FROM THE CHAIR

Improving Your Operating Day

Recently, I taught on a new RACS course, Surgeons as Leaders in Everyday Practice (SAL). The course looks at four domains of leadership: Understanding Leadership, Understanding Yourself, Communication, and Leading Teams. One of the hottest topics we discussed was the use of the World Health Organisation (WHO) surgical safety checklist and the use of preoperative briefing to enhance teamwork.

Recent evidence suggests that operating theatre culture is associated with patient outcomes. Team member perceptions of safe surgical practice were surveyed over 31 diverse hospitals. For every 1-point increase on a 7-point scale for respect, clinical leadership, and assertiveness, there were associated decreases in the relative risk of postoperative death after surgery from 14% – 29%. Assertiveness in this context means people feel invited to speak up with concerns. The authors, who include several physicians prominent in the introduction of the WHO surgical safety checklist, comment that their findings suggest ‘the perception of safety of surgical practice among OR staff may be predictive of postoperative death rates’.

A well-supported team communication training programme at the Veteran’s Health Administration showed a significant reduction in surgical mortality. And while recognising that there are wider considerations for mortality, these findings suggest an important role for team culture in patient safety.

After extensive research into effective team frameworks, Salas et al. suggest that the central aspects are team leadership, mutual performance monitoring, backup behaviour, adaptability and team orientation. These are coordinated by the mechanisms of shared mental models, closed-loop communication and mutual trust. Those of you who have participated in NetworkZ (previously called MORSim) simulation scenarios and other team training will be aware of these ideas.

As our theatre teams are often an ad hoc grouping, briefing can help establish a common goal and promote teamwork. As surgeons, we generally like to consider that our role in the operating theatre is pivotal and the rest of the team is always aware of what we are doing. But this is not always true. In a large exit survey, Makary et al. identified that nearly 12% of people were not sure where the planned incision site was before the start of a case. While we usually regard our teamwork as very good, nurses in the same operating theatres often do not. In another survey, half of the staff did not know the names of all the team they had just worked with, but communication scores increased significantly if they did.

Atul Gawande, known for his active role in the development of the WHO checklist, discusses ‘activation phenomenon’, whereby people are more likely to feel responsible for a procedure and help problem solve if they have been asked to speak at the start.

Medical team training, including briefing, objectively and significantly improves operating room team function and decreases delays. Improved teamwork has implications not only for patient safety, but also for job satisfaction and sick leave taken. The main concern about implementing the briefing process is...
adding complexity and delay to already extensive theatre processes. However, at Johns Hopkins, standardised 2 min briefings reduced unexpected delays by 31%.8

A preoperative briefing takes place at the start of the list, before the first patient is in theatre. It involves establishing team members and their roles, a discussion of factors that might affect the list, and an overview of the cases and relevant information. It should only take a few minutes. If it’s not already part of your practice, I’d like to challenge you to talk to your teams about trying out briefings next year. And consider coming along to a Surgeons as Leaders course to discuss these ideas further!

All the best to you and your families for the holiday season. I hope those of you on leave have the opportunity for reflection and re-charging; to those of you on-call, thank you for your contribution to ongoing patient care over this time.

Success in the Fellowship Examinations

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

Roberto Sthory Sosa – General Surgery
Tim Chuang – Orthopaedic Surgery
Rachel Care – Otolaryngology Head & Neck Surgery
Kumanan Selvarajah – Otolaryngology Head & Neck Surgery
Kerri Mooney – Plastic and Reconstructive Surgery
Nelson Hao Wang – Urology
Manar Khashram – Vascular Surgery

FROM THE CHAIR (continued)


RACS DIARIES

2019 diaries are available from the NZ office
email: college.nz@surgeons.org
or call 04 385 8247

Best wishes for the Festive Season

The New Zealand RACS staff extend their best wishes for a safe and happy Festive Season.

The New Zealand Office will be closed from Tuesday 25 December, re-opening on Thursday 3 January 2019.

Justine, Andrea, Celia, Gloria, Isobel, Jaime, Raji and Richard.
Surgery 2019: Back to the Suture!
An action packed programme that should appeal to all RACS surgeons – young and old.

Speakers invited include: Anthony Hill, Health and Disability Commissioner advising us on his expectations around consent, and Ashley Bloomfield, Director General, Ministry of Health talking on the future of surgery and surgical funding.

Surgery 2019 will look at aspects of surgery in the future, including social media, robotics and virtual reality and will include discussion on professional dilemmas, diversity in the workforce and controversies of venous thromboembolism.

Overall this plans to be a great programme with dinner overlooking Wellington’s waterfront on Thursday night.

Associated Courses/Workshops

Surgical Pioneers – in the afternoon of Wednesday 14 August 2019

Surgeons As Leaders in Everyday Practice Friday evening and Saturday 16 -17 August 2019
SAVE THE DATE
SURGERY 2019: BACK TO THE SUTURE!

15 - 16 August 2019
Te Papa, Wellington

Contact:
RACS New Zealand Office
+64 4 385 8247
college.nz@surgeons.org
Safe Working Hours for Surgeons

The eight-hour day or 40-hour week was a social movement to regulate the length of a working day, to prevent excesses and abuses. It had its origins in the Industrial Revolution in Britain, where industrial production in large factories transformed working life. At that time the use of child labour was common. The working day could range from 10 to 16 hours, and the work week was typically six days a week. What has changed since the industrial revolution and has surgery followed suit in restricting hours of work in the name of patient safety?

