we have lived.

It is what difference we have made to the lives of others."

—Nelson Mandela

What a year it has been. COVID-19 has dominated nearly every aspect of our lives. More than ever, it makes me think of the communities that do not have the health infrastructure we have, and the dire situations they are in.

At this time of the year we start to hear the first carols and see the first decorations of the festive season. This year I hope it is also the time that we reflect on our fortunate lives and remember that there are many in a far less fortunate position. This might be the occasion you take a moment to consider a donation to the Foundation for Surgery. Every donation makes a tangible difference to help the lives of children, families and communities so they can access safe and quality surgical care when they need it most.

As Chair of the Foundation for Surgery and former RACS President, I have an enormous sense of pride that surgeons have not only achieved so much in their own careers, but also have proven to be great philanthropists in supporting the Foundation. We are joined by incredible donors, who have a shared commitment to increasing the accessibility of quality surgical care. It is through your extraordinary support that so much has been achieved in global health, Indigenous health and research over the last 40 years.

Amidst the unprecedented turbulence of the last 12 months, it would be easy to forget that there have also been some major steps forward, significant wins that have only been possible because of dedicated supporters like you.

Thanks to your support, the Foundation for Surgery has had significant results. Over the last year, more than 1167 patients from developing countries in the Asia-Pacific region have undergone procedures that would have otherwise been inaccessible. In these same countries, 2303 local health workers have attended training to meet the ongoing health needs of their communities. Several projects supported the urgent COVID-19 response in the Asia-Pacific region. Nineteen Indigenous doctors received scholarships to support their surgical careers. In addition, 50 scholarships and grants were awarded to fund groundbreaking surgical research to help us all live our healthiest lives. But there is still a lot more to be done and we need your help to continue and expand on these essential activities.

This year, as you reflect on the difference you have made, I urge you to consider the Foundation for Surgery. Please help ensure more children, families and communities can access safe and quality critical care when they need it most.

The Foundation for Surgery relies on donations and bequests to continue to support disadvantaged communities, health equity and research that improves surgical outcomes for all.

As you know, no overhead or administration fees are deducted from your donations so that 100 per cent will assist in addressing critical surgical needs and achieving the greatest impact in the community. ■

Mr John Batten FRACS
Chair, Foundation for Surgery

Royal Australasian College of Surgeons

Foundation for Surgery

Donating is very simple and there are several ways you can make a difference. Please consider one of the following:

1. Go to surgeons.org/foundation/ to donate and receive an instant tax receipt
2. Complete and return the flysheet form attached to this edition of *Surgical News*
3. Donate when you pay your annual subscription or fee.

Alternatively, if you would like to make a more substantial personal contribution or even establish your own scholarship, please contact Jessica Redwood, Manager, Foundation for Surgery at foundation@surgeons.org.

Whatever you do, please donate today. This simple act will make an enormous difference to someone's life when they need it most.

A message from the President of the Royal College of Surgeons of Edinburgh

As the President of the Royal College of Surgeons of Edinburgh, I am delighted that we will be co-hosting the 2021 Royal Australasian College of Surgeons (RACS) Annual Scientific Congress in Melbourne in May 2021. I hope upon hope that I can be with you in person to welcome you to Melbourne but, we all know that decision is not in my hands. It feels like there may now be light at the end of the tunnel with the announcement of the first vaccine. It looks promising, but there is still a long way to go.

It has been a difficult year for all of you working within the healthcare sector, but also for all those across the globe whose families, friends and loved ones are dealing with an extraordinarily challenging situation. We, as surgeons, dentists and healthcare workers, must set the example of social distancing, meticulous hygiene and restraint, in our workplace and at home, and hope that the population, in general, appreciates and realises the serious risks if we do not adhere to these principles.

As someone who has dedicated their life to saving lives, it is abhorrent to me that we are having to choose between the health of people and the health of the economy. I have to say that Australia and New Zealand have shown us how it ought to be done by moving quickly to lock down borders, test, test and test again, and to lock down regionally. Your strategy has worked.

I have long been an admirer of RACS and it gives me great pleasure to be hosting this joint enterprise next year, whether that be virtually, face-to-face or as a blend. I am really looking forward to the conference in whatever guise it is held. As two prestigious colleges, we share strong bonds and common values, especially when it comes to looking after our members and Fellows in the workplace. Our campaign, #letsremoveit, sought to stamp out bullying and undermining in the workplace and our latest campaign, 'Making it Better for Everyone', builds on that work and now focuses on diversity, patient safety and sustainability, all of which I know are high on the agenda for RACS.

Now, more than ever, it is important that we continue our strong bonds and work together to strive for the best standards of patient safety and care, even in such challenging conditions. The widespread adoption of teleconferencing, webinars and the beginning of online examinations has not only allowed us to continue our important work, but also to find new ways of educating and developing the incoming generations of surgeons, dentists and healthcare professionals. We will utilise what we have learnt to share best practice, to debate and to discuss the issues as a collective group in May. The program looks outstanding, with a mix of online and in-person events (COVID-19 dependent), allowing us to share learnings across specialities, forge new relationships, seek out new opportunities and tighten our strong bonds with colleagues around the world.

Professor Michael Griffin OBE

I am still optimistic that over the coming six months we will reach a new normal that allows us to get elective surgery back on track and hold more face-to-face meetings, as well as remote, educational meetings. We all miss our friends and colleagues around the world. I look forward to a time when we can all meet safely again. In the meantime, I send my very best wishes to you all. ■

A snapshot of the Royal College of Surgeons of Edinburgh

In 2021, RACS will be collaborating with the Royal College of Surgeons of Edinburgh to host the 89th Annual Scientific Congress. Read on to find out more about this illustrious college.

- The Royal College of Surgeons of Edinburgh is 515 years old, and came into existence through the Seal of Cause, granted on 1 July 1505.
- The College formally became 'The Royal College of Surgeons of Edinburgh' in 1778, after being granted a new charter by King George III.
- The College contains seven Faculties, the latest being the Faculty of Remote, Rural and Humanitarian Healthcare, launched in 2018.
- The College currently has a membership of approximately 30,000 individuals.
- Forty per cent of the membership is comprised of international affiliates, members and Fellows in over 100 countries around the world.
- The College is not only based in Edinburgh, but includes a satellite office in Birmingham, England, and an international office in Kuala Lumpur, Malaysia, to meet the needs of the growing international membership.
- Surgeons' Hall Museums, originally developed as a teaching museum for students of medicine, officially opened to the public in 1832, placing it among Scotland's oldest museums.
- The College Library today contains around 40,000 books, some of which are very rare. Among these is a copy of the *Nuremberg Chronicle* dated 1493, two *Books of Hours* dated 1450 and 1490 and a first edition of William Harvey's *Exercitatio anatomica de motu cordis* (1628).
- Joseph Lister, a former College Fellow, was world-renowned for his groundbreaking work in the prevention of wound infection, which contributed greatly to the advancement of surgical standards and led to him becoming known as 'the father of modern surgery'.
- James Young Simpson, another Fellow, was the first physician to show the anaesthetic properties of chloroform and helped popularise its use in childbirth as a method of pain relief.
- The current patron of the College is His Royal Highness Prince Philip, Duke of Edinburgh, who was awarded Honorary Fellowship on the 450th Anniversary of the College.
- Joseph Bell, a former President of the College (1887-1889), was known for his powers of observation and diagnostic acumen. One of his students, Arthur Conan Doyle, used Bell as the model for the character of the famous detective, Sherlock Holmes. ■


doldash Australia

Spotlight on

Giving back

The College wouldn't be the success it is without you.

This is the time we reflect on what has happened during the year and 2020 has certainly been unique. However, throughout all the turmoil we have continued to give back. We want to acknowledge and thank all those who work to empower and uplift others.

Read on to find out more about the fantastic work you and your colleagues contribute to by donating time to keep the College running, and mentoring and educating our next generation. See your contributions through the work done by the Foundation for Surgery and our Global Health program, and more.

There are a large number of surgeons, Trainees, Specialist International Medical Graduates and retired Fellows like you who give back so generously of your time, expertise or financial donations.

Thank you for everything you do – this year more than ever.

Aboriginal and Torres Strait Islander and Māori health

Facilitating long-term change by addressing some of the cultural, social and economic barriers to Aboriginal and Torres Strait Islander and Māori people being over-represented in the poor determinants of health through supporting aspiring Indigenous surgeons in Australia and New Zealand.

Working to enhance recognition and awareness of Aboriginal and Torres Strait Islander and Māori health issues, promoting excellence in care and improving understanding of culturally appropriate treatment.

Research and scholarships

Forging higher levels of excellence in surgical practice supporting ground-breaking research to ensure the safety, effectiveness and appropriateness of surgical practice is based on the best evidence, and all people have access to enhanced levels of early detection, surgical care and treatment when they need it.

Supporting advocacy for higher levels of patient care to ensure that surgeons and other health professionals have the most up-to-date knowledge to provide the highest quality patient care.

1167 Life-changing procedures delivered in developing Asia-Pacific countries

1 Major advocacy project, improving ear health in Aboriginal communities

45 Scholarships/Grants awarded

Global health

Addressing needs in developing countries in the Asia-Pacific region by providing essential medical and surgical services to disadvantaged communities that would otherwise be unable to access specialist care. Working with local partners, volunteer specialists address sight, hearing, and mobility as well as many other critical needs.

Investing in people is essential to increase healthcare capacity and meet the ongoing needs of low-income communities within the Asia-Pacific region. Local surgeons and health professionals are supported through professional development, ongoing mentoring, as well as training provided by volunteer specialists.

Increasing capacity for diagnosis, treatment and care through the provision of vital medical equipment and supplies.

Providing specialist health services and/or training in Timor-Leste, the Cook Islands, Fiji, Kiribati, Micronesia, Nauru, Samoa, the Solomon Islands, Tonga, Tuvalu, Vanuatu, Nauru, Papua New Guinea, Myanmar and Indonesia.

The Foundation for Surgery relies on donations and bequests to continue to support children, families and communities to live their healthiest lives. All fundraising costs for the Foundation for Surgery are provided for by the Royal Australasian College of Surgeons so that 100 per cent of your donation achieves its maximum impact in the community.

Your donations, your impact.

Thanks to your generous support this year, together we have achieved the following results ...

* Map not to scale
Data as at 30 September 2020

Dr Ollapallil Jacob nominated for 2021 Senior Australian of the Year

Dr Ollapallil Jacob was recently one of four Northern Territorians to be nominated for the 2021 Senior Australian of the Year. Of these four nominees, one will go through to national judging. "I only found out when they called saying that I'd been nominated for the Northern Territory (NT). It was a bit of a surprise to me – I was not expecting anything like this," Dr Jacob told *Surgical News*.

A general surgeon in Alice Springs for more than 20 years, Dr Jacob provides elective and emergency care – including Neurosurgery and thoracic surgery – for central Australia residents. He has led the understanding of surgical management in a range of areas, including acute pancreatitis, for which local survival rates are among the best in the world. His adaptive surgical style has also significantly reduced the number of amputations for Indigenous people. He advocates for continual improvement in healthcare services.

"We are working tirelessly with the NT Government to address the challenges we face," Dr Jacob said. "To some extent we have already been successful, in terms of introducing alcohol-related harm minimisation policy, domestic and family violence policy and a speed limit in NT." Dr Jacob says he had already seen the positive effects of liquor laws in the reduction of patients presenting with alcohol-related medical issues.

His community work has shone a spotlight on other public health issues and reduced rollover car accidents and skin infection rates. He is an inspiring educator and mentor for junior doctors and medical students at the Flinders University Rural Clinical School. "The main message I'd like to communicate, especially to young surgeons and Trainees, is that Alice Springs is now recognised as an excellent hospital for training in surgical specialties, especially General Surgery." Of his work in this area he said, "We practise true General Surgery in that our spectrum is very broad."

Dr Jacob is passionate about the rights of patients and ensuring their voices are heard. He has received numerous local and national honours for his contribution, including the inaugural Royal College of Surgeons Indigenous Award in 2015.

"Access to good health care and surgery is a basic human right," said Dr Jacob. "I'm just an ordinary surgeon working in Alice Springs trying to provide surgical services to people across the barriers of distance and culture." ■

For more information go to: australianoftheyear.org.au

Our thanks to Mr Andrew James Cowle and family

Our thanks to the late Mr Andrew James Cowle and his family for their extraordinary generosity. Mr Cowle recently passed away and left half his estate to the Foundation for Surgery and the Royal Australasian College of Surgeons to support a Global Health project.

Although Mr Cowle was not a member of the College, he deeply appreciated the importance of accessible safe and quality surgical care.

If you would like are considering creating a living legacy or leaving a gift in your Will, please contact Jessica Redwood, the Manager of the Foundation for Surgery by phoning +61 3 9249 1110 or by visiting foundation@surgeons.org.

The Davison Family Trust: empowering Indigenous doctors to gain surgical qualification

The Davison Family Trust, the first scholarship to address the low number of Indigenous Australian surgeons, was recently initiated by Mr Ian Davison, a retired orthopaedic surgeon.

Ian and his now deceased brother, Greg, were graduates of Sydney University and residents at Sydney's Royal Prince Alfred Hospital. Both pursued a career in surgery and the Davison Family Trust acknowledges that privilege, and honours Greg's memory.

Aspiring initially to journalism, Ian was diverted to medicine by Greg's endorsement of his own experience. After completing a general surgical Fellowship in England, he was drawn to the reconstructive aspects of Orthopaedic Surgery, and returned to Australia to undertake his orthopaedic Fellowship.

Following a year's Fellowship in knee surgery, Ian left for the country to become the first orthopaedic surgeon in Nowra, on the south coast of New South Wales. He and his wife settled on a 250-acre property and bred alpacas, which numbered 850 at their peak.

In recent years, Ian and his partner, Janie Forrest, have been supporters of Yalari and the Australian Indigenous Education Foundation, organisations that sponsor Indigenous children to attend private secondary schools. Growing up on a remote sheep station in the Pilbara region, Janie had first-hand experience of the disparity in educational opportunities available to Indigenous children. During their recent trips to remote parts of Western Australia, both observed the social dilemma of many Aboriginal communities and the challenges and issues faced by those communities.

Then, in 2017, Ian received a circular from the Royal Australasian College of Surgeons (RACS) Foundation for Surgery inviting surgeons to donate the proceeds of one operation to advance surgery as a postgraduate choice for young Indigenous medical graduates. To his amazement he discovered that RACS had only two Indigenous Australian Fellows.

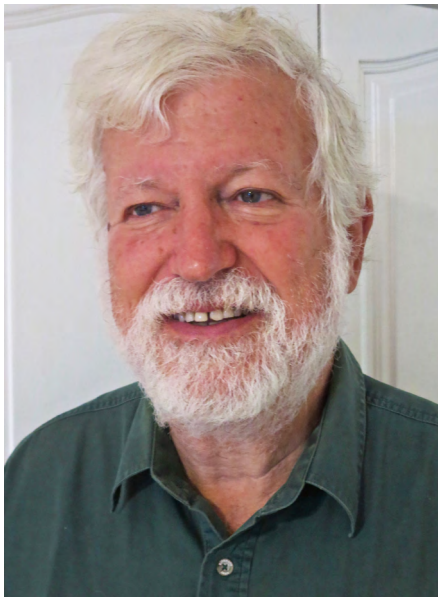
"It occurred to me that more encouragement and assistance was required if we were to address this disparity," he said. An explanation for the lack of Indigenous surgeons was the cost of postgraduate education and the financial drain resulting from the support offered by many successful medical graduates to their own communities and families. "I hoped, somewhat simply, to reduce financial hardship as a barrier preventing young graduates from seeking a career in surgery," he said.

> "Surgical intervention is a privilege that patients extend to their trusted physicians. That trust puts surgeons in a position of extraordinary power and responsibility. We need to share that honour with more Indigenous Australians."

"In Australia, there are increasing numbers of Indigenous politicians, doctors, sportsmen, artists, musicians and leaders who can inspire their young brothers and sisters to positions of community leadership and respect. It is now time that we add surgeons to that list," Mr Davison said.

So the Davison Family Trust scholarship was born to take some small leadership in establishing that trend.

"There are few successful professionals whose education and career have been realised without the example and encouragement of a mentor or exemplar. Many young Indigenous Australians will find inspiration and reason to embrace ambition when others have successfully negotiated that path before them," Ian explained.



Mr Ian Davison

"If young Indigenous Australians can be assisted and encouraged to rise to positions of eminence, authority and respect in our society, it will provide an example and inspiration for others to do the same. Surgery is only one of the many vocations that can promote Indigenous Australians to that position of respect. And, if the scholarship is successful in achieving that outcome, it will have served its purpose," Ian concluded. ■

Meet our new Global Health team

Since 1994, the Royal Australasian College of Surgeons (RACS) Global Heath Program has worked with AusAID, now the Department of Foreign Affairs and Trade (DFAT), to support delivery of specialist surgical services and medical training and education activities in Papua New Guinea (PNG) and the Pacific Islands (Cook Islands, Fiji, Kiribati, the Federated States of Micronesia, Marshall Islands, Nauru, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu) and, since 2001, in Timor-Leste and Myanmar.

Drawing on over 20 years of experience in health development, RACS Global Health builds on lessons learnt and the latest knowledge in global health while responding to changing national contexts and priorities.

With the leadership of the Global Health Chair, Miss Annette Holian, and the Head of Global Health, Philippa Nicholson, RACS Global Health is leading a strategic approach to health systems strengthening in the Asia-Pacific region. It is delivering quality improvements for healthcare recipients and collaborating with governments and regional institutions to ensure the best possible outcomes.

The Global Health department relies on the critical contribution of over 200 specialist volunteers who work with us to support delivery of health, education and leadership activities.

In 2020, the RACS Global Health team has seen a rejuvenation of its leadership and team, with many new team members joining to support continued delivery of services, despite the impacts of COVID-19, and in a year of DFAT accreditation. The Global Health team would like to take this opportunity to introduce ourselves to members and staff. Over the coming year, and with the planned establishment of a Global Health Section, we look forward to working with you.

Miss Annette Holian
Chair of Global Health

From 1997-2003 I was a volunteer orthopaedic surgeon working and teaching on short trips to PNG and Vietnam. In July 1998, I responded to the Aitape tsunami on the north coast of PNG as a civilian under the Australian Defence Force Joint Task Force JTF-110.

Following that experience, I joined the Royal Australian Air Force to serve in East Timor, completed two years of trauma Fellowships and continued clinical work as a full-time trauma surgeon. I worked with The Royal Australian Navy (RAN) in Solomon Islands in 2003, responded to the Boxing Day tsunami in December 2004, served with RAN again in western Sumatra, responding to an earthquake in 2005, and served in the Middle East area of operations in 2008, 2010 and 2012.

I have led clinical teams in very austere environments and this, combined with my qualification in surgical education, has set me up well to support regional partners in developing their own sustainable surgical capabilities.

I very much regard our support as that of a friend with some capability supporting a partner-in-need – and in this partnership, both parties stand to gain improved understanding. We will walk with our regional partners hand in hand, side by side.

My favourite thing about working in this field is the opportunity to influence the future model of support to those tasked with providing sustainable surgical and medical services.

Philippa Nicholson
Head of Global Health

I am an experienced leader in development and humanitarian program and partnership management, coming to RACS Global Health with over 20 years of experience in senior management of global programs, advocacy, partnerships and funding in the not-for-profit sector. I'm a team-orientated, but independent leader and have previously worked in Africa, Asia-Pacific and Europe with UNICEF, the International Committee of the Red Cross, the Australia Government and ChildFund Australia.

I am proud to be the recipient of the Overseas Humanitarian Service Medal for my work with UNICEF during the Ebola response in Sierra Leone in 2014. I enjoy

working in international development in partnership with other countries to build a sustainable and improved quality of life for the country and its communities.

Robyn Whitney
Program and operations manager
I have worked in aid and development for many years, first at Plan International and then at the Burnet Institute, in senior program management roles. I worked extensively across Asia and then Sub-Saharan Africa while completing a Masters in Evaluation and learning Portuguese. I became proficient in juggling a diverse range of professional activities.

I established the Burnet Institute's presence in Mozambique and also designed and managed a large program that built the technical and organisational capacity of government, key national umbrella organisations, local non-government organisations (NGOs) and community-based organisations to respond to HIV and AIDS.

My favourite thing about Global Health is working with individuals and groups to build capacity to stimulate lasting and positive change, and making lifelong friends along the way.

Erika Watton
Volunteer mobilisation and engagement senior advisor
I am new to the health sector, but have 10 years' experience in international development. I worked at Australian Volunteers International (AVI) in both the recruitment and learning, and development teams and I have two years' experience in managing global programs at Monash University.

While at AVI, I managed the repatriation support program for DFAT's international volunteer program, debriefing over 300 long-term volunteers, facilitating pre-departure training sessions and re-entry workshops.

My favourite thing about working in international development is learning about different cultures and working with overseas colleagues and partners.

Stephanie Korin
Country manager, Timor-Leste program
I have been lucky enough to work across several country projects including Timor-Leste, Indonesia and Myanmar, as well as the Global Health Scholarships Program. I was Secretary to the Global Health Committee for a number of years and supported the College's advocacy work in global surgery. For the past two years, I was based in the Timor-Leste country office before evacuating back to Melbourne during the COVID-19 pandemic.

An achievement I'm really proud of is supporting the training and professional development of committed and inspiring young doctors through the postgraduate medical education program in Timor-Leste and Global Health Scholarships. ▶

My favourite aspect of international development is the relationships with overseas doctors and health professionals across Asia-Pacific, especially my Timorese colleagues at Guido Valadares National Hospital in Dili. Working in international development offers many opportunities to develop a really broad skill set, for which I am grateful.

Gabbi Hamilton
Volunteer mobilisation and engagement advisor
Prior to starting at RACS, I completed a Masters of International Development and a Bachelors degree of Public Health. In this role I have been lucky enough to travel to Kiribati in the Pacific last year to assist with data collection for an evaluation. A lot has changed in this space due to COVID-19 travel restrictions, but I look forward to being able to start deploying teams again in the near future.

I really enjoy the work we do across the Asia-Pacific and hearing the stories about how we have improved people's quality of life.

James O'Keefe
Global Health engagement coordinator
I have had the privilege of supporting the needs of Australian and international health partners throughout the Asia-Pacific in my previous roles, and I look forward to building on that experience with the RACS Global Health team.

My favourite thing about working in international development is the opportunity it provides to engage with and learn from local communities, build new partnerships and support community-driven skills and capacity-building needs throughout our region.

Gillian Pye
Medical equipment coordinator
I am a perioperative nurse and my whole nursing career has been clinically based in the operating theatre. In my new role with Global Health I basically hit the ground running and have been tasked with moving vital medical equipment and supplies to Timor-Leste (with 20 patient monitors to Dili as part of the COVID-19 response in my first week). The Global Health team has many new members and it has been interesting to join the team during a pandemic, as we have all come to know each other remotely. In a relatively short period of time we have been able to work together and achieve our goals.

