Surgery remains a popular career choice amongst New Zealand junior doctors despite the significant challenges that a surgical career brings with it for themselves and their families. However we cannot ignore overseas trends where some surgical disciplines are struggling to fill their training positions. One of the main reasons cited is the poor work-life balance which comes with a surgical career and the younger generation is probably right in pointing out that all is not well within our craft group.

So are we working too hard and putting our lives and those of our patients at risk? This is a quality and safety issue and needs to be looked at from that perspective. It is not safe for surgeons to be on call for 24 hours, operate during the night and then do a full operating list the next day. The aviation and other industries have recognised this a long time ago and put in place regulations that limit working hours to improve safety.

The College published standards to address safe working hours in 2007 for fellows, trainees and IMG’s as follows: normal working hours should be less than 70 hours per week, on calls no more than 1:4 rotation and day and night shifts a maximum of 14 and 12 hours respectively. A recent RACS workforce survey showed that fellows work on average 51 hours per week plus on call and I guess surgical trainees would clock up around 70 hours plus depending on the surgical speciality and call roster.

The College, through ASERNIP-S, recently carried out a systemic review on the effect of fatigue on surgeon performance and surgical outcomes. The findings unfortunately were that there is paucity of high quality research in this field. The available evidence shows that there does not seem to be a clear link between sleep deprivation or fatigue and clinical, academic and cognitive performance. Psychomotor performance may or may not be affected. It appears that fatigue can be compensated for in the operating room setting but more research is required before any definitive conclusion can be drawn.

When you talk to surgeons and ask how they are you get the stereotype answer “I’m busy”. On one hand we are encouraged to reduce our working hours but on the other hand, as a result of serious surgeon shortages, particularly in the smaller centres, our colleagues are constantly asked to do extra duties. In addition we are constantly asked to be more efficient.
i.e. increase clinical throughput without using additional resources and it is this constant pressure of increasing workload and the lack of time which generates stress.

We now acknowledge that technical as well as non technical skills like communication, teamwork and decision making are important factors in surgical performance and it seems that all these skills can be compromised by mental stress experienced by surgeons.

Stress is defined as bodily processes that result from physical and psychological demands on an individual that outweigh the perceived resources to cope. Common stressors in surgery are technical complications, time pressure, distractions, interruptions, complaints and increased workload.

A recent large survey of surgeons in the US has revealed that 40% of respondents indicated that they were ‘burnt out’ which is a psychological term referring to emotional exhaustion leading to decreased effectiveness at work (Annals of Surgery, 250, 463-471). Stress has a negative effect on the quality of surgical care and increases the risk of error and adverse outcome. It is clear that surgery is a stressful occupation and this needs to be acknowledged by the surgical community. We need to make sure that our trainees are prepared for this through specifically designed training modules which will allow them to learn and practice stress management skills. Our Fellows also need to be reminded to look out for early warning signs of stress and deteriorating surgical performance.

A recent systematic review by Arora et al (Surgery, volume 147, 2010) divided stressors into technical (related to the surgical procedure) and non technical (related to human factors like distraction, time pressure, personality issues etc). There is no perfect tool to measure stress directly. The only way to quantify stress is to measure its effect on surgeon’s perceptions of themselves (subjective) or their physiological state (objective).

There are no validated subjective stress assessment tools designed for surgeons and the most widely used objective measure of stress is heart rate. The mean heart rate has been shown to increase during surgery but less so in senior versus junior surgeons. Greater stress levels have been reported in laparoscopic versus open surgery but none of the studies has shown a correlation between increased stress and poorer performance. The effect of distraction is interesting. A number of studies have shown that distraction correlated with poorer performance as measured by increased operating time and number of errors.

Overall research on the effect of stress on surgical performance is limited but there appears to be some link between stress and performance. This obviously has implications for patient safety and surgeons need to be aware of this potential consequence. As far as training is concerned we have to make sure we select young doctors who have adequate stress and coping skills and our training programmes should include stress management modules. Some of that training can be carried out using simulation to avoid placing patients at risk.