There are long standing concerns about the impact of extended working hours for surgeons. Fatigue and sleep deprivation create risk for both the health and safety of surgeons and for the quality of care afforded to patients. Similarly, insufficient training due to restricted Trainee working hours can also compromise patient welfare and must also be considered when determining safe working hours. Individual surgeons should be aware of the number of hours they are working per week, including on-call periods, to identify at-risk work practices that may need modification. There should be cooperation and negotiation amongst all parties involved in the provision of surgery.

Sufficient time should be allocated during the week to allow all the following: audit and peer review, education, training, research, recreational leave and effective handover with the implementation of robust communication networks to ensure continuity of care.

There are safety implications for both surgeons and patients for operations performed outside of normal daytime hours: that is, between the times of 17:00 hrs and 08:00 hrs, but particularly between 22:00 hrs and 08:00 hrs. During night shifts, surgery should be performed on life, limb or organ-threatening emergencies only. Other surgical non-elective cases are best performed during daytime hours and many hospitals already run "sub-acute" theatre lists for this purpose. It is acknowledged that stringent safe-hours rules would impact most on hospitals. As such, cooperation and negotiation amongst all parties are mandatory to ensure a safe working environment, and infrastructure alterations and extra resources may be necessary to facilitate non-urgent surgery being performed in daylight hours.

On-call workloads and the number of participating surgeons on the on-call roster vary widely throughout New Zealand. It would be impossible to apply a single formula that would be applicable to every surgical department. On-call rosters more frequent than 1:4 are not ideal and should only be undertaken if the workload during these times does not impact on both patient safety and the well-being of the surgeon.

PDSB 3.3.1

The filling of “roster gaps” by surgeons such that they are forced to work excessive hours should be avoided. Where such gaps occur beyond the control of the surgeons, it should be the responsibility of the hospital administration, in cooperation with the surgeons, to resolve the shortfall, and locums may be required. Filling such gaps should not simply be an added burden imposed upon other surgeons.

Continuing work while fatigued constitutes a patient safety risk, which needs to be recognised and dealt with. There should be mechanisms in place to enable a fatigued surgeon to be able to hand-over his or her clinical responsibilities if no adequate rest has been taken. An example would be during a weekend of on-call that was unexpectedly busy and entailed a large number of hours operating on a Saturday night, leaving the doctor extremely fatigued on the Sunday morning and unable to continue.

A major activity of surgeons has always been the need to anticipate, identify and bridge discontinuity of care. Within all periods of a surgeon’s workload, there needs to be adequate time allocated for handover of patients to ensure continuity of care. This applies to all doctors at all levels of training and experience. A patient’s care must be formally handed over to the next colleague whenever there is a change of on-call period or shift. This is particularly important when transferring the care of patients to and from locum surgeons and during holiday periods.

Subtleties of a surgeon’s examination and the nuances of his/her observations of critically ill patients cannot be easily handed over. There are also times when, for various reasons, a surgeon may be unable to leave a critically sick patient. In this situation, the surgeon (or trainee) has an ethical obligation and duty of care to remain with this patient until such time that handover can be performed safely, or the crisis is resolved.

A predictable consequence of decreasing hours is that multiple doctors now care for each individual patient. Certainly, a lack of dedicated time for handover results in poor outcomes. Specifically, problems identified when there are multiple medical staff shift handovers occurring each 24-hour period include: prolonged decision making, omissions, translation errors, failure in triage and failure to modulate management in response to situational fluctuations.

In the USA recently, senior residents, specialty societies, certifying boards and the graduate medical education community presented the Accreditation Council for Graduate Medical Education Task Force with a consensus recommendation to eliminate the 16-hour requirement for first-year residents. Reasons they cited for their
Reflecting on Reflective Practice

Sally Langley FRACS

Reflective practice is the capacity to reflect on action so as to engage in a process of continuous learning. In its simplest form it involves thinking about, or reflecting on, what you do. It is closely linked to the concept of learning from experience. Of course, most of us think about what has happened, it is part of being human. However, the difference between casual ‘thinking’ and ‘reflective practice’ is that reflective practice requires a conscious effort to think about events, and develop insights into them. Reflective practice is a process by which you: pause and think about your practice; consciously analyse your decision making; and draw on theory to relate it to what you did (or didn’t do) in practice.

Reflective practice was added, in 2017, as the 4th category of RACS Continuing Professional Development (CPD). The other 3 categories (Audit and Peer Review, Governance and Quality Improvement, Knowledge and Skills) are well known to us and we have all been compliant with CPD. Compliance with CPD is extremely important since it is required for registration with the Medical Council of New Zealand and Medical Board of Australia. We can only practice if we have a current Annual Practising Certificate.

Without realising it we all undertake reflective practice. We plan, undertake and analyse what we do whether it is operations (our most familiar territory), new techniques, teamwork, leadership or administration. RACS surgeons are supposed to be trained and skilled in all nine of the competencies, which are:

- Collaboration and Teamwork
- Communication
- Health advocacy
- Judgement - clinical decision making
- Management and Leadership
- Medical expertise
- Professionalism and Ethics
- Scholarship and Teaching
- Technical expertise

We are more inclined to address the medical and technical competencies by attending conferences and courses as well as teaching, reading journals etc.