Recently, as reported in the last issue of *Surgical News*, we have been moving Advanced Paediatric Life Support Kits to PNG through the humanitarian corridor with assistance from DFAT. This kit will be utilised through a new local training program, funded by the DFAT Australian NGO Cooperation Program (ANCP). There continues to be a fantastic partnership with DFAT to move medical equipment and supplies through the humanitarian corridor, and just recently another shipment of equipment left RACS on its way to Guido Valadares National Hospital.

One of the things that stands out to me is how rewarding it is to be involved with an organisation and a team of people dedicated to providing safe, quality care and support to partner countries in the Asia-Pacific region.

Kathryn James
Senior program advisor, Pacific Islands program
Most recently I worked with Marie Stopes International Australia managing a reproductive health program being implemented in South-East Asia. I also spent several years with CBM Australia, advising DFAT and a range of NGOs on disability inclusion within international development, particularly within the Asia-Pacific.

My favourite part of the job is developing links and working closely with colleagues and partners overseas – which we will need to do remotely for a while!

Monique Schobben
Project accountant
Working with Global Health has been unique compared to my previous professional experiences (mostly in local government in Europe). One of the key elements is that I have had the opportunity to be part of the accreditation process since the beginning. It was, and still is, intense and rewarding.

I'm particularly proud of the improvement of our finance processes and seeing the positive impact of our work on the community.

Giang Nguyen
Grants and partnership manager
I have over 10 years' experience at a senior level in both field-based and Australian international development. My experience is in the areas of grants acquisition and managements.

I have demonstrated my excellent skills in working collaboratively and effectively both within the team and in the areas of grants contract negotiation, donor compliance management, project financial management, and grants finance processes and systems improvement.

My favourite thing about working in international development is being part of building more prosperous societies, and particularly improving the health of people around the world.

Shannon Farrow
Program advisor, Pacific Island Program and Samoa hearing program
I have completed a Masters of International Development and spent the last five years working with different aid and development organisations in Australia and overseas.
I am looking forward to being able to travel again and connecting with people face-to-face rather than through a screen.

Although new to the global health field, my favourite aspect is working with people who have a strong commitment to social justice values and health being human rights, being exposed to different cultures and practices, and learning from the many wonderful people we work with across the Pacific. ■

Providing a fresh perspective on money management

Siobhan Blewitt is a financial adviser who donates her time to chair and advise the Royal Australasian College of Surgeons' (RACS) Investment Committee. With more than 25 years' experience in equities, specialising in domestic and global stock markets, Siobhan provides a fresh and different perspective on money management.

Siobhan's company, Stellan Capital, helps family groups and businesses look after their money. She is passionate about helping her clients navigate the intricacies of markets and making it easy for them to interpret financial information.

Three years ago, Siobhan became a member of RACS' Investment Committee. RACS' objectives tie in with her own beliefs and values, providing education and insight to help people.

Siobhan's interest in money matters started when she was in Year 10, after her family incurred a significant financial hardship. Financial literacy and independence became critical, and she started learning about the stock market, its relationship with the economy and the real world. A Hollywood movie about the stock market clinched the deal and at university she chose subjects that helped her in this pursuit – economics and commerce.

Like many, Siobhan had a part-time waitressing job while at university, which paid her $12 an hour. "I learnt the value of money and invested my salary in the stock market, where my $12 might become $24 or zero – an understanding that was totally novel and opened up opportunities for me," Siobhan said.

At 21, she found herself working for a father–daughter team at a prominent Melbourne stockbroking firm. She worked there for 10 years as an assistant and apprentice. "With less than 10 per cent of women in stockbroking, I was lucky to be part of a forward-thinking team. My employer coached and mentored me – his daughter was an Olympic athlete so they brought a strong sense of sportsmanship and fair play to their business. He became my strongest advocate, and from him I learnt important skills and insights – the psychology behind people, winning and losing, and how to remain calm during good and bad times," Siobhan said.

Siobhan learnt how to read people, the conventions and protocols, when and how to engage, how to speak and communicate with different people who were typically much older and senior, all while honing her skills.

"It was very important to learn how to get your message across in an appropriate and palatable way, to deliver the technical information and make it relevant and understandable," Siobhan continued. "At the same time, I had to ensure that I built my reputation of being solid and consistent. All this takes time and 10 years just flew."

Having worked in large investment banks and now heading her own boutique wealth management business, Siobhan understands both start-ups and big business. This helps her to understand the industry and more effectively walk in her clients' shoes.

It is this experience Siobhan brings to RACS – to provide insight, and to challenge conventions or assumptions in markets. As part of the Investment Committee she assists the group that provides oversight and different perspectives on equities markets and investment opportunities. The goal is to ensure these always align to RACS' core values and their investment philosophy.

Siobhan provides "a different perspective and energy, a modern insight and overview of what is happening in the market. We have access to some of the smartest equity analysts in the country and we share these observations with

Siobhan Blewitt

RACS. It offers a broad perspective to the committee."

There are six honorary advisers on the Investment Committee along with representatives from RACS and the investment manager. Dr Greg Witherow, RACS Treasurer, finds their advice incredibly valuable. "As Treasurer, I am acutely aware of the importance of our Investment Committee to the health of College finances. The committee is chaired by Siobhan who, working pro-bono, is generous with her time and expertise. Siobhan and our other honorary advisers have consistently exceeded our investment benchmarks.

"Their expertise has provided funding for work undertaken by the RACS Foundation for Surgery. All Fellows should be appreciative of the time and expertise they provide pro-bono to allow RACS to carry out its extensive funding obligations," Dr Witherow said.

Siobhan continued, "As volunteers we provide a forum of free-flowing ideas beyond one view and draw our different expertise to the conversation. We also learn from each other, as each one of us brings our own expertise and experience to the forum." ■

Improving the state of health care globally

Surgical News talks to Dr Liz McLeod about her deep commitment to giving back.

In her final year of medical school, paediatric surgeon Dr Liz McLeod undertook an elective in the Solomon Islands that, in her own words, "was a massive eye opener". While it was a "fabulous, rich and wonderful time", she said, "it took the blinkers off about the state of health care in large parts of the world".

While Dr McLeod's interest in global health never dimmed, surgical training and family responsibilities took priority for a number of years. In the 1980s, the Royal Australasian College of Surgeons (RACS) Global Health model was different to what it is today. Visiting medical teams would go out into the regions with little information and operate in challenging low-resource environments.

For Dr McLeod, "It was a difficult time of life to just take two weeks off and leave the kids," she said. "But also, in that early stage of your career, it's quite a daunting thing to do," she explained, adding that surgeons in Australia and New Zealand are accustomed to being well-supported with plentiful equipment, fabulous teams in theatre and great colleagues who can be called on at any time to provide opinions.

Working in developing countries can mean limited equipment, poor infrastructure and having to make difficult clinical decisions due to resource-constrained environments. "It wasn't something I thought I was ready for in the early stages of my Fellowship," she said.

In 2007, with an MD from the University of Melbourne, a Fellowship in General Surgery and a Fellowship in Paediatric Surgery under her belt, Dr McLeod departed on her first Global Health trip to Atambua, on the border of Timor-Leste in West Timor. As a new program in Eastern Indonesia, there were no established relationships, no contact and no communication, she said. "We were very much anticipating the kind of cases we'd have, and the locals didn't know what we could do and what we couldn't do."

In the Pacific it's a different context, Dr McLeod said. There have been good ongoing relationships with local counterparts and national Ministries of Health for more than 30 years. "They know who we are and we can communicate directly. Before a trip visiting medical teams will be working patients up in liaison with in-country hospital partners; in-country clinicians know the kind of cases they need assistance with and the specific equipment required," she explained. "It's all based on relationships." Advances in technology have meant that triage and communication can happen prior to a trip and teams know what equipment will be needed and the cases they're likely to see due to preparation with in-country partners.

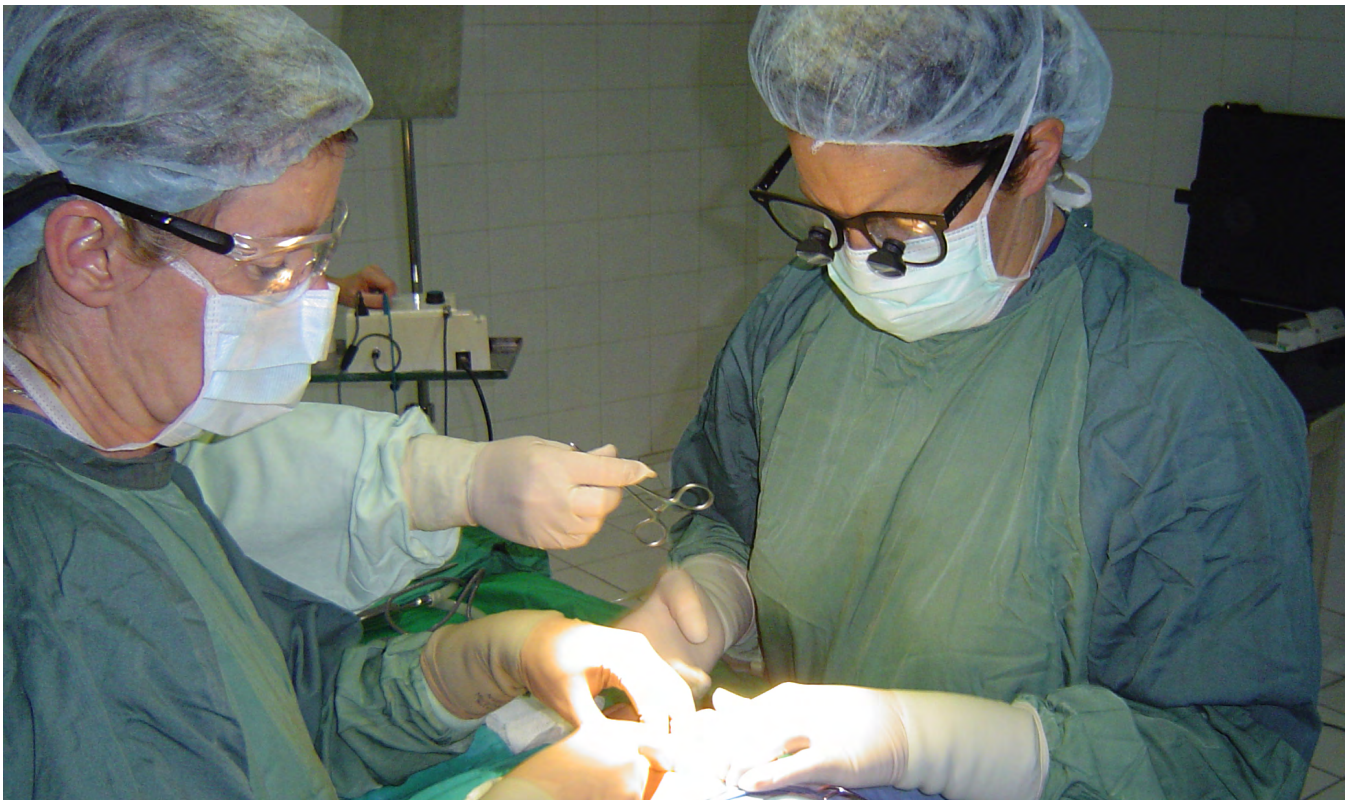
RACS is a trusted institution in the region and the work done by Global Health is based on the outreach that started decades ago, Dr McLeod said.

> "Many Fellows have very longstanding relationships in the region. They are people who poured their hearts and souls into building Global Health at the College."

Dr McLeod now provides technical advice to the monitoring and evaluation component of RACS' Global Health program. In 2014, she graduated with a Master of Public Health from the University of Melbourne and her administrative expertise has been directed at program design and the evaluation process, as well as lots of "thinking, planning, designing and evaluating."

Ultimately, her work contributes to the improvement of health outcomes for people in Timor-Leste, the Pacific Islands, Papua New Guinea (PNG) and Myanmar. Over the past 25 years RACS' Global Health initiatives have delivered 900 visiting medical teams to the Pacific, conducted an estimated 97,000 consultations and performed 26,000 operations.

Surgeons have always been happy to contribute and be part of visiting medical teams, Dr McLeod said. "It's very rewarding on a personal level and they love to contribute outside the normal



Dr Liz McLeod (right) with Miss Mandy Robertson.

paradigm. It's also common for surgeons to want to go back and Global Health encourages it because they're keen for people to go to the same place, meet the same in-country partners and build relationships. That's where the value is added."

Challenges facing RACS activities in the region

There are a number of challenges facing RACS activities in the region and the most immediate of these is COVID-19. It's causing chaos in health systems across the world, including the Pacific, and figuring out how to work "synergistically with the other enormous challenges that are facing human beings is something we have to factor into all our thinking," Dr McLeod said. How to respond as surgeons and mitigate risks is an ongoing discussion, and "safety mechanisms in a hospital in PNG, for example, as opposed to Melbourne, where we've got a lot more resources to throw at things, is being discussed a lot online."

While RACS has not been able to send any visiting medical teams overseas, it has continued working with surgeons and Trainees from the region. The evolution from being 'deliverers of services' to teaching colleagues and trainees to perform surgery and manage health care independently has been an unexpected benefit of COVID-19. "It's kind of a low-hanging fruit we should have plucked years ago," Dr McLeod said. "I can't believe we're only just waking up to the possibilities of Zoom and Teams and so forth."

Online meetings and workshops have enabled the training and education of local workforces to continue. An ear, nose and throat (ENT) session was organised recently, where an Australian ENT specialist was able to discuss difficult cases and do some basic teaching.

Chair of RACS Global Health Dr Annette Holian also recently instigated an online Pacific women's forum for female medical staff to come along and chat about anything that interested them. "We're maintaining contact," Dr McLeod said.

While RACS has been proactive in supporting women in surgery, Dr McLeod would like to see more women surgeons and Trainees in the region actively supported so they, too, feel empowered throughout their journey.

"Climate emergency is another big challenge and it puts at risk everything we've achieved so far," Dr McLeod said. The amount of disruption that's coming in the Pacific is immense, she added, and there are synergies between building climate change resilience and strengthening the infrastructure, supply chains, health information systems and governance of surgical systems.

RACS Global Health is currently preparing for re-accreditation with the Australian Government Department of Foreign Affairs and Trade (DFAT). Accreditation is now an important part of any development assistance program and RACS Global Health and its volunteers are invested in maintaining the high standards that come with this accreditation.

Usually, you can find Dr McLeod consulting and operating at The Royal Children's Hospital and Monash Children's Hospital in Melbourne, a role she loves. "Looking after kids is great and I can't conceive going back to adult practice. They're just so gorgeous and fun and resilient," she said. Some of her families have enormous problems and a lot of the children have significant long-term morbidities, but she finds inspiration in the way they live life in small grateful steps.

And of RACS Global Health, Dr McLeod said, "It's not just about surgery, it's about everything we do. It's about education. It's about gender. It's about social justice. And all of it is complex and interwoven." ■

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SET/SIMG Supervisors of the Year pay it forward for future generations

Mr Dilhan Cabraal (right) is presented with his award by Professor David Fletcher.

The Royal Australasian College of Surgeons (RACS) appreciates and values the work our supervisors do, and we are constantly working to support these hardworking surgeons, who find value in giving back to their Trainees. This could be because of their own educational experiences, the chance to continue learning, or watching their students flourish.

When one teaches, two learn

Teaching works both ways. The teacher often finds they learn while explaining a concept or when answering questions. When you teach, you open yourself up to different points of view, and take on a new perspective, fostering creativity and critical thinking for you and your student.

"Surgical education is a way of paying it forward for our future generations of surgeons just as was done for us," said Professor Peter Friedland. "It is a unique opportunity to contribute one's own knowledge and keep learning simultaneously."

Mr Richard McMullin has found teaching offers unplanned moments of exchange where one can both teach and learn. "Almost every clinical encounter, X-ray image and pathology result can be a way into a discussion that can lead into general principles, related examples, patterns and pitfalls," he said.

Mr Simon McMahon agreed. "My experience is that teaching is invaluable and, for me, very much a win-win," he said. "I always seem to learn much more than the Trainees and interacting with the junior colleagues is generally a lot of fun."

Learning the value of a dedicated teacher

Many of the surgeons became supervisors after being inspired by their own exceptional supervisors. "As a junior doctor, I always had very dedicated consultants taking time to teach me, which inspired me to become a teacher after I became a consultant," Mr Dilhan Cabraal said.

Associate Professor Sivakumar Gananadha had a similar experience, and now views his involvement in surgical education as a way to give back. "During my surgical training I was inspired by surgeons who were amazing teachers, with their ability to teach and explain with such clarity and deep understanding of the surgical techniques," he said. "These surgeons have had a lasting impact on my training and my surgical career."

Giving back

Giving back and sharing Trainees' successes is a major source of pride for supervisors. "Students, residents and Trainees always appreciate the teaching they have received," explained Associate Professor Gananadha, "and it is satisfying to know you are helping educate the next generation of surgeons."

Mr Simon McMahon

Mr Cabraal echoed this sentiment. "I find teaching and supervising registrars a highly rewarding experience," he said. "Recognising the different needs of registrars and helping them to overcome these is a very satisfying experience."

"You can make an enormous difference to students, residents and Trainees as a role model," Professor Friedland said. "In turn, the personal reward you experience will keep invigorating you." ■

Each year the Academy of Surgical Educators recognises a SET Supervisor/ SIMG Supervisor of the Year. This is awarded in each state or territory of Australia and New Zealand, where an appropriate candidate has been nominated. Do you have a supervisor you want to recognise? Nominations for 2021 Educator of Merit awards will open in February next year. See the next issue of Surgical News *for more information.*

RACS has a new Supervisor Support Hub. For resources, policies, interviews and more go to surgeons.org/Fellows/for-educators-trainers/supervisor-support-hub.

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

Professor Peter Friedland (right) is presented with his award by Dr Sally Langley.

The Younger Fellows mentoring program

The Younger Fellows mentoring program, which takes place each year, has been running since 2017. It pairs up Royal Australasian College of Surgeons Younger Fellows (Fellows in their first 10 years of service) with more experienced surgeons so they can share their ideas, expertise and advice. The mentor–mentee relationship more often than not evolves into a reciprocal relationship of mutual sharing and support – a space to share immediate challenges and ideas for the future. We asked a number of Fellows who have taken part in the program to share their experiences.

Mentor Mr Darren Katz and mentee Mr Kenneth Buxey

Mr Katz is a urologist from Melbourne.

I have always enjoyed the mentorship and teaching aspect of surgery, and so I was eager to be a Royal Australasian College of Surgeons (RACS) mentor to a surgical colleague. I started mentoring RACS Fellow Ken Buxey in 2018. Having gone through the stages of building a large private practice from scratch, the mentoring program facilitated sharing this experience, including the aspects that have gone both right and wrong. By imparting my knowledge, I hoped to help Ken grow his private practice in a more expeditious way. It informed my practice as a surgeon too. As we talked through the various aspects of private practice, it re-emphasised to me the importance of ensuring good and timely communication with not only patients, but with staff, referrers and colleagues.

Mr Buxey is a general surgeon from Melbourne.

I was initially made aware of the mentoring program via email contact from the College. I indicated I would be interested in participating and was paired up with Darren. The best part of the program is having the opportunity to get advice from someone who has been in specialist practice for about five years prior to you becoming a consultant yourself. You don't get any formal training or advice on how to establish practice or work as a consultant, and so it is invaluable to have a resource to discuss these things with you. Someone who has a better idea of what some of the challenges are and how best to overcome them. It has been particularly helpful since Darren has a well-established practice in the same hospital that I am now practising in, which means I feel very supported there. Although I am specialised in colorectal surgery and Darren is a urologist, these two specialties actually intersect often and are quite complementary – even to the point where one day we may work on a case together!

Professor Peter Anderson

Professor Anderson is a plastic and reconstructive surgeon from Adelaide.

A fantastic part of the RACS mentoring program was realising that the process could be mutually beneficial. As a mentor, I have learnt to appreciate that, while some training issues remain the same, other issues facing surgical Trainees are different to my own experience. I discovered that mentees are very appreciative of the opportunity to discuss sensitive workplace issues with an outside trusted adviser, who is independent of both the training unit and the local processes of job progression, but who can facilitate a considered review of their options in relation to the big picture and their long-term goals. Although mentoring with an interstate colleague undoubtedly had geographical challenges, mutual goodwill was supplemented with demonstrated reliability, and the use

of regular emails and teleconferencing helped to overcome them.

Dr Edwina Moore

Dr Moore is a general surgeon from Melbourne.

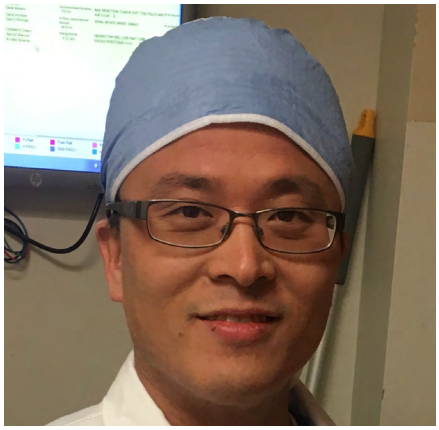
While I had already finished training and was about to embark on an overseas Fellowship, I was still eager to participate in the RACS mentoring program with a view to making a new friend, gaining perspective on surgical practice post-training and advice on how to juggle an academic career with motherhood. I was also keen to experience being the mentee, as I was already involved as a mentor with a (medical student) career mentoring program through the University of Tasmania. I think most Fellows would benefit from having a confidante who is attuned to the health system and has some past experience to draw from. Mentoring is not just about fixing problems, but rather offering perspective, helping to make professional introductions and broadening your exposure outside the microcosm of the training network.

Professor David Fletcher

Professor Fletcher is a general surgeon from Fremantle.

As a College Councillor, I was given the opportunity to participate in the mentoring program. I have had two mentees: one was a Fellow who was recently appointed to a head of department role and was looking for advice and strategies on how to take up the role; the other was a Fellow returning from overseas to an academic appointment looking for advice on how to develop research and involvement in surgical academia. I have always seen mentoring as an increasingly required function of a surgeon as they mature and have life experiences that they can impart to others. It is something I have done for students for over 40 years and to Trainees and Fellows as a head of department for 25 years. It is great to be working in a department surrounded by colleagues who you have advised and supported, and many of whom surpass you.

Mr Ming Ho



Mr Ming is a general surgeon from Central Queensland.

Throughout the program I got good advice from my mentor and I think the advice added another aspect to the virtual experience when I was in difficult situations – surprisingly not clinical, but interpersonal challenges. Keeping in contact was not easy since we both had busy schedules, but emails and quick chats helped! That might be the way to go in the current COVID-19 situation.

Dr Sanjay Adusumilli

Dr Adusumilli is a general surgeon from Sydney.

The best part of the RACS mentoring program was being able to assist the younger generation of surgeons in pursuing their career aspirations. The younger Fellows are grateful for the advice given and that sense of gratitude provides you with the feeling that you are making a difference.

