FROM THE CHAIR

Choices...

Last week I found myself caring for an elderly Maori lady who was clearly in her last days. As the whanau gathered around I spent a little time chatting to them, trying to offer what comfort I could. One of the daughters was a middle-aged woman who had come back to NZ from her home in Australia to be with her mother at the end. As we talked about her mother’s situation she expressed that she had been through similar emotional stress about a year before with her husband’s death. When I offered my sympathy for that, she stated quite simply that his death was in large part due to his poor health choices.

I picked up on this, in the light of the coming election and the promises that all parties make about their provision of health care, I asked her what she thought the politicians could do better to improve healthcare in this country. Is it education? Is it the basics of warm, safe, healthy housing? Is it better nutrition? Is it more funding to access medical care? She agreed that improvements in all of those areas would be helpful but, and this quite surprised me, she pointed out very practically that even with the best of all of these resources, people still have freedom of choice and that allows them to make good choices or bad choices. She clearly felt that her own husband’s health was far more due to his choices in life than his lack of opportunities.

Frankly I found this approach very refreshing. Too often we hear about how society has let people down or how it is the fault of the "system", the medical establishment, that the underprivileged have worse healthcare. It was rewarding to hear someone on the receiving end of health services espousing the need for people to take more responsibility for their own choices in lifestyle and healthcare. Having said this, there is much we could do to improve the health care of those who are less fortunate. The continuing inequities in surgical outcome of the socio-economically deprived (and this particularly applies to Maori) have recently been pointed out by the annual POMRC report on perioperative mortality.

Choice remains a major issue. People, even with resources and information, will continue to make poor choices and perhaps it is in this regard that we have an opportunity to improve outcome. We should empower people to make choices but also assist them to make the right choices. Every time I go to the supermarket I find myself just about overwhelmed with the range of choice present. Simply selecting a loaf of bread or the "right" breakfast cereal can be hard work. Medicine is really not that different. We have an enormous range of choices and options available to us. Many of those are promulgated by people or companies with a vested interest in a financial outcome.

As doctors and surgeons, we need to help patients make choices that are the best in terms of outcome not only for them but also for the society that we live in. In the public health sector, and largely in private as well, we are obligated to be as fiscally responsible in these choices as we can.

There is help. Choosing Wisely is an international initiative which commenced activity in New Zealand in December 2016. Run by the Council of Medical Colleges it has the backing of The Health Quality & Safety Commission and Consumer NZ with
FROM THE CHAIR (continued)

further support from numerous medical organisations and colleges, the Ministry of Health and Pharmac.

Choosing Wisely has promulgated a wide range of guidelines which continue to expand. As well as an initial contribution from our General Surgery colleagues there has recently been an addition from the New Zealand and Australian Societies of Otolaryngology Head and Neck Surgery. The full list of guidelines have a range of applicability that would render them useful for every doctor making clinical decisions in this country.

And as far as the General Election goes? Well I’m certainly not going to tell anyone who to vote for. The NZ National Board did try to evaluate the approach of the various political parties on some of the major health issues facing NZ, by sending a questionnaire to each party. At the time of writing four parties have responded – their answers will be collated and distributed in the near future. Let’s hope that the outcome on September 23rd will be based on evaluation of the options, and not just a knee-jerk reaction for “change at whatever cost” that seems to have prevailed in the UK and USA in the past year. I wish all of you the best in choosing a government that will aspire to deliver the fairest, most sustainable and highest quality health care system possible.

Note: at the time of publication 7 of the 8 parties had responded

RACS Extends Support Program to immediate family members of Fellows, Trainees and IMGs

Did you know that all RACS Fellows, Trainees, International Medical Graduates and members of their immediate family or household can access the RACS Support Program (RACSSP)? The program is provided by Converge International, a leading Employee Assistance Program provider, where members can access confidential support via counselling, coaching and advice on workplace, emotional and personal issues. When you contact the RACSSP you always speak with a qualified mental health professional. Consultants are registered psychologists and counsellors, and have extensive experience in their specialty areas with a deep knowledge of, and experience in providing care to people who work in the healthcare sector. Converge has also recently launched its EAP Connect app – download this today on your smartphone.

More information is on the RACS website

SAVE THE DATE

SURGERY 2018

9 - 10 August 2018
Rydges Lakeland Resort
Queenstown

Contact
T +64 4 385 8247
E college.nz@surgeons.org
In a change of scenery from past years, New Zealand’s 2017 Annual Surgical Meeting, Surgery 2017, swapped the mountains of Queenstown for the harbour of Wellington. The theme of Surgery 2017 was Future Proofing Surgical Practice and was held on the waterfront at New Zealand’s national museum Te Papa. Despite the capital’s notorious wind initially disrupting flights into the city and Auckland’s fog delaying some on the second day, the event was an excellent two days of engaging presentations as attendees considered the challenges and opportunities facing the future of their practice and surgical care. This was punctuated by an enjoyable welcome function at Te Papa, followed by the conference dinner at the excellent Te Wharewaka, located right beside the harbour.

Surgery 2017 featured a fantastic International Speaker in Professor Taylor Riall, Acting Chair of the Department of Surgery at the University of Arizona, who gave three outstanding presentations. These included opening the first day with a talk on the effect that technology, regulation and extensive subspecialisation was having on surgical training and practice in the USA. Professor Riall also presented on the impact of personalising medicine to the patient and spoke on the importance of maintaining a work-life balance as a surgeon, drawing on her experience as a professional life coach.

