My impending retirement both as Chair of the NZ National Board and as a senior surgeon over 65 years, leads me to turn to the phenomenon of change as a topic for this my final contribution as Chair, to Cutting Edge.

Change with a ‘new’ FRACS

For the young surgeon, getting a RACS Fellowship heralds a time of important change in professional status and clinical responsibility. However, RACS Committees have recently discussed the difficulties that young Fellows are apparently experiencing in getting a hospital appointment. One of the factors cited is the phenomenon of older surgeons not retiring but rather staying on, and thereby potentially creating “a road block” to progress for younger Fellows.

Undoubtedly some will be contemplating a possible trade-off between a wealth of personal experience and the loss of manual dexterity and visual acuity. There are of course opportunities for senior surgeons to remain and ‘evolve’, continuing in (say) a teaching, academic or administrative role.

‘No Change’ for (some) Senior Surgeons

The recent RACS Surgical Workforce Census Report for 2016 shows that 81% of responding surgeons over the age of 65 intend to continue in paid employment for the next two years. The “primary reason” stated was that they were still enjoying their work (48%) or because they felt they added value to the workforce (28%); 10% continued to work for financial reasons. The census does not have information about the reasons why surgeons plan to stop working when they do, so we can only speculate on that.

Undoubtedly some will be contemplating a possible trade-off between a wealth of personal experience and the loss of manual dexterity and visual acuity. There are of course opportunities for senior surgeons to remain and ‘evolve’, continuing in (say) a teaching, academic or administrative role.

The Reality of Change for Older Surgeons

Growth in skill and knowledge generally progresses over time in the manner of a rising curve … with superimposed steps as new technology is introduced. Eventually, however, the pattern of the curve will plateau, then decline. An individual’s response to the decline can take the form of “hanging on”, “stepping down”, “letting go”, or “moving on”.

For those approaching the end of their professional surgical career it is critical to employ personal insight into how well one is travelling surgically, especially in an environment of changing, complex technology.

Retirement while still “on top” is a nice idea, but it can be difficult to recognise the peak until it has passed. So we need a colleague to be frank with us and inform us sensitively about our perceived performance as we progress.
Measuring Change in Performance over Time

Age is a surrogate for what we really need to measure, namely: mental capacity, surgical dexterity and physical health. There is undoubtedly a correlation between these factors and age, but in the hospital / surgical environment, experience and expertise also count for a lot, and senior surgeons can still make an important contribution.

It’s all about Respect

In essence, the RACS “Let’s Operate with Respect” programme should apply at both ends of the professional time continuum. We should respect not only our older colleagues approaching retirement for what they still have to offer, but also our younger colleagues for the promise that they hold, when seeking that first step on the professional ladder.

Patient informed consent for treatment by trainees

Anthony Hill - Health and Disability Commissioner

It is important that consultant surgeons of the future are adequately trained, and an essential element of training is the opportunity to develop surgical skills by performing operations. This article discusses a case where I considered what information a trainee surgeon needed to provide to a patient. Right 6(1)(d) of the Code of Health and Disability Services Consumers’ Rights (the Code) states that every consumer has the right to the information that a reasonable consumer in that consumer’s circumstances would expect to receive, including “notification of any proposed participation in teaching …”. Clause 4 states that teaching “includes training of providers”.

Research suggests that patients support the involvement of trainees in surgery, but want to be informed in advance. In 2009 Ritchie and Reynard found 96% of patients thought that patients should be told if a trainee was involved in a procedure. 90% were happy for supervised trainees to operate as a general concept but, when questioned about their specific procedure, only 77% were happy for a supervised trainee to do their operation. 17% felt that any trainee operating, whether supervised or unsupervised, was not appropriate for their operation.

In an HDC case (13HDC01345) a woman consented to undergo an epiretinal peel operation on her eye. HDC’s independent expert advisor said this surgery is extremely delicate and precise, being intracocular microsurgery at about the limit of fine manual dexterity. The expert advised that a minor loss of control of an instrument or a misjudgement of depth had the potential to cause permanent harm to the delicate tissues of the central retina. He stated that it is understandable that such an injury is more likely in the hands of a relatively inexperienced surgeon and this therefore represented an increased risk to which the woman was exposed by virtue of having her surgery performed by a surgeon in a training role.

Prior to her surgery, the woman was visited by a senior ophthalmology trainee. The woman and her husband both understood from the information provided by the trainee that the consultant surgeon would perform the procedure and the trainee would observe it. The trainee told HDC that he introduced himself and explained he would be one of the surgeons working with the consultant that day.

The trainee performed the surgery under the supervision of the consultant. During the procedure the trainee inadvertently touched the tano scraper onto the woman’s retina. The consultant stated the action took less than a second and occurred too quickly for him to prevent it. The consultant took over and completed the surgery. However, the woman suffered permanent damage to her eye and loss of sight.

I found that in the circumstances of this case, the trainee breached Right 6(1)(b) of the Code in that he did not explain to the woman sufficiently that he would perform the surgery, and did not inform her of any consequent increased risks. It followed that the woman was not in a position to give informed consent and so the trainee also breached Right 7(1)(b) of the Code. I also made adverse comment about the consultant as I considered that it was the consultant’s responsibility as the supervising ophthalmologist to ensure that appropriate informed consent is obtained.

My findings in this case were specific to the particular circumstances. Most institutions will have policies to guide practice in this area. I encourage practitioners to be aware of those policies, their obligations under the Code and to carefully consider how they deploy in a particular context.
SURGERY 2017: Future Proofing Surgical Practice

THURSDAY 17 & FRIDAY 18 AUGUST 2017
TE PAPA, WELLINGTON

Surgery 2017 will discuss the future of surgery, the right treatment for the right patient, fees, burnout, resilience, greening the hospitals, climate change effects on health and more. An interesting cast of international and local speakers will present on the various aspects of future proofing surgery and healthcare.

Whether your practice is public or private, and regardless of specialty, this year's theme is pertinent to all who are conscious of the future of the profession. Join us in Wellington for two days of excellent presentations, discussion and debate.