We must now formally undertake Reflective Practice which will comply with our RACS CPD requirements. Possible activities include:

- Multisource feedback using a structured framework of surgical competencies e.g. the College’s Surgical Competence and Performance Guide
- Surgical or Clinical Attachment with clear learning objectives and self-reflection
- Development of a structured Learning Plan including self-reflection
- Participation in a structured mentoring program
- Patient Feedback Survey including action plan
- Participant in or Recipient of a structured Practice Visit by a peer with evaluation and action plan

In 2017 completion of the RACS, Operating With Respect eLearning course gained us compliance.

If you attended an Operating With Respect course (face to face) in 2018 this meets your 2018 Reflective Practice CPD requirements.

Otherwise you must do one or more of the possible listed activities and the deadline is 31 December 2018. Some of you will not have attended to this so I will give you advice about what you can do. Then next year you can make more considered plans.

This is not difficult with two achievable options before years end being: A Learning Plan and Cultural Competency Course.

Learning Plan

This can be done online via your RACS Portfolio where you will see your “My CPD Overview” which shows what you have achieved and/or documented so far for 2018. There is a box in the top row, the dashboard, “My CPD”. Click on MyCPD and you will be taken to another set of boxes, one of which is “Learning Plan”. This is a very helpful concept all set out for you to map out your Reflective Practice activity. Think about what you have done in 2018 or have underway, write a plan about what you want to achieve, the course, workshop, visit, study, which will achieve it and then your thoughts to document what you have learned from it. This is a personal activity which is of value only to you. I think that it helps to write a few paragraphs about your plan and what you have achieved and how you might change for the future. You can scan your page or two of reflection and upload to your portfolio.

Cultural Competency

There are eLearning programmes on the RACS and Ministry of Health websites. Each of these takes 2-3 hours
but you might choose to take longer. There is information about communication methods and skills. You will be provided with a certificate which you can upload to your portfolio. I found that the RACS one works best on a desktop computer, rather than iPad or Mac.

For future compliance:
- A surgical or clinical attachment could be planned
- A Patient Feedback Survey could be suitable, particularly for sole practitioners in private practice
- Participation in a formal mentoring programme could be considered for future years

Audit

Did you know that RACS can facilitate and support your audit needs?

The College is a leading advocate for surgical audit. It is a key part of the annual Continuing Professional Development cycle.

MALT, the College’s online logbook tool offers a peer-review feature to help make conducting an audit easier. MALT also offers self-audit functionality, providing data collection, exporting and reporting features.

Why use MALT for peer-review audit
- Surgeons without access to local audit activities can use MALT as a peer review tool
- Audit groups can be set up to include anyone with a MALT account, regardless of specialty, member type (Fellow, Trainee, IMG, J-Doc) or location
- MALT provides the data points recommended in the College’s Surgical Audit and Peer Review Guide (PDF)
- Procedures are coded using SNOMED CT-AU terminology, meaning data is comparable internationally.

MALT audit reporting

A suite of reports allows easy comparison of outcomes whether you use MALT in a peer review audit group or for self-reflection with the self-audit reports.

Surgical outcome reports are available for:
- Complications
- Mortality
- Return to theatre
- Unplanned ICU admission
- Unplanned readmission.

The reporting suite can assist in facilitating your Mortality and Morbidity meetings by allowing you to:
- Share de-identified, tabulated information
- Undertake basic risk adjustment
- Compare your surgical results with the aggregate
- Compare performance and identify outliers with funnel plot reports.

Want to know more?

If you are interested in whether MALT audit functionality can assist you, please enquire with the MALT Helpdesk or submit an Expression of Interest form (PDF).
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 behalf of Fellows, Trainees and IMGs in the MOPS programme. Some of these activities since the previous Cutting Edge are commented on below.

Surgical Mesh
Mesh Surgery Roundtable consists of representatives from RACS, RANZCOG, RNZCGP, ACC, HDC, Worksafe, MOH and the consumer group (Mesh Downunder), Sharon English (FRACS Urology) and Richard Lander (as EDSA (NZ)) are members of this. The Roundtable has recommended to the Minister of Health that the Ministry set up an interim “Provider Registry” to begin collecting prospective data at a DHB level. This registry will likely contain some limited outcomes data. A full national registry is planned for the future. At present there are divergent opinions from Roundtable members on pausing the insertion of mesh for stress urinary incontinence (SUI), so NZ is not following the actions of the UK and Northern Ireland. Currently surgical mesh for other surgical indications is not on the agenda.

Patient information on SUI and the use of mesh is due for release shortly and will be an aid to informed consent for SUI mesh surgery. A subgroup of the Roundtable is looking into the appropriate credentialing of surgeons for SUI mesh insertion and removal. Another group is looking at care pathways for patients with symptoms following mesh insertion.

RACS expressed disappointment to the DG of Health that DHBs have been directed to follow the Australian Commission on Safety and Quality in Health Care credentialling guidelines without consultation with RACS. A credentialling framework already exists in New Zealand, so it is considered inappropriate to assess surgeons undertaking urogynaecological surgical mesh procedures here against credentialling guidance developed for Australia. They may well be appropriate in that country but we have different regulations for vocational registration, credentialling and scope of practice here. Seven DHBs have indicated that they comply with the Australian SQHC guidelines, giving a total of approximately 21 surgeons “adequately credentialled”, including both urology and O&G. Some DHBs have indicated that they have paused doing mesh surgery for SUI.

