Cutting Edge

December 2025

FROM THE CHAIR

Unmet need — The challenge we can no longer ignore

As we reach the end of another year, the familiar pre-Christmas surge is once again upon us—an influx of referrals, limited operating slots, and the annual race to get patients seen before the summer shutdown. It is a pattern we all know too well, but beneath the seasonal rush lies a deeper, structural fatigue across our health system.

In recent months, discussions with colleagues, council members, and the Health Board have been dominated by a single theme: pressure—pressure on clinicians, resources, and access. Both the public and private sectors are feeling the squeeze, and the result is an increasing level of unmet need across our communities. Even insurers are tightening their belts, with rising premiums and narrower cover, pushing more patients back toward an already stretched public system and widening inequities in access.

> When asked, 'Who should we treat, and for what?' the answer most of us would give instinctively is 'everyone, for everything.' Yet reality is far from that ideal.

A recent BMJ Open paper examining unmet health needs in Aotearoa underscores just how far adrift we are from the OECD norm. Across 27 OECD countries, the 2020 Europe State of Health data reported an average unmet need of 2.6 per cent. In contrast, Ministry of Health (2023) data shows that 12.9 per cent of New Zealanders experience barriers to accessing primary healthcare.

Within surgical specialties, the situation is even more concerning. Approximately 30 per cent of all First Specialist Assessment (FSA) referrals to public services are for surgical conditions, yet surgery has one of the highest rates of declined FSAs. There are also well-documented inequities in access—women are more likely to be declined, and significant geographical variation persists across districts.

Without national, standardised criteria for access, clinicians are left to make decisions case by case, often in isolation. The result is implicit rationing—decisions made under local constraints rather than explicit, transparent policy. Declined FSAs are a poor proxy for unmet need, and systematic undercounting almost certainly exists. This is particularly true in areas of high deprivation where patients are less likely to be enrolled with a GP or to receive a referral even when one is clinically warranted.

For general practitioners, this burden is especially heavy. They are left managing patients with legitimate, specialist-level needs but no pathway forward—an unsustainable position that compounds primary care strain and delays definitive treatment.

If we are serious about delivering equitable, needs-based care, we must first understand the scale of the gap. Te Whatu Ora is not yet consistently collecting national data on unmet need. Until this changes, we are effectively working blind. Measurement is not bureaucracy; it is the foundation for accountability, planning, and fairness.

What is required now is universal, transparent access criteria that extend beyond simple clinical urgency scores to include quality of life and functional impact. Only then can we ensure that rationing—which is inevitable in any finite system—is at least explicit, evidence-based, and equitable.

As we close the year, it is worth reflecting that the integrity of our health system depends not only on how much we can deliver, but also on how fairly we deliver it. Unmet need in Aotearoa is real, measurable, and growing. Recognising it is the first step; addressing it must be our collective priority in the year ahead.

Dr Ros Pochin,

Chair, Aotearoa New Zealand National Committee

Issue *highlights*

AoNZ Office closing dates

The RACS Aotearoa New Zealand office will be closed from 24 December 2025 and will re-open on 5 January 2026.

On behalf of your RACS Aotearoa New Zealand team, we wish you happy holidays and a happy New Year.

Operating with Respect 2026 Wellington course

Date: Saturday 15 August 2026

Time: 8:15am – 4:00pm

Location: RACS NZ Office – Wellington (exact location TBC)

Cost: RACS Members (Fellows or SIMGs): NZ$430 (fully refundable if course is attended)

Non-members (Fellows or SIMGs of other Colleges): A$650 or NZ$700 (non-refundable, even if course is attended)

To register for this course, please register at the following link.

Courses and Workshops| RACS (surgeons.org)

The *Operating with Respect* Wellington course is the only course held in Aotearoa New Zealand in 2026 and is available to Fellows and SIMGs, offering seven CPD hours on completion.

The *Operating with Respect* course is compulsory for surgical supervisors and RACS Committee members, and is taught by surgeons, providing participants with practical strategies and skills to respond appropriately to unacceptable behaviour. It also promotes reflection and self-awareness, challenges common biases, assumptions, and erroneous views.

The *Operating with Respect* course was developed in response to the release of the RACS *Action Plan on Discrimination, Bullying and Sexual Harassment in the Practice of Surgery*. It is designed to deliver advanced training in recognising, managing and preventing discrimination, bullying and sexual harassment, to help all surgeons create a safe, respectful workplace culture that positively impacts Trainee learning and ultimately improves surgical care.

Information on the course can be found here – Operating with Respect | RACS (surgeons.org)

Royal Australasian College of Surgeons

Let's operate with respect

HDC case round-up

A survey on their use in Aotearoa New Zealand

This report summarises several recent Health and Disability Commissioner (HDC) cases relevant to surgical practice. Each case highlights key failures in systems, communication, and consent processes, along with cross-specialty lessons applicable to all surgical teams and services.

1. Neurosurgery Case – Pituitary Surgery

Lessons in supervision of International Medical Graduates (IMGs)

1.1 Case summary

A patient admitted following a myocardial infarction developed a haemorrhage into a pre-existing pituitary adenoma, resulting in pressure on the optic chiasm and visual symptoms. Although initially managed conservatively, an urgent transsphenoidal evacuation was then deemed necessary acutely.

The IMG neurosurgeon correctly identified that he lacked experience for this complex procedure and sought assistance from another neurosurgeon not employed by the public hospital. The IMG surgeon's primary supervisor was on leave, and the case was not escalated to the secondary supervisor based at another hospital.

The initial haematoma evacuation was uneventful. However, the assisting neurosurgeon extended the surgical field intending to remove the underlying tumour.

This resulted in major bleeding—likely from the right internal carotid artery—cardiac arrest, and ultimately the patient's death.

1.2 Findings

Both the HDC and local Adverse Event Review concluded the root cause was the failure of the initial surgeon to contact colleagues at the second hospital for appropriate guidance and support.

Additional contributing factors included:

Absence of a protocol for supervision of an IMG surgeon when the primary supervisor is on leave or absent and lack of escalation guidance for complex cases.

Lack of a clear plan/protocol for managing acute complex pituitary surgery, resulting in an inexperienced IMG surgeon performing urgent surgery without appropriate supervision.

- Absence of a protocol outlining the role, scope, and responsibilities of non–public hospital surgeons assisting in public procedures.
- No discussion with the patient regarding involvement of a surgeon not employed by the public hospital, and no documentation of this arrangement.
- No clinical basis for attempting acute tumour removal after the initial haematoma evacuation.
- Incomplete operative documentation (brief handwritten notes only).
- Poor communication and disconnected workflows between neurosurgical teams across hospital sites.
- Accreditation processes failed to identify procedures the IMG surgeon should not perform.

1.3 Generic lessons for all surgical specialties

- Ensure specific protocols are in place requiring IMG surgeons under supervision to seek advice from other consultants when their named supervisor is unavailable.
- Maintain a clear, documented list of procedures that IMG surgeons may perform independently, and those requiring direct supervision.
- Develop clear policies for when supervision can be provided by clinicians who are not employees of the public hospital, including defined roles and scope.
- For multi-site services, provide structured orientation to both sites to build collegial relationships and improve communication.
- When additional supervisors or surgeons are involved in patient care, the nature of their role must be clearly documented in the patient record and included in the consent process.

2. General Surgery case – Hernia repair

Lessons in informed consent processes

2.1 Case summary

A patient complained to the HDC about inadequate informed consent for a hernia repair. She initially believed mesh would not be used. Surgery was discussed at an initial consultation where the surgeon thought the hernia was a femoral hernia not an inguinal hernia. Mesh was not discussed at this stage. An ultrasound was ordered that confirmed an indirect left inguinal hernia. However, this result was not discussed with the patient because it was not felt by the surgeon to alter the surgical plan.

Attempts to speak with the surgeon by the patient before the operation was unsuccessful. The completed booking form made no mention of mesh.

On the day of surgery, the patient raised concerns related to a family history of mesh complications and asked about alternatives, but felt pressured to consent after being told mesh was the only suitable option. The consent form did not document the use of mesh.

