Cutting *Edge*

July 2026

FROM THE CHAIR

From Committee to Council

Welcome to the midpoint of 2026. The first six months of the year have been marked by steady momentum and meaningful progress across the College and within Aotearoa New Zealand.

The recent College elections—both Fellowship-wide and within Council—have resulted in five New Zealand Councillors, strengthening Aotearoa's representation at the highest levels of governance. We also welcome the leadership of Dr Phil Morreau as the new president, while Dr Richard Wong-She has taken on the role of Censor-in-Chief.

Having two Aotearoa Fellows in these senior executive leadership positions will further enhance our voice, influence, and visibility within the College.

A major focus for the office this year has been preparations for the College's upcoming Centenary celebrations and Aotearoa's role as part of them. The Centenary will be marked by a year-long programme of events and celebrations across the binational College community. We are proud to be beginning these celebrations here in Aotearoa, and it is particularly fitting that we are hosting the Founders Centenary Event alongside our Annual Scientific Meeting in February in Dunedin—the same city and month in which the College began.

The programme will begin on Thursday 11 February with a course run by Otago University's MIHI Department, followed by the Louis Barnett Prize to be held in the historic Louis Barnett Theatre.

We are especially excited to welcome as many previous Louis Barnett Prize recipients as possible to join us in person for this occasion. The conference will then continue over the following two days, including a dinner at Larnach Castle on the evening of 12 February, complete with a traditional ceilidh. Please scan the QR code on page 2, to register your interest and receive more information.

This edition of *Cutting Edge* will be my final message as Chair. Reflecting on this period, we have navigated a time of significant change, including a change in government, major policy shifts within Te Whatu Ora, and constitutional reform within the College. Throughout this time, we have worked to strengthen the visibility and influence of Aotearoa New Zealand within both national healthcare leadership and the College. This has included securing the chair's position as a co-opted member of Council and the Council Executive, as well as membership of the RACS Health Policy and Advocacy Committee.

Advocacy has remained a central priority. The re-establishment of a dedicated Aotearoa Health Policy staff role in 2024 has enabled the office to take an increasingly active role in national health policy and reform.

In 2024, the office delivered 14 formal submissions, followed by 30 submissions in 2025. Importantly, these contributions have gone beyond responding to government consultation processes. They have positioned the College as a proactive, credible, and influential voice in the national health conversation.

As I reflect on the future of the Aotearoa New Zealand National Committee, I remain optimistic about the role we will continue to play in shaping healthcare delivery across Aotearoa. I am confident the incoming Executive will continue to advocate strongly for Aotearoa surgical voices—both nationally with Te Whatu Ora and the Ministry of Health, and within the wider binational College community.

It has been the privilege of my career to serve as your chair. I look forward to continuing to represent Fellows in my ongoing role on Council.

E noho rā, mā te wā.

Dr Ros Pochin,

Chair, Aotearoa New Zealand National Committee

Image: Dr Ros Pochin, Calum Barrett and Associate Professor Sarah Rennie.

Issue *highlights*

RACS Founders Centenary

Join us for the RACS Founders Centenary Thursday 11 - Saturday 13 February 2027 to celebrate 100 years of RACS in Dunedin, the city where it all started.

The programme includes a half day cultural competency workshop, the 2027 Louis Barnett Prize and our Annual Scientific Meeting: *Evolution Through Necessity*. Topics will include history of surgery and the College, evolution of surgery in war, unmet need, coping with uncertainty, the future of training & selection, and surgical innovation. We will also be celebrating with a Ceilidh at our Centenary Dinner. This will be held at Larnach Castle, and we will be joined by the Dunedin Ceilidh Orchestra.

Register your interest now to find out more and be the first to hear when registrations open.

Aotearoa New Zealand surgical advisor update

2025 Torohia Survey - RACS Surgical Trainees

The 2025 Torohiasurvey offered a broadly encouraging picture of surgical training in Aotearoa New Zealand. Surgical Trainees reported strong clinical supervision, high confidence in patient safety processes, and general satisfaction with their training experience.

These are meaningful findings that reflect well on the commitment of supervisors and training environments across the country.

At the same time, the survey identifies important areas where further work is needed:

- workplace culture and psychological safety,
- Trainee wellbeing,
- access to equity-focused and culturally responsive learning opportunities,
- rates of bullying and harassment, and
- the ongoing tension between service demands and protected training time.

The response rate of 60 Trainees– representing 23 per cent of RACS surgical Trainees in Aotearoa New Zealand, is lower than hoped for, and limits the conclusions that can be drawn with confidence. It is anticipated that as Trainees see the survey translate into tangible change within their training environments, participation will grow in future years.

RACS is committed to using these results constructively, and to working with specialities, Trainees, supervisors, and health system partners to address the concerns raised.

RACS SET Key Strengths

Clinical supervision is highly rated

- 95 per cent of Trainees reported that day-to-day supervision is provided by specialists.
- 98 per cent felt they could access senior medical support during working hours if their supervisor was unavailable, and 91 per cent could access support after hours.
- Overall clinical supervision was rated positively by 82 per cent of Trainees
- The strongest supervision domains were:
  - Helpfulness of supervisors (84 per cent)

- Accessibility of supervisors (84 per cent)
- Ensuring work was appropriate to training level (82 per cent)

Assessment and training progression

- 93 per cent reported their performance had been formally assessed.
- 96 per cent intended to continue in their specialty training programme.
- 88 per cent reported training had increased their clinical confidence.
- 81 per cent described their training as rewarding.

Access to teaching and educational opportunities

- 93 per cent could attend conferences, courses, and external educational events.
- 72 per cent felt supported by employers to attend teaching sessions.
- 93 per cent reported access to clinical skills learning opportunities.
- Bedside teaching (75 per cent), multidisciplinary meetings (60 per cent), mentoring (68 per cent), and formal education programmes (85 per cent) were all viewed as valuable learning activities.

Patient safety culture

- 88 per cent knew how to report patient safety concerns.
- 96 per cent felt safe handover processes were in place.
- 80 per cent felt confident raising patient safety concerns.

RACS SET Areas of Concern

Māori health, equity and cultural safety training

While traditional clinical skills were well supported, opportunities in Māori health and equity-focused practice were substantially weaker:

Area	Sufficient opportunities
Clinical skills	93%
Procedural skills	95%
Cultural safety	64%
Hauora Māori	64%
Pro-equity care	55%
Reflecting tikanga Māori in practice	25%

These findings suggest a persistent gap between traditional surgical training priorities and the expectations of Te Tiriti-responsive, culturally safe healthcare.

Workplace culture and wellbeing

Although support from senior medical staff was strong (84 per cent), wellbeing indicators were less favourable:

- Only 60 per cent agreed their workplace supports staff wellbeing.
- Only 58 per cent believed there was a positive workplace culture.
- Just 54 per cent felt they had a good work-life balance.
- Only 63 per cent felt able to access support after stress or traumatic events.

The major contributors to poor wellbeing were:

- Workload (57 per cent reported it often or always affected wellbeing)
- Expectations of supervisors (46 per cent)
- Lack of appreciation (62 per cent)
- Workplace conflict (35 per cent).

Bullying, harassment and discrimination

Rates were generally higher than national averages for other training programmes:

Behaviour	Experienced in previous 12 months	Witnessed in previous 12 months
Bullying:	19%	29%
Harassment:	8%	24%
Racial harassment:	4%	10%
Discrimination:	19%	10%

Of those who experienced or witnessed these behaviours:

- 68 per cent identified senior medical staff as responsible.
- 46 per cent reported the perpetrator was a supervisor.
- Only 21 per cent reported incidents.

The major barriers to reporting were:

- Concern about repercussions (59 per cent)
- Belief nothing would change (53 per cent)
- Lack of support (53 per cent).

These findings indicate a significant cultural and psychological safety challenge within surgical training environments and a significant call to arms for the RACS complaint process for trainees.

Service vs Training Tension

A recurring theme is of service demands interfering with training:

- 67 per cent said job responsibilities sometimes or often prevented them meeting training requirements.
- Only 63 per cent had access to protected study leave/time.
- Nearly half (45 per cent) rated workload as heavy or very heavy.
- 76 per cent worked more than 40 hours per week, with 20 per cent working more than 60 hours.

Interestingly:

- 33 per cent reported unrostered overtime often or always negatively affected training.
- Only 16 per cent felt overtime often or always created additional training opportunities.

This suggests overtime is increasingly perceived as service provision rather than educational opportunity.

Infrastructure and Training Environment

Infrastructure was mixed:

Strengths

- Reliable internet (76 per cent)
- Educational resources (60 per cent)
- Video conferencing facilities (72 per cent).

Weaknesses

- Teaching spaces (48 per cent)
- Private meeting space with supervisors (42 per cent)
- Dedicated meal-break space (24 per cent)
- Dedicated rest facilities (26 per cent).

The poor ratings for rest facilities are notable given the workload and wellbeing concerns identified.

The most significant strategic message is that while Trainees are becoming technically competent surgeons, the survey highlights ongoing work needed to create training environments that are psychologically safe, culturally responsive, and aligned with Aotearoa New Zealand's health equity aspirations.

Ongoing Development and Collaboration

RACS continues to play an active role on the working group responsible for ongoing development of the survey, reviewing feedback and considering potential changes to the survey as well as strategies to increase engagement. It is important that we also consider the results and how to impact positive change within our training.

Faecal Immunochemical Test (FIT) for Symptomatic Patients

Colorectal cancer is Aotearoa New Zealand's second-leading cause of cancer death, claiming around 1200 lives every year–a toll that is disproportionately borne by Māori and Pacific peoples, who experience poorer survival outcomes than other population groups. Despite this, Aotearoa New Zealand's colonoscopy services have been under sustained pressure, with waitlists for symptomatic patients exceeding available capacity across many districts. Against this backdrop, the national rollout of the FIT for symptomatic pathway represents one of the most significant changes to bowel cancer diagnostic practice in Aotearoa New Zealand in recent years and one in which RACS has played an active and instrumental role.

What is the FIT for Symptomatic Pathway?

The faecal immunochemical test (FIT) is a validated, non-invasive laboratory test that detects microscopic traces of blood in a small stool sample, a recognised early warning sign of colorectal cancer. Similar to the test used in the National Bowel Screening Programme, it can be completed at home and returned within 14 days. Under the new symptomatic pathway, patients of any age who are referred by their GP with bowel symptoms are offered a FIT test to assess their individual risk, rather than being automatically placed on a colonoscopy waitlist. Those who return a negative result are considered unlikely to have bowel cancer and are discharged back to primary care for ongoing management. Those with a positive result are prioritised for colonoscopy, ensuring that limited endoscopy resources are directed to those at greatest clinical need or for CT colonography. In cases where symptoms are more severe or alarming, clinicians retain the discretion to refer directly to colonoscopy , CT colonoscopy or specialist review, bypassing the FIT step entirely.

The Evidence Base and National Rollout

The pathway is grounded in robust Aotearoa New Zealand evidence. A pilot study conducted across two health districts from July 2022 to January 2024 confirmed that FIT is a powerful biomarker for colorectal disease, with high sensitivity and specificity for cancer detection in a symptomatic population. Modelling incorporating FIT into the referral and triage pathway demonstrated 97 per cent sensitivity for colorectal cancer, while requiring 47 per cent fewer colonoscopies than the current direct access criteria, a compelling case for system-wide adoption. Te Whatu Ora estimates the FIT for symptomatic pathway has the potential to reduce non-urgent colonoscopy referrals by 30 to 60 per cent nationally, creating significant capacity within the endoscopy workforce.

The rollout began in Waikato in August 2025, followed by Waitematā, Counties Manukau, and Hawke's Bay later that year. By April 2026, the pathway was operating in MidCentral, and full national coverage across all districts is expected by September 2026.

RACS's Role: Rewriting the Direct Access Criteria

RACS's contribution to this programme extends well beyond support for the rollout. The College is instrumental in a multidisciplinary working group currently undertaking a comprehensive rewrite of Aotearoa New Zealand's Direct Access Criteria for colonoscopy–the clinical guidelines that govern when and how patients are referred for lower gastrointestinal investigation from both primary and secondary care. These criteria have historically had low specificity for colorectal cancer, resulting in many patients undergoing colonoscopy with no significant finding, unnecessarily consuming limited endoscopy capacity with risk of an invasive test for patients. The revised guidelines embed the FIT for symptomatic test alongside colonoscopy, CT colonography, and abdominal CT within a coherent, risk-stratified referral framework, one that is clinically rigorous, equitable in its application, and calibrated to the realities of Aotearoa New Zealand's health system. The aim is to give both primary and secondary care clinicians a clear, evidence-based pathway for every symptomatic patient, reducing unwarranted variation in practice and ensuring the right investigation is matched to the right patient at the right time.