The future orientated theme of Surgery 2017 lent itself to a varied and interesting programme, which was highlighted by the diverse range of subjects discussed over the course of the meeting. This included sessions on the future of surgery and training in the USA, Australia and NZ, health equity, cultural competence and unconscious bias, and methods to improve teamwork and performance.

There was also a session on climate change titled Environmental Challenges and Opportunities. Climate scientist Dr James Renwick provided an excellent, albeit unsettling, overview of climate change, its causes and the consequences of our current trajectory. This was followed by Professor Alistair Woodward speaking on climate change as a health issue, including the proliferation of tropical diseases, its impact on food supplies and the results of social disruption. The news was not all negative however, Professor Philippa Howden-Chapman presented on the impact that good urban design can have on promoting health; and anaesthetist Dr Forbes McGain spoke on the many initiatives that clinicians at Western Health in Melbourne have implemented to help reduce waste and their carbon footprint.

The meeting concluded with a valuable session on Resilience and Wellbeing which had a strong focus on the importance of maintaining one’s own health while practicing medicine. This message was reinforced with a humorous but thought-provoking presentation from Plastic & Reconstructive Surgeon Dylan James who spoke on his personal experiences as a patient in the health system. Excellent talks were also given by past-Chair of the New Zealand Medical Association, Dr Stephen Child, on the health of the doctor, and intensivist Dr Carl Horsley on building team resilience. Surgery 2017 was concluded with a final presentation by Professor Taylor Riall, a highly beneficial talk on the role that mindfulness and emotional intelligence plays in surgeon well-being and optimal performance.

Looking ahead to next year, Surgery 2018 will be returning to Queenstown on 9 and 10 August. We hope to see you there!

Surgical Pioneers

Held the day prior to the NZ conference, Surgical Pioneers is a keenly anticipated annual fixture for history enthusiasts. It provides an opportunity to learn about and discuss the pioneers of surgery in New Zealand.

As has become the standard, the programme was filled with captivating presentations. Bill Sugrue spoke on Hugh Acland, the scion, surgeon, soldier and public servant; Wyn Beasley on the six founders of the then “College of Surgeons of Australasia (which includes New Zealand)”; Ross Blair on NZ Hospitals in Egypt and the UK during WWI; Stephen Vallance on George Cleghorn, who brought many advances in procedures and techniques to NZ surgical practice; and Stephen Packer on Sir Gordon Bell, the second professor of surgery in NZ and wartime surgeon.

We were very privileged this year to be joined by Dr Christopher Pugsley, a former Lieutenant Colonel in the New Zealand Army who is regarded as New Zealand’s pre-eminent military historian. Dr Pugsley gave a riveting and impassioned presentation on the Battle of Passchendaele in WWI and the tremendous obstacles that the medical services had to overcome in that campaign.

Surgical Pioneers will again be held the day before Surgery 2018. We warmly welcome anyone with an interest in history to join us then!
Continued from Page 3

Louis Barnett Prize

A yearly fixture of the NZ ASM is the Louis Barnett Prize, in which young researchers (being surgical trainees or Fellows under the age of 40) present and answer questions on their research. All eight presenters at Surgery 2017 were exceptional, with the judging panel (Nicola Hill, Taylor Riall and Nigel Willis) noting that any one of them would be deserving of the prize. The overall winner on the day however was orthopaedic Trainee Dr Ryan Gao with his presentation *Lactoferrin Increases Bone Regeneration in a Rat Critical-sized Calvarial Defect Model*. Dr Renus Stowers, also an orthopaedic Trainee was highly commended for his presentation *Tranexamic Acid in Knee Surgery (TRACKS) Study*.

68.7% of Fellows, Trainees and IMGs in New Zealand have completed the mandatory e-learning module. Please don’t put your CPD in jeopardy! If you have completed this valuable online course already – thank you! To those who haven’t time is running out! Please log in to the RACS website to complete this.

The module is designed by surgeons for surgeons with input from experts to help us identify inappropriate behaviour and build a culture of respect and excellence.

Please contact the NZ office with any queries College.NZ@surgeons.org or 04 385 5691.

These manuals and those listed below are available on our website http://www.surgeons.org/policies-publications/publications/ or you can contact the NZ Office for a copy to be sent to you.

- Code of Conduct
- Preparation for Practice
- Bullying & Harrassment - Recognition, Avoidance and Management

These manuals and those listed below are available on our website http://www.surgeons.org/policies-publications/publications/ or you can contact the NZ Office for a copy to be sent to you.

- Code of Conduct
- Preparation for Practice
- Bullying & Harrassment - Recognition, Avoidance and Management
At the Surgery 2017 Welcome Function

L-R Judith Potter, Ian Burton, Elizabeth Ritchie

L-R Andrew Kennedy-Smith, Cathy Ferguson, Stu Gowland

L-R John Lengyel, David White, Jaclyn Aramoana, Russell Blakelock

L-R Jonathan Wheeler, Rita Yang, Sally Langley

L-R – Andrew Connolly and Richard Reid

L-R Rod Maxwell and Lawrie Malisano

L-R Philippa Mercer, Convener and Taylor Riall

Patrick Medlicott, Ross Pettigrew, Catherine Pettigrew
Overlapping and Concurrent Surgery

Following a flurry of opinions in the popular press and in the medical literature and the need to update a RACS position paper, RACS research was tasked to review the literature on overlapping and concurrent surgery and a report was produced in January this year.

Concurrent surgery is where the critical portions of a procedure overlap and the primary surgeon circulates between the two cases, whereas overlapping surgery is where critical portions do not overlap and the surgeon migrates from one theatre to the next after the critical portions have been completed in the first theatre.