See the Provisional Programme — Register now on the College website

Invited speakers include

Dr Cathy Ferguson – Vice President of RACS and Otolaryngology Head & Neck Surgeon. Dr Ferguson has previously served as Chair of the RACS New Zealand National Board, the Deputy Chair of the New Zealand’s Perioperative Mortality Review Committee and President of the New Zealand Society of Otolaryngology, Head and Neck Surgeons.

Professor Des Gorman – Executive Chair, Health Workforce New Zealand and Professor of Medicine and Associate Dean, Faculty of Medical and Health Sciences at the University of Auckland.

Professor Philippa Howden-Chapman – Professor of Public Health at the University of Otago, Wellington where she lectures in public policy. Professor Howden-Chapman has a strong interest in reducing inequities in the determinants of health and has published widely in this area, receiving a number of awards for her work including the Prime Minister's Science Prize in 2014.

Dr Rhys Jones – Public Health Physician and Senior Lecturer at Te Kupenga Hauora Māori, University of Auckland. Dr Jones is a previous Harkness Fellow in Health Care Policy based at Harvard Medical School, and is the Principal Investigator of the Educating for Equity study, an international research project examining how health professional education can reduce inequities and improve health outcomes for indigenous populations.

Professor James Renwick – Deputy Head at the School of Geography, Environment and Earth Sciences at Victoria University. Professor Renwick has a background in atmospheric physics, mathematics and statistics, and has research interests in paleoclimate reconstruction, synoptic climatology, climate modelling and climate change. He is involved with the Intergovernmental Panel on climate change and was previously Chair of the Royal Society's Climate Expert Panel.

Professor Alistair Woodward – Head of Epidemiology and Biostatistics at the University of Auckland. A medical graduate, with postgraduate qualifications in public health and epidemiology, Professor Woodward’s research has included environmental health and the social determinants of health.

With College Fellows:

Professor Spencer Beasley – Paediatric Surgeon
Dr Jonathan Foo – General Surgeon
Mr Dylan James – Plastic & Reconstructive Surgeon
Mr Andrew MacCormick – General Surgeon

Mr Lawrence Malisano – Orthopaedic Surgeon
Mr Kiki Maoate – Paediatric Surgeon
Mr Stephen Mark – Urology Surgeon
Mr Rod Maxwell – Orthopaedic Surgeon

For further info visit http://www.surgeons.org/about/regions/new-zealand/
Mr Andrew Connolly is a general and colorectal surgeon at the Counties Manukau District Health Board and has been the Chair of the Medical Council of New Zealand since 2014. He has a strong interest in governance and clinical leadership and has been the Head of Department of his DHB’s General and Vascular Surgery since 2003. He has served on the Ministerial advisory group that was responsible for the ‘In Good Hands’ document, and in 2015 was on the Ministry of Health’s Capability and Capacity Review of the Health Sector.

Under Mr Connolly’s leadership, the Medical Council of New Zealand have been strong advocates for eliminating the health inequities experienced by Māori and improving the medical workforce’s cultural competency. In the Council’s view, where health inequities exist, there is a professional and moral obligation for the medical workforce to address them. Māori engagement with, and representation at, all levels within the health sector will be vital to improving Māori health outcomes.

Mr Connolly will be presenting at Surgery 2017 on the need for cultural competency from the regulator’s view and on the future of surgery in New Zealand.

Dr Stephen Child

Dr Stephen Child is an Auckland based General Physician and the immediate past Chair of the New Zealand Medical Association, which he chaired from 2015 until May 2017. As Chair of the NZMA, Dr Child had a strong focus on strengthening the medical profession and delivering effective health services to patients, advocating on a wide range of issues such as health equity, end of life care, and doctors’ health and wellbeing.

For doctors, helping patients stay healthy is a top priority. In order to achieve this however, it is important that doctors also look after their own physical and mental wellbeing. The health of a doctor affects themselves, their families, the work that they undertake and the patients they serve. The need for members of the medical profession to maintain their own health and wellbeing is vital, but is often overlooked in the desire to provide better care for patients.

The NZMA recommends that doctors practice healthy lifestyle behaviours such as good nutrition, exercise, leisure, regular leave and family time, to the maximum extent possible given the demands of their job. It is also important that doctors regularly see their own general practitioner, rather than practice self-diagnosis, treatment and prescribing.

See Dr Child presenting on this subject at Surgery 2017.
Surgical Pioneers

Wellington

Wednesday 16 August 2017, 1pm - 6.30pm

Jerningham Room, Copthorne Hotel, 100 Oriental Parade, Wellington

The 7th presentation on New Zealand Surgical Pioneers will be held on 16 August, the day before Surgery 2017. Discussion centres on the pioneers of the late 19th and early 20th century, who established surgery in New Zealand on such a sound footing.

We are delighted to have among our presenters this year Dr Christopher Pugsley, ONZM, DPhil, FRHistS, a former Lieutenant Colonel in the New Zealand Army who is regarded as New Zealand’s pre-eminent military historian.

Registration from 12.30

Session 1: Our Pioneers 1 – 2.30pm

Hugh Acland – scion, surgeon, soldier and public servant
Bill Sugrue

The Six Good Men – founders of the College of Surgeons of Australasia – Acland, Barnett, Ferguson, McGavin, Robertson, & Wylie
Wyn Beasley

Afternoon Tea 2.30 – 3pm

Session 2: The Great War 3 – 4.30pm

NZ Hospitals in Egypt and the UK
Ross Blair

Passchendaele
Christopher Pugsley

Break 4.30 – 4.45pm

Session 3: The Marlborough Men 4.45 – 6.15pm

George Cleghorn – the Prime Ministers choice in the 1890’s
Stephen Vallance

Sir Gordon Bell – Second Professor of Surgery in NZ and war surgeon
Stephen Packer

An informal dinner is held in the evening – friends and partners are most welcome to attend both Surgical Pioneers and the dinner.

Surgical Pioneers in 2018 will broaden its focus and move away from the war theme.