Equity Considerations

Equity is a central consideration in all aspects of the FIT for Symptomatic programme, and RACS has consistently raised this in its engagement with the working group and with Te Whatu Ora.

Māori and Pacific peoples have poorer colorectal cancer survival outcomes and are less likely to present early–factors that make access to timely, appropriate investigation all the more critical for these communities.

The pilot study itself noted that further work was needed to ensure equity for Māori if the pathway were introduced nationally, and this work is ongoing.

The College's position is clear: a pathway that improves efficiency for the majority but inadvertently disadvantages those who are already underserved would be a poor outcome. Equitable implementation, including ensuring that GP access to the FIT test is expanded and the pathway functions well in communities with lower health literacy or more complex care needs, must remain a priority throughout the national rollout and beyond.

RACS Annual Scientific Congress 2026 – Perth: The Art and Science of Collaboration

The 94th RACS Annual Scientific Congress (ASC) was held at the Perth Convention and Exhibition Centre from Thursday 30 April to Sunday 3 May 2026, drawing together surgeons, Trainees, scientists, researchers, and health leaders from across Australasia and beyond. Organised under the theme *The Art and Science of Collaboration*, the Congress served as a timely reminder that progress in surgery is never made in isolation.

A Congress Centred on Partnership

The Congress programme shone a spotlight on the many dimensions of collaboration in modern surgical practice–between surgeons and allied

health professionals, researchers and clinicians, biomedical engineers and policy makers, emerging technologies and the patients they serve.

Plenary and concurrent sessions explored how meaningful partnership across disciplines continues to drive innovation, improve patient outcomes, and strengthen the surgical workforce. The programme also featured masterclasses, workshops, breakfast and lunch sessions, and an industry exhibition, offering delegates rich opportunities to engage with the latest advances in surgical science and practice while accumulating CPD points across all domains.

The Convocation ceremony on Thursday 30 April marked a joyful opening to proceedings, welcoming new Fellows into the College. It was really pleasing to see so many new surgeons from Aotearoa New Zealand gain FRACS, becoming our colleagues. The Welcome Reception that followed provided an early opportunity for delegates to reconnect with colleagues, mentors, and peers—a fitting expression of the Congress's broader theme of collegiality and shared purpose.

Cultural Competency and Bicultural Leadership

A dedicated session on Cultural Competency reflected the College's commitment to embedding cultural safety as a core surgical competency rather than an optional addition to professional development.

This session provided a meaningful opportunity for delegates from across Australasia to engage with the principles of culturally safe practice as they apply to Aboriginal and Torres Strait Islander peoples and Māori, and to reflect on the responsibilities that come with the College's binational identity.

For the Aotearoa New Zealand delegation, this was a particularly resonant moment. The College's work on cultural competency—including the introduction of Cultural Competence and Safety as a standalone surgical competency in 2020, the establishment of the Māori Health Advisory Group in 2015, and the creation of Te Rau Poka, the Māori Surgical Academy in 2023, formed a natural backdrop for discussions at this year's Congress.

The ASC offered a platform to share progress, highlight ongoing challenges in achieving a surgical workforce that reflects the diversity of the communities we serve, and reinforce the College's long-term commitment to equity in surgical care.

Sustainability and Environmental Responsibility

Consistent with themes raised at the ECO Care Equity Conference in Suva last year and in numerous recent RACS forums, environmental sustainability featured prominently at the ASC 2026. The Congress itself was designed with sustainability in mind, encouraging industry partners to eliminate paper handouts, provide reusable materials, and consider the environmental footprint of their exhibition presence. These efforts reflected a broader cultural shift within the College, recognising that surgeons are uniquely positioned to influence theatre practices, procurement decisions, and systems thinking in ways that extend well beyond the operating room. For our colleagues in Aotearoa New Zealand and the wider Pacific, where the consequences of global carbon emissions are most acutely felt, this commitment to sustainable surgical practice carries particular weight.

Innovation, Technology, and the Future of Surgery

Technological innovation was a thread running throughout the Congress, from sessions on robotics and minimally invasive techniques to discussions about artificial intelligence, digital health, and biomedical engineering. The Congress examined how collaboration with technology, rather than competition with it, is reshaping surgical training, operative precision, and patient communication. For Aotearoa New Zealand surgeons, these conversations carry direct relevance to questions of equitable access: how can the benefits of technological advancement be extended to patients in regional and rural settings, and how can smaller health systems engage meaningfully with innovation that is often developed and deployed in larger, better-resourced environments?

Looking Ahead

The 94th ASC was, in many respects, more than a scientific meeting. In an era of rapid change, in health system structures, regulatory frameworks, technology, and societal expectations of medicine, the Congress offered the surgical community a moment to pause, reflect, and reconnect. The power of the ASC lies not only in the quality of its science but in the relationships it sustains and renews.

For the Aotearoa New Zealand delegation, Perth 2026 was a valuable opportunity to bring our own perspectives, challenges, and achievements into the binational conversation and to return home reinvigorated for the work that lies ahead.

Advocacy Update – Aotearoa New Zealand

The following items are some advocacy highlights from Aotearoa New Zealand in the past three months.

1. Budget 2026

We were pleased to see investment in the health sector as a significant priority in Budget 2026 on 28 May 2026 with an additional $5.8 billion, a 10 per cent increase on Budget 2025. However, much of this is spread over several years with a compound annual growth rate to 2029/30 of almost 3.5 per cent very close to the inflation rate. This will help meet frontline cost pressures but is unlikely to support growing demand.

We welcomed funding for 24,000 additional planned care treatments and strongly recommended these should be allocated as a priority to public hospitals, with private provision only where Te Whatu Ora cannot employ surgeons soon enough. To this effect we will continue discussions with government to increase both training and consultant positions in areas of unmet need, especially in regional and rural hospitals.

Although we welcomed the lowering of eligibility for government funded bowel cancer screening by only two years from 58 to 56 years of age – this is still 11 years later than eligibility in Australia at 45 years. We continue to advocate for returning eligibility for Māori and for Pacific peoples to 50 years, as was rolling out in 2025. Bowel cancer is the second most common cause of cancer-related deaths in Aotearoa New Zealand; Māori are more likely to be diagnosed with bowel cancer at a younger age and at more advanced stages; and earlier screening would have great impact on reducing preventable deaths in our communities.

Primary care also needs investment and attention. Growing unmet needs are mounting the pressure on general practice. The lack of investment in primary care increases pressure on the hospital system. We must remain committed to working collaboratively with government and other health professionals to provide high-quality, accessible, and equitable surgical services to meet the needs of our diverse communities.

2. Health Practitioners Competence Assurance Amendment Bill 2026

On 19 May 2026, the government introduced the Health Practitioners Competence Assurance Amendment Bill 2026 (the Bill). The timeline for the Bill, including whether it will be referred to the Health Select Committee, is still to be determined.

The introductory section of the Bill says the key objectives are to:

- better align health workforce regulation with patient needs, health system policy, and government priorities
- ensure regulation is responsive to support innovative health services
- ensure efficient recognition and registration of health practitioners.

Some key features of the Bill are:

- making regulatory authorities such as the Medical Council of New Zealand (MCNZ) subject to directions from the Minister of Health on policies, administrative processes, or procedures; noting the power of direction is similar to that in Australia. A direction could include for example a requirement for MCNZ to accelerate registration of international medical graduates to meet workforce shortages. Directions cannot be about a particular person or qualification. The regulatory authorities would be required to consult and consider the views of the public before issuing a notice relating to a scope of practice, or a qualification required for a scope of practice.
- creating a new ministerially appointed committee, which can review and overturn a decision by MCNZ to refuse a particular doctor's registration and certain decisions about scope of practice. This replaces the current arrangements whereby appeals

are handled by the courts. The appointments to and processes relating to the committee are set out in detail.

- making the regulatory authorities and their members accountable to the Minister of Health in a manner more akin to Crown entities, including for financial reporting.

In early 2025 RACS submitted against these changes when foreshadowed by the Minister in a discussion document. Our key concern was the tone of the document undermined the role of regulators and professional colleges in maintaining health standards and implied health workforce regulation is the cause of New Zealand's health workforce shortages. We were concerned about the lack of focus on the purpose of the Act to "protect the health and safety of members of the public by providing mechanisms to ensure that health practitioners are competent and fit to practise their professions", including a proposed reduction of focus on cultural safety, which is crucial for patient-centred care.

In September 2025, when releasing the subsequent cabinet decisions, the Minister said, "The planned amendments to legislation will allow overseas trained health professionals to be registered more quickly and make regulators more accountable". It was clear the intention remained for the Minister of Health to be able to direct MCNZ to accelerate registration of international medical graduates to meet workforce shortages.

RACS intends to make a submission on the Bill if government provides an opportunity for Select Committee consideration. We expect to focus on the over-riding need for the Minister to protect the health and safety of the public when considering directions to accelerate registration of international medical graduates to meet workforce shortages.

3. Consultations by the Medical Council of New Zealand

The Medical Council of New Zealand (MCNZ) has consulted colleges on several matters in 2026.

a. Regulation of Physician Associates

The final scope of the Physician Associate (PA) profession has not been announced at time of publication, however MCNZ have confirmed that the Physician Associate name will not be changed. The chair of the Aotearoa National Committee submitted in February 2026 in response to MCNZ consultation on a draft regulatory framework for PAs in Aotearoa. We supported the overall framework of the proposed provisional and general scopes of practice, the qualifications and registration pathways, supervision requirements, and expectations around cultural safety and equity in healthcare delivery. However, we recommended a tighter scope of practice, tighter supervision, greater emphasis on cultural competence, and that progression from provisional to general scope based on competence, not time. We recommended using the title Clinical Assistant in Aotearoa. We also collaborated in and endorsed a submission from the New Zealand Council of Medical Colleges.

RACS has opposed the introduction of the PA scope of practice in Aotearoa New Zealand. Given the government's decision to regulate PAs and allocation of responsibility to MCNZ, we contributed to design of the draft regulatory framework alongside doctors, physician associates, unions, consumers, and other health sector organisations. Culturally safe practice is essential for patient trust, equity, and quality of care. Given all PAs initially practising in Aotearoa New Zealand will have trained overseas, we recommended greater emphasis on training in cultural safety and hauora Māori and demonstrated cultural competence. Cultural safety must be recognised as a system responsibility, not an informal training burden to be shifted onto other members of the medical workforce.

b. Statements on Cultural Safety and Cultural Competence, and Hauora Māori

MCNZ is responsible for setting standards of clinical competence, cultural competence (including competencies to enable respectful and effective interaction with Māori), and ethical conduct (Health Practitioners Competence Assurance Act 2003). Following a review of the 2019 Statement on Cultural Safety, MCNZ developed for consultation draft statements on Cultural competence and cultural safety, and Hauora Māori (Māori health and wellbeing). We welcomed the opportunity to contribute to developing the consultation drafts, which were informed by external experts with significant input from Te Kāhui Whakamana Tiriti (MCNZ's expert Māori advisory group), and Whakawaha (consumer advisory group).

The Chairs of AoNZ National Committee and Māori Health Advisory Group submitted jointly supporting the draft statements, stating that they were reasonable, proportionate, and easy to read. As of 25 June, the draft statements are yet to be published.

c. MCNZ Fees

MCNZ consulted colleges on proposed practising certificate fees, disciplinary levies, and other fees, to take effect from 1 July 2026. The fees proposed were based on activity-based costing and an increase in disciplinary activity. We submitted the proposed fees and levy were reasonable.

4. Changes to Road Rules to improve the safe use of lanes

The Chairs of the RACS Aotearoa New Zealand Trauma sub-committee and Aotearoa New Zealand National Committee made a submission supporting five proposed changes to the Land Transport Rules to improve the safe use of lanes.

Our submission to NZ Transport Agency - Waka Kotahi supported the five proposals to:

1. allow children aged 12 years and under to ride bikes on footpaths
2. set a minimum passing gap for when vehicles pass other road users
3. allow people to ride e-scooters in cycle lanes
4. require drivers to give way to buses leaving bus stops
5. clarify signage requirements for enforcing berm parking restrictions.

We also urged Waka Kotahi to move more quickly toward a roading system based on three separated lanes or pathways, which are safe and suitable for a defined set of users: the roadway for motorised vehicles; cycle lanes for bicycles and e-mobility devices; and footpaths for pedestrians, children, and people using mobility devices.