The Boston Globe’s Spotlight Team featured a story on overlapping and concurrent surgery in late 2015 on orthopedic surgeon Dr Kirkham Wood. The facts were as follows:

Dr Kirkham Wood arrived in the operating room at Massachusetts General Hospital before 7am one August morning with a schedule for the day that would give many surgeons pause. Wood, chief of MGH’s orthopedic spine service at the time and a nationally renowned practitioner in his specialty, is a confident, veteran surgeon. He would need all of his talent and confidence this day, and then some, as he planned to tackle two complicated spinal surgeries over the next many hours — two patients, two operating rooms, moving back and forth from one to the other, focusing on the challenging tasks that demanded his special skills, leaving the other work to a general surgeon, who assisted briefly, and two surgeons in training.

Waiting for Wood in operating room 72 that day in 2012 was Tony Meng, a 41-year-old father of two from Westwood who had been diagnosed that summer with a serious degenerative condition that constricted his spinal cord, causing pain, tingling, and numbness. To relieve the symptoms, the surgeon would have to slice through the front of Meng’s neck, navigate around arteries that supply blood to the brain, and remove parts of his vertebrae. Then, he would turn Meng over onto his abdomen and operate some more.

Down the hall in room 64 was Wood’s other patient, an elderly woman awaiting her own complex surgery, a spinal fusion that would also require precise work spanning much of the day.

Meng wouldn’t know he was sharing Wood with another patient that morning until long after he woke up in a recovery room following the 11-hour operation to hear a medical resident say, “Mr. Meng, can you move your arms or legs, or squeeze my fingers or wiggle your toes?” He could not. Nothing in the medical record indicates that Meng’s sudden paralysis — a known risk of the surgery — had anything to do with Wood’s decision to juggle his care with another patient’s for about seven hours. Wood said he did nearly all of Meng’s surgery himself and did not even scrub in for the second part of the other patient’s procedure, leaving it to the surgical fellow.

There is considerable debate as to whether this was deemed concurrent or overlapping surgery and whether Dr Wood was present for the “critical” portion of each of the surgeries.

The American College of Surgeons defines the critical portion of the surgery as those portions of a surgery that require the essential technical expertise and judgment of the primary surgeon to achieve the optimal patient outcome. Essentially concurrent surgery is where the critical portions overlap and the primary surgeon circulates between the two cases, whereas overlapping surgery is where critical portions do not overlap and the surgeon migrates from one theatre to the next after the critical portions have been completed in the first theatre. As surgeons we know intuitively what we are responsible for and what portions of the procedure can be delegated. One would think that common sense dictates that the critical portions are those parts of the operation that cannot be delegated to another health practitioner.

The actual critical portion of a surgical procedure cannot be defined precisely and depends on a number of factors depending on the surgeon and the skill and expertise of members of the surgical team. Often it can only be defined by the surgeon him or herself and are those portions that cannot be delegated to another health practitioner.

Tony Meng’s case resulted in a US Senate enquiry and its report contains some insightful material. Of interest the US Centers for Medicare & Medicaid Services’ Medicare Claims Processing Manual contains some critical requirements before reimbursement can be claimed:

1. The teaching physician must be physically present during all critical or key “critical” portions of the procedure and be “immediately available” during the entire procedure.
2. The critical portions of two surgeries performed by the same teaching physician may not take place at the same time.
3. If circumstances prevent the teaching physician from being immediately available during noncritical or non-key portions of the surgeries, then she/he must...
EDSA CORNER (continued)

arrange for another qualified surgeon to be immediately available to assist with the procedure, if needed.

The debate is in the definition of what is deemed critical and what is meant by immediately available.

Is overlapping surgery safe? There is limited evidence in the literature.

In an article by Hayer (Hayer et al, Mayo Clinic 2016), two separate databases, the University Consortium cohort and a second NSQIP cohort with a large number of overlapping and non-overlapping cases, showed no significant differences in outcomes including anaesthesia duration, operative time, length of stay, morbidity or mortality across a broad range of specialties.

Zhang and his group from the University of California in San Francisco reported on 3,640 cases in an article on the Experience from an ambulatory orthopaedic centre (Zhang, Sing et al. 2016). They found no significant differences between overlapping and non-overlapping surgery in terms of: procedure time, anaesthesia time, total operating time, 30-day complications, unplanned readmission or reoperation.

In the cardiothoracic setting Yount and others, reporting on 1,748 cardiac cases and 1,800 general thoracic cases, in a presentation to the American Association of Thoracic Surgery reported (Yount, Gillen et al. 2015) they found ‘no statistically significant differences in observed for risk-adjusted outcomes in any category’.

In summary, none of the peer reviewed data available at this stage suggests that the practice of overlapping surgery poses harm to patients.

However, all studies considered only overlapping, not concurrent surgery. Only the Mayo Clinic study considered a broad base of surgical specialties. The definition of a ‘critical’ portion of surgery was not provided, rather the decision about what constitutes critical activities is at the discretion of the surgeon.

The recommendations following the RACS Research review are that:

- Surgeons should not be performing concurrent surgery.
- Overlapping surgery is acceptable as long as patient safeguards are in place.
- Every surgical facility should have a policy on concurrent and overlapping surgery.
- The primary surgeon’s presence and absence from the operating room should be documented in the operative notes.
- An adverse event reporting systems should be utilised to help identify and understand adverse outcomes.
- Patients must be informed when trainees or other delegated health professionals perform some critical or key parts of the operation.
- Disclosure and informed consent should be timed so that patients can choose whether or not to undergo surgery with a surgeon practicing in this way.

