Cutting Edge

Issue No 74 | March 2020

New Zealand National Board

Nicola Hill
(Chair)

FROM THE CHAIR

INSIDE THIS ISSUE

2 Medicolegal Professional Development opportunities

2020 election issues

3 Cancelled/Postponed

NZNB elections

4 EDSA Corner

5 Activities of the NZ National Board

6 Colin McRae Medal

7 Obesity

8 Queen's New Year Honours 2020

9 Surgical Pioneers

10 Obituaries

Dude walls and manels - why do they matter?

A popular topic on the social media feeds I follow is 'manels' – the all-male panel. This can promote a gendered stereotype of surgical excellence and leadership – only male surgeons are considered talented enough to be invited to speak. As a female surgeon, it can be extremely frustrating to attend conferences where I do not feel represented or included.

Manels can communicate to female surgeons that there is no place for them in the surgical profession. I see them as a form of microaggression, positioning a dominant culture as the normal. Female surgeons frequently receive subtle (and not so subtle) cues that they may not belong. In my specialty of otolaryngology, there are frequent comments about the feminisation of the specialty. However, women have made up only 30% of trainees over the past ten years. On applying for a head of department role, a colleague was asked how she would cope with the role and devoting time to her children. Some Australasian hospitals still label their change rooms 'nurses' and 'surgeons'. Emails beginning with 'Gentlemen'. My personal favourite, a message mainly directed to me and another female physician, was addressed to 'Gents, etc'. While many of these examples may seem trivial, the effect is cumulative.

As a profession, by constantly highlighting and promoting a limited proportion of our members, diversity of thought and innovation is limited. Evidence suggests that diversity at scientific meetings results in better science.[1] In addition, we potentially lose a talented group who do not see themselves represented and do not imagine joining the profession of surgery. Gender diversity is by no means the only area to concentrate on, and I am not suggesting gender diversity should be addressed before other types of diversity. However, if we have difficulty embracing 50% of the population, this implies we will struggle with diversity in other areas such as ethnicity, disability, sexual orientation, and geographical location.

So, how might we approach this topic? Specifically thinking about conferences, the first step is to be aware that this is an issue, and to maintain a type of wider situational awareness. At the New Zealand RACS ASM last year, we were so focused on one particular panel's makeup, and trying to ensure viewpoints from various regulators, that it was not until the panel was seated on stage that I realised there was no age, gender or ethnic diversity. And although the rest of the conference was widely diverse, it was this panel that received the most attention on social media. Further tactics include conference attendees asking organising committees about their speaker invitations, and letting specialist societies know why they have decided to attend (or not attend) conferences. There is a strong movement for invited speakers to set standards and decline to present at conferences where women are under-represented.[2]

I applaud the Australian Orthopaedic Association's (AOA) new policy, Female Members Inclusion in AOA Scientific

Continued on Page 2

FROM THE CHAIR (continued)

& Educational Meetings, which mandates a female involvement in meeting organisation and provides an opportunity to engage women in roles as panellists, speakers, chairs & co-chairs. Our New Zealand National Board has an unofficial policy of male and female co-chairs at our Annual Scientific Meeting. For organising committees, a short piece by Jennifer L Martin (Institute for Molecular Bioscience, University of Queensland) is an excellent checklist for ways to achieve gender balance at conferences.[3]

Those of you active on social media may also be familiar with the term 'dude walls'. This term refers to the collections of official portraits often seen in College meeting rooms and other institutions, almost invariably of (mostly white) men. Personally, I am conflicted about 'dude walls'. On one hand, I consider that they are a mark of respect for our College founders and past presidents. I like the reminder that we are a part of a long history of professionalism and tradition. I personally do not want to do away with this rich celebration of surgical history. However, they also serve to subtly reinforce the stereotype that 'this is what a surgeon must look like'. As a woman, they can make me wonder if I have a place at this table.

With this in mind, the New Zealand National Board has been encouraged by RACS Councillor Andrew Hill to start a project called 'Women on Walls'. The Royal College of Surgeons in Ireland commissioned portraits of female surgeons and doctors to highlight their contributions.[4] Over coming months, we will be launching a similar project at the RACS NZ Office in Wellington, most likely with photographs and accompanying biographies. This project will include past and present inspiring female surgeons and Fellows. I envisage that the display will run for approximately two years, and then move onto feature another group such as rural surgeons.

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[1] https://www.boa.ac.uk/uploads/assets/2c846ce5-2e3f-466f-a9eaa76c7c2efcbb/Diversity-women-in-orthopaedic-surgery-IODA-perspective.pdf

[2] https://pacificsoutheast.wordpress.com/2017/12/01/the-changing-conference-culture-club/

[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4238945/

[4] http://women.rcsi.com

Burning 2020 election issues

Assuming the general election goes ahead as planned in September this year, RACS will be asking the major political parties for their positions on issues that are important to you.

