NZOA
New Zealand
Orthopaedic Association

New Zealand Orthopaedic Association

ANNUAL REPORT 2022 – 2023

To preserve patient mobility and pain reduction
To advance the science and art of orthopaedic surgery
To preserve and promote international fellowship and mutual assistance

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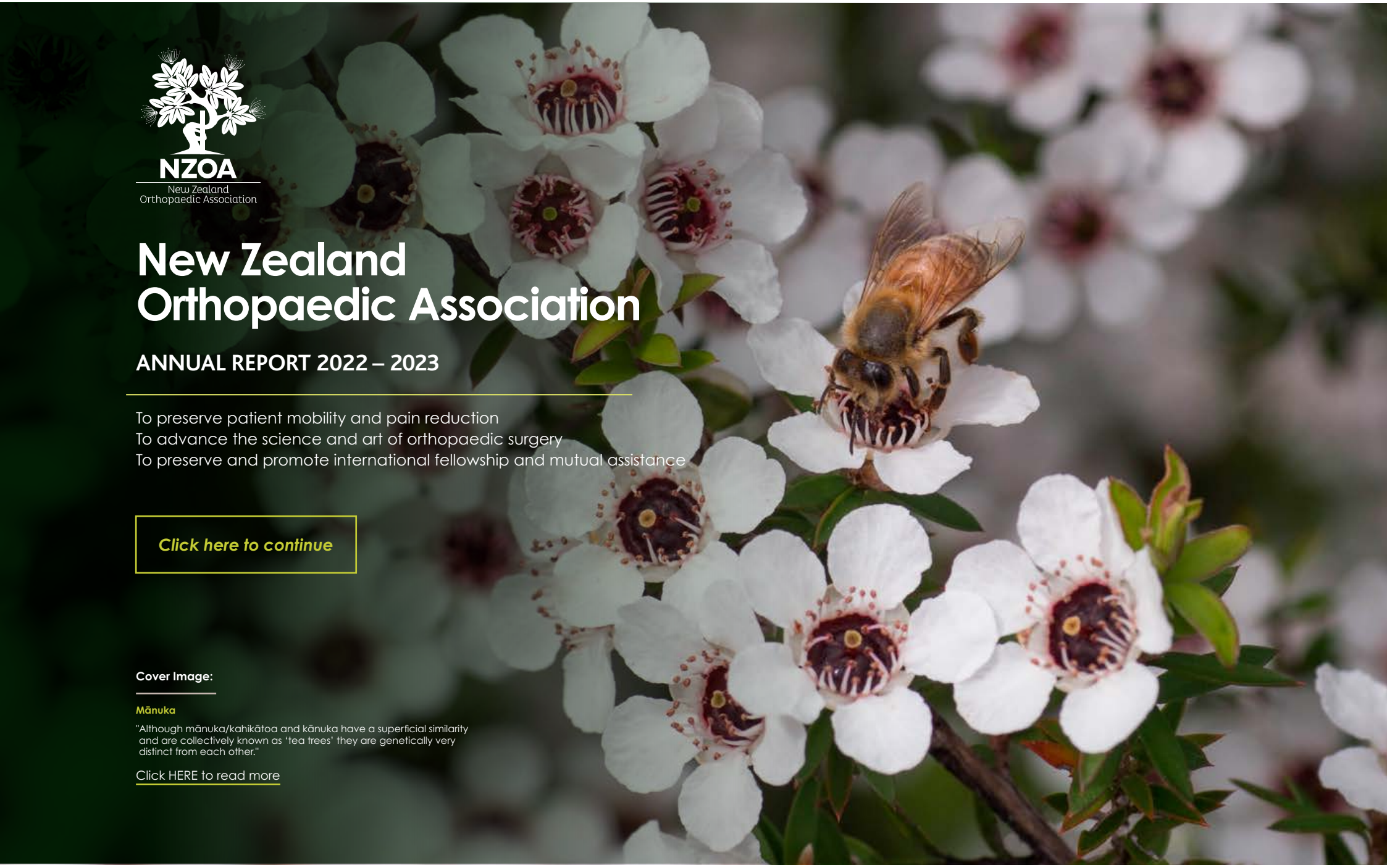

Cover Image:

Mānuka

"Although mānuka/kahikātoa and kānuka have a superficial similarity and are collectively known as 'tea trees' they are genetically very distinct from each other."

Click HERE to read more

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President's Report

I would like to start by thanking the Members of this Association for giving me the honour to serve as your President for the past 12 months.

Haemish Crawford
President 2022/2023

The NZOA is in great shape due to the wonderful staff we have in the office and the significant amount of time that Members volunteer to continue to make this Association what it is. I cannot thank everyone enough for their commitment to improving the care of Orthopaedic patients.

2023 has been an interesting year from a governance perspective with Te Whatu Ora (TWO) starting to function as an entity, the Royal Australasian College of Surgeons (RACS) almost becoming insolvent and an election year. Despite this the NZOA has achieved some significant milestones:

1. Signed the Partnering Agreement with RACS.
2. Had 5 fulltime funded training posts approved by TWO.
3. Secured $20.25 million dollars in outsourced funding for all Orthopaedic surgery.
4. Agreed Outsourcing Guidelines with TWO.
5. Developing a MSK pathway for GP referrals to allied health partners to decrease unnecessary First Specialist Assessments (FSA).
6. Developing a NZOA Diversity Plan.
7. Reached $1 million dollars in the Wishbone Trust Research Fund.
8. Celebrated over 50% Trainees selected in 2023 are women and our first female Māori Trainee will graduate this year.
9. All Sub Specialty Societies of the NZOA are now fully Incorporated entities.
10. Negotiated some minor ACC cases that require no pre approval and no 7-day delay to treatment.