Post-operatively, the patient developed significant pain consistent with mesh-induced fibrosis. ACC accepted her claim, and subsequent surgery was required to remove the mesh.

2.2 Specific lessons

- Surgeons should not assume patients understand differences between types of mesh use. Media coverage regarding pelvic mesh complications can contribute to heightened anxiety.
- Extra caution and clarity are required when discussing mesh with patients, even when it is standard practice.

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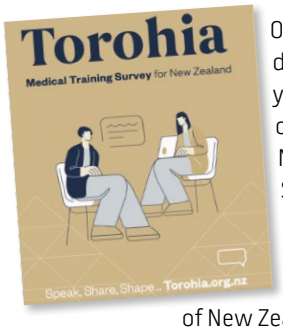
FROM THE EDGE

Surgical Advisor update: Advocacy, Innovation, and regional collaboration

Over the past several months, RACS in Aotearoa New Zealand continues to be closely involved in a wide range of advocacy and system-improvement initiatives. Much of this work has required sustained collaboration across national health organisations, specialty colleges, junior doctors, and regional partners. Several major projects are now either reaching important milestones or transitioning into evaluation and implementation phases.

Torohia – Medical Training Survey for New Zealand



One significant development this year is the rollout of Torohia, the new Medical Training Survey developed by Te Kaunihera Rata o Aotearoa (Medical Council of New Zealand MCNZ). This survey represents a major step forward in assessing and improving the quality of medical training nationwide at both prevocational and vocational levels.

Background and Purpose

Torohia has been modelled on the highly successful Australian Medical Training Survey (MTS), which is administered annually to junior doctors. This has become a cornerstone in identifying training needs, wellbeing concerns, system pressures, and areas requiring reform. The Aotearoa New Zealand version has been carefully customised to reflect the unique structure, demographics, and training pathways of Aotearoa's health system.

Development and collaboration

RACS has played an active role in the working group responsible for developing the survey. This group includes:

- Other specialist medical colleges
- Prevocational training providers
- Junior doctors at varying stages of practice
- Medical schools.

This broad representation has ensured that Torohia captures training experience in the early prevocational years and vocational Trainees across all specialties.

Current progress

The survey has now been distributed to all junior doctors nationwide. MCNZ is currently analysing and curating the responses. Once complete, data will be released to training providers to inform quality-improvement initiatives.

Expected impact

Experience from Australia shows the value of such a dataset:

- Identification of systemic issues affecting Trainee safety and wellbeing
- Insight into workforce pressures and resource limitations
- Improved supervision, teaching quality, and professional development pathways.

We expect Torohia to become a powerful tool for driving positive change in the Aotearoa New Zealand medical training environment for years to come.

Sepsis Technical Advisory Group – Finalisation of National Resources

The Sepsis Technical Advisory Group, coordinated by the Health Quality & Safety Commission (HQSC), has now concluded its major development work. RACS has been a key contributor to this group, which was tasked with designing evidence-based, nationally consistent resources to improve the recognition and management of sepsis.

What has been achieved

The group has developed several sepsis bundles informed by the latest international literature but tailored to Aotearoa New Zealand's healthcare context. These include:

- Clinical pathways for adult, maternity, and paediatric patients
- Early recognition tools suitable for diverse care settings
- Educational resources for clinicians
- A measurement and evaluation framework
- Audit tools to support local implementation.

Significance for healthcare delivery

Sepsis remains a leading cause of preventable mortality and morbidity. Variability in early recognition and response can significantly affect patient outcomes. The new resources aim to streamline care pathways, reduce delays in treatment, and support a consistent national approach.

HQSC will guide dissemination and adoption, ensuring that district-level implementation is supported by ongoing evaluation and quality-assurance measures.

Faecal Immunochemical Test (FIT) for symptomatic patients

RACS has continued its close involvement in the development and national rollout of the symptomatic FIT pathway, in collaboration with Te Whatu Ora. This initiative is expected to bring meaningful improvements to colorectal cancer detection and reduce growing pressures on colonoscopy services.

Challenges facing current colonoscopy pathways

Across several districts, colonoscopy waitlists for symptomatic patients have exceeded available capacity. This has created risks such as:

- Inconsistency in triage decisions
- Patients with low-risk symptoms being placed on long waitlists
- Missed opportunities to offer alternative or more appropriate investigations
- Delayed diagnosis of significant bowel pathology, which may not have significant symptoms.

Benefits of the FIT for symptomatic use

The faecal immunochemical test is a validated biomarker strongly associated with risk of colorectal cancer (CRC). Internationally, it has been successfully integrated into symptomatic triage pathways.

Trial findings in Aotearoa indicate:

- Around 80 per cent of patients currently referred for non-urgent colonoscopy are FIT-negative, suggesting low likelihood of CRC.
- FIT-positive patients can be fast-tracked for colonoscopy, reducing diagnostic delays.
- Clinicians still retain discretion to review FIT-negative patients who may still need a clinic review or colonoscopy when clinically indicated as not all significant treatable bowel pathology is bowel cancer.

RACS' role in implementation

RACS sits on the FIT Evaluation Translation Group, which is overseeing national rollout, evaluating clinical impact, and ensuring equitable access across the motu. This work is vital to ensuring that the pathway improves safety, efficiency, consistency and patient outcomes without inadvertently disadvantaging vulnerable groups.

ECO Care Equity in the Asia-Pacific Conference – Suva, Fiji (pictured above)

In October, the Pacific Island Surgical Association (PISA) partnered with the G4 Alliance to host the ECO Care Equity in the Asia-Pacific Conference at the University of Fiji in Suva. The event brought together a diverse group of more than 120 in-person attendees and many more online, including:

- Surgeons
- Anaesthetists
- Obstetricians
- Nurses and midwives
- Trainees and students
- Representatives from Pacific Islands, PNG, Timor-Leste, Pakistan, USA, Australia, Aotearoa New Zealand, and Ghana.

Focus and themes

The conference centred on strengthening emergency, critical, and operative (ECO) care systems across the region—an urgent priority as climate change places increasing strain on health infrastructure, supply chains, and clinical resources.

Sessions addressed topics such as:

- Building climate-resilient health systems
- Workforce strengthening and regional training pathways
- Innovations in surgical delivery for remote and resource-constrained settings

A particularly inspiring highlight was the session *Breaking Scalpel Ceilings – Women Shaping Pacific Surgery*, which showcased the leadership, challenges, and achievements of women advancing surgical practice in Pacific nations.

Climate change and surgical practice – A growing imperative

A prominent and recurring theme throughout the conference—and many recent RACS discussions—has been the urgent need to address the environmental impact of healthcare.

Global actions, distant consequences

Although healthcare systems in high-resource countries contribute significantly to carbon emissions, it is often low-lying Pacific nations that experience the harshest effects through:

- Sea-level rise
- Increased cyclone intensity
- Salinification of freshwater sources
- Disrupted food systems
- Impacts on health infrastructure and supply chains.

Examples of high-impact, routine practices

Many everyday decisions in surgical practice carry significant carbon and waste costs, such as:

- Leaving laminar flow systems running overnight or during weekends in unused theatres
- Reliance on polypropylene wraps for sterile equipment
- Widespread use of disposable gowns, drapes, and single-use instruments.

These actions, while often automatic or habitual, collectively create significant environmental burdens and generally these consequences are felt far from where the decisions are made. Climate change will have a very significant negative impact on the Pacific Islands and as surgeons we need to become more intentional about our decisions in theatre and consider their environmental impact.

A call for intentional, sustainable practice

As surgeons, we are uniquely placed to influence theatre practices, procurement choices, and systems thinking. A shift toward environmentally responsible surgical practice requires:

- Awareness of environmental impacts
- Intentional decision-making in theatre
- Advocacy for sustainable procurement
- Participation in organisational sustainability initiatives
- Support for research into low-carbon surgical approaches

The choices we make within our operating theatres ripple far beyond our immediate work environment, affecting communities across the Pacific and generations to come.