In 2017 we asked the parties where they stood on: elective prioritisation and unmet need; Māori health equity; health workforce; alcohol related harm; and obesity.

Please tell us if these continue to be the most important issues for you or if other ones have overtaken these, please let us know what they are.

We'll develop some questions which we'll put to the parties, then compile the answers in a booklet for you to peruse before you cast your vote on 19 September.

Please send your suggested issues and questions to college.nz@surgeons.org

Medicolegal Professional Development opportunities

From time to time RACS is asked to recommend surgeons who could provide expert advice on reviews and investigations carried out by organisations such as the Health and Disability Commission, the Accident Compensation Corporation, the Medical Council or District Health Boards. Surgeons may be asked to provide expert evidence, comment on cases or provide expert opinions.

Unlike other countries around the world, there is limited court work in New Zealand because of the no fault treatment injury provisions under the Accident Compensation Corporation. The New Zealand National Board is considering developing, in conjunction with RACS Professional Standards Committee, a NZ-specific professional development course for those who are involved in, or interested, in medicolegal work.

We would really like to hear from Fellows, Trainees and IMGs about what kinds of subjects you would like such a course to cover, the names of possible speakers and whether this kind of course would be of interest to you.

Please email us at college.nz@surgeons.org by 30 April 2020 to indicate your interest and give us ideas for topics and presenters.

Cancelled/Postponed

COVID-19 has led to many sudden and significant decisions being made by governments and also by organisations such as our College. RACS continues to seek to act in the best interests of patients and the wider community, as well as our Fellows, Trainees, International Medical Graduates and staff. Check out RACS Coronavirus information hub for information.

Surgery 2020: Reflecting on Practice

The decision has been made to cancel the Surgery 2020: Reflecting on Practice conference scheduled for 20 and 21 August in Queenstown.

A great deal of hard work had already occurred to make this year's annual meeting a fabulous one with a range of inspiring and insightful speakers and sessions. The Organising Committee is disappointed that this decision is necessary but knows that this is the appropriate call to make.

Whether any of the planned presentations might be moved to next year's conference is not yet known. We will keep you advised as decisions are made.

This means that we will not be calling for abstracts for the Louis Barnett Prize either. Whether that might occur later in the year in some alternative format is not known at this time.

If you have any queries about the cancellation of Surgery 2020, please contact the New Zealand Manager, Justine Peterson, via email (Justine.Peterson@surgeons.org) or by phone on +64 27 279 7455.

Nicola Hill
Chair, NZ National Board

Rachelle Love
Surgery 2020 Convenor

New Zealand Office

RACS New Zealand staff will be working from home and will be contactable by email.
We are working on setting up a phone transfer. If this is not connecting and you need to talk to a staff member you can call Justine Peterson on 027 279 7455.

Australian Offices

Most RACS staff in Australian offices will be working from home, from 30 March, and available by email.

Examinations

The RACS Fellowship Exam sitting in April-May has been postponed until further notice.
In addition, the upcoming Generic Surgical Sciences Exam (GSSE), Specialty-specific Surgical Sciences Exams (SSEs) and Clinical Exam (CE) sittings in June have now been postponed until further notice. RACS will provide all exam candidates with a minimum of three months' notice when a decision to reinstate exams has been made.

Mandatory courses

All RACS face-to-face events including courses are postponed until further notice and all enrolments have been suspended. Alternative arrangements are being explored. Should any courses be rescheduled, a minimum of three months' notice will be provided to participants.

WE'LL BE BACK

We are grateful for all the medical and emergency staff who will be working on and wish for all of us the best possible outcome.

We can only support what Jacinda says - Be kind and stay calm and we will get through this.

Time to cast your vote in NZNB elections

Electronic voting for your representatives on RACS New Zealand National Board is now open – make sure you cast your vote.

NZNB speaks on your behalf as the voice of RACS in New Zealand. It makes decisions on your behalf about surgical standards and surgical issues that impact on all or many of the RACS specialties and advocates on a range of issues pertaining to surgery and health in New Zealand.

All New Zealand Fellows should have received an email with information about the candidates and directions on how to vote. If you haven't received this information, please email college.nz@surgeons.org

Voting closes on Monday 6 April at 7pm, NZT.

Richard Lander
EDSA (NZ)

EDSA CORNER

Retention and Disposal of Medical Records

How long patient records should be retained?

By law, medical practitioners in private practice must retain health information for a minimum of 10 years and 1 day from the date of the last consultation with the patient. You should consider retaining the records for longer than the minimum 10-year and 1-day period in situations where the medical record may be helpful in the patient's future care such as children with significant health problems, or patients with long-term or rare conditions. Guidelines for timeframes for publicly stored information such as those held by District Health Boards are set out by Archives New Zealand and are in accordance with Section 20(1) of the Public Records Act 2005.