The Partnering Agreement with RACS that had been ongoing for 6 years was a bittersweet achievement. We were not made aware while negotiating this that the College was in such severe financial distress. It was therefore very disappointing to learn soon after signing that they were facing insolvency. It was important however to have an Agreement in place as it was about to expire and we needed to keep continuity of training for our registrars. The loss of trust in the College has led to a number of Specialty Societies becoming disillusioned with RACS and I predict we will be renegotiating our relationship with them in the near future. One positive that has come out of the RACS collapse is the close relationship we have built with the other New Zealand Specialty Societies and with the Australian Orthopaedic Association. These relationships will keep us in a very positive position going forward. There is no doubt the College provides a very important role in examination, education and accreditation but it has to stick to its core goals and remain financially viable. The College has tremendous history associated with it and I believe we must stay part of it but in a renegotiated way.

Our engagement with TWO has been a highlight this year and I really hope it continues this way. The health system at such a low point and the introduction of a new Authority it really gave us an opportunity to become part of the solution. Andrea and I have met with Dr Derek Sherwood (Clinical Lead for Planned Care, Hospital and Specialist Services) and Duncan Bliss (Group Manager – Planned Care Hospital and Specialist Services) weekly to address key issues. The key is that both these TWO representatives have the ability to make decisions, which has accelerated policy making. We have concentrated on 4 main areas: instituting the Planned Care proposal from last year including rules around outsourcing and insourcing, increasing training positions and funded private rotations for Trainees, developing a pathway for allied health referrals and national MSK pathways.

The Planned Care proposal was disappointedly rejected by the Minister despite the Presidential Line meeting with her in person. The result however has been the ability to negotiate a $20.25 million increase in funding allocation to Orthopaedics, which is the highest to any single Specialty. Although we would have liked to have had more control over how to distribute and use this money TWO simply does not have the infrastructure or permanent personnel yet to embrace new initiatives. It is still relying on contracts that are in place until they get more organised. The result is that any Orthopaedic patient that looks like they will have waited 12 months for surgery by 1 August 2024 is entitled to be outsourced or insourced if surgery cannot be performed at the public hospital. Marginal capacity is limited in the private sector however the NZ Private Surgical Hospitals Association (NZPSHA) is on board with this so we all need to work together to maximise the opportunity. Our Joint Registry figures show that 2/3 of TWO funded joint replacements are performed in private. The opportunity now exists to increase the ability to treat all Orthopaedic patients. At the same time, we need to maximise the efficiency and output within the public system so we can accurately assess the need for more infrastructure development.

Trainee education has been severely affected by the decrease in elective surgery in the public hospitals. We continue to try and address the huge discrepancy in ACC funding of TWO for trauma care (PHAS). At the same time the NZOA ACC & Third Party Liaison Committee have been negotiating hard to have some of the common low level trauma diverted directly to the private sector to decompress the public hospital. This has worked for a limited number of hand cases but hopefully will be extended and rolled out to Foot and Ankle and other soft tissue injuries in the near future. The key here is to get ACC to work more closely with TWO and we have a commitment from the Minister that NZOA will have a meeting with both Ministers together in the near future. In the meantime, TWO has approved the funding of 5 fulltime training positions and including 3 private rotations for Trainees from February 2024 to improve their exposure to elective surgery. The Education Committee increased selection numbers to 19 this year to accommodate this and have approved 3 new private run rotations in Christchurch, Wellington and Hamilton for 2024. More may be added in 2025. While the Trainees are excited about these new rotations, they are concerned about future consultant appointments now that the Trainee numbers are increasing. Workforce analysis clearly shows a need to train more consultants however the infrastructure within TWO cannot yet accommodate the increase in consultant posts. We need to be innovative in how we work to create more positions and continue to advocate for more capital expenditure on operating theatres, outpatient clinics and beds.

TWO has initiated a national health provider system called "Clinical Networks". This is a system to nationalise care to limit postcode inequity and get patients care in the appropriate facility. Traditionally we have called these "referral pathways" however TWO has increased the complexity of these pathways into "networks" based on the NHS system. The NZOA Council had a workshop with TWO on what this will look like and it will be very important to be at the forefront of developing these, as it is the future for the care of our patients. We will involve the Sub Specialty Societies extensively in developing guidelines for this, specific to your area so please get involved and spend time helping with this. The NZOA are fortunate to have been selected to engage early in this initiative and I believe it is due to the good relationship we have developed with TWO, our weekly meetings and our ability to create solutions with them.

The creation of the NZOA NZ Trauma Orthopaedic Society has been a fantastic development this year. Under the leadership of their inaugural president Jonny Sharr, they have already started on developing some national guidelines for severe Orthopaedic trauma. We now have 7 Sub Specialty Societies in the NZOA and thank you to all the office bearers who have helped achieve Incorporated status for them this year. It is vitally important that the Sub Specialty Societies are involved in developing the direction of the NZOA. Having representatives from each Society on the NZOA ACC & Third Party Liaison Committee really gives that Committee strength in negotiations. There is no question that when we "sing from the same song sheet" as an Association we can achieve so much more that individuals trying to do it alone. The more Members can bring issues to their Society office bearers or NZOA leadership to help solve the more successful it will be. Societies or Members negotiating with authorities alone undermines the unity of the NZOA which is our real strength.