In our catch-ups we spoke about exams, developing a practice, how to obtain a job in the future, research and managing difficult working relationships. Taking part in the program made me feel that the difficulties I faced as a surgeon are experienced by others. It gave me the confidence that many of the challenges we face are shared in common and with support we can all get through them. ■

Applications to become a mentor are open to all RACS Fellows. To apply to be a mentee you must be a RACS Fellow in your first 10 years of practice. For more information about the 2021 program please contact Molly Mckew at molly.mckew@surgeons.org

A hero of surgery: Dr John Hargrave

Aboriginal and Torres Strait Islander people are advised the following content contains images of deceased persons.

Australia lost a hero in August. A surgeon who made it his life's work to eradicate leprosy in the Northern Territory. A gifted educator who shared his vast medical knowledge with health workers and Aboriginal people, and a doctor of unparalleled humility and generosity.

Dr John Hargrave has been called a surgical pioneer, a living legend, an icon of surgery and 'a living saint'. But when he was alive, his friends say he would have none of that. He never spoke about being appointed a Member of the British Empire in 1967, or about becoming an Officer of the Order of Australia in 1995. There was also an Honorary Doctorate from Charles Darwin University, the ANZAC Peace Prize in 1996, the ESR Hughes Award in 1999, and the Royal Australasian College of Surgeons (RACS) International Medal in 2007, but he was happiest when the attention was on other people.

Dr Hargrave died in Hobart on 6 August 2020. He was 89 years old. He never married or had children, but he had thousands of friends. Among them were many Aboriginal people whose languages he'd learnt so he could converse with them. He'd trained hundreds of Aboriginal people as Indigenous health workers so they could care for patients in the East Arm Leprosarium and within their own communities.

Dr John Hargrave at Lake Mackay, 1957

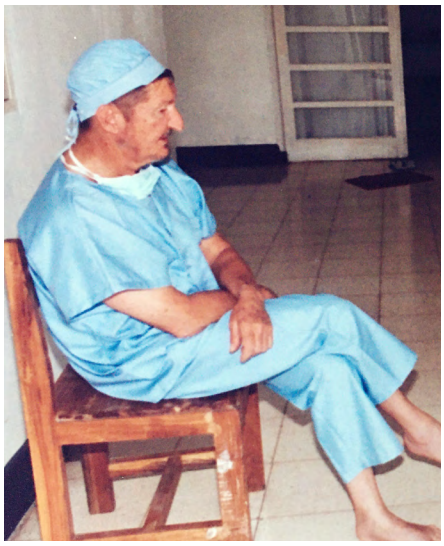
Born in Perth, Dr Hargrave studied medicine in South Australia before doing his internship in Perth. In 1955, he was appointed Survey Medical Officer in the Northern Territory. Then, in 1957, he was the medical officer with a patrol of government officials visiting Lake Mackay in search of the last groups of nomadic Pintubi people of the Western Desert – Indigenous Australians who had never had any contact with white colonists.

When they found the Pintubi people, Dr Hargrave examined many of them individually and reported that they were "in excellent condition; well-built, well-nourished and healthy."[1] Further, he recommended that "they be left entirely alone" and "be protected from white people, as this inevitably leads to their contracting diseases foreign to them".

During his work in the Northern Territory, Dr Hargrave noted that leprosy was a significant health issue. It had been brought into the Territory in the 1880s by gold miners and labourers, and had spread disproportionately into Aboriginal communities. Leprosy patients, including children as young as four years of age, were forcibly removed from their families and incarcerated, usually for the rest of their lives, first on Mud Island then on Channel Island in the Darwin Harbour.

In 1956, the East Arm Leprosarium on the mainland replaced the island leprosarium. Dr Hargrave became its medical superintendent and he brought a respectful, collaborative approach to the care of Aboriginal patients, who had grown afraid of Commonwealth institutional powers. They were so fearful that they would often hide their leprosy symptoms to avoid being separated from their families.

Dr Hargrave's warmth and sincerity helped him gain the trust of his patients



Dr John Hargrave in East Timor

and their families. With assistance from the Catholic sisters from the Order of Daughters of the Sacred Heart, who worked with him in East Arm Leprosarium, more people were diagnosed and treated. He established a leprosy register, set up an operating theatre and formalised the training program for Aboriginal health workers. He also got a pilot's licence, so he could fly throughout the Northern Territory to attend to his patients. At some point, however, Dr Hargrave realised it wasn't enough. More would be required if the East Arm Leprosarium was to offer world-class leprosy treatment.

Dr Hargrave visited leprosy centres throughout South-East Asia and, with the assistance of a World Health Organization scholarship, he travelled to India and worked alongside Dr Paul Brand, the pioneer of muscle tendon transplant. For several months he stayed and learnt how to transplant tendons to correct foot drop, restore movement in fingers and thumbs, and perform other reconstructive surgeries for deformities resulting from nerve damage.

On his return to the Northern Territory, Dr Hargrave established a reconstructive surgery program at the East Arm Leprosarium, and implemented a

comprehensive program that included diagnosis, medical and surgical treatment, and rehabilitation. With the rise of microsurgery in the 1970s, he recognised the potential of using free flaps in nerve repair and reconstruction.

There were a number of firsts, including the first free flap procedure to be performed at Darwin Hospital, the first reimplantation of an amputated digit, and being one of the first to perform reconstructive surgery for claw hands in Australia. In recognition of his exceptional surgical expertise, Dr Hargrave was awarded an honorary Fellowship of RACS in 1987, in Plastic and Reconstructive Surgery.

Then, in his forties, Dr Hargrave was diagnosed with bi-polar disorder. He didn't hide his struggle with mental health from his friends or a number of his colleagues. Associate Professor Phillip Carson, who was a surgical colleague and friend at Darwin Hospital in the 1980s and 90s, said Dr Hargrave's "fortitude and productivity through the highs and lows of this challenging condition were both remarkable and inspirational". He was "constantly questioning himself, but also very self-contained and comfortable with himself", Associate Professor Carson said. Dr Hargrave's capacity to work as a hospital superintendent and a highly skilled surgeon while experiencing cyclic bouts of depression gained him the respect and admiration of those around him.

There were back and heart problems as well, for which Dr Hargrave underwent surgery. "He was often in a lot of pain," close friend and former director for Aboriginal Health in the Northern Territory, Dr Dayalan Devanesen AM said. His dedication to his Aboriginal patients' wellbeing was unwavering. "He wanted Aboriginal people to be recognised for what they have – a world and wisdom that is so important and relevant today, handed down from an ancient tradition and culture," Dr Devanesen explained.

Together, Dr Hargrave and Dr Devanesen recognised that western health services had been 'superimposed' on traditional Aboriginal systems of health care. They also noted that while Aboriginal people were choosing western medicine to treat their sicknesses, they were explaining the causes of those sicknesses through their traditional beliefs.[2] The two doctors discussed a bicultural approach to health care and the education and training of Aboriginal health workers.

East Arm Leprosarium Darwin 1968

Dr Hargrave performed many operations using an operating microscope to reverse the sterilisation of women. He trained Aboriginal health workers to assist in theatre and to use the operating microscope. One of the health workers, Joe Daby, assisted Dr Hargrave and reported that "he was the only doctor in Darwin who could do the operation at the time."[3]

To maintain his skills, Daby practised on rabbits. "Dr Hargrave and myself would put the rabbit to sleep. We would operate on the rabbit's groin, cutting a vessel and stitching it up. This operation would take 3-4 hours," he said.

With Dr Hargrave's comprehensive training, Daby worked at East Arm until it closed in 1982, and then he became Dr Hargrave's assistant at the Darwin Hospital. There Daby became known for his expertise as a specialist health worker who, in turn, helped train hundreds of other Aboriginal health workers. Daby worked in theatre alongside surgical luminaries such as Professor Fred Hollows, Dr Victor Bear, Father Frank Flynn and Dr Rory Willis.

Another of Dr Hargrave's prodigies, Jack Little, spent five years at East Arm Leprosarium after he caught leprosy as a young man. He had never attended school, but trained as a medical assistant under Dr Hargrave. When the Aboriginal health worker training program opened up, Little was one of the first to enrol. Such were the leadership skills nurtured by Dr Hargrave that he ended up principal of the Katherine Institute for Aboriginal Health – which trained Aboriginal health workers.

"If it wasn't for Dr Hargrave," Little told author Margaret Carroll,[4] "I would not know how to look after my own people. I never saw a doctor doing such wonderful things to help Aboriginal people. Not only that, he can talk half a dozen languages, my language too."

Dr Hargrave's work wasn't confined to Australia. In the late 1980s, he heard about untreated deformities among the people of Eastern Indonesia. In his typical patient-centred collaborative way, he set up a locally supported reconstructive surgical program in Timor and Flores. To support this surgical work, Dr Hargrave established a not-for-profit organisation in Darwin and, in 2000, transferred the operation to the Overseas Specialist Surgeons Association. His work continues today. ■

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Fellowship exam a success

The Royal Australasian College of Surgeons' (RACS) Fellowship Examination is the culmination of years of training, and a vital step for a Trainee or Specialist International Medical Graduate (SIMG) to become a Fellow. Three Fellowship exams are normally held each year: two in Australia (in May and September) and one in New Zealand (in May).

However, COVID-19 caused a major disruption to the delivery of RACS examinations. From March 2020, all face-to-face activities were suspended until further notice, and the May exams were cancelled. The consequence of suspending examinations was significant, as they are linked to selection and training. We were aware that prolonged suspension could result in significant future workforce shortages, as well as delay the completion of training or supervision for many candidates.

RACS embraced the principle of being flexible in approach, while ensuring safety remained our priority. In May 2020, an Exams Working Party, chaired by Associate Professor Julie Mundy (RACS Vice President), was formed. She said that the aim of the group was to "try to run an exam that was as close to normal as possible for as many candidates as possible, without compromising the quality of the exam."

"It was a major step for the President to set up a working party and that, along with direct reporting lines through the Vice President, demonstrated how grave and important it was," said Professor Christopher Pyke, Chair of the Court of Examiners.

As well as Associate Professor Mundy and Professor Pyke, the working party was composed of senior examiners (incoming and outgoing), Censor-in-Chief Associate Professor Phillip Carson, Chair of the Board of Surgical Education and Training Mr Adrian Anthony, the Chair of SIMG Assessment Associate Professor Kerin Fielding and the Chair of RACS Trainee Association, Dr James Churchill. Professor Pyke called Dr Churchill's contribution from the Trainee perspective "invaluable".

The key, Professor Pyke said, was "getting the right people together in the room – and the rest followed." Professor Pyke spoke highly of the senior examiners involved. "These surgeons are at the top of their game," he said. "Not only academically, but also as on-call surgeons who often also run successful practices. They brought all of those problem-solving and logistical skills to the table."

Associate Professor Mundy agreed. "The senior examiners were fantastic and really rose to the occasion." There was also a massive cohort of surgeons who had retired from the Board of Examiners, but who came out of retirement for the event, including Associate Professor Mundy herself.

Widespread travel was not possible, so a devolved exam model for delivery of the clinical/viva component was developed using a hybrid face-to-face and remote examiner model. There were 255 examiners in total, including 27 remote examiners. There were also 51 remote observers. The exam was delivered across six cities, five time zones and 59 venues.

It was a big change for some of the specialties, in that patients could not always be physically examined, and in these cases significant changes had to be made to the format of the viva. Candidates were often examined in their own cities by examiners they knew. A formula of rotating examiners had to be created to avoid conflicts of interest. Meanwhile, exemptions were required to run the exam in both countries. There were restrictions on interstate travel, and on regional travel in and out of Melbourne and Sydney. Some candidates from Western Australia and Tasmania were required to travel to sit their exam and quarantine on their return. Associate Professor Mundy found the relevant Chief Medical Officers and Health Ministers were very approachable and accommodating to reasonable requests to allow the exams to proceed safely.

There were more than 50 RACS staff working across two weekends to support the event, but the work involved in planning began at the beginning of the year and involved many more. Apart from the exams team, who were central to the event's success, it included staff from departments such as Education, the State, Territory and New Zealand (STANZ) offices, Finance and IT. "It was a big collaboration," said Julian Archer, Executive General Manager of Education. "It was a huge amount of work to try to balance the best of what we do physically with the best of new technology."

The use of technology was one of the major takeaways from the event for Professor Pyke. "We've learnt that you can observe the conduct of an exam in the virtual world, from a tablet inside the room," he said. He also added that "electronic marking is almost certainly the way of the future."

Meanwhile Associate Professor Mundy pointed to structural lessons. "The world may never return to how it was indefinitely," she said. "This year has forced us to look at how we can modify the exam and still provide the same standard. I think every specialty has had to do something a little differently and they will have lessons from that. They will have a backup plan for how they will disaster-proof their exam."

Professor Pyke commended the "glorious problem-solving skill of our College: small groups of surgeons getting together to find solutions." ■

New South Wales Surgeons' Month

Leadership in a time of crisis

'Leadership in a time of Crisis' was the theme for New South Wales (NSW) surgeons as they joined together throughout November to celebrate the annual NSW Surgeons' Month.

The event, now in its seventh year, was initially designed to provide learning opportunities for surgeons and other medical professionals. Over the years, it has grown to highlight the diversity within surgery and medicine.

Despite the many challenges posed by COVID-19, the Royal Australasian College of Surgeons (RACS) NSW Chair, Associate Professor Payal Mukherjee, said the committee was determined the event should go ahead, albeit in a slightly modified format.

"Surgeons' Month has grown every year since its inception. When I took over as Chair of the NSW State Committee, I had big plans for how I wanted to continue to shape this event and expand its profile. But COVID-19 threw all those plans in to disarray, and for a long time it looked as if we would have to cancel it altogether," Associate Professor Mukherjee said.

"It has been a tough year for everyone in our community, including medical professionals, who have been at the front line, not only during the pandemic, but also during the devastating summer bushfires. I have been very proud of the way health workers have responded and, in the case of surgery, have worked tirelessly to alleviate the pressures that have been placed on the system.

"I have been touched by the many examples of leadership that I have personally witnessed, and it seems only fitting that we recognised and celebrated this. During Surgeons' Month several of our colleagues were presented with awards for their outstanding contributions to surgery and to our community over many years."

Associate Professor Mukherjee said that while the pandemic had created challenges for organisers, it had also provided an opportunity to consider alternative models.

"For the first time we offered hybrid events where people could attend either virtually or in person. This isn't something we have previously considered, but it has been really exciting and has helped us to connect with a broader audience, particularly our rural colleagues," she said.

"It is really important we continue to do this in future years. I also think it is vital to keep a face-to-face element as well. As much as I have enjoyed the convenience of virtual meetings and communications, the experience of gathering together is irreplaceable."

This year Surgeons' Month included five events in total. These were:

- Preparation for Surgical Education and Training Workshop
- Younger Fellows Preparation for Practice Workshop
- Australian Defence Force and Surgery Dinner with guest speaker Georgeina Whelan AM CSC and Bar, who is a retired Army brigadier, and current Commissioner of the Australian Capital Territory Emergency Services Agency.
- Women in Surgery with guest speakers the Minister for Women Bronwyn Taylor and Carrie Marr, CEO of the Clinical Excellence Commission
- Surgeon's Evening with guest of honour Secretary of NSW Health, Elizabeth Koff.

During the month several awards were presented to NSW members to recognise their contribution to surgery and the community over a number of years. The award recipients were presented as part of Surgeons' Evening, where they were honoured in front of family, friends and colleagues.

Among them was Professor Jonathan Clark AM, who delivered the Graham Coupland Lecture and was also presented with the Graham Coupland Medal. Professor Clark is a head and neck surgeon and the Director of Head and Neck Cancer Research at Chris O'Brien Lifehouse. He was also recently appointed as the inaugural Lang Walker Family Foundation Chair in Head and Neck Cancer Reconstructive Surgery and has many other positions and achievements to his name. He described receiving the award as a privilege.

"Honestly, it is a bit daunting," he said. "Especially after looking through the list of previous recipients. There are so many other surgeons also doing remarkable clinical work and research that would have been very deserving."

Despite his many achievements and accolades, Professor Clark said he ▶

found it difficult to identify a particular career highlight and that it was the immense satisfaction of successful operations that were most memorable and motivating to him.

"Registrars often ask me 'What is your favourite operation?' My response is always: 'One that goes well'," he said. "Surgery is challenging and unpredictable. There are many nuances to achieving favourable results that I don't understand, but I would really like to because good and bad outcomes have a major impact on patients' lives – physically, psychologically, and socially," he said.

"In head and neck cancer surgery, there are plenty of complications, many patients live with the devastating effects of radical surgery, and many patients will develop recurrent disease. So it is always a highlight when surgery successfully cures a patient of their cancer while restoring form and function."

Also among the award recipients was Dr Lynette Reece, who received a merit award. Dr Reece is a popular figure in the Maitland Region and a number of her patients meet at the local club to 'drink to her health' every week.

Since joining the Maitland Hospital, she has grown the size of the department noticeably, with more surgeons and supporting junior doctors. Throughout the past 20 years she has provided training to registrars, general practitioners, physiotherapists, medical students and nursing staff, and is an instructor with the Operating with Respect course for RACS. Dr Reece lists her involvement in training the next generation as one of her career highlights.

Dr Lynette Reece

"I always implore Trainees to choose the path they want because they enjoy it, not to do it for somebody else's requirements or expectations," she said. "I am also a big advocate that once they have finished their training they make sure they leave time for themselves and their families."

Another recipient of a merit award was Associate Professor Jonathan Hong. He is an academic colorectal surgeon in Sydney and is the supervisor of General Surgery training and the Deputy Director of Surgical Education at the Institute of Academic Surgery at the Royal Prince Alfred Hospital. He is developing expertise in surgical education and is currently undertaking a Master of Surgical Education.

"It is a great honour and a welcome recognition. I am sure there are many other deserving people out there – I am just lucky somebody happened to nominate me," Associate Professor Hong said.

"I was fortunate enough to be mentored and taught by lots of good surgeons and good people throughout my training and part of my motivation is a natural enjoyment of teaching. The ultimate motivation, though, comes from seeing people you have taught progress and develop in their careers, and to be able to share in their success in some small way."

Despite all the disruption of COVID-19, Surgeons' Month 2020 was an enormous success, with attendances at many events selling out in record time. The NSW Committee would like to thank everyone who supported the event and made it possible under difficult circumstances.

We look forward to Surgeons Month 2021!

Educator of Merit: SET Supervisor/SIMG Supervisor of the Year (NSW) Award

On 27 November 2020, New South Wales (NSW) surgeon Professor Raymond (Ray) Sacks was presented with an Educator of Merit Award for his exceptional contribution towards supporting Trainees and Specialist International Medical Graduates (SIMGs) for more than two decades.

Professor Sacks was presented with the award at NSW Surgeons' Evening, an event held as part of Surgeons' Month. The popular local surgeon spoke of his

Professor Ray Sacks

surprise and great honour at the receiving the award.

"I was totally shocked and never expected this. As an educator you do it for the love of teaching and not because you expect recognition, but even so, this award means so much to me and I am absolutely thrilled to receive it."

Professor Sacks initially migrated to Australia from South Africa as a SIMG (formerly referred to as IMG). On his arrival in Australia, the support and guidance that he received from across the medical profession left a lasting impression on him.

"There were so many people and great mentors who helped me when I first arrived in Australia, which was greatly inspiring. When I achieved my Fellowship I felt that it was my turn to return the favour.

"My initial start to teaching was motivated because I enjoy teaching, but the main reason I have carried on the way that I have is because I have a desire to give back. Now that I am a retired examiner, I feel that I can help Trainees in a different sense in terms of preparation for their exams and by offering practical advice and tips," Professor Sacks said.

During his career, Professor Sacks has published over 100 scientific papers in peer reviewed journals and 13 book chapters, and he has a particular interest in examining registrar burnout. One of his other many achievements include being awarded the Australian Society of Otolaryngology Head and Neck Surgery Medal for Outstanding Contribution to the Art and Science of Otolaryngology Head and Neck Surgery. He was also awarded the International Rhinology Society certificate for Distinguished Service to the

International Rhinologic Community in Brazil in 2015.

On receiving the award, Professor Sacks said he would encourage anybody to become involved in teaching and other College activities. "I genuinely believe that, whatever you are doing, the more you give back, the more you get out of it," he said. "It is not only a great joy to be seeing others achieving, but you also feel a great sense of self-satisfaction."

Professor Phillip Truskett

Read more from previous awardees on page 23.

The Michael Donnellan Medal

Former RACS President Associate Professor Phil Truskett was recently awarded the Michael Donnellan Medal. The award recognises a NSW Fellow who has made an outstanding contribution promoting the art and science of surgery, but with particular emphasis on surgical leadership.

It was established by the NSW Regional Committee in recognition of the contributions made to the College and to cancer care in NSW by Dr Donnellan. A former Chairman of the NSW State Committee between 1988 and 1990, Dr Donnellan was instrumental in securing the funding for the Albion Street offices of the College. He was also heavily involved with the establishment of breast screening services.

Surgical News recently spoke with Associate Professor Truskett about what the award meant to him.

Congratulations on your well-deserved award. How does it feel to be recognised by your peers in this way?

I feel both embarrassed and humbled by this award. I am embarrassed because many years ago, when I was NSW Regional Committee Chair, the late Bev Lindley, then NSW Regional Manager, suggested we develop a NSW award to recognise the contribution that Michael Donnellan had made to the College and to surgery in NSW. Michael was a man who could only be described as 'larger than life'. He was a fearless oncological surgeon with a particular interest in soft tissue tumours and testicular malignancy. He had an encyclopaedic knowledge of the literature and was probably the first person I saw who would put his case with evidence and not just eminence. His knowledge was matched with a surgical skill that allowed him to pioneer major oncological resections. I knew him as a student, a Trainee and as a young consultant before his untimely death. He was affectionately known as 'the Don' by all who knew him because of his strength of leadership. We decided that we would focus on his leadership qualities when defining this award.

I am humbled to be given this award. I have never really looked upon myself as a leader and I suspect many would agree with me. The College is an extraordinary organisation and I am very proud to be part of it. I recall when I was a supervisor of training and I rang Bev to complain about the direction the General Surgery training program was heading. It seemed that the focus was heading towards narrow subspecialty training before Fellowship, which in my view was not fit for purpose. Bev responded by saying, "Phil, it's not 'the College'. It is 'your College'. If you are unhappy it is your obligation to do something about it." I know for sure I was not the only one she said this to. She was right and all Fellows should remember those words. It was a great pleasure for former NSW regional chairs to witness when Bev was awarded an Honorary FRACS for her contribution to surgery. We'd all had the lecture and benefited from her wise counsel.

What motivates you, and what do you find most satisfying about being a surgeon?

I think the strongest motivation we all have as surgeons is the shoulders we stand on. We have all experienced working and training with people who can only be described as inspirational. I accept that this is not universal, but hopefully the mentors we choose display the professionalism that we can only aspire to achieve. Professional identity is an emerging concept about which we must all be mindful. In the clinical setting, we are always on show. Those who wish to become surgeons are likely to emulate what we do and pay little attention to how we say they should behave. The most satisfying aspect of surgery to me is the trust that patients put in us to help them, and the support from our colleagues when we need it.

What have been some career highlights?