So what are the coping strategies surgeons use to deal with stress. There are quite a number and they are divided into task-orientated, emotion-orientated and avoidance (through distraction or social diversion). Most senior surgeons use them quite effectively but that might not be the case for our trainees and junior colleagues. Early recognition of stress symptoms is very important and without insight stress will insidiously pervade the surgeon’s professional and personal life leading to burn out and all its detrimental effects. Surgeons are well trained to deal with intra operative crisis situations but it is the chronic stress of excessive workload which puts the surgeon and sometimes patients at risk.

It is time that the surgical community acknowledges that stress and burn out is an increasing problem amongst our colleagues and as a College we have a duty to put in place safety nets through stress awareness programmes, stress management training and peer support. Stress in the workplace is a health and safety issue and it is also the responsibility of our employers to make our work environment as stress free as possible.

This is my last editorial as my term as Chairman of the New Zealand National Board comes to an end next month. It was a privilege for me to lead the Board over the last 2 years and without the help of all the Board Members as well as Justine Peterson and Allan Panting I couldn’t have done it. For that I must sincerely thank you. I thoroughly enjoyed my time as Chairman and my ultimate task is to hand over the reins to John Kyngdon and wish him well for his term.

Jean-Claude Theis
Chairman
New Zealand National Board

Update on Overseas Connections

Professor John Collins FRACS, former Dean of Education of the Royal Australian College of Surgeons and now the Chairman of the Independent Review of the UK Foundation Programme (in England) has recently been awarded a Hunterian Professorship by the Royal College of Surgeons of England. Along with this, Professor Collins will receive an Honorary Fellowship of the Royal College of Surgeons of Ireland.
I can hardly claim to make a living from the use of words (though an occasional book commission does help put bread on the table) but I devote enough time to putting words together to notice certain trends which do not, I fear, augur well for the future of the language.

These trends involve both spoken and written language. I have railed in the past against the barbarians – a few colleagues, the occasional candidate who displays a lack of the very observational powers that surgeons are supposed to possess, and far too many radio commentators – who pronounce ‘dissection’ as ‘die-section’, who thus offend against one of the most basic rules of English pronunciation: that the vowel ahead of a double consonant becomes short. More recently another barbarism has crept into pronunciation; this too affects radio and television newsreaders: the use of ‘thuh’ ahead of a vowel, instead of ‘the’. ‘Thuh cat sat on thuh mat’ is good basic Doctor Seuss stuff; but Dr Seuss would never countenance ‘Thuh interviewer is on thuh intercom.’ It comes over as a crude form of hiccups.

But written language is also doing itself mischief by taking on ‘variant’ definitions, with the unfortunate consequence that words which have a specific and useful connotation are robbed of this by their misapplication. It is a process that falls short of frank Malapropism, and is therefore more subversive of clear English.

Let me illustrate: a generation ago ‘problematic’ meant concerning because uncertain; these days it has become common enough in the crude sense of difficult to deprive ‘problematic’ of a meaning that is specific to it. Those people who speak of a situation as problematic, when they simply mean difficult, lay waste to a useful word-meaning.

The same process is beginning to affect ‘fortuitous’ which is increasingly being used where the correct word is ‘fortunate’. These two words are not synonyms: ‘fortuitous’ carries a payload of coincidence, ‘fortunate’ of a happy outcome. If a spring high tide coincides with heavy rain in the hinterland, the event may be fortuitous but the outcome for dwellers near the mouth of the river is hardly fortunate.

As I write the College is in process of gaining a new Constitution. We are told it will set out the principles which drive the College, in plain English and without the legalese of a past century. This is a commendable ideal, and it is only fair to acknowledge that the architects of change have consulted widely – and for the most part have responded to suggestions on the drafting of the document. But for outdated legalese they have substituted a certain amount of word-mangling. In particular the verb ‘effect’ which, in olden times, meant simply to bring about, accomplish (as in ‘to effect a cure’) is here used as a synonym for ‘achieve’, and we are invited for instance to examine nine subheadings under which the ‘purpose’ of the College will be ‘effected’. We are invited to go through this same linguistic process on a number of occasions in the explanatory article in the latest Surgical News.

At least the final document does allow the College a ‘purpose’ (the draft did not, and I claim a share of the credit for its introduction). The Founders used the term ‘objects’ in their Memorandum of Association, and their first object was ‘to cultivate and maintain the highest principles of surgical practice and ethics’; now we have a four-item purpose, but hardly a series to convey inspiration to the reader. Indeed I am mischievous enough to propose that the document is not bad enough to reject, but not good enough to inspire.