5. Appointments to health sector boards

Health NZ - Te Whatu Ora

On 16 April, Hon. Simeon Brown, Minister of Health announced the appointment of Mark Darrow as Chair of Te Whatu Ora from May 2026, replacing Prof Lester Levy. He also appointed Michael Schubert and Dr Bryan Betty as members of the Board. Roger Jarrold, Deputy Commissioner, will finish his term on the Board at the end of July. The minister said he expected the Board to maintain focus on strong governance and accountability– ensuring the organisation operates efficiently, transparently, and with patients at the centre.

Accident Compensation Commission (ACC)

On 5 May, Hon. Scott Simpson, Minister for ACC, announced the appointment of three new Board members, Richard Keys, Lindsay Wright, and Michael Playford, who have combined experience in health and disability, investment management, and actuarial forecasting. He said they are expected to play a key role in supporting the performance of ACC under its Turnaround Plan. ACC is under significant financial pressure with the Turnaround Plan to reduce the average time it takes people to return to work and reduce the Long Term Claim Pool (LTCP).

Medical Council of New Zealand (MCNZ)

The Council has recently elected Dr Kenneth Clark as its chair. Dr Clark was appointed to Council in August 2020 and has served as chair of Council's Education Committee for the past six years. He is a past president of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and was until recently vocationally registered in Medical Administration. Dr Clark was Chief Medical Officer (CMO) of MidCentral DHB for 17 years and chaired the national DHB CMO group for nine years until leaving his CMO role in 2019.

The Council also elected Ms Ming-Chun Wu as Deputy Chair. Ms Wu is a lay member of Council with extensive experience in governance, policy, and strategy. Her regulatory experience includes her roles as deputy chair of the Pharmacy Council and on the Board of the Chinese Medicine Council

The minister declined to reappoint Dr Rachelle Love, chair of MCNZ, and deputy chair Simon Watt when their terms expire, although both were and eligible for reappointment. Two other members have also finished their terms. The minister said MCNZ had become increasingly distracted by matters such as consultation on draft statements on cultural competence, cultural safety and Māori health and wellbeing.

RACS published a response to the Minister's decision, which is available on the RACS website.

Congratulations to Dr Helen Buschel, recipient of the 2026 John Corboy medal

The John Corboy medal is the highest honour a surgical Trainee receives from RACS. It is one of RACS' distinguished awards and is awarded annually by the RACS Trainees' Association (RACSTA). The medal commemorates Dr John Corboy, a General Surgery Trainee from Aotearoa New Zealand, who was also RACSTA chair in 2007 before passing away during his tenure. The award reflects everything Dr Corboy strove to achieve—outstanding leadership, selfless service, tenacity and service to Trainees of the College. This medal is presented to Trainees who embody these traits.

Dr Helen Buschel was presented with the John Corboy medal at the Convocation Ceremony at the 94th RACS Annual Scientific Congress in Perth. Currently a senior SET Trainee in Paediatric Surgery at Queensland Children's Hospital, Dr Buschel has already established herself as a leader of remarkable integrity and influence within the Australasian surgical community.

She is widely respected as a mentor, educator, and trusted colleague, generously giving her time to support junior doctors and fellow Trainees through examinations, interviews, and challenging professional circumstances. Her commitment to others is matched only by her unwavering dedication to patient care and clinical excellence.

Nominations for the 2027 John Corboy medal are now open until 31 July. If you know an exceptional Trainee that demonstrates outstanding leadership, selfless service, tenacity, and service to Trainees, we encourage you to put your nomination in at John Corboy Medal Nomination Form – Fill out form

Pūhoro - ki te hoe! Paddles up and ready!

Te Rau Poka, RACS' Māori surgical academy is back on the road this year as part of the Pūhoro STEMM programme. The programme travels to high schools around the country promoting careers in STEMM to students. Pūhoro now has 12 locations around Aotearoa New Zealand that the Pūhoro team coordinates with several high schools and hundreds of Māori high school students in attendance.

Pūhoro and RACS Te Rau Poka formed a partnership in 2021. Funded by the Foundation for Surgery, RACS Te Rau Poka Academy attends about six of the Pūhoro wānanga each year between May and August. This is the fourth consecutive year for RACS Māori Health Equity Lead -Kaiwhakarite Dr Ruth Herd, who says that each year RACS' presence at the events gets better. We have now acquired two new laproscopy trainers, and several instruments that can travel with our team to the various locations. We also received a generous donation from the SKILLS team of suturing kits, which we have discovered can be reused many times.

The programme depends on the pro bono support of local surgeons, surgical trainees, and aspiring trainees, including recently a T1 intern who was keen to volunteer their time to share some of their journey with the students. The first event kicked off this year in the Manawatū region at Awapuni Racecourse. Professor Jonathan Koea, the lead surgeon opened thee first of three sessions, with Maia Tipene and Mikayla Kahi then presenting on their experiences in medicine.

Team work makes the dream work as 'Kaiārahi' Prof. Jonathan Koea opens the first session with a karakia and introductions to the team.From left to right: Dr Maia Tipene,'Kaiawhina' Liberty Koea and Dr Mikayla Kahi.

Maia Tipene is a PGY3 currently serving three years military service at Linton Military Camp in Palmerston North. Maia, who is from a small town in the Far North, spoke about how initially she was not doing well in school. Her parents moved her to a boarding school in the Waikato region where she was steered in the right direction and ultimately chose medicine as a career.

Mikayla is from the Manawatū region and is also a graduate of the Pūhoro programme. She told the students that she was sitting in their place nine years ago and was so happy to be able to share her journey with them including why she chose medicine—to help her whānau members navigate the health system.

The sessions received glowing feedback from the students who were grateful for the information that was shared on what it takes to get into medical school, the years of work and dedication, and the

A student getting to grips with the intricate task of extracting a lolly from its wrapper.

compelling reasons to choose medicine as a career.

The students also enjoyed the hands-on activities with suturing and using the laparoscopes to cut a lolly out of its wrapper, which some managed in under a minute.

Next, we are heading to the Taranaki region famous for its maunga (volcanic cone) to a venue beside the beautiful Pukekura Park. General surgeon Dr Nigel Henderson and two SET Trainees, Awhina Meikle and Jaymee McNab-Hand, will be helping us there.

We are very grateful for the support we receive from the Foundation for Surgery, our partners Pūhoro Trust, the SKILLS team with special thanks to Erella Sonnino and a mention to Nick Ingram who set up our lap trainers for us.

Prof Jonathan Koea watching on as Maia Tipene speaks in session one

Glossary of terms

Ki te hoe! A term used in waka ama (outrigger canoe racing) to denote the team is ready to paddle.

Kaiarahi – Leader – Supervisor of Surgical Training

Kaiawhina – Field assistant

Kaiwhakarite Hauora Māori – Māori Health Equity Lead

Pūhoro- a Māori design seen on the side of a canoe and a tattoo pattern

Te Rau Poka- the surgical branch. Te Rau Poka is named after Te Rau **Puāwai**- a Māori mental health workforce initiative.

Wānanga- a series of workshops

Whānau- family.

ASC 2026 wrap up

RACS ASC focussed on collaboration, culture and the future of surgery

More than 1300 surgeons, Trainees and health leaders from Aotearoa New Zealand, Australia and around the world gathered in Perth for the 94th Royal Australasian College of Surgeons (RACS) Annual Scientific Congress (ASC), exploring this year's theme, The art and science of collaboration.

Across four days, the ASC brought together local and international experts to examine the evolving role of surgeons—from global health and professionalism to artificial intelligence (AI) and the future of care. Among scientific sessions, keynote lectures, there was also opportunities to connect and catch up with the surgical community through section dinners, yoga, speciality meetings and more.

Conveners Associate Professor Mary Theophilus and Associate Professor Rob Love set the tone early, emphasising the need to move beyond traditional boundaries in surgical practice.

"The idea that excellence sits within silos no longer holds sway," Associate Professor Theophilus said. "To compete, protect, differentiate is increasingly out of step with modern surgical care."

Collaboration extended across disciplines and borders, with sessions highlighting how surgeons can improve access, equity and outcomes. Global health discussions underscored the importance of building local capability, while Professor Annie Sparrow challenged delegates to rethink antimicrobial resistance as a systems issue shaped by global inequity.

Convocation was a standout moment, with more than 100 new Fellows welcomed to the College. In his George Adlington Syme Oration, Professor Mark Edwards reflected on the meaning of legacy: "Legacy is not built on victories. It's how you carry your failures."

A key moment of the ASC came at the Annual General Meeting and Congress dinner, where Dr Philip Morreau and Dr Christine Lai formally began their roles as RACS president and vice president. The occasion was marked with a special performance by attendees from Aotearoa New Zealand, who sang a waiata in honour of the new College president.

Technology and innovation were key themes throughout the ASC. In a compelling plenary, engineer and inventor Dr Jordan Nguyen explored the balance between technology and human connection in surgery.

"Trust is such an important aspect of surgery. Technology should not replace human connection."

RACS Aotearoa New Zealand Councillor Associate Professor Matthew Clark reinforced that change is inevitable:

"As a surgeon, will I still have a job in 10 years? Yes, but it will be different."

Sessions also examined the growing role of AI, with Chelsea Gordon, specialist health lawyer from Minter Ellison and is also the Legal Lead in our AI Advisory team, noting measurable benefits when used appropriately:

"Where surgeons were assisted by artificial intelligence, specificity increased by 18 per cent, and precision increased by five per cent."

The ASC also turned inward to examine surgical culture, standards and accountability. Dr Rachelle Love from Aotearoa New Zealand challenged the profession to address behaviour and uphold standards:

"The standard you walk past is the standard you accept. Culturally safe care uplifts everyone."

Members from Aotearoa New Zealand also had their opportunity in the spotlight, including Professor Spencer Beasley who delivered the Archibald Watson Memorial lecture and receiving the Archibald Watson medal.

Beyond the plenaries, delegates connected through section dinners, the Women in Surgery networking event and breakfast, Trainees yoga sessions and informal networking across the exhibition hall.

The RACS booth was a hive of activity with RACS staff handing out 1300 pairs of socks, over 1000 goodie bags, while 50 Fellows completed their CPD. The RACS Foundation for Surgery booth raised awareness about their initiatives. There were exhibitor displays from surgical technology to a LEGO operating theatre, a coffee van—creating a vibrant hub of activity.

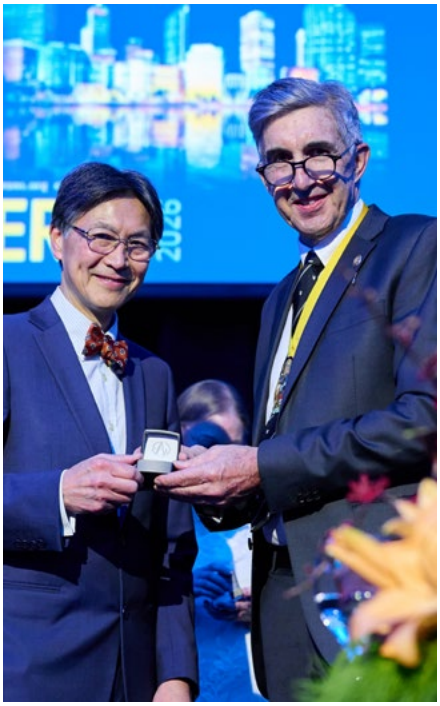
As RACS looks ahead to its centenary in 2027, this year's ASC highlighted both the challenges and opportunities shaping the next chapter of surgery, and the collective role of Fellows and Trainees in leading that future.

Thank you to our convenors, Associate Professor Rob Love and Associate Professor Mary Theophilus and the ASC organising committee. We appreciate the generous support of our sponsors, for a great four days of bringing the surgical community together in Perth.

You can catch up on our daily recaps at Annual Scientific Congress | RACS

Next year's ASC will be held in Melbourne at the Melbourne Convention and Exhibition Centre from 29 April to 2 May.

Images (clockwise from top): The new President and Vice President; Christine Lai and Phil Morreau; (L-R) Siobhan Clayton, Cameron Wells (AoNZ Trainee Representative), Scott Mclaughlin, Teagan Fink, Kristy Mansour; Owen Ung handing over the presidency to Phil Morreau; Aotearoa New Zealand Councillors and Surgical Advisor: (L-R) Phil Morreau, Richard Wong-She, Sarah Rennie, Ros Pochin, Matthew Clarke; AoNZ attendees performing a waiata as Phil Morreau accepts the presidency at the gala dinner; Women in Surgery breakfast.



NZ IMGs and Assessors

Intro to the Vocational Registration Portfolio

International Medical Graduates (IMGs) make a vital contribution to Aotearoa New Zealand's surgical workforce and play an important role in supporting access to specialist care across Aotearoa.

As part of the vocational registration process, Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand (MCNZ) may seek advice from the Royal Australasian College of Surgeons (RACS) on whether an IMG's training, qualifications, and experience are comparable to those of a locally trained surgeon practising within the same vocational scope. Acting on behalf of the MCNZ, the College provides expert advice across its nine surgical specialties to support robust and consistent assessment of vocational registration applications.