RACs Certificate of Outstanding Service

Recently in Palmerston North a RACS Certificate of Outstanding Service was presented to Ramez Ailabouni. The citation read:

In 2015 Ramez was elected the NZ RACSTA Trainee representative on the NZ National Board. He represented all New Zealand RACS Trainees across the 9 surgical specialties at the NZ RACS National Board meetings and at RACSTA meetings in Australia, advocating on matters affecting Trainees and training. Ramez demonstrated exceptional leadership, selfless service, tenacity and service to Trainees of the College and his peers.

Ramez was elected New Zealand Orthopaedic Association Education Committee representative in 2015. He attended annual Education Board meetings and served as the go between the education committee and orthopaedic surgical Trainees.

At hospital level Ramez took charge of senior and junior registrar allocation and rostering for 16 registrars for the Christchurch Hospital Orthopaedic Department and provided ongoing guidance to junior orthopaedic staff on career development and quality service delivery. He actively participated in formal and informal house officer education including presentations on orthopaedic topics, communication and handover.

Ramez was the Medical Representative on ISBAR Development Committee that is actively involved in the creation of the promotional and education package including posters and educational digital media on Allied Health wide communication tools. Ramez submitted thoughtful and considered quarterly articles to the NZ Cutting Edge magazine during his tenure on the NZ National Board.

Ramez is a deserving recipient of a RACS Certificate of Outstanding Service.
**John Buckingham Travelling Scholarship 2018**

Re-Opened for 2018 Applications by SET Trainees, due to funding availability.

Applications close 30 September 2017.

This scholarship was established to encourage international exchange of information concerning surgical science, practice, and education. It also aims to establish professional and academic collaborations and friendships amongst trainees. The American College of Surgeons (ACS) has agreed to sponsor one SET Trainee from RACS to attend the ACS Clinical Congress each year. In exchange, RACS will sponsor one ACS resident to attend the RACS Annual Scientific Congress.

The recipient will attend the ACS Annual Clinical Congress on 21-25 October 2018 in Boston, USA, and is valued at $4000.

The deadline for applications is 30 September 2017. For more information, please go to the awards web page or contact Sue Pleass on scholarships@surgeons.org.

**New Zealand Trauma System Review**

In recognition of the UN Decade of Road Safety Action 2010 – 2020 and the fifth pillar of the safe system - ‘Post Impact Care’ - the New Zealand Transport Agency (NZTA) is focussing on crash victims and the trauma care they receive. As such, the NZTA is seeking independent and consultative guidance on the NZ trauma system and optimisation of resources to ensure that injured patients (from pre-hospital to rehabilitation) are treated at the right facility in the right amount of time. The NZTA is working with the Major Trauma National Clinical Network to create a better understanding of the major trauma process to ensure that more informed decisions are made in relation to the reduction of road trauma and its consequences.

The NZTA has invited RACS to undertake a review of the trauma system in New Zealand. The structure of this review will be based on the RACS Australasian Trauma Verification Program which reviews systems of trauma care from a hospital perspective. The Australasian Trauma Verification Program has been running for 17 years and has matured into a highly respected, robust multidisciplinary review. The verification process assists hospitals with their analysis of the trauma care provided and allows the hospital to benchmark its services against international standards.

A Trauma System review is a consultative process involving a wide ranging system review across a country, region, state or territory to assist in the development of an inclusive and effective trauma system within that country, region, state or territory. This pilot project will be the first time that the Australasian Trauma Verification Program has conducted a trauma system review of a country.

The National Trauma Research Institute is providing assistance with the development of documentation for the review using its experience with trauma system development in Asian and Pacific nations.

The review is being conducted at the end of November 2017. During this time, the review team will be holding meetings at the RACS Wellington office – as well as meeting with key stakeholders throughout the country.

**BrowZine now available**

After a successful testing period, the RACS Library is taking up a permanent subscription with BrowZine, a service which provides Fellows with a streamlined means of browsing thousands of RACS journals.

Through the BrowZine, users can create a personal, virtual bookshelf of favourite titles, receive alerts when new articles are available, and save articles for offline reading.

BrowZine can be accessed either through the RACS library website or on smartphones and tablets with the BrowZine app. Select “Royal Australasian College of Surgeons” as the provider and use your College website credentials to log in.
Congratulations to the College’s immediate past Vice-President Professor Spencer Beasley who was presented with the Colin McRae Medal at Surgery 2017. The citation below was read by Sally Langley and the medal presented by Cathy Ferguson.

Colin McRae Medal

The Colin McRae Medal commemorates the life and work of Colin Ulric McRae, an outstanding New Zealand surgeon and former President of this College. This award recognises and promotes the art and science of surgery and honours outstanding contributions to surgery in New Zealand through clinical excellence, surgical leadership, research and/or surgical education.

Spencer is currently the Clinical Professor of Paediatrics and Surgery at the Christchurch School of Medicine and Health Sciences for the University of Otago.

He spent his early consultant years in Australia before returning to New Zealand in 1996. Spencer has held the position of Clinical Professor in Christchurch for the last 20 years.

Spencer encompasses all the elements to justify his award of the Colin McRae Medal. He was recently the Vice-President of RACS and completed his 9 years as a RACS Councillor in May 2017. During that time he has held many of the roles on Council Executive, and has held all of the executive positions in paediatric surgery. In his roles of Chair of the Board of SET, Chair of the Court of Examiners, Senior Examiner for Paediatric Surgery and Chair of the Board of Paediatric Surgery his influence on surgical training and the governance of training has been wide reaching. He has helped propel the education and assessment programmes of the College to where we are today.

