November 2nd seemed a great day for a jaunt in the Cessna. I flew to New Plymouth midmorning, had lunch in town, and was a little late getting back to the airfield for a scheduled 3pm departure. However, after a quick preflight check and topping up the oil I was in the cockpit in good time. The tower gave me a more complex clearance than I’d expected with extra waypoints added in. That took a few minutes to enter on the GPS, but still I looked OK for the 3pm departure as long as I didn’t mess around.

Looking up from the dash, I noticed the oil hatch on the cowling was open. “Bugger! How did I forget that?” I hopped out and closed it quickly, then got back in and started up. The engine run up and cockpit checks were all OK and by 3:01pm I was lined up and rolling down the runway. Great.

The instruments were looking good and the plane was accelerating nicely. I patted myself on the back for a well-compensated crosswind takeoff. At 300ft I eased back on the power and set pitch and trim for the climb....and noticed an oily haze on the lower part of the windshield. By 500ft there was quite an oil slick, with a definite decrease in forward visibility.

This was a decision point. The engine instruments and performance remained good, but I didn’t know why oil was spraying out of the engine, nor how long that could go on before the engine would stop. I turned crosswind and called tower, requesting a circuit to land. I then turned onto downwind early and low (I didn’t want to get any further away from that runway than I had to) and continued my climb on the downwind.

On most small aircraft engines the oil dipstick and filler cap are a combined unit. It was about this time that it dawned on me that when I closed the hatch I hadn’t checked that the dipstick/filler cap was firmly in place. In fact, I hadn’t checked it at all - I had left it resting on a ledge on the cowling while I refilled the oil and hadn’t put it back. OK so that was STUPID, but right now I had a plane to fly. There would be plenty of time to dwell on mistakes later....
had some forward view, at least of the edge of the runway through the side of my now well-oiled windshield. As I pulled into the final flare stage of the landing I reflected that this was a bit like a night landing. I knew the runway was ahead, but I was judging height and round out by the relative aspect of the runway edge markers. My compensation for the crosswind was automatic.

The landing was probably best described as abrupt. I taxied back to the fuel stands wondering what my chances were of finding a replacement dipstick. Amazingly, when I got out of the plane it was still sitting on the side of the engine where I had left it. I replaced the dipstick carefully and cleaned the plane up. Very little oil had been lost according to the dipstick, but it had still made a decent mess of the cowling and windshield. About twenty minutes later I was back in the air on a flight home which was boringly pleasant and uneventful.

So, there have to be some “learnings” from an episode like this. According to my GPS watch, the whole flight took 4min 12sec. My average heartrate throughout was 130 bpm, more than double my usual resting pulse. In surgery we often talk about analogies with flying and what we can learn from the cockpit. What can I take out of this?

Decisions
Perhaps first is that both disciplines require decisiveness. In this case the decision to turn back rather than push on into uncertainty was a fairly easy one to make.

Checklists
We have them and we use them with the specific objective that we don’t forget stuff. But you can’t regulate for every possibility. I don’t think that my preflight checklist includes “check that you’ve put the oil cap back on”, and if it did it would probably mean that the list was such an unwieldy volume that I would skip steps, or spend more time working through the checklist than on conducting the actual flight. Probably more important is adhering to your routine check without interruption. For me, taking off at a controlled airport and having to get clearance prior to engine start put my routine out of whack. On this occasion the change in the flight plan route and my desire to get away on time were no doubt factors as well. I’m not making excuses - my point is that these are the times when it is particularly important to go back to the routine of the checklist and make sure that nothing has been missed. I guess the surgical analogy would be to have someone come in to ask for urgent advice about another case while you’re halfway through the time out. Nothing’s gone wrong, but you really need to go back to the top of the page and make sure you’ve done all the checks.

Training
This whole flight was conducted in clear daylight, but I have no doubt that having been trained in both night and instrument flying made it easier. I didn’t think about positioning the plane high and close to the runway, it was just a natural reflex after multiple engine failure practices, and while I was busy thinking about landing with decreased visibility, I compensated for the crosswind automatically. Surgical training and examination mandate a depth and breadth of experience for good reason. Hopefully our surgical trainees feel similarly prepared, and while we don’t want to engineer emergencies for them in the operating room, use of simulation as in the many courses run by the RACS can emulate these situations.

Communication
I must thank ATC at New Plymouth. The controller was immediately “on to it” and was proactive in offering help. During the flight there was nothing he could do other than clear me to get back on the ground ASAP, but it was immensely reassuring to have a friendly and helpful voice on the other end of the radio. While we train surgeons to achieve individual levels of expertise and competence, there should be no hesitance to ask for help with complex or unusual cases.

Our ASM in Queenstown next 9 & 10 August will focus on planning, including a session on how to deal with things when the plan goes wrong. I would encourage everyone to attend it. In the meantime please have a happy and safe festive season.
In 2018 New Zealand’s Annual Scientific Meeting returns to the stunning surroundings of Queenstown, with the focus being on how to plan for, and tackle, the challenges associated with change. Sessions will explore subjects such as challenging patients, challenging situations, and how to manage when things change pre-operatively, intra-operatively, and post-operatively.

The Surgery 2018 programme is curated to be relevant to surgeons rather than specialities, as well as being relevant to other health professionals and administrators.

**Plan to attend - enter the dates in your diary now!**

**International speakers include:**

**Dr Claudius Conrad** – Assistant Professor, Department of Surgical Oncology, Division of Surgery, The University of Texas MD Anderson Cancer Centre

Dr Conrad holds an MD, a PhD in stem cell biology, and a PhD in music philosophy—all from the University of Munich where he was the principal investigator of the research group on stem cells in the Department of Surgery. He subsequently completed his training in general surgery at the Massachusetts General Hospital and a Minimal Access Fellowship of the International Hepato-Pancreato-Biliary Association at the Institut Mutualist Montsouris in Paris.