Māori Health Action Plan
The Māori Health Advisory Group September hui with the five specialties that select specifically for training in NZ discussed cultural competence in selection and in training curriculum. Several specialties had incorporated some assessment of cultural competence, using Māori examples, into their selection processes this year and two included Māori on their selection panels. All are keen to take this on and demonstrate the importance of this to prospective trainees. The Advisory Group is working on resources to assist the specialties and is planning to meet with them again in the first quarter of 2019.

Pacific Health
The Pacific Islands Surgeons Meeting held in Fiji in October (in conjunction with GSA on this occasion) has been reported on in Surgical News. RACS supports the Pacific Islands Surgeons Association (PISA) in the running of these biennial meetings. We were very grateful to the Ministry of Foreign Affairs and Trade’s Aid programme for its financial support of 15 surgeons and surgical trainees from 10 Pacific Islands countries to attend this meeting. Closer to home, the inequitable health outcomes of Pacific Islanders in this country will be known to surgeons. Having some focus on that will be discussed by the NZNB when it is reviewing its strategic plan early next year.

ACC & unintended consequences
NZNB representatives meet with ACC representatives several times each year, and most recently in early December. The recent Court of Appeal decision around the definition of ‘ordinary consequence’ as it relates to treatment injury was discussed. Justice Churchman ruled that ordinary consequence “means a consequence that has a 50% or greater chance of occurring” (ie. it is more likely than not). Anything up to 50% would be considered a treatment injury. This is a very different interpretation than has been applied to date; and ACC is considering whether it may, or can, appeal that decision. ACC’s most recent report on treatment Injuries is available through its website.

Choosing Wisely New Zealand
The Chair of Choosing Wisely New Zealand (CWNZ), Dr Derek Sherwood attended a recent NZNB meeting to talk further with the Board, particularly about the information for consumers on procedures and/or tests that are associated with RACS nine surgical specialties. There have been concerns from some that lists put forward by one medical specialty impact on another; and there hasn’t been sufficient consultation between the two specialties to agree on the Choosing Wisely information. All medical colleges have been asked to identify a member who will be sent all proposed CWNZ lists. That person will review these, consult within their College and, if necessary, advise of any potential conflicts. The specialties involved will be required to resolve the issue(s) before CWNZ will post the list on its website. The EDSA (NZ), Richard Lander, has been identified as the initial contact in RACS. He will ensure the relevant RACS specialty/ies are brought into the discussions.
When I was a young boy I rang a very large bell. Unfortunately it had a wasp nest in it… History seems to have repeated itself.

The New Zealand Trainees continue to be well represented on College boards and we are very lucky to have Rachel Care as the Chair of RACS Trainees Association (RACSTA). Her feisty nature ensures New Zealand trainees are well represented. She has been a wonderful colleague to work with and useful ear to bend when I have had issues.

This will be my last Cutting Edge article as the New Zealand Trainee Representative on RACSTA position is passing to Bryce Jackson. Bryce is a plastics registrar who is keen and motivated. I am sure he will do a great job representing our surgical Trainees.

For me it has been a tough 2 years trying to juggle life, exams and College responsibilities. This has included considerable advocacy around our continued access to training opportunities. As with most things you always feel you could have done more. It has been a worthwhile experience and I am very privileged to have played a part in the huge machine that is our College. I leave my role in awe of the New Zealand surgeons on the College and New Zealand National Boards. They give so much of their time and experience. We are very lucky to have such wonderful leadership. We are also very lucky to have a wonderful New Zealand based support team at the College office in Wellington. Justine, Isobel and Andrea have made my role infinitely easier to manage and have never got cross when my articles and reports were late (which was very often).

The year is rapidly ending and for many trainees the dreaded shift to a new hospital, a new home and a new way of life is approaching. To all those moving, good luck. To all those studying for exams, please take a short break over Christmas and enjoy your family – the books can wait.

Merry Christmas and Happy New Year everyone.

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**Damian McMahon Trauma Research Travel Grant for Trainees**

Dr Damian McMahon FRACS was an integral and influential member of the RACS Trauma Committee and Chair of the Trauma Verification Subcommittee. The Damian McMahon Travel Grant has been established to recognise and honour the commitment and work that Dr McMahon gave to RACS as well as rewarding excellence in trauma research.

The Damian McMahon Trauma Research Travel Grant is based on research into cause, prevention and/or management of trauma and is awarded to the best trauma research paper presented by a Trainee at the RACS Annual Scientific Congress (ASC). The competition encourages SET trainees to undertake trauma and injury research. The 2019 ASC will be held in Bangkok in May and the Damian McMahon Trauma Research Travel Grant is a session in the ASC trauma program.

**Abstracts open in October 2018 and close Sunday 28 January 2019 – visit asc.surgeons.org**

The Damian McMahon grant will assist the recipient with travel expenses to attend and present their paper at the 2019 Advanced Trauma Life Support (ATLS®) Asia-Pacific Region XVI paper competition. The winner of the Asia-Pacific Region XVI meeting is supported to compete at the American College of Surgeons Committees on Trauma scientific meeting in the US in March 2020, where the winning research paper will be published in the ACS Journal.
There are a number of Younger Fellows activities I would like to highlight and encourage people to enter into their calendars for 2019.

The Younger Fellows Forum (YFF) will be held in Bangkok, Thailand Friday 3 – Sunday 5 May 2019. The YFF is held annually prior to the RACS Annual Scientific Congress. It is an important opportunity for Younger Fellows to engage and have a voice in the strategic vision of RACS and provides Younger Fellows a direct opportunity to engage with College council and highlight issues of importance to our group. Although nominations for 2019 close in December I would encourage all NZ Younger Fellows who did not nominate to consider attending the 2020 YFF in Melbourne. Further information and contact details for enquiries can be found on the College website.