Twenty years ago Spencer had a vision to develop a specialist Paediatric Surgical Service for the South Island. This is now well established with a 4 surgeon unit based in Christchurch and with outreach clinics and operating lists in all the regional centres. This required significant leadership in both the clinical and management arenas. The Service is premised on equity and access to quality services for all families in the South Island. An audit process was developed early on to monitor trends to inform practice and management issues. This has been maintained as part of the quality assurance process for the unit.

Spencer has contributed significantly to the development of Pacific Islands’ surgeons through mentoring, training and specialist team visits to Pacific Island countries. His support and participation have been invaluable in the development of paediatric surgery in the Pacific over the past 20 years.

Spencer’s academic profile shows his passion and commitment to surgical training, education and research. His CV would be difficult for most surgeons to match. His support and active involvement in laboratory and clinical research is apparent through his many published journal articles, book chapters and books. He has mentored and had an influence on the training of almost all the younger paediatric surgeons in Australia and New Zealand.

Spencer is recognised as a fantastic colleague who is easy to work with, very supportive of his peers and always helpful in times of need for those involved with him. He sacrifices a significant amount of his personal and family time to achieve what is best for his patients and colleagues and to achieve the long-term goals he has set out for the patients of the Paediatric Surgical Service, surgical education and developing the workforce.

Spencer Beasley is a very worthy recipient of the Colin McRae Medal.
About the turn of the millennium I was making a study of the doctors who travelled with Cook on one or more of his three voyages of discovery, and had reached the stage of a draft text when I found myself caught up in my other enthusiasm: the medical history of Winston Churchill, which became all-consuming for a season, and forced Cook on to the back burner.

The approach of the 250-year commemoration of Cook's rediscovery of New Zealand – which had the effect of turning this country from a squiggle on Tasman's map into a well-documented land – has made Cook into a 'topic' again, and (looking back at that draft text) I was impressed by the amount of 'research' I had put into studying him, and the medical personalities who were his companions over periods of some years. For they were, or had, rich personalities, many of them, which influenced Cook himself in a variety of ways; but he himself casts such a long shadow as to have obscured them from recognition – until now.

My working definition of research is 'applied curiosity'; and I have found my curiosity in this field to be rewarding to the extent that I now think of these men as people rather than mere names. They fall into two groups: the naval surgeons, certified at Surgeons' Hall and working up a progression from surgeon's mate to 'full' surgeon; and a group of mostly Swedish medically-qualified naturalists, who had abandoned the practice of medicine to become disciples of Linnaeus – Carl von Linné of Uppsala, whose influence would revolutionise natural history in general and botany in particular. Between them these men would impart a generous measure of scientific thought (and a more literate prose style) to a captain who was receptive to learning, from wherever it came.

On the Endeavour voyage Cook had as surgeon William Brougham Monkhouse, with his young brother Jonathan also aboard, as a midshipman. The elder brother provided Cook with an insight into natural history, and a better prose style than the breathless unpunctuated writing of Joseph Banks (who has been credited with helping Cook's literacy – mainly because Banks had influence and the resources needed to publish his journal, as well as the good fortune to survive the voyage, whereas W B Monkhouse died at Batavia on the way home). He had meanwhile neglected his administrative duties as surgeon, so engrossed had he become in the ecotourism aspects of the voyage. Young Jonathan helped succour Endeavour, by fothering a sail over the gash in her hull, suffered when she struck an outcrop on the Great Barrier Reef during the run up the east coast of Australia, 'very much to my satisfaction', said Cook – but Jonathan too perished as a victim of Batavia.

Two medically qualified Swedes were members of the Banks retinue which irrupted into an already overcrowded vessel on this first voyage: Daniel Carl Solander, who was selected as an 'ambassador' to London to impart Linnaeus' teaching to the English; and Herman Didrich Spöring, son of the professor of medicine at Åbo (present-day Turku, on the west coast of Finland). Young Spöring did a course in surgery at Stockholm before migrating to London, where he eeked out a meagre living as a watchmaker before Solander took pity on him and took him on as his secretary. Spöring was a talented artist who did valuable work – which was mostly attributed to one of the other artists of the voyage until quite recently; and he himself was to be one of the casualties of Batavia, where her Dutch founders had laid out a city of canals on the pattern of Amsterdam but which (in the sweltering heat of the Tropics) had become a giant sewer, where malaria and dysentery could flourish – and accounted for about a third of Endeavour's people.

It will be evident from this short synopsis of just one voyage that I have a rich assembly of narrative to play with here; all I now need is to find a publisher who will produce an equally rich volume for me, and support enough to permit me to make my modest contribution to the celebration of another of my heroes.
The College offers a range of skills training courses to eligible medical graduates that are supported by volunteer faculty across a range of medical disciplines.

**ASSET: Australian and New Zealand Surgical Skills Education and Training**

ASSET teaches an educational package of generic surgical skills with an emphasis on small group teaching, intensive hands-on practice of basic skills, individual tuition, personal feedback to participants and the performance of practical procedures.

**EMST: Early Management of Severe Trauma**

EMST teaches the management of injury victims in the first hour or two following injury, emphasising a systematic clinical approach. It has been tailored from the Advanced Trauma Life Support (ATLS®) course of the American College of Surgeons. The course is designed for all doctors who are involved in the early treatment of serious injuries in urban or rural areas, whether or not sophisticated emergency facilities are available.

**CCrISP®: Care of the Critically Ill Surgical Patient**

The CCrISP® course assists doctors in developing simple, useful skills for managing critically ill patients, and promotes the coordination of multidisciplinary care where appropriate. The course encourages trainees to adopt a system of assessment to avoid errors and omissions, and uses relevant clinical scenarios to reinforce the objectives.