There are too many highlights to mention, but I think the great thing is I've never lost the motivation to go to work. There are highs and lows, but I have been very fortunate to work at Prince of Wales Hospital in a collegiate environment with great colleagues. Working as a surgeon is great fun. I often feel a little uneasy when people talk about work/life balance. It seems to denigrate the worth of work, as if it is a bad thing. I much prefer to think in terms of work/life integration to recognise the importance of activities outside of surgery to avoid a blinkered existence without experiencing outside influences.

What advice would you offer to young aspiring surgeons?

Never lose sight of those who have trained you and those you will train. The College is important as part of this process. It is important to understand that we are all judged by the behaviour of each individual surgeon. We have a very important social contract to uphold for the community we serve. It is a gift and not a privilege. ■

Turning the tide on racism

No matter where you live, racism has taken centre stage in 2020. The Black Lives Matter protests and COVID-19 pandemic have shone a spotlight on racial injustice around the world.

On May 25, George Floyd, an African-American man, died after being handcuffed and pinned to the ground by a White police officer's knee. The tragedy, captured on video, sparked large protests against police brutality and systemic racism across the United States (US). The rallies triggered a global resurgence of the #BlackLivesMatter hashtag on social media. In Australia and New Zealand, news feeds on Facebook and Instagram turned black and thousands of people marched the streets. The message was clear: Black people are tired of being silenced, abused and dehumanised.

At the same time, the spread of COVID-19 triggered new displays of xenophobia. As some politicians chose to describe COVID-19 as the 'China virus', racism took off. In a Sydney cafe, a blackboard read: 'Coronavirus won't last long because it was made in China.' It was the tip of the iceberg. Soon enough, people of Asian descent were reportedly being verbally abused and spat on. Healthcare workers were among them. The Australasian College for Emergency Medicine reported a marked increase in racial abuse towards hospital staff, with patients refusing to be treated by some health professionals.

In February, Queensland general surgeon Dr Rhea Liang encountered a patient who refused to shake her hand (this was before social distancing). "This is not sensible public health precautions," she wrote on Twitter after the incident. "This is racism." Unsurprisingly, the Australian Human Rights Commission recorded a surge in racial discrimination complaints.[1] The allegations involved everything from verbal abuse and exclusion from public establishments to physical violence.

The pandemic also highlighted health inequalities. As the virus took hold in the US and the United Kingdom (UK), health authorities quickly noticed that people from racial and ethnic minorities were at increased risk of getting COVID-19 and experiencing severe illness and death. In the US, African Americans have died from the disease at almost three times the rate of White people,[2] and in the UK, Black and minority ethnic groups have suffered twice the death rates of White people.[3]

The trend has prompted new discussions about social determinants of health and structural racism across the world. While New Zealand's public health measures have protected many of its citizens so far, researchers have predicted that the risk of dying from COVID-19 is at least 50 per cent higher for Māori people than New Zealanders from European backgrounds. This is partly due to higher rates of existing health conditions such as heart and lung diseases, which are strongly associated with more severe outcomes from COVID-19. Similar risk factors put Indigenous Australians at high risk, too.[4]

But there are other factors that increase the risk of getting infected for Māori and Pacific people. Research from the UK shows that people who live in large households, or in poorer areas, are at greater risk of being infected. About 25 per cent of Māori and 45 per cent of Pacific people live in crowded housing.[5] They are also more likely to work in jobs or workplaces with higher health risks, including of infection.[6]

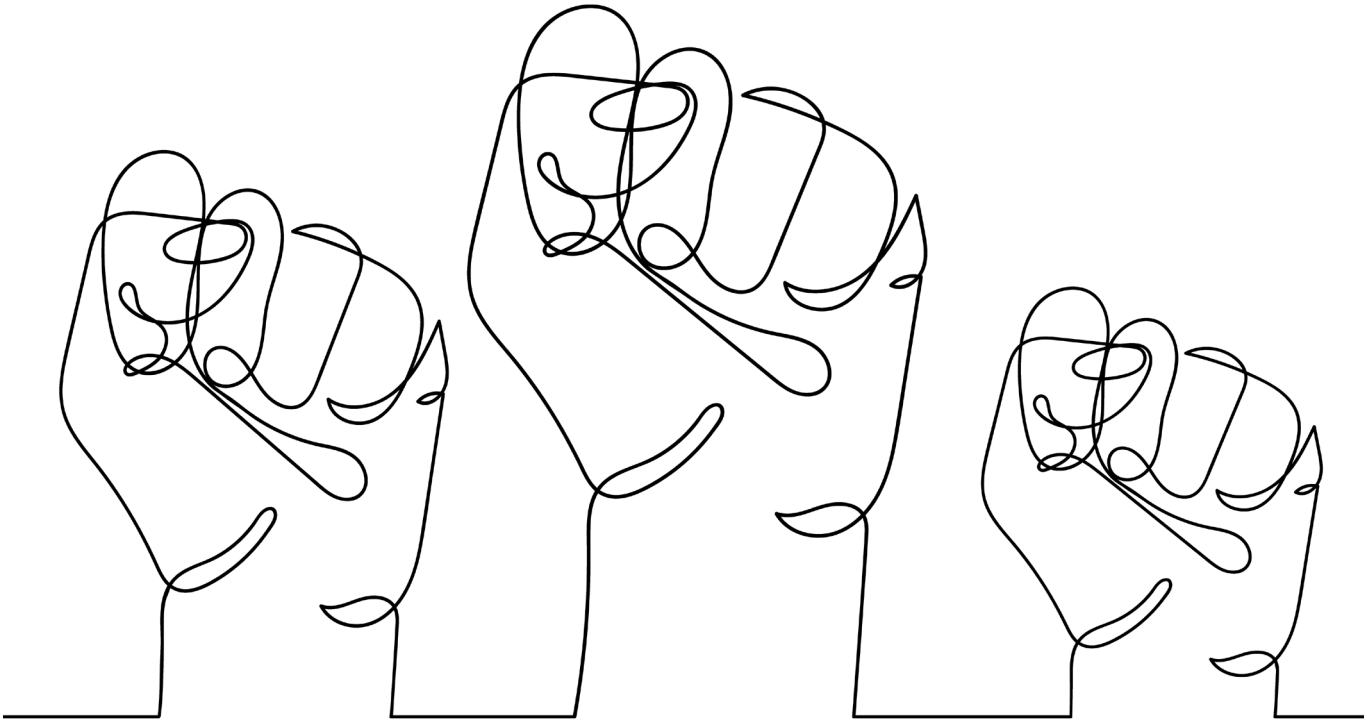
Māori and Pacific people also experience greater rates of unmet healthcare need and greater levels of poverty, which have been shown to have a significant effect on fatality rates from COVID-19.[7] Writing in *The Conversation*, the researchers who created the modelling said COVID-19 'has potential to intensify existing social inequities that result from colonisation and systemic racism.'[8]

The perfect storm of such factors has been seen in the US where many African Americans are essential workers, such as cashiers, bus drivers or hospital assistants – jobs that increase the chance of exposure to COVID-19. In addition, many predominantly Black neighbourhoods experience problems such as food insecurity and industrial pollution, leading to higher rates of conditions such as diabetes and lung diseases, which are COVID-19 risk factors. Then there is the issue of access to health care and money to pay for preventative care as well as treatment such as oxygen when being discharged from hospital.

These problems are not new for surgeons, especially those involved in the Royal Australasian College of Surgeons' (RACS) Indigenous Health Committee (IHC), which focuses on ways to achieve health equity for Aboriginal, Torres Strait Island and Māori people. The committee's efforts include campaigning for funding to reduce the burden of diseases prevalent in these communities through more prevention, screening and treatment.

The committee has also looked at factors that reduce access to health care among Indigenous people, such as the impact of previous trauma experienced in health services. In 2019, RACS introduced a new requirement for surgeons to improve their cultural competence and cultural safety knowledge. The College recognised that the significance of health inequities on poor health outcomes – particularly Indigenous peoples in Australia and Māori in New Zealand – was not adequately reflected within the competency framework. The new addition requires surgeons to demonstrate a willingness to embrace diversity among all patients, families, carers and the healthcare team and respect the values, beliefs and traditions of individual cultural backgrounds different to their own.

RACS is also aware of racial discrimination against Trainees, Fellows and Specialist International Medical Graduates. In 2015, a survey commissioned by the College found that one in five had experienced discrimination and some of it was racial.[9] In response, RACS launched Let's Operate with Respect – a campaign to help reduce discrimination, bullying and sexual



harassment in surgery. In 2016, the College also created its first Diversity and Inclusion Plan to try to ensure the surgical profession reflects the community it serves.

While racism is not new, the atrocities seen in 2020 have triggered large scale soul searching around the world. Organisations are looking for new ways to combat racism beyond the usual platitudes, and their efforts are becoming more visible. In June, the *British Medical Journal* published a special issue on racism in the UK health system.[10] Articles in the issue discuss treatment shortfalls for patients from minority backgrounds, prejudice in employment and career progression for doctors, and racism in medical education. After racist attacks drove Indigenous footballers out of the Australian Football League, the league's Inclusion and Social Policy General Manager Tanya Hosch created videos this year, pleading for fans to stand up to racism and abuse directed at players.[11]

More organisations are being monitored and publicly held to account for sticking with their policies. The University of Otago in New Zealand came under fire this year amid rumours it was winding back its scheme to encourage people from minority backgrounds to study health courses.[12] The progressive scheme meant students from Māori, Pasifika, rural, low socio-economic and refugee backgrounds are given priority entry to health professional programs as part of a drive to generate a health workforce more reflective of New Zealand society's make-up. The scheme, known as the Mirror on Society policy, is due for review next year.

It is yet to be seen if the global focus on racism this year will deliver meaningful change for the people who suffer its effects. As American political activist and academic Angela Davis said, "In a racist society, it is not enough to be non-racist, we must be anti-racist." There is a real need to challenge the systems that perpetuate racist outcomes and discourse.

Closer to home, Tanya Hosch, South Australian of the Year, said that everybody has a role to play. "If you get the opportunity, use your voice to make sure that people don't forget that everyone matters, that not one of us is any better than anyone else, regardless of your station in your life, regardless of the privileges you've had." ■

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Associate Professor Kelvin Kong on Black Lives Matter

Associate Professor Kelvin Kong was striding into John Hunter Hospital in Newcastle to treat a patient with COVID-19 when he was stopped in his tracks.

"Deliveries are out the back," a hospital worker said to him.

A surgeon with 13 years' experience, Associate Professor Kong was offended to be mistaken for a truck driver. But he didn't get angry. He simply explained who he was, entered the hospital and got on with his job.

When the incident was described on Twitter by a colleague, Associate Professor Kong remained remarkably gracious. "Awareness of unconscious bias is required, so we treat everybody kindly," he wrote. "I can manage, I worry for my mob."

The tweet prompted others to share similar experiences. One Indigenous general practitioner said he had been asked to refrain from eating food that was set up for a committee meeting he was attending. A British barrister with dark skin said she was mistaken for a defendant three times in one day.

Associate Professor Kong said these acts are generally not malicious but highlight how much people need to be taught about unconscious bias and racism. And 2020, for all its devastation, seems a good year to discuss it.

Racism in all its forms has been in the spotlight this year. The suffocation of George Floyd by a police officer in the United States (US) reignited the Black Lives Matter movement, prompting similar action in Australia. The message went global via social media. At the same time, COVID-19 has ravaged Black and other minority communities in the US and the United Kingdom, mostly due to health inequities.

In July, Associate Professor Kong and his family participated in a Black Lives Matter rally in Newcastle along with some of his medical colleagues. He relished the opportunity to discuss racial injustices, including deaths in custody and Australia's history of slavery.

Associate Professor Kelvin Kong's son, Lewis, at a #BlackLivesMatter rally in Newcastle.

"For me it's been a wonderful conduit to start the conversation," he said. "A lot of people are fearful of the conversation and scared of being called racist when they're not racist, they're just lacking the truth."

When COVID-19 reached Australia, Associate Professor Kong knew it posed an extraordinary risk to Indigenous people, who have higher rates of risk factors for severe illness, such as hypertension and diabetes. He was quick to shut down clinics he attends in remote areas of New South Wales and the Northern Territory to prevent transmission.

While this undoubtedly reduced the risk of COVID-19 in those communities, the action was a double-edged sword, exacerbating delays for other medical care.

Despite these setbacks, Associate Professor Kong wants to build on the momentum created in public health this year. He said that if Australian health authorities can do such a good job of protecting Indigenous people from COVID-19, it's time to devote similar effort to other problems plaguing his people.

Associate Professor Kong has good reason to fear for Indigenous people. Aboriginal and Torres Strait Islander people are twice as likely as non-Indigenous Australians to have a severe or profound disability,[1] and can expect to die almost 10 years earlier than non-Indigenous Australians.[2]

One thing Associate Professor Kong would like to see is a revision of triage systems to ensure life-changing interventions for children, such as treatment for otitis media, are prioritised. It saddens him to see Indigenous children waiting up to three years for treatment, causing their hearing, speech and wellbeing to deteriorate. The pain and disruption for such children causes other problems for their families who are shunted around the health system, costing them money and time off work.

"If that kid gets an operation and gets their hearing back, within weeks they will be back on the curve of normal learning," he said.

Associate Professor Kong is also passionate about making health services more attractive to Indigenous people. When he hears statistics about the proportion of Indigenous people who leave hospital without being treated he wants health professionals and their staff to reflect on why this is the case. These statistics should prompt services to ask whether they are delivering culturally appropriate care, and if not, why not? He is pleased that the College is doing its part to educate surgeons about cultural competence and cultural safety in its Cultural Competence and Performance Guide.

Associate Professor Kong understands why Indigenous people are frightened of hospitals. For as long as he can remember, hospitals were considered places to avoid.

"If you went to hospital you would be turned away. If you went to hospital you wouldn't come home," Associate Professor Kong said of the anecdotes he heard while growing up.

Hospitals were associated with particularly traumatic events in his family, too. When Associate Professor Kong's mother was in hospital as a child with her mother – Associate Professor Kong's grandmother – they were warned not to return to her community because "the ordinance officers were coming". Children were being taken away from their parents as part of Australia's assimilation policy. Associate Professor Kong's mother and grandmother promptly ran away with his grandfather and didn't see the rest of their family for another 40 years. Associate Professor Kong's grandfather later died of a heart attack in his 50s. To this day, the family wonders if he received appropriate treatment.

Despite the intergenerational fear, Associate Professor Kong's mother decided to become a nurse, and her interest in medicine rubbed off on him and his older sisters. It wasn't the most natural path to follow. In secondary school, he remembers a careers counsellor encouraging him to become a tradie. But after hearing two Aboriginal medical students speak at a careers day, everything changed. Associate Professor Kong and his sisters decided to put their heads down and pursue medicine. They wanted to serve their community.

Associate Professor Kelvin Kong with his daughter, Ellery.

This was confirmed to Associate Professor Kong when he treated his first Aboriginal patient at St Vincent's Hospital in Sydney. The Aboriginal Elder reminded Associate Professor Kong of his grandmother. After he took an extensive history, the woman started to cry.

"I thought what have I done? I've mucked this up … And then she said: 'I never thought I would live to be treated by an Aboriginal doctor'. It highlighted to me the professional inequity we have. To have someone understand the trauma she'd been through in her life was huge."

In 2007, Associate Professor Kong became the first Indigenous surgeon in Australia when he completed his Fellowship in Otolaryngology Head and Neck Surgery. He is now an ear, nose and throat surgeon and Associate Professor of Medicine at the University of Newcastle and the University of New South Wales. One of his sisters became the first Indigenous obstetrician in Australia and his other sister is a specialist general practitioner. He takes some pride in this, but is mostly embarrassed that it's still such a novelty for Aboriginal people to become medical specialists.

Rather than standing out, Associate Professor Kong wants to see more diversity among surgeons so that Australia's multicultural community is truly reflected in its health workforce. He said the College has been extremely supportive and continues to break barriers down in Aboriginal, Torres Strait Islander and Māori health.

As part of the College's Diversity and Inclusion Plan, Associate Professor Kong wants to see young Indigenous doctors and Trainees being mentored the way he was, so they get practical advice. He is encouraged by the calibre of young Indigenous doctors he mentors and says other surgeons have also been very willing to mentor.

Closer to home, Associate Professor Kong feels optimistic that Indigenous people are speaking up and being heard. When his Nan and mother were growing up, they tended to hide their Aboriginal culture for fear of persecution.

"When I was growing up you could talk about it, but most of the time it was suppressed. Now my son wears his Koori t-shirt to pre-school and is proud as punch. That's what we want in Australia, for people to feel safe." ■

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Surgical professionalism paramount for better patient outcomes

The Royal Australasian College of Surgeons (RACS) is globally recognised for its leadership in implementing a long-term program of work to build respect and increase patient safety in surgery.

For a fresh lens on cultural change in the health sector, RACS spoke to close-range observer of health sector culture Dr Mark O'Brien, the medical director of the Cognitive Institute, which operates across Australia, New Zealand, Singapore and the United Kingdom. He is also the international program lead of Risk Prevention for the Medical Protection Society, United Kingdom and a Board Director at St John of God Health Care, Australia.

A growing understanding of the link between non-technical performance and patient safety is shifting the culture of medicine and increasing the value placed on professionalism, according to Medical Director of the Cognitive Institute, Dr Mark O'Brien.

But he suspects the big drivers of future cultural shifts in Australian health care will be generational change, closer links between funding and patient outcomes and the impacts of COVID-19.

"There's already really great data to show that professionalism matters a lot. There are more infections, more complications and more re-admissions because of the impact of unprofessional behaviour on coordination of care," he said.

Into the future, Dr O'Brien is looking out for the cultural impacts of tighter links between patient outcomes and funding.

"Internationally there is a very significant trend among healthcare funders to move the dial on payment for healthcare services away from 'process' to 'outcome'. The drivers and incentives are changing, and the focus is shifting from doing things, to rewarding the results," Dr O'Brien said.

This is where the role of professionalism and a healthy culture comes in. The best patient outcomes result from optimal "communication, coordination, teamwork, professionalism, engagement with your college and professional development – not just whether you did a technically good operation," he said.

Dr O'Brien said COVID-19 will accelerate that trend, with the resulting recession increasing pressures on healthcare funding, possibly reducing rates of private health insurance and patients' capacity to fund out-of-pocket expenses.

"I'm not sure anyone knows exactly how the dust will settle, but I do think there will be significant change in the next 18 months. I suspect these pressures will see a focus by funders on value for money and patient outcomes that we haven't seen before," he said.

Another emerging aspect of cultural change is generational, with generations X and Y adopting a different model of professionalism.

"Younger professionals seem more willing to sacrifice some autonomy in exchange for security, access to leave, lifestyle and work conditions. In general, they don't want to manage the business of being a doctor and are happier being managed than previous generations," he said.

And then there is the impact of increased procedural complexity.

"We are doing things now that we wouldn't have dreamed of doing 30 years ago, and these advances have increased the pressure and stress on doctors," he said.

But resilience and burnout also affect professionalism, and Dr O'Brien said he wonders if this is another area in which the impact of COVID-19 will be felt.

"How can surgeons boost resilience and avoid burnout – for themselves and for their teams? If they're flagging, there will be poor patient outcomes," he said.

Dr O'Brien's approach to professionalism is expressed in the 'Speak Up for Safety' programs that the Cognitive Institute has developed. This is linked to the Vanderbilt University's 'Promoting Professional Accountability' program of work, which guided RACS' Action Plan: Building Respect, Improving Patient Safety.

RACS' face-to-face Building Respect training and Speak Up app are specifically designed to support surgeons to speak up for the culture they want to be part of.

Dr O'Brien quotes Professor Charles Vincent, "the Oxford guru on patient safety", and his conviction that a 'speaking up' culture is central to patient safety. "If you don't have a speaking up culture, it will undermine everything else you do," Dr O'Brien said. "We look at everything through a patient safety lens, rather than a clinician behaviour lens."

When it comes to patient safety and high performance, Dr O'Brien sees bullying and harassment as "a microcosm of a bigger picture".

"Bullying and harassment are a subset of a range of performance-disabling issues that can manifest in a team," he said.

Dr O'Brien is positive about RACS leadership in this area and encourages the College to be "aspirational around high performance" and to continue to prioritise professionalism, emotional intelligence and resilience, as well as technical skills, in selecting surgical leaders.

He asks whether professionalism holds the key to unlocking exceptional performance more widely in health care.

"What mindset, emotions and environment do you create for superior performance? It's not just about intelligence and technical ability, but we have yet to identify the systems, teamwork and processes that will create a high safety, high performance culture," Dr O'Brien said. ■

Making surgeons' fees and the complaints process more transparent

Public attention on surgical fees has definitely increased in recent years. Although occasionally raised as an issue in New Zealand, in Australia the costs patients occur when undergoing surgery are well and truly under the public microscope. Regular news stories about patients turning to crowdfunding websites to pay for $100,000+ surgeries, and media investigations such as *Four Corners*' 2018 'Mind the Gap' report have contributed to significant community and government concerns about 'excessive fees' and 'bill shock'.

In this context, RACS has been working hard to demonstrate that we appreciate these concerns by making surgeons' fees, and how RACS deals with complaints about them, more transparent.

RACS' position is that fees, where they are manifestly excessive and bear little, if any, relationship to utilisations of skills, time or resources, are exploitative and unethical. As such, they are in breach of the RACS code of conduct. However, defining what actually constitutes an 'excessive fee' is tricky legally. Even if RACS wanted to set or enforce a schedule beyond which we would consider fees to be 'excessive', it's unlikely we would be able to. This is because the Australian Competition and Consumer Commission (ACCC) has provided guidance to professional organisations – such as RACS – which suggests that any attempt to take disciplinary action in relation to fees may amount to a breach of the *Competition and Consumer Act 2010* (Cth). In addition, and in part, related to these legal restrictions, the complaints framework we launched in 2016, on the whole proved to be unsatisfactory in dealing with fee and other complaints. Although the framework was found to be effective in facilitating patients in coming forward with their concerns, formal processes resulted in lengthy review without resolution to either party.

Therefore in 2019 and 2020, to demonstrate that the College is serious about the public's concerns regarding fees, RACS has changed the way it deals with fee complaints as part of a wider revamp of our complaints framework, and has put more emphasis on promoting 'informed financial consent'.

Now, when RACS receives a complaint about fees it may, depending on the facts and if the complainant is happy for us to do so, have an informal discussion with the Fellow concerned, and/or refer the complainant to an agency suited to responding to the issue – such as their local healthcare complaints commissioner. RACS now also provides general assistance to both the complainant and the respondent to help them navigate the system. We believe that this more transparent process will produce more satisfactory outcomes.

As mentioned, in addition to complaints reform, RACS has put renewed emphasis on promoting 'informed financial consent' (IFC). Promoting IFC is about ensuring greater transparency around fees by empowering patients to ask the right questions of their surgeon, and educating surgeons to ensure they provide their patients with everything they need to know.

With the aim of making what can be a complex topic more understandable, we are currently working on an online video and other resources to assist patients navigate discussions around fees – in several languages. We have also revised our own IFC position paper and have co-badged the Australian Medical Association's IFC Guide.