While the College contributes specialist advice to the registration process, decisions regarding vocational registration remain the responsibility of the MCNZ. Through this important work, RACS helps support high standards of surgical practice while assisting appropriately qualified surgeons to contribute their skills and expertise to communities throughout Aotearoa.

Admission to Fellowship of RACS is a separate College process and is not part of the vocational registration assessment. Surgeons who obtain vocational registration in Aotearoa may subsequently apply to the College for assessment for Fellowship through the IMG Assessment team.

College submissions

Between January and May 2026, the College provided timely and comprehensive advice to support the assessment of IMGs. During this period, College submissions achieved a strong on-time submission rate of 90 per cent for interview-based advice, and 100 per cent for paper-based advice.

A total of 18 paper-based applications were received. The College submitted advice on 12 and has advice on six currently in progress. In addition, 25 interview-based applications were received, of which 17 have received advice and 8 are currently in progress.

Across the same period, 14 assessments and logbook reviews were undertaken and advice submitted to MCNZ, contributing to the overall evaluation of clinical experience. There were also three approvals for full vocational registration, reflecting successful progression of suitably qualified IMGs through the registration pathway.

Projects

Summary logbooks

The NZ-IMG team has been collaborating with assessors to create Summary Logbooks, an important information source in the IMG application for provisional vocational registration with the MCNZ. The summary logbooks will provide a clear overview of the procedural experience gained by IMGs throughout their training and clinical practice, helping assess comparability with the training and experience expected of an Aotearoa-trained surgeon in the same specialty.

IMG Assessment Form

The IMG Assessment Form is an important part of the six-monthly reporting process, helping supervisors and IMGs reflect on progress, performance, and readiness to practise at the standard expected of a consultant surgeon in Aotearoa New Zealand.

To better support this process, the NZ-IMG team is working closely with assessors from across the surgical specialties to develop a refreshed assessment form designed specifically for IMGs. The aim is to create a more relevant, practical, and consistent tool that supports high-quality assessments and helps ensure IMGs are well prepared for independent practice in Aotearoa.

RACS Additional information form has been updated

The RACS Additional Information Form is a key part of the assessment process for IMGs seeking provisional vocational registration in Aotearoa. The form captures a comprehensive overview of an IMG's training, qualifications, and professional experience, from graduation through to specialist practice, providing assessors with the information needed to evaluate comparability with an Aotearoa-trained surgeon.

To support a more thorough and efficient assessment process, the NZ-IMG team has recently refreshed the form. The updated version is designed to help IMGs provide clear, complete, and relevant information about their professional journey, ensuring assessors have the information they need to make robust and well-informed recommendations to the MCNZ.

Assessors

College assessors are vocationally registered Fellows across Aotearoa and play a vital role in making recommendations to support the safe and effective integration of suitably trained and experienced IMGs into the surgical workforce. They ensure that IMGs practising in Aotearoa meet the standard expected of a locally trained consultant surgeon, helping to maintain high-quality, safe patient care.

Assessors contribute by carefully reviewing IMG application documentation and participating in assessment panels for IMG interviews, as required by the MCNZ. This work is central to the College's ability to provide robust, independent advice to the MCNZ, so that the regulator can make their determination.

The NZ-IMG team appreciates their time, expertise, and commitment of our assessors, without whom this important work would not be possible. The assessor pool includes 23 assessors across the nine surgical specialties, including the Aotearoa Censor and Deputy Censor, reflecting a broad base of senior surgical expertise supporting the IMG vocational registration process.

From applicant to assessor: Dr Emma Lacey

Dr Emma Lacey left the United Kingdom searching for a better life for her young family, never imagining she would one day help decide whether other international surgeons could practise in Aotearoa New Zealand.

A decade after arriving as an International Medical Graduate (IMG), the orthopaedic surgeon now serves as the RACS Aotearoa Orthopaedic Surgery Assessor for IMG applications to the Medical Council of New Zealand (MCNZ).

Dr Lacey says the IMG pathway can be lengthy, stressful and emotionally draining, but ultimately protects patient safety and surgical standards.

Her experience navigating the pathway and turning a new country into home helps others at the beginning of their own process.

Seeking better balance

Dr Lacey had only recently become a consultant in the United Kingdom when she and her husband began reconsidering their future. “I knew I needed a better work-life balance,” she says.

Her connection to Aotearoa New Zealand began years earlier during a sailing race that brought her into Wellington.

“I fell in love with the country and people,” she says. Her family intended to embrace the opportunity wholeheartedly, even though her husband had never been to Aotearoa New Zealand before emigrating. “That was 10 years ago.”

She arrived with her husband and a young family as the first hand and wrist surgeon in Invercargill and discovered colleagues across the country openly discussing hobbies and interests outside medicine.

“Here, people asked what you did in your spare time. I loved that.”

Daunting early process

Despite securing a role in Invercargill before arriving, Dr Lacey says the IMG registration process initially felt intimidating. “It was terrifying.”

At the time, she was a relatively inexperienced consultant and found the provisional registration interview confronting. The interview panel encouraged her to complete a Fellowship at Middlemore Hospital in Auckland—advice she now credits with shaping her career.

“That Fellowship was probably the making of me,” because the 10-week Fellowship helped her establish professional relationships and support networks that remain invaluable today. “If I have a complex case now, I still ring colleagues or discuss cases in hand meetings.”

Dr Lacey says many IMGs “often go to rural centres where they don’t always have the support they need.”

Learning new systems

Adapting to Aotearoa New Zealand healthcare requires more than clinical knowledge. “You can only read so much in a book. You have to live it practically,” she says.

Understanding Māori culture, health inequities and the realities of the healthcare system takes time and reflection. “It’s impossible to fully understand the roots of culture and privilege without living it.”

Practising in Aotearoa New Zealand also exposed her to resource limitations she had not previously experienced.

“There’s a moral injury when you feel like someone should be treated but resources are limited. It creates challenges you don’t fully understand until you work here.”

Fellowship opened doors

Dr Lacey says attaining Fellowship of the Royal Australasian College of Surgeons (FRACS) significantly changed her professional opportunities. “It opened all sorts of doors.”

The qualification enabled her increasing involvement in education, governance and IMG assessment processes. She now

reviews applications and helps assess whether IMG surgeons meet Aotearoa New Zealand standards.

Her own experience helps her approach applicants with empathy while still maintaining rigorous standards. “That person can feel like they have their whole life in your hands, so I try to be friendly, sincere, fair and consistent.”

She says the IMG assessment process has become more standardised over the past decade, improving consistency while safeguarding patient care.

“We want the best surgeons who are well trained and can provide high-quality outcomes. We do have a really robust process, but that does safeguard us.”

Advice for IMGs

Dr Lacey encourages doctors considering the IMG pathway to embrace the opportunity despite the uncertainty.

“Take the risk. It’s a friendly, beautiful country and your skills can make a real difference.”

Moving countries transformed not only her career, but also her family life.

“Our children can grow up the way children should,” she says. “You could always go home, or perhaps, like we did, you’ll find this is home.”

A CENTURY OF SERVICE:
THE FUTURE IS YOU

95TH RACS ANNUAL SCIENTIFIC CONGRESS

Thursday 29 April – Sunday 2 May 2027

Melbourne Convention and Exhibition Centre

Destination Partners: MELBOURNE Convention Bureau · MELBOURNE Victoria Australia

asc.surgeons.org #RACS27

Royal Australasian College of Surgeons

1927-2027
Celebrating 100 years

Call for nominations – RACS awards

Nominations are now open for RACS awards, which recognise the outstanding contributions made by our Fellows.

If you have a colleague that you believe deserves a RACS awards, please get in touch with us at College.NZ@surgeons.org. The Aotearoa New Zealand Awards Committee will be meeting several times over the next couple of months, before submitting nominations to the College's Awards Committee.

The list of available awards and their criteria are available on the RACS website:

- Distinguished awards
- Singular awards

Congratulations to RACS Fellows recognised in the King's Birthday 2026 Honours List

Professor Richard Douglas, Dr Mark Fraundorfer and Dr Udaya Samarakkody were all recognised on Monday, 1 June for their outstanding contributions to the surgical profession and wider community.

Professor Richard George Douglas

To be a Member of the New Zealand Order of Merit

For services to rhinology

Dr Mark Robert Fraundorfer

To be a Member of the New Zealand Order of Merit

For services to health, particularly men's health

Dr Udayangani Kumudu Sriya (Udaya) Samarakkoddy

To be a Member of the New Zealand Order of Merit

For services to Paediatric Surgery and the Sri Lankan community

100 years. 100 stories.

100 years. 100 stories. What's your story?

Our history is shaped by people, moments and progress.

As our College approaches its centenary in 2027, we are calling for contributions to our 100 years. 100 stories initiative.

We're inviting submissions from members, staff past and present, patients and more. What's your story?

We're looking for stories about:

- people – colleagues, mentors, patients and those who have made an impact on the profession,
- events – milestones, turning points and wartime contributions,
- innovations – advances in surgery, research and technology,
- objects – tools, equipment and items of significance,
- activities – training, outreach, global health and education.

Together, these stories will help tell the story of our organisation's first century; how we continue to uphold the highest standards while evolving and adapting to meet the changing needs of the communities we serve.

Find out more and submit your story here

AoNZ Library

The following Aotearoa New Zealand publications are now available:

Appleby N et al. *Access to bariatric surgery in Aotearoa, New Zealand - a scoping review.* International Journal for Equity in Health. 2026;25:140.

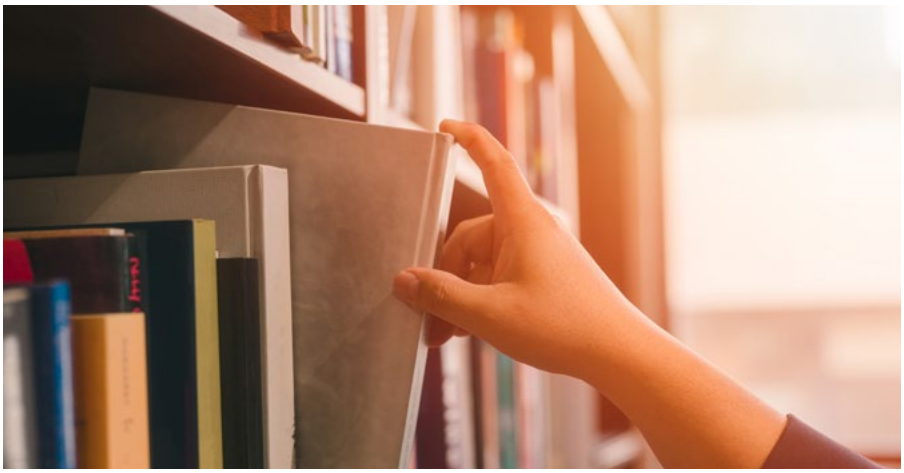
https://link.springer.com/article/10.1186/s12939-026-02844-9

Clarke M et al. *The prevalence and factors associated with workforce attrition and intention-to-leave among healthcare workers in New Zealand: a systematic literature review and meta-analysis. Journal of the Royal Society of New Zealand.* 2026;56(1):e70025.

https://rsnz.onlinelibrary.wiley.com/doi/10.1002/snz2.70025

George M, Kennedy R, Richard L, Norris P. *Expectations shaped elsewhere: refugee experiences of healthcare in Aotearoa New Zealand.* Health Expectations. 2026;29(3):e70492.

https://onlinelibrary.wiley.com/doi/10.1111/hex.70492



Glynn L et al. *Pae Ora - Healthy Futures: lessons learned from the first New Zealand Rural Health Strategy. Rural and Remote Health.* 2026;26(2):9922.

https://www.rrh.org.au/assets/article_documents/article_print_9922.pdf

Moore JE, Cole E, Gabbe BJ. *Outcomes of major trauma patients by hospital level of care in New Zealand.* Injury. 2026;57(5):113090.

https://ezproxy.surgeons.org/login?url=https://www.clinicalkey.com.au/playContent/1-s2.0-S002013832600077X

2026 Louis Barnett winner

Congratulations to Dr Jayvee Buchanan, winner of the 2026 Louis Barnett Prize, awarded on Thursday 2 July in recognition of excellence in surgical research.

Jayvee received the $2,500 NZD prize for their presentation, *Performance and failure analysis of real-time surgical computer vision in clinical practice*. He was selected from a strong field of five finalists whose presentations on the night highlighted the breadth, quality and impact of surgical research being undertaken across Aotearoa New Zealand.

The Louis Barnett Prize is one of the College's most prestigious research awards and recognises advanced academic work by Aotearoa New Zealand surgeons.