Dr Sarah Rennie
Surgical Advisor, Aotearoa New Zealand

Surgical pre-list briefings

A survey on their use in Aotearoa New Zealand

Pre-list briefings (also known as surgical briefings or huddles) were introduced across NZ hospitals by the Health Quality and Safety Commission (HQSC) from 2014 when the surgical safety checklist went to a paperless form. Other structured communication tools and debriefings were also encouraged at this time.

Pre-list briefings are a simple way for the team to share vital information about patients and discuss potential and actual safety issues before the surgical list or procedure takes place. They encourage an environment where the team can share this information without fear of reprisal.

Scientific publications from this period support the position that up to a third of pre-list briefings identify a problem, ambiguity, or critical knowledge gap, provoke a change in plan, or prompt a follow-up action. Up to a half of pre-list briefings have a direct impact on patient care by changing the decisions or actions team members take during a surgical procedure.

Despite the rationale and the ubiquitous uptake of the surgical safety checklist from 2010 onwards, pre-list briefings were never adopted with the same enthusiasm. A range of barriers were presented, which varied by individual, location and discipline.

Ten years on, the current status of pre-list briefings is unclear with the only certainty being that there is variation and as W. Edwards Deming famously said, “Uncontrolled variation is the enemy of quality”. So, what is the situation with pre-list briefings?

Pre-list briefing practice in NZ was discussed at a meeting of the national anaesthesia quality leads (AQINZ, Anaesthesia Quality Improvement NZ committee) in 2024. It was clear that there was variation in practice across the country with some hospitals struggling to embed them.

A survey of current practice

A survey of public hospital anaesthetists was designed to investigate this issue and was carried out over a six-week period from January to March 2025. Nearly 211 anaesthetists from 12 regions responded, including most of the main centres, with seven regions not responding.

The survey responses showed broad use of pre-list briefings for elective operating lists. When asked how often an elective pre-list briefing occurs, the responses were 66 per cent always, 26 per cent most of the time and eight per cent sometimes. However, there was far less use in acute operating lists (18 per cent always, 40 per cent most of the time, 32 per cent sometimes and 10 per cent never).

Pre-list briefings were more likely to be led by a consultant surgeon (73 per cent of the time) for an elective list, but only 11 per cent of the time for an acute list, where they were most often led by a surgical registrar (60 per cent of the time).

The most common reasons for a pre-list briefing occurring were team member engagement (40 per cent of respondents), the presence of team members (35 per cent) and organisational culture (18 per cent). Surgical attitude was mentioned as a contributing factor by 14 per cent of respondents.

The commonly reported barriers to a pre-list briefing occurring were the availability of staff (43 per cent of respondents) and acute list case or speciality changes (43 per cent). Surgical attitude, either not being present or unwillingness to engage, was again reported by 14 per cent of respondents.

Perceived effect of pre-list briefings

There were many positive comments regarding the effect of pre-list briefings on improving communication with 81 per cent thinking they were either very or extremely effective. The most common reasons cited were sharing information, planning the list, identifying issues and facilitating teamwork and open communication.

> When asked about reducing harm to patients, 58 per cent thought pre-list briefings were very effective or extremely effective.

When asked about reducing harm to patients, 58 per cent thought pre-list briefings were very effective or extremely effective. This was backed up by observed improvements in the discussion of risks and issues and the transfer of vital information, as well as the promotion of more open communication with the whole team.

This survey showed that pre-list briefings are generally viewed very positively when done well and seen as an important teamwork and safety tool. However, there seems some lack of awareness or use of all the elements of the briefing and an

understanding of how to achieve the full benefit. There remain significant barriers to uptake with both discipline of surgery and region of the country being identified as factors associated with routine high-quality use of pre-list briefings.

Recommendations

The survey discussed here was undertaken by anaesthetists and the opinions expressed come from that perspective. A comprehensive view of the issues and attitudes would benefit input from members of all surgical disciplines. Support for pre-list briefings as a safety tool would be expected but more information on the barriers from a surgical perspective would help facilitate embedding this activity in all operating rooms not just in some disciplines in some hospitals.

The following recommendations can help improve uptake and engagement from operating theatre teams:

- Safety culture in a hospital needs to insist on a mandatory approach to pre-list briefings for all surgical disciplines as it does for the surgical safety checklist.
- Pre-list briefings are a surgical unit expectation, supported by management and clinical directors.
- Pre-list briefings are scheduled at a specific time, with all team members pausing duties to attend.
- Pre-case briefings for acute lists are encouraged.
- Staff are educated on good quality briefing practice via resources available on the HQSC website.

Dr Lisa Chapman
Consultant Anaesthetist
Department of Anaesthesia & Perioperative Medicine
Te Toka Tumai, Auckland
lisa@adhb.govt.nz

Emeritus Professor Ian Civil
Trauma and Vascular Surgeon
Department of Surgery
Te Toka Tumai, Auckland
IanC@adhb.govt.nz

RACSTA report

RACS Trainees Association (RACSTA) has continued to represent and support surgical Trainees across Aotearoa New Zealand this year.

One key focus has been improving support for Trainees who experience Fellowship exam setbacks. The team is exploring new ideas like better feedback systems and more specialist support options for those needing extra help.

The annual RACSTA Induction Conference was held on 6 December and was free and easily accessible, with a hybrid format. This event is a great chance for incoming Trainees to hear from senior registrars and Fellows about life in surgical training, how RACSTA works, and where to turn for support.

RACSTA has also provided feedback on the proposed RACS Pregnancy Guidelines—highlighting the need for better recognition of training challenges during pregnancy, including support for partners and those undergoing fertility treatment.

Outsourcing remains a major system-level issue for Trainees in Aotearoa, with concerns about safeguarding SET training opportunities as more operations shift to private providers.

The need for consistent access to outsourced cases and the potential for Trainee involvement through structured arrangements is a topic of ongoing advocacy to Health New Zealand.

RACSTA Committee with Rachael Morgan from RACS

With ongoing discussions around the format of decoupling Fellowship exams and strengthening flexible training options, Aotearoa New Zealand's Trainee voice remains strong at the College level. RACSTA's efforts continue to ensure Trainee needs and wellbeing stay front of mind as surgical education evolves.

Author: Dr Cameron Wells

Aotearoa New Zealand National Committee Representative to RACSTA

Advocacy Update – Aotearoa New Zealand

The past quarter has continued to be busy in the advocacy space as agencies try to complete their consultations by the end of the year. The AoNZ National Committee continues to engage in advocacy to strengthen patient safety, support our surgical workforce, and influence health policy across Aotearoa.

Building Strong Stakeholder Relationships

Our advocacy relies on constructive engagement with key health sector leaders:

- **Te Whatu Ora – Health New Zealand**
  We welcomed the release of new *Other Employment and Conflict of Interest* guidelines, which reflect our recommendations for clearer rules on dual roles and private practice. These changes acknowledge the reality that many surgeons work across public and private sectors, and they provide clarity on scheduling, referrals, and resource use.
  We also contributed to principles for training surgical registrars in private hospitals, ensuring outsourcing arrangements embed education and patient safety. This is critical as outsourcing grows to address surgical waiting lists.
- **Medical Council of New Zealand (MCNZ)**
  We continue to work with MCNZ on accreditation protocols for training sites and safe practice standards for cosmetic procedures. Our submissions emphasised that invasive procedures require advanced surgical training and should only be performed by appropriately qualified specialists.
  We are also contributing to discussions on physician associates and the ethical use of AI in patient care, ensuring safeguards and clear consent processes are in place.
- **Ministry of Health**
  We are monitoring the *Healthy Futures (Pae Ora) Amendment Bill* and upcoming changes to health workforce regulation. The proposed reforms aim to speed up overseas registrations and make regulators more accountable, while ensuring cultural safety remains central to patient care.
- **Other Partners**
  Regular engagement continues with ACC, Southern Cross Healthcare, NZ Private Surgical Hospitals Association, and the Council of Medical Colleges (CMC). These relationships help us influence outsourcing policies, workforce planning, and training standards.