To promote greater understanding of the principle among the Fellowship we are also rolling out micro-learning activities for Fellows on IFC, and are putting greater emphasis on it in 'preparation for practice' courses for Trainees.

By promoting transparency in these ways, we believe public confidence in the manner surgeons set and communicate their fees will be maintained. But as demonstrated by the launch late last year of the 'Medical Cost Finder' website, the Australian Government is taking a very active interest in this issue. Although the project is currently 'on ice' due to the pandemic, the government has announced its intention to broaden the website's functionality to get individual fee data for doctors and specialists – including surgeons – onto the website.

RACS leadership has been, and will be, talking with government about these planned changes, and is interested in the views of our Fellows. ■

Input to RACS' Sustainability in Healthcare Working Group is welcomed via advocacy@surgeons.org

John Biviano
RACS CEO

Crossing continental barriers to focus on cultural change in surgery

A podcast collaboration between RACS and the Royal College of Surgeons of England

Culture change in surgery: it's a tough and uncomfortable, but important, subject that we must talk about. That's exactly what Associate Professor Rhea Liang, general and breast surgeon on the Gold Coast and Chair of the Royal Australasian College of Surgeons (RACS) Operating with Respect Education Committee, and Mr Simon Fleming, an orthopaedic Trainee based in London, crossed continental barriers to do.

In the first ever podcast collaboration between RACS and the Royal College of Surgeons of England (RCS England), Associate Professor Liang and Mr Fleming combined their knowledge, experience and ongoing work on discrimination, bullying and harassment to produce a four-part podcast series on the theme of culture change in surgery. *Surgical News* spoke to Mr Fleming and Associate Professor Liang to find how the concept came about.

"Simon heads the #HammerItOut campaign, an orthopaedic-led cultural change initiative in the UK, which has now extended to other specialties through related hashtags such as #CutItOut," said Associate Professor Liang. "It has obvious similarities with the #OperateWithRespect program run by RACS, and we share information and ideas regularly.

"So when Rhea Folkers, Digital Learning Coordinator at RCS England, contacted us about recording a single podcast as part of The Theatre, an ongoing podcast series, which looks at innovation in surgical education, we thought it was a great idea to share experiences from our respective programs," she said.

"As we brainstormed, it became apparent that we would do the topic a disservice if we tried to shoehorn everything into one podcast," Mr Fleming said. "And so the four-part podcast series around 'culture change' was born. It's a collaboration that we are very proud of, and it feels almost serendipitous, as I will be in Australia in about two years to begin my Fellowship."

The podcast series has been a success, having been listened to almost 2000 times since its launch.

The series aims to bring conversations about bullying, harassment and discrimination in the surgical workplace to the forefront of professional discourse, in the hope of encouraging long-term changes in attitudes and behaviour at all levels.

> "There's that saying, 'Oh, terrible bedside manner, but they're a good surgeon.' And I think we have to challenge that. Because the evidence shows that the competencies that don't relate to your actual technical ability do affect the outcomes for your patients. So it's not possible to say that you're a good surgeon when you have bad bedside manner," Associate Professor Liang said in the first part of the Culture Change podcast.

Mr Fleming and Associate Professor Liang explore, among other issues, the common misconception that behaving respectfully is the same as being nice and non-assertive.

"The measure of respect in a team is if you feel safe enough to disagree with and challenge each other," Associate Professor Liang said in the first episode of the series. "It's not about being nice and acceding to every request without question."

"Bullying is about power and silence," agreed Mr Fleming. "Not feeling able to speak up and say something's wrong is just as disempowering."

How can we attain culture change in surgery?

Mr Fleming and Associate Professor Liang have an open discussion about why we need culture change in surgery and what is being done and can be done to achieve it. Their conversation suggests ways that ongoing national and international initiatives to attain culture

change might be applied to your own working culture.

Operating with Respect will be familiar to RACS members, but it is a new concept for many RCS England listeners. Similarly, #HammerItOut will be new for many RACS listeners. However, although there are differences in context, the issues of disrespectful behaviours in the workplace are common in Australia and New Zealand and the UK.

Culture change is not easy and takes time. For instance, consider how long it has taken to address smoking in public places or driving while drunk. "Without outside influence, the culture we inherit is the one we will pass on," said Associate Professor Liang. "I hope that surgeons listening to this series will feel that their experiences of disrespectful behaviour are not isolated, and that there are practical things that can be done to address them in the workplace.

"I also hope they will feel inspired to work together to gradually change the culture of surgery so that disrespectful behaviours will become as unacceptable as smoking in public or driving while drunk. We deserve it for our own wellness, and our patients deserve it because respectful culture improves communication and patient outcomes."

The standard you walk past is the standard you accept

"If you can speak up, then speak up," said Associate Professor Liang. "If you can't speak up, especially if there is a power or seniority differential, then you should confide in a trusted colleague. The behaviour will only continue to be acceptable for as long as we collectively stay silent."

One of the ways surgeons can feel emboldened enough to speak up is if they feel empowered, and if they feel they will be listened to. "We are asking for people to change their minds, attitudes and beliefs, and we can't make people do that," said Mr Fleming.

"What we can do is hope that people will listen – really listen and reflect. The real goal is to empower others and give a voice to those who might feel voiceless and to use the power and privilege we have to set surgery on a path that, in time, we can look back at and say: 'Wow, can you ever imagine people acted that way?'"

Listening to this podcast series will give you a deeper understanding of what you, as an individual can start doing right now, and how you can spread that to your hospital and to your colleagues.

"Once you know better, you can try to be a bit better," continued Mr Fleming. "We owe it to our patients, our colleagues and ourselves to be better." ■

Listen to the four-part podcast series on culture change atrcseng.ac.uk/news-and-events/podcast/

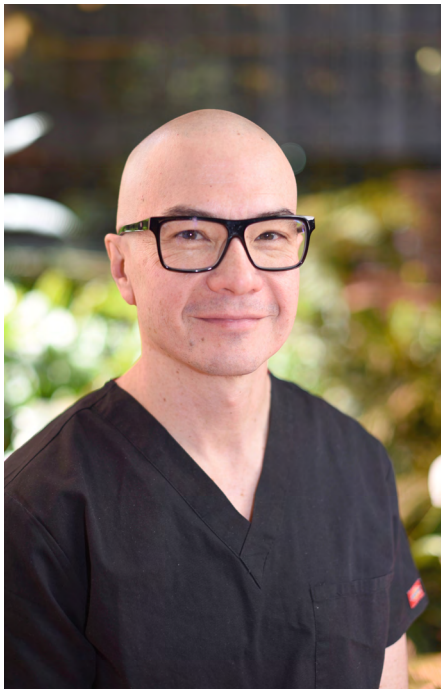
Taking surgical training to a new level in Zoom

When COVID-19 caused the cancellation of the Cardiothoracic Surgery Trainees Meeting in May, convenor Dr Chris Cole took the meeting online with outstanding results.

So far this year there have been two professional firsts for Dr Chris Cole, a consultant cardiothoracic surgeon at the Princess Alexandra Hospital in Brisbane.

Back in February, he performed a world-first operation when he combined cardiology and cardiac surgery techniques to give a patient who'd been turned down for surgery with standard techniques a chance to return to normal life instead of an impending demise.

The 51-year-old patient had a completely calcified aorta due to radiotherapy as a child. In his 20s he'd had a mechanical valve replacement, but it had come loose. The valve was now tearing up red blood cells and swinging in and out of the heart, so Dr Cole created an operation that replaced the mechanical valve without going near the aorta at all.



Dr Chris Cole

Then in May, COVID-19 travel restrictions forced the cancellation of the Cardiothoracic Surgery (CTS) Trainees Meeting. As convenor of the meeting, Dr Cole came up with an original and innovative way to run a comprehensive virtual learning program in place of the meeting.

He also endeavoured to incorporate feedback from the Board of Cardiothoracic Surgery about unsuccessful Fellowship exam candidates needing more integrated knowledge. In addition, he wanted to include one of the Royal Australian College of Surgeons' (RACS) surgical competencies, technical competency, in a virtual meeting.

Welcoming the Trainees

The Australian and New Zealand Society of Cardiac and Thoracic Surgeons (ANZSCTS) is a small specialty and this means SET (Surgical Education Training) Trainees are often geographically isolated from their peers.

"Often they're the only Trainee in that hospital, and sometimes the only Trainee in the city or state," Dr Cole said. A particularly large cohort of Trainees last year meant there were 10 Trainees who had never met anybody else training in Cardiothoracic Surgery. "If we'd had a face-to-face meeting it would have been their first opportunity to meet other Trainees," he added.

With this in mind, Dr Cole sent all 40 Trainees a hamper before the meeting with a message that read:

'Keeping isolated at this time has saved us and our patients, but at the expense of meeting together. I hope this package makes our virtual meeting more like a face-to-face meeting, and reminds you that the journey to being a cardiothoracic surgeon is not one you are taking alone.'

At the virtual meeting, Dr Cole asked the Trainees to introduce themselves and explain where they were from and who they were to "put names to faces," Dr Cole said. "It was important for SET 1 Trainees to know that they're not alone, that it's collegial and that we're here for them," he explained.

Planning the virtual Trainees Meeting program

Dr Cole knew he didn't want the Trainees "sitting there having lectures" so he created activities to engage them on multiple levels. In order to encourage interaction between the Trainees and faculty he used Zoom, which has a function called 'Breakout Rooms'. This meant he was able to split the Zoom meeting into separate sessions for small group discussions and then bring them back together into a large single meeting when required. As Zoom host he was able to switch between the small group sessions himself, and also group – either manually or automatically – the Trainees, faculty and presenters into specific sessions.

Dr Cole used 15 Breakout Rooms for 46 SET Trainees, post-SET pre-Fellowship and Specialist International Medical Graduates; 24 faculty and 11 presenters. The sessions were conducted over three days and each Breakout Room was equipped with audio, video and screen-share capabilities.

Zoom meetings are usually arranged by email invitation, but Dr Cole wanted to avoid overloading the participants' inboxes, so he created a website to

present the program with live links to each of the password-protected sessions. Session times were set at times that were convenient for everybody – from Perth to New Zealand.

While face-to-face meetings were the usual practice for CTS Trainees Meetings, the 2020 Zoom meeting provided some surprising highlights:

- The website made it as simple as a click for students and faculty to locate sessions and access meetings.
- Virtual meetings enabled faculty and presenters from across Australia and New Zealand to attend the meeting.
- Trainees were able to talk to senior surgeons.
- Trainees were exposed to different ways of doing things, rather than location-specific ways, which was often the case at CTS Trainee Meetings.
- SET 1 Trainees were able to meet other Trainees for the first time.
- Trainees had a meeting to themselves to discuss Trainee issues.
- Videos from most of the sessions were available on the website.

Hands-on teaching session using Zoom

To encourage integrated thinking, Dr Cole changed the program structure to basic, advanced and technical subjects that were all related to one section of the curriculum – coronary surgery. Then he focused on a deep dive approach that would ultimately take place during technical sessions in Breakout Rooms on Zoom. But first, he had to create the content for the technical sessions.

The Trainees had anastomotic simulators, forceps and a needle holder, so Dr Cole uploaded a sample video of himself on the website performing an anastomosis in his kitchen. Then he asked the Trainees to record a video of themselves performing an anastomosis on their simulators in their homes prior to the meeting.

The Trainees' high-resolution videos were then uploaded to a paid Vimeo account that was integrated with Dropbox. Dr Cole retrieved the videos and uploaded each of them to a separate page on the password-protected website.

At the meeting, Trainees were divided into groups with two faculty members. They then went to their allocated Breakout Rooms and played the simulated anastomosis videos, explaining their techniques to the surgeons who provided them with feedback.

"I wanted it to be a technical session and an interactive session," Dr Cole said. The activity provided a much wider array of surgeon involvement and contact with the Trainees than in previous years, Dr Cole added, and this resulted in them getting feedback from surgeons they hadn't met before. It "sharpened their reflective practice and opened them up to techniques they had no previous exposure to" – for example "technical feedback from a left-handed surgeon to a left-handed Trainee."

Dr Cole approached the Supervisors of Training as a group and asked them to contribute as a group or to nominate a surgeon to assist in small group discussions. The result was "a much wider array of surgeon involvement and contact with the Trainees than in previous years," Dr Cole said.

From personal experience, Dr Cole knew that sitting through long Zoom meetings could be challenging and result in what is now known as 'Zoom fatigue'. To avoid this, he worked hard to provide high-quality information and external experts that kept the Trainees engaged throughout the three days of learning.

Trial vivas in Zoom

The attendees also participated in a trial viva with faculty acting as examiners. Conducted via Zoom, all the attendees joined one initial meeting room where three short case websites were published live.

Attendees were then given 30 minutes to prepare their answers, while examiners were moved to a separate Breakout Room for discussion and preparation. After the preparation period all attendees and examiners were assigned Breakout Rooms where attendees were designated as candidates or observers so that those sitting the Fellowship exam in 2020 and 2021 were given appropriate attention.

Dr Cole said the trial vivas were highly rated by Trainees in their feedback, and he hopes to conduct further viva sessions in Zoom for the Trainees.

Dr Cole also ran a trial written exam, using Zoom to facilitate the exam. He created a question website that was only available from the time of the trial exam and candidates had 50 minutes to type their answers into the website form, which they then submitted for marking.

"Once you've set it up, it's really easy to replicate," Dr Cole said of the virtual CTS Meeting "You can use exactly the same template – just copy and paste and change the dates and times." He intends using the same process for future meetings and hopes it has lowered the barrier to running part of the Fellowship Examination online. ■

Richard Lander: the last word

In their lifetimes my grandparents and their parents witnessed the Second Industrial Revolution, the age of steam and the rise of science. In my lifetime, I have witnessed a technological revolution.

At primary school I had a desk with an ink well into which I dipped a pen with a nib and by secondary school it was a biro. At secondary school I used a slide rule and log tables to solve complex maths problems. I saw the evolution of the calculator and the personal computer, and a man land on the moon. I watched television go from black and white to colour.

In my career in Orthopaedic Surgery I have seen the evolution of plates and screws, intramedullary rods, complex external fixation, computerised navigation of joint replacements and the introduction of robotics into surgery. I now have the computing power of early NASA missions in my pocket. I have learnt to tweet and follow friends on Instagram and Facebook.

My old filing cabinet is now on my computer. Instead of penning a letter I can email, Google search, Skype, Zoom and Facetime. In the College I have seen a progression of CEOs, presidents and councillors, each with their own ideas and ideology. The College is slowly evolving and continues to evolve, with its ups and downs along the way.

In the last 42 years as a doctor, 30 years as a consultant surgeon and six years as the College's Executive Director of Surgical Affairs in New Zealand, I have learnt four things that I think may be helpful for colleagues. First, plan your journey; second, enjoy your journey; third, develop the next generation; and fourth, recognise your own cognitive decline.

My advice to my junior colleagues is that at the start of your career you should plan out a rough guide to where you want to be in 30 years. On your journey, when you come to the many crossroads, take the path that will challenge you and accept opportunities as they arise. As you travel your roads will change depending on circumstances, often beyond your control. Be accepting of change, it is called 'evolution'.

Develop what I would call your families. Your families are your spouse and children and their children, your work families, including both your national and international colleagues, and your local surgical teams, and your social families, friends and people outside your immediate family and work colleagues.

Develop life balance with the families you choose. The best experiences have come from working in teams, and working in teams of enthusiastic, dedicated and talented people has been my greatest pleasure. Most of these people have been smarter than me.

Develop values of respect, compassion and humility. Recognise when you become overwhelmingly physically and emotionally exhausted. Recognise when you are becoming cynical and detached from your work, and when you develop a sense of ineffectiveness and lack of accomplishment. It is time to move on when you overidentify with work to the exclusion of other activities. If your aim is perfection you will be disappointed, it is okay to accept less than perfect.

Develop a positive attitude and protect time away from work. Sleep and eat well, discuss life with friends. Become curious and ask unscripted questions.

Become mindful, listen to the birds singing and watch the grass growing. Admire the small things in life. See, smell, feel and listen.

It is our vocation to develop talent and look for our own successor. Talent can come from any quarter so encourage diversity. We know from population studies that clones inbreed and mutate while diversity thrives.

My advice to colleagues is at the age of 30, look to develop the younger generation while they are still at school. At the age of 40, develop those with a desire to learn, and at the age of 60, develop your junior colleagues because they will take your job and will care for you and your patients.

Surgeon William Mayo (1861-1939) said, "Age carries mental scars left by experience which shortens vision, but age also carries wisdom."

Research shows that with age our mental faculties decline, particularly conceptual reasoning, memory and processing speed. The curves show a steady decline beginning in your 30s and 40s. It would

be helpful to know the T and Z scores, the 95 per cent confidence limits and the threshold for maintenance of clinical competence and, even more importantly, where you are on the graph at any point in time. I would suggest we all take the test, see where we are, monitor our cognition and predict our own withdrawal from clinical practice. I guess this takes me back to my first point, plan your journey.

Thank you all for being part of my family, being part of my journey and allowing me to share my experiences and wisdom.

Hapaitia tea ra tika pumau ai te rangatiratanga mo nga uri whakatipu.

Foster the pathway to knowledge to strength, independence and growth for future generations.■

Mr Richard Lander – gone fishing

South Australian surgeons share prestigious award

On 6 November 2020, Adjunct Associate Professor Franklin Bridgewater OAM and Professor Peter Reilly AO were jointly presented with the Sir Henry Newland Award in front of family and friends at the South Australian Annual Dinner.

The award is named after Sir Henry Newland, who is remembered for the extensive and honorary service he provided to the South Australian, Australian and international surgical communities throughout his lifetime. His accolades include being recognised for his services during World War I, with the Distinguished Service Order in 1917, and then later being appointed C.B.E in 1919.

Following the war, he was one of the founders of the Royal Australasian College of Surgeons (RACS), where he served as College president (1929-1934), and chair of the RACS State Committee in South Australia (SA) (1939-1942). The award in Sir Henry's honour recognises a surgeon who has provided distinguished service to surgery in the state.

Dr Amal Abou-Hamden, RACS SA Committee Vice Chair, provided a citation to Professor Reilly and described him as an inspiration to a generation of SA surgeons.

"A particular focus for Peter has been collaboration for establishing protocols for head trauma prehospital care management guidelines – contributing to South Australia's world leadership in this field," she said at the dinner.

She spoke about his many achievements. "In 2002, he became an Officer in the General Division of the Order of Australia (AO) for service to the advancement of neurosurgery through clinical practice, research, education, and professional organisations and in the prevention of head injuries.

"His interest in traumatic brain injury brought him remarkable collaborations from around the globe, including chairing the Asian Australasian Society of Neurological Surgeons Neurotrauma Committee from 2014 until 2018," she continued. "Peter Reilly remains a quiet achiever and an inspiration, mentor and friend to many surgeons in Australia and worldwide."

In his acceptance speech Professor Reilly said he was humbled to receive the award, and paid tribute to the man for whom the award is named.

"Henry Simpson Newland was multidisciplinary before disciplines had developed separate identities. The first recipient of the Henry Simpson Newland medal, Donald Simpson, described him as 'in the fullest sense a general surgeon' and, being so, several disciplines can claim him as a pioneer.

"I had the great good fortune to have been inspired and trained – sometime later – by his successors," Professor Reilly said. "I thank you, my colleagues, and the College, and I acknowledge my debt – our debt – to that heroic general surgeon and pioneer neurosurgeon, Henry Simpson Newland."

Friend and former colleague Mr Glenn McCulloch provided the citation for Adjunct Associate Professor Bridgewater, as the pair have worked together and known each other for 45 years.

"He has had a distinguished career at a personal level, with work in Papua New Guinea as a consultant surgeon and ▶

Mr David King (left) with Adjunct Associate Professor Franklin Bridgewater OAM

Left to right: RACS President Mr Anthony Sparnon with Ms Natasha Stott Despoja and SA State Committee Chair Mr David King

at The Queen Elizabeth Hospital from 1979 to 2014," Mr McCulloch said.

"His contribution, however, while distinguished, can more appropriately be marked by the impact he has had on surgical Trainees within South Australia. As a consultant surgeon he has been extraordinarily supportive of junior Trainees working through the surgical training program at The Queen Elizabeth Hospital. In addition to that, he has been a strong supporter of medical students, providing extensive tutorial and one-on-one teaching opportunities to them.

"His contribution to surgery through his attachment to the Australian Defence Force has seen him posted to Bougainville, East Timor, and in 2014 in Banda Aceh in Sumatra following the devastating earthquake and tidal wave," Mr McCulloch continued.

"There is no one more suitable to be recognised with the Sir Henry Newland Award than Associate Professor Frank Bridgewater, OAM. I recommend him for the award. "

Speaking at the ceremony, Adjunct Associate Professor Bridgewater recounted how his own father had known Sir Henry after migrating to Australia from England (including having once received a personal reference from Sir Henry).

"In the 1930s and early 40s, my father was employed as boiler attendant and maintenance man at Ru Rua Hospital. His job meant that he had frequent contact with the matron and visiting doctors, particularly the surgeons," Adjunct Associate Professor Bridgewater said.

"As children, sitting around the kitchen table at night, dad would often regale us with stories about that time. He spoke highly of Matron Birchell, Sir Arthur Cudmore and Sir Thomas Wilson, but reverently of Sir Henry Newland."

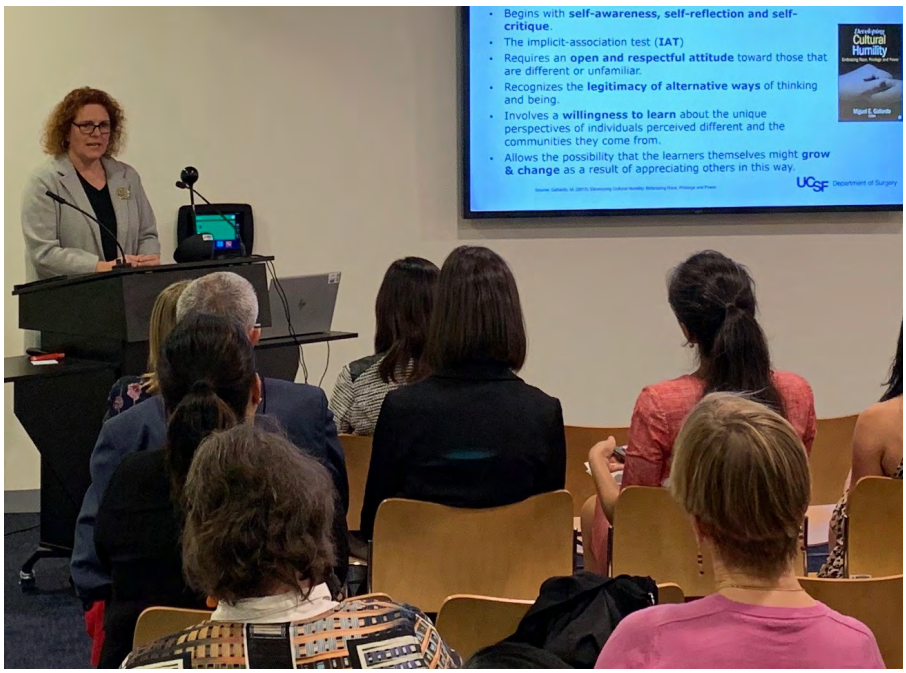
Left to right: Mr David King, Professor Peter Reilly and Dr Amal Abou-Hamden

Another highlight from the dinner was the annual Anstey Giles Lecture, which was delivered by Ms Natasha Stott Despoja. Stott Despoja is a former senator for SA (1995-2008) and former leader of the Australian Democrats.