An internationally renowned expert in the field, Dr Conrad has also contributed to a growing body of research indicating that music helps patients, their relatives, and even operating room surgeons. Previously the director of the Music in Medicine Research Group at Massachusetts General Hospital, he was one of the first to investigate the mechanisms that account for the healing properties of music. Some of his most recent research suggests that the central pathway that mediates music-induced relaxation acts by stimulating release of a growth hormone from the brain usually associated with stress, not healing. A pianist since the age of four, Dr Conrad finds that his dexterity at the keyboard and his prowess with a scalpel are directly related.

**Dr Rodney Cooter** – Plastic Surgeon, Adelaide, South Australia

Dr Rodney Cooter has held a range of professional appointments including being Head of Plastic and Reconstructive Surgery at the Queen Elizabeth Hospital, and Director of Plastic and Reconstructive Surgery at the Royal Adelaide Hospital.

Although based in Adelaide, Dr Cooter also works one day per week as a consultant in an advisory role as Clinical Professor at Monash University (Melbourne) where he is a clinical lead for the national Australian Breast Device Registry.

Dr Cooter is a past-president of the Australian Society of Plastic Surgeons and a member of the TGA Review Committee and Chief Medical Officer’s Advisory Panel. As a commitment to improving patient safety standards, Dr Cooter is also lead coordinator of the International Collaboration of Breast Registry Activities and the Oceania representative on the newly formed International Confederation of Plastic Surgery Societies.
Dealing with unconscious bias

In 2015 a survey of RACS Surgeons, IMGs and Trainees identified discrimination and particularly racial bias as an issue in the surgical community. 33% of 448 respondents reported experience of cultural or racial discrimination. 6% of 412 respondents who were asked about harassment said cultural or racial issues were the cause.

Is cultural insensitivity ingrained in our community and particularly is it ingrained in the surgical community?

A little more than a few years ago it was a different society. The history of segregation of ethnic groups in America, Africa, Australia and New Zealand and elsewhere in the world is well publicised and unfortunately remnants of this legacy still persist to this day. Many would say that these persisting deviations from acceptable contemporary cultural awareness and cultural safety are a legacy of our past. But are they? Overt racism is still common in our community.

Last year the Proceedings of the National Academy of Sciences published the results of a survey of 222 white medical students where questions were asked about the physical differences between whites and blacks. Surprisingly a large proportion of the group thought there were differences where no difference existed. And where true differences actually do exist there was also a significant proportion who thought they were false.

We know that different social groups get different outcomes and interactions with health professionals when accessing health services. There is a perception that indigenous people have a higher pain threshold and there is literature showing that indigenous people are prescribed fewer analgesics, investigated less and offered fewer interventions.

Cultural mores or the essential or characteristic customs and conventions of a society or community, are often overlooked. In some societies a man may object to a female patient may do what should only be done with or by a young female nurse attending to him. A male attending to a female patient may do what should only be done with or by a female. Another example may be the lack of provision of translation services.

Medical Council of New Zealand literature notes that Māori in New Zealand receive fewer prescriptions for chronic illnesses such as COPD & depression, consultation times are shorter than non-Māori, they have lower referral rates for diagnostic tests and tertiary services and cardiac intervention rates are lower. Even allowing for socioeconomic status they have higher overall mortality rates and lower life expectancy, and they have higher rates of certain cancers including breast, cervical and lung.

Racism is defined as prejudice, discrimination, or antagonism directed against someone of a different race based on the belief that one’s own race is superior.

In practice we encounter racist patients, racist clinicians and racist institutions.

Take the example of a woman in need of open-heart surgery who asks her surgeon to make sure that there are no African-American men in the operating room at the time of the surgery. She and her husband do not want an African-American man looking at her naked body. The couple is unwilling to agree to the surgery unless the surgeon agrees to accommodate this request, and they tell him that he is their last hope. The surgeon agrees to these terms, concerned that otherwise she will not undergo this potentially life-saving procedure. On the day of the operation, an African-American male perfusionist is assigned to operate the heart lung bypass machine. The surgeon quietly asks him to leave, and replaces him with a Caucasian technician.

This vignette raises a number of questions: Was the surgeon’s conduct appropriate? Should a patient have the right to request members of a specific race, religion, sexual orientation, or ethnic group to give them care?

In responding to the racist patient the first response is often combative with anger & resentment. We all know that pitting rational arguments against irrational beliefs is often a futile exercise. The initial temptation is to withhold care and we often accommodate the request or advise to seek care elsewhere.

The decision to accommodate may only be sound when the accommodating doctor is comfortable with the decision, employment rights are protected, and the decision does not compromise good medical care. However institutional policy statements should discourage such bigoted behavior.

There are many examples of overt racism by individuals in our hospitals and other institutions. Personally mediated racism can be expressed by the way you treat others particularly the people you dislike, disrespect, with whom you are indifferent or the people you devalue. This racism can not only be overt but also be unconscious or even covert.

Institutional racism refers to the ways in which racist beliefs or values have been built into the operations of social institutions in such a way as to discriminate against, control and oppress various minority groups. The media and the medical literature have many examples of racism within hospitals. In New Zealand about 400 people each year make formal complaints to the Race Relations Commissioner about racism. I have no doubt that some of these stem from the health sector.