First awarded in 1962, the prize commemorates Sir Louis Barnett CMG, a pioneering surgical researcher, founder of the Royal Australasian College of Surgeons (RACS), and the first surgeon from Aotearoa New Zealand to become President of the College.

The College congratulates Jayvee on this significant achievement and acknowledges all finalists for their outstanding contributions to advancing surgical knowledge and improving patient care.

More information on this prestigious award can be found here.

NZAPS ASM 2026

This year marks a historic milestone as the New Zealand Association of Plastic Surgeons / Te Kāhui Whakamōhou Kiri (NZAPS/TKWK) celebrates its 50th anniversary. To commemorate five decades of advancement in the specialty, several landmark events will run alongside the NZAPS Annual Scientific Meeting (ASM), hosted at the Te Pae Convention Centre in Christchurch from August 21–22.

The center of the academic program will be international keynote speaker Dr Simon Wood, a renowned plastic and reconstructive surgeon from Charing Cross Hospital in London, specialising in complex reconstruction. The comprehensive, two-day programme will span seven distinct sub-themed sessions, offering deep insights into the current and future state of the specialty.

The golden jubilee celebrations will culminate on the evening of Saturday 22 August with a spectacular 50th Anniversary Celebratory Gala Dinner. Hosted at the Christchurch Art Gallery, this landmark evening will provide an elegant backdrop for members to reflect on the association's rich history, reconnect with colleagues, and celebrate five decades of excellence in style.

NZSOHNS update and ORL 2026

Over the past few months, NZSOHNS has been moving through an important period of renewal and strengthening. There has been a strong focus on improving governance, modernising systems, clarifying priorities, and building a stronger operational foundation to support members, advocacy, education, and the future direction of the Society.

A key part of this next chapter is the appointment of Richard Cooper as Chief Executive Officer. Richard brings senior leadership, operations, governance, business development, and organisational change experience to the role.

A major highlight on the horizon is **ORL 2026**, the **79th Annual General and Scientific Meeting of NZSOHNS**, taking place at **The Cordis Hotel, Auckland, from Tuesday 27 to Friday 30 October 2026**. The conference will bring together clinicians, surgeons, researchers, allied professionals, industry partners, and sector leaders for four days of learning, networking, workshops, scientific sessions, and discussion across the full breadth of Otolaryngology, Head and Neck Surgery.

Together, these changes mark a positive step forward for NZSOHNS. With Council leadership, renewed operational support, and the energy building toward ASM 2026, the Society is well placed to strengthen its voice, support its members, and continue advancing excellence in ORL care across Aotearoa New Zealand.

Welcome Richard Cooper - Kaiwhakahaere Matua | Chief Executive Officer

27–30 October 2026
The Cordis Hotel, Auckland
79th NZSOHNS Annual General and Scientific Meeting
Early bird registration closes
24 August 2026

Your voice to design a new CLEAR Course for consultants

The CLEAR course teaches how to find, understand, and apply evidence to guide your clinical practice. After the successful rollout of a redesigned course, help us to curate a course focused on the needs of RACS Fellows. Complete the survey here.

This is the link: Survey: Current CLEAR course and future CLEAR Consultants course – Fill in form

Operating with Respect: Strengthening Surgical Culture

The *Operating with Respect (OWR)* course is a highly regarded program designed to equip surgeons with the skills and confidence to recognise and respond to unacceptable behaviour, while fostering a culture of respect across the profession.

The only OWR course to be delivered in Aotearoa New Zealand in 2026 will take place on Saturday, 15 August in Wellington. While compulsory for surgical supervisors, the course is also open to Fellows and Specialist International Medical Graduates (SIMGs), offering participants the opportunity to reflect on leadership, professionalism and self-awareness while earning 7 CPD hours.

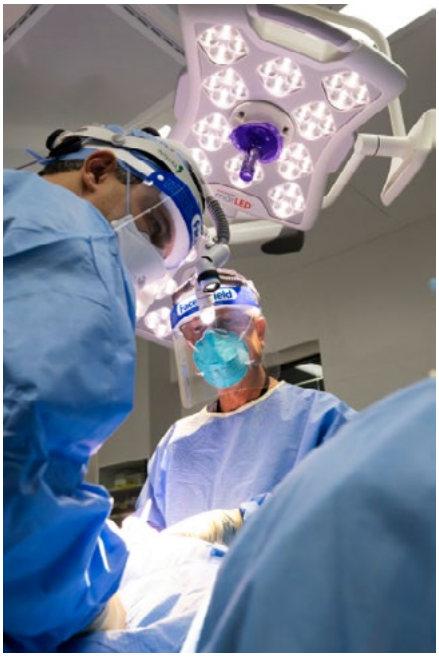
Delivered in an interactive, face-to-face workshop format, the course provides practical strategies for managing challenging behaviours, examining implicit bias, and strengthening communication within surgical teams. It also supports supervisors and trainers in building psychologically safe learning environments—critical to both team performance and patient outcomes.

Taught by surgeons, the OWR course combines real-world insight with practical tools to recognise, address and prevent unacceptable behaviour. Participants are encouraged to challenge assumptions, reflect on their own behaviours, and develop a more conscious and respectful approach to leadership.

Feedback from 2026 participants highlights the tangible impact of the program:

- 85 per cent reported they could apply their learnings directly in the workplace
- 95 per cent felt confident recognising and addressing unacceptable behaviour
- 100 per cent said they would feel confident initiating a respectful "cup of coffee" conversation with a colleague.

Developed in response to the *RACS Action Plan on Discrimination, Bullying and Sexual Harassment*, the OWR course reflects the College's ongoing commitment to cultural change and professional excellence. It delivers advanced training to help surgeons recognise, manage and prevent harmful behaviours—supporting safer



workplaces, better training environments, and improved patient care.

Places are limited. To register, visit: *Operating with Respect* | RACS

From Health NZ - the Direct Payment Process for College Fees

As of December 2025, Health NZ introduced a simplified way to support Trainees by paying training and membership fees directly. This process applies to Health NZ employees, employed as RMOs. The College will work directly with Health NZ to confirm eligibility.

If you are a Trainee employed under the ASMS collective, Health NZ are unable to pay your College fees directly, however, the usual claiming processes, as outlined in your terms and conditions of employment, will still apply.

What you need to do

- Keep your MCNZ number up to date with your College.
- Submit your training/placement details early.
- Let your College and RMO Support Service know if you want to opt out.
  - if you change districts, please notify the new RMO Unit to make them aware you wish to opt out.

What this means for you

- Less admin for you.
- Training & membership fees paid directly, no need for claims.

Have any questions?

Please reach out to either your RMO Support Service in you employing district or the RDSS Coordinator, Michelle Lind- michelle.lind@tewhatuora.govt.nz

Reflections on Operating With Respect

Professor Ian Civil

The *Operating With Respect* course was born out of the recognition that the behaviour of surgeons, both in the operating room and in their wider practice, did not match the expectations of being a Fellow of the RACS. The issues, which sparked its development had been around for years, or maybe decades, and were certainly a feature of my time on Council, some five plus years previously.

My first involvement in OWR was a participant in a pilot course in October 2016. Like many pilot courses, there were aspects that needed reconsideration, and the course on which I learnt to be an instructor in March 2017 was quite different. It was a reflection of both the course itself and the Fellows who developed it, including our current president, that so much of the feedback from participants in the pilot course was used to modify and improve it.

As many will remember, the course was promulgated for all Fellows, but just mandated for those who had major educational and governance roles and initially, there was a high demand. I taught four courses in 2017, five in 2018 and three in 2019. Subsequently most years I have just taught one course annually.

Unlike courses where the curriculum relates to clinical practice and your actual behaviour is not evaluated as emulating the teaching material, I found teaching OWR quite introspective. Every nuance of behaviour is open for evaluation by the participants and referenced against the expected professional standards. No one liners, no offhand remarks, and certainly no innuendos of any sort. It is a demanding course to teach in that regard and certainly allows the instructors to be evaluated on their behaviour on the day and in their day-to-day practice.

My most significant experience on the course related to a feedback role play scenario. It relates to the handling of a complaint by an SIMG about the experience he was getting. In the scenario he complained that he had been treated unfairly and unprofessionally by a Fellow who was his supervisor. All scenarios in teaching courses are designed to emphasise a teaching point and often are at some distance from the reality of the clinical workplace. In this particular case however, after reading the scenario brief, an SIMG who was on the course came up to me with tears in his eyes and said he could not role play that scenario. For him it was exactly what had happened to him and he found it overwhelming just to read it, let alone act it out. That event reminded me that even though the scenarios were made up, they did actually reflect the workplace situations very well and for those who had experienced those situations, they were very real indeed.

OWR is a great opportunity not only for participants to assess their own behaviour in relation to expected

professional standards but also for instructors to do the same.

I am disappointed that more Fellows are not doing the course and that the College has not developed a similar course for Trainees, which was on the agenda a few years ago.

If you are reading this column and have not done OWR please sign up. If you have, encourage others who you work with to challenge themselves and the College by doing the course and taking the opportunity to discuss with the Faculty what professional behaviour in the workplace should be.

ACC guidelines for returning to work after surgery

ACC have recently notified us that they have published their new guidelines for returning to work after surgery: acc.co.nz/guidelines

The guidelines are intended to be used by surgeons to support their certification practices and their conversations with patients about their recovery to help them get back to work and independence sooner. These may also be useful for GPs and other certifying providers, employers and vocational providers supporting clients to return to work safely.

By following these guidelines, surgeons can help support an early and safe return to work, including return to work in a modified or graduated capacity where appropriate.

Call for Abstracts - RACS Annual Research Conference

Abstract submissions are now open for the Royal Australasian College of Surgeons (RACS) Annual Research Conference, with submissions closing on 31 August 2026 at 11:45pm (AEST).

The conference will be held on 12–13 November 2026 at the Australian Hearing Hub, Macquarie University, Sydney. It will bring together students, Trainees and Fellows from Australia and Aotearoa New Zealand.

A key highlight of the conference will be the Jepson Lecture, delivered by Professor Ian Bissett add who is a Professor of Surgery at the University of Auckland and a Consultant Colorectal Surgeon at Auckland City Hospital.

Hosted by the RACS Academic Surgery Committee in partnership with the US Association of Academic Surgery, the event will feature the popular *Developing a Career in Academic Surgery (DCAS)* stream, including an innovation-focused session. A key part of the meeting is oral and quickfire presentations of abstracts accepted for the Surgical Research Society program across both days, with prizes awarded for the highest ranked presentations.

The DCAS program will feature two hot topic presentations:

- *Becoming an Academic Surgeon and Avoiding Burnout: Professor Zsolt Balogh.*
- *How to Combine Research and Innovation with Private Practice: Associate Professor Michael Talbot.*

Another key highlight will be a visit to the cochlear site after the first day of the conference.

This is an excellent opportunity to connect, present and advance your surgical research in front of a dedicated audience.

Registrations will open soon, stay tuned for more information on the website. RACS Annual Research Conference | RACS

2026 Skills Training Courses

Kia ora!

It's not too late to register for 2026 RACS Skills Training courses. Click on the course link below to see what's available and register to secure your place today:

- ASSET: Australia and New Zealand Surgical Skills Education and Training
- ATLS®: Advanced Trauma Life Support (formerly known as EMST: Early Management of Severe Trauma)
- CCrISP®: Care for the Critically Ill Surgical Patient
- CLEAR: Critical Literature Evaluation and Research
- TIPS: Training in Professional Skills

If you are interested in join one of our courses, please contact us at skills.nz@surgeons.org.

We look forward to seeing you!

Have you started your 2026 CPD Plan yet?

By now, you should have started your CPD Plan. To discuss your goals and keep moving forward, book a short appointment, email cpd.college@surgeons.org, or call +64 4 595 1432.

Started your CPD Plan but want to know what you can do?

Below are newly released microlearning activities to help you meet CAPE requirements for 2026.

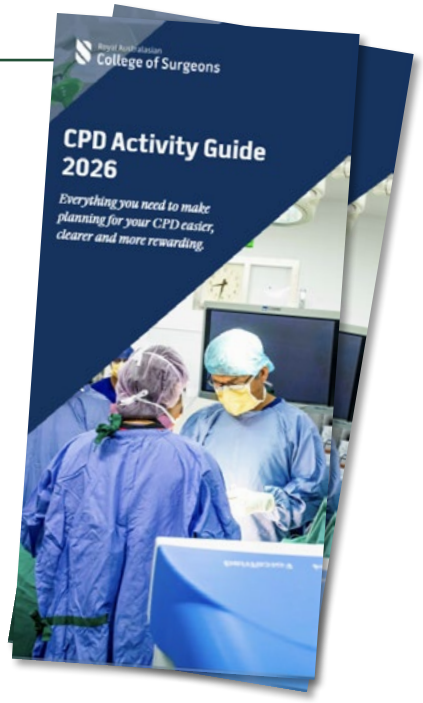
- Activism in Healthcare
- Academic Opportunities in Sustainable Healthcare
- Excellence through Diversity, Equity and Inclusion for Rural Healthcare

Te Kaunihera Rata o Aotearoa - Medical Council of New Zealand (MCNZ) requires all doctors to meet cultural safety standards. To help you achieve this, here are some modules, programmes and resources which may assist you.