If you have a particular interest in medical history or are interested in presenting at future Surgical Pioneer sessions contact Bill Sugrue on 022 034 2118 or RACS on College.NZ@surgeons.org.

REGISTER ON THE COLLEGE WEBSITE FOR SURGICAL PIONEERS AND/OR SURGERY 2017
This article explains how the Royal Australasian College of Surgeons (RACS) deals with complaints involving: standards of clinical practice, excessive fees, conduct that affects the reputation of the profession or the College, and unacceptable behaviour.

RACS can assess and sometimes help manage complaints: about any RACS Fellow, Trainee or International Medical Graduate (IMG) and from any member, or patient, family or other health consumer, or other registered health practitioner.

RACS cannot: get involved in complaints related to findings or decisions made about members by regulators or in other legal proceedings. RACS cannot assist or legally represent members involved in action by regulators or in other legal proceedings however RACS can help members access counselling and other collegial support.

RACS is committed to assessing and managing complaints promptly and fairly. Each complaint is unique and is assessed individually, on the available evidence. We recognise that it is particularly difficult for Trainees and IMGs to make a complaint and we do what we can to manage these concerns sensitively.

RACS recognises that individuals are unique, and so are complaints. Our response to each complaint is tailored to the details of each case.

We recognise that it is often difficult to make a complaint, especially about unacceptable behaviour by someone in the same profession.

Some people are not sure if they want to lodge a complaint, or they don’t want anyone to know they have raised a concern or are involved in an investigation of the complaint. Often, people want the unacceptable behaviour to stop but feel powerless to make this happen and they want somebody independent to step in.

Under the RACS complaints framework, it is possible to lodge an enquiry or talk to someone at RACS and seek guidance before making a formal complaint. The person making the enquiry can decide whether to be identified, maintain confidentiality or be anonymous.

An anonymous complaint is when the person doesn’t want to be identified for various personal and professional reasons but still wants to raise the issue as a matter of concern.

A confidential complaint is when a person is happy to disclose their identity to RACS but doesn’t want their identity disclosed to the person they are concerned about.

If an anonymous enquiry is lodged, or if the person raising the concern wants to remain confidential, RACS will register the enquiry on the complaints database. In many cases the person making the enquiry will seek guidance on the appropriate process. The database will record only the details of concerns raised about the incident/incidences of unacceptable behaviour but RACS is, under normal circumstances, unable to take the matter any further.

It is important to understand that RACS can only act on a complaint when the person making the complaint gives their consent and authority for RACS to proceed.

Sometimes addressing a complaint directly can identify the person or group of people making the complaint. RACS will do its best to make sure that no one is victimised for making a complaint, but we can’t control the behaviour of the person being complained about.

If you want to lodge a formal complaint on behalf of other people, and are giving RACS second or third hand information about something that happened, we first need to have consent from the people who were directly affected by the unacceptable behaviour. If you have a complaint of this nature, for procedural fairness, it is important to channel this through the appropriate RACS complaints channels and not through other RACS committees or boards.

If anonymous or confidential complaints are received that indicate a pattern of conduct, RACS can decide to look more closely at the issues raised. This could involve analysing the concerns raised, identifying a possible pattern of conduct, gathering corroborative evidence and/or if appropriate, talking with the person about the concerns that have been raised about their unacceptable behaviour. Often, providing someone with feedback and encouraging them to reflect on their behaviour is enough for them to change the way they operate.

There is a range of things that we can do if a person is willing to give RACS details about who they are, the name of the person they are concerned about, what happened and details of any witnesses. The Manager, Complaints Resolution will work with senior RACS managers to identify the most appropriate way to address and ideally resolve the complaint. This may involve the RACS CEO, an Executive Director for Surgical Affairs, RACS General Counsel, Divisional Directors and Department Managers.

There are a range of different options for resolving complaints and disputes, including: assessment by a senior surgeon, conciliation and document exchange, mediation or formal proceedings.
People make complaints for different reasons. Most often, people who make a complaint want acknowledgement of what happened or the issues raised, an apology for the offence caused, an explanation for what happened, or a commitment from the person complained about to change their behaviour so the same thing doesn’t happen again. Other outcomes people sometimes look for include a change in reporting lines, a transfer, a penalty or punishment. Not all of these outcomes are achievable in all cases.

RACS is a college and membership organisation, not an employer and cannot require or make workplace changes or enforce disciplinary proceedings started or being conducted by another agency, like an employer or a regulator. RACS may work with employers to decide which agency is best placed to manage the matter. RACS does everything possible to avoid duplicating a process that is already underway by another agency.

RACS is committed to procedural fairness. We know that there are always at least two sides to every story. If someone has made a complaint or raised a concern about you, we encourage you to call the RACS Manager, Complaints Resolution, to discuss it. If you receive a letter from the office of the RACS Manager, Complaints Resolution, an EDSA or the RACS CEO giving you feedback about an issue that has been raised about you, we ask you to do some things, and avoid doing others.

Do:
• Review the allegation(s) and complainant comments
• Genuinely reflect on your behaviour in the circumstances
• Review the Code of Conduct
• Thoughtfully choose how to respond. For example have you considered the position of the complainant? How would you have reacted if you were the complainant? Do you have records to support your perspective?

Write back in a timely way, acknowledging the concerns that have been raised and explaining your perspective of what happened. You might want to offer to apologise to the person who has raised the concern or offer a solution.

If you are upset about the allegation(s) that have been made and/or you are not sure what to do or how to respond, call the Manager, Complaints Resolution, or the person writing to you for a confidential discussion.

Don’t:
• Ignore the request for a response, it won’t ‘just go away’
• Be dismissive, aggressive or threatening
• Over-think the ‘what ifs’…or dwell on wondering “if only I….they had done……”

You can’t change what has happened. You can choose how you respond and you can learn from what happened. You can also get support from the RACS Support Program and your medical defence organisation.

It also helps to discuss the matter with a family member, peer or trusted colleague.