In dealing with unconscious bias or racism we first need to recognise and deal with that bias personally.
Dr Sondra Thiedeman has provided advice for defeating bias in the workplace:

- Become mindful of your biases, step back and recognise those biases.
- Triage your biases and sort out what is most important.
- Identify the secondary gains of your biases and ask “what am I, or they, likely to gain or lose if I am biased?”
- Dissect your biases and ask “are my biases relevant in this situation?”

Our culture dictates that we have different needs and we think differently. Our views of sickness and health are different. Our behaviour needs to reflect the values of integrity, respect and compassion.

**Health and Safety at Work: Are you a PCBU?**

The Health and Safety at Work Act 2015, known as HSWA (the Act), came into force in April 2016. Its main purpose is to provide a balanced framework to secure the health and safety of workers and workplaces. WorkSafe is the regulator under the HSWA.

It introduced the concept of Persons Conducting a Business or Undertaking (PCBUs). PCBUs have responsibilities for the health and safety of people at risk from its work activities, including customers, visitors or the general public, but especially for its workers and other workers it influences or directs.

Both medical practitioners who run their own businesses (if they have employees) and private hospitals are PCBUs. Credentialed medical practitioners and private hospitals have a duty to manage the risks of the work activity where they have control or influence.

As PCBUs sharing a workplace, private hospitals and credentialed medical practitioners must work together to identify and address their overlapping risks and responsibilities. They both must have policies and procedures to effectively address their duties under the Act. They must also confirm that other PCBUs in the same workplace also have policies and procedures to meet the Act’s obligations.

This is achieved through collaboration and communication and includes:

- Identification and assessment of risks
- Consultation to plan the management of these risks
- Coordination of the work
- Cooperation to minimise the risk of harm
- Monitoring the effectiveness of measures that are being taken to maintain a safe workplace

Risk management initiatives could include minimising:

- Exposure to blood, body and other substances (e.g. surgical plume from patients known to carry blood borne viruses or other diseases)
- Worker(s) injury from body stressing and handling (e.g. use of handling and moving equipment for obese or disabled patients)
- Psychological harm to worker(s) from unprofessional behaviours

1 A notifiable event is any of the following events that arise from work: a death or a notifiable illness or injury or a notifiable incident. http://www.worksafe.govt.nz/worksafe/notifications-forms/notifiable-events
• agree on the degree of influence and control each has
• agree on who will manage what and how it will be managed
• agree on the use of shared facilities
• monitor and check how things are going on an ongoing basis.

A surgeon who is self-employed must also ensure, so far as is reasonably practicable, his or her own health and safety while at work whether that be at his or her own office or while working at a private hospital.

Medical indemnity insurance such as that provided by the Medical Protection Society (MPS) does not cover liability against these risks. The Act says that no one can insure themselves against their liability to pay a fine or infringement notice imposed under it.

The Act requires PCBUs to tell WorkSafe about any notifiable event arising from work (this includes PCBUs that are private medical institutions or that employ medical professionals). WorkSafe recognises there are specialised processes for dealing with notifiable events arising from medical treatment under other legislation. Because of this, WorkSafe expects medical PCBUs to use those specialised processes where a notifiable event arose from medical treatment. However, PCBUs must still tell WorkSafe of all notifiable events resulting from non-clinical care or equipment failure.

New Zealand has a rich and fascinating surgical history, filled with pioneers who would drive the profession forward and shape the future of surgery - both in New Zealand and abroad. As history continues to be written, it is important that these stories are recorded and remembered.

For the past decade, retired Fellow and amateur historian Bill Sugrue, of Whangarei, has been keeping a growing historical record of New Zealand’s surgeons. Alongside organising the annual Surgical Pioneers forum, Bill has been collecting and assembling a physical archive of records, articles and obituaries cataloguing the lives and many achievements of New Zealand’s surgeons from the last century and half.

What initially started as an interesting hobby has grown into a project with amazing potential. Bill is now looking for a Fellow, or Fellows, with the enthusiasm and interest needed to take over and conserve this historical archive and ensure that New Zealand’s surgical history is not lost to the annals of time.

If this task sounds like it would be of interest to you, of if you would like more information, please contact Isobel McIntyre at the RACS NZ Office on 04 385 8247 or at Isobel.McIntyre@surgeons.org.

SEASONS GREETINGS

The College staff in New Zealand – Andrea, Calum, Celia, Isobel, Katarina, Paul, Raji, Richard and myself wish all Fellows, Trainees and MOPS participants, and their families, a safe and happy Christmas and New Year.

We look forward to being of service to you all in 2018.

Justine Peterson
New Zealand Manager

A Call to the Surgical Historians

N
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If this task sounds like it would be of interest to you,
Surgical Supervisors and Trainers who have not completed a Foundation Skills for Surgical Educators course this year must register by the end of March to attend a course in 2018. New dates are progressively being opened – visit the College website.

Appointment to the Court of Examiners

Applications for appointment to the Court of Examiners for 2018 are now open. The following specialties have vacancies on their Court:

- Cardiothoracic Surgery
- General Surgery
- Neurosurgery
- Orthopaedic Surgery
- Otolaryngology Head and Neck Surgery
- Plastic and Reconstructive Surgery
- Urology
- Vascular Surgery

Applications from eligible Fellows willing to serve on the Court of Examiners should be forwarded to the RACS Examinations Department no later than Friday, 26 January 2018 for appointment in 2018. You can find out more and download the application form on the College website.