The wait for a patient to get a first specialist assessment has increased dramatically over the past few years. There are a number of reasons for this: COVID, growing population, pressure on GP's to refer for physiotherapy or high tech imaging, increase in ACC declines, less efficient clinics etc. Allied Health was allocated $20.25 million dollars in the Reset and Restore budget and the NZOA have become involved in trying to help rationalise the use of that money effectively. There has been a strong desire by TWO Allied Health to actually see all GP referrals to Orthopaedic surgeons. We appreciate that all FSAs to the Orthopaedic surgeons do not necessarily need to be seen by one of our Members however a considerable number do. We initiated the development of a working party with TWO to address this and are well into designing a solution. Some Physiotherapists will be embedded within the Orthopaedic departments (a number exist already) and will help with triaging referrals alongside the surgeons responsible for doing this. GP's will also be able to refer directly to a newly developed group of TWO Community Physiotherapists who can assess and treat patients where a clear surgical pathway is not the solution. A separate pathway for GP and Physiotherapy referrals for high tech imaging and simple injections is also in the making; cognizant that overuse of these modalities needs to be monitored. All in all, this should decease the burden of FSAs and rationalise assessment and treatment to benefit the patient. It will be up to individual departments to develop what works for them within this national framework.

Waiting lists for elective Orthopaedic surgery continue to grow in every hospital as trauma continues to consume resources, staff shortages keep operating theatres closed and ward beds are scarce. This has led to pressure by TWO for us to prioritise patients who have been waiting the longest and more recently instigating without our knowledge a prioritisation score for different groups of patients.

This was debated extensively in the public arena during the year and I will not expand on that in this Report. We received a large amount of feedback from Members and overwhelmingly there was support to help disadvantaged patients but not by altering the prioritisation score that had been given to them by the surgeon based on clinical need. Due to the highly charged political nature of this debate the NZOA was not prepared to enter into a public stoush on this. We continue to work weekly with TWO to address the best care for all patients and strongly support helping find ways to help disadvantaged groups negotiate the present health system. TWO are keen to relook at the CPAC scoring system to see why there is so much regional variation and NZOA will assist with this and look at ways to improve access to care and appropriate prioritisation at this level based on clinical need for disadvantaged groups. We will not support TWO manipulating the priority for treatment after a surgeon has decided it on clinical need.

I have had the honour of representing the NZOA on the "Carousel" this year. The Carousel is the Presidents of the English speaking Countries and comprises the British, Canadian, American (and AAOS), South African, Australian and New Zealand Association's Presidents. We meet at the Associations Annual meetings, present papers and have a short retreat each time to discuss international issues. It has been a wonderful experience and is very beneficial for all Associations. Similar challenges face each organisation at present and sharing these and different solutions that have been tried globally is very helpful. This tradition has been in place since 1952 and its benefit in these tough times is invaluable. Understanding international diversity enhances patient care and we can all try and pick the best practices from each country to implement in our own. The relationship with the Australian Orthopaedic Association is particularly strong. We hugely benefit from our working relationship with them in Trainee education and examination. Tim Gregg, Dawson Muir, Simon Hadlow, Tim Lynskey, and Prue Elwood from the NZOA office all travelled to Sydney for the AOA21 review. This education and curriculum review is the foundation programme for both Associations' training. There is no doubt we will need to progress to some hybrid type of training where we maintain some of the "apprenticeship" model we have at present but also add a "competency-based" training component. Our close association with the AOA is also going to be important as we re-negotiate our relationship with the College of Surgeons.

One of the strengths our Association is the work ethic of our employees at the NZOA office in Wellington. Andrea Pettett our Chief Executive has now been in that role for 7 years and her institutional knowledge is invaluable. The amount of work she does advocating for our Members and the patients we treat is unbelievable. Andrea has developed the office staff into a great "team" that are all multiskilled and can help each other in their defined roles. To improve the governance of the NZOA we have decided that each Incoming President Elect will attend the New Zealand Institute of Directors (IOG) week long course. Simon Hadlow and I put ourselves through this and found it hugely beneficial. Andrea spent a week at the IOG course this year and likewise bought back some great ideas to improve the governance of our Association. Defining the roles of the Council Members and Chief Executive is paramount in delivering transparent and effective management of our Association and I can't thank Andrea enough for her leadership in this. The RACS crisis highlights what poor governance can result in and I'm proud to say that the NZOA is in great shape going forward. A huge thanks to all the staff at the NZOA office who work tirelessly for our Members.

The NZOA Diversity Plan was initiated this year by the Council after extensive input from the LIONZ and Ngā Rata Kōiwi Representatives Josie Sinclair and John Mutu-Grigg. The feedback from Members will help finalise the document, which aligns us with similar organisations. The NZOA signed up to the International Orthopaedic Diversity Alliance (IODA) last year along with the other English speaking Orthopaedic Associations. Being part of IODA requires a diversity plan as does the government organisations we negotiate with in New Zealand. Notwithstanding that, it is important as an Association that we recognise the importance of respecting all cultures and genders. The diversity plan is a "living document" and the Council will review it each year.

The strength of the NZOA is our unity. The key to our success has been the structure that has been put in place by our forbearers. The continued vision of the subsequent Council Members to change with the times but not lose sight of our core values has made the NZOA such a wonderful Association. It beholds all of us Members to continue to volunteer to make it even stronger, especially in time like the present which are challenging.

It has been an honour to serve you as President this year and lead a Council that is energetic and proactive in making this Association as strong as possible. I can't thank Andrea and the staff at the NZOA office enough for their hard work and commitment to the core values of this organisation.

To the many Members who volunteer so many hours to the running of the NZOA, thank you so much. You are the backbone of this Association. To the outgoing Council Members thank you for your hard work. John McKie rotates off Council as Past President. John's service to NZOA and Orthopaedic surgery in New Zealand is second to none and he will continue as an examiner and NZ Joint Registry Chair. Andrew Graydon has done a great job as NZOA Secretary and was instrumental in creating the new position of Education Committee Secretary to relieve the increasing workload of his position. This has been an excellent initiative. Angus Wickham has been an amazing Treasurer and was instrumental in the review of the NZOA Trust's investments that led to a change in companies and improved financial return. Ed Yee has been superb in Chairing the Continuing Professional Development Committee. His attention to detail and work ethic is second to none and he will be greatly missed. Gary Hooper has been a superb Editorial Secretary, and his wisdom and institutional knowledge has been invaluable around the Council table. Stephen McChesney has been an excellent contributor on Council and it has been fantastic having some Waikato region input. Stephen was instrumental in initiating the formation of the Trauma Society founded this year. Simon Hadlow will be an outstanding incoming President. He has been a huge support this year and his wisdom, cool head and tremendous foresight will serve the NZOA extremely well. I look forward to assisting him as Past President.