Perhaps I have been reading too much of the speeches and writings of Sir Winston Churchill, in my study of his medical history over recent years. But I do feel a certain nostalgia for the ability of his words to inspire and encourage an entire nation.

I think I should collaborate with my Latin American colleague, Professor Lex y Cografa, with a view to producing a compendium of mangled words, which can serve as a warning to the English-Speaking Peoples whose history Churchill wrote between the Wars, only to have its publication delayed by greater events.

New Zealand Honours 2010

New Years
Officer of the New Zealand Order of Merit (ONZM)
Professor James Geoffrey Horne - for services to medicine

Members of the New Zealand Order of Merit (MNZM)
Dr Daniel Charles Sundersingh Devadhar - for services to medicine and the community
Mr David William Sabiston – for services to ophthalmology and the community

Queens Birthday
Member of the New Zealand Order of Merit (MNZM)
Mr John Cameron Cullen - for services to medicine
The Plenary Session "Professionalism in Surgery" was just one of many excellent sessions at the recent Annual Scientific Congress in Perth. Three thought provoking 20 minute papers by Thomas Dehn (Reading, UK), Kingsley Faulkner (Perth, Australia) and Linda De Cossart (London, UK) formed the basis of this session, which was concluded with a panel discussion. Linda de Cossart encouraged the consideration of what “profession” and “professionalism” meant and how this influenced our behaviour. This discussion was timely as it reflects the recent concerns of the RACS Council and the Professional Development and Standards Board. The College Code of Conduct policy will be subject to review this year (having been last reviewed five years ago), and it is likely that this will correlate closely with the Australian Medical Council and the Medical Council of New Zealand codes of conduct, but with the addition of some clauses more specific to surgeons.

There are numerous definitions of a “profession”, but that found in Wikipedia is as good as any – “a profession is a vocation, founded upon specialised educational training, the purpose of which is to supply disinterested counsel and service to others for a direct and definite compensation, wholly apart from expectation of other business gain. A profession is characterised by the power and high prestige it has in society as a whole and it is the power, prestige and value that society confers upon a profession that more clearly defines it.” Professions tend to be autonomous, with a high degree of control of their own affairs. Professional bodies have power and tend to insist upon self-regulation, are relatively independent of government and usually have codes of conduct or ethics for the members and disciplinary procedures for those who infringe the rules. Members of the profession – “professionals” - are autonomous in so far as they can make independent judgements about their work. Professionals enjoy a higher social status and esteem within society, arising primarily from the higher social function of the work, which is valued as vital to society as a whole.

Professional autonomy which is an essential characteristic of the concept of professional ideology is based on three principles.

- The work of professionals entails such a high degree of skill and knowledge that only fellow professionals can make an accurate assessment of professional performance.
- Professionals are characterised by a high degree of selflessness and responsibility, and can be trusted to work conscientiously.
- In the rare instance in which individual professionals do not perform with sufficient skill or conscientiousness, their colleagues may be trusted to undertake the proper regulatory action.

Members of the medical profession are bound by a number of codes of conduct beginning with the Hippocratic Oath and including the Declaration of Geneva and the International Code of Medical Ethics issued by the World Medical Association. These codes focus particularly upon the doctor-patient relationship. The Medical Council of New Zealand Code of Conduct faced little penalty as the College lacks the resources to undertake formal investigation to determine guilt or innocence. The recent introduction of the Breach of Code of Conduct policy recognises these inherent difficulties and following a complaint, without formally adjudicating upon guilt or innocence, asks the fellow/s to sign a statutory declaration that they will henceforth comply with the College Code of Conduct. While some might see this as a relatively mild response, it must be noted that a second complaint may result in withdrawal of fellowship of the College - a very significant penalty.

As leaders within our society, we have a position of privilege and esteem. With privilege comes responsibility and while a high standard of behaviour is expected with each professional interaction there is an expectation of a similarly high standard in all other spheres of life. Society’s requirements of the professional are higher than those of the community as a whole and it is vital that we strive to meet those expectations.