Dates to Note

- The NZ College office last day of business is Friday 22 December. It re-opens on Wednesday 3 January 2018.
- 2018 subscription fees are payable by 1 January 2018.
- The date for final submission of 2017 CPD data is 28 February 2018.
- NZ National Board meetings will be held on 2 March, 8 June, 10 August and 7 December 2018.
- Cutting Edge contribution dates for 2018 are 2 March, 6 June, 3 September and 3 December 2018.
- Applications for May 2018 Fellowship Examinations open on 3 January and close on 24 January 2018. All examination dates are on the College website.
- Registration for SET selection opens on 4 January and closes on 2 February 2018. Full details can be found on the College website.
- The ASC is in Sydney over 7 - 11 May 2018.
- Surgery 2018: Planning For Change is at Rydges Lakeland Resort, Queenstown on 9 & 10 August 2018.
- Foundation Skills for Surgical Educators courses confirmed dates, for NZ, are below. More NZ dates are to be added and the website will be updated as they are finalised.
  - Monday 26 February 2018 - Wellington
  - Friday 16 March 2018 - Wellington
  - You can find out more and register on the College website.
- Operating With Respect courses will be held in NZ:
  - Saturday 17 March 2018 – Auckland
  - Thursday 7 June 2018 – Wellington
  - Tuesday 16 October 2018 – Queenstown
  - You can find out more and register on the College website.
- A DSTC/DATC/DPNTC course will be held in Auckland 30 July – 1 August 2018.
  - You can find out more and register on the DSTC website.
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ACTIVITIES OF THE NEW ZEALAND NATIONAL BOARD

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:

Briefing to the Incoming Minister

In mid-November, RACS sent a Briefing to the Incoming Minister (BIM) to the new Minister of Health, Dr David Clark. The BIM builds on the RACS Election Statement that was presented to all political parties in July. It provides an overview of RACS, as well the issues that we perceive to be of importance to the provision of quality surgical care in New Zealand, and the actions that we believe need to be taken to address these. Those issues are:

- Prioritisation of elective services
- Funding for elective surgery
- Health workforce
- Registries and audits
- Māori health equity
- Preventative health - obesity, trauma, and alcohol-related harm

Climate Change

RACS’ Governance and Advocacy Committee has supported a request from the NZNB and the Younger Fellows Committee for RACS to become active on this issue, a move which has subsequently been endorsed by Council. A position paper is now being developed which will focus particularly on the link between climate change and surgical practice.

Surgical Mesh

A meeting was held with the Ministry of Health in late October with representatives from RACS, RANZCOG, the Mesh Down Under (MDU) consumer group, ACC, HDC and Medsafe to discuss surgical mesh. The meeting agreed to focus primarily on synthetic polypropylene mesh used in the pelvis for pelvic organ prolapse and stress urinary incontinence. A number of agreed recommendations came out of the meeting, including that the Ministry undertake a cost-benefit analysis reviewing the utility of creating a registry for surgery using mesh.

Health Workforce New Zealand

Health Workforce New Zealand (HWNZ) has indicated that they intend to proceed with a contestable funding model despite strong opposition from RACS and many other colleges concerned about the damage this could cause to training for the future surgical (and wider medical) workforce. The NZNB commented on this within the BIM (see above item), recommending that the Health Minister not support HWNZ’s proposal. The NZNB will be approaching other medical organisations with the aim of sending a joint letter to the Minister of Health on this issue.

Council of Medical Colleges

The NZNB Chair, Dave Adams, attended the Council of Medical Colleges (CMC) quarterly board meeting in late November. A large focus of this meeting was on Pasifika health and how the CMC, and its member colleges, could contribute to improving this both in New Zealand and in the Pacific Islands. Discussions were also held on Choosing Wisely NZ (which is administered by the CMC), the reaccreditation of training posts, and PHARMAC’s process for funding new medicines and devices.

Health and Disability Commissioner – Wording on Surgical Consent forms

Following a decision by the Health and Disability Commissioner (HDC) regarding informed consent and Trainees’ participation in procedures, the NZNB has reviewed the surgical consent forms of all 20 DHBs. Wording clarifying for patients the role that a Trainee may have was sent to the HDC for his comment. Unfortunately he did not consider that it satisfied the patient’s right to know who will be performing their procedure. This issue was discussed again at the November CMC meeting as it impacts on quite a number of the medical colleges. It was agreed that CMC will write to all DHBs and encourage them to review the wording of their consent form in light of the HDC’s comments.

RACS Peer Support Programme

RACS is seeking expressions of interest to develop a network of peer supporters across all specialties and regions in Australia and New Zealand.

We are looking for those who are interested in providing peer support to Fellows, Trainees and IMGs involved in making or having been the subject of a complaint within the RACS Complaints Framework.

The role of providing peer support includes listening, enquiring as to an individual’s welfare and recommending any professional assistance required, providing advice relevant to the process of natural justice and keeping in touch periodically. Interested Fellows, Trainees and IMGs are asked to provide a current CV and brief statement against the criteria on the RACS website no later than 31 December 2017.

Further information can be found on the College website.
Preparation For Practice

We had another successful Preparation for Practice workshop in September. This year we held it in Auckland and had our biggest turnout yet. We covered topics such as private and academic practice, business structures, working with GPs and what they want from surgeons, and insurance company expectations. We are in the process of organising the workshop for 2018. We would like the programme to be as dynamic as possible and to reflect what it is that you as Younger Fellows or final year Trainees want to know about setting up in practice. Therefore we are asking for suggestions for topics that you would like to see addressed.

Younger Fellows Forum

The Younger Fellows Forum (YFF) runs for the weekend prior to the ASC. The purpose of this is for RACS to engage with Younger Fellows. This is both to listen to what issues are concerning younger fellows that are reported back as recommendations directly to RACS Council. It is also an opportunity to meet directly with RACS Councillors including the President. An example of the impact that can come of this forum is one of the recommendations from last year. This was about the impact of climate breakdown and the need for surgeons to be responsive to this global issue. This has led to RACS changing the terms of reference to include climate breakdown as an area in which we will advocate.