The 2019 ASC, 6 – 10 May will follow the YFF and will also be held in Bangkok. There is an excellent Younger Fellows programme in the ASC organised by Sarah Usmar and Andrew MacCormick. For those who cannot attend the YFF I encourage you to make time to attend the Younger Fellows activities at the ASC.

Save the date for the 2019 Preparation for Practice workshop to be held on Friday 2 August 2019. This is an excellent programme that covers issues important to Younger Fellows transitioning to independent specialist practice. The workshop is aimed at senior RACS Trainees and new Fellows and covers important issues including practice establishment, medicolegal topics, financial practice issues, dealing with private and public employers along with presentations from insurance and funding providers. If you are a recent Fellow or senior Trainee I encourage you to pencil this date into your diary for 2019.

Members of NZ Younger Fellows Advisory group are:
- Cardiothoracic Surgery and NZ Younger Fellows representative – Sean Galvin sean.galvin@cdhb.org.nz
- General Surgery – Linus Wu Linus.Wu@waikatodhb.health.nz
- General Surgery – Marianne Lill C/- Whanganui Hospital
- 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 - Anna Lawrence - drannalawrence@gmail.com
- Vascular Surgery – Parminder Chandhok – Parminder. Chandhok@middlemore.co.nz

Surgical Pioneers – Festschrift in Honour of Wyn Beasley

A festschrift in honour of Wyn Beasley was held in the RACS office, Wellington on 9 November. Friends and history enthusiasts gathered to hear memories of working with Wyn, living with history (ie: Wyn by Spencer Beasley) and from Wyn, on History and Serendipity. Other presentations covered Charles Begg, Bob Spencer, the NZ Medical Team in Vietnam, the RNZAMC and the History of Orthopaedics.

Following the afternoon of presentations and discussion the group adjourned to the Wellington Club for its Remembrance Day dinner.

Right: Front, left to right – Bill Gillespie, Spencer Beasley, Alice Beasley, Wyn Beasley, Rosalie Thurston, Ron MacKenzie
Middle row, left to right – Randall Morton, Stephen Packer, Jeremy Hornibrook, Ste Garland, Elizabeth Milford
Back row, left to right – Bill Gilkison, Allan Panting, Chris Hoffman, Bill Sugrue, John Begg, Tony Hardy, Ross Blair

BreastSurgANZ Level 1 Oncoplastic Workshop

Saturday 10 August 2019,
Crowne Plaza, Queenstown
For more information: T +61 3 9249 1260
E: BreastSurg@surgeons.org
Douglas Waddell Jolly (1904–1983)
BATTLEFIELD SURGEON AND FOREIGN FIGHTER AGAINST FASCISM 1936–1945

Patrick Medlicott FRACS

Douglas Jolly was born in 1904. His father was a businessman and soldier and was killed at Armentieres in WWI. His mother was an educated woman and after her husband’s death brought up the family all who became professional people.

He was educated at Cromwell Primary then in Dunedin at Otago Boys High School and Otago University Medical School. While at University he lived at Knox College and became a member of the Student Christian Movement. He came under the influence of the Reverend Donald Grant a charismatic man who believed Christians should fight for their beliefs.

After graduation Douglas had House Surgeon jobs in Dunedin, Wellington and Palmerston North. He then moved to London for further surgical education and stayed with the Grant family who had now returned to England. There he passed primary FRCS.

The years 1935-36 saw turbulent times with the rise of Fascism and Moseley’s Black Shirts which Douglas was involved in marches against (The Battle of Cable Street). Just before he was due to sit final FRCS in 1936 he joined the medical services of the International Brigades (volunteers from Europe, US, New Zealand and Australia) and went to Spain.

The Spanish Civil War (the war) (1936-1939) was the prelude to WWII and was between the rebel General Franco (Nationalists) and the elected (Republican) government of Spain. Douglas served in the siege of Madrid initially and then in every campaign of the war ending in the Ebro campaign of 1938. By then he was a Major in the Republican medical services and was awarded the Ebro medal. While in Spain he treated around 5,000 casualties and performed over 1,000 abdominal operations.

He developed the concept of the Mobile Surgical Team to operate as close to the front line as possible and the Three Point Forward organisational system to facilitate this. The mobile surgical unit was taken up by New Zealand Surgeons in WWII on his model. His “window” then was to achieve a maximum of 5 hours between wounding and emergency surgery. This is now the “Golden Hour”. The Republican services were deficient in air superiority and, where possible, operated in disguised tents, caves and railway tunnels to avoid air attack. He was regarded by Archie Cochrane of the Cochrane Collaboration as “The best volunteer from the British Commonwealth in Spain, I could never understand why he never got his FRCS” and Alexander Tudor-Hart Orthopaedic Surgeon 1900-1992 said “Jolly was like me, only better. He was the best surgeon we had”.

The International Brigades suffered horrendous casualties and were the shock troops for the Republicans. They were withdrawn in 1938 in an agreement to hasten peace negotiations and end the war. This agreement was ignored by Franco and the nationalists and their Fascist supporters Hitler and Mussolini who then overran the remaining Republican forces and “won” the war. Between 500,000 and 1 million people died during the war and many thousands were exiled. The Franco fascist dictatorship lasted until 1975 and many thousands were executed or fled Spain during this time.