**CLEAR: Critical Literature Evaluation and Research**

CLEAR is designed to provide surgeons with the tools to undertake critical appraisal of surgical literature and to assist surgeons in the conduct of clinical trials. Topics covered include: Guide to clinical epidemiology, Framing clinical questions, Randomised controlled trial, Non-randomised and uncontrolled studies, evidence based surgery, diagnostic and screening tests, statistical significance, searching the medical literature and decision analysis and cost effectiveness studies.

**TIPS: Training in Professional Skills**

TIPS is a unique course designed to teach surgeons-in-training core skills in patient-centered communication and teamwork, with the aim to improve patient care. Through simulation participants address issues and events that occur in the clinical and operating theatre environment that require skills in communication, teamwork, crisis resource management and leadership.

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**Letters to the Editor**

Cutting Edge welcomes letters to the editor. We will endeavour to publish all letters, but please keep them to no more than 300 words! Letters can be sent to: College.NZ@surgeons.org
The New Zealand National Board (NZNB), its representatives and the NZ National Office are involved in promoting high standards of surgical practice and advocating on matters of importance to surgery on behalf of Fellows, Trainees and IMGs in the MOPS programme. Some of these activities since the previous Cutting Edge are identified below:

Submissions
In the past three months the NZNB has provided written submissions on a number of discussion documents and consultations, including:

- BPAC\textsuperscript{c2} – Guidelines for Sepsis: the recognition, diagnosis and early management of sepsis
- New Zealand Transport Agency – Land Transport Rule: Setting of Speed Limits [2017]

Ministry of Health Professional Behaviour Taskforce
RACS was represented at the Taskforce meeting in July by NZ Manager Justine Peterson. DHB representatives reported on the resources they are gathering that employers might use to respond to lack of professional behaviour; the meeting was updated by Otago University representatives on the progress of its CAPLE (Creating a Positive Learning Environment project); and there was discussion around the linkages between this Taskforce and the Medical Workforce Taskforce of HWNZ.

RACS Election Issues Document
Ahead of the General Election on 23 September, the NZNB distributed an election issues document to the eight highest polling political parties. The document posed policy questions on five key issues: elective prioritisation and unmet need, health workforce, Maori health equity, alcohol-related harm and obesity. The parties were asked to respond by 1 September. Responses received have been collated and circulated to all NZ Fellows, Trainees and IMGs along with the original election issues document.

Council of Medical Colleges (CMC)
Professor Randall Morton attended the CMC’s quarterly board meeting on behalf of the NZNB on 24 August. The meeting included a presentation by Anthony Hill, the Health and Disability Commissioner, who spoke on the importance of having clinicians in leadership roles. Another visitor to the meeting was Dr Kate Baddock, Chair of NZMA, who spoke about their ‘manifesto’ (which has highlighted health investment priorities, sustainable workforce and public health policies) and their interest in health literacy. Te Oraiti Reedy, from Te ORA, briefed CMC on its work with MCNZ to develop a cultural competency framework for all medical practitioners.

Choosing Wisely New Zealand – Launch of Otolaryngology Head and Neck Surgery List
Choosing Wisely New Zealand launched five new lists of unnecessary procedures / tests following the CMC meeting. Amongst these is a list for Otolaryngology Head & Neck Surgery that has been approved by the NZSOHNS, taking the number of surgical specialty lists in the Choosing Wisely New Zealand Campaign to two (the other being General Surgery). Professor Randall Morton, an Otolaryngologist himself, spoke at this launch on behalf of RACS.

POMRC
POMRC held its annual symposium in late June to coincide with the release of its sixth report. This was attended by NZNB representatives, alongside Fellows Cathy Ferguson, Justin Roake and Maxine Ronald in their capacity as POMRC members (and the first two as symposium presenters). POMRC reported in detail on two special topics – the relationship between socioeconomic deprivation and perioperative mortality, and perioperative mortality following abdominal aortic aneurysm repair. “Unacceptable discrepancies in the mortality rates for New Zealand’s most deprived populations” have been identified and, along with POMRC’s Māori Caucus, recommendations have been made that support actions intended to reduce inequities in perioperative mortality. Other recommendations emphasised the need to improve access to medical and surgical care; and a recommendation on the endovascular treatment of abdominal aortic aneurysms.

Official Information Request – Surgical Mesh
The NZ office received an official information request from the office of the New Zealand First MP Barbara Stewart pertaining to the use of surgical mesh and the training of surgeons in its removal. As RACS is not a government entity, it does not have to comply with official information requests. However, RACS is always willing to assist with enquiries around surgical education and training and consent processes so a response to the questions posed was sent by the EDSA (NZ).

New Zealand Medical Students Association (NZMSA) Annual Conference
The NZMSA held its annual conference in Tauranga in June. RACS had a stand at the conference and the EDSA NZ, Richard Lander, and Policy & Communications Officer, Calum Barrett, attended. The stand was well visited throughout the conference with the medical students showing a considerable amount of interest in a career in surgery. These were valuable interactions as the majority of visitors to the stand had only a basic understanding of the specialties available and the pathways to becoming a surgeon.

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The year continues to race along and everyone is very busy. I can’t believe we are into the last quarter of the year.

I would like to congratulate Ryan Gao for winning this year’s Louis Barnett Prize for his work on lactoferrin and bone regeneration. He had stiff competition! Well done to all who were selected to present. The quality of the talks was fantastic.