The RACS Complaints Hotline is New Zealand 0800 787 470 or Australia 1800 892 491 or email complaints@surgeons.org

1. RACS Complaints Use Guide published October 2016

The Queen’s Birthday Honours 2017

Companion of the New Zealand Order of Merit (CNZM)
Professor Peter John Gilling – For services to Urology

Professor Peter Gilling is an internationally renowned Urological Surgeon who has contributed significantly to the development of this field of medicine in New Zealand for more than 25 years.

Professor Gilling is a Tauranga-based Urologist and is Professor of Surgery at the University of Auckland and Head of the University’s Academic site in Tauranga. He is the Head of the Bay of Plenty District Health Board Clinical School and Head of the Clinical Trials Unit for that DHB, and was primarily responsible for the development of both these entities. In the field of Urology he is nationally and internationally known for the research and treatment of prostate disease, particularly Benign Prostatic Hyperplasia (BPH) and Cancer of the Prostate. He has pioneered a number of surgical treatments but particularly laser prostatectomy using the Holmium Laser, which has been adopted throughout the world. He has also introduced many advanced surgical treatments into New Zealand including open, laparoscopic and robotic approaches to common urological conditions.

A former Examiner for the Royal Australasian College of Surgeons, Dr Gilling is on the Editorial Board of six major urology journals and has published extensively in the scientific literature.
The ability for New Zealand's public health sector to meet the healthcare needs of every individual is ultimately limited by finite resources. It is therefore important that the resources that are available are used effectively and not on practices such as tests, procedures or interventions which are of little or no value to patients.

Choosing Wisely New Zealand is a campaign which encourages health professionals and patients to work together to improve the quality of care that is delivered by limiting low-value practices and interventions. The campaign is being run by the Council of Medical Colleges in partnership with the Ministry of Health, Health Quality & Safety Commission and Consumer New Zealand. It is supported by many other health sector groups, including RACS. Choosing Wisely is widely established internationally and already has 16 campaigns underway in countries such as Canada, the USA and Australia.

Led by clinicians, Choosing Wisely is centred on helping patients make good choices regarding their care and focuses on areas where evidence shows that a test, treatment or procedure provides little or no benefit, or could even cause harm.

There are a number of factors which could contribute to health professionals ordering such services for their patients. These include the patient’s expectations, a lack of consultation time, overall uncertainty and fear of missing a diagnosis or malpractice concerns, reimbursement incentives, the way a health professional was taught, or a desire to avoid the challenge of telling a patient they do not need a specific test.

Choosing Wisely New Zealand aims to limit these practices by encouraging patients to ask their health professionals these four questions:

• Do I really need to have this test treatment or procedure?
• What are the risks?
• Are there simpler, safer options?
• What happens if I do nothing?

By having these conversations, patients are empowered to make informed and evidence based decisions regarding their own treatment. Consumer New Zealand is promoting these questions to the public.

Choosing Wisely New Zealand needs clinicians to develop specialty specific lists of tests, treatments and procedures their specialty considers provide little or no benefit, or could cause harm and which clinicians and consumers should at least discuss before proceeding. As part of its commitment to the Australian campaign, RACS has already worked with General Surgeons Australia (see below) and the Australian Society of Otolaryngology Head and Neck Surgery to develop specialty lists.

RACS encourages New Zealand Fellows to work together and identify tests, interventions and surgical procedures in particular, which can be of low value to New Zealand patients. By working together with the specialty societies, it is hoped that RACS can contribute a number of comprehensive lists specific to the Choosing Wisely New Zealand campaign.

For more information, visit the Choosing Wisely New Zealand website as www.choosingwisely.org.nz.

The following list was created by General Surgeons Australia (GSA) in collaboration with RACS for the Choosing Wisely Australia campaign:

• Don’t perform repair of minimally symptomatic or asymptomatic inguinal hernias without careful consideration, particularly in patients who have significant co-morbidities.
• Do not use ultrasound for the further investigation of clinically apparent groin hernias. Ultrasound should not be used as a justification for repair of hernias that are not clinically apparent.
• Don’t transfuse more units of blood than absolutely necessary, noting that many hospitals have developed policies on indications for transfusion with a view to minimisation.
• Do not use endoscopy for investigation in gastric band patients with symptoms of reflux.
• Don’t do computed tomography (CT) for the evaluation of suspected appendicitis in children and young adults until after ultrasound has been considered as an option.

New Strategy to Address NZ’s High Melanoma Rates (continued from page 9)

other cutaneous malignancies. Further information and registration can be found at: http://worldmelanoma2017.com/.


1 MelNet is a non-profit network of over 1000 professionals passionate about reducing the incidence and impact of melanoma and non-melanoma skin cancer in New Zealand.
The New Zealand Skin Cancer Primary Prevention and Early Detection Strategy 2017 to 2022 has recently been released. The Strategy is sector led and has been released by the Health Promotion Agency and the Melanoma Network (MelNet) in partnership with the skin cancer control sector, including the Cancer Society of New Zealand and Melanoma New Zealand.

Skin cancer is by far the most common cancer affecting New Zealanders and surgeons and all health professionals are encouraged to read the new strategy. New Zealand and Australia have the highest rate of melanoma in the world. Each year over 2200 New Zealanders are diagnosed with melanoma and over 300 die from it. Although most melanomas occur in people over 50 years of age, it can occur at any age. In 2013, it was the fifth most common cancer in females aged 0–24 years. In 2013, it was the fifth most common cancer affecting patients in New Zealand – Provisional (2013), all doctors have a responsibility to ensure that patients are offered this information.

The key advice for patients is to:
- Slip on a shirt/top with long sleeves and a collar and slip into the shade
- Slop on sunscreen that is at least SPF 30, broad spectrum and water resistant. Apply 20 minutes before going outside and reapply every 2 hours
- Slap on a broad-brimmed hat that shades the face, head, neck and ears
- Wrap on close fitting sunglasses
- Don’t use sunbeds.

Gary also urges surgical colleagues, even those for whom melanoma is not their area of speciality, to recognise their role in its diagnosis. “When we see a patient for whatever reason, we need to be alert to an ‘ugly duckling’ dermal lesion that stands out from the others. In this opportunistic way, we can contribute to a reduction in thick melanomas.” New Zealand data shows that advanced age, male sex, non-European ethnicity, and nodular and acral types of melanoma are associated with thick melanomas.