I hope those attending the Annual Scientific Meeting in Nelson have a great experience and celebrate what we do so well. Thank you again for allowing me to serve as your President for the past year.

Haemish Crawford
President 2022/2023

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Chief Executive's Report

I have pleasure in writing my report for 2023. This has been a busy year with the Combined NZOA AOA ASM in Christchurch November 2022, finalising the RACS Partnering Agreement, the dispute with the NZ Institute of Independent Radiologists, and strong engagement and advocacy with Te Whatu Ora (TWO).

Andrea Pettett
Chief Executive

Education and Training

As I read my comments from last year's report, it is clear we have made great progress. Last year I was disappointed we did not select any female Applicants; we didn't have enough training posts to train the desired 15 Trainees; and we were struggling to find a funding model to enable us to sustainably open up training in the Private sector. This year TWO increased our available training posts to 20; we had a large number of excellent female Applicants and 12 females were selected, 7 males selected; and with the support of TWO we are establishing three private training rotations in Christchurch, Wellington and Waikato respectively. The working group comprises TWO Planned Care Leads, rostering Association staff, STONZ, RDA, and the NZ Private Surgical Hospitals Association. My thanks to Tim Gregg, Dawson Muir and Prue Elwood who are working towards accrediting these hospitals and approving training runs. The Private Hospitals will need to review their consenting and credentialling processes. We envisage the key stakeholders will enter into a Memorandum of Understanding to ensure the health and safety of our Trainees.

The Private rotations will be evaluated and I am sure more will follow in 2025. We are the envy of other Surgical Specialties as all surgical Trainees are experiencing a less than ideal training experience in our Public hospitals.

Conference and Events Management

A substantial effort was required to organise the Combined NZOA AOA ASM in Christchurch in November 2022. We spent the latter part of the year wrapping up the finances and the split with the AOA. We were very pleased to make a good surplus from this once every ten year event. My thanks to the entire NZOA team who supported Nikki Wright to run this successful event. This year the NZ Society for Surgery of the Hand COE in Queenstown was well attended and the combined Spine, Hip, Paediatrics, and ASM meetings this year is a new approach which we hope will be a successful model for future years.

Continued Professional Development

Whilst all of our Members are once again CPD compliant this year, the effort taken to get there was considerable. The Professional Development Plan is a new requirement by the Medical Council of New Zealand (MCNZ) which many Members were unaware of. We are taking steps to ensure the CPD website makes it abundantly clear when this has not been completed. Following up non-compliant Members takes considerable office resource and this year involved the CPD Chair and President. Our resources are better focused elsewhere. My thanks to Ed Yee (Chair) for his tireless support and Bernice O'Brien for many hours on follow up.

NZOA Infrastructure

Our infrastructure needs constant maintenance and upgrades. Vanya Schoeler oversees our CiviCRM (Client Relationship Management), Bernice O'Brien our CPD website and Prue Elwood and Elaina Fellows our Trainee Management Platform (TIMS). The CPD website has just been upgraded, and TIMS will be upgraded and replaced with Protrak early in 2024. These upgrades require oversight, testing and training.

NZOA ACC & Third Party Liaison Committee

This Committee is very active, but we have not made the progress we had hoped to this year with ACC. Our request for a review of procedure codes and costs has resulted in an external review of the methodology by external consultants which we await. Our work on non-prior approved codes has stalled as ACC view any procedure that is acute (needs surgery within seven days) falls within the PHAS agreement. Our work on WALANT codes has met similar obstacles. The many repeated concerns about the delays in ARTP approvals, declines, and some unethical cash offers being made to patients has resulted in acknowledgement that problems and delays exist. ACC has established a Rehabilitation Improvement Group (RIG) involving key stakeholders, the objective being to understand the entire client journey and improve rehabilitation outcomes. Hopefully this in-depth review of the current processes will result in meaningful change.

My thanks in particular to Peter Robertson (Chair) and Karyn Eggers for their support.

NZOA Trust

Following the review of the investment policy settings for the Trust's investments, we distributed the funds equally between JBWere and Simplicity. The same process was followed for the surplus funds managed on behalf of the NZ Joint Registry and the Wishbone Research Foundation Trust. JBWere then undertook a portfolio reallocation exercise. We are pleased with their excellent communication and returns. My particular thanks to Richard Street (Chair), Angus Wickham and Louise Gibson for their detailed work on this.

The New Zealand Joint Registry

Whilst we have had a few delays as Jinny Willis picks up the reins as the NZ Joint Registry Coordinator we have now published the 2023 Report and this is earlier than previous years. The Registry has received a large number of late forms showing the recent growth in surgery in private. This is our new focus to catch up with data input. Budget for the NZ Joint Registry is lean and we will be increasing the price per procedure to $30 plus GST which will make the NZJR Trust a small surplus. We have commenced a discovery phase for a new platform for the NZ Joint Registry as the existing access database is well past its use by date. We plan on using some of our saved funds for this new project. My thanks to Jinny Willis, John McKie, Lynley Diggs, Donna Thomson and Shona Tredinnick for their efforts this year.