I would also like to congratulate and welcome all the new Trainees who will be starting in December. When I was accepted into training a consultant rang to congratulate me. He proceeded to tell me that it was both the best and worst day of my life. Four years later I see his point! It’s a big commitment and a difficult journey, but very rewarding. To welcome the new Trainees the College has a welcome event and induction course in Melbourne on 11 November. I urge all the roster writers to endeavour to support our new colleagues in getting there. This is especially important for those specialties with no SET induction course.

The end of the year is near and with it a lot of changes. The DHBs are contractually obliged to bring in Schedule 10 RDA changes. For the most part the only way to implement the changes in a surgical roster is to employ more junior doctors. Unfortunately, the funding and bums on seats to do this is lacking. This is leading to creative re-rostering and combining of jobs. With change there is always teething problems. As a group of Trainees we recognise that these roster changes may have an effect on our training exposure and experience. We also worry about an increase in handovers and the potential risk that this brings to patients. As a result, a union separate to the RDA is being developed. This new union is still in its infancy, but hopefully it will be rolled out early next year.

Lastly, after a review of DHB consent forms we have found that most lack a statement regarding the possibility of Trainees performing and being involved in a procedure. We have created a statement to this effect that will be circulated to the DHBs shortly. We hope that this statement will be included in future consent forms.

Good luck to all those sitting exams in the near future. Any questions please feel free to contact me on nzheath@hotmail.com.

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The College Online Web Store enables the easy purchase of College Merchandise via one-stop shopping. Wearable items such as College scarves, ties, bowties and cufflinks, as well as gifts of distinction bearing the College crest are available for purchase from the Store, which can be accessed via the College website. (College login and password are required): Goods will be mailed within 24 hours of orders being placed.

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New Zealand Association of Plastic Surgeons (NZAPS) Conference

RACS also had a stand at the recent NZAPS Conference in Queenstown. This was an opportunity to promote RACS advocacy activities and Building Respect initiatives, and to answer questions on a range of issues such as CPD requirements, RACS skills and professional development courses, and the complaints processes. RACS Vice-President, Cathy Ferguson, presented during the conference on the building respect initiatives.

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John Garland Lester FRCS FRACS
15 January 1933 - 4 March 2017
ORTHOPAEDIC SURGEON

John Lester was born in Christchurch, the eldest child of Stephen Lester (a stock and station agent) and Eleanor West-Watson (secretary to her father, Bishop of Christchurch). He had a younger sister, Elizabeth, and brother, Michael. John commenced school at Fendalton Open Air Primary School and then attended Christs College. At College John excelled at sport, playing rugby for the 1st XV and cricket for the 1st XI – as captain in his final year. He went on to represent Canterbury in the Brabin Cup team.

In 1951 he commenced at Otago University gaining entry to the Otago Medical School the following year. During his time in Dunedin he resided at Selwyn College, his entry into which was no doubt helped by his grandfather being the Anglican Archbishop of New Zealand. John graduated MB ChB in 1956 and the next year worked in Greymouth spending time with the then legendary West Coast surgeon, Steve Barclay. With his appetite for surgery stimulated, John sailed for the United Kingdom working his passage as a cargo ship doctor.

In England John worked at the Royal Free and Marsden Hospitals gaining experience in general surgery. He subsequently obtained a position at the National Orthopaedic Hospital where he obtained training in orthopaedic surgery. His final three years in the UK were spent in Cambridge at Addenbrookes Hospital. He completed his FRCS in 1961. While working at Addenbrookes he met Elizabeth Hewitt, a member of the nursing staff. Her father, impressed that John had obtained a British Fellowship before the age of 30, were spent in Cambridge at Addenbrookes Hospital. He completed his FRCS in 1961. While working at Addenbrookes he met Elizabeth Hewitt, a member of the nursing staff. Her father, impressed that John had obtained a British Fellowship before the age of 30, supported the relationship, despite their sailing for New Zealand the day following their wedding.

On his return to New Zealand in 1964, John was initially employed as a senior orthopaedic registrar at Christchurch Hospital. In 1966 he was appointed to a position as full-time consultant. This subsequently became a part-time appointment and he practised in both the public and private sectors until he retired from his public hospital appointment in 1992. It was while employed in the public hospital that John developed his interest in hand surgery. When he retired from his hospital appointment he pursued full-time private practice. His workload which included surgery, consulting and medico-legal work was intentionally slowly reduced, until he fully retired in 2000. In 1973 John, with the support of Swiss colleague and friend Prof Hardy Weber, organised the first hands on AO course to be held in NZ. This began what would become a major change in fracture management in New Zealand. At a time when the antero-lateral approach to the hip for arthroplasty was almost universally used, John promoted the posterior approach and this was progressively more widely adopted. John provided strong support to Alastair Rothwell as he liaised with the plastic surgeons in 1982 in the formation of the Hand Unit. With his increasing interest in hand surgery, John was involved in the formation of the New Zealand Hand Society in 1976, serving on the Executive and as President in the early 1980s. He was responsible for changing its name to The New Zealand Society for Surgery of the Hand. John was also a member of the New Zealand Orthopaedic Association’s Executive Committee and served as Secretary of that Association from 1976-80.

John had a kind, considerate and generous nature. He was a conservative surgeon, a congenial colleague who was totally committed to his patients (not infrequently at the cost of some personal discomfort) and cared greatly for those who worked closely with him. With the prompting of Liz, a keen skier, John commenced this sport following his return to New Zealand and distinguished himself by sustaining an ankle fracture soon after commencing employment. In retirement John remained very active, playing golf regularly and well and enjoying gardening. He devoted time to learning silver-smithing and picture framing.

John is survived and greatly missed by his wife, Liz, children Ben, Richard, Stephen, & Tamara, sister, Elizabeth, and brother, Michael, and 10 grandchildren.