1. patient’s trust their doctors because they believe that in addition to being competent, the doctor will not take advantage of them.
2. doctors will display qualities such as integrity, truthfulness, dependability and compassion.
3. in professional life, doctors must display a standard of behaviour that warrants the trust and respect of the community.
4. at all times a doctor’s conduct should respect their patient’s trust in them and the public’s trust in the profession.

Council has been concerned that there have been instances when individual Fellow's failure to adequately meet the fourth expectation has resulted in public criticism of the College and the profession. This is damaging to the concept of professionalism and reduces society's esteem for the medical profession, the College and its fellows. Until recently, Fellows who failed to meet the requirements of the Code of Conduct faced little penalty as the College lacks the resources to undertake formal investigation to determine guilt or innocence. The recent introduction of the Breach of Code of Conduct policy recognises these inherent difficulties and following a complaint, without formally adjudicating upon guilt or innocence, asks the fellow/s to sign a statutory declaration that they will henceforth comply with the College Code of Conduct. While some might see this as a relatively mild response, it must be noted that a second complaint may result in withdrawal of fellowship of the College - a very significant penalty.

References on page 5
79th Annual Scientific Congress in Perth, May 2010

Professionalism in Surgery
Continued from page 4

1. Thomas Dehn (Reading, UK), Paper RACS ASC Perth 2010, Not so perfect-facing up to our problems
2. Kingsley Faulkner (Perth, Australia), Paper RACS ASC Perth 2010, Who will want to be a surgeon?
4. wikipedia.org/wiki/Profession
New Zealand National Board Election Results

Congratulations to Jonathan Koea, General Surgeon from Auckland, who has been elected to fill the vacant position. Mr Koea will take on this role from 1 July 2010.

We also welcome the new specialty representatives to the Board, those people are:

- Agadha Wickremesekera for Neurosurgery
- Rob Robertson for General Surgery
- Bryan Thorn for Orthopaedic Surgery

And lastly a big thank you to the following people who have now stepped down from the Board:

- Nicholas Finnis, was the Neurosurgery representative
- Rod Maxwell, was a general elected member as well as being a co-opted member
- Helen Tobin, was the Orthopaedic Surgery representative
- Stephen Vallance, was the General Surgery representative

The provision of acute care throughout New Zealand is a challenge for all surgeons. This 1½ day meeting will explore ways in which New Zealand surgeons can meet this challenge.

Surgery 2010: Challenges in Acute Care

19 & 20 August 2010

Crowne Plaza Queenstown

This meeting is the “revamped” New Zealand ASM. It is designed to be of interest and value to fellows and trainees in all nine specialties.

You can send your completed registration to PO Box 7451, Wellington or fax to 04 385 8873 or email to college.nz@surgeons.org

A registration form is enclosed.
Emeritus Professor John Parr was born in Roxburgh, Central Otago in 1922, the son of the headmaster of the local school who had himself graduated from Otago University with a Masters degree in ‘Mental Sciences’. The family later moved to Dunedin where John was to study medicine at the Otago Medical School.

John excelled at medical school, graduating MB ChB in 1945 and winning the University of New Zealand travelling scholarship in Medicine. He remained in Dunedin for the next few years, working as a House Surgeon at Dunedin Public Hospital before becoming a demonstrator in the Anatomy Department. During this time he worked with Murray Falconer, who was keen that John should train as a neurosurgeon. Although tempted, John decided in favour of Ophthalmology, reflecting the significant influence of Rowland Wilson, with whom he had worked as a house surgeon.

In 1949 John took up his Travelling Scholarship and worked at the newly established Institute of Ophthalmology in London, completing the Diploma of Ophthalmic Medicine and Surgery (DOMS) in early 1950. He became a registrar at Moorfields Eye Hospital in 1951 and then Senior Resident Ophthalmologist in 1952. During this period of training he obtained the newly introduced Fellowship in Ophthalmology. Parr described the Moorfields training as predominantly surgical with insufficient emphasis on medical ophthalmology and related topics such as neuro-ophthalmology. However the surgical training was internationally recognised, this being the era of giants, including Hyla Stallard, an Olympic medallist, whose textbook “Eye Surgery” is a classic, Sir Harold Ridley, the pioneer of intra-ocular lenses and Lorimer Fison. John met his first wife, Diana Cretney, in London where she was a nursing sister and they married in 1952.