Nothing in the regulations requires any health information to be retained in any particular form, and health information may be held and retained in such form as you think fit. Where the medium on which health information is kept may deteriorate before the expiry of the minimum retention period with the result that that health information cannot be read or retrieved, it is sufficient if you keep an accurate summary or interpretation of that information and retain that for the balance of the minimum retention period. This can be applied where paper-based records are selectively scanned and stored electronically.

Disposal of Medical Records

After the required storage period your patient records must be destroyed in a way that preserves the patient's privacy. Burning or shredding records is acceptable, sending them to the landfill is not. You can contract a document destruction company to securely destroy the records.

Leaving a practice or planning for retirement?

If you are a specialist in private practice, well before you leave a practice or retire from it, you should arrange with another medical practitioner or provider firstly to accept responsibility for your patients' records (for example, through a power of attorney), secondly let your patients know if they need to collect their records from the practice they can do so and thirdly inform the practitioners who have referred patients to you. There are some practical considerations and implications of this requirement for you to consider particularly around how you notify your patients and how you notify your referrers.

If you are leaving a group practice, you need to discuss and agree within the practice how your patients' records will be managed.

If you die or become incapacitated without making any arrangements for your patients' records your executor or power of attorney will need to either return the records to the patient (or the patient's family if the patient is dead) or arrange for your records to be transferred to another doctor (or provider as defined in the regulations). My suggestion is that you should provide for this in your will or advanced directive.

For definitive advice on these matters a legal opinion would be appropriate.

References and Further Reading:

1. Medical Council of New Zealand statement on "Managing Patient Records", October 2019
2. New Zealand Medical Association member advisory service information sheet on "The Medical Record: Rights and Obligations",
3. Medical Protection Society advisory, "Transfer of Health Information Between Healthcare Professionals", January 2014
4. New Zealand Privacy Commissioner, On the Record 3rd Edition 2011, "A Practical Guide to Health Information Privacy".
5. Heath (Retention of Information) Regulations 1996 Reprint 1 July 2013
6. Functional Disposal Authority: FDA1 Personal Health Information. Archives New Zealand, Version 7 October 2019

Access to Counselling Services

Fellows, Trainees, International Medical Graduates (IMGs) and members of their household or immediate family have access to confidential counselling for any personal or work-related issued through Converge International. Provision of services covers 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: 0800 666 367 in New Zealand or 1300 687 327 in Australia or via email: eap@convergeintl.com.au

Converge international
Call 1300 687 327 AU
0800 666 367 NZ
convergeinternational.com.au

Royal Australasian College of Surgeons
Te Whare Piki Ora o Māhutonga

ACTIVITIES OF THE NEW ZEALAND NATIONAL BOARD

The New Zealand National Board (NZNB) and its representatives continue to advocate on behalf of Fellows, Trainees and IMGs in the MOPS programme. Some of the NZNB's activities and interests since the previous Cutting Edge are commented on below.

COVID-19

Like many others, surgeons and Trainees activities are affected by processes being introduced to prevent, as much as possible, the spread of COVID-19 in New Zealand. RACS President, Tony Sparnon, has been advising all of the decisions RACS has made regarding courses, examinations, conferences and business meetings. Up to date information is posted on the RACS website. RACS is very mindful of the stress this may be causing for individuals. If needed, please make use of the professional support services RACS provides to help you manage difficult and stressful situations. To talk to someone or make an appointment, call 0800 666 367.

Consultations

The NZNB is preparing to respond to a number of consultations from government or statutory agencies, including:

Review of the Burials and Cremations Act: This review, by the Ministry of Health, includes consideration of options to modernise the death certification system, an issue that is of special concern to surgeons.

Accessible Streets: This consultation by the NZ Transport Agency proposes the introduction of some national rules and regulations for the safe use of e-scooters. Since public access to these vehicles was increased in major cities around New Zealand 12-18 months ago, there has been a significant increase in presentations at Emergency Departments of e-scooter related injuries.

MCNZ has indicated it will soon release two documents for consultation – one on Artificial Intelligence, looking at the ethical considerations for the Medical Council and its role in this area; and the other a revised statement on unprofessional behaviour, providing guidance on how to address and manage inappropriate behaviour and / or concerns about such behaviour. These will be reviewed when available and responded to.

Te Rautaki Māori approved by Council

RACS' Te Rautaki Māori Strategic Action Plan 2020-2023 was approved at February Council. The vision of Te Rautaki Māori is for RACS to advocate for health equity, including through surgical training and workforce development. The Plan reflects Te Tiriti o Waitangi obligations of tino rangatiratanga, partnership, active protection, options and equity. Its objectives include: strong governance strucutres to support Te ao Māori and Māori health; embedding Māori knowledge into RACS activities to ensure culturally capable Fellows, Trainees and staff; developing a surgical workforce that reflects the communities it serves; and strengthening the cultural knowledge and capability of non-Māori to improve Māori health. Te Rautaki Māori will be available on RACS website by the end of March.