A climate breakdown policy is to follow. If you are interested in being involved in the development of this please let me know.

Mentoring

The Younger Fellows Committee is running a pilot on the back of the recently released RACS updated resource on mentoring. We will be running another mentor matching session at the ASC in Sydney 2018. If you are interested in this topic, hunting for a mentor or willing to be a mentor for a Trainee we encourage you to look out for the registration details or for some helpful information visit the RACS website or see the RACS publication-Mentoring – A Practical Guide.

Workforce Planning

We are aware of issues around workforce planning, succession planning and misdistribution of the workforce as they affect Younger Fellows and Trainees looking for consultant posts. There are particular issues affecting NZ compared to Australia. Different specialties also have particular pressure points. To address these RACS is organising a meeting for early next year which will likely invite stakeholders such as Health Workforce NZ and DHBs.

NZ Younger Fellows Advisory Group

Sean Galvin, Cardiothoracic Surgeon, Wellington, is the new Younger Fellows representative on the New Zealand National Board. Sean would be pleased to hear from you with any issues related to Younger Fellows so he can represent these within RACS. Please feel free to contact Sean at the address below.

As part of efforts to improve communication of Younger Fellow issues we have representatives of the various groups who meet as the NZ Younger Fellows Advisory Group. The idea is to have Younger Fellows communicate important issues for the various specialties to their specialty representative so that these can be relayed to the various committees of RACS on which we have representation. The members of this and their contact details are listed below.

Cardiothoracic Surgery and NZ Younger Fellows representative – Sean Galvin - sean.galvin@ccdhb.org.nz
General Surgery – Amit Reddy - amit.reddy@ccdhb.org.nz
General Surgery – Linus Wu - Linus.Wu@waikatodhb.health.nz
Neurosurgery – Simon John - Simon.John@cdhb.health.nz
Orthopaedic Surgery – Shaneel Deo - shaneel.deo@middlemore.co.nz
Otolaryngology Head & Neck Surgery – Sam Greig - Samuel.Greig@cdhb.health.nz
Paediatric Surgery – John Atkinson – johna@adhb.govt.nz
Plastic & Reconstructive Surgery – Simon Chong - simon.chong@waikatodhb.health.nz
Urology Surgery – tba
Vascular Surgery – tba

SUCCESS IN THE FELLOWSHIP EXAMINATIONS

Congratulations to New Zealand based Trainees who were successful in the September exams in Brisbane.

<table>
<thead>
<tr>
<th>Name</th>
<th>Specialty</th>
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<tr>
<td>Rebecca Thomas</td>
<td>General Surgery</td>
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<tr>
<td>Jen-Chen Huang</td>
<td>Orthopaedic Surgery</td>
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<tr>
<td>James Sanders</td>
<td>Otolaryngology, Head &amp; Neck Surgery</td>
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<tr>
<td>Robert Ma</td>
<td>Vascular Surgery</td>
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Nga mihi nui,
Andrew

Andrew MacCormick
Younger Fellows Website: http://www.surgeons.org/member-services/interest-groups-sections/younger-fellows/
One disadvantage of longevity is that you spend much of your time, and get much of your exercise, in attending the funerals of your friends. You play no very active part in proceedings – you are (rightly) regarded as no longer sturdy enough to be chosen as a pallbearer, nor closely enough involved to be called on for a eulogy; and increasingly the deceased friend is younger than you are yourself.

Two recent funerals have been those of colleagues who had, during their lives, been loyal servants of the College, and the commemoration of their lives prompted me to reflect on mortality, which is universal, inevitable, and yet random in its application. The first was that of John Simpson, who became executive director of surgical affairs for this country when his health drove him to abandon clinical surgical practice, and who, with Justine Peterson, made the New Zealand office a model of efficiency; and the other Ted Watson, who followed me as secretary to the then New Zealand Committee, of which he rose to become chairman, and who sat on the Medical Council in challenging times. And as it happens both of them were younger than me.

That fact cannot fail to impress an essayist. And the impression I have taken away from those two funerals (out of a total of six in the past month!) is that there is a time for everything, even the retirement of the essayist. So this may be enjoyed as my final contribution to Cutting Edge.

I use the term deliberately, because the kind remarks that friends and colleagues have made over the years have given me great pleasure.

But nothing keeps a scribbler quiet, except mortality itself. In the first decade of this century I became interested in the surgeons who travelled with James Cook on his voyages of exploration. They were interesting men, but because Cook casts so long a shadow, they have been little noticed; and yet they were important – both as influential on the evolution of Cook’s scientific ability and of his prose style; and one saved Cook’s life.

There were about a dozen of them: two groups, the naval surgeons and surgeons’ mates who were posted into the four expedition ships over the three voyages; and a group of mainly Swedish medical graduates who had forsaken medical practice to become disciples of Linnaeus and his botanical classification, and who formed the scientific component of those same voyages.

I had got as far as a draft of the book, provisionally entitled Cook’s Doctors, when I became preoccupied in the Churchill project, about which I bored my readers regularly until the publication of Churchill – the supreme survivor in 2013. But after that, and the publication of my biography of Bernard Freyberg VC, Zeal and Honour, followed by Flags of the Commonwealth when the flag debate and referenda made that subject topical, I fished out the draft of Cook, re-read it and enjoyed what I read, and realised that in 2019 it will be 250 years since a keen-eyed cabin boy in Endeavour gave his name to Young Nick’s Head at the vessel’s landfall.

After that, New Zealand evolved from being a squiggle on the charts made by Tasman and Visscher to become a country, well charted and defined.

At this point, getting Cook’s Doctors published in time for 2019 becomes another preoccupation.