For reasons of patriotism rather than opportunity John returned to New Zealand in 1952, working part-time as an ophthalmic surgeon at Dunedin Public Hospital and as a Lecturer in Clinical Ophthalmology at the University of Otago Medical School and establishing a private practice. Parr’s Dunedin colleagues were Rowland Wilson and Gair MacDonald. When Wilson retired in 1961 Parr gave up private practice and succeeded him as full time senior ophthalmologist at Dunedin Hospital and senior lecturer in ophthalmology, University of Otago. He became an Associate Professor in 1968 and in 1977 was elevated to a Personal Chair in Ophthalmology.

Despite working in a small, isolated city with a heavy load of teaching medical students, Parr made many contributions to New Zealand ophthalmology. His foremost contribution was to education, not only of medical students, but of registrars training in his department. Parr’s contribution to education in ophthalmology became worldwide with the publication of his undergraduate textbook ‘Introduction to Ophthalmology’ by The University of Otago Press. It received favourable reviews including in the New England Journal of Medicine, and by Trevor Roper in The British Journal of Ophthalmology. Now in its third edition it has been adopted by The Oxford University Press and remains in print. John Parr is also quoted extensively in the small pocket “bible” of most house surgeons, The Oxford Handbook of Clinical Specialties.

In clinical practice Parr’s strength was in the field of medical ophthalmology, and he completed significant research in retinal and optic nerve blood flow. Indeed he was very knowledgeable in all aspects of ocular physiology. Pioneering work with fluorescein angiography and subsequently diabetic retinopathy screening, each resulted in an improved outcome for many patients with potentially blinding eye diseases. John’s research into hypertensive retinopathy has enjoyed a recent renaissance with his work on retinal A/V ratios being revisited by both the Blue Mountains Eye study and the Beaver Dam study.

John established the Education and Qualification committee of the Ophthalmological Society of New Zealand in 1975, and remained its chairman until 1982. This committee oversaw registrar selection and training programmes throughout New Zealand. In 1982 Parr established a six week residential course in basic sciences of ophthalmology designed to prepare candidates for the part one examination of The Royal Australasian College of Surgeons and The Royal Australian College of Ophthalmologists, as the latter was then known. While only 9 candidates attended the first course, it grew to attract over 30 candidates a year from all over New Zealand and Australia until it ceased in 2001, to be replaced by the current diploma in ophthalmic basic sciences.

Parr lamented the difficulty of attracting staff to Dunedin
because of its relatively small population that could not support a number of privately practicing ophthalmologists. In Parr's Presidential address to The Ophthalmological Society of New Zealand in 1965, he spoke in support of employing medical auxiliaries, optometrists, and orthoptists. As Parr said, why use ophthalmologists who take thirteen plus years to train to do tasks which can be done by others appropriately trained? At the time this was bitterly opposed by many of his colleagues, both in New Zealand and Australia, but time has proved Parr was right, and the employment of optometrists and orthoptists is now accepted.

John Parr was President of the Ophthalmological Society of New Zealand in 1965. In 1996 the Royal Australian College of Ophthalmologists, honouring his vast contribution over many years to the advancement and teaching of ophthalmic basic sciences in Australia and New Zealand, gave his name to a Travelling Scholarship awarded to a candidate exhibiting excellence in the Part I Examination. The John Parr prize, awarded to the top final year medical student in ophthalmology, is named in his honour. In 2008 he was honoured by the Royal Australian and New Zealand College of Ophthalmologists with its Distinguished Service Medal.

John's first wife, Diana, died in 1994. John is survived by his second wife, Margaret Swan, who was at one time Deputy Matron of Dunedin Public Hospital, and his only daughter of the first marriage, Alison, who is well known in New Zealand as a broadcaster, oral historian and author.

Obituary prepared by Assoc Prof Gordon Sanderson, Otago Medical School; and edited for RACS by Allan Panting FRACS

---

Conjoint Australia & New Zealand Upper GI & HPB Meeting

28 & 29 September 2010
Millennium Hotel, Queenstown

Keynote Speakers are;
Dr John G Hunter
Professor Attila Csendes
Professor William R Jarnagin

Please visit www.queenstown2010.co.nz for updated meeting and programme information!