Recent Submissions

Over the past three months, we have provided submissions on the following consultations:

- **Te Whatu Ora – Secondary Employment and Conflict of Interest Guidelines** – securing fair treatment for surgeons working across public and private sectors, and ensuring registrars can train in private facilities during outsourced lists.
- **Te Whatu Ora - Principles for Private Training** – embedding training in outsourcing agreements to maintain surgical education standards.
- **MCNZ - Cosmetic Surgery Standards** – reinforcing that invasive procedures require advanced surgical training and should only be performed by appropriately qualified surgeons.
- **MCNZ - AI in Patient Care** – supporting safeguards, transparency, and clear consent processes as AI becomes more integrated into healthcare.
- **National Melanoma Working Group - Melanoma Guidelines** – promoting equity and Māori health outcomes, and recommending inclusion of data sovereignty considerations.
- **The University of Auckland - Antibiotic Guidelines** – backing a national resource for sustainable prescribing and alignment with Health Pathways.
- **Te Whatu Ora - Advance Job Offers for Fellows** – advocating for measures to retain surgical talent in Aotearoa, including secure roles post-fellowship and incentives for regional placements.
- **The Public Service Commission - Public Sector Code of Conduct** – ensuring doctors can continue to advocate for patient safety without breaching neutrality requirements.

All of our advocacy outputs are published promptly on the RACS website. You can read full copies of our submissions here: News, media releases and advocacy | RACS

CPD reminder

Kia ora! It's now time to start finalising your CPD. Please check your inbox for a reminder notice, along with some helpful FAQs.

Kindly ensure you have completed your structured conversation with a peer, and embedded cultural safety, addressing health inequity, professionalism, and ethical practice across your reported activities.

If you have any questions, the CPD Team is always happy to assist you. You can reach them on +64 4 595 1432 or email them: cpd.college@surgeons.org.

Congratulations to Dr Cameron Wells

2025 Louis Barnett Prize winner

Why are some patients more likely to die after surgery than others, and what causes this inequity in outcomes?

This question is at the centre of Dr Cameron Wells' research into postoperative mortality in Aotearoa New Zealand.

His presentation, *Failure to Rescue after Gastrointestinal Cancer Surgery: a driver of hospital variation, ethnic inequities, and a target for quality improvement in Aotearoa* recently won the 2025 Louis Barnett Prize.

Named after the first president of the Royal Australasian College of Surgeons, the Louis Barnett Prize recognises outstanding research that benefits patients and the community.

"It is a real honour to join the list of previous winners", Dr Wells says.

However, most critically, is the recognition the prize gives to his work in turning research "into action to improve surgical care in Aotearoa New Zealand".

Recognising and managing complications

Dr Wells' research focuses on "failure to rescue"—deaths that occur after potentially treatable postoperative complications. His studies show that differences in "rescue" are the major factor driving variation between hospitals in Aotearoa New Zealand. Additionally, Māori patients are more likely to die when complications occur after surgery.

"The difference is not in the rate of complications. It is in how quickly they are recognised and managed. That delay in response is what drives the mortality gap," he explains.

Even after adjusting for age, gender, health status, socioeconomic factors and hospital size, inequities remain.

These differences are a system-wide problem, impacting all hospitals, whether big or small. They arise from a "complex chain of processes" involved in postoperative care, including monitoring, communication, escalation, and access to senior decision-making. Some of this variation may also reflect underlying structural biases within the health system. Addressing these inequities will require a coordinated approach to strengthening postoperative rescue across all settings.

"We need to examine the process that drives variation and inequities in more detail, and make sure we have equity embedded into every step in solutions."

Dr Wells also believes that early detection of cancers and improved access to primary care are also vital to reducing inequities.

"We need to catch disease earlier and make sure every patient can access quality screening and treatment."

From patient to surgeon

Dr Wells' interest in medicine began during his own experience as a patient. As a teenager, he underwent vascular surgery to repair blood vessels in his leg.

"I was looked after by a vascular surgeon in Hamilton who probably has no idea the impact he had on me," he says.

With a father who worked as a laboratory scientist, science was already part of his life, but surgery offered something more.

"I liked the applied nature of surgery, the mix of science, solving practical problems and connecting with people. You can see the difference you make in real time."

Using technology for solutions

Dr Wells also leads a research group at the University of Auckland that focuses on using data and technology to improve patient outcomes. Supported by the Health Research Council of New Zealand, his team is developing ways to use artificial intelligence (AI) and new monitoring systems to detect deterioration earlier and make surgery safer.

"We are working on wearable devices that monitor patients' vital signs and use AI to identify early warning signs of complications," he explains.

These innovations aim to bridge the gap between technology and patient care.

"If we can identify problems early, we can intervene before patients become critically unwell. This can result in better outcomes for everyone and fewer inequities."

Dr Wells also sees a future where recovery extends beyond hospital walls.

"We are moving towards models where patients can be safely monitored at home," he says. "It is about making care smarter, more connected and more equitable."

Mentorship and collaboration

Dr Wells is also committed to collaborative research and training. He plays a key role in STRATA, Aotearoa New Zealand's Trainee-led collaborative research network in General Surgery. "Research is a team sport. No one can do it alone," he says.

He credits senior mentors for guiding his journey. "I have been fortunate to have people who supported my research ideas early on. That kind of mentorship is what builds the next generation of surgical leaders."

A vision for equity

As he completes his PhD, Dr Wells remains focused on translating research into meaningful change, using technological innovations, better clinical care, and system-level interventions.

"The long-term vision is simple," he says. "A health system where every New Zealander has the same chance of excellent surgical outcomes, with no preventable deaths after surgery and no inequities in who survives."

"We have the data, the technology, and the will to do better. Now we need to make sure every patient benefits."

Watch the 2025 Louis barnett Prize Presentations

Keep an eye out for more information coming soon about the 2026 prize - entries open in January.

RACS Honours Māori Health Medal recipient

Aotearoa New Zealand orthopaedic surgeon Dr John Mutu-Grigg FRACS (Ngāti Kahu, Te Rarawa) has been recognised with the RACS Māori Health Medal for his outstanding contribution to Māori health and his leadership in strengthening the Māori surgical workforce.

The medal was presented on 11 November 2025 at a special ceremony held at the University of Auckland's Old Government House, following the Māori Health Advisory Group's (MHAG) annual general meeting. The celebration was a surprise for Dr Mutu-Grigg, whose whānau (family) joined for the occasion.

Professor Jonathan Koea opened the evening with a mihi whakatau (welcoming ceremony), and MHAG members Dr Alison Scott FRACS and Dr Benjamin Cribb FRACS closed the event. Previous medal recipient Dr Maxine Ronald FRACS read the nomination, and RACS President Associate Professor Owen Ung FRACS presented the medal. Guests included RACS CEO Stephanie Clota, previous medal recipient Professor Pat Alley FRACS and Aotearoa New Zealand National Committee Chair Ros Pochin FRACS.

This year's medal was engraved with Mangopare, the hammerhead shark design symbolising tenacity and strength. The accompanying whakatauākī - *Me mate ururoa, kaua e mate wheke* - means Fight like the hammerhead shark, not to give up like a squid.

RACS President Owen Ung presented the medal to John.


John Mutu-Grigg and his proud whānau

Dr Mutu-Grigg's mother, Professor Margaret Mutu, a respected Māori academic at the University of Auckland, expressed her pride in her son saying he was raised to work with his people.

A leader in Māori health and surgical equity

Dr Mutu-Grigg has been a core member of the RACS Indigenous Health Committee and Māori Health Advisory Group since 2017; the latter of which he has chaired since 2019. He also serves on the Executive of the Aotearoa New Zealand National Committee and is deeply involved with the New Zealand Orthopaedic Association as a member of their Board.

He was instrumental in establishing Ngā Rata Kōiwi, the Māori orthopaedic surgical group that supports Māori registrars throughout their training journey. Under his leadership and advocacy, Orthopaedics now has the highest representation of Māori surgical Fellows and Trainees of all the nine RACS surgical specialties.