Wish me well …

Editors note – Thanks to Wyn for his many interesting articles over the years. We do wish him well with Cook’s Doctors.

Anyone interested in writing a regular column please contact Isobel.mcintyre@surgeons.org.
The year has flown past and the holiday season is upon us. To everyone Merry Christmas and to those having time off enjoy the break.

The NZ Trainee representatives continue to work well as a group and are very active on behalf of their respective specialties within the College. We have recently had some changes to our team; I would like to welcome Suheelan Kulasegaran the new General Surgery representative and Blair York the new Plastic & Reconstructive Surgery representative. I would also like to congratulate Rachel Care (NZ Otolaryngology Head & Neck Surgery Trainee) who was voted in as the new Chair of our Australasian Trainees Association (RACSTA). It’s great to have a Kiwi representing all the Trainees from both NZ and Australia. Rachel has some very big and capable shoes to fill! I am sure she is up to it.

Due to recent concerns, the College reviewed its processes for distributing Fellowship Exam results. As of next year candidates will have the choice of collecting written results along with other candidates or receiving their results online in a setting of their choosing. This has stirred up a number of emotions from various groups but the final decision came from a place of caring and compassion. Traditions are important and successful candidates will still be invited for presentation to the Court of Examiners.

Training continues to evolve and the way we are assessed is changing. There is fast developing a push to competency based training. The Australian Orthopaedic Association has adopted this and the Australian and New Zealand Otolaryngology Head & Neck Surgery Trainees are trialling it. Competency based training still requires passing exams, but you sit exams once you have fulfilled all your competencies, rather than after an arbitrary time allotment. Competency based training requires more intensive and frequent assessments which will add complexity to training. As always change is difficult and competency based training is being approached with trepidation, however it will become a fact of life for many Trainees.

The Schedule 10 safer working hours are being rolled out for some rosters in the next couple of weeks. With any change there are teething problems – be mindful of this especially over the holiday period. As Trainees we need to ensure these changes benefit our patients and don’t dilute our training experience. Around the country some creative rostering to be compliant is underway. The reality for most rosters to be compliant is to employ more surgical registrars. Where these doctors come from and how we pay for them remains to be seen. To those Trainees writing rosters if you are struggling please contact your Trainee representative or me; we can advise you on your options.

To all those studying over the summer for exams in April (myself included) all the best, try not to stress too much and try get into the fresh air as much as your anxieties allow.

Completion of Operating With Respect e-Learning module for RACS Fellows, Trainees and IMGs

Thank you to the over 83.4% of Active Fellows, Trainees and IMGs across New Zealand who have completed the mandatory Operating With Respect online training module as of 29 November 2017.

For those who have not, time is running out. The online module must be completed by the end of 2017 in order to comply with CPD requirements which may impact on your registration with the Medical Council of New Zealand. By completing this course you will be demonstrating a commitment to making safe and inclusive workplaces for all in our profession.

To complete the online course, visit https://www.surgeons.org/about-respect/ and follow the links to the online module. Fellows can trigger password resets online if needed. This is one of many actions collectively being progressed to build a better and safer culture within healthcare.
Outstanding Service to the Community Award

Mr John Matheson

Congratulations to Mr John Matheson on being awarded the RACS Outstanding Service to the Community Award for over 30 years of outstanding service to the Otago community. John was presented with the award at the annual Bruce McMillan Memorial Lecture in Dunedin in October. The Bruce McMillan Trust, of which John is a Trustee, distributes funds for orthopaedic research projects in the Otago area.

John has a long history of service to the Otago community, starting with his appointment as Consultant Orthopaedic Surgeon at Dunedin Hospital and Clinical Lecturer (later to be Senior Clinical Lecturer) at the Otago Medical School in 1983. He has since provided orthopaedic services at Dunedin and Mercy Hospitals, and has run clinics across the region.

A former Otago rugby representative, John has previously served as a Board member of the Highlander Rugby franchise and provided orthopaedic services to the Otago rugby community for many years. In recognition for his expertise in treating sports related knee injuries John was appointed President of the NZ Knee Society and later an elected member of the Executive Committee of the NZ Orthopaedic Association (NZOA). He subsequently became a member of the Continuing Education and Standards Committee of the NZOA, Chairman of the Orthopaedic Education Committee of the NZOA and finally President of the NZOA in 2008.

John is described by his colleagues as a true gentleman and people's person, who takes an interest in people's wellbeing and welfare, be they his patients, friends, students, or people he barely knows. He remains a passionate teacher, and through his enthusiasm and dedication to his work, John has inspired countless young doctors who have had the opportunity to work with him, with many going on to become leading orthopaedic surgeons themselves in New Zealand and abroad.

Mr Andrew MacDiarmid

Congratulations to Mr Andrew MacDiarmid who was presented with the RACS Outstanding Service to the Community Award earlier this year. The award recognises Andrew's long standing contributions to both his community in Tauranga and the surrounding regions, as well as the peoples of Pacific Island countries.

Andrew has a long association with the Cook Islands in particular, having undertaken regular visits at his own expense to teach and provide orthopaedic services. Andrew is also known for providing facilities for Cook Island patients to have treatment in Tauranga, often providing accommodation for relatives in his own home. He is held in high esteem by his colleagues for his dedication to his patients, his willingness to always go the extra mile by doing additional lists and clinics, and his readiness to help those who had no insurance cover or other means of accessing surgery.

Andrew has also committed a lot to the New Zealand Orthopaedic Association and Royal Australasian College of Surgeons, having served on the former's Education Committee for a long period of time, and as an examiner and Chair of the Orthopaedic Education Committee for the College.

Over 5 billion people worldwide do not have access to safe, affordable surgical care when they need it most. That's two out of three of us.