---

The 36th Annual Scientific Meeting of the New Zealand Pain Society Inc.

17 & 20 March 2011
Hotel Grand Chancellor, Christchurch

For further information go to – www.nzps.org.nz
Warwick passed away on the ninth of February in the company of his wife Elizabeth, children Peter, Rebecca, Sarah, Josephine and his grandchildren.

Warwick was educated at Wanganui Collegiate and gained his medical degree in Melbourne, receiving the Ryan Prize in Surgery in 1943. He was a Captain in the New Zealand Medical Corps 1945-46 and Surgeon Lieutenant in the RNZNVR from 1950-55.

Postgraduate study was undertaken in Melbourne in 1947, gaining his Master of Surgery that year and also being awarded the Gordon Craig Scholarship. Further post graduate study followed in England where he passed the FRCS in 1947. He specialised in Urology working at the Westminster Hospital. He was awarded the FRACS in 1950 and throughout his life was dedicated to the advancement of what he referred to as the craft.

Warwick returned to New Zealand and was Tutor Specialist in Surgery at Greenlane Hospital 1950-51. He was then appointed Visiting Urologist in Auckland Hospital, becoming senior Urologist and Head of Department until he retired in 1985. He set up the Ormond clinic with consulting rooms and day stay capability for private Urology at a time when the term day stay had not been coined. The Ormond clinic was a nurturing ground for younger consultants for some thirty years.

Warwick was very proactive in both College and Urological Society affairs. He served on the New Zealand Committee of the College from 1955-1963, College Council 1965-1977 and was Vice President 1975-1977. He was an examiner in Urology 1966-75, New Zealand Censor 1975-77, and a member of the Court of Honour 1981-2010.

Warwick was on the Executive of the Urological Society and President in 1965-1966. He hosted the Society's Annual Conference in Auckland in 1966 and invited David Innes-Williams, a Paediatric Urologist, to not only be guest speaker at the meeting but also to work in the Auckland Unit for four weeks.

Warwick was instrumental in establishing the Marion Davis now the Ernest and Marion Davis Memorial Library which was the original Post graduate medical library in Auckland, and became the home of the College and sister Colleges in Auckland. This was not only a library but also a conference centre.

He was Visiting Medical Officer to the Crippled Children's Society (Dadley Foundation) from 1966-72 and was also co-founder and Director of the Southern Cross Medical Society, serving as Chairman. He was a director of Brightside and Huia hospitals. Outside medicine Warwick was instrumental in the founding of St. Kentigern School and was its Chairman for many years.

Warwick had a lifelong love of sailing and his yacht “Ilex” was the place where his children and grandchildren learned to sail, two going on to become world champions. In this as in all his life he was ably supported by his wife Elizabeth.

His was a life of immense service, he was always the gentleman but did have a somewhat impish sense of humour. His wisdom and mentorship has been personally valued over the years and will be sorely missed.

Vale Warwick Macky

Obituary prepared by Russell Melbroy FRACS
To the following New Zealand Trainees and International Medical Graduates who recently passed the Fellowship Examinations held in Auckland and in Sydney.

ORTHOPAEDIC SURGERY
Stephen Andrews  
Godwin Choy  
Kristian Dalzell  
Hamish Deverall  
Nigel Hartnett  
Warren Leigh  
Nigel McCoubrey  
Arvind Puri  
Fraser Taylor  
Angus Wickham  
Nichola Wilson  
Albert Yoon

GENERAL SURGERY
Antonio Foliaki  
Nigel Henderson  
Aleksandra Popdich  
Jonathan Potter  
Peter Shin  
Maree Weston

CARDIOTHORACIC SURGERY
Dominic Parry

VASCULAR SURGERY
Anantha Ramanathan

OTOLARYNGOLOGY, HEAD & NECK SURGERY
Nalaka De Silva  
Shashinder Singh

UROLOGY
Muthuthantrige Fernando  
Andrew Lienert
In 2010 the College is offering exciting new learning opportunities designed to support Fellows in many aspects of their professional lives. PD activities can assist you to strengthen your communication, business, leadership and management abilities. With a July workshop in Wellington, please make the most of this opportunity to benefit from this valuable training.