Gary also recommends fellow surgeons become familiar with the Standards of Service Provision for Melanoma Patients in New Zealand – Provisional. The standards were developed in 2013 by a multidisciplinary working group chaired by Richard Martin, a surgical oncologist and member of the MelNet Executive Committee. To be used as a quality improvement tool, the standards aim to promote nationally coordinated and consistent standards of service provision across New Zealand.

To Gary and his fellow MelNet Executive Committee members, implementation of both the skin cancer strategy and the melanoma standards are critical to reducing the incidence and impact of both melanoma and non-melanoma skin cancers in New Zealand.

“For this reason MelNet is concerned that the standards remain ‘provisional’ when they should be finalised and applied consistently throughout the country. What’s more, the original standards already are outdated in light of recent major advances in melanoma diagnosis and management.”

MelNet therefore continues to advocate for a review and finalisation of the standards as well as their promotion among DHBs.

Gary invites surgeons who are not already MelNet members to join and support its initiatives. Membership is free of charge and takes only a minute or so at http://www.melnet.org.nz/register.

“We need the support of all surgeons to help strengthen MelNet’s efforts to promote policy and action to reduce New Zealand’s significant burden of melanoma and non-melanoma skin cancer.”

MelNet was formed in 2008 to facilitate communication and collaboration between professionals and to promote education and the advancement of best practice. With the oversight of its multidisciplinary executive committee, MelNet activities include:
- Monthly e-newsletters (latest research, upcoming events, opportunities for collaboration)
- Two-yearly national summits
- Advocacy
- Regional dermoscopy courses.

On 9 September 2017 MelNet, in partnership with Melanoma New Zealand and the Queenstown Research Week, will be hosting “Melanoma Research and Therapy in New Zealand: Raising the Bar through Collaborative Action”. This highly focused one-day event in Queenstown will feature Australia and New Zealand’s top experts in melanoma treatment, clinical trials and scientific research. Further information about this event can be found at http://www.queenstownresearchweek.org/melnet/

MelNet also encourages health professionals in New Zealand to attend the 9th World Congress of Melanoma to be held in Brisbane from 18-21 October 2017. This congress will join with the Society for Melanoma Research to bring together the world’s leading melanoma researchers and clinicians to showcase the latest developments in melanoma diagnosis, treatment and research. It will cover the entire field of melanoma and...
SUCCESS IN THE FELLOWSHIP EXAMINATIONS

Congratulations to New Zealand based Trainees who were successful in the May exams in Wellington and Melbourne.

Cardiothoracic Surgery
Gareth Crouch

General Surgery
Janice Chen
Jesse Fischer
Daniel Mafi
James McKay
William Perry
Sarah Rennie
Simon Richards

Orthopaedic Surgery
Georgina Chan
Nikki Hooper
Tom Inglis
Andrew Irving
Satyen Jesani
Anand Segar
Joshua Sevao
Hogan Yeung

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
Foundation Skills for Surgical Education (FSSE) Course

Under the RACS Action Plan: Building Respect and Improving Patient Safety, the completion of the FSSE course before 31 December 2017 is required for all surgeons who are involved in the training and assessment of trainees. The aim of the course is to establish a basic standard expected of RACS surgical educators and to further knowledge in teaching and learning concepts.

Courses are planned for Queenstown (NZAPS ASM) in August, Taranaki Base Hospital in October, Nelson Hospital and North Shore Hospital in December. You will find the dates of, and can register for, these 2017 FSSE courses on the RACS website.
Flying back from Adelaide last month, I found myself reflecting on the events of ASC week, and speculating that 2017 may be remembered as the year when the proper role of women in surgery has been defined and acknowledged by this College.

What began as an investigation into bullying and became a venture into corporate compassion has already achieved recognition as a model programme for recognising and applying standards of ‘decent behaviour’ in the practice of medicine generally, and of surgery in particular.

Two centuries ago it was possible for a woman to practise as a surgeon only by subterfuge (or masquerade, for those who prefer the term). Dr James Miranda Steuart Barry graduated MD – then the qualifying degree – from Edinburgh University in 1812, with a thesis on femoral hernia. Barry went on to a distinguished career as a military surgeon, in the course of which, during a posting to Cape Town, he performed the first successful Caesarean section in Africa. His subsequent career took him over much of the old Empire, and at the end of it he was Inspector General of Military Hospitals. Only after his death in 1865 was it established that he was a woman, born Margaret Anne Bulkley: born in Cork and brought in early childhood to London. A maternal uncle was James Barry RA the painter, and influential patrons, including General Miranda the Venezuelan patriot, and David Steuart Erskine, Earl of Buchan, are believed to account for his assumed name.

Things were not too much better a century later. Women in this country were enfranchised in 1893, but in Britain not until after the First War, and then only those over the age of thirty. Rather more generous was the British legislation in 1876 which allowed women to attend medical schools and graduate in medicine, but in New Zealand the first woman medical graduate did not emerge until 1896.

Eleanor Davies-Colley, in 1911, became the first woman Fellow of the Royal College of Surgeons of England; while in 1920 two women became Fellows of the Edinburgh College in the same year: the first was Alice Hunter, who was shortly joined by Gertrude Herzfeld who, being resident in Edinburgh (where she went on to be a pioneer paediatric surgeon) was able to be the first woman Fellow to take her seat; while Alice Hunter spent her career in India.

None of the founders of the Australasian College was a woman, though a number of women had made significant contributions during the First War, often in conditions as challenging as any that their male counterparts faced. Typical of these was Agnes Bennett, who in early 1915 offered her services, but in vain, to the New Zealand government. Undeterred, she set off for Europe to seek to join the French Red Cross; but in Cairo she was snapped up by 1NZEF and spent almost a year working, for captain's pay – but without a formal commission – in military hospitals. In April 1916 she resigned and continued her voyage north; this time she joined the Scottish Women’s Hospital organisation, and as commanding officer of the 7th Medical Unit she went to Serbia. She worked in harsh and dangerous conditions until malaria drove her to resign in October 1917: she was decorated by both the Serbian Government and the Serbian Red Cross.