Dr Mutu-Grigg has championed the inclusion of Cultural Competency and Cultural Safety as core clinical competencies for surgical Trainees, helped introduce culturally safe selection processes for Orthopaedic Surgery, and has been a powerful advocate for health equity for Māori. He also works tirelessly to inspire future generations, attending Pūhoro wānanga for Māori secondary school students interested in STEM subjects and regularly participating in Te Ora careers hui, where he has twice been voted "best in show."

Although he works primarily in the private sector, John provides pro bono care to his iwi and remains passionate about achieving equity of representation in the Māori surgical workforce by 2040. He is a staunch defender of Indigenous rights and an inspiring role model for Māori and non-Māori alike.

Dr Ruth Herd
Kaiwhakarite Hauora Māori, RACS AoNZ Office

A big thank you to Dr Nigel Willis FRACS

At the Aotearoa New Zealand National Committee Annual Dinner on 3 September, we had the honour of thanking Dr Nigel Willis FRACS for his long years of commitment to RACS. Nigel has just finished serving as the Aotearoa New Zealand Censor for nine years, and as a member of RACS' New Zealand National Board for the nine years prior to that, leading the Committee as Chair for several of these.

As a small token of our appreciation, Nigel was presented with a Patu Pakohe (Argillite), carved by the Koro Rāwiri Collective (Ngā Puhi) symbolising the strength and leadership that Nigel brought to RACS in his role. A Karakia Pakohe from Ngāti Kuia (Pelorous Sound) was presented to Nigel along with the Patu, which Nigel performed as a Waiata.

Alongside the admiration of his colleagues, Nigel is warmly regarded by the staff of the AoNZ office and will be missed.

Caption: Nigel, his partner Carl, and current Chair Ros Pochin

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RACS ASC 2026 registrations now open

The 94th RACS Annual Scientific Congress (ASC) is shaping up to be an inspiring and forward-looking event, bringing together surgeons, scientists, innovators, and thought leaders from across the surgical and wider healthcare communities.

Taking place at the Perth Convention and Exhibition Centre from Thursday 30 April to Sunday 3 May 2026, the Congress will explore the theme *The Art and Science of Collaboration*.

The program offers an outstanding opportunity to earn CPD points across all domains designed to encourage continuous learning and professional growth. The ASC remains the premier event for advancing surgical knowledge, fostering collaboration, and celebrating excellence in scientific and clinical practice.

As surgery becomes increasingly interdisciplinary, the Congress provides a valuable platform to connect with peers and experts from diverse specialties—all working towards improving patient outcomes. Join this exploration into innovation, precision, and collaboration that continues to shape the future of surgical care.

Beyond the scientific program, ASC 2026 offers rich networking opportunities. Connect with colleagues, share experiences, and form partnerships that will influence the next era of surgical practice.

Start planning your ASC 2026 experience by visiting ASC 2026 website to register, view the provisional program, or to submit an abstract to this landmark event.

Early bird registration discounts are available until Sunday 15 March 2026.

We look forward to welcoming our Aotearoa New Zealand colleagues to Perth for ASC 2026. If you can't make it in person, we are streaming all sessions live so you can watch from anywhere in the world. Content will be available for all in person and virtual attendees to watch for 12 months post ASC.

Inspiring the next generation of Māori surgeons

For Te Rau Poka – Māori Surgical Academy, the highlight of the year is Te Rā Tuhura / Careers Day at the Te Ohu Rata o Aotearoa (Te ORA) Māori Medical Practitioners AGM. Held at Te Whare Wānanga o Raukawa in Otaki, an hour north of Wellington, the Te ORA hui ā tau is attended by several hundred Māori doctors, medical students, and high school students looking at careers in medicine.

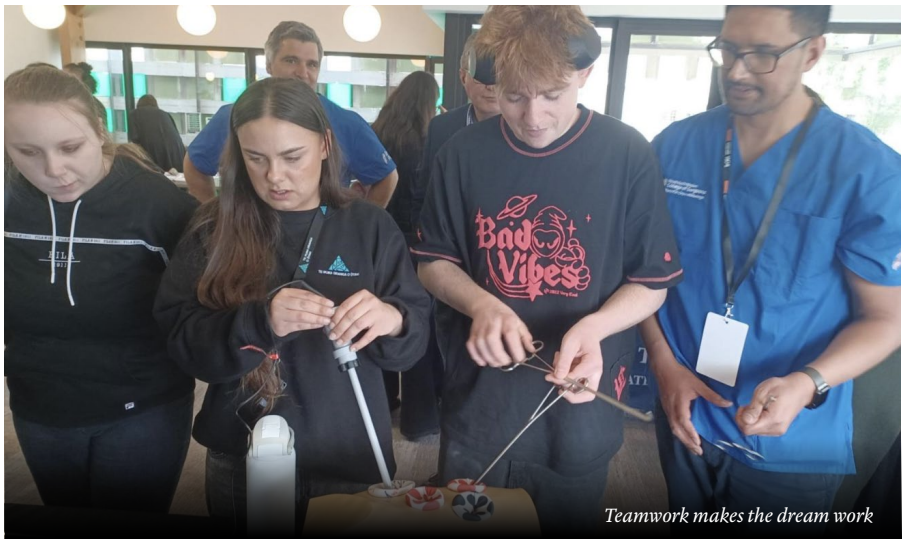
RACS is one of the many medical Colleges that sponsors the event and takes part in the Careers Day, scientific conference and gala dinner.

Professor Jonathan Koea FRACS attended the three-day event in his role as Kaiārahi Trainee Liaison and lead of the Academy. Dr Ruth Herd, Calum Barrett and Kevin Falzon represented RACS and Leanne Wagner and Di Waters attended in support of the Te Rau Poka team.

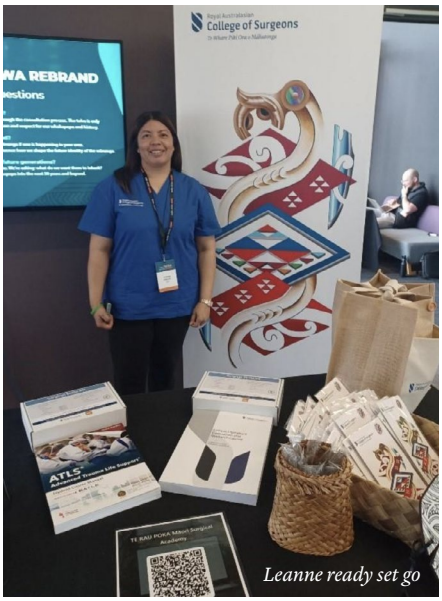
Dr Kopa Manahi FRACS and Dr Wiremu MacFater (SET) volunteered their services to demonstrate surgical procedures using the Stupnik model and some suturing kits provided by the Skills team at RACS. We are very grateful for these kits that are used throughout the year at the Pūhoro STEMM wānanga (workshops) for high school students around the country and for the Te Oranga Māori Medical Students Association gatherings.

RACS has won the coveted best stand award previously two years in a row. Despite our best efforts, The College of Palliative Medicine took out the students vote with a poetry recital. Professor Koea is already working on his poem for next year's Shark Tank.

Huge thanks to our team Leanne and Di who were a great help with the task of setting up our tables and packing down at the end of the day. It was great to have Calum and Kevin on board as well and we all wore the customised scrub tops to look the part.



Teamwork makes the dream work



Leanne ready set go


Wiremu MacFater showing a student how to suture


Left to right: Di Waters, Leanne Wagner, Kevin Falzon, Calum Barrett, Ruth Herd

AoNZ Annual Scientific Meeting 2025 round-up

Enhancing quality and compassion in surgery

Held at Wellington's iconic parliament building, the Beehive, in September, the 2025 RACS Aotearoa New Zealand Annual Scientific Meeting (ASM) brought together surgeons from across RACS' nine specialties. It also welcomed other medical professionals to connect, reflect, and share knowledge.