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www.surgeons.org/foundation/
LEO JAMES "JIM" WALKER FRCS FRACS
4 December 1926 – 16 October 2012
GENERAL SURGEON

Jim Walker was a General Surgeon with a broad range of interests. His parents were Beryl (nee D’Ath) and Jack. By virtue of descent, Beryl was of the iwi of Ngāti Raukawa. Jack Walker’s family emigrated from St Andrews in Scotland in 1841 and arriving in New Zealand at Petone Beach.

Jim, an only child, attended Plimmerton School, Marist Brothers in Thorndon and St Patricks College in Wellington. A scientist by nature, he was given a book on anatomy as a young teenager and the fascination was instant. He went into the professional stream at St. Patrick’s and on receiving the usual talk from the careers master – ‘there were three choices for boys in this stream, you can be a lawyer, a doctor or a priest’ - Jim had a fairly easy time deciding upon medicine, although a devil of a job getting into medical school (reflecting priority being given to returned soldiers at that time), but make it he did. He was a natural at anatomy and of course surgery; and over the years he became a teacher in the schools of nursing and medicine.

Completing medical training in 1952, Jim married Jeannette Nash. They had first met when Jeanette was 14 years old and they later shared time together at Otago University where Jeannette studied languages. House surgeon years were spent in Wellington and Whakatane Hospitals and this was followed by a year as surgical registrar. During this time their two eldest children John and Philip were born. In 1956 Jim, Jeanette and their young children set off to England so Jim could gain additional experience and obtain his FRCS (England). He worked as a surgical registrar at Mount Vernon Hospital with Ian Durden-Smith, Ivor Griffiths and Sir Ralph Marnham and later as a senior surgical registrar at Whipps Cross Hospital. During their time in London, their third child, Jane, was born.

The family returned to New Zealand in 1959, and Jim quickly obtained his FRACS. For two years he worked at Hutt Hospital as a senior surgical resident and then moved to Wellington Hospital. In 1963, associated with Ian Prior, he undertook research into acute pancreatitis. As his experience in surgery increased, he moved to establish a private practice alongside his work in the public system. He bought a share of Roland O’Regan’s rooms in Kelvin Chambers on the Terrace, and began a long association with Calvary Hospital and the Home of Compassion. Settled back in Lower Hutt, Wellington, the family increased with the birth of Julia 1961, Adrian 1962, twins Sarah and Suzanne 1963 and Justin 1969 – James, born in 1959, died a few days following birth.

Jim enjoyed surgery and meeting with and helping patients. He was a thoughtful clinician, strongly influenced by his medical teachers to not jump to conclusions, but to firstly thoroughly examine the situation before reaching a decision. From this he developed a characterising expression whenever a situation merited more careful consideration – ‘Let’s get some proper light on this!’ While he was appreciative of his clinical environment, he became frustrated by the progressive intrusion of management structures and the accompanying administrative requirements. On retirement from surgical practice he became Surgical Superintendent of the Home of Compassion.

Jim loved entertaining and was a great raconteur, enjoying telling stories and jokes. He appreciated music and was an accomplished jazz musician. Jim got great pleasure out of tennis, golf, and taking his children boating and fishing. He was above all else a devoted father and husband. Jim was a man for whom his marriage, his family and his faith were paramount. After Jeannette’s death in 2008, Jim’s health problems with a “tricky” knee rapidly worsened. He was helped at home by wonderful caregivers and, after two and half years, he decided to move to Shona MacFarlane Rest Home in Avalon where he experienced great kindness and exceptional care.

Jim was a doctor who was a wonderful role model for all who had the pleasure of knowing him. He was a much admired senior practitioner – a man of strong faith with many skills and interests. He was the devoted husband of Jeannette, father of John (anaesthetist), Philip (Māori Language authority), Jane (graphic designer), Julia (homemaker), Adrian (forestry and conservation), Sarah (nurse), Suzanne (graphic designer), and Justin (greenkeeper) and grandfather of 13 grandchildren.

John Simpson FRACS and Philip Walker
George Wilson was a pioneer of ENT surgery to the people of Northland, providing a marvellous regional service for over 30 years. He was the sole ENT surgeon in the region for 26 years and during that time made a major contribution to improved hearing.

George was born in Auckland to David Wilson (a plumber) and Edna Flannery (a registered nurse). He had two younger siblings – David (Buster) and Mary. George attended Whau Valley Primary School and subsequently Whangarei Boys High School. He commenced medical intermediate at Otago University in 1943 entering Medical School the following year.

George worked as a House Surgeon at Auckland Hospital 1949-1950. His personal hearing loss was noted at that time and he was seen by ENT surgeon Bill Bridgman, who recommended George should study ENT rather than other areas of medicine. As an ENT Registrar at Greenlane Hospital in 1951 (he was the first trainee at Greenlane), George met Trish Mannion (a nurse), and they married in December 1952. Just a few weeks later they sailed to the UK where George received further training at Edinburgh, Guilford and then during five years as Registrar at the Royal National Throat Nose and Ear Hospital at Grays Inn Road. George started to use hearing aids while working in England and as they had an obvious component worn on the body this sometimes proved a helpful talking point, particularly during his final fellowship oral exams. He gained his FRCS(Ed) in 1956.

George and Trish sailed back to New Zealand at the end of 1956. George working his passage as a ship’s surgeon on a refrigeration ship which berthed at Port Chalmers. Northland Hospital Board was seeking an ENT surgeon to start a service for Northlanders and George commenced work at Whangarei Hospital in January 1957. As there had been no resident ENT surgeon previously, the work initially involved dealing with gross pathology. There was an epidemic of juvenile tracheo-bronchitis in the winter of 1957. Airway restoration at that time was by tracheostomy, as endotracheal intubation was not in vogue. Tonsillectomy was performed with guillotine under ether. Some years later the Doughty ET tube was used with inhalation anaesthetics.