Progress towards the empowerment of women over the past century has, at times, threatened to stall; but at Adelaide their achievements were manifest and reward of these achievements converged in spectacular fashion. Clare Marx is an orthopaedic surgeon in Ipswich, who was a successful president of the British Orthopaedic Association in 2009. Already prominent on the Council of the English College, she went on to be that College’s first woman president. She has attended the RACS ASC each year during her (once again, very successful) College presidency. Plainly capable and charming, she is used as a ‘star performer’ year by year, and Adelaide was no exception. Another star performer was Professor Maryawn of Stanford, CA, who is a connoisseur of quality. And a third, called on to deliver the Weary Dunlop Memorial Lecture, was Susan Neuhaus, who has had a second career as a military surgeon (retiring as a full colonel) in tandem with her civilian practice. She paraded in her Fellow’s gown, embellished with a medal bar whose

Left: young Barry. This miniature was given by Barry to Thomas Munnick, the father of the boy he delivered in Cape Town. It remains in the Munnick family.

Right: old Barry. This photograph was taken in Jamaica in 1862.
proportions would not have disgraced Weary himself, and spoke movingly about women and war.

And then there were the recipients of awards: Margaret Rode joined the College staff during Colin McRae’s presidency, as his PA; these days she attends to the needs of the Court of Honour, and controlling surgeons has been likened to herding cats – but she manages to remain unruffled! And our own Justine Peterson (who does her share of cat-herding too) is now an honorary FRACS. Finally, Cathy Ferguson, who was a member of the expert advisory group that identified the need to deal with bullying and who is now the College’s vice-president, was awarded the Louis Barnett medal.

* * *

The title of this essay was loosely derived from a pamphlet written in 1558 by John Knox, who ‘drove’ the Scottish Reformation. Finding himself surrounded by ruthless queens, most of whom would cheerfully have burned him at the stake, he published a polemic entitled The First Blast of the Trumpet against the Monstrous Regiment of Women. In a College which has shown itself to be gender-immaterial, we have no need to share Knox’s prejudices.

Younger Fellow Representative Required

A New Zealand representative on the College’s Younger Fellows Committee is being sought. The previous representative, Andrew MacCormick, is now Chair of that Committee and therefore unable to continue as the NZ representative. Younger Fellows are, by definition, Fellows within 10 years of receipt of their fellowship.

This position would entail

- attendance at the Australasian Younger Fellows’ Committee Meetings (a mixture of teleconference and face-to-face meetings)
- quarterly teleconferences with NZ Younger Fellows from each specialty to identify issues
- attendance at the NZ National Board meetings (four times per year in on a Friday afternoon – usually in Wellington) and provision of a report for those meetings
- representing and promoting issues relevant to Younger Fellows
- organisation of an annual Preparation For Practice course
- providing a quarterly update for the New Zealand newsletter, Cutting Edge

Please send a CV and covering letter, including details of any previous leadership involvement and your interest in Younger Fellow issues to: Andrew MacCormick through the NZ office of the College – PO Box 7451, Wellington 6242 or by email to Justine.Peterson@surgeons.org

If you want to discuss this role please feel free to contact Andrew MacCormick on Andrew.maccormick@middlemore.co.nz

PROCESS COMMUNICATION MODEL

Recommended for Fellows, Trainees, junior doctors and other medical specialists. Partners are encouraged to register.

Process Communication Model Seminar 1

Fri 20 – Sun 22 October 2017, Auckland City Hospital

Patient care is a team effort and a functioning team is based on effective communication. PCM is a tool which can help you to understand, motivate and communicate more effectively with others. It can help you detect early signs of miscommunication and thus avoid errors. PCM can also help to identify stress in yourself and others, providing you with a means to re-connect with those you may be struggling to understand.

Find out more and register.

Process Communication Model Refresher

Sunday 24 September 2017, RACS Melbourne

Refresh skills regarding:

- establishing relationships necessary to lead and develop teams
- motivating the people around you according to individual needs
- identifying signs of distress within individuals and develop ways of responding
- communicating with patients in a way that suits their preferred style of communication.

Find our more and register.
The year is rapidly marching on. To those who passed their fellowship exams recently congratulations. To those who weren’t successful my condolences, it’s hard to pick yourself up and keep at it, we are all cheering for you.

A few issues have arisen for trainees recently. The current group of trainee reps have been fantastic in their help and their support.

The schedule 10 RDA changes are now a thing of certainty. For those trainees not on a call-back roster the changes will affect you and are to be implemented by November. Change is always fraught with teething problems; we must be collegial through the changes and remember our patients care comes first. We do have concerns - our training experience may be diluted and with increased handovers we need to be vigilant that errors don’t creep in. We will be keeping a close eye on the changes. For some training centres the changes may not be workable. If this is the case please contact me, there are options and solutions I can advise you on, we have back up plans!!

In the near future all NZ trainees will receive a survey through the College. The survey is to canvas opinion on changing the start time of each year to late January / early February. Please take the time to complete it and have your say. I will keep you up to date with the plans.

The nationwide review of consent forms is ongoing. In the near future DHB’s will be supplied with consent wording around trainees being involved in a procedure. It will still remain up to trainees to inform and consent patients appropriately before embarking on a procedure. There are also plans to distribute to DHB’s a patient education pamphlet to compliment the new consent wording and to help educate patients about the structure of their surgical teams.

You may have read in the news recently that the Waikato Orthopaedic service has come under scrutiny. From a trainee perspective Waikato has become very trauma heavy at the detriment of trainee elective experience. The Waikato Orthopaedic service is having its accreditation for training reviewed and I am pleased to say the surgeons of Waikato have been excellent in their response. Watch this space, hopefully things continue to improve.

Should anyone have issues with training or with the upcoming roster changes please feel free to contact me. If I can’t help, I can most certainly direct you to someone who can.