Day one looked ahead to the future of surgical care, with sessions on consent, registries and workforce planning. Keynotes from Michael Webster (Privacy Commissioner), Professor Dame Helen Stokes-Lampard (Chief Medical Officer, Te Whatu Ora - Health New Zealand), and Dr Andrew Connolly (Deputy Chair, Te Whatu Ora Board) brought national priorities and challenges into sharp focus.

Dr Connolly asked: "Are you ready for rapid change?" With advances in drugs and technology, he sees a "less operative" future for the surgical profession; with "less cutting and more speaking" but where surgeons' technical skills remain paramount.

Day two turned the lens on compassionate leadership. Speakers including Carlton Irving (HQSC), Sally Walker MNZM (2024 Kiwibank NZ Local Hero of the Year), and Sarah Jackson (Te Whatu Ora) spoke about cultural safety, learning from mistakes, and patient-centred care.

Sally Walker shared her experience as a mesh patient advocate and explained why it's vital patients feel seen, heard and thus empowered. "Genuine compassion and effective communication necessitate both courage and dedication." She had nothing but praise for the compassionate care she received from her urologist Dr Eva Fong, who was also on the programme discussing Patient-Reported Outcome Measures (PROMS).

The ASM was also an opportunity to acknowledge three RACS award recipients for their contributions that inspire and strengthen the surgical profession in Aotearoa New Zealand.

- Dr Timothy (Tim) Lynskey – Louis Barnett Medal for outstanding contributions to education, training and advancement in surgery.
- Professor Peter Gilling – Colin McRae Medal for outstanding contributions to the art and science of surgery.
- Professor Ian Civil – Educator of Merit, Facilitator of the Year for exceptional educators shaping the future of surgical education.

A standout moment of the two-day conference was psychiatrist, author and comedian Dr Jo Prendergast, who shared "humour from [her] tumour" journey while reminding us of the serious importance of healthcare professionals caring for themselves.

The ASM dinner was held in Parliament's Legislative Chambers, offering a unique location for attendees to enjoy an excellent meal and each other's company.

The ASM continues to be a vital platform for surgeons to connect across specialties and shape the future of surgical care in Aotearoa New Zealand.

With RACS' centenary scheduled for February 2027, the ASM organising Committee has decided that the 2026 ASM, traditionally held in September each year, should be aligned with the centenary celebrations in early 2027. We will provide more information on this event in the coming months.

Images (clockwise from top): Having dinner in the Legislative Council Chamber; Dr Eva Fong, FRACS and Sally Walker MNZM (2024 Kiwibank NZ Local Hero of the Year); Professor Ian Civil, FRACS receiving the Educator of Merit, Facilitator of the Year award from RACS President Professor Owen Ung, FRACS.

Fee announcement: 2026

Delivering savings and value to our members

Over the past two years, RACS has tightened financial controls, introduced efficiencies, strengthened governance, and grown new revenue streams. These measures are helping us manage rising costs while passing savings directly back to our Trainees and Fellows.

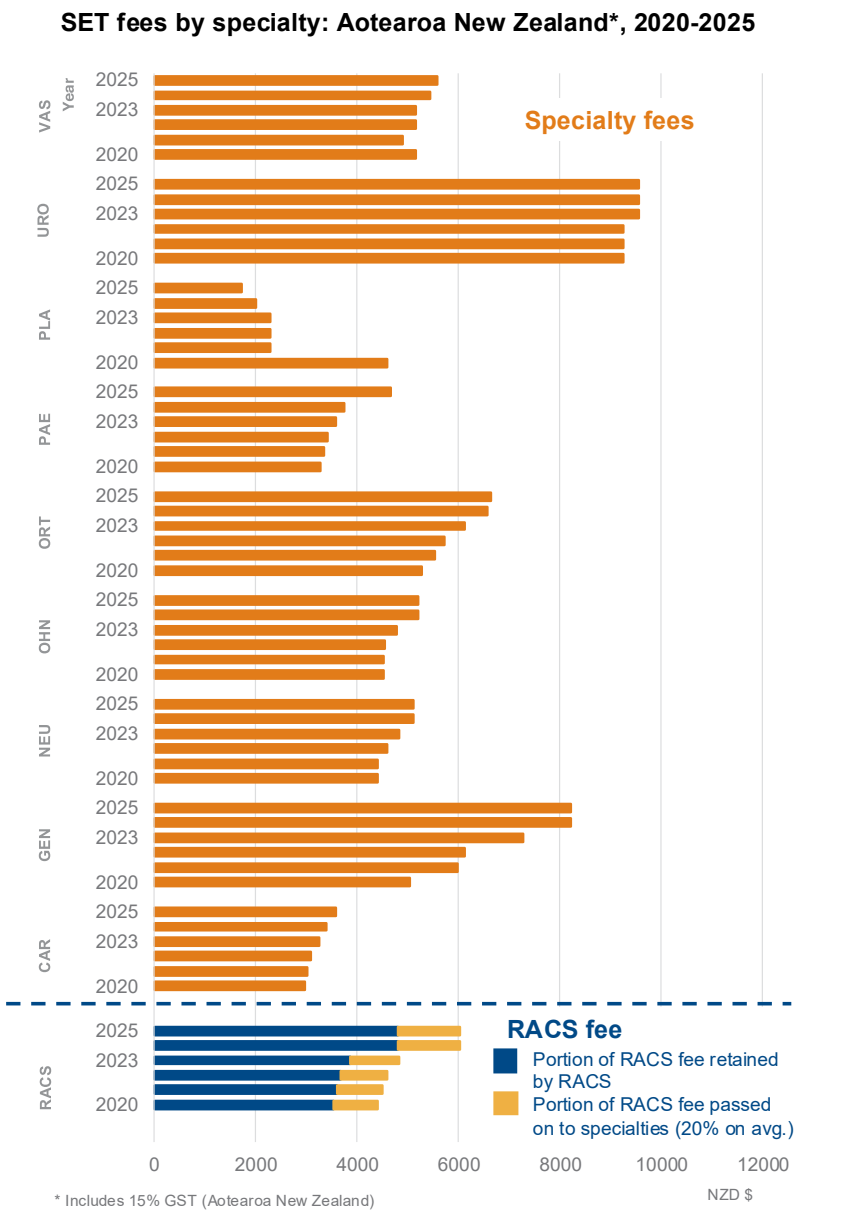
For Trainees, this means a 5% reduction in the College component of SET fees for 2026, following a 0% increase and lower instalment surcharge in 2025. We know training is professionally, personally, and financially demanding, and we're committed to supporting you through this stage of your career. We are also pleased to share for 2026 onwards we have partnered with Te Whatu Ora to invoice them directly for training fees, removing the need for Trainees to seek reimbursement. More information on this change is available on the RACS website.

For Fellows, subscription fees will remain at 2024 levels in 2026, continuing the 0% increase applied in 2025. Your fees are reinvested into the core work of the College — member services, standards, education, CPD, advocacy and research. Through careful financial management and delivering meaningful value, we're committed to supporting you so you can focus on what matters most: your career, your patients, and your profession.

Like surgery, we're stronger when we work together. Read the full communiqués for more details:

Training fees for 2026

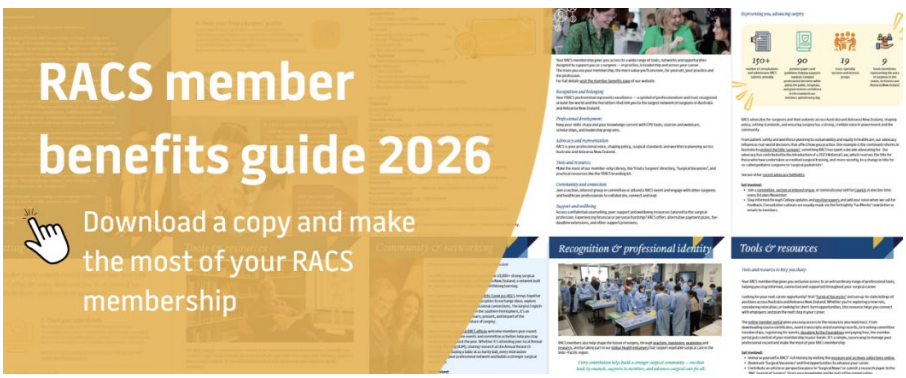
Member fees for 2026



Bring your RACS membership to life

Your RACS membership connects you to a powerful professional community, and opportunities to learn, lead, connect, and contribute. Our member benefits guide 2026 helps you get the most from your membership—from CPD and wellbeing resources to scholarships, networking, advocacy and more.