New Zealand Hip Fracture Registry Trust

The Australia and New Zealand Hip Fracture Registry continues to grow and evolve, and recent Hip Fests are a great example of the enthusiasm throughout the country for this valuable Registry. The Hip Fracture Registry and the newly established Fragility Fracture Registry are both ably supported by Nicola Ward.

The Wishbone Research Foundation

For over 25 years the Wishbone Foundation has been funding NZ based Orthopaedic research and last year we awarded a total of $58,575.00 to five of the ten Applications. The Wishbone Research Foundation Trust was formed in 1993 to support and fund research into Orthopaedic conditions in New Zealandand has already supported over 180 local projects and from them approximately 120 scientific papers were published.

This year we have received a record 17 Applications for Wishbone grants, and these applications will now be considered by the Wishbone Research Foundation Committee. My thanks to Gary Hooper Chair of the Wishbone Research Committee.

We thank the following Societies for their contributions towards Wishbone: the NZ Foot and Ankle Society, and the Tauranga Orthopaedic Research Society.

The Wishbone Relay is a significant fundraising initiative led by Perry Turner and Ian Galley. Vanya Schoeler and Nikki Wright have been key to planning and communications for this exciting new venture in 2024.

NZOA Health Technology Committee

This is a new Committee recently established to undertake evaluation of new technologies leading to advice on the training requirements for the managed introduction of the technology. The Committee has only met a few times with the operation and circulation of the NZOA Robotic TKA Training Requirements for Surgeons, Implant Companies and Hospitals Guidelines. My thanks to Richard Peterson who was the inaugural Chair, and Mark Clatworthy the current Chair.

RACS

A significant milestone this year was the conclusion of our Partnering/Collaboration Agreement with RACS which has only taken six and a half years to agree upon! The main area of disagreement was the 'ownership' of the Specialty Orthopaedic Training Board which by necessity sits under the NZOA Governance umbrella. Thankfully we moved past this objection and signed an Agreement which commenced on the 1st March 2023. Since that time, RACS has announced serious financial concerns and many key staff have been made redundant or have left. With only zoom meetings taking place, we don't envisage a lot of engagement with RACS in the foreseeable future.

Te Whatu Ora

We initially had little or no engagement with Te Whatu Ora (TWO), but pleasingly this situation has changed markedly with the close engagement of Hospital and Health Services Duncan Bliss (Group Manager – Planned Care Hospital and Specialist Services), and Derek Sherwood (Clinical Lead Planned Care). The first successful initiative was the increase in training posts and the agreement to commence private training rotations. We are still working through the

formalities as now we have moved 20 DHB's to one health entity, and there is a need to move informal arrangements to a more robust agreed model. Other workstreams underway with Te Whatu Ora include the development of a Musculoskeletal Pathway, outsourcing arrangements, and early discussions on moving cold trauma/semi acute ACC cases out of our Public hospitals. These workstreams will continue over 2024.

Australian Orthopaedic Association (AOA)

A close working relationship with the AOA is hugely beneficial to NZOA. Prue and I travel at least annually to catch up with their Chief Executive, Education and Training team and leverage their knowledge and experience which they are happy to share.

British Orthopaedic Association (BOA), Canadian Orthopaedic Association (COA), South African Orthopaedic Association (SOA), American Orthopaedic Association (AOA), American Academy of Orthopaedic Surgeons (AAOS), Australian Orthopaedic Association (AOA)

The Chief Executives of the Carousel countries have formed a close alliance and agreement to meet annually and share knowledge. This is very helpful to me as we have common issues and challenges. Understanding our respective approaches to meeting these is beneficial for us all and to attend other ASMs.

Advocacy and Stakeholder Engagement

We continue to maintain relationships with the Minister of Health, Ministry of Health, NZ Association of General Surgeons (NZAGS), NZ Association of Plastic Surgeons (NZAPS), Physiotherapy New Zealand (PNZ), NZ Society of Anaesthetists (NZSA), Commissioner for Older Persons, Health & Disability Commission (HDC), Medical Council of New Zealand (MCNZ), Medical Protection Society of New Zealand (MPS), Medical Technology Association of New Zealand (MTANZ) and the Financial Services Council (FSC).

The dispute with the NZ Institute of Independent Radiologists (NZIIR) involved complaints to the MCNZ and a legal action against ACC. New MCNZ Guidelines 'Doctors and Health-Related Commercial Organisations' have since issued. MPS lawyers are preparing advice for our Members on adhering to this Guideline. ACC are taking a close look our Members with such interests. NZOA has been advocating on behalf of Members rights to have commercial interests, but not individual cases.

Membership Services and Secretariat Support

Membership services are ably supported by Karyn Eggers and Elaina Fellows. Secretariat support and diary management is superbly managed by Karyn who supports the Chief Executive, Presidential Line, Council and various Committees.

NZOA Staff and Council

I would like to thank the NZOA Council, NZOA Trustees, NZOA Joint Registry Trust Board and Management Committee, the Specialty Orthopaedic Training Board, the Education Committee, the NZOA ACC & Third Party Liaison Committee, the CPD Committee, the New Zealand Hip Fracture Registry Trust Board, the Wishbone Orthopaedic Research Foundation Trust Board, the NZOA Health Technology Committee, Ngā Rata Kōiwi, and LIONZ, for all their hard work during the year. A special thanks to Angus Wickham (NZOA Treasurer), and Andrew Graydon (NZOA Secretary) whom I have worked closely with and are due to retire from these roles. My particular thanks to the NZOA Presidential Line whom I communicate with on a daily basis. Haemish Crawford has been a hugely busy innovative leader and great support this year.

Andrea Pettett
Chief Executive

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Statement of Financial Performance

New Zealand Orthopaedic Association Incorporated
As at 31 July 2023

Angus Wickham
Honorary Treasurer

I am pleased to report on the Financial Performance for the NZOA Incorporated year ending 31 July 2023.