Protected Quality Assurance Activities (PQAA)

Dr Andrew Simpson, Chief Medical Officer, Ministry of Health, attended the March NZNB meeting to discuss PQAA – a special legal status that can be sought for activities such as Morbidity and Mortality (M&M) meetings, to enable clinicians to have open and honest conversations in a safe forum with the objective of improving future health outcomes. Conversations with PQAA status are not discoverable under the Official Information Act and cannot be made available to patients' families or members of the public. Dr Simpson said fewer DHBs have PQAA in place compared to previous times, but surgeons may not necessarily be aware of this. PQAA status has to be reapplied for every five years and it is quite possible surgeons may not know if their M&M meetings still have PQAA status. If this is a matter of concern to any surgeon NZNB encourages you to talk to your colleagues and, if in doubt about the status of your M&M meetings, check with the CMO of your DHB. The PQAA application process takes about three months to complete. More information can be found on the Ministry's website, www.health.govt.nz .

Haere rā and heartfelt thanks, Richard Perry

The Board was sad to say goodbye to Richard Perry, who attended his last National Board meeting in March. Richard completes his nine years on Council in May and will then no longer be a member of the National Board. He has made a huge contribution to RACS over those nine years in a range of roles. In his current position as Vice President he has overseen a comprehensive review of RACS' governance structures to enable the College to stride competently and confidently into the future. Kia ora, Richard, for your tremendous work over the last nine years and we wish you all the very best.

Justine Peterson
New Zealand Manager

Given the timing of receipt of Cutting Edge articles and the speed with which NZ has moved through the Covid-19 precautions, some of the articles in this edition may seem incongruous, but they were written when we were in a different world.

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 in the later part of 2020.

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

CLOSING DATE FOR NOMINATIONS:
30 April 2020

Obesity

Paul Anderson FRACS

Reversing the global tide of excessive weight gain requires innovation, starting with the language we use, writes Paul Anderson.

Excess weight gain is a global health problem. There has been a 400% increase in the number of people with a Body Mass Index over 45 in the last 12 years. In the United States 74% of the population are significantly overweight or obese, in Europe 60% and in Australia and New Zealand nearly 78%. Worldwide, an estimated 442 million adults are developing weight-related diabetes.[1-5] The Chief Medical Officer in the United Kingdom has described obesity as a national threat to the health system, flooding the health system to the disadvantage of other desperately needed areas.[6]

The medical profession has labelled the worldwide phenomenon of weight gain an obesity epidemic, firmly, if inadvertently, establishing the negativity and associated fat shaming of that term. And obesity is now labelled a disease. To the wider public, disease is associated with Tuberculosis, Leprosy or HIV. To associate that term with overweight patients is harmful psychologically, and it is incorrect by way of common usage. Unlike some diseases, conditions associated with obesity, such as obstructive sleep apnoea, type II diabetes, fatty liver disease, heart failure, infertility, dementia, and depression can be at least partly, if not fully remediated, through weight loss and exercise. Telling patients they have a reversible condition related to weight gain, not a disease, gives hope and encouragement. Removing the other derogatory synonym, fat, from our lexicon would also be progressive. Such positivity should be our new focus as medical practitioners, with our commitment to healing. It is an approach which is more sensitive, starting importantly through our language, and secondly through new positive eating programmes.

Strategies centered on positive reinforcement and cognitive behaviour therapy need to be complemented by information and education about the lethal nature of fast foods. Fortunately, some governments, worldwide and in New Zealand, are starting to understand the implications of junk food for health. In addition, the World Health Organisation has suggested regulations on advertising, particularly to children in and around schools.[8] A medical fightback is now needed on the scale of the anti-smoking campaign. Drastic change is needed if we are to be successful in dealing with the current health-destructive fat/obesity crisis. Positive images on food packaging of the time needed to run off calories are not researched in terms of efficacy, but do create awareness of the issue of weight and health. Similarly, a sugar tax, while arguable in terms of efficacy, psychologically contributes to an awareness of the dangers of sugar overload. Arguments that healthy foods are too expensive for our lower socio-economic groups need to be corrected.

If the New Zealand government made healthy foods GST free, as per Australia, that would be helpful. Many fast foods, with their trans fats/preservatives, have cancer risks and this could be highlighted more by the medical profession on social media.

Diet is yet another term which should be replaced due to its money making nature and spectacular failure rates. At any time in the United Kingdom more than 17 million people are on a diet; the disconcerting statistic is that 80% give up their diet four months after starting.[1-3] This then argues for a new approach, an eating strategy, not a diet, which can also motivate, educate and potentially be more successful. A strategy which aims for sustainable long term weight loss, through healthy eating and calorie reduction. The utilisation of the KISS principle, Keep It Simple Slim is something I introduced in a recent book *Fat Off –the right way*, and can be used as a concept to keep things simple through healthy eating.[1] Central to this approach is volume reduction, with associated calorie reduction, sugar denial, and selecting food which is as healthy, affordable and as organic as possible. A smaller plate to eat from, and no desserts, other than fruit or nuts, is a far easier strategy than counting calories.