About 1958-59 Whangarei Hospital procured a Zeiss microscope, which revolutionised ear surgery. Chronic suppurative otitis media (CSOM) with its high incidence in Maori became a large part of George’s practice. During the mid-1960’s George went to Boston to study stapedectomy, returning to operate on many cases, as there was a large residual population with otosclerosis. He also returned with the first grommet produced by Sheehy.

George travelled regularly to the small peripheral hospitals at Kaitaia, Rawene and Dargaville. In the early years he spent two - three weeks away each time as the journey was long and slow on metal roads. The concept of the Ear Caravan for managing CSOM was conceived by Sir Patrick Eisdell-Moore, but there were issues in Auckland so the first one came to Northland in about 1975. The van visited each school for a week providing daily aural toilet and drops, which usually resulted in a dry ear which either healed spontaneously or was made suitable for surgical repair. The caravan was so successful that the incidence of CSOM was significantly reduced, but as a result the incidence of otitis media with effusion (glue ear) increased and this provided continuing work for the caravan. George obtained his FRACS in 1979. With the increasing workload a second ENT surgeon was appointed to Northland in 1983 (Jeremy Gathercole).

Audiologists did not come to Northland till the 1970’s and prior to that George held weekly clinics at the NZ League for the Hard of Hearing. George continued to be involved with the Northland branch of the Hearing Association until after he retired. He was President for many years and was later made Patron. In the 1970’s and early 1980’s George worked with aid programmes to the Pacific Islands spending time in the Solomon Islands, Niue and the Cook Islands. On these visits he was accompanied by Trish, who provided audiometry and other support.

Alongside his professional commitments George was an energetic Rotarian. He and Trish ran a farm with Charolais cattle for many years. As retirement neared they moved to Headland Farm Park. George became heavily involved in conservation projects, specifically weed eradication from native bush, and pest control, and he received several civic awards for this work. Following George’s retirement from clinical practice in 1990 he and Trish enjoyed some great camper-vans trips in the USA and Australia, travelling for over 2 years in total.

George is survived by his wife Trish and 3 children, Craig (landscaper and garden centre owner), Andrew (lawyer) and Oriole (audiologist) and five grandchildren.

This obituary is based upon one prepared for The New Zealand Society for Otolaryngology by Jerry Gathercole FRACS, with the further assistance of Trish, Oriole and other members of the Wilson family.
James Fenton (known as Jamie) was the youngest child of Jim and Margaret Fenton (nee Kidd). He had three sisters, Kathy, Linda and Evelyn and a brother John. Jamie grew up in Whakatane in the Bay of Plenty, attending Apanui Primary School and Whakatane High School, where he was Head Boy in his final year.

Jamie entered Auckland Medical School in 1980. Following House Surgeon years in Rotorua and Adelaide he began his Orthopaedic training in 1992. Returning to the Rotorua Hospital for one year of his training resulted in a strong desire to practise there and, on completing his training, he returned to Rotorua with his young family a few years later and was warmly welcomed back by his colleagues.

Jamie was the youngest of the Orthopaedic Surgeons when he commenced in Rotorua but, providing care for patients in both the Public and Private sector, he quickly became highly respected by colleagues and patients alike. In his private practice Jamie shared facilities and staff with Derek Stanley-Clarke for approximately 18 years, until Derek’s retirement two years ago. Jamie’s secretary for 13 years, Tania, observed that he was a wonderful boss and friend who cared deeply for his patients and staff alike and that he and Derek had created a great working environment. With a great sense of humour, he readily developed a rapport with his patients providing comfort and reassurance to the most anguished patient, and this was widely appreciated. They often came out of a consultation saying “what a wonderful man and so easy to talk to and down to earth.”

Jamie was a skilled and safe surgeon. He was extremely conscientious, always offering his patients the best of care and if he could not provide that he would make sure they would get the best elsewhere. Approximately fifteen years ago, aiming to improve the outcomes, he persuaded Derek to join him in providing a revision hip and knee surgery service for the Rotorua region. This proved a most satisfying and enjoyable experience for each of them as they swapped sides on the operating table and produced greatly improved outcomes for their patients.

Derek noted that he and Jamie had shared values in life and they had beachside homes only a few kilometres apart in the Eastern Bay of Plenty. It was here that Jamie had hoped to retire one day. He was a totally reliable friend and would always be of assistance if called upon and a pleasure to spend time with. He was a keen fisherman and duck shooter.

There was no doubt Jamie’s first love was his family. Although fairly private people, he and Shonagh opened their heart and home to many, and anyone who visited was welcomed with open arms. Jamie’s much loved wife, Shonagh, and their two sons Sam and Hamish have been left absolutely devastated and heartbroken by Jamie’s passing. He was a wonderful husband and father who would do anything for his family. He was also the adored brother and brother-in-law of Kathy and Tony, Linda and Johnny, John and Michelle, Evelyn and Ross and Sue and a much loved uncle.

Sadly, and in common with many surgeons, he sometimes struggled in coping with the stresses of his chosen career and balancing this with the typical issues and stresses of family life. Being the private man he was, Jamie regretfully failed to seek the support of those close to him, be it family, friends, colleagues or professional advisors and, in a moment of acute stress, took his own life. This was totally unexpected and devastating to all he knew.

James will be greatly missed by so many.

This obituary is based upon contributions from Derek Stanley-Clarke FRACS, Shonagh Fenton and Tania O’Brien.

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