Among her many other notable roles, Stott Despoja was Australia's Global Ambassador for Women and Girls (2013-2016), responsible for the promotion of women's economic empowerment, women's leadership and the reduction of violence against women and girls internationally. Her presentation, 'The Shadow Pandemic – inequality and violence', highlighted the devastating escalation of domestic and family violence during the COVID-19 lockdowns, and the need for our society to remain vigilant in addressing this 'shadow pandemic'.

Earlier in the day the RP Jepson Medal and Justin Miller Prize papers were held at the same venue (the Sanctuary, Adelaide Zoo), with the winners announced later in the evening at the dinner. Congratulations to Dr Vineet Binu, who won the Justin Miller Prize for his presentation 'Ultrasound imaging as the first line of investigation to diagnose malrotation in children – safety and efficacy'. Congratulations also to Dr Nuwan Dharmawardana, who won the RP Jepson Medal for his presentation 'Non-invasive detection of head and neck cancer – breath analysis'. ■

Academy of Surgical Educators year in review



Educational Events
Educator Studio Sessions, Special Educator Studio Sessions
Educational events at the Royal Australasian College of Surgeons (RACS) were severely affected by COVID-19. However, for the Academy of Surgical Educators (ASE) Educator Studio Sessions (ESS), this resulted in a distinct increase in ESS offerings, as webinars were already part of ASE's lineup. In fact, ASE also began to hold Special ESS – in similar format to ESS with a non-surgical education focus to provide RACS Fellows with an opportunity to obtain CPD points. Over 2020, ASE conducted 15 ESS and Special ESS webinars, nearly twice the number of sessions as last year! Attendance for the ESS and Special ESS is free, with members of the Academy provided access to the recordings via the Academy e-learning portal.

COVID-19 webinars
ASE took up the mantle of keeping our Fellows, Trainees and Specialist International Medical Graduates (SIMGs) up to date with the latest developments and information regarding surgical training, exams and progression, which were affected by COVID-19. The webinar series featured senior clinicians and Trainee representatives and helped answer any questions participants had. This proved to be an important tool in communicating exam changes to the target group, as participants had the opportunity to clarify any questions they had during this challenging time. ASE held nine COVID-19 webinars with a total of 1234 participants. Recordings of all COVID-19 webinars are available via the RACS COVID-19 webinar page.

Rewards & Recognition
Educator of Merit
The Academy recognises the contribution of Surgical Education Training (SET) supervisors, SIMG supervisors, facilitators and instructors via the ASE Recognition Awards.

The recipients of the Educators of Merit for 2020 are as follows.

Category: SET Supervisor/ SIMG Supervisor of the Year Awards:
- New Zealand: Mr John Lengyel FRACS
- Australian Capital Territory: Dr Bryan Ashman FRACS
- New South Wales: Professor Raymond Sacks FRACS
- Queensland: Mr Kenneth Cutbush FRACS
- Victoria: Dr Katherine Martin FRACS
- South Australia: Mr Robert Stuklis FRACS

Note: No nominations were received for Tasmania, Western Australia or the Northern Territory.

Category: Facilitator/Instructor of the Year Award
Dr Marion Andrew

The Educator of Merit winners will be presented with their awards at the local state or territory or New Zealand office events (where possible). The Academy also recognises the length of service of SET supervisors, SIMG supervisors and professional development facilitators through the Educator of Commitment Award. The list of awardees will be available in *Surgical News* in 2021. ■

Image: Dr Sanziana Roman presenting a session.

Trainees talk about supervisors

Joseph Xavier, SET 2 in General Surgery

How have your supervisors had an impact on your development and training?
I have been really lucky throughout my time as a junior doctor and as a junior SET Trainee to have had some really wonderful supervisors. I remember when, as a Senior Resident Medical Officer (SRMO), I had just failed my primary exam for the first time. An upper GI surgeon who was quite senior sought me out and supported me, even though I wasn't on his unit at the time. He made it clear that this wasn't the end of the world and that he was there to help me. He was really encouraging, and he didn't have to be. I still thank him for his support and his belief in me.

When I was on a rural term I had a supervisor who was an incredible role model in how he acted and conducted himself with nursing staff, ancillary staff and medical students. He really considered himself part of the team and would do things to help out and ensure the team functioned well. He even shared the note-writing duties on weekend ward rounds with me. It was a great example to me, as someone junior, that a senior consultant was still willing to do 'grunt' work to ensure the best patient care.

What makes a good supervisor?
I think availability is important to a supervisor so that if you run into trouble you know you can contact them and they will be approachable. A good supervisor must also understand your level of training. You need someone who is invested in you and your training, sits down with you and tells you what they expect, and asks you what you hope to get out of the term.

I also think a good supervisor is someone who allows you the opportunity to upskill and gives you autonomy, but is still within reach if you need them. This gives you the opportunity to gain skills in a safe way.

A good supervisor has a focus outside the immediate work, such as research or academia, and shares this with you and gets you involved.

What advice would you give other Trainees for working with their supervisors?
Planning is the key. Make sure that you start out right: to do this you need to speak to previous registrars and find out what the unit's expectations are and how the team functions. Set tangible goals for each term and share these with your supervisor so that they know what you are hoping to achieve. The other aspect of planning is before theatre. Be prepared; know the patient, the operation, the potential complications and be able to discuss this with your supervisor. This preparation helps you get the best out of the relationship.

Benjamin Thurston, SET 3 in Vascular Surgery

How have your supervisors had an impact on your development and training?
I have had three supervisors with quite contrasting approaches to their role – and I have been lucky that each of them has provided me with formative advice and guidance. My standout supervisors have taken the time, not only to guide me in the requirements of training, but also to mentor me in the attributes and qualities that I will require to be a good surgeon. My supervisors have set an inspiring example and have left an impression that will remain with me for many years to come.

What makes a good supervisor?
I think a good supervisor is someone who takes the time to understand who their Trainee is. This allows them to identify weaknesses and strengths in their Trainee's experience to date, both to enable the Trainee to maximise their learning within the unit and to maximise the unit's benefit from the Trainee.

Understanding who a Trainee is, both in and out of hospital, allows supervisors to give appropriate guidance and understand the complexities of any issues that may arise. It can also highlight

Trainees who may be a good fit for a unit in years to come.

What advice would you give other Trainees for working with their supervisors?
Each Trainee–supervisor relationship is unique. I have found that being open and receptive to different supervisor styles, together with clear and honest communication, allows for a healthy relationship. Ensure you discuss your training goals and any post or personal concerns as early as possible, but equally seek to understand how the unit you are in works and their expectations.

James Churchill, SET 5 in Urology

How have your supervisors had an impact on your development and training?
While all six of my training supervisors have had a different approach, I've found the common theme has been their approachability and genuine interest in helping me to be the best surgeon I can be. The most positive impacts have been in setting realistic expectations. As a Trainee it can often be tempting to set fantastic goals, but frustrating to find skills developing more slowly than expected. The best advice I've had was from my first Urology term supervisor, who likened gaining surgical skills to a child learning to eat with a spoon. While it can be initially frustrating to find most of a meal on the face or bib or floor, invariably once the connection is made and spoon makes it to the mouth, it sticks, and you (or the child) never look back.

What do you think makes a good supervisor?
In my view, good supervisors are those with whom Trainees can build up rapport, trust and see as approachable beyond the formal Trainee–supervisor structures. Feedback and development can then occur naturally in everyday interactions, with any issues that arise resolved in a continual, low-stress process (rather than just at high-stress assessment time). The best supervisors are also monitoring the feedback of their colleague trainers and ensuring the Trainee always knows where they stand – that any issues aren't flying under the radar for too long.

What advice would you give other Trainees for strengthening how they work with their supervisors?
I have found that my best relationships with supervisors have been where we both knew exactly what we were signing up for, right from the start. If you don't already, I recommend sitting down with your supervisor in the first couple of weeks (or even a couple of weeks before starting) and writing down your goals, both training and personal, for your term. Allowing time to review these, either before, or as part of your assessment report process, gives you both an idea of how things are going and allows articulation of what's next. ■

Human factors online modules available

To complement the launch of the new edition of the Training in Professional Skills Course (TIPS), the TIPS Committee, together with a working group of subject matter experts, developed a series of human factors e-learning modules.

Human factors are also known as professional skills, behavioural skills and non-technical skills. 'Non-technical skills' is perhaps the most well-recognised term, but it is considered by some as a misnomer as these skills are highly technical. The knowledge, experience and rehearsal required to conduct a difficult conversation with patients and relatives, or perform in a team as both an active follower and leader is just as technically demanding as what is required for a difficult surgical procedure. A lack of skills in human factors can be just as devastating and dangerous as a technical operative failure to a patient, your team and your own wellbeing.

As a way of giving back in a year that has been incredibly challenging for us all, the Skills Training Department is making these popular human factors e-learning modules more widely accessible. The modules are now available to all Fellows, Trainees, Specialist International Medical Graduates (SIMGs) and junior doctors, as well as Skills Training faculty and College staff.

The modules include topics such as:

- Conflict management
- Decision-making
- Patient-centered communication
- Situation awareness
- Speaking up in response to unacceptable behaviour
- Stress and resilience
- Team dynamics

The modules were developed to increase awareness of the impact of human factors on surgical practice and risk mitigation, and to improve patient outcomes.

The comprehensive suite of online resources, which includes videos, interactive activities, reading and knowledge checks, is available online.

Log in to your profile to access these modules or click here to learn more. ■

Changes to the RACS CPD Program
A roadmap for 2020 and 2021

With the Medical Council of New Zealand (MCNZ) and Medical Board of Australia (MBA) about to introduce new standards for continuing professional development (CPD), the Royal Australasian College of Surgeons (RACS) has been undertaking a comprehensive review of our CPD program to ensure we comply with the new requirements and support our Fellows in their ongoing professional development.

There will be a period of transition as we move towards the new program, and we are looking forward to hearing your feedback about how we can support you and your learning goals. We have developed a roadmap to outline the upcoming changes and the CPD Team is available to assist with any questions.

CPD 2020

In 2020, Fellows are expected to report CPD participation from 1 January to 31 December 2020 by 28 February 2021. We know that 2020 has been a difficult year, and that many Fellows have experienced significant disruption to their CPD activities. We have made some adjustments to this year's program to recognise these challenges including:

- Claim up to 10 points for COVID-19 activities in 'Category 2: Clinical Governance', which meets the full requirement for this category in 2020.
- An additional 10 points can be claimed for general activities in 'Category 3: Maintenance of Knowledge and Skills'. This is an increase of the annual threshold to 30 points, recognising the significant reading and research activities many surgeons have undertaken this year.
- To support compliance in 'Category 4: Reflective Practice', Fellows can complete a Learning Plan (self-directed or using the tool in CPD Online), the new Indigenous Health Online modules or an online reflective activity available on the RACS website in November.
- RACS will not be asking Fellows to verify their CPD participation in 2020.

If you are looking for CPD activities please visit our CPD resources page. There are many virtual and in-person activities happening in Australia and New Zealand.

Important links:

1. The RACS CPD Activities page can be found by searching 'CPD' at surgeons.org.

2. Visit the College Calendar on the surgeons.org homepage for a list of events online and in-person. Under 'Region' select 'Virtual' to view all online options.

CPD 2021

In 2021, we will be working to bring you a comprehensive CPD program that is aligned with your scope of practice and supported by a streamlined and intuitive online platform. The new program will be launched in July 2021, and we look forward to providing more information on the new program in the new year.

As we transition to the new program, there will be a condensed CPD requirement from January 2021 to June 2021, which will involve participating in two out of three activities:

- Learning Plan (available online)
- Online Activity – CPD 2021
- Attendance at the RACS Annual Scientific Congress or Specialty Society Annual Scientific Meeting

A new online platform will be available in the new year to support this interim program and Fellows' participation in these activities will be automatically updated.

We encourage you to have a look at our roadmap, which is also available on our website, and we are always available to help. If you have any questions or would like to have your say on CPD, please phone us on +61 3 9249 1282 or email cpd.college@surgeons.org. ■

Professional development 2021

Selected 2021 Professional Development courses are now open for registration.

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

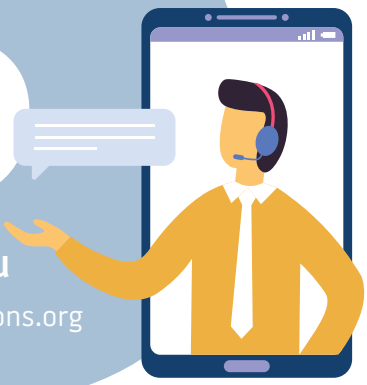
For any queries, please email the Professional Development department at PDactivities@surgeons.org.

CPD ROADMAP 2020-2021

Welcome to CPD 2020

1 Jan to 31 Dec 2020
Due 28 Feb 2021

COVID-19 How do I do my CPD?



Let us help you

CPD.College@surgeons.org
+61 3 9249 1282

Peer Review Audit
(Category 1)

Clinical Governance and Quality Improvement
(Category 2)

You **can** claim your COVID meetings for 10 points

Maintenance of Knowledge and Skills
(Category 3)

- CPD activity list
- Micro Learning activities
- General activities now capped at 30 points

Reflective Practice
(Category 4)

- Cultural Competence for Medical Specialists
- Learning Plan available in your portfolio
- Micro learning Activity

Happy New Year!!!

CPD January to June 2021

Choose 2 out of 3 activities
Learning Plan
Micro learning activity or RACS ASC or your society ASM

Complete your CPD activities and they will populate into your CPD

1 July 2021
Welcome to the NEW IMPROVED RACS CPD program

Raymond Broadley Etherington-Smith (1877-1913)

Oarsman. Surgeon. MRCS FRCS MA MB BCh

Raymond Broadley Etherington-Smith was featured in the *Vanity Fair* issue of the 5 August 1908, as Man of the Day No 1131. His caricature, simply captioned 'Ethel', was the work of Sir Leslie Ward, 'Spy'. In his autobiography *Forty Years of Spy*, Ward wrote, 'the finest and handsomest young athlete I ever drew as an undergraduate was R.B. Etherington-Smith, known to his intimates as "Ethel".'

Vanity Fair noted that 'Ethel started on the race of this life in 1877.' He was the second son of JH Etherington Smith, an important legal figure who was appointed Recorder of Derby and a Bencher of the Inner Temple. He was also a member of the crew that won the 1863 Grand Challenge Cup at the Henley Regatta.

Following his father, Ethel was educated at Repton School, Derbyshire, entering in 1890 and leaving in 1893, apparently without distinguishing himself at work or at games.

He entered Trinity College Cambridge in 1895, and his first two years were comparatively uneventful, but in his third and fourth years he established his reputation as a first-rate oarsman. When he began to row, the University Club was torn by dissension and it was mainly due to Ethel's charming gifts of character and wise guidance that Cambridge was able to come into its own on the river. In 1899, when Ethel was aged 22, he was president of the University Boat Club when Cambridge won 'The Boat Race' after nine consecutive defeats by Oxford.

Ethel excelled in rowing, winning important events with both single scull and double sculls, the University pairs, and fours, as well as the eights. He was a member of the Leander Club, that, in 1896, had re-located from Putney to Remenham, Berkshire. The clubhouse continues today as the epicentre of the annual Henley Royal Regatta.

Leander Club

The Leander Club (logo pictured above) celebrated its bicentenary in 2018, and retains the same rowing attire as seen in Spy's 'Ethel'. The original darker club colour of cerise, at some stage, and for reasons unknown, was changed to pink. Its symbol is the hippopotamus, King of the River.

Ethel was Captain of the Leander Club on four occasions. He captained its United Kingdom eight, which won the gold medal for the rowing eights in the London Summer Olympics

Photograph on the steps of Leander Clubhouse Henley 1908. Etherington-Smith in centre foreground, surrounded by members of his gold medal–winning crew and support staff.

of 1908, defeating Belgium by two lengths. At 31 years of age Ethel had participated in one of the great races in Olympic rowing history. Over a century later, in September 2012, at Christie's in London, the family auctioned his gold medal for £17,500.

Plarr's Lives of the Fellows of the Royal College of Surgeons (RCS) of England recorded:

'He was a magnificent specimen of a man, tall, lean, with wavy fair hair, of the type loved by the Grecian sculptors. He had a host of friends who ardently admired him and affectionately called him 'Ethel-Smith'. Not that there was anything feminine about him, for he was eminently virile both in his physique and in his attitude to life and men'.

He entered St Bartholomew's Hospital in 1900, as a university student with the highest reputation both on account of his athletic prowess and also his personal qualities: he subsequently made his way very rapidly at the hospital, holding the successive posts of surgical registrar, demonstrator of surgical morbid anatomy, assistant surgeon, and Warden of the College, the latter post first held by James Paget.

He went through his ordinary career as a medical student without special distinction, graduating MA, MB, BCh Cantab., in 1903. He then spent over two years on the resident staff at St Bartholomew's Hospital, with terms spent as an ophthalmic house surgeon, house surgeon, extern midwifery assistant and later, resident administrator of anaesthetics.

In 1906 he was elected junior demonstrator of anatomy in the medical school and in June 1907 he was admitted a Fellow of RCS on the same day that he received his Membership (MRCS). He was appointed surgical registrar in 1910, and, in 1912, assistant surgeon at St Bartholomew's Hospital.

Vanity Fair noted that 'not only as an athlete has he gained distinction; he is demonstrator of anatomy at St Bartholomew's Hospital, and has held all the residential appointments, including that of House Surgeon … He is at his best as an oarsman and friend; as a motorcyclist he is a danger to himself and the public.'


St. Bartholomew's Hospital
Journal.
Vol. XX.—No. 8.] May, 1913 [Price Sixpence.

Banner of Bart's Journal of May 1913, containing details of Etherington-Smith's demise.

Driving in his car, commonly with a friend, he was a familiar sight in the streets of London on his way to the chief athletic events of the year. Ethel was also an ardent motorcyclist who remained unmarried.

There was no doubting Etherington-Smith's early surgical prowess, as shortly following his appointment as assistant surgeon, a colleague recalled that Ethel dealt with, among other emergencies, four perforated gastric ulcers between 7 pm Saturday night and 3 pm Sunday afternoon, along with two acute appendix cases, while he was simultaneously on duty at the West London Hospital.

Tragically, he was taken acutely ill with pneumococcal peritonitis on Thursday, 17 April 1913, after operating on a patient with an abscess of the lung. A laparotomy was performed that afternoon, and though subsequently 'everything was done that could be done', he never rallied, dying at 8.15 am on the following Saturday.

The St Bartholomew's Hospital Journal of May 1913 contains the following Editorial Notes:

'It is indeed difficult fully to realise, and it is impossible to find adequate words in which to express the enormous loss which the Hospital has sustained in the death of Mr Etherington-Smith. His illness, with all its tragic suddenness, seemed almost incredible in one so full of strenuous vigour, and his death following with such appalling swiftness came as a tremendous shock to all those who knew him.

'He was only 36 years of age, with a brilliant career before him, and a record which can be described in one word – success.'

His obituary in the *British Medical Journal* of 26 April 1913, noted, inter alia:

'Even-tempered, courteous in manner and quiet in address, he held decided opinions based upon assured knowledge, and expressed them clearly and pleasantly. In professional subjects his opinion was always sound, for it was based upon a broad platform of accumulated facts.'

Obverse of Olympic gold medal, London 1908

The first part of his funeral service on 23 April 1913 was held in the Priory Church of St Bartholomew the Great, which was filled to overflowing. The coffin, surmounted by the Cambridge and Leander flags and a laurel wreath, was carried from the hospital to the church by members of the hospital staff closely associated with him.

After the service, the procession set out to Putney led by a large grey motor hearse. This was followed by the car that was so familiar an object to all at the hospital – empty.

The committal service was carried out in the Putney Vale Cemetery among a wealth of flowers, the coffin being lowered into the grave by four Cambridge Blues who had shared with him many a hard-won race.

'He was never self-conscious, yet always confident; an irresistible magnet, sublimely ignorant of his magnetism, an Apollo who knew not vanity. Because the gods loved him, he died young.' ■

Mr Peter F. Burke
FRACS

Deux et deux font cinq (2 + 2 = 5)
When things do not add up
The equation – part I

OPUS LXVI

Alphonse Allais

The French have an expression – *les choses ne s'edditionnent pas* – which translates to 'when things do not add up'. If this article is a little confusing in a surgical sense, I invite you to be patient and read on because I will be relaying some surgical anecdotes reflecting this adage.

Any updated observational practice in modern medicine may be inconsistent with what was once the established norm. Modernism supersedes what was once entrenched in history. Truth is not beauty, merely refinement in thinking; whereas, beauty embraces both (as I discussed in my Canon articles recently).

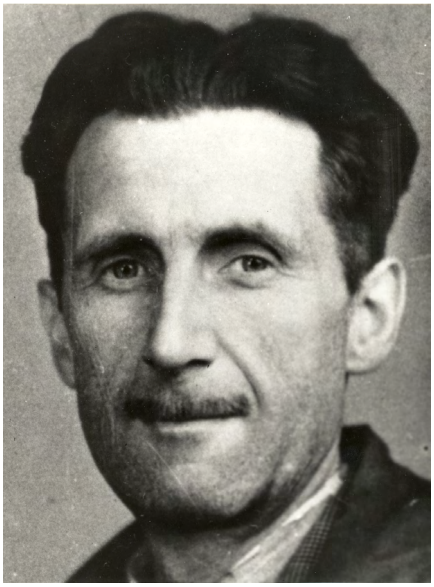
I must reveal how I came upon this equation during my COVID-19 confinement (how the French describe quarantine) and how I survived .

It was Alphonse Allais in the 1890s who wrote the book *Deux et Deux Font Cinq*. This followed on from Abbe Sieyès before the French Revolution when, in the 1760s, he questioned the polemic (when controversy produces confrontation) of 200,000 from the established classes, aristocracy and the Church controlling 26 million people.

Allais' writings are well known and one of his famous sayings is, 'When you leave you die a little, when you die you leave a lot.' In this text he writes about the falsity of physical realism and when dictated dogmas need to be questioned.

"Big Brother is Watching You"
George Orwell

Orwell's novel *1984* is a modern version of the earlier writings of Allais. His tome is about political, social and human intrigue and relates to totalitarianism and strong regimentation, which is still reverberating in the modern world. It was quite coincidental that I put these ideas together, while watching the French News on the very anniversary of the death of Charles de Gaulle, on 9 November 1970. And a whimsical quote of de Gaulle's is always worth repeating. He once said, "Do you think I have trouble as President, organising a nation of 60 million people who make 256 different varieties of cheese?" – control gets beyond us.