MEMBER BENEFITS

Member benefits are available to all Fellows, Trainees, IMGs and staff of the College and include a range of cost-saving offerings selected specifically for the College.

The College encourages you to experience the unique benefits of your membership by taking full advantage of these value-added financial and lifestyle member services.

Member Advantage has been working with the College to extend and enhance the member benefits available for New Zealand members. Recent additions for New Zealand members are:

- SPECSAVERS
- PETALS FORIST NETWORK
- NZ MILLENNIUM HOTELS & RESORTSAMERICAN EXPRESS CREDIT CARDS.

Other benefits available through Member Advantage are:

- KORU CLUB
- HOTEL CLUB
- BEST WESTERN
- INTREPID TRAVEL
- AVIS CAR RENTAL
- EXPERIENCES & GIFTS
- FOREIGN EXCHANGE
- MAGAZINE SUBSCRIPTIONS

Visit www.surgeons.org/memberbenefits or call Member Advantage on 0800 453 244
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.

**Council of Medical Colleges (CMC)**

The Chair of the NZNB, Randall Morton, attended the CMC’s quarterly meeting in May. Items covered in this meeting included opposition by the DHBs, RDA, NZMA, medical schools and MCNZ to the use of confidential referee reports; amendments to the Health Practitioners Competence Assurance Act that are to be proposed by the Ministry of Health; initiatives to promote the well-being of the colleges’ Fellows; and updates from the Professional Behaviour Taskforce (see the section below).

**Ministry of Health Taskforce on Inappropriate Behaviour in the Medical Profession**

This Taskforce met in April. It was agreed that, with its wide membership from employers, unions, medical education and professional medical organisations, it continued to be a useful group. However, its roles and purpose needed greater clarity, the group itself needed to be better publicised and its title needed to reflect its focus on building positive cultures and behaviours. The suggested new name is the Professional Behaviours Taskforce. Discussions also covered the influence that Ministry targets had on stress levels, use of confidential references and their impact on doctors’ willingness to complain about behaviour, and a report from the DHBs on the resources they have gathered that are linked to improving professional behaviours.

**Memorandum of Understanding with Auckland DHB**

In late May, Randall Morton signed a Memorandum of Understanding between RACS and Auckland DHB to address bullying and other inappropriate behaviours in the workplace. That event was timed to coincide with pink shirt day and the launch of ADHB’s ‘Speak Up’ programme. RACS now has MOUs with three DHBs (Auckland, Nelson-Marlborough and Canterbury), the Otago University Medical School and the NZ Private Surgical Hospitals Association.

**MCNZ Cultural Competence Symposium**

The MCNZ in partnership with Te Ohu Rata o Aotearoa (Te ORA – Māori Medical Practitioners Association) hosted a Symposium on Cultural Competence, Partnership and Health Equity in June. Several members of the NZNB and of our Māori Health Advisory Group attended, with the latter presenting on the development and progress of the College’s Māori Health Action Plan, the challenges of
being a Māori Consultant Surgeon and the challenges for a Māori doctor applying for SET. The Symposium presented a valuable opportunity to learn about some of the barriers preventing health equity in New Zealand and to hear how other medical colleges were progressing with their Māori health initiatives.

Choosing Wisely New Zealand Symposium
Representatives of the NZNB attended the Council of Medical Colleges’ symposium to promote the Choosing Wisely New Zealand Campaign in Wellington on 30 March. This brought together a diverse range of speakers to share their experiences with implementing Choosing Wisely initiatives in their workplaces. Professor Wendy Levinson, Chair of Choosing Wisely Canada, was the keynote speaker and shared her experience with implementing and maintaining the Canadian campaign. Further details on the Choosing Wisely New Zealand campaign are included in this edition of Cutting Edge.

Other Meetings
NZNB representatives have also attended the following meetings with external groups:

• Southern Cross: This meeting in June discussed the impact of changes to health and safety legislation on surgeons in private practice.
• ACC: This meeting, also in June, discussed ACC coverage of patients who are normally resident in this country who suffer treatment injuries overseas; and also the quality of medical opinions from medical practitioners.

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

• Health Workforce New Zealand (HWNZ) – Investing in New Zealand’s Future Workforce
• Health Quality and Safety Commission (HQSC) – proposed National Recognition and Response System for the Deteriorating Patient
• Perioperative Mortality Review Committee (PoMRC) – Draft Recommendations for the Perioperative Mortality Review Committee’s 2017 Report

Access to Counselling Services
Fellows, Trainees and IMGs have access to confidential counselling for any personal or work-related issues through Converge International. Provision of services cover New Zealand and Australia and can be in person, on the phone or via Skype. RACS will cover the costs of up to four sessions per calendar year to this arms-length service.

Contact Converge via phone: 1300 687 327 in Australia or 0800 666 367 in New Zealand or via email

NZ National Board members – current and incoming at the June meeting
MULTIDISCIPLINARY SERIES

8th National Colorectal Pelvic Floor & Anorectal Disorders Course
8-9 September 2017

Endorsed by CSSANZ / Proudly sponsored by Medtronic Workshop Fund

Convened by:
Mr Rowan Collinson
Colorectal Surgeon,
Auckland

International Guest Speakers
Professor Marc A Gladman
PhD, MRCOG, MRCS (Eng), FRCS (Gen Surg), FRACS
Director, Specialist Colorectal + Pelvic Floor Centre
Head, Enteric Neuroscience & Gastrointestinal Research Group
Adelaide Medical School,
The University of Adelaide
South Australia

Ms Taryn Hallam
B.App. Sc (Physiotherapy), MAPA
Senior Physiotherapist, Alana Health Care for Women, Randwick
Director, Women’s Health Training Associates
Visiting Lecturer, Australian Catholic University and University of Sydney

Venue:
Advanced Clinical Skills Centre
Gate 3, 98 Mountain Road,
Epsom, Auckland 1023

This 1½ day course for Surgeons, Physiotherapists and interested GI Clinicians will focus on the management of patients with faecal incontinence, defaecatory disorders and pelvic organ prolapse including imaging and surgical advances.