- RACS Cultural Safety Resources - Cultural Safety Training | RACS
- Introduction to Māori Health (online) https://www.taikura.net.nz/introduction-to-maori-health

What about the rest of your CPD?

We have activities you can do for every category. Download the CPD Activity Guide today and see what activities you can do in 2026.



Interested in joining the RACS Medico-Legal Section Committee?

The RACS Medico-Legal Section Committee is inviting Fellows to join the Committee to help broaden representation and ensure a diverse mix of perspectives.

Joining the Committee offers the opportunity to contribute to discussions on medico-legal matters impacting surgeons in Australia and Aotearoa New Zealand, and to shape standards and guidance relevant to medico-legal practice.

Commitment:

- February 2026 – mid 2028
- Meetings: online, three times a year
- Annual Business Meeting: online: once a year

Eligibility:

- Open to all Fellows, including those not currently members of the Section.
- Secretariat support available to assist with joining the Section.

How to nominate

Please review the RACS Sections Terms of Reference and contact the Secretariat, nadia.mencinsky@surgeons.org, to submit your nomination. For further information, you may also contact the Section Chair, Professor Simon Carney, at simoncarney@me.com.

OBITUARY

Dr Randall Payne Morton

Randall Payne Morton

6 November 1947 - 11 September 2025

ORL Head and Neck Surgeon

Kua hinga te tōtara i Te Waonui-a-Tāne – A tōtara has fallen in the great forest of Tāne

Dr Randall Morton was a giant in his specialty. With a friendly personality and a good sense of humour he was a highly respected teacher and mentor to many colleagues both in Aotearoa New Zealand and internationally. A very productive researcher, his work on the quality of life experienced by head and neck cancer patients was groundbreaking. It paved the way for patients' views to be considered and included in subsequent reporting on outcome measures of treatments of head and neck cancer.

Randall was born in a small town, Cowell, in South Australia to Kathleen Payne and Clair Morton, a schoolteacher. Randall was the younger of two children, his sister Adrienne four years older. The family moved to Adelaide for Randall's high schooling, where he proved to be a very capable sprinter and participant in Aussie Rules football. Following advice from a family friend, Randall applied for, and was accepted into the Adelaide Flinders University Medical School, continuing his sporting interests throughout student days, and also admitting to wasted hours playing bridge. In his final student year Randall learned of opportunities for hospital work in Aotearoa New Zealand for senior medical students, and secured a summer job in Hastings Hospital.

Following graduation in 1972 Randall returned to Aotearoa New Zealand as a house surgeon, working in Auckland. He subsequently obtained a surgical registrar post and after gaining some general surgical experience, commenced Otolaryngology training at Greenlane Hospital. Having just passed the RACS Fellowship examination in late 1978, Randall met his future wife, Hanneke Bouchier, a lawyer. During 1979 Randall visited several overseas centres specialising in head and neck surgery, this being the pathway he had resolved to follow and he accepted a Fellowship with Professor Philip Stell at the Royal Liverpool Infirmary. After their marriage in 1980, Randall and Hanneke, and her daughter Kim, left for Liverpool.

The Liverpool experience profoundly impacted Randall's future career. Observing the significant impact on patients from what might be described as 'heroic' surgery, he began questioning the limits of surgery, considering more seriously the quality-of-life issues which resulted. This marked the beginning of what became a dominant focus in Randall's professional life. At the end of 1983 the family moved to South Africa following Randall's appointment as lecturer in Otolaryngology at the University of Cape Town. There he completed a MSc with the thesis entitled *Sinonasal Cancer in South Africa: a Clinical and Epidemiological study*. During his Cape Town time, Randall joined the Groote Schuur cricket team, and also trained for, and ran the Cape Town Marathon.

On returning to Aotearoa New Zealand in 1984, Randall was appointed as an ORL Head and Neck consultant at Green Lane Hospital, Auckland. The arrival of a daughter, Katie, in 1985 completed the family. Described by colleagues as an affable, friendly intellectual with an inquisitive mind, he was determined to contribute to the specialty of otolaryngology head and neck surgery. He was deeply invested in his patients, who felt a strong connection with him. Passionate about teaching at all levels, he was appointed Professor in the Auckland School of Medicine in 2000. Randall was a valued tutor and mentor to many current otolaryngologists and allied health professionals in New Zealand and internationally. In addition to his own ongoing research, he dedicated much time to fostering and assisting junior colleagues to engage in research projects on surgery-related topics for scientific presentations and publications. Despite this strong and time-consuming academic commitment, Randall maintained his clinical focus on head and neck surgery, further developing his interest in clinical outcomes, epidemiology and sialoendoscopy

Randall was involved in the preparation and publication of more than 200 papers, also making significant contributions to textbooks and prestigious journals. With colleagues Zahoor Ahmed and Malcolm Giles, Randall produced a three-volume textbook - *Symptom Orientated Otolaryngology Head and Neck Surgery*. In contrast to ORL-Head and Neck textbooks available this started with symptoms rather than a list of diseases. Randall was a member of the editorial and review boards for several journals and convened several national and international congresses, notably leading the 13th Asia-Oceania ORL-NHS Congress (quadrennial meeting) held in Auckland in 2015. Widely recognised internationally, he was the invited 2009 Semon Lecturer at the Royal Society of Medicine, London, and the Eugene N Myers International Head and Neck Cancer Lecturer at the American Academy of Otolaryngology meeting in 2010.

A thoughtful and strong leader, Randall held numerous roles within the public health system, the ORL Head and Neck surgical speciality and the Royal Australasian College of Surgeons (RACS). He was Head of the Auckland District Health Board Department of ORL for an extended period until 1995. After serving in several roles with the New Zealand Society of Head and Neck Surgery he was president 2003-05 and on retirement made a life member. A strong supporter of the RACS, Randall contributed substantially to the ORL training scheme

and subsequently served as an Examiner in ORL-Head and Neck surgery for 10 years. He completed a term as chair of the RACS Head and Neck Section and was the 2005 RACS Foundation Lecturer in Head and Neck Surgery. Randall became a RACS Councillor and as a long-term member of the New Zealand National Committee and served as treasurer and chair. His very substantial services to surgery were recognised in the award of the Colin McRae Medal.

Away from surgery Randall's favourite place was the family bach at Piha Beach where he was most relaxed when entertaining friends, especially those from overseas, with a selection from an extensive collection of red wine and an inexhaustible trove of jokes. He continued a life-long love of sport, particularly cricket, and while an enthusiastic golfer got to play rarely and then lamented his performance! A keen bridge player he became a weekly participant following retirement. From early in his career Randall had two 'bucket list' items. One was to learn to play the bagpipes, which he achieved after being given a chanter for his 50th birthday and subsequently becoming a valued member of the Point Chevalier Community Pipe Band. The second was to complete a PhD—and this was completed in 2019 when he was awarded a PhD by Flinders University, exactly 50 years after first graduating from the university. His thesis, covering his Quality-of-Life work, was highly commended

Randall Morton, a true friend and a significant contributor to the care of so many, died peacefully surrounded by family at Mercy Hospice on 11 September 2025, aged 77 years. He was the beloved husband of Hanneke, cherished father of Kim and Katie, grandfather to Madeleine, Georgina and Serena, adored brother of Adrienne and uncle of Bryn and Mark.

This tribute is based upon obituaries provided by Professor Patrick Bradley FRCS, Dr Julian White FRACS and contributions by Hanneke Bouchier.

OBITUARY

Dr Parma Nand

Parma Nand

12 June 1961 - 3 May 2025

Cardiothoracic surgeon

Parma Nand was born in Labasa, Fiji, to Ram Dasi (mother) and Ram Lal (father) both of whom worked as tailors. He was the youngest of six boys and had five sisters. Parma started his schooling at Lambasa Sangam Primary School and subsequently attended Lambasa College. A very capable student, he was top of his class most years and Dux in his final year at college. Although he grew up in extreme poverty (his home had a simple tin roof and earth floor), the family were very supportive and encouraged his study at night by the light of the single lightbulb they shared.

Wanting to give back, Parma decided to pursue a medical career and gained entry to the Fiji School of Medicine in Suva. Topping the class in his first year and awarded gold medals in physiology and pharmacology, he received an RSL Australia scholarship to the University of NSW in Sydney. In his class he met Kushma Singh, also on a scholarship from Fiji, and they graduated in 1983. Parma was awarded a distinction in obstetrics and gynaecology and the gold medal in surgery. Parma and Kushma returned to Fiji working as house officers for two years at Colonial War Memorial (CWM) Hospital in Suva and they married in 1985. Parma then spent the next two years as a general surgical registrar while Kushma's training led to a career in nephrology.

In 1987, following the military coup in Fiji, Parma and Kushma moved to Wellington, where a daughter, Komal, was born in 1990. Parma completed his general surgical training gaining his FRACS (Gen Surg) in 1996. The family then moved to Auckland where Parma trained in Cardiothoracic Surgery at Green Lane hospital securing cardiothoracic endorsement in 1998. Additional experience was gained working in Freeman Hospital in the United Kingdom, Toronto General Hospital in Canada, and Westmeade Hospital, Sydney in Australia.

Parma returned to Auckland as a consultant cardiothoracic surgeon in 2000 with appointments at Auckland City Hospital, Mercy Specialists Centre and Allevia Hospital, where he routinely undertook coronary artery bypass surgery and cardiac valve repairs and replacement. He was a very compassionate surgeon with a tireless commitment to healing and an unwavering devotion to service. Generous with his time to support his colleagues and participate in the teaching of junior colleagues, Parma was widely respected for his technical skill, particularly in complex and high-risk cases, and transplants. He was recognised for his aortic surgery, including valve-sparing root replacements and aortic arch procedures. With his expertise extended to minimally invasive lung surgery, complex chest deformity corrections and advanced cardiac device implantations, he was instrumental in the introduction of several innovations to the Auckland cardiothoracic service.

While Parma's clinical practice was remarkable, his humanitarian efforts defined him as an extraordinary individual. Completing an MBA through the Australian Institute of Business, he was well-prepared to fulfil his unwavering commitment to his homeland. In 2006 he initiated the founding of a charity to assist people in Fiji and Samoa in

need of cardiothoracic surgery. In the period 2006 - 2023, he led mobile cardiac surgery teams on 15 charity missions to Fiji, providing more than 770 surgical treatments and 4200 screening assessments and the associated services for Fijian and Samoan residents, who would otherwise not have been able to afford that treatment. He also co-founded Heart International, the only specialised heart clinic in Fiji. Located at Namaka, Nadi, it provides state-of-the-art heart investigations and stent treatment, meeting international standards. These initiatives have resulted in a significant contribution to the improvement of healthcare outcomes for those in need.

Parma had a love of golf and enjoyed tramping, completing the majority of the NZ Great Walks. He also enjoyed travel and particularly flying, and this resulted in multiple family trips overseas. In addition, Parma was stimulated to obtain his private pilot license. He appreciated music of all forms. However, time spent with his family, and particularly his grandchildren, was greatly valued.

Parma Nand died on May 3, 2025 in Auckland. He was a healer, a mentor and a visionary whose mission was to ensure that every patient he treated received the best possible care. His compassionate approach to medicine and his commitment to excellence will continue to influence future generations of surgeons who will carry his legacy forward. He is survived by his daughter, Komal, son-in-law and friend, Richard, twin sons Thomas and William, and granddaughters Sierra and Rumi.

This obituary is based upon that prepared for the ANZSCTS by Krish Chaudhri FRACS and Nick Kang FRACS. Additional material obtained from descriptions by Venkat Raman and considerable help from Komal Nash.

OBITUARY

Colin Barrett Fitzpatrick

Colin Barrett Fitzpatrick

6 April 1940 – 26 October 2025

Orthopaedic Surgeon

Colin Fitzpatrick was born in Hamilton to Norrie and Eva Fitzaptrick, dairy farmers. Colin was the second eldest of a family of six children (Dennis, Bruce, Keith, Lester and Maryanne). He commenced school at Koromatua transferring to St Peters College in Cambridge three years later. There he developed what would become a lifelong love of music, learning to play the cello and participating in the choir. A capable student, he was awarded the Bevan Cup for music with a further award for arts and crafts. Following the family's move to a sheep farm on the edge of the Manukau Harbour, Colin developed a keen interest in bees (encouraged by Edmund Hillary's family who lived nearby). By the time he commenced at university he owned 30 hives and the income covered his costs during the subsequent years.