Much needs to be done. A good starting point for the medical profession is to change the negativity mindset, and the language associated with weight gain. As a medical profession we also need to pressure our politicians to regulate - not allow the fast food industry to self-regulate. Lobbying politicians is not in our Hippocratic DNA, but it is now necessary to effect national change.

[1] Anderson PG. Fat Off-- the right way, a clever and sustainable eating guide for weight loss and healthy living. Johnson Publishing/ Amazon. 2019; 11 – 12

[2] Swinburn BA Sacks G Hall KD et al. The global obesity pandemic: shaped by global drivers and local environments. Lancet. 2011; 378: 804-814

[3] Finucane MM Stevens GA Cowan MJ et al. National, regional, and global trends in body-mass index since 1980: systematic analysis of health examination surveys and epidemiological studies with 960 country-years and 9·1 million participants. 2011; 377: 557-567

[4] Butland B Jebb S Kopelma P et al. Tackling obesities: future choices—project report. Government Office for Science, London2007

[5] Rittel H Webber M. Dilemmas in a general theory of planning 4. Elsevier Scientific Publishing Company, Amsterdam1973: 155-169

[6] Lang T Rayner G. Overcoming policy cacophony on obesity: an ecological public health framework for policymakers. Obesity Rev. 2007; 8: 165

[7] Chapman J System failure. 2nd edn. Demos, London2004 http://www.demos.co.uk/publications/systemfailure2

[8] Bixby, H., Bentham, J., Zhou, B. et al. Rising rural body-mass index is the main driver of the global obesity epidemic in adults. Nature 569, 260–264 (2019) doi:10.1038/s41586-019-1171-x

Queen's New Year Honours 2020

Congratulations to Mr Donald Evan Murray (Murray) MacCormick recognised in the New Years Honours.

Companion of the New Zealand Order of Merit (CNZM)

Mr Murray MacCormick has been a surgeon for 45 years, specialising in breast cancer and vascular surgery.

Mr MacCormick has worked as a tutor, consultation surgeon, and clinical director of General Surgery at Auckland Hospital. He is an Honorary Senior Lecturer in the Department of Surgery at the University of Auckland, where he has introduced numerous surgical procedures, including breast reconstruction following mastectomy, carotid artery surgery, and a number of laparoscopic procedures now in general use.

He founded the first multidisciplinary service for the management of breast cancer in Auckland in both the public and private spheres, and led the establishment of breast screening in Northland.

He was also was one of the pioneers of renal transplant surgery in New Zealand. His recognition as a highly skilled surgeon has seen him assist with difficult cases across all specialities. He has also been significantly involved with the Cancer Society, as a Board Member of the Cancer Society Auckland Northland Division from 1992 to 2012, including time as Chair, and as a Board Member of the New Zealand Cancer Society from 2000 to 2014, including three years as Chair.

He has been a Trustee of the Society's Auckland Northland Division Endowment Trust since 2000. Mr MacCormick is Chair of the Credentialing Committee at Mercy Ascot Hospital.

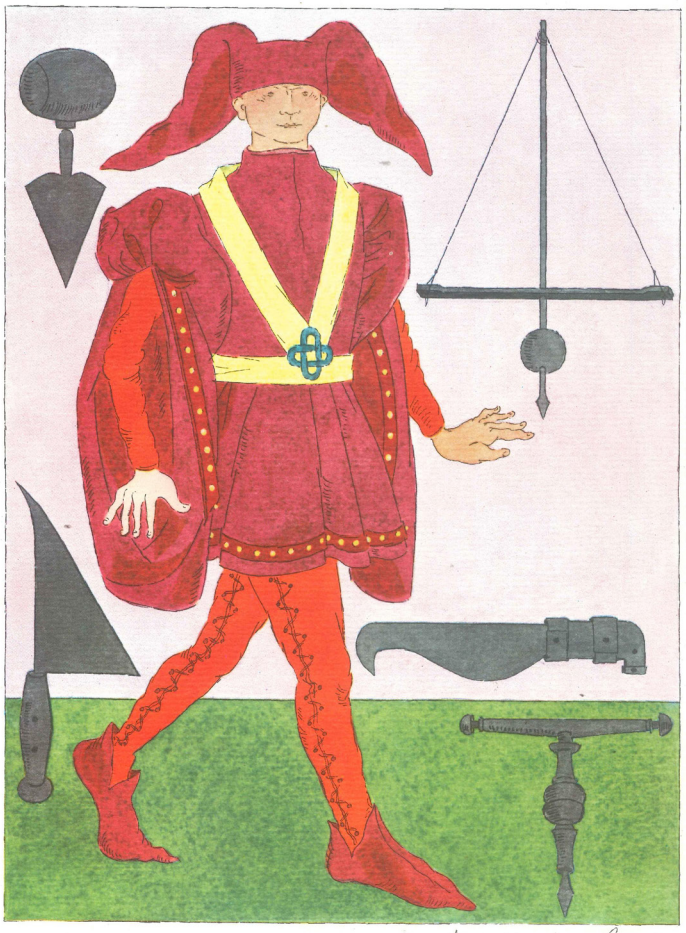
SURGICAL PIONEERS

These costumes from the 14th, 16th and 18th century, are a little bit different from what surgeons wear in operating theatres today – thank goodness!