Find out what's available and discover how your RACS membership can work harder for you.



Younger Fellows – update

Non-Clinical time: Why flexibility matters and what we stand to lose

Our department has recently been asked by management to formalise non-clinical hours into a structured Monday–Friday AM/PM schedule. While the goal appears to be greater transparency, this proposal has generated understandable concern among clinicians.

Non-clinical time encompasses the essential work that supports safe, high-quality care—teaching, quality assurance and audit, departmental administration, CME/CPD, research, and supervision. In short, anything that does not involve direct patient care. As we often remind colleagues, "if you have to look up an NHI, it's not non-clinical."

At present, clinicians manage this work with considerable flexibility, frequently completing tasks after hours or outside the standard weekday timetable. For Younger Fellows balancing new hospital responsibilities with family and personal commitments, this flexibility is not just convenient, it is crucial.

A changing landscape

This local discussion sits within a broader Ministry push to scrutinize potential conflicts of interest between public and private work. We have been advised that conflict-of-interest declarations will soon be required by public hospital employers. While transparency is reasonable, the unintended consequences of more rigid oversight could be significant, especially if clinicians are prohibited from undertaking private work during designated public non-clinical sessions.

Potential outcomes—none of them good

If new restrictions are imposed, two scenarios seem likely:

1. Reduced private capacity:

   Clinicians may simply stop seeing private patients during any scheduled public non-clinical time. Because non-clinical work does not include direct patient care, this would not increase public throughput. The net result would be fewer available appointments overall, and decreased capacity across the health system.

2. Reduced public capacity:

   More plausibly, clinicians may reduce their public FTE, or leave the public system altogether, to protect the viability of their private practice. Given current workforce shortages, even a modest reduction in public commitment would have serious implications for patient access and hospital function.

   Some may note that such changes could allow clinicians to reclaim their evenings. But the trade-off would be a health system with even less capacity, and fewer senior doctors available to teach, supervise, and lead.

A need for balance, not bureaucracy

Many clinicians choose to work in public hospitals not because it is financially advantageous but because of collegiality, professional satisfaction, and a commitment to community service. Policies that erode flexibility or penalise clinicians for maintaining dual practice risk undermining those motivations, and could push doctors away from public work entirely.

Bottom line

Non-clinical time is vital for education, quality improvement, service development, and the long-term sustainability of our profession. Any changes to how it is scheduled or governed must strike a careful balance between transparency and flexibility. If we get this wrong, we risk reducing patient access, weakening both public and private capacity, and compromising the very health system we are trying to strengthen.

Author: Dr Mike Bergin

Younger Fellows' Representative, AoNZ National Committee

From page 3 ...

2.3 Generic lessons for all surgical specialties

- Provide written information sheets about surgical procedures, including materials to be used.
- Ensure patients have opportunities to discuss their operation with the surgeon before the day of surgery.
- Implement a clear process for patients on waiting lists to raise concerns—these must be documented, escalated, and addressed.
- Patients with significant anxiety or concerns should receive a dedicated in-person or telephone appointment to discuss options prior to surgery.

3. General and Cardiothoracic Surgery case – rectal cancer and heart valve disease

Lessons in coordination and communication across services

3.1 Case summary

This case involved a patient with severe aortic stenosis, unsuspected SBE (subacute bacterial endocarditis), and rectal cancer. A sequence of communication failures and misinterpreted referrals contributed to delayed diagnosis and treatment.

Key events included:

- A GP referral for cardiac assessment was incorrectly conflated with later bowel surgery preparation due to documentation errors.
- A GP letter questioning possible SBE was mislaid in ED, leading to incomplete assessment.
- A colonoscopy revealed a rectal mass.
- Later admission showed sepsis, pulmonary embolism, anaemia, and heart failure.
- Cardiology proposed a multidisciplinary meeting (general surgery, oncology, cardiology, cardiothoracic surgery), but the meeting never occurred.
- Cardiothoracic Surgery appeared unaware of the patient's rapid deterioration with notes suggesting a decline over several years rather than months in a fit and health patient.

The patient's deterioration was underestimated, and he was ultimately deemed unsuitable for surgical aortic valve replacement. Workup for TAVI with a second echo revealed aortic valve vegetations and abscess. The patient subsequently died.

3.2 Findings

The report identified significant failings in:

- Timely diagnosis and management of SBE
- Coordination between specialties
- Communication between primary and secondary care
- Recognition of urgency in both cardiac and cancer pathways.

It concluded that earlier aortic valve replacement and more proactive investigation of SBE were warranted.

3.3 Generic lessons for all surgical specialties

- Ensure referrals from primary care are received, read, and stored promptly in clinical notes.
- Replace paper-based referral systems with end-to-end electronic referral pathways incorporating prioritisation and audit functionality to reduce lost or misinterpreted information.
- Ensure better multidisciplinary communication with meetings for complex patients whose medical problems cross several disciplines.

4. Conclusion

These HDC cases highlight system-wide issues in supervision, communication, informed consent, and coordination across services. They reinforce the need for:

- Clear protocols
- Robust documentation
- Effective communication channels
- Consistent supervision frameworks
- Patient-centred consent processes
- Electronic systems that prevent information loss

These lessons should be reviewed and adopted across all surgical departments to improve safety, quality, and patient outcomes.

We want to understand your views, attitudes and perceptions on wait times for specialist care for children

There is growing concern that wait times for child health services are becoming untenable, echoing challenges seen internationally. Yet in Aotearoa, centralised reporting remains limited, and paediatric-specific data are often obscured within general hospital waitlists.

As paediatricians and specialists providing care for children, you are at the frontline of navigating these pressures. Long waitlists and system constraints can lead to moral distress, affecting professional wellbeing and advocacy for children, while forcing difficult decisions about equity and clinical priority.

By completing this survey, you will help us:

- Document the realities of paediatric wait times in Aotearoa
- Understand the impact on clinicians' wellbeing and practice
- Inform evidence-based advocacy for children's access to timely care

Take the survey here:

https://bit.ly/3LGCcBF or
https://auckland.au1.qualtrics.com/jfe/form/SV_a36X7pZv94uSpnM

You will also find the participant information sheet and consent form at this link. Participation is voluntary, and you can choose to go in the draw to win one of three $100 vouchers (grocery or petrol).

Survey closes on 19 December!

Thank you for sharing your valuable insights and for the care you provide to children and their whānau.

Approved by the Auckland Health Research Ethics Committee on 3/11/2025 for three years.

Reference number AH30377.

OBITUARY

Dr Anthony Eric Hardy

Dr Anthony Eric Hardy

2 February 1946 - 20 December 2024

Orthopaedic surgeon

Tony Hardy, the man, the friend, the orthopaedic surgeon, was sui generis, a "one off." His remarkable intellect and extraordinary knowledge of the arts and literature, as well as orthopaedic surgery, defined him as a captivating and colossal presence. His compassion, generosity, kindness and grace away from work were a large part of a multifaceted man set apart from others. It was William Blake who said, "the road that is straightened by correction may be predictable and safe, but it is the crooked roads without correction that offer us the roads of genius."

Anthony Eric Hardy (known as Tony or Hards) was born in Napier in 1946 and spent his early life on Motonui Station in Hawkes Bay. The youngest of Eric and Norah (Gleeson) Hardy's four boys, he had brothers Michael, Denis and Brian. Because of the remote situation of Motonui Station all were home-schooled by their parents for several years. Tony later attended Elsthorpe Primary School and then, from the age 11 years, St Patricks College, Silverstream as a boarder. In 1960 the family moved 70km south to Beckford at Makaretu, and holidays were subsequently spent on the family farm. Tony found his hero figure in Winston Churchill, who in the year of his birth, had delivered his "Iron Curtain" address, saying, "as a people you must feel not only the sense of duty done, but also some anxiety lest you fall below the level of achievement required." That sentiment expressed by Churchill was to form the ethos by which Tony conducted much of his life, both personally and professionally.