After successfully completing Medical Intermediate at Auckland University, Colin gained entry to Otago Medical School commencing there in 1960 and in the same year meeting Christina Hutching, a second-year student at Teachers College. They married in 1963 during Colin's 5th year as a medical student. As Palmerston North Hospital provided accommodation for junior medical staff, they moved there for Colin's house surgeon years 1965-66. Interested in a surgical career Colin obtained a position as an Anatomy Demonstrator in Dunedin, successfully completing the Surgical Primary examination in 1968.

At that time it was considered easier to compete the Final Fellowship examination in the UK and, at short notice, with the opportunity to travel free courtesy of the Navy, Colin accompanied an unwell sailor back home. Sharing a freezing flat with friends in Edinburgh, he studied in the heated Royal College of Surgeons Hall and obtained his FRCSEd. Chris with three small girls, then joined Colin who had obtained a position at Princess Margaret Rose Orthopaedic Hospital. The following year the family moved to Reading and subsequently Oxford when Colin obtained

a position on the Oxford Orthopaedic rotation.

Colin and the family returned to Dunedin in 1972 where he was appointed initially as a tutor specialist and soon after gained consultant recognition and an appointment as a lecturer in the Otago Medical School. He obtained his FRACS later the same year. The birth of a son, Richard, in 1973 completed the family. Of a very calm disposition and experienced across the range of orthopaedic surgery, Colin was technically a brilliant surgeon, able to turn his hand to anything. While most of us learn the art of surgery, he had a natural flair and made the most difficult procedure look easy. His patients invariably recovered well. He was innovative and in the early 1970s he and Alastair Rothwell introduced the technique of closed rodding of femoral shaft fractures in New Zealand – Dunedin and Seattle being among the first hospitals outside Europe to utilise this major technical advance in improving patient care.

Colin's special interest was paediatrics. He had a particular gift for looking after children with orthopaedic deformities and supporting their families. Recognised as a rising star by his colleagues, he was awarded a Wolff-Fisher Travelling Fellowship to North America and the United Kingdom to update on children's orthopaedics. Colin improved the quality of life of many disabled children, not only through surgical intervention but also by supporting them into adulthood. His advocacy and support for the disabled community and their families was outstanding and he was revered by this community.

Colin was instrumental in setting up regional Orthopaedic clinics in Central Otago and Maniototo in the 1970s and he visited them monthly until his retirement in 2010. John Matheson observed that punctuality was not Colin's strong point and he was readily distracted, much preferring to chat to patients, nurses or support staff. He describes a trip to a clinic in Clyde when, already an hour late, while driving near Roxburgh Colin spotted a road worker who had been a patient and stopped for 10 minutes. to have a chat. Colin's priorities were clear and he was highly respected by the local population - his vehicle consequently often loaded with food and farm produce on return to Dunedin. There were also the fish that he caught with his consummate skill in his favourite fishing spots after his clinics.

Colin spent most of his working life in a mix of Public and Private practice as well as being a senior lecturer in the Medical School. In 1986 he was joined in part-time private practice by John Matheson, together forming the basis for the Marinoto Clinic. During the initial years they struggled financially until their accountants observed that they could not afford to provide free advice and care for so many vulnerable patients whom they perceived may have had difficulty paying. With a close relationship with the Sisters of Mercy, Colin also served on the Mercy Hospital Board for several years. In the latter part of his career Colin worked solely in private practice retiring in 2010.

Colin was highly respected by his colleagues and the Otago community. His humanity and care for others was legendary. With a strong faith, following retirement he fulfilled many roles in the Presbyterian church. He was actively involved in support networks for disadvantaged youth and rehabilitation of prisoners at the Otago Corrections Facility. In his spare time he was an expert apiarist and skilled fly fisherman. He continued his love of music as an active member of Cellists of Otago. The family bach at Moeraki provided a place where the family relaxed together for more than 30 years.

Colin Fitzpatrick aged 85 years, died peacefully at Leslie Groves Hospital. He was the dearly loved husband of Christina for 62 years, much loved father of Mary, Janice, Tina and Richard, grandfather of ten children and great-grandfather of three children.

This obituary is based upon the eulogy provided by John Matheson FRACS and material provided by Chris Fitzpatrick and family.

HDC Case Review Summary

This report summarises several recent Health and Disability Commissioner (HDC) cases relevant to surgical practice. Each case highlights key failures in systems, communication, and consent processes, along with cross-specialty lessons applicable to all surgical teams and services.

Case 1: Thermal Burn from Warming Mattress During Surgery (24HDC00181)

Case Summary

A patient underwent a mastectomy and during surgery was positioned on a warming mattress designed to maintain normothermia. At the completion of surgery, a significant thermal burn (15 × 10 cm) was identified over the hip, buttock, and thigh. The injury ultimately required skin grafting. Investigation found that the warming mattress alarm activated twice during the procedure, but staff reset the device without investigating the cause of the alarm. The exact mechanism of injury could not be determined, but the likely contributors were sensor interference and prolonged pressure combined with heat exposure.

Key Findings

- A warming mattress alarm activated twice during surgery.
- Staff reset the device without investigating the cause.
- Resetting alarms had become normalised practice within the theatre environment.
- The warming device was functioning correctly and no equipment fault was identified.
- Failure to respond appropriately to safety alarms contributed to the adverse outcome.

Key Generic Surgical Lessons

- Intraoperative warming devices require the same vigilance as other critical patient-monitoring systems.
- Patient positioning and prolonged pressure points can interact with thermal devices to cause significant injury.
- Any alarm activation from patient-warming equipment must trigger immediate investigation rather than device reset.
- Surgical teams should maintain awareness of pressure-related injury risks during prolonged procedures, particularly in lateral positions.
- Documentation and review of equipment alarms should form part of intraoperative safety processes.
- Alarm fatigue and normalisation of deviance are significant patient safety risks.
- Safety systems only protect patients when alerts are actively investigated.
- Team members share responsibility for responding to equipment warnings.
- Organisational culture can contribute to adverse events when workarounds become accepted practice.
- Adverse events often arise from system failures rather than equipment malfunction.

Case 2: Delayed Radiotherapy for Craniopharyngioma (22HDC01972)

Case Summary

A young man underwent surgery for a pituitary-region craniopharyngioma. Multidisciplinary recommendations included follow-up imaging and referral for radiotherapy. However, due to communication failures, unclear ownership of follow-up actions, and failures in multidisciplinary team (MDT) processes, the recommended referral was not completed. Radiotherapy was delayed by approximately 12 months, during which the tumour progressed, resulting in recurrent symptoms, further surgery, and likely worsening visual outcomes.

Key Findings

- MDT recommendations for MRI and radiotherapy referral were not actioned.
- A referral was created, closed, and subsequently lost within the system.
- Multiple clinical encounters failed to identify that radiotherapy had not occurred.
- Responsibility for implementing MDT decisions was unclear across services and sites.
- Delayed treatment contributed to tumour progression, repeat craniotomy, and likely permanent visual impairment.

Key Generic Surgical Lessons

- MDT recommendations require clear allocation of responsibility for implementation.
- Management of complex patients must include robust tracking of planned adjuvant therapies.
- Failure to obtain histological diagnosis may complicate downstream treatment planning.

- Patients with recurrent symptoms require reassessment of treatment plans rather than symptom-focused intervention alone.
- Postoperative management should include explicit documentation of intended surveillance imaging and adjuvant treatment pathways.
- Decisions made in MDT meetings have little value unless systems ensure completion of agreed actions.
- The lead clinician retains responsibility for ensuring recommended care is delivered, even when tasks are delegated.
- Care transitions between hospitals and specialties are high-risk points for communication failure.
- Closed-loop communication systems are essential for referrals, investigations, and treatment planning.
- Patients should be informed of planned investigations and treatments so they can participate in monitoring their own care.
- Robust documentation and follow-up systems are critical components of safe surgical practice.

Case 3: Management of Large Bowel Obstruction and Deteriorating Patient (21HDC02106)

Case Summary

A 54-year-old woman with metastatic rectal cancer underwent a defunctioning colostomy followed by chemotherapy. Shortly afterwards she presented with acute abdominal pain and large bowel obstruction. An attempt was made to decompress the stoma using a chest drain. She deteriorated overnight, transfer to a tertiary ICU was delayed, and she died immediately prior to air transfer. Postmortem examination identified a bowel perforation strongly associated with insertion of the chest drain.

Key Findings

- Early Warning Score (EWS) escalation thresholds were repeatedly breached without appropriate escalation.
- Significant hypotension was not managed according to local deterioration pathways.
- Monitoring systems contributed to delays when a portable monitor remained assigned to another patient (failure to identify the correct patient).
- Pain management was inadequate following discontinuation of PCA analgesia.
- Communication with the patient and whānau during deterioration and transfer was insufficient.
- The use of a chest drain for stoma decompression represented a moderate departure from accepted practice but was not considered a breach.

Key General Surgery Specific Lessons

- Foley catheters remain the preferred instrument for decompression of an obstructed stoma.
- Blind insertion of rigid devices through a stoma carries significant risk of bowel injury, particularly in dilated or compromised bowel.
- Failure of a Foley catheter should prompt reconsideration of the diagnosis and management plan rather than escalation to increasingly rigid devices.
- Immunocompromised patients may demonstrate atypical signs of perforation or sepsis and require heightened vigilance.
- Emergency bedside procedures require informed consent whenever circumstances allow.

Key Generic Surgical Lessons

- Immunocompromised patients may demonstrate atypical signs of perforation or sepsis and require heightened vigilance.
- Emergency bedside procedures require informed consent whenever circumstances allow.
- Deterioration recognition systems only improve outcomes when escalation pathways are followed.
- Objective clinical triggers should supplement, not be overridden by, clinical judgement.
- Monitoring equipment must be correctly assigned and functioning before reliance is placed on recorded observations.
- Pain management requires ongoing reassessment, particularly in deteriorating patients.
- Communication with patients and whānau during critical illness is a core component of safe and compassionate care.
- Clear coordination and communication are essential when multiple teams are involved in complex cancer care.

Case 4: Failure to Complete Written Referral Following Discovery of Intracranial Aneurysm (22HDC01475)

Case Summary

A 66-year-old woman was found to have an incidental intracranial aneurysm during investigation of a transient ischaemic attack. A verbal discussion occurred between the referring hospital and tertiary neurosurgical service, and the patient was discharged with the expectation of specialist follow-up. However, no formal written referral was submitted. Several months later the aneurysm ruptured, resulting in a catastrophic subarachnoid haemorrhage from which she did not recover.

Key Findings

- A verbal referral occurred but no written referral was submitted.
- The patient was discharged believing specialist follow-up had been arranged.
- There was no auditable record confirming referral receipt or acceptance.
- Existing referral systems lacked safeguards to ensure completion of inter-hospital referrals.
- The patient was effectively lost to follow-up until presenting with aneurysm rupture.
- Health NZ was found in breach of Right 4(1) for failing to ensure continuity of care.

Key Specialty-Specific Lessons

- Identification of significant neurosurgical pathology requires a documented and verifiable follow-up pathway.
- Verbal discussions between clinicians do not constitute a referral.
- Responsibility for ensuring referral completion remains with the referring service.
- Patients discharged with a plan for specialist review should only leave once referral arrangements have been confirmed.
- Cross-organisational referrals require clear ownership and tracking mechanisms.

Key Generic Surgical Lessons

- Verbal discussions between clinicians do not constitute a referral.
- Responsibility for ensuring referral completion remains with the referring service.
- Patients discharged with a plan for specialist review should only leave once referral arrangements have been confirmed.
- Patients should never be discharged on the assumption that another service will initiate follow-up.
- Cross-organisational referrals require clear ownership and tracking mechanisms
- Written referrals are essential components of safe clinical handover.
- Systems should provide confirmation that referrals have been sent, received, and accepted.
- Patient enquiries regarding expected appointments should trigger urgent review of referral status.
- Closed-loop communication is essential for safe continuity of care.

Case 5: Delayed Diagnosis of Colorectal Cancer Due to System Failures (25HDC00796)

Case Summary

A 56-year-old man presented with rectal bleeding and anaemia. A gastroenterology referral for colonoscopy was declined as criteria were not met, and subsequent referral to General Surgery was delayed by administrative errors and prolonged wait times resulting from significant capacity constraints. Colonoscopy eventually confirmed metastatic colorectal cancer approximately three months beyond the recommended assessment timeframe.