This obituary is based on contributions by Paul Armour FRACS, colleagues and Liz Lester and the family.

COLIN HOOKER (continued from page 15)

love of literature and reading, particularly biographies of eccentric scientists or politicians, and kept a handwritten summary of every book he read. Churchill was a hero – he could recite his speeches with perfect accent and a large portrait adorned the office (and later bedroom) wall. He maintained a keen interest in politics throughout his life. With his friend Dick Clark, an anaesthetist, he owned and developed a plantation forest at Waitomo.

Colin was predeceased by Val, who died almost six years ago. He was the loved and respected father of Jane (Office Management), Simon (Marine Biologist) and Andrew (Lawyer), grandad of seven children and great grandfather of five.

This obituary was provided by Jane Burton, Andrew Hooker and orthopaedic colleagues.
Colin Hooker's two passions in life were his profession and his family. With his motto for the way he lived, a quotation from Thomas Huxley, “Try to learn something about everything and everything about something”, he participated fully in all life offered.

Colin Hooker was born in Pukeroro just outside Cambridge (New Zealand) the son of James Stanley Hooker, a dairy farmer, and Betty Cohen. He was the second youngest of five children - Aubrey, Desmond, Brian, Colin and Yvonne. Commencing at Cambridge Primary School he next attended Cambridge High School where he excelled, topping New Zealand in School Certificate Latin (helped by learning Latin verbs while milking, these having been carefully written out on paper and pasted on the cow bails). In 1945, at the age of 15, he had to leave school to work on the farm, because his oldest brother had been called up for service in the Pacific.

When war ended, and with his mother’s encouragement, Colin decided that he wanted to attend university, something no other member of the family had achieved. However, having left school early required 18 months study at home by correspondence in English, Latin, maths, chemistry and geography to meet the entry qualification. He commenced medical intermediate at Auckland University in 1948 but, although obtaining high marks, he failed to gain entry to Medical School. However, following a second year he won a place and commenced at Otago Medical School in Dunedin in 1950 completing his MB ChB in 1954.

Whilst a house surgeon in Hamilton, Colin met a pretty nurse from Taihape, Valerie Cunningham, and in 1956 they married. Deciding to become an orthopaedic surgeon he and Val sailed for England in 1957, Colin employed as the ship’s doctor on the freighter, Port Phillip, a voyage marred by a crew member jumping overboard despite Colin’s best efforts. Surgical training was obtained at Oswestry, Winchester and the Royal National Orthopaedic Hospital in London. In 1959 he was awarded his FRCS. Colin and Val were delighted to be able to adopt their first child, Jane, in 1960. Specific orthopaedic training was obtained during the next three years at the Manchester Royal Infirmary and subsequently Oswestry Hospital.

In 1962 Colin was appointed as consultant orthopaedic surgeon at the Waikato Hospital, Hamilton, and the family returned to New Zealand by sea on the maiden voyage of the Canberra. With the arrival of Simon that year and Andrew in 1963, the family was completed. Five years following their return to Hamilton Colin and Val purchased an amazing house set in an acre of land on the bank of the Waikato River. With large oak trees, an orchard and a steep bank to the river this was a haven for a growing family. There was also a swimming pool which Colin -“darned if I will pay for water!” - filled each year courtesy of the neighbours and close friends to avoid any such payment.

Colin worked at Waikato Hospital for thirty years, retiring in 1992 to continue in medicolegal work, before ceasing all practice in 2009. He had a love for teaching and a particular interest in paediatric orthopaedic surgery. Beneath a sometimes crusty exterior, Colin had a big heart and was very committed to his patients, showing genuine concern for them. During his time at Waikato hospital the orthopaedic service increased greatly in size and Colin served as Head of Department for ten years from 1978. He was a very capable and conscientious administrator and put a lot of effort into this and the work of the New Zealand Orthopaedic Association. With Ross Nicholson and Alan Aldred he was instrumental in setting up the New Zealand orthopaedic training program. Colin obtained his FRACS in 1969 and subsequently served as a member of the Court of Examiners. He served a term as Chair of the Waikato Hospital Senior Medical Staff. Colin was President of the New Zealand Orthopaedic Association 1984–1985.

Colin published a number of widely recognised articles on club foot and received the New Zealand Orthopaedic Association Sir Alexander Gillies Medal in 1978 for his paper on radical soft tissue surgery in club feet. In the mid-1970s, concerned by the prevalence of catastrophic spinal injuries in schoolboy rugby as a consequence of scrum collapses, and with the help of the media, he challenged the New Zealand Rugby Union resulting in rule changes to largely eliminate this source of injury. He enjoyed travel, and with Val travelled widely to attend orthopaedic meetings in South America, the Soviet Union, Scandinavia, Australia, UK, South Africa, Canada, and the USA. In 1996, he published a book - "The History of Orthopaedics in New Zealand – The First 90 Years". For his services to orthopaedics, Colin was invested as an Officer of the New Zealand Order of Merit in 2007.

Living on a substantial block of land, Colin became an avid vegetable gardener, providing tomatoes to the whole neighbourhood and keeping Val in the kitchen for countless hours bottling, preserving and freezing. Although a keen “bootie”, Colin was not so good with the necessary maintenance and this resulted in some family “adventures”. A non-swimmer, he usually sat at the helm wearing wide rimmed glasses, orange toweling hat on his head, his bright yellow life jacket, and often clenching a large cigar, Churchill-like, in his mouth. Colin had a

Continued on page 14
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Please email these to: college.nz@surgeons.org
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