After leaving Spain, Douglas briefly returned to NZ. He lectured on the war and its lessons to medical and non-medical groups and raised money for the Spanish diaspora. He then returned to England working his passage on a cargo ship.

In 1940 he wrote “Field Surgery in Total War”. This described his medical and organisational experiences in Spain. This book was published in England and the US and became the “Bible” for New Zealand, British and American military surgeons during WWII, especially the New Zealand Mobile Surgical team in the Western desert. A sand-stained copy is still held by the family of the Late Lieutenant-Colonel Stanley Wilson DSO, FRACS, father-in-law of the late Michael Shackleton FRACS who served in Vietnam and wrote the book “Desert Surgeons”. Both were friends of my family.

Douglas then enlisted in the Royal Army Medical Corps (RAMC). He saw service in North Africa (Tobruk and Tripoli) and in the Italian campaign. He received many accolades, was awarded the OBE in 1943 and became 2IC of a surgical hospital in Italy. His CO in 1945 wrote that he had “Brought forward surgery specialism to a remarkably high standard, developed two stage wound treatment to an astonishing level of success, reduced chronic sepsis to negligible proportions, perfected the use of Penicillin, reduced mortality to a level unsurpassed in history, advanced the technique of early skin grafting, appreciated the importance of maintaining the normality of the blood during convalescence and unselfishly allowed devotion to the welfare of the patient to triumph.”

Douglas demobilised from the RAMC in August 1945, returning to civilian practice in the UK. He never sat for his final FRCS and a family story says he did go to sit but decided to walk away. He retrained in Prosthetic practice and joined the staff of Queen Mary’s Hospital, Roehampton, London and rose to become Medical Superintendent. He was involved in the treatment of war and civilian amputees and later in management of the Thalidomide epidemic. He retired to the village of West Horsely in Surrey where he became an avid wood worker and was often visited by Jolly relatives from NZ. He married late to Jessica Kain, the widow of his best friend, and his step children and step grandchildren remember him fondly. Douglas died in 1983.

Cutting Edge | Issue No 69. December 2018
I had not heard of Douglas until I was asked by Bill Sugrue in 2014 to do a paper on him for “Surgical Pioneers” in 2015. Since then I have presented on his life and works twice overseas and he has become part of my life. During this time I have been helped by Mark Derby the NZ historian and by David Lowe FFARACS, an Intensivist from Sydney, who has managed to find Douglas Jolly’s step-daughter (now deceased) and step-granddaughter in Canberra. They have provided us with all his memorabilia.

I led the group to get his memorial (right) placed in Cromwell. Mark Derby is writing a full biography and David and I are helping with surgical details. Mark and David have recently published an article on Douglas for the journal of Medical Biography.

Our next project may be to try and get one of the most famous war surgeons of the 20th Century an honorary posthumous FRCS or even FRACS.

Right: The bronze plaque, unveiled 23 March 2018 by the Charge D’Affaires of the Spanish Embassy to New Zealand, on the wall of the Jolly family store in Cromwell.

**Dates to Note**

The New Zealand College office last day of business is Monday 24 December. It re-opens on Thursday 3 January 2019.

- **1 January 2019**
  
  2019 subscription fees are payable by 1 January 2019.

- **3 January 2019**
  
  Applications for May 2019 Fellowship Examinations open on 3 January and close on 28 January 2019. All examination dates are available on the College website.

- **4 January 2019**
  
  Registration for SET selection opens on 4 January and closes on 1 February 2019. Full details can be found on the College website.

- **28 February 2019**
  
  The date for final submission of 2018 CPD data is 28 February 2019.

- **4 March, 4 June, 3 September and 2 December 2019**
  
  Cutting Edge contribution dates for 2019 are 4 March, 4 June, 3 September and 2 December 2019.

- **8 March, 7 June, 16 August and 6 December 2019**
  
  New Zealand National Board meetings will be held on 8 March, 7 June, 16 August and 6 December 2019.

- **3 – 5 May 2019**
  
  Younger Fellows Forum will be held in Bangkok 3–5 May 2019

- **6 – 10 May 2019**
  
  The ASC is in Bangkok over 6 –10 May 2019.

- **29 – 31 July 2019**
  
  A DSTC/DATC/DPNTC course will be held in Auckland 29 – 31 July 2019. You can find out more and register on the DSTC website.

- **15 & 16 August 2019**
  
With the death of Joan Chapple on 22 May 2013 New Zealand lost its first female plastic and hand surgeon. In a male-dominated environment, Joan struggled to gain acceptance and recognition by her colleagues. Her advocating for the gentle handing of soft tissues with an emphasis on haemostasis, avoidance of tension and the unnecessary use of sutures was slow to gain recognition. However, Joan’s contributions to medicine and the community were ultimately recognised when she was made CNZM in 2001.

Joan was born in Te Puke to Kingsley (King) and Winifred Chapple, the middle of five siblings (James, Jocelyn, Joan, John and Jefferson). The children attended Te Matai primary school in rural Bay of Plenty, where their father was headmaster and where of the hundred or so pupils only the Chapples and one other family were non-Māori. Interestingly, George Plumb, the rascible and stubborn social activist clergyman portrayed in the acclaimed novel, Plumb, written by Joan’s cousin Maurice Gee, was closely modelled on their mutual grandfather James Chapple. Joan may have inherited some of his attributes.