We have experienced a remarkable turnaround compared to the previous year, culminating in a substantial profit of $1,210,350 for the NZOA group - a significant improvement from the deficit we faced last year.

This remarkable achievement can be attributed to sound management practices, the success of our conferences, and robust performance of the financial markets. In an era of increasing financial, technological, and regulatory complexities, we have prioritised delivering value for money to our Members, reflected in our decision to maintain relatively stable Membership fees.

Our conferences, including the Paediatric, Knee and Sports Surgery Society, Sarcoma, and LIONZ events, have continued to be major contributors to our income. Notably, the Combined ASM has been a significant revenue booster this year. It is important to acknowledge that while the profit from this event was substantial, it came with inherent risks, particularly given the uncertainties surrounding COVID restrictions. It is essential to recognise that we cannot rely solely on such events for our financial stability, as the next Combined meeting is not slated for another 10 years.

The NZOA Trust, which serves as the investment and dispersal arm of the NZOA, has had a positive year under the guidance of our new fund managers, JBWere and Simplicity. They have delivered positive returns, with JBWere managing $2.2 million of investments and achieving a 9.06% return, while Simplicity manages $2 million with a 7.6% return.

Combined with our prudent financial management, including the $1.7 million transfer of funds from the NZOA Association, these efforts have significantly improved our financial position.

The NZ Joint Registry continues to be a vital resource for Orthopaedic research and quality control. However, we are grappling with challenges such as modest increases in revenue, static contributions from ACC and Te Whatu Ora (TWO), and rising costs, primarily related to salaries, travel, and consultancy work. While we managed to achieve a modest profit of $52,316 for the year ending in 2023, sustaining this financial stability will require increased income.

The Wishbone Research Foundation Trust reached a significant milestone, surpassing $1 million in assets. The upcoming financial year will witness a substantial fundraising effort, starting with the national relay in early 2024. This initiative, combined with our existing investment strategy, will create a self-sustaining fund that further supports and advances our outstanding orthopaedic research.

Looking ahead to the coming financial year, we anticipate a return to normalcy with COVID restrictions fading. Expenses and income are expected to revert to pre-COVID levels. While we do not foresee any windfalls similar to the combined ASM, we project a modest surplus for the year ending 2024. Key aspects of our budget include an increase in Member subscriptions to match the CPI, measures to minimise the risk associated with the financial difficulties RACS is facing, and gradual IT upgrades. We anticipate a modest profit of $64,000 for 2024.

My four-year term as Treasurer will conclude at the Nelson AGM. I have deeply enjoyed this role, especially the opportunity to gain a comprehensive understanding of the inner workings of the NZOA. COVID was a prominent topic at one of my first Council meetings, and its financial repercussions have persisted throughout my tenure. The adept planning, problem-solving, and sometimes tough decisions made by Louise, the Presidential Line, and Andrea have been exceptional, positioning the NZOA into a robust financial position. The financial challenges RACS is grappling with serve as a poignant reminder of the perils of poor financial planning and not accurately accounting for the true costs of running an organisation.

With James Blackett taking over the Treasurer role in November, in conjunction with the current Council Members and management staff, I am confident of the continued success of the NZOA.

Angus Wickham
Honorary Treasurer

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Statement of Comprehensive Revenue and Expenses

New Zealand Orthopaedic Association Incorporated

As at 31 July 2023

	Group		Association	
	2023	2022	2023	2022
Revenue				
Non-exchange revenue				
Donations, fundraising and other similar revenue	45,987	147,173	36,624	36,624
Exchange revenue				
Fees, subscriptions and other revenue from members	879,161	796,002	879,161	796,002
Revenue from providing goods or services	3,173,398	1,040,693	2,633,768	561,994
Interest and dividends	118,358	108,634	18,277	1,326
Total exchange revenue	**4,170,917**	**1,945,329**	**3,531,206**	**1,359,322**
Total Revenue	**4,216,904**	**2,092,502**	**3,567,830**	**1,395,946**
Expenses				
Volunteer and employee related costs	1,319,804	1,129,665	977,848	829,892
Expense related to public fundraising	-	313	-	-
Costs related to providing goods or service	1,349,567	269,723	1,278,461	204,331
Grants and donations made	13,646	49,983	-	-
Other expenses	711,877	550,997	540,166	448,334
Total Expenses	**3,394,894**	**2,000,681**	**2,796,475**	**1,482,557**
Other Income and Expenses				
Donation of excess funds to NZOA Trust	-	-	1,750,000	-
Total Other Income and Expenses	**-**	**-**	**1,750,000**	**-**
Surplus/(Deficit) for the year before other comprehensive income	**822,010**	**91,821**	**(978,645)**	**(86,611)**
Other Comprehensive revenue/(expenses)				
Realised gains/(losses) on investments	154,903	(13,436)	-	-
Unrealised gains/(losses) on investments	233,437	(150,624)	-	-
Total Other Comprehensive revenue/(expenses)	**388,340**	**(164,060)**	**-**	**-**
Total Comprehensive revenue/(expenses) for the year	**1,210,350**	**(72,239)**	**(978,645)**	**(86,611)**

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Statement of Financial Position