George Orwell

It was also during this time in November 1970 when I received my Australasian Fellowship, 50 years ago. I walked up the stairs at the College to be greeted by Mr Chapman and invited to pass through the door on the right to meet the president and receive a glass of sherry. This was our surgical reward for convincing the examiners of one's merit. This Fellowship stands us in good stead, and we gain respect, integrity and a way to contribute to the welfare of people, which should be our prime aim in any career, rather than financial gain.

Let us turn now to some of these clinical experiences I mentioned – really 'Tales from Spring Street Club', representing some surgical happenings, akin to the threads of a woven tapestry.

My New Zealand colleague, Earle Brown, always acquaints me with the memoirs of Bill Manchester, who was a regimented thinker, with a mind matching the sternness of his regimental rank of lieutenant colonel. He sought perfection in life as reflected in his plastic surgery. Likewise, Benny Rank in his Heidelberg days, still in uniform, was photographed discussing clinical cases of the returned soldiers (as illustrated in the recent Canon I article). He had the same stern approach to life, but always put the patient's interest first. As a little aside, on the day after I gained my Fellowship,

I met him in the PANCH (Preston and Northcote Community Hospital) corridor, thinking that he would greet me with the salutation, the specialist eponym, of Mr Behan … I was belittled when he simply said to me, "Well, Doctor, you finally convinced them." Did his regimented style reflect Orwellian thinking?

Now let me embark on a few surgical vignettes.

When I was developing reconstructive flaps for lower limb repair in the 1980s, I did a fascio cutaneous island flap for a chronic ulcer on a lady's leg. She was cleverly trying to rort the Transport Accident Commission (TAC) Insurance system with a repeat effort of orchestrating another MCA injury. This was one of my first fascio cutaneous island flaps based on the superficial peroneal neurovascular system. I achieved healing in 14 days, whereas the patient's outpatient dressings had gone on for months. She had to consult the TAC plastic surgeon, Benny Rank, for his opinion of the outcome. Let us not forget it was Benny Rank, through the Hamer government, who established the TAC system of insurance payments at Australian Medical Association fee rates. These immediate settlements of accounts contrasted markedly with the earlier cases, when surgical fees and reports had to wait for court settlements.

Now back to the consultation the patient had with Benny. He was openly critical of anyone doing reconstructive flaps on the lower limb, which broke his rules and eroded his regimented thinking. When she recounted the story to me, mimicking his critical gruff response, she said to him, "Who cares how it was done? It's healed." And even Helen Keller is quoted "the heresy of one age becomes the orthodoxy of the next". Thus, one learns to bypass some of surgical teaching when the issue and management can find alternatives.

I still recall the statements made by my mentor in Brisbane, the late Brian Courtice, who had a reputation for being the best general surgeon in Queensland in his heyday. In our regular conversations before he passed, he gave me a little synopsis of his success in life: "My time in surgery reflects an ever-decreasing range of major surgical mishaps", that is, "increasing experience equates to declining complications".

IE=DC – yet another equation.

Now with the skin grafting technique. In my embryonic days at PANCH, I still recall the nursing sisters rolling seromas from skin grafts of the lower limb repeated daily to expedite healing. That original thinker John Hueston, the Francophile who taught me the word fenestration, from the French word for a window '*la fenetre*'. He said, "Felix, if any graft will not heal, fenestrate it." This technique became the basis of the success of the mesh grafting technique now used universally. I even applied it to composite grafts for nasal reconstruction, the *bête noire* of most plastic surgeons. It can be used whenever a quarter of the helix rim is inserted into the nasal alar defect. It succeeds. Why? It is full of fenestrations – another unfinished symphony.

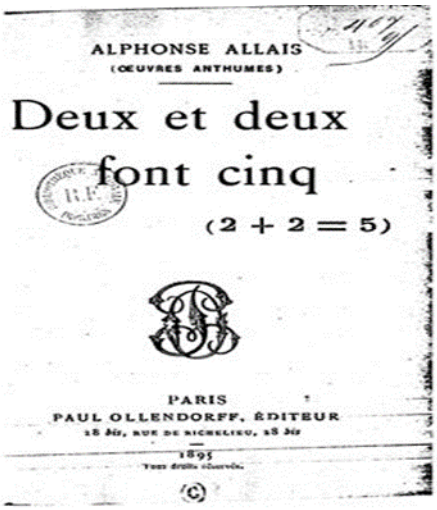
Flexor tendon repairs warrant an inclusion in this story of entrenched dogma being questioned. In the 1960s Benny published an absolutely superb flexor tendon series in the *Medical Journal of Australia*. The orthopaedic surgeons in Melbourne, particularly at the Royal Children's Hospital, recognised the superior technique reflecting his perfectionist style. As a result, all hand surgery became the domain of the plastic and reconstructive field in Melbourne, contrary to other states. Benny even became the first president of the Australian Hand Surgery Society as an acknowledgement of his contribution.

When Benny Rank said to me to go out and work at Western Health, he used the words, "Son, go and cut your teeth out there," as this was the stomping ground for the most important surgeons before they graduated to the Royal Melbourne Hospital. These included the likes of Brian Fleming, John Hueston, Jack Swan, Kingsley Mills and Kevin King. Yes, after 40 years, I was still doing emergencies like flexor tendons and supervising registrars. I fondly recall one Christmas Day in this period when I did a total forearm flexor compartment. Were there a dozen flexor tendons? I cannot remember. But this delayed our Christmas lunch yet again, much to the annoyance of my French wife, quoting the French expression "You wait for the soufflé because the soufflé won't wait for you."

Another revealing Christmas story that is worth mentioning: once, when John Hueston was doing some emergencies on Christmas Day at the Cotham, there was an issue at Box Hill theatre where a young child was already on the table with a bad facial laceration and they could not find the plastic surgeon. Somebody suggested, "John's always working, let's ring the Cotham." And on his way home to have a late lunch with his family, he solved the problem. Again, the dedicated mind respected his surgical commitments. I doubt if the hospital administrators were contactable.

Still on flexor tendons, Dr Harold E Kleinert from Louisville originally walked the world stage in the late 1970s with his superb results. He managed to minimise paratenon adhesions, the reason for restricted tendon glide in the tendon sheath, to optimise a full range of movement. His technique used a Kessler suture to repair the tendon and the wrist was placed in a flexed position, with passive glide activity commenced under the care of the hand therapy team as soon as clinically tolerated and the wounds were comfortable. This produced spectacular results. Again, he questioned entrenched principles when even the American hand surgery establishment did not believe him and came to inspect the unit. But numbers speak volumes and he was still doing emergency surgery and teaching to the end of his days. ■

Equation II has more clinical cases.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The titlepage of the aforementioned book

Associate Professor Felix Behan

Royal Australasian
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Researching tumour recurrence in regenerating livers post-hepatectomy

Foundation for Surgery scholarship recipient Dr Georgina Riddiough talks about her promising research

Dr Georgina Riddiough, a PhD candidate in the Liver Research Group at the Austin precinct of the Department of Surgery, University of Melbourne, and an Austin Health surgical registrar, was awarded the Royal Australasian College of Surgeons (RACS) Reg Worcester Research Scholarship in 2019. It is an honour she has put to good use.

The scholarship provided her with the opportunity to research tumour recurrence in regenerating livers post-hepatectomy, and the findings are very encouraging.

The liver's ability to regenerate after hepatectomy is well-known but, unfortunately, failing to identify a small cancer because it can't be seen on a scan, or because it gets left behind, means it may "grow significantly during the regenerative process", Dr Riddiough said.

"A lot of the processes that drive liver regeneration are linked to how tumours grow and how organs grow in the uterus when we're developing – so if you've got cancer hanging around it can be a risky process."

For the liver to regrow, cells have to proliferate, blood vessels and new lymphatics form – and all of these things are exactly what cancer is trying to do, she explained. "The regenerating liver creates a perfect storm."

Using mouse models, Dr Riddiough induced colorectal liver metastasis and then hepatectomised, removing 70 per cent of their liver, in order to try and understand how the tumour progressed in the regenerating liver. She then looked at whether renin-angiotensin inhibitors (RASi) could attenuate the progression of the tumour, and found that they did, indeed, slow the progression of the tumour in the regenerating liver.

"Importantly, we showed they were safe to administer within the immediate postoperative phase and in that very early regenerative phase," Dr Riddiough said. "At the moment if you undergo any cancer resection, we will not administer chemotherapy during that immediate post op time because the body is healing." However, this drug, which has been around for about 20 years and is FDA-approved to treat hypertension and cardiac failure, is slowing the tumours at this critical phase.

"The drug doesn't make the tumour melt away or vanish, but it does significantly reduce the tumour burden in mice," Dr Riddiough said.

"Obviously, we wanted to know how it was doing this, so we delved in and a couple of interesting findings emerged."

The first was that the RASi appear to completely switch the immune response on its head. Cancer grows by "manipulating the immune landscape of its environment so it can hide from T cells that would normally attack and kill cancers," Dr Riddiough explained. "It also uses another arm of the immune system – myeloid-derived suppressor cells (MDSC) – to dampen the normal immune responses that would kill the cancer."

In one respect, she said, the cancer uses MDSC to make the tumour microenvironment more immunosuppressive and, in another respect, it switches off some of the functions of these cytotoxic T cells that normally kill cancer cells. "We found that RASi actually enhance the T cell response while dampening the immunosuppressive effects of MDSC." The drug specifically enhanced a specific population of liver-resident T cells, Dr Riddiough said.

The drug was also enhancing the population of T cells that express a marker called PD-1, which is the marker for activation. "It's an important marker because people have tried to target it for immunotherapy and there's a lot of emerging evidence surrounding the anti-tumour functions of these tissue-resident T cells, which have been a bit neglected," Dr Riddiough said. "Their role

in anti-tumour immunity hasn't been fully appreciated."

A second novel finding was the discovery that the mice being treated with RASi "had changes in expression of some of the target genes of the Wnt/ß-catenin pathway, which is central to the development of colorectal cancers ... and that was pretty exciting," Dr Riddiough said.

The final part of Dr Riddiough's PhD research will be translating the findings into human settings. She is working with liver surgeons at the Austin Hospital and scientists at the Doherty Institute to obtain small samples of both tumours and livers from consenting patients and establish organoid cultures.

In the lab Dr Riddiough has processed the samples and established patient-derived organoids. "We've tested the drug on human colorectal liver metastasis organoids and it also suppresses their growth," she said. ■

Standing on the shoulders of giants

CTANZ and the Royal College of Surgeons of England

The success the Clinical Trials Network Australia New Zealand (CTANZ) has experienced has been, in great part, due to the support of the Royal College of Surgeons of England (RCS) Surgical Trials Initiative immediate past clinical director, Professor Dion Morton OBE, and current Clinical Director, Professor Peter Hutchinson.

Wisdom and experience were freely shared when CTANZ was finding its feet. The strong collaborative links formed have borne outstanding results, with the most recent being the SUNRRISE international clinical trials collaborative. We aim to reciprocate by offering Australian and New Zealand – originated multi-centred clinical trials to further strengthen collaborative ties with the RCS Initiative's specialty networks.

We have invited Professor Hutchison and Mr Murat Akkulak from RCS England as guest contributors to this issue of Surgical News *to detail the development of RCS Initiative's model, which we have adapted to our unique Australia and New Zealand clinical research environment.*

— Professor David Watson, Clinical Director, CTANZ

Prior to the launch of the RCS Surgical Trials Initiative, the RCS already had a strong track record in delivering research of a basic, translational and clinical nature across a wide range of surgical specialties. The RCS Research Fellowship scheme has supported over 800 fellows in its 26-year existence, directly contributing to numerous studies and changing practice across the world, while nurturing the next generation of surgeons who are passionate about clinical research.

In 2013, it was recognised that there was a need for a new scheme to deliver surgical trials, now called the RCS Surgical Trials Initiative. The trials initiative was created by Professor Derek Alderson and Professor Dion Morton and launched with thanks to the commitment of key partners, including Rosetrees Trust, which provided significant grants from the onset to nurture this new innovative network of Surgical Trials Centres (STCs) and Surgical Specialty Leads (SSLs).

The role of the SSL is to develop a holistic model, bringing together surgical specialty associations and charities affiliated with each discipline, with the aim of securing engagement across each surgical specialty. STCs were established across the United Kingdom, and tasked with launching new surgical trials and developing training programs for trainees and consultants interested in surgical clinical research.

We now have SSLs in every discipline who, in turn, have appointed Associate SSLs to lead trainee engagement work and run trainee-led studies. In recent years we have developed the position of RCS Professorial Chairs in Surgical Trials, which are set up at each STC to grow capacity at these centres. We now have eight RCS Professors across six STCs.

Having such a broad and holistic network meant the RCS was very well placed to tackle the challenges faced across the world by COVID-19. The RCS COVID Research Group was launched in April 2020, with five projects and now has over 50 projects being supported by the College. The group assists in the funding and coordination of studies, and in recruitment. The portfolio includes major international cohort studies investigating the outcomes of COVID-19 patients undergoing surgery, the impact

Professor Dion Morton and Professor David Watson

of COVID-19 on cancer treatment pathways, and the impact on healthcare professionals. The findings from the group projects continue to change practice.

This wide surgical clinical network has also been instrumental in creating global surgery groups, with funding from National Institute of Health Research (NIHR), driving research in low- and middle-income countries across the globe. There is currently one unit (Global Surgery, Birmingham) and four National Institute for Health Research groups (Global Surgical Technologies, Leeds; Neurotrauma, Cambridge; Post conflict trauma, Imperial London; Burns, Swansea). These initiatives aim to answer important research questions, particularly in low- and middle-income countries, and to promote access to surgical care by changing healthcare policy.

The College is proud to have supported Professor David Watson, Dr Lorwai Tan and their colleagues to set up CTANZ, and continues to work closely by engaging collaboratives in both regions to set up new studies and recruit to existing trials, such as SUNRRISE . We are committed to continuing to work with the NIHR and the Medical Research Future Fund to create and deliver new surgical trials to change practice and improve outcomes for patients. ■

Mr Murat Akkulak
Research Co-ordinator RCS England

Professor Peter Hutchinson
Director of Clinical Research RCS England

2021 scholarship and grant recipients

The Australian and New Zealand Scholarship and Grant Committee (ANZSGC) thanks the many applicants who applied for limited scholarships and grants available this year. Congratulations to the following successful recipients.

Thank you to all donors and sponsors who made the following scholarships and grants possible. Without your support, the following critical research and education would not be able to occur.

A considerable amount of time and energy is spent assessing the many high-quality applications received. Thank you to all those involved in the assessment process, in particular Associate Professor Christopher Young, Associate Professor Niall Corcoran and Associate Professor Siven Seevanayagam, who all put in a great deal of work towards this result.

Research Scholarship, Fellowship and Grant Recipients

These opportunities are for one year unless otherwise stated.

Herbert and Gloria Kees Research Scholarship

$66,000

Dr Joseph Dusseldorp (New South Wales)

Speciality: Plastic and Reconstructive Surgery

Topic: Evaluating closed-loop spinal cord stimulation to alleviate spasticity lower limbs in children living with cerebral palsy.

Travel and Education Scholarship, Fellowship and Grant Recipients

Margorie Hooper Travel Scholarship

$75,000

Dr George Balalis (South Australia)

Specialty: General Surgery

Travel to Utrecht Medical Centre, Netherlands to further his robotic oesophagogastric resection techniques.

RACS Aboriginal and Torres Strait Islander SET Trainee One Year Scholarship

$20,000

Dr Rachel Farrelly (New South Wales)

Specialty: Orthopaedic Surgery

Funding from Johnson & Johnson will be utilised to offset the significant out-of-pocket costs associated with SET (Surgical Education and Training) program, including the OPBS (Orthopaedic Principles and Basic Sciences) exam, College training fees and extracurricular skills courses.

RACS Aboriginal and Torres Strait Islander SET Trainee One Year Scholarship

$20,000

Dr Anthony Murray (New South Wales)

Specialty: Orthopaedic Surgery

This funding will be utilised to offset the cost of the Royal Australasian College of Surgeons (RACS) Fellowship Examination as well as associated RACS and Australian Orthopaedic Association fees for the next 12 months.

RACS Māori SET Trainee One Year Scholarship

$20,000

Dr James Johnston (New Zealand)

Specialty: Otolaryngology Head and Neck Surgery

Research: "An investigation into aetiology of adenotonsillar disease in Māori." ■

Applications for 2022 scholarships will open in March 2021.

Please visit surgeons.org/scholarships for more information on opportunities in your area. For other enquiries please contact the Scholarship and Grant Department at scholarships@surgeons.org

Professor Henry Woo
Chair
Australia and New Zealand Scholarship and Grant Committee

Australian Society of Plastic Surgeons and Top End Workforce Project to fix skills shortfall

Two Melbourne-based specialist plastic surgeons have been working in Darwin as part of a new initiative to address a plastic surgery skills shortage in the Northern Territory.

Dr Will Alexander and Mr Damien Grinsell were the first to volunteer for a two-year rolling roster of specialist plastic surgeons from across Australia. They are completing six-week to three-month stints at the Royal Darwin Hospital and Palmerston Regional Hospital.

The program was initiated by the Australian Society of Plastic Surgeons (ASPS), which represents Plastic and Reconstructive Surgery. It is working in partnership with the hospitals, and more broadly in regional Australia, is working to match specialty needs in public hospitals.

"We've been aware of the shortage of plastic surgeons in Darwin and have worked with Top End Health Service and senior surgeons at Royal Darwin and Palmerston hospitals to develop a COVID-19 Darwin Work Plan," said ASPS Vice President Dr Nicola Dean.

Previously, the shortfall was met by a range of international practitioners and Australian locums.

"While sustaining the service for many years, we are keen to find a more permanent solution to ensure equity of access to specialist plastic surgery skills for the population of Darwin and surrounding areas," Dr Dean said.

Executive Director of Integrated Surgical Services at Royal Darwin Hospital Mr Mahiban Thomas welcomed the partnership with the ASPS. "Specialist plastic surgeons are critical in the management of trauma, burns, cancer and reconstructive surgeries," he said.

Mr Sabu Thomas, Director of General Surgery and Acting Director Plastic and Reconstructive Surgery at Royal Darwin Hospital, said, "It is heartening to note that ASPS and plastic surgeons outside the Territory are responding to the needs of people under the care of Royal Darwin Hospital."

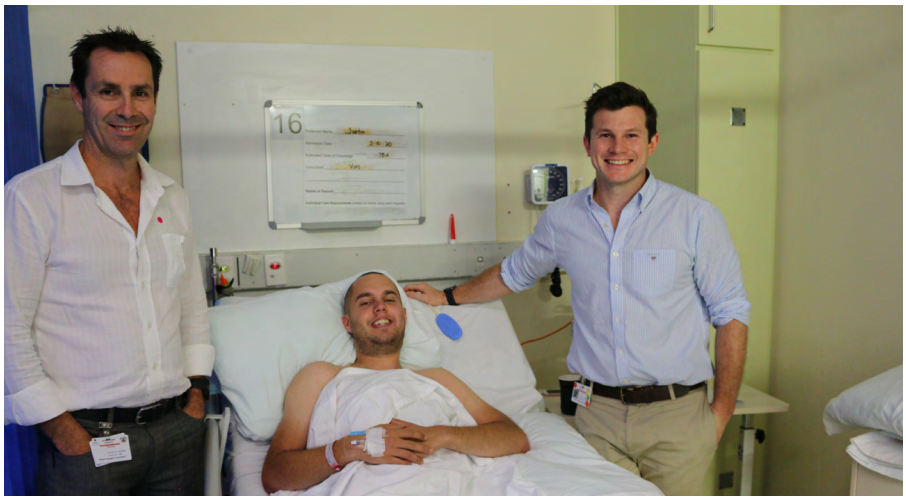
Dr Alexander operates at St Vincent's, Royal Children's and Monash hospitals in Melbourne with a subspecialty interest in paediatric congenital hand microsurgery for children. He is looking forward to working across a broad scope of cases in Darwin including trauma, skin cancers, hand trauma and complex reconstructions, as well as the opportunity to work with the Indigenous community.

Mr Grinsell is a pioneer of perforator flaps used for microsurgical reconstruction of a range of complicated defects. "I have always been interested in giving back to the system that trained me," he said.

For Dr Alexander and Mr Grinsell, the COVID-19 lockdown in Melbourne was an added incentive to volunteer. Both relocated to Darwin with their families.

One of the first patients to benefit from the visiting surgeons was Justin Trezise, who had been on a waiting list for an operation to treat a venous malformation – a deep form of birthmark – that covered much of his calf. Mr Grinsell was able to perform a more complex surgery than Justin would otherwise have received, by excising and reconstructing the affected area with a free flap from his back.

"We already have around a dozen members who have indicated their willingness to participate in this program, particularly from the Melbourne area where many are being underutilised due to COVID-19-related restrictions," Dr Dean said. "ASPS is pleased to have been able to assist with facilitating a reliable specialist workforce for Darwin and hopes this will lead to some longer-term commitments from surgeons to the area," Dr Dean added. ■



Melbourne specialist plastic surgeons Mr Damien Grinsell and Dr Wiliam Alexander, with patient Justin Trezise, were the first volunteers to participate in a new program to address specialist skill shortages in the Top End.

AOA leading the way on the 10th competency

Orthopaedic surgeon Dr Jennifer Green talks to *Surgical News* about the progressive work of the Australian Orthopaedic Association (AOA) on diversity, and gender and cultural inclusion.

Dr Jennifer Green

After extensive consultation, the Royal Australasian College of Surgeons (RACS) has revised its Surgical Competence and Performance Guide to include 'Cultural Competence and Cultural Safety'.

This 10th competency was added in recognition of the significant health inequities that correlate to poor health outcomes among Indigenous and Torres Straight Islander peoples in Australia and Māori in New Zealand.

The Australian Orthopaedic Association (AOA), one of RACS' specialty societies, has been doing ground-breaking work in gender equity and diversity for several years. It has both a Diversity Strategic Plan 2018–2023, and a vision to "create a culture of inclusion that promotes and enables all people into and within the profession of Orthopaedic Surgery."

Dr Jennifer Green is Chair of the AOA Orthopaedic Women's Link (OWL) Committee, AOA representative on the Diversity Council of Australia and a member of the AOA Cultural Inclusion Working Group (CIWG).

The Cultural Inclusion Working Group

"Having achieved all these goals in gender diversity, we started looking at what we should be doing in cultural diversity and inclusion," Dr Green said. A significant part of the answer was the formation of the CIWG, which has been in operation for several months.

One of the most diverse working groups that AOA has ever set up, CIWG is proving to be a dynamic source of perspectives and ideas. They're working towards several aims, Dr Green said. One of the most important of these is "working out how to harness voices from more diverse backgrounds and contribute to the development of AOA".

Three of the five Indigenous RACS Trainees in Australia are AOA Trainees. The most senior is Dr Anthony Murray, who will be the first Indigenous Australian orthopaedic surgeon and is a member of CIWG. Dr Martin Richardson, who is also in CIWG, has a wife and daughter who are both Indigenous doctors and his perspective is a strong force for equity, Dr Green said.