Registration
For further information and to register for this course, contact us:
Phone: +64 9 923 9304
Email: acscadmin@auckland.ac.nz

Registration fees
Full Course, CR Fellows $250.00 inc. GST
Full Course, Physiotherapists $230.00 inc. GST
Surgeons $345.00 inc. GST
Registration closes 20 August
Full catering will be provided, including a course dinner at 7pm on Friday 8 September

Please register online at: www.fmhs.auckland.ac.nz/acsc

ADVANCED CLINICAL SKILLS CENTRE

MEDICAL AND HEALTH SCIENCES
COLIN McRAE MEDAL

NOMINATIONS ARE CALLED FOR THE AWARD OF THIS MEDAL WHICH RECOGNISES AN OUTSTANDING CONTRIBUTION TO NEW ZEALAND SURGERY

Colin Ulric McRae (1942 – 2000) was an outstanding New Zealand Surgeon who made many contributions to surgery in this country, including serving as President of the Royal Australasian College of Surgeons from 1996 – 1998.

The Colin McRae Medal commemorates the life and work of the late Colin McRae. This medal recognises and honours those who have made an outstanding contribution to the art and science of surgery and surgical leadership in New Zealand.

CRITERIA

The Colin McRae Medal will be awarded to a person who is judged to have made an outstanding contribution to New Zealand surgery in one or more of the following areas:

- Clinical excellence over a period of time.
- A major contribution to surgical research and/or surgical education.
- Surgical leadership in New Zealand.

The award will normally be made to a Fellow of the Royal Australasian College of Surgeons resident in New Zealand, but under exceptional circumstances may be made to a non-fellow or a non-resident.

NOMINATIONS

Nominees must be proposed and seconded by Fellows of the Royal Australasian College of Surgeons normally resident in New Zealand. A detailed justification for the nomination and, if possible, a curriculum vitae should accompany the letter of nomination.

If a nomination is approved, this award will be presented at a College Event.

NOMINATIONS MUST BE ADDRESSED TO:

Chair
New Zealand National Board
Royal Australasian College of Surgeons
PO Box 7451
Wellington 6242
(c/- Justine.Peterson@surgeons.org)

DEADLINE FOR NOMINATIONS:

Monday 31 July 2017, 5pm
Tony Allison was born in Mania, Taranaki the first child of Peter Allison, a dermatologist and Hazel, an anaesthetist. Four siblings followed - Mary, Dick, Judith and Bey. Following the family’s move to Christchurch Tony attended Fendalton Primary School. He commenced high school at Timaru Boys High School where his sporting prowess was recognised when he broke Jack Lovelock’s school mile record. He performed well academically, particularly in maths and science. In 1938 Tony went to Christ's College where he became the Senior Athletic Champion and the Heavy Weight Boxing title holder in 1940. Unfortunately, his enthusiasm for sport and participation was curtailed after a spinal injury received in the school gymnasium.

In 1941 Tony followed in his parents’ footsteps and entered Otago Medical School graduating in 1947.

Tony returned to Christchurch for his house surgeon experience and during this time he and his brother Bey purchased an Astor plane, which they had crated out from Britain. Moving to Motueka in 1948, to work as a locum in general practice, he kept in touch with family and friends by flying, often with his spaniel in the seat beside him. Following 18 months in general practice in Motueka, Tony worked his passage on a twelve-passenger cargo boat to Britain.

Tony spent the next three and a half years working in a number of hospitals in the UK obtaining surgical experience and Fellowship of the London, Edinburgh and Irish Colleges. He joked that his enthusiasm in this respect was due the largesse of his mother on receiving each instruction to breathe slowly to save air!

Tony was an innovative handyman, building one of the first home swimming pools in Christchurch with a primitive, but effective, filtered heating system provided by running water over a shed roof and through a drum filled with stones. Friends helped on the proviso they could use the pool day or night! Tony, with family help on this occasion, spent every second Saturday for a year (according to the eldest child) nailing old slates onto the roof of the villa. In 1959 Tony and Jane purchased an old multi-coloured cottage and continued to examine pilots for flight medicals for many years.

Tony’s hobbies included flying, tennis, amateur radio, bridge, fishing and scuba diving. With a wet suit specially ordered from the USA, he enjoyed diving in the outer sounds for crayfish, occasionally getting caught up in the excitement of the chase and having to be rescued. He taught Jane and the elder children to dive, giving instructions to breathe slowly to save air!

In 1983, after 30 years in practice, Tony retired and he and Jane purchased an old multi-coloured cottage in the Marlborough Sounds and this became a haven for relaxation and summer holidays. Each January a locum was employed so Tony could spend the month in the Sounds with his family.

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In 1983, after 30 years in practice, Tony retired and he and Jane farmed deer at Loburn, North Canterbury for the next 30 years. They had five children - Amanda, James, Antonia, Caroline and Belinda. Tony’s days were full, with surgical consultations at Harley, surgery at Calvary Hospital, mornings visiting patients in their homes, and afternoon and evening general practice at Ilam Road. Working as a solo General Practitioner, weekends were arduous until about 10 years later, when he and three others set up a weekend roster. For several years he was a lecturer in surgery to final year students at Christchurch Hospital, the doctor at Medbury School and he was on the board of Selwyn House School for nine years.

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In 1983, after 30 years in practice, Tony retired and he and Jane farmed deer at Loburn, North Canterbury for the next 19 years. Tony pursued his love of flying, learned to glide, and continued to examine pilots for flight medicals for many years.

Sadly, Tony developed Alzheimer’s over the last six years of his life and died 18th April 2009. Tony is greatly missed by Jane, and children Amanda, James, Antonia, Caroline and Belinda, and 8 grandchildren.

Allan Panting FRACS with the assistance of Jane Allison and Mandy Carpenter (nee Allison)
We encourage letters to the Editor and any other contributions
Please email these to:
college.nz@surgeons.org
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VIEWS EXPRESSED BY CONTRIBUTORS ARE NOT NECESSARILY THOSE OF THE COLLEGE

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