Mastering Difficult Clinical Interactions
23 July 2010, Wellington

Difficult people and situations are often the biggest stressors for healthcare professionals yet the responsibility of many clinical jobs makes these encounters unavoidable. This whole day workshop examines the cause of difficult interactions and presents a proven step-by-step approach for dealing with these situations. It is designed to give you confidence in handling difficult patient interactions and focus on finding effective solutions by practising specific communication skills in a safe environment with a trained actor.

Further Information
Please contact the Professional Development Department on +61 3 9249 1106, by email PDactivities@surgeons.org or visit the website at www.surgeons.org - select Fellows then click on Professional Development.

Support for Surgeons Group - Contact Details

The following surgeons can be contacted to provide support for colleagues experiencing stress for whatever reason. This is a confidential service. Names are organised by specialty but contact does not need to be restricted to a colleague from the same specialty.

Orthopaedic Surgeons
Allan Panting
Ph: 03 548 3455
Ian Peters
Ph: 021 989 416
Email: ipeters@nhl.co.nz
Chris Dawe
Ph: 07 578 1211
Email: cldawe@xtra.co.nz
John Dunbar
Ph: 03 454 3432
John Cullen
Ph: 09 488 0222
Nigel Willis
Ph: 04 233 0886
Email: nigelwillis@xtra.co.nz
Roy Craig
Ph: 04 976 0218
Email: royandjosie@slingshot.co.nz

General Surgeons
Murray Pfeifer
Ph: 03 214 4207
Mobile: 027 488 0875
Email: mjpfeifer@xtra.co.nz
Pat Alley
Ph: 021 285 2990
Email: pat.alley@waitematadhb.govt.nz
John Kyngdon
Mobile: 021 276 5724
Email: John.Kyngdon@bopdhb.govt.nz

Otolaryngologist
Cathy Ferguson
Ph: 04 971 6011
Mobile: 021 472 772
Email: dfcm.urology@clear.net.nz

Vascular Surgeon
Ross Blair
Ph: 07 858 0755
Email: rdblair@wave.co.nz

Neurosurgeon
Edward Mee
Ph: 09 520 9672
Email: Edward.mee@xtra.co.nz

Urologists
David Mason
Mobile: 027 442 8916
Email: dfcm.urology@clear.net.nz
John Cadwallader
Ph: 09 623 0161

Cardiothoracic
Dick Bunton
Mobile: 027 221 8468
Email: dickb@es.co.nz
Email your contributions to: college.nz@surgeons.org
Our deadline for Issue No. 36 is 20 August 2010

Royal Australasian College of Surgeons
NZ National Board, Elliott House, 43 Kent Terrace
PO Box 7451, Wellington South 6242, New Zealand

Executive Director of Surgical Affairs - NZ
Allan Panting
Allan.Panting@surgeons.org

Skills Training/Basic Surgical Training
Rachel Turner
Rachel.Turner@surgeons.org

Surgical Education and Training
Linda Porter
Linda.Porter@surgeons.org

Accounts
Raji Divekar
Raji.Divekar@surgeons.org

Projects and Executive Support
Sarah Horn
Sarah.Horn@surgeons.org

Specialist Societies and Accounts
Celia Stanyon
Celia.Stanyon@surgeons.org

General Administration/Reception
Andrea Lobo
College.NZ@surgeons.org

NZ NATIONAL BOARD
Chair
Jean-Claude Theis
Deputy Chair
John Kyngdon
Honorary Treasurer
Nigel Willis

OFFICE OF THE NZ NATIONAL BOARD
Elliott House
43 Kent Terrace
Wellington South 6011
New Zealand
Tollfree (NZ only) 0800 787 469 / 0800 SURGNZ
Phone: +64 (4) 385 8247
Fax: +64 (4) 385 8873
Email: College.NZ@surgeons.org

NZ SECRETARIAT
NZ Manager
Justine Peterson
Justine.Peterson@surgeons.org

The Cutting Edge is published 4 times a year.
VIEWS EXPRESSED BY CONTRIBUTORS ARE NOT NECESSARILY THOSE OF THE COLLEGE