Joan first attended Te Puke High School and later boarded at Epsom Girl’s Grammar School in Auckland where she was a school prefect in 1951. She became an accomplished cellist and developed a lifelong interest in woodcarving and pottery.

After a medical intermediate year at Auckland University, Joan was accepted to the University of Otago Medical School. She was a diligent and capable student and during her later years, stimulated by Professor Alan Aldred, took a particular interest in orthopaedic surgery. Joan was one of only nine women among over ninety graduates in 1957. She gained distinction in surgery and was awarded the Stanley Wilson Prize.

Returning to Auckland as a house surgeon she was a registrar in Plastic Surgery in 1961 completing her FRACS in General Surgery in 1963 and, following in the footsteps of Jean Sandel in New Plymouth who had gained FRCS in 1947, became the second woman in New Zealand to gain a specialist surgical qualification. Joan travelled to Australia, Britain and Russia for postgraduate training. In Vellore, India, she worked with the celebrated hand surgeon, Paul Brandt, who was pioneering tendon transplantation in the hands of lepers. She finally visited the USA, but she was forced to leave prematurely being accused of un-American activities in the aftermath of the McCarthy era.

On her return to Auckland Joan was appointed to a full-time post in the Plastic Surgical Unit at Middlemore hospital, working under William Manchester, later Sir William. As the only woman surgeon, she never felt welcome in the Auckland surgical fraternity. It was understood that she would not attend regular meetings at the men-only Northern Club. In 1972, unmarried, she gave birth to a daughter, Raven. While she asked for only five months maternity leave, this was denied and her job was terminated. It was widely perceived that her dismissal was primarily for moral rather than professional reasons, and it resulted in considerable controversy in the medical and wider community.

Joan was later appointed to a part-time position in the Accident and Emergency department at Auckland Hospital, and served in this position until her retirement in 1994. She developed and practiced a then unorthodox thesis of wound management avoiding where possible the use of sutures and emphasising the importance of haemostasis, gentle handling of tissues and preservation of tissue blood supply with avoidance of tension and pressure. Although she taught these principles to junior doctors, general practitioners and nurses, who adopted them enthusiastically, her ideas were slow to be accepted by practicing surgeons and her criticism of their techniques aroused some resentment. In 1980 she self-published her ideas in a book entitled “Wound Care and Healing: The Physiological Challenge”: This was based on her experience and included case studies and a unique series of clinical photographs. It was expanded and updated in 2001.

Outside medicine Joan was actively involved in Alliance politics and the International Physicians for Prevention of Nuclear War. She also served on the Auckland University Council. She was passionate about the plight of the underdog and sometimes provided hospitality for disadvantaged people at her property at Karaka Bay.

Joan was made a Companion of the New Zealand Order of Merit for services to medicine and the community in 2001. Her retirement was marred by major medical issues, first with colonic and later ovarian cancer.

Joan was a compassionate and caring doctor and a generous and loyal friend. Her gender and unconventional attitudes may have restricted her from reaching her full potential as a surgeon, but she was in many ways ahead of her time. Her achievements were significant, and she will be remembered with affection and respect.

She is survived by her daughter Raven and grand-daughter Tilly Lamb.

This obituary was provided by Mr Alan Kerr FRACS and Raven Chapple.
Dick was born at the family home in Kilbirnie, Wellington, to Jack, a general practitioner, and Gladys. He was the second of four children – Evelyn, Beatrice and Bruce. Dick commenced school at Eastern Hutt School and, successfully completing a proficiency examination, gained entry to Wellesley College. When he was 12 years old his father died suddenly leaving Gladys to raise the family. As a consequence of his father’s death, and on a hardship scholarship, Dick was sent as a boarder to Christ’s College in Christchurch for some male influence. While bullying of junior boarders was the norm at that time, Dick’s musical talents became evident as he commenced playing the piano and participated in the Chapel Choir. He was a very capable gymnast, becoming a member of the Gym-eight.

Strongly influenced by his father’s choice of career and sister Evelyn’s commencing medical training, Dick gained entry to Otago University Medical School in 1942. During this time the family lived in Dunedin and Dick was strongly motivated to study to avoid being enlisted for the army. However, there was time to enjoy participation with the University Dramatic Society. Sadly, Evelyn died in a horse accident during her final year at medical school.

Completing his MB ChB in 1947, Dick worked as a house surgeon at Wellington Hospital. In 1949, working his passage as ship’s surgeon, he travelled to Sydney to commence study for his FRACS before returning to Rawene in the Hokianga District for four months general practice to meet his medical bursary obligations. While there he mastered basic Māori. In 1950, in common with many other aspiring surgeons, he travelled to the United Kingdom to obtain surgical training, securing positions at Whipps Cross Hospital, St Andrew’s Hospital, Essex and then Edinburgh – where he obtained his FRCS(Ed). During 1952 he worked as a surgical registrar at Southampton General Hospital. The next year Doug Short, who had worked in Edinburgh with Dick, recommended he apply for the position he was vacating, as Assistant Medical Superintendent at Nelson Hospital.

Taking up employment at Nelson Hospital Dick covered an extended range of general surgery which included urology, ENT, acute orthopaedic surgery, and emergency Caesarean sections. When Dr Low retired in 1955, Dick was appointed to a visiting consultant position providing him the opportunity to become involved in private practice, while continuing his public hospital work. He also became FRACS at that time. From an early stage he specialised in vascular surgery and continued that alongside his wide range of general surgery throughout his 34 year career at Nelson Hospital, as well as in his private practice and operating sessions at Manuka Street Hospital. A younger colleague who operated with Dick over the years felt a quote from a surgical journal in 2014, also fitted his own experience of Dick: “His operations were swift without being hurried... he was calm... he had a plan for every circumstance.’ He maintained this role, assisting in the provision of a one in three roster, until his retirement from full-time clinical practice in 1995.