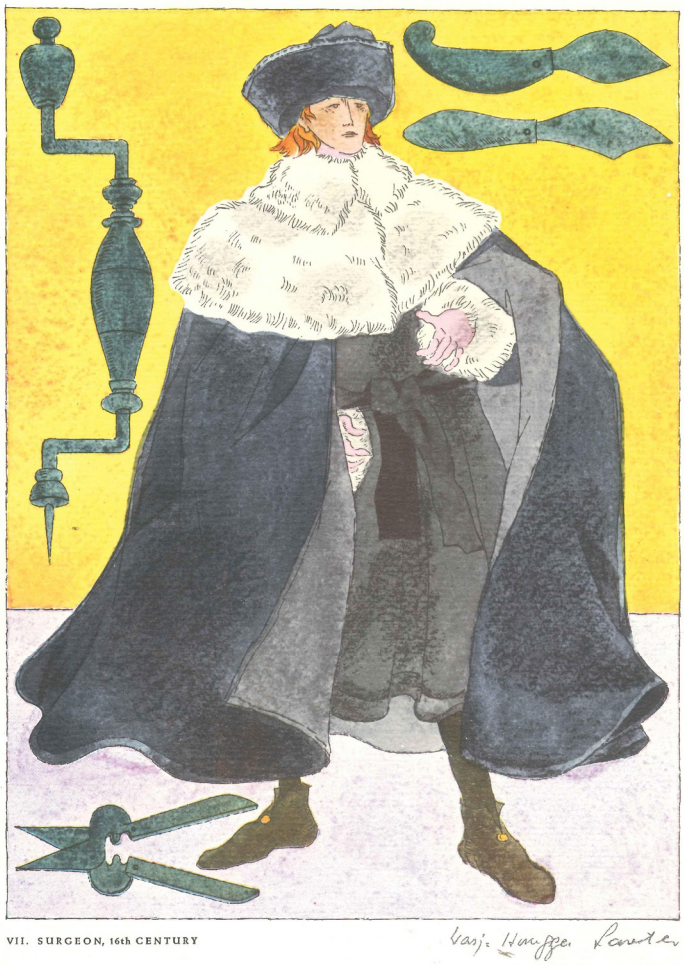
Authentically portrayed by the Swiss illustrator Warja Honegger-Lavater from costume reproductions in the University of Rome, Institute of Medical History, these three images are excerpts from a publication of 12 vibrant prints, entitled '2300 years of medical costume : distinctive garb of the medical and related professions from the time of Hippocrates to the Napoleonic era'.

The elaborate robes, coats, sandals, and hats are indicative of the clothing of the eras in which they were worn.

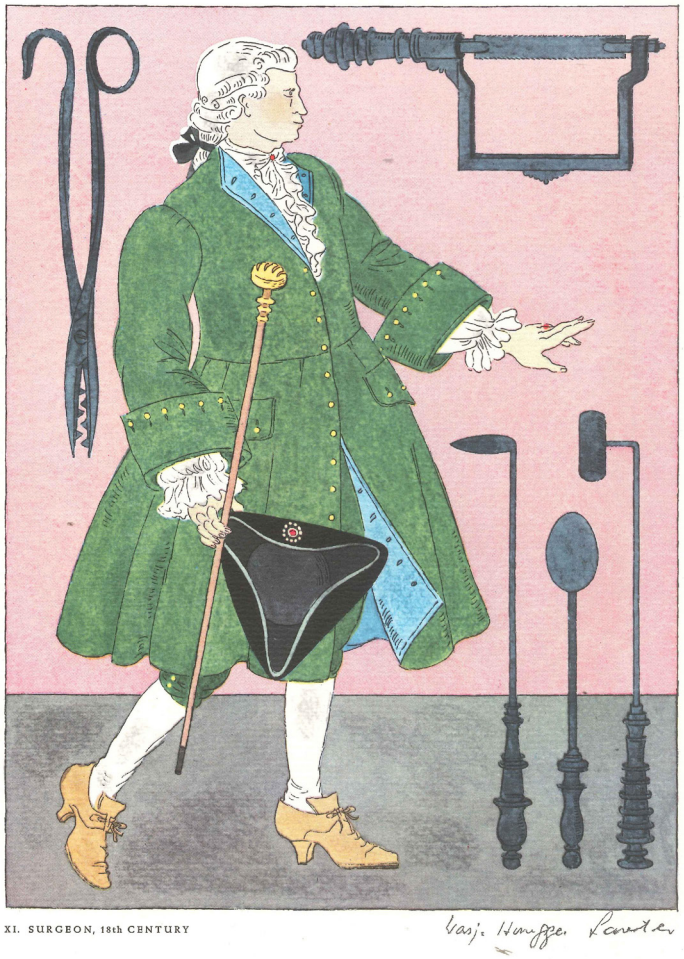
The series was kindly donated to the RACS NZ by Spencer Beasley, from the collection of his father Wyn – a stalwart of the College and the fount of RACS' history - who died last year.