Key Findings

- Initial gastroenterology referral was declined without further clarification or direct redirection.
- An administrative error resulted in an incorrect treat-by date.
- Monitoring systems failed to identify prolonged delays for patients at risk of serious pathology.
- Significant mismatch existed between clinic demand and available capacity.
- The patient experienced substantial delay before diagnosis of advanced colorectal cancer.

Key General Surgery Specific Lessons

- Rectal bleeding accompanied by anaemia in patients over 50 should trigger a high index of suspicion for colorectal malignancy.
- Referral pathways should allow direct redirection between specialties when appropriate rather than requesting the GP to refer to another service
- Triage decisions should incorporate recognised risk factors for colorectal cancer.

Key Generic Surgical Lessons

- Standardised referral criteria and terminology reduce variability in clinical decision-making.
- Consideration of template referral documentation with all relevant information.
- Waitlist monitoring systems should identify patients at risk of significant pathology.

- Capacity constraints are patient safety issues when they create unacceptable diagnostic delays.
- Administrative processes require regular auditing to identify errors affecting access to care.
- Risk stratification should be applied to patients awaiting specialist assessment.
- Transitions between referral systems and digital platforms require robust safety checks.
- Referral pathways should minimise duplication and preserve accrued waiting time.
- System failures often arise from the interaction of multiple small process weaknesses rather than a single error.

Case 6: Inadequate Informed Consent for Allograft Bone Surgery (C22HDC01429)

Case Summary

A Māori patient underwent wrist surgery involving the use of donor bone allograft tissue. The consent process referred only to a 'bone graft' and did not explicitly disclose that tissue from a deceased donor would be used. The patient subsequently experienced significant distress as the use of donor tissue conflicted with his cultural and spiritual beliefs. The opportunity to undertake appropriate tikanga and whānau consultation had been lost.

Key Findings

- The consent documentation did not specify that donor tissue from another person would be used.
- There was no evidence that the nature and source of the allograft had been discussed.
- The patient was denied the opportunity to make an informed decision consistent with his cultural values.
- Documentation failed to demonstrate that informed consent had been obtained.

Key Generic Surgical Lessons

- Consent for allograft procedures must explicitly identify the use of donor tissue.
- Discussion should include the origin and nature of the graft material.
- The use of human tissue may have significant cultural, spiritual, and religious implications.
- Māori patients should be given sufficient opportunity to engage whānau, tikanga, and cultural support before making decisions.
- Consent documentation should clearly record discussions about donor-derived materials.
- Informed consent is a process of shared understanding, not merely completion of a form.
- Clinicians must ensure patients understand material information relevant to their decision-making.
- Cultural safety is an integral component of informed consent.
- Written consent documents should reinforce, not replace, meaningful discussion.
- When understanding is uncertain, additional steps are required before proceeding.
- Respect for patient values, beliefs, and preferences is fundamental to ethical surgical practice.

Case 7: Chest Drain Insertion Complication Resulting in Hepatic Injury, Cardiac Arrest and Paraplegia (23HDC00147)

Case Summary

A man sustained multiple traumatic injuries following a motor vehicle accident and during his recovery, persistent tachycardia and respiratory compromise prompted investigation, which identified a significant right pleural effusion requiring drainage. Real-time radiology-guided chest drain insertion, as recommended by local policy, was unavailable. An ultrasound was attempted to mark the insertion site, but poorly tolerated by the patient. A plan to revisit real-time radiology-guided insertion the following day was made. However, a bedside chest drain insertion using the Seldinger technique was undertaken on the surgical ward without USS guidance. Following two unsuccessful attempts by a registrar, a senior trauma Fellow continued the procedure.

The drain was inadvertently inserted through the abdominal wall, traversing the liver and entering the hepatic venous system. Massive haemorrhage occurred, resulting in hypovolaemic shock, cardiac arrest, emergency laparotomy, and prolonged resuscitation. Although circulation was restored, the patient suffered spinal cord ischaemia, bowel ischaemia, and permanent paraplegia.

Key Findings

- Chest drain insertion was clinically indicated, but the procedure was undertaken in an unsafe environment.
- Health NZ policy required real-time radiological guidance for pleural fluid drainage where feasible, but this was not used.
- Ultrasound was not to guide the drain in real time.
- Multiple failed insertion attempts occurred before senior trauma Fellow proceeded.
- No experienced nurse was present during the procedure despite policy requirements.
- The chest drain traversed the liver and entered the middle hepatic vein and inferior vena cava, causing catastrophic haemorrhage.
- Resuscitation efforts were significantly impaired by a cluttered environment, poor communication, inadequate leadership, and difficulty accessing emergency equipment.
- Written informed consent for the procedure was not documented.
- Real-time imaging should be the standard for pleural drainage

Key Generic Surgical Lessons

- Environment matters as much as technical skill (procedures become high risk when performed in environments lacking appropriate space, equipment, imaging support, staffing, or escalation pathways).
- Failed attempts should trigger reassessment.
- Senior operators must lead high-risk procedures from the outset.
- Rare complications must still be planned for.
- Team members have a duty to speak up.
- Emergency response systems require leadership.
- Ward-based procedures require the same safety standards as theatre procedures.

Informed consent must be documented.

Case 8: Delayed Diagnosis of Prostate Cancer Due to Missed Histology Results (22HDC02105)

Case Summary

Mr A underwent a repeat transurethral resection of the prostate (TURP) for lower urinary tract symptoms, elevated PSA levels, and prostate regrowth as an outsourced patient to the private hospital. Histology from the procedure demonstrated aggressive acinar adenocarcinoma. The reporting urologist's colleague reviewed the result and generated an urgent referral for specialist review through the referrals function of the Éclair electronic clinical information system. However, the referral was not seen or actioned because the nursing staff at the secondary hospital were unaware of, and had not been trained to use, that component of the system.

Despite multiple postoperative nursing reviews, the histology result was neither reviewed nor discussed. The cancer remained undiagnosed until Mr A presented with kidney failure and was subsequently found to have locally advanced prostate cancer.

Key Findings

- Failure of critical results management–pathology report was available and reviewed but was not acted upon for six months. Multiple opportunities existed to identify and escalate the abnormal result.
- Inadequate training on clinical information systems.
- System design and governance failures. Clinicians working across different hospitals used the system differently, creating a significant risk of communication failure.
- Lack of closed-loop communication. The referral was sent but there was no mechanism to confirm receipt, acknowledgement, or completion of the requested action.
- Missed opportunities during follow-up. Histology results were not reviewed despite existing nursing checklists requiring this step.

- Shared responsibility across organisations. Although the private provider delivered the clinical service, Health NZ retained responsibility for training, governance, and safe operation of the information systems used within its facilities.

Key Urology Specific Lessons

- TURP histology can reveal significant malignancy. Every histology result requires formal review regardless of the preoperative level of suspicion.
- Postoperative TURP reviews must include histology confirmation with documentation of results, communication of findings to the patient and GP, and escalation pathways for abnormal findings.
- PSA and histology findings require integrated review.

Key Generic Surgical Lessons

- Histology follow-up must be an active process. Sending tissue for pathology creates an ongoing responsibility for ensuring the result is reviewed, communicated, and acted upon. Reliance on assumptions that another clinician or clinic will identify abnormal findings is unsafe.
- Every investigation requires a reliable results management process:
  1. The result is available.
  2. The result is reviewed.
  3. Appropriate action is taken.
  4. The action is documented.
  5. The patient is informed.
- Electronic systems do not replace clinical responsibility.
- Closed-loop communication is essential.
- Induction and training are safety interventions. Staff must be trained in all systems required to perform their role safely, including electronic health record and results-management platforms.
- Checklists only improve safety when consistently used.

Case 9: Catastrophic Neurological Injury Following Oblique Lateral Interbody Fusion (21HDC00219)

Case Summary

Mrs A, a 64-year-old woman, underwent elective lumbar spinal fusion surgery (L2/3 and L4/5 Oblique Lateral Interbody Fusion (OLIF)). During insertion of the L2/3 interbody cage, she sustained a catastrophic intraoperative neurological injury. Immediate return to theatre confirmed a large dural defect and transection of multiple cauda equina nerve roots.

Mrs A was left with complete L1 AIS A paraplegia, resulting in permanent loss of motor and sensory function in both lower limbs, neurogenic bladder and bowel dysfunction, chronic neuropathic pain, wheelchair dependence, and the need for both a suprapubic catheter and colostomy. ACC accepted the event as a treatment injury.

Key Findings

- Inadequate preoperative assessment: The most recent MRI available to the surgeon was more than three years old. Despite concerns raised during preoperative assessment, updated imaging was not obtained, contrary to accepted spinal surgery standards recommending imaging within 12 months of surgery.
- Failure of ongoing clinical review. Mrs A was not reviewed by the operating surgeon for approximately 16 months prior to surgery, despite evolving symptoms and an intervening epidural steroid injection that was intended to be followed by reassessment.
- Multiple technical errors during surgery.
- Independent reviews identified several compounding technical failures.
- Inadequate use of intraoperative fluoroscopy.
- Incorrect patient and retractor positioning.
- Poor orthogonalisation of instruments.
- Incorrect interpretation and response to neuromonitoring changes.
- Excessively posterior placement of the L2/3 cage, increasing the risk of entry into the spinal canal.
- Failure to respond appropriately to neuromonitoring alerts. Significant abnormal neuromonitoring activity occurred during cage insertion but was not interpreted as indicating a spinal cord problem.
- Deficiencies in credentialling and introduction of new procedures. The surgeon was not credentialled to perform OLIF procedures, and the hospital's formal process for introducing a new clinical procedure was not followed.
- Organisational Governance Failures. Health NZ failed to ensure appropriate credentialling, oversight, supervision, and governance arrangements for the introduction of a new and complex spinal procedure. The organisation also failed to adequately consider whether the surgery should have been performed in a centre with full multimodal neuromonitoring capability.

Key Spinal Surgery Specific Lessons

- Updated imaging is essential for surgical planning.
- OLIF requires strict adherence to technical principles:
  - accurate patient positioning
  - correct retractor placement
  - meticulous orthogonalisation of instruments
  - continuous fluoroscopic confirmation of trajectories
  - appropriate cage placement within the disc space.
- Posterior cage placement carries significant risk, increasing the likelihood of breaching the spinal canal and injuring neural structures.
- Fluoroscopy is a dynamic safety tool. Both lateral and anteroposterior views are required to verify safe instrument positioning.
- Neuromonitoring alerts require immediate surgical assessment. Neuromonitoring is an adjunct to surgical decision-making, not a substitute for it. Significant changes in signals should prompt immediate reassessment of anatomy, instrumentation, and surgical strategy.
- Multimodal Neuromonitoring Represents Best Practice.
- Revision and adjacent-level surgery carry higher risk.

Key Generic Surgical Lessons

- Credentialling must match actual practice. Surgeons should perform only procedures for which they are formally credentialled.
- New procedures require formal introduction and oversight. Introduction of new surgical techniques should include:
  - formal approval processes
  - defined training pathways
  - peer support and mentorship
  - outcome monitoring and governance oversight.
- Concerns raised during preoperative assessment must be actioned.
- Complex surgery requires appropriate infrastructure.
- Surgical responsibility cannot be delegated. While information may be provided by neurophysiologists, nurses, radiographers, and other team members, responsibility for operative decisions remains with the operating surgeon.
- Peer review and collegial support improve patient safety.
- Transparency following adverse events is critical. When serious harm occurs, clinicians and organisations must provide timely, accurate, and complete disclosure to patients and whānau, including a clear explanation of known contributing factors.

Overarching Learning Themes

Across all cases, the primary failures were not technical surgical errors but failures in systems, communication, follow-up, and patient-centred care.

Key themes include:

1. Failure to respond appropriately to safety signals (equipment alarms, uncompleted referrals, clinical deterioration, incidental findings, cancer symptoms, cultural considerations).
2. Breakdowns in communication between clinicians, services, patients, and whānau.
3. The central importance of informed, culturally safe, patient-centred care.
4. Deficiencies in informed consent processes.
5. Lack of clear ownership of critical actions, particularly referrals and follow-up plans.
6. Over-reliance on assumptions rather than verification that care plans had been completed.
7. System weaknesses contributing to patient harm, including administrative errors and capacity constraints.
8. Normalisation of unsafe practices within teams.
9. Insufficient systems to ensure planned care is actually delivered.
10. The importance of organisational culture in supporting patient safety.
11. Inadequate procedural planning and risk assessment.
12. Inadequate attention to local credentialling.
13. Failure to utilise the safest available imaging techniques.
14. Performance of a high-risk procedure in an unsuitable environment.
15. Insufficient supervision and procedural leadership.