New Zealand Orthopaedic Association Incorporated

As at 31 July 2023

	Group		Association	
	2023	2022	2023	2022
Assets				
Current Assets				
Cash and cash equivalents	1,126,383	2,837,900	552,070	1,850,092
Trade receivables	378,751	582,360	293,727	603,628
Prepayments	156,815	449,610	130,972	388,009
Inventory	2,707	1,789	-	-
Investments	365,009	1,577,526	-	104,289
Other current assets	190,975	57,334	-	2,034
Total Current Assets	**2,220,640**	**5,506,519**	**976,769**	**2,948,052**
Non-Current Assets				
Property, plant and equipment	85,337	84,082	83,630	82,475
Intangibles	168,337	226,902	167,290	224,810
Investments	6,357,951	2,813,461	-	-
Total Non-Current Assets	6,611,625	3,124,445	250,920	307,285
Total Assets	**8,832,265**	**8,630,964**	**1,227,689**	**3,255,337**
Liabilities				
Current Liabilities				
Trade and other payables	201,797	204,604	137,619	162,684
Income received in advance	227,272	1,384,161	196,022	1,384,161
Goods and services tax	72,349	167,395	44,612	124,498
Employee costs payable	95,869	74,471	82,406	62,614
Other current liabilities	224,645	350	224,645	350
Total Current Liabilities	**821,932**	**1,830,981**	**685,304**	**1,734,306**
Total Liabilities	**821,932**	**1,830,981**	**685,304**	**1,734,306**
Total Assets less Total Liabilities (Net Assets)	**8,010,333**	**6,799,984**	**542,385**	**1,521,030**
Accumulated Funds				
Accumulated surpluses or (deficits)	7,275,110	6,397,084	398,402	1,321,030
Available-for-sale financial assets fair value reserve	591,240	202,900	-	-
Reserves	143,983	200,000	143,983	200,000
Total Accumulated Funds	**8,010,333**	**6,799,984**	**542,385**	**1,521,030**

Continuing Professional Development & Standards Committee Report

This will be my last report, as Michael Flint will be taking over as CPD Committee Chair. I have thoroughly enjoyed my last eight years as CPD Chair and the challenges it has brought.

Edward Yee
NZOA CPD Chair

CPD Committee

Edward Yee	Chair
Julian Ballance	Chair for Practice Visit Programme
Grant Kiddle	Senior Advisor
Richard Lander	Senior Advisor
Andrea Pettett	NZOA Chief Executive
Bernice O'Brien	Professional Development Coordinator and Website Manager

As always, I am in debt to Julian for the excellent job he does as PvP Chair, the experienced and balanced views Richard and Grant provide as senior advisors and the enormous amount of work Bernice and Andrea do to keep our CPD Programme functioning. A special thank you to all the Presidents I have had the opportunity to work with over the years. And to the Association Members for completing their annual CPD requirements and being receptive to my prompts when there were outstanding obligations.

CPD Compliance

All Members who were required to report CPD activities for 2022 achieved compliance on 28 July 2023. For uncertain reasons the RACS requested the NZOA to disclose our non-compliant members to them this year. RACS claimed they were furnishing a report on all surgeons CPD compliance for the MCNZ. It is uncertain if this is a RACS or MCNZ initiative. Fortunately, we managed to stall our report until all our Members were compliant but in the process some RACS staff have taken a grievance to our tactics.

Changes to NZOA CPD Programme

Completion of a Professional Development Plan (PDP) and Structured Conversation with a Peer was mandated by the MCNZ mid last year. Timing of its introduction midway through our CPD year was not ideal and it has caused issues for a number of Members. Some Members around the country have already been completing this process as part of their hospital annual employment requirements. For them it was simply a case of uploading the documents. The concept itself is simple but for many Members it does entail some additional work. I have emphasised in previous communication that this is a MCNZ initiative and not a misguided NZOA or RACS objective.

The template for the PDP has been revised to make it easier to use and hopefully be adequately suitable to most Members practice. It is simply a guide and other PDPs including an individually developed one can be used. The MCNZ has guidelines on their website on what is required. The NZOA one can be downloaded from the website.

Registries

The late release of NZJR data last year for the 2021 period resulted in problems for many Members trying to complete their Joint Registry audit. This has been acknowledged by the NZJR and the release of results this year will be timelier. The introduction of graphical reports and nematode/snail trails has made interpretation of the data much easier.

The NZ ACL Reconstruction Registry has reached a milestone of 10 years of data collection. There remain a few surgeons performing ACL reconstructions who are not participating and they have been reminded it is a mandatory requirement.

RACS

The news of the disastrous state of the College finances and governance overshadows the introduction of their new CPD Programme. The MCNZ midyear introduction of Completion of a Professional Development Plan and Structured Conversation with a Peer meant RACS has had to amend their CPD Programme for New Zealand surgeons in order to meet MCNZ requirements.

Practice Visit Programme

The PvP continues to be refined. Previously selection of visitees and visitors has been based on an interval cycle. With the progressive growth of the Association Members the original envisioned time cycle is difficult to adhere to. A practice visit to a young surgeon who has yet to establish a routine in their practice or a senior surgeon on the verge of retirement is likely to be of minimal advantage. However, this group is highly useful as visitors and the PvP will aim to focus on visiting surgeons in their mid-career.

The adoption of digitalised data collection for the PvP has significantly improved the organising and implementation of the visits. The collation of data for each visit is now easier and with greater accuracy.

Edward Yee
NZOA CPD Chair

Practice Visit Programme Report

Julian Ballance
PVP Chair

This year's Visit Programme has been successfully completed despite the impact of Cyclone Gabrielle and the need to reschedule due to the ongoing impact of hospital disruptions and unavailability of Members for personal or health reasons.

High staff turnover has also made it challenging for some Members to obtain feedback from co-workers.

The CPD Committee continues to evaluate the Programme each year. With an increasing Membership it is clear we can no longer adhere to the original 7-10 year cycle. Practice visits are considered most useful midway in a surgeon's career (5-20 years). Surgeons in the early stages of their career are more likely to be selected as visitors along with a more experienced colleague. Those nearing the end of their career will not generally be selected for visits but again are valuable as visitors. Specialist International Medical Graduates (SIMGs), who are often experienced surgeons, may be selected for a visit after 2-3 years of practice in New Zealand.