III. SURGEON, 14th CENTURY



VII. SURGEON, 16th CENTURY



XI. SURGEON, 18th CENTURY

OBITUARIES

GEOFFREY WYNNE-JONES FRCSEng FRACS
28 January 1925 – 24 October 2019

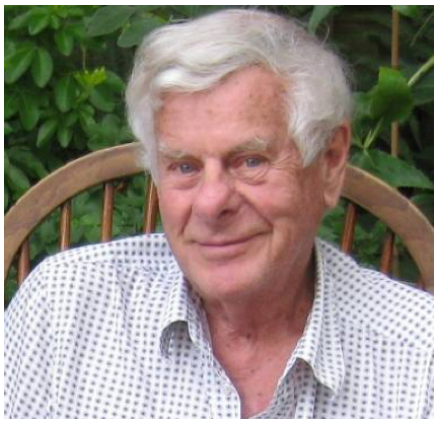
General Surgeon

Geoffrey Wynne-Jones, the youngest child of Frederick Arthur Jones, a monumental mason, and Catherine Emily Parker was born in Hawera. He had two brothers, David and Richard, and a sister, Elizabeth. Geoffrey commenced school at Hawera Main School and subsequently attended Hawera Technical High School, where he was dux. His uncle, Mortimer Townsend, a Fellow of the Royal Astronomical Society and an active Southern Hemisphere observer, taught him the fundamentals of astronomy, and with this interest he enrolled at Auckland University studying mathematics and physics. However, he changed direction after graduation, gaining entry to Otago Medical School.

On completing his MB ChB in1949, Geoffrey moved to Middlemore Hospital in Auckland where he met Jenefer Fea, a nurse assisting in a medical procedure. She enthusiastically accepted his invitation for a ride on his motorbike, a strong friendship developed, and they married in 1952. After undertaking a series of general practice locums around the country and under a bursary obligation, Geoffrey received call-up papers from the military. This resulted in serving a year on active service in Korea 1952-1953 with the 16th Field Regiment. Embarking as a Lieutenant, he returned as a Captain and, although he never talked much about his experiences to his family, he was clearly pleased to return home.

Following his return from Korea, Geoffrey, Jenefer and Peter, their first child born in 1954, set off by ship for London via the Panama Canal so Geoffrey could gain his surgical Fellowship. Enjoying life in London they took advantage of the many plays, concerts and musicals on offer. However, the pressure of Geoffrey's study was such that on one occasion the baby-sitter was despatched as concert partner for Jenefer while Geoffrey burned the midnight oil! In July 1956 he successfully gained Fellowship of the Royal College of Surgeons. Their second child, Jeremy, was born the same year. Fellowship completed, Geoffrey secured a paediatric orthopaedic run with H.H. Nixon and Denis Brown at Queen Mary's Carshalton and Great Ormond Street. This was followed by two years in Sheffield where Geoffrey gained experience in general and paediatric surgery, spending some time with Bob Zachery, at that time one of only eleven designated Specialist Paediatric Surgeons in Great Britain.

Geoffrey, Jenefer and their two children returned to New Zealand in 1959 and the family was completed with the birth of Stephen 1959, Rodney 1961 and Julie, adopted in 1964. He set up practice in Hamilton, the first surgeon in the region to do so without doing any general practice, and experienced a rather lean introduction into consulting practice until 1961, when he was appointed to a 3/10th part-time position at Waikato Hospital as "Visiting Assistant



Casualty and Outpatient Surgeon." From this base he joined the Lomas team with Archie Badger. Geoffrey became a Fellow of the Royal Australasian College of Surgeons in 1960. Working part-time in private practice, he initially consulted from rooms in Wesley Chambers and then later in Collingwood Street, with surgery provided at Braemar Hospital. Despite working long hours each day, he endeavoured to get home in the evenings for dinner with the family. To his children, the sound of his key in the front door was one of the happiest times of their childhoods.

