**SL001P**

**DR ALMA DEA MORANI: A TALENTED PLASTIC SURGEON WHO UNIFIED THE ART AND SCIENCE OF MEDICINE**

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Dr Alma Dea Morani well known as the first female plastic surgeon in the United States, melded her surgical skill and talent for sculpture into a medical art form that helped restore both form and function. Born in 1907 in New York City to parents who were sculptors and painters, Dr Morani’s parents wanted her to be a sculptor too under the belief that medicine was too aggressive a career for women. Dr Morani earned her medical degree in 1931 from the Woman’s Medical College of Pennsylvania and became the first female surgical intern in New Jersey. Initially she was only allowed to work as a surgical assistant, she then spent six years trying to find a surgical training course that would accept women. Eventually in 1946 she worked for Colonel J Barrett Brown, a renowned plastic surgeon who noticed her persistence and was inspired by her ‘feisty, strong, not a push over’ attitude hence allowed her to assist him in surgery on Saturdays when ‘all the male surgeons were out playing golf’. Dr Morani served in a variety of capacities including being a lecturer, female advocate, the clinical professor of surgery, serving in World War II and she even established Philadelphia’s first Hand Surgery Clinic in 1948. The Alma Dea Morani Renaissance Woman award today has been created in her name since 2000 to honour women physicians or scientists who have made compelling contributions. Dr Morani has inspired a generation of women to pursue careers in plastic surgery while combining the skill set of a plastic surgeon with an appreciation of the role of art.

**SL002P**

**AUSTRALIAN AND NEW ZEALAND SURGEONS’ ATTITUDES TO OUR ROLE IN CLIMATE RISK MITIGATION**

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**Purpose:** Surgery contributes significantly to Aus/NZ healthcare’s carbon footprint. Understanding the behaviours and beliefs that contribute to these emissions is essential to their reduction. Thus, we present a comprehensive description of Aus/NZ surgeons’ attitudes to climate risk mitigation.

**Methods:** An electronic, cross-sectional survey was distributed to members of the Royal Australasian College of Surgeons (RACS). Frequencies were recorded using Likert attitude scales. Logistic regression analysis was performed for Likert terms against demographic data. Thematic analysis was applied to qualitative data.

**Results:** 253 eligible responses were collected. Over 70% strongly agreed/agreed that climate change is an urgent public health crisis, that RACS should advocate for carbon-efficient policy and surgical devices, and provide climate education to members. Over 85% strongly agreed/agreed that surgical manufacturers should provide recycling options and reusable products. Compared to current practice, if supporting evidence/guidelines were provided, surgeons were most likely to change their practice in relation to reusable gowns and drapes (26% currently, 82% with guidelines), and consider the carbon footprint of the treatment pathway in their clinical decision making (33% currently, 69% with guidelines). ‘Waste reduction and recycling’ and ‘Advocacy and leadership’ were the most frequent themes identified as the actions individuals, industry and RACS should use to reduce emissions.

**Conclusion:** RACS members are calling on the College, our colleagues, industry, and government to mitigate climate risk. Recycling, reusable products and advocacy are identified by surgeons as important strategies to reduce carbon emissions in surgery.

**SL003P**

**CONTEMPORARY SURGEON ATTITUDES AND EXPERIENCES TOWARD HIGHER DEGREES BY RESEARCH (HDR)**

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**Background:** Within Australia, completing a Higher Degree by Research (HDR) is at the discretion of the individual surgeon. There is currently little contemporary evidence surrounding why HDRs are undertaken. As such, this study aims to describe the attitudes and experiences of surgical trainees and surgeons towards HDRs.

**Methods:** An 18 question cross-sectional survey of surgical trainees (pre-SET and SET) and consultant surgeons within Sydney Local Health District (covering three public hospitals) was undertaken between August and December 2022.

**Results:** Out of 270 participants invited, 72 completed the survey (27% response) including 30 (42%) trainees and 42 (58%) consultants. Overall, 43 (60%) participants had either completed or were progressing a HDR, which was similar between trainees and consultants. The majority of trainees were focused on Masters (72%) whilst consultants had completed more Doctorates (52%). Having a HDR was linked with more publications (70% vs. 34% >11 publications), and having an academic title for consultants (72% vs. 59%). The foremost drivers for completing a Masters was to strengthen ones CV and to enhance the ability to get onto SET. Doctorates were undertaken to pursue research interests and an academic career. The main factors reported to facilitate a HDR were personal commitment along with an academically focused department.

**Conclusion:** These results provide valuable insights into the academic pursuits of surgical trainees and consultants, with an improved understanding of the role HDRs currently play, critical for guiding future support strategies.

**SL004P**

**EVOLVING LEADERSHIP IN SURGERY: STRENGTH IN DIVERSITY**

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**Background:** Leadership is a complex and demanding skill that is crucial to maintaining quality in surgical systems of care. Once an autocratic practice, modern-day leaders must demonstrate inclusivity, flexibility, emotional competence, team-building, and a multidisciplinary approach. However, the complex healthcare environment challenges those in positions of leadership.

**Findings:** We searched Google Scholar, PubMed, and OVID databases for literature on the models and challenges of leadership, and located fifty-seven relevant articles. Internationally, surgical colleges have identified the importance of increasing representation of marginalised groups in leadership positions, including women, ethnic groups, the queer community, and ageing professionals, to improve advocacy for diverse patient populations. Furthermore, leaders must create a collegial environment with proactive, honest communication and robust reporting pathways for victims of workplace harassment. The retention of diverse, empowering and educating leaders relies on equitable opportunities, salaries, recognition and support. Thus, it is equally important to advocate for leaders by implementing formal training and mentorship, burnout prevention, conflict management, and wellbeing advocacy.

**Conclusion:** There are two aspects to addressing the challenges facing leadership in surgery; improving advocacy by and for leaders. Systems must be designed to support surgical leaders through formal education and training, meaningful mentorship programs, and wellbeing advocacy, enabling them to proactively and productively advocate and care for their patients, colleagues and professional communities.
We present the history of the largest Accredited Plastic Surgery unit in Australia – Monash Health – and how it rose from a small suburban hospital to become the largest Plastic and Reconstructive Surgery training network in Australia. Monash Health started in 1988 when Queen Victoria Hospital and Prince Henry Hospital closed to open one major hospital in the South Eastern Corridor of Melbourne – Monash Medical Centre (MMC). The Monash Health Plastic Surgery Unit was founded by Associate Professor Don Marshall in 1998, based at MMC, with Mr Simon Laurie. That year, Mr Simon Laurie founded the second Cleft and Craniofacial unit in Victoria, together with Mr Chris Bennett, also at MMC. In 1988, the current director – Associate Professor Michael Leung, commenced at Dandenong Hospital. Through the formation of the Southern Health Network, the Plastic Surgery Unit was gradually expanded across the multiple sites to what it is now; MMC, Monash Children’s Hospital, Casey Hospital, Moorabbin Hospital, Kingston, Monash Heart (opened 2022) and Dandenong Hospital. In the mid-1990s, Monash Health welcomed the first Plastic Surgery Trainee. Today, Monash Health Plastic Surgery Unit consists of 29 consultants, 3 trainees, and 8 unaccredited registrars. A population of approximately 1.2 million are serviced, and over 5300 operations across all plastics subspecialties were provided in 2018. As per hospital round table data, Monash health is consistently the largest training network in Australia. This talk outlines how the Monash Health Plastic Surgery unit evolved into its current state, and credits the Surgeons who were instrumental in that process.