In 2019, a senior AOA member attended the Australian Indigenous Doctors Association (AIDA) conference in Darwin, and "started a conversation with Indigenous doctors about Orthopaedics as a potential career path" by facilitating a workshop and encouraging delegates, Dr Green said.

In 2020, AOA had planned even greater involvement, with a workshop to attract medical students and junior Indigenous doctors with hands-on activities and an interactive Q&A session at the AIDA meeting. Unfortunately, it was cancelled due to COVID-19, but "we're in touch with AIDA and hope to run it next year", Dr Green added.

There is also ongoing discussion in CIWG about the value of mentorship and creating an Indigenous pathway for Orthopaedic Trainees. Dr Green pointed out that surgeons of different cultural backgrounds were not highly represented in AOA. There is a need, she said, "to bring more people with multicultural backgrounds into the discussion" as well as Indigenous people.

The Orthopaedics Women's Link Committee (OWL)

OWL is a committee within AOA that advocates for gender issues, career support, training, flexibility and educational opportunities for female orthopaedic surgeons, as well as other pertinent issues.

In 2018, AOA was made up of 95 per cent male orthopaedic surgeons and 5 per cent female. In early 2018, the AOA launched a strategy to increase gender diversity within the organisation, after wide consultation and workshops. Dr Green became OWL Chair later that year and has been advancing the strategy ever since.

'Shoulder-tap' appointments within AOA ceased and all committee appointments are advertised. This change has resulted in a 50 per cent increase in female members on committees, a number of them in leadership positions.

A policy was also developed mandating the inclusion of women in scientific and educational meetings, and change has been ongoing as people become more aware about including women in roles such as chairs, panellists and speakers.

"In addition to that, we have 40 per cent females who were voted onto the AOA Board at our last election and, in 2021, Dr Annette Holian will become the first female president of the AOA," Dr Green said.

AOA has also gradually modified its Trainee selection process to minimise bias. The selection process has two parts. The first is the CV and referee report to assess who will be interviewed. The second is a series of mini-interviews, each with a three-person interview panel including at least one female and one non-orthopaedic member. Due to a limited number of female orthopaedic surgeons, women from medical specialties and nursing, allied health and human resources are invited to sit on the interview panels.

"The interview process appears to have less implicit bias than the first part of the selection process," Dr Green said. "And this year, rather than interviewing only 50 per cent of applicants, AOA interviewed 75-80 per cent." In selection over the years, referee reports have contributed a smaller proportion to final selection scores, helping reduce the impact of any implicit bias.

AOA Cultural Inclusion Working Group
From top left to right, rows 1 to 4: Chair Dr Chris Morrey, Mr Ashraf Chehata, Dr Sarah Coll, Dr Jennifer Green Dr Ruth Mitchell, Dr Peter Moore, Dr Chris Mulligan, Dr Anthony Murray, Mr Buki Oloruntoba, Mr Travis Perera, Mr Marinis Pirpiris, Associate Professor Martin Richardson Dr Dolapo Sotade, Dr Aman Singh, Dr Jai Sungaran, Dr Stephanie Weidlich.

Of the successful applicants commencing AOA21 Training in 2020, a record 24 per cent are females.

Dr Green stressed the importance of bringing the people you are advocating to into the room. All the evidence and data suggest you can't advocate for gender diversity in a closed shop of women, she said. "You need your male colleagues there to understand the messages and evidence." As a result, OWL has two male orthopaedic surgeons on its committee – Champions of Change Chair, Dr Andrew Wines and Board representative, Dr Chris Morrey.

The Champions of Change Working Group

AOA also created the 'Champions of Change' Working Group (CCWG) to encourage gender equity within the organisation. A male representative from every Australian state is on CCWG, along with two female representatives from the OWL Committee – Dr Green as OWL Chair and Dr Rekha Ganeshalingam representing younger female surgeons.

CCWG works with the OWL Committee and the AOA membership. Its objectives include "to listen and learn from their experiences and leadership, and advocate for female representation" and to "prioritise achieving progress on female representation".

Diverse organisations decrease health inequities

Data tells us that a leadership committed to cultural change and visible role models are two of the most important factors in advocating diversity messages such as cultural change, Dr Green said.

"We know there's a lot of evidence now that diverse organisations attract the top talent; they are more innovative and they also make better decisions than less innovative organisations."

Most importantly for health care, she added, "We know that we need a more diverse workforce in order to decrease all the health inequities, particularly in Australia where it's very relevant for Indigenous health care."

Diversity strategy must have milestones

"There's no point having a strategy unless you have goals and aims," Dr Green said. "And you have to achieve those goals and be accountable."

Of the discussion about diversity versus merit, and the concern that some people have unfair advantages, Dr Green pointed out that it's more about removing unconscious biases and creating a level playing field.

A 2019 article in *The Lancet*, unravels the myth that 'promoting diversity contravenes meritocracy.'[1] 'An abundance of research evidence shows our so-called meritocracies are not meritocratic,' Kang and Kaplan explain.

'So, if anything, underlying biases appear to be causing the current meritocratic systems to bypass many highly capable women and members of other minority groups. We are drawing heterosexual, white men from much further down the distribution of talent than we are for other social categories.'

If you're not diverse, "you're only really dipping into the small part of the pool of talent," Dr Green said. "If we are only taking a handful of people from different cultural backgrounds, we are missing out because we're not opening ourselves up to the entire talent pool and all these people can make our organisations greater."

Dr Green does offer a word of caution. Diversity without inclusion is of no value to an organisation, she said. "You need to include those voices. There's no point ticking the box if they're not in leadership roles; if they're not on committees and if they're not being active members of your community and contributing those diverse ideas to your organisation." ■

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1. Kang, S. K., Kaplan, S. Working toward gender diversity and inclusion in medicine: myths and solutions. The Lancet. 2019, Feb 9 ;393:579–86.

Case note review

General Surgery: ineffective transfers

Reviews of important surgical procedures help us improve outcomes. This is a case study selected by the Australian and New Zealand Audit of Surgical Mortality (ANZASM) Committee for your information.

Case Summary:
A patient in their early 60s was admitted to the emergency department of rural hospital A with a history of abdominal pain (10 days-3 weeks), haematemesis (one week), melaena and hypotension. The patient had pneumonia about three weeks prior. Co-morbidities included hepatitis C from previous intravenous drug use, heavy alcohol intake of one cask of wine daily, emphysema (smoker of 35 cigarettes daily), depression and benign prostatic hyperplasia.

About four hours afterwards, the patient was transferred to regional hospital B, arriving in the emergency department at 00:30. Noradrenaline infusion and IV antibiotics were started. Lactate was noted to be 13, with pH 7.24, haemoglobin (Hb) 143 and white cell count of 4.3. Generalised abdominal tenderness was documented. The patient was admitted to the Intensive Care Unit (ICU) where the ICU consultant and on-call anaesthetist were reported to be 'happy to manage the patient'. Surgical review by the registrar at 05:15 stated that the patient was not accepted by the surgical team prior to transfer. The patient was seen by the surgical consultant at 07:25. The CT at that time showed diffuse mural thickening of the rectum up to 10 mm, perirectal inflammatory change, diffuse oedema of presacral/extraperitoneal fat and diffusely thick-walled oesophagus. Ischaemic colitis was diagnosed and arrangements made for transfer to metropolitan hospital C. The patient was on noradrenaline 20 mg/min and vasopressin.

The patient eventually arrived at hospital C at 20:00 (24 hours after the first hospital admission) and was attended by the surgical Fellow almost immediately. By that time noradrenaline was down to 4, platelets at 12, Hb 90. The patient was taken to theatre within an hour and underwent a gastroscopy and flexible sigmoidoscopy, which found old blood throughout the oesophagus and stomach, distal oesophagitis and grossly ulcerated rectal mucosa 10-15 cm from the anal verge and inflammation from 5-10 cm. Laparoscopy showed 'pus around liver, right paracolic gutter and pelvis; normal small bowel with no fibrin to suggest perforation'. The colorectal Fellow and gastroenterology registrar were present during surgery, and discussion with the surgical consultant concluded with the agreed diagnosis of 'bacterial peritonitis from rectal translocation'. A drain tube was placed, and 3-litre washout performed. No laparotomy was conducted.

The patient was managed postoperatively in ICU. A repeat CT the following day showed diffuse colitis associated with splenic infarct, with sparing of transverse colon. Throughout the stay, the patient battled issues of persistent thrombocytopenia/anaemia requiring transfusions, bilateral lung consolidation thought to be aspiration from intubation, candidaemia on cultures and delirium. Input was sought from infectious diseases, cardiology, colorectal and gastroenterology subspecialties during this time.

On postoperative day six the patient was stepped down from ICU, but quickly had a MET (Medical Emergency Team) call that night for tachypnoea and altered conscious type, acute pulmonary oedema and type 2 respiratory failure. Following readmission to ICU, it was decided with the family not to escalate respiratory support or reintubation. The patient died two days later.

Comments:
An area of consideration in this case was the initial decision to transfer the patient from rural hospital A to regional hospital B without first discussing with the admitting surgical team their capability to manage the patient. Similarly, it is unclear why the surgical team at hospital B then decided to transfer the patient to hospital C despite the availability of an ICU bed with ventilator and a willing anaesthetist. Ischaemic colitis usually is managed with IV antibiotics, and a patient is only transferred if no postoperative ICU bed is available. Nevertheless, besides the waste of resources from multiple transports, this probably would not have changed the outcome.

Patient management at hospital C was thorough and complete. It was reasonable not to convert the patient from a laparoscopy to a laparotomy when it seemed that most of the rectal ischaemia was under the peritoneal reflection and a platelet of 12 indicated the patient was extremely unwell. The fact that the patient never recovered post-surgery is a reflection of the extensive comorbidities. Further surgical intervention in the form of laparotomy, colorectal resection and stoma would probably have been futile in such an ill patient.

ANZASM Clinical Directors Comment:
Poor care related to the transfer of

patients between hospitals has been highlighted by ANZASM on many previous occasions. The most important and repeated problem documented by ANZASM is a failure of adequate communication between the referring and receiving teams.

A single, simple step that would address this would be for the patient to be directly and personally discussed with the receiving consultant. ANZASM has previously recommended consultant-to-consultant discussion as an embedded part of the transfer protocol. Its formal introduction is now well overdue.

Importantly, it would permit the receiving consultant to provide professional and personal support to the referring colleague who is often managing a stressful situation in isolation. Consultant-to-consultant discussion is also a professional courtesy. ■

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

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

Farewell to Library Manager Graham Spooner

What has changed in his seven years at RACS?

Graham commenced in the role of Manager, Library and Information at the Royal Australasian College of Surgeons (RACS) in November 2013 around Melbourne Cup time, so it will be just over seven years' service when he retires.

While Melbourne and Victoria were exciting, new and different to the born and bred Sydneysider, working in a college library was not; Graham had previously spent 19 years managing the library at the College of Nursing.

At RACS he inherited a very experienced, professional and expert library team that has supported him very well throughout his tenure. The library service was already in good shape thanks to Graham's predecessor. RACS is also an organisation that values and supports its library, recognising that surgeons and Trainees require a quality information service to inform and support them in their roles.

Nevertheless, inheriting a good service did not mean that things could not be improved. Looking back at 2013 and comparing the state of the library with its present day incarnation reveals a number of enhancements that have greatly benefited the users of the service.

Online ordering of documents and literature and database searches were already in place in 2013, but the forms used to make these requests have been enhanced and made easier to use. IT projects throughout the College will soon improve and streamline these services even further.

A Library Review, undertaken soon after Graham's commencement, identified that awareness or alerting services were not available to patrons but could prove to be a worthwhile addition. Two options were evaluated and introduced, and both are still operating successfully in 2020. The eTOCs (electronic Tables of Contents) service now has over 1300 subscribers who receive regular email alerts of new journal articles of interest. There are 15 sets, including one for each surgical specialty and some sub-specialties, as well as topic-based sets. For more details and to sign up to eTOCs visit surgeons.org/library/etocs.

The other option was the Read by QxMD app, which allows for a customisable means of receiving alerts for individual journals or topics via a mobile device or desktop. There are currently 946 subscribers. Further information about Read can be found here.

Graham also undertook the successful trialling and roll out of the BrowZine phone, tablet and desktop app, which is now used hundreds of times a day by library clients. It facilitates the creation of a personal, portable "virtual bookshelf" for any device. Find out more details here.

The developer of this app has also continued to enhance and expand the scope of their products. LibKey Nomad will check our holdings and provide a link to the full text of any RACS subscribed article from anywhere on the web (PubMed, Wikipedia and other publisher sites). Download the extension (desktops/laptops only) and choose "Royal Australasian College of Surgeons" as your Library. Available now for Chrome and Edge, Vivaldi, Brave and Firefox. Find out more here.

LibKey Nomad was also added to the Summon search tool, and makes it much easier to access the PDF full text of subscribed journal articles. If a searcher has a citation that lists its DOI ▶

or PMID, they can simply enter either into the new request form to access the PDF or full text quickly and easily (where we have a subscription). If the Library does not hold the article, it will revert to the usual request form. Look for the new form on the RACS Library website or visit the LibKey website. These ongoing improvements and access to new products have all been added by the developer Third Iron at no extra cost to RACS.

Graham's predecessor successfully led the team in undertaking the massive move to a virtual library, which was soon well-valued and used by the membership. Unfortunately, RACS staff did not engage with it as much. However, Graham was able to slowly change the erroneous perception that the library and its resources were just for Fellows, Trainees and SIMGs. Library use by staff has steadily grown, along with the realisation that staff can call on the library team and the vast resources available to support them in their roles. A library space on the RACS' intranet was also developed to reinforce the message that library staff are at the service of all RACS employees.

As Graham continued to look for opportunities to improve RACS' overall operations, he became aware that the organisation had no mandated referencing style. Based on its existing use in the RACS journal (the *Australia and New Zealand Journal of Surgery*), his efforts led to the adoption of the Vancouver style and inclusion of the relevant information in the Style Guide. Two workshops on using Vancouver for referencing were developed and successfully run by Graham for Melbourne staff. He will pass the idea of adapting the face-to-face workshops to online formats for non-Melbourne staff on to his successor.

After discussion with those within the organisation who developed courses, seminars and other educational events, the library team began to undertake the preparation of linked reading lists (in Vancouver style, of course!). These were added to the library website with hyperlinks to individual e-books or e-journal articles to provide easy access for pre- or post-course reading and follow-up materials for participants. The preparation of reading lists has also been made available to groups affiliated with RACS to enhance their events.

Very soon after his commencement at RACS, Graham found out that he would be attending the Annual Scientific Congress (ASC) in Singapore in May 2014. Closer to the event, he discovered that he would also be responsible for finalising the organisation of the RACS booth and managing it on the ground.

After a bit of a hiatus, he planned and organised the RACS booth for the last three years. He said he feels privileged to have travelled to Singapore, Bangkok, Perth, Brisbane, Gold Coast, Sydney, Lismore and Adelaide (twice!) to attend the ASCs and other events to engage with members about what the library can offer them. New Zealand was in his sights before he decided to retire.

Graham has also ensured that RACS does the legal and correct thing regarding copyright compliance in terms of its educational and organisational activities. The two licences negotiated with the Copyright Agency Ltd mean that RACS has more scope to use copyright materials while remaining compliant as far as the fair use of others' copyright materials is concerned.

In 2013, RACS was not participating at all in social media. Once Facebook and Twitter accounts were established, Graham and the library regularly supplied content to the Communications team for posting and tweeting. In addition, Graham has constantly kept library resources and services front and centre through regular contributions to Fax Mentis and *Surgical News*.

Graham was asked: 'What will you miss about working at RACS?'

When reflecting on his time at RACS, Graham noted that he will sorely miss being surrounded by great colleagues throughout the organisation who are committed to their roles and are really trying their best for Fellows. He will miss working with, and supporting, his team and all the other departments with whom he has regularly interacted or collaborated.

He has loved being a librarian for 40 years and will continue to support and promote libraries' important role and function in society. Graham has sorely missed his morning and afternoon walks to work and back through Yarra Park and Fitzroy Gardens in 2020. He said he is a bit sad that he will not be able to resume his daily walks before retiring.

Graham wishes everyone in the organisation the very best for the future and is very satisfied to have made his seven-year contribution to the development and progress of the organisation. He said he has left the library in a great position and wishes his successor well as they continue to develop and enhance the services and resources on offer. ■

Council 2020 elections

The pro bono contributions of Fellows has been and continues to be the College's most valued asset and resource. We are grateful for their commitment and are also grateful to the voting Fellows who demonstrate their engagement with the governance of the College.

The results of the 2020 elections to the Royal Australasian College of Surgeons (RACS) Council will be tabled at our Annual General Meeting in Melbourne on Thursday 13 May 2021, when newly elected Councillors take office.

Congratulations to the successful candidates and sincere thanks to all candidates who nominated.

Fellowship Elected Councillors
Nicola Hill – Otolaryngology, Head & Neck Surgery, New Zealand (newly elected to Council)

Andrew Hill – General Surgery, New Zealand (re-elected to Council)

Christine Lai – General Surgery, South Australia (re-elected to Council)

Maxine Ronald – General Surgery, New Zealand (re-elected to Council)

Specialty Elected Councillors
Cardiothoracic Specialty Elected Councillor:

Andrew Cochrane, Victoria (newly elected to Council)

Paediatric Specialty Elected Councillor:

Philip Morreau, New Zealand (newly elected to Council)

General Specialty Elected Councillor:

David Fletcher, Western Australia (re-elected to Council unopposed)

Vascular Surgery Specialty Elected Councillor:

John Crozier, New South Wales (re-elected to Council unopposed)

Farewell to outgoing Councillor
Thank you to our outgoing Councillor – James Churchill, RACS Trainee Association co-opted Councillor.

Congratulations to all award recipients, as approved by the Awards Committee and Council in 2020

Singular Awards

Award for Excellence in Surgery
Dr Bryan C. Mendelson FRACS

Sir Alan Newton Surgical Education Medal
Professor Ian W. Incoll FRACS

Distinguished Awards

John Corboy Medal
Dr A. Anna Morrow

Gordon Trinca Medal
Associate Professor Andrew Kurmis FRACS

ESR Hughes Award
Dr Richard A. Barnett AM FRACS

Mr Neil A. Vallance FRACS

RACS International Medal
Mr Keith L. A. Mutimer FRACS

Colin McRae Medal
Mr Andrew B. Connolly FRACS

Rural Surgeons Award
Mr R. John Kyngdon FRACS

Mr Bal Krishan FRACS

Other Awards

Henry Windsor Visiting Lectureship
Professor Michael J. Solomon FRACS. ■

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 mentioned below.

Robin Cripps (NT)

John C Hargrave (NT)
(see page 26)

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

Robin Leslie Cripps FRACS

Orthopaedic trauma surgeon

6 February 1944 – 6 October 2020

Many thousands of Northern Territorians owe their ongoing function, mobility and wellbeing to the life and tireless work of orthopaedic trauma surgeon Robin Cripps FRACS.

Robin was born in Biggenden, near Maryborough in regional Queensland. The youngest of four children, his family's life was shattered when Robin was four years old and his father died from the effects of a snake bite. Due to severe financial difficulty, Robin became a ward of the state, while still being allowed to live with the family. Life was constrained and difficult.

Robin developed an early interest in electronics and mechanics while working in his brother's auto electrical business. This continued as an abiding and satisfying hobby throughout his life. Despite his circumstances, Robin's intelligence, drive and ability led to a scholarship and entry into medical school at the University of Queensland.

Upon graduation in 1969, he undertook residency years in Maryborough and Rockhampton. He was greatly appreciated as a young doctor of significant ability across multiple areas, but especially in the surgical arena. He was observed to be energetic and kind, especially to the elderly, and a man to depend on in a crisis or moment of difficulty. Robin was self-effacing and shy but encouraged confidence and calm as he carefully and logically worked through clinical problems and complex scenarios.

It was in Rockhampton that Robin met his future wife, Erna and, after marrying in 1975, the couple formed a powerful team for the next 45 years. That year the young couple went to England for further clinical experience and spent a memorable 18 months at Northallerton in the Mowbray Valley in north Yorkshire. Robin's time was consumed with satisfying work serving the population as a surgical registrar with only a little time to enjoy the beautiful 'Herriot' countryside.

Upon returning to Australia, Robin undertook several jobs in Queensland and then Launceston, Tasmania, but was frustrated that his procedural skills could not be fully utilised. He applied for positions in the Northern Territory and in 1979 was appointed Medical Superintendent to the isolated town of Tennant Creek in the Barkly district. He transferred to Darwin at the end of 1981 and thus began his role as anchor-man for orthopaedic trauma in the Top End of the Territory.

At that time Steve Baddeley was the recently appointed, sole orthopaedic surgeon in the whole of the Territory. The trauma load was - and continues to be - very onerous and Robin was soon assigned to support Steve with this work. Robin's surgical experience along with his natural and acquired dexterity and mechanical genius was a natural fit for the challenges of reconstructing shattered limbs with the newest techniques of osteosynthesis and internal fixation. He rapidly became the focus for traumatic orthopaedics in the Top End of the Northern Territory. He subsequently undertook sponsored AO workshops in Switzerland and impressed the instructors and the other course participants and observers with his effective, out of the box solutions to difficult reconstructive problems.

Associate Professor Phill Carson FRACS

For the full obituary please visit our website.

Royal Australasian College of Surgeons

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- Nelson Mandela

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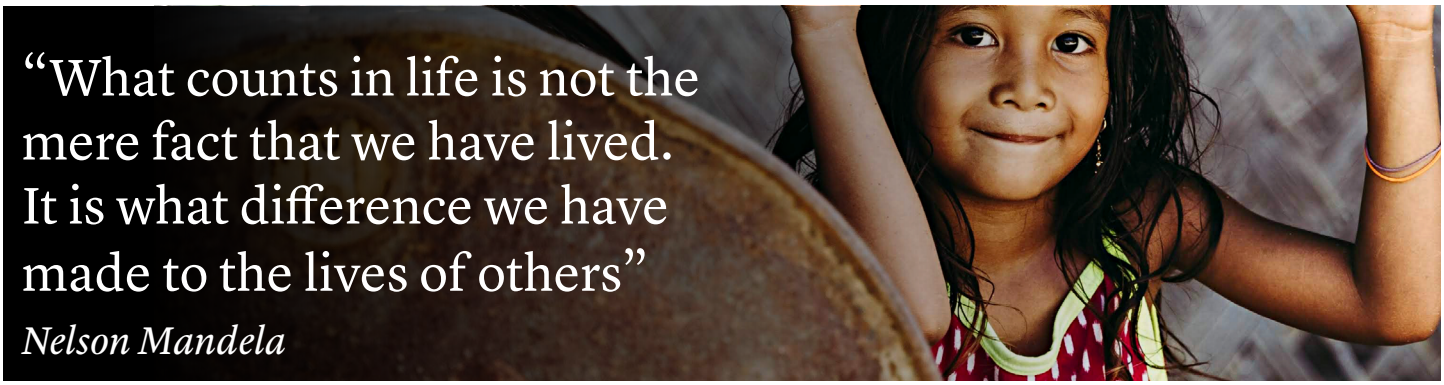

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