Initially, Geoffrey, like all general surgeons, covered all surgical specialties except orthopaedic surgery and obstetrics and gynaecology. He took a special interest in paediatric and neonatal surgery and for a while managed most of that work in Waikato. However, with the advent of the "Neonatal/Paediatric Surgeon" that part of his work vanished. Soon after a "Plastic Surgeon" (including burns) was appointed and another segment of work dropped away. In the mid 70s gastric ulcers were a major problem and a new sophisticated operation was being reported from Leeds. Geoffrey decided from his reading that he should start doing this new procedure of "Highly Selective Vagotomy". Possibly the only one doing it in NZ initially, this procedure proved to be a great advance over anything else available at that time. But with the introduction of Tagamet/Losec the problem of peptic ulcers vanished overnight. Yet another area of interest and great skill was removed from his tool-box. As the surgical solution to the peptic ulcer became redundant Obesity Surgery took its place and Geoffrey was one of the pioneer surgeons in stomach bypass surgery. As there was very little documented information available at the time and, having to "experiment" somewhat, in terms of distances etc., Geoffrey documented all aspects of his surgery very carefully and included extensive follow up. This resulted in numerous publications and conference presentations. Then along came the specialist "Obesity surgeon" and another area of interest was severely reduced!

Geoffrey played a role in the establishment of a Waikato Hospital Postgraduate Medical Committee and the development of an active postgraduate programme in the early 1960's. He later became head of the Waikato Department of Surgery. He was an appointed member of the 1971 Minister of Education's Committee on

nursing education set up to review a report by Dr Helen Carpenter, Dean of the Faculty of Nursing at the University of Toronto (published Feb.1971). Although the Committee subsequently recommended, in the Carpenter Report, that nursing education take place in educational institutions rather than in hospitals, Geoffrey was strongly opposed to the proposed move to Technical Institutes, and wrote a minority report, subsequently often cited. With his early involvement in private surgical practice, he was committed to the development of the Braemar Hospital Trust and its rebuilding programme, serving a period as its chair. He was a long-term member of the Hamilton Officers' Club, proudly retaining involvement until the final couple of years of his life.

Geoffrey never lost his interest in the universe. He became an active member of the Hamilton Astronomical Society, serving as President and Patron, and was often quoted in the Waikato Times opining on meteorites and unusual sights to watch for in the night sky above Hamilton. In the mid-1990s Geoffrey was instrumental in the fundraising and building at Rotokauri of one of New Zealand's largest telescopes, a 61cm Nasmyth-Cassegrain with a polar mount and 11-metre dome. Sceptical about the Big Bang Theory he gradually developed explanations for an alternative view, which he called the Infinite Non-Expanding Universe Theory. In 2000 he presented a paper to the Royal Astronomical Society of New Zealand on alternatives to the Big Bang Theory, largely relating to Compton Red Shifting.

In the early 1960s Geoffrey and Jenefer, deciding skiing would be a great family activity, joined the Christiania Ski Club on Mt Ruapehu. Another family love affair involved the family bach built at Waihi Beach. Travel was a passion and, once the children had left home, the couple travelled extensively. Geoffrey enjoyed golf and played bridge well into his 90s. In 2011, after Jenefer had two successful operations for her cataracts, Geoffrey followed suit. Unfortunately, his operations did not have the same positive results and his eyesight was further impaired. With the help of carers, Jenefer and Geoffrey were able to stay at their River Road home (their only home following their return to New Zealand from the UK) until their move to Possum Bourne Retirement Village in May 2018 where they were closer to family. They died within months of one another.

Geoffrey Wynne-Jones, husband of the late Jenefer, is greatly missed by his children, Peter, Jeremy, Stephen, Rodney, and Julie and 11 grandchildren.

This obituary is based upon that prepared by Charles Riddle and published on Stuff Nov 9 2019, with subsequent contributions by Dean Williams CBE, FRCS, FRACS, Peter Rothwell MNZM, FRACP and members of the Wynne-Jones family.

Royal Australasian College of Surgeons
Te Whare Piki Ora o Māhutonga

NZ National Board,
PO Box 7451,
Wellington 6242,
New Zealand

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Tollfree (NZ only) 0800 787 469 / 0800 SURGNZ
Phone: +64 (4) 385 8247 Fax: +64 (4) 385 8873
Email: College.NZ@surgeons.org

NZ Manager
Justine Peterson
Justine.Peterson@surgeons.org

Executive Director of Surgical Affairs – NZ
Richard Lander
Richard.Lander@surgeons.org

Accountant
Raji Divekar
Raji.Divekar@surgeons.org

Committees & Projects
Isobel McIntyre
Isobel.Mcintyre@surgeons.org

Executive Assistant (NZ Manager & EDSA)
Gloria Aumaivao-Tasi
Gloria.Aumaivao-Tasi@surgeons.org

General Administration/Reception
Andrea Lobo
College.NZ@surgeons.org

IMGs(NZ) and Training
Celia Stanyon
Celia.Stanyon@surgeons.org

Māori Health Project Officer
Chelsea Jacobs-Prescott
Chelsea.Jacobs-Prescott@surgeons.org

Policy & Communications Officer
Philippa Lagan
Philippa.Lagan@surgeons.org

Skills Training
Jaime Winter
Jaime.Winter@surgeons.org