Dick had first experienced a taste of surgical locum work in Nuie in 1978 when he had taken his family with him. On retirement from Nelson Hospital he spent some years undertaking surgical locums throughout New Zealand and in Apia and Rarotonga. In 1987 Dick volunteered for a term with Medecins Sans Frontieres in Sri Lanka, this proving a profoundly moving experience, during which he was ambushed and dealt with horrific war injuries.

At the time Dick commenced work in Nelson, the “cold war” dominated international relationships and with the New Zealand government providing a subsidised pilot training programme, Dick took to the air with enthusiasm, learning to fly tiger moths and Auster planes. Hiring a plane for three pounds an hour, and with no extra cost for parking at regional airports, Dick and friends enjoyed air travel to places such as Christchurch, Wellington and Farewell Spit. When Dick’s mother suffered a broken ankle in the late 1950s he met her delightful physiotherapist, Sally Reid, and they married in 1958. Their first child, Jane, was born in 1960 and their second, Tom in 1961. The Rawson family was completed in 1965 with the birth of their third child, Sally Reid, and they married in 1958. Their first child, Jane, was born in 1960 and their second, Tom in 1961. The Rawson family was completed in 1965 with the birth of their third child, Jane, was born in 1960 and their second, Tom in 1961. Their third child, Sally Reid, and they married in 1958. Sally developed aggressive cancer and died within a short time and within two years the quads had left home for tertiary education.

With a love of music and acting, Dick joined the Nelson Repertory Society soon after his arrival in Nelson. He continued this throughout his life and, while working as a locum for six months in Gisborne towards the end of his medical career, gained media attention through a stage performance in the role of Lord Chancellor in Iolanthe. Dick was a member of Nelson Civic Choir and a foundation Member of the National Male Choir of New Zealand in 2000, enjoying a month-long tour of Wales and the UK including appearances on BBC TV. While tramping had been a life-long pleasure, on retirement Dick became an avid solo cyclist covering many thousands of kilometres in numerous countries – including an extended period in

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William Owen Sawtell (known as Bill) Phillipps was born in Wellington to William John Phillipps, an Ethnologist at the Dominion Museum, and Esther (née Waldie), who was a graduate of Wellington Girls College. Bill commenced his education at Khandallah School and then went to Wellington College, where he excelled academically and at athletics. With an ear for music, Bill learned to play the piano and was a singer in the Anglican Boys Choir.

Although his father thought Bill might like to take up a career in accounting, being very proficient at mathematics, he chose medicine instead. He was admitted to Otago Medical School, graduating MB ChB in 1950. During his time in Dunedin he was University table tennis champion for several years and was awarded a University Blue. After spending a year as an Anatomy Demonstrator, Bill worked as a House Surgeon at Wellington Hospital, meeting Patricia Martin, a trained nurse. They married in 1952 and moved to Rotorua Hospital for one year. In 1954, after working briefly as a locum for general practices in the North Island, Bill and Pat travelled to England where Bill took up a position as a senior house officer at Kingston on Thames. In 1956 he moved to a similar position at Carshalton Childrens Hospital, spending two years there and gaining his FRCS.Ed. Bill was a surgical registrar at South Devon and East Cornwall Hospital, Plymouth during the years 1958-9 and at Southend General Hospital in 1960.

In the UK Bill acquitted himself well and was highly thought of by both staff and patients alike. His colleagues described him as a ‘first class surgeon’, capable, enthusiastic and conscientious. Surgeon A.G. Dingley of Southend-On-Sea Hospital noted his common-sense approach to surgery and being trustworthy with even the most complicated of cases. Mentors included Sir Gordon Gordon-Taylor, Dick Franklin (who was a protégé of George Grey Turner), Harold Nixon and Denis Browne.

Bill and Pat, now with four children, Jeanette, Michelle, Matthew and Adam, returned to New Zealand by sea, when Bill became Acting Surgeon Superintendent at Oamaru Hospital. The following year, 1961, he was admitted FRACS and was appointed to the North Canterbury Hospital Board. The family duly moved to Christchurch and the youngest child, Michael, was born. Bill was a Consulting Surgeon with a part-time private practice there until 1991 when he retired from his hospital appointment. By that time he had developed a special interest in bariatric surgery. He was supportive and encouraging of junior staff and his gentlemanly kindness was often commented upon. He ceased private practice in 1994 and eventually Bill and Pat moved to Auckland to be near their family.

Bill's hobbies included vintage cars and he owned an Overland 1929 which he often took on rallies. He was also very interested in antiquarian horology and had an extensive clock and watch collection which he maintained himself. Under the tutelage of Christchurch furniture maker Frank Hill, he compiled a number of items from recycled kauri, including two small desks and a carpenter’s workbench. Bill was a vegetarian for much of his life.

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Bill is greatly missed by his wife Patricia, his children Jeanette, Michelle, Matthew, Adam and Michael, seven grandchildren and three great-grandchildren.

This obituary was prepared by Michelle Osborne and other members of the Phillipps family.
We encourage letters to the Editor and any other contributions
Please email these to:
college.nz@surgeons.org
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