Tony gained entry to the Otago Medical School in 1963 shortly after his 17th birthday and graduated youngest in his class just 22 years old. After spending his first three years in Aquinus Hall, Tony then shared a rather rundown flat at the bottom of Stuart Street with Bill Baber, Andrew Macintosh and John Henley. A member of the Otago University Rugby club Tony went on to represent Otago. He remained in Dunedin from 1969 -70 as a house surgeon and towards the end of that time he married the love of his life, Rosemary Gilchrist, a physiotherapist. Tony then completed three years in surgical rotations in Dunedin obtaining his FRACS in 1973.

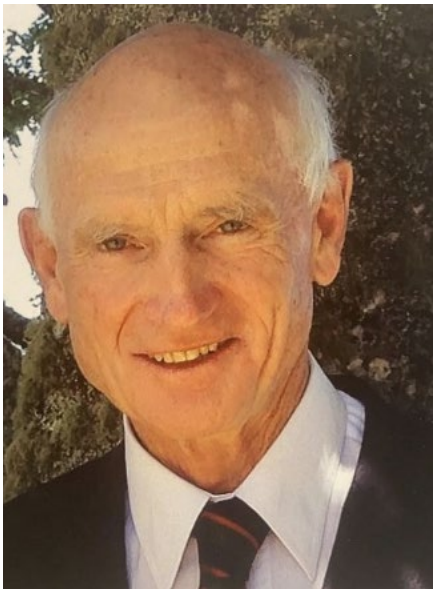
In 1974 Tony and Rosemary moved to Auckland, where Tony worked as an orthopaedic registrar at Middlemore Hospital. During 1975 they travelled to Edinburgh where Tony worked at the Edinburgh Royal Infirmary and Princess Margaret Rose Hospitals. At this time Edinburgh orthopaedics was led by Professor JIP James, a revered figure in British orthopaedics of that era, and the department included George Fulford, Willie Soutar, Mike McMasters and John Chalmers—leaders in orthopaedic surgery. This environment shaped the practise and conduct of those, including Tony, who worked alongside them.

Tony and Rosemary returned to Auckland Hospital in 1976; Tony being appointed as a consultant aged just 31 years. Three children—Charlotte, Anna and Richard, subsequently completed the family. With an interest particularly in paediatric orthopaedics and lower limb surgery, he quickly established himself in Auckland. Pre-eminent in Auckland Hospital orthopaedics almost from the time of his arrival from Edinburgh, Tony chaired the department for the extraordinary duration from 1991 until 2014. His leadership, executive organisation and formidable obduracy in face of repeated management attempts to move the service off-site, resulted in the service transitioning seamlessly to the new Auckland City Hospital in 2004. Always strongly backing members of the department, he was rewarded with unwavering and resolute loyalty with equal conviction. What other head of department would lie down, in his suit, on the asphalt in front of a tow truck driver to prevent his colleague's car getting towed? Loyalty of that ilk is unsurpassable and immutable!

Punctilious by nature, he set and demanded the highest standards, but this created internal conflicts as Tony often agonised over patient care, always wanting to give them the best and he was the first to self-reprimand, sometimes with an angst. His always immaculate presentation and attention to detail was a metaphor to house surgeons and registrars for the exemplar he expected, and his intransigence in this regard was for the ultimate benefit of his patients, for whom Tony cared deeply. While he could be fearsome, he was always a deeply respected, complex and sometimes abstruse character who was truly three dimensional—a man who stood head and shoulders above the homogeneity of personality that medicine is now the poorer for.

Many orthopaedic surgeons who were fortunate enough to have been taught, exhorted, bolstered, guided or influenced by a man for whom integrity, honesty and loyalty were non-negotiable attributes will recognise the debt owed to Tony. He understood that a surgeon's education was only made complete when the pillar of science was aligned to the pillars of history, philosophy and the humanities. Tony's lectures and contributions to clinical meetings and informal tutorials were not only luminary and memorable but grounded. He had a genuine enthusiasm for his subject, allied with a rare ability to pitch content at the appropriate level, and his encyclopaedic knowledge was delivered with an unrivalled intensity. Tony's gravitas was a rarity in today's flatter world. You listened as he drew you in, were inspired and challenged. He sought a response and encouraged deeper thought and was somehow able to weave the prosaic nature of much of orthopaedics into history, art and literature and invite parallels.

Like all great leaders, his guiding ethos was to fortify and refresh for the greater good of the department, and he was adept in guiding young consultants towards their full potential, while allowing them to flourish professionally



without feeling suffocated or servile. He also championed the cause of women orthopaedic surgeons at a time when that was not the norm. Tony's scientific publications were numerous, one particularly on birth injuries to the brachial plexus being viewed as a seminal work. His commitment to a study on cast bracing for femoral shaft fractures as an alternative to intramedullary rodding early in his career was legendary! When Tony left Auckland City Hospital in 2014, it was like Trafalgar Square losing its Nelson.

In 1982 Tony was selected as the New Zealand ABC travelling Fellow to the USA and Canada and this was the foundation for Tony's life-long commitment to this highly valued exchange. He subsequently held almost every executive position in NZ Orthopaedics. This included secretary and chairman of the Auckland Orthopaedic Society, executive member of the NZOA from 1992-95, examiner for the RACS Part 2 Fellowship from 1992-2000 (both feared and venerated in equal measure by candidates!), president of the NZOA 2001-02, member of the NZ Committee RACS for nine years, and a Councillor from 2003-07. In 2013, Tony was the recipient of the prestigious RACS Hamilton Russell medal following his delivery of a masterly lecture titled 'Science and Charity', in homage to the famous 1897 Picasso painting of the same name.

Away from work, Tony was a thorough gentleman, relaxed and engaging, sociable and impeccably mannered, his chivalry almost anachronistic in the modern era. With an aphoristic, intellectual and perceptive sense of humour, he was at his most animated when discussing life, literature, art, history and people. The purchase of a property in Algies Bay in 1985 provided an escape from the pressures of work where Tony enjoyed the company of friends and family, while pushing his limits running and swimming. Tennis remained a significant form of relaxation and time was found to manage golf on a regular basis. Bridge learnt as a student remained a lifetime source of challenge and pleasure. During later years cycling became a significant part of Tony's life and formed the basis for several international cycling tours.

The last few years of Tony's life were cruel in that he was cheated of his natural erudition, and his ability to read widely and prodigiously. Through all this Rosemary stood steadfastly by his side, as she has done for 54 years. If legacy is defined as 'not leaving something behind for other people, but leaving something behind in other people,' then Tony's legacy is irrefutable. Tony Hardy died 20 December 2024 and is greatly missed by Rosemary, children - Charlotte, Anna and Richard, brothers—Michael and Dennis (Brian deceased) and three grandchildren.

Clayton Brown FRACS, John Henley MRACP, Rosemary and Richard Hardy contributed to the preparation of this obituary.

RACS seeks surgeons' insights to boost rural health care

Help shape the future of surgical services in regional Aotearoa New Zealand

RACS is investigating the factors that influence surgeons' decisions to work in rural and regional areas across Aotearoa New Zealand. By identifying both the barriers and incentives at play, the College hopes to recommend actionable strategies that attract more surgeons and enhance access to surgical care across these communities.

We invite RACS Fellows or SIMGs who have spent at least 12 months working in areas outside the major cities of Auckland, Christchurch, Dunedin, Hamilton, Tauranga and Wellington to participate in a one-hour individual online interview. Your input could help shape future policies, support strategies for recruitment and retention, and improve access to surgical services for countless New Zealanders.

If you would like to participate or learn more about the study, please contact Dr Ann Scott (ann.scott@surgeons.org) or Professor Wendy Babidge (wendy.babidge@surgeons.org) for more details.