The CPD Committee has now developed a Policy to guide Members when a core element of the visit process such as theatre observation cannot take place or there is insufficient feedback from patients or colleagues/co-workers. If theatre observation does not take place the visit is considered incomplete and another visit should be scheduled to complete the visit process.

Another colleague(s) may be selected if the original visitors are unable to carry out the visit. They will then liaise with the original visitors for completion of the visit report. If there is a delay in providing practice data or there is insufficient feedback from patients and/or colleagues co-workers the visitors may need to delay issuance of the visit reports until that is received.

Julian Ballance
PVP Chair

Specialty Orthopaedic Training Board Report

Tim Gregg
Chair SOTB

In March 2023 a Partnering Agreement for the Specialty Training Programme in Orthopaedic Surgery was signed between the NZOA and RACS. This Agreement has been a long time coming and outlines the roles and responsibilities of the NZOA and RACS in delivering our training programme.

The NZ Specialty Orthopaedic Training Board reports to both the NZOA and to RACS. As per the Agreement:

2.4 When acting in relation to College matters and the delivery of College Services, the Specialty Training Board shall be deemed to be a Committee of the College and acting on behalf of the College.

2.5 If, and when, acting in relation to Society matters and delivery of the Society Services, the Specialty Training Board shall be deemed to be a Society Committee and acting on behalf of the Society.

For example, when it comes to selection, RACS is responsible for policies on selection and surgical training, online registration to determine eligibility, and generic training for interviewers. The NZOA is responsible for the implementation of selection process and notification of outcome.

With regards to curriculum and training requirements, the College is responsible for policy on development of curricula for Specialist Training Programmes, the RACS competencies and policy/s on training requirements (including mandatory teaching and learning, and forms of assessment) and delivery of general surgical education in relation to RACS competencies, including surgical skills courses (such as EMST, ASSET, CCrISP, CLEAR and TIPS). The NZOA is responsible for development of the curriculum, regulations relating to training requirements and delivery of Orthopaedic education via courses, training weekends etc. NZ Specialty Orthopaedic Training Board (SOTB) Members are involved in many of these activities.

Over the last year there have been several workshops run by RACS that Prue Elwood (Education and Training Manager), Dawson Muir (Chair, NZOA Education Committee) and I have been involved with. These workshops are held at the same time as the CSET (Committee of Surgical Education and Training) meetings that we attend. These meetings previously have been face-to-face. Recently, because of RACS financial situation, there has been a change to virtual meetings. We have found that this format is more difficult for meaningful engagement. Workshops are generally related to aspects of accreditation for the College.

The Monitoring and Evaluation Framework workshops are developing an overriding document for all Surgical Specialties. This framework will outline the process for training programmes to be regularly evaluated to make sure that they are producing the desired graduate outcomes. The Hospital Training Post (HTP) Accreditation project has progressed, but implementation will be delayed because of the RACS current financial situation. This project has created accreditation standards that are generic to all Specialties and specialty specific standards. The HTP Accreditation project will improve our hospital accreditation process, but at this stage won't be implemented until at least 2025.

The Professional Skills Curriculum is now in place. This will stand alongside our curriculum. A RACS guide to assessing Professional Skills has been developed (David Bartle has been involved in this). This document is more user friendly and will help with how to implement assessment.

In conjunction with the AOA, curriculum mapping has been completed. This maps our curriculum to RACS requirements.

SET Selection and SET Training regulations have been reviewed, and in some parts re-written this year. The current selection process has been in place for at least four years. The most difficult component to standardise continues to be the Composite Assessments. In-training research requirements have been altered to include a much broader definition of what constitutes research.

Competency-based training will be a focus for the Board over the next two years. A discussion document has been developed for a competency-based curriculum. The timeline is for a NZOA competency-based curriculum to be ready to be presented to the wider Membership at the November 2024 ASM.

Prue Elwood, David Bartle, Tim Lynskey, Simon Hadlow, Dawson Muir, and I attended the AOA21 review of their competency-based training programme earlier this year. There was a great deal of enthusiasm from academic educators, particularly those who have been involved in the process from its inception. It does increase workload for Supervisors and Trainees as well as creating a competitive system of 'gaming' to get competencies signed off to allow earlier sitting of the exam and ultimately shorter training.

The reliability of Supervisors signing off Trainees has also been questioned by subsequent assessors. There are certainly some enormous potential benefits to an improved curriculum-based assessment process. Competency-based training is being promoted around the world and has the potential to enhance our already excellent training programme. Despite the reservations expressed above, there are several compelling arguments in favor of Competency Based Education (CBE).

These include:

a) Alignment with the AOA and our common qualification.

b) Enhanced assessment and directed learning.

c) Curriculum targeting (focus on what we think is important – especially relevant for professional skills acquisition); and

d) Compliance with our regulatory requirement.

With the TIMS platform already in place, adding specific modules will not be too challenging. We are likely to transition towards competency-based training over the next two years. Based on the Australian experience, there is no appetite to abandon the time-based training model with respect to when Trainees can sit the exam or exit the programme. A working group is being established with a range of Sub Specialty interests and from multiple regions.

Un-coupling of the written and oral components of the Part 2 Fellowship exam was planned for 2024 and now likely to be delayed until 2025. This means that if a candidate fails both components of the written exam, they will not be invited to sit the oral component. If a candidate fails both components of the Fellowship exam there is a less than 2% chance that they will pass the overall exam. This un-coupling will save a lot of resources from going into candidates who have little chance of passing. Financially this also makes sense for candidates. In addition, candidates who pass both written exams, but fail overall, will be given an exemption from sitting the written component again at the next sitting.

The Board welcomes new member, Catriona Doyle. Catriona's role is as a Community Representative. Catriona's input so far has been invaluable. Stephanie Van Dijck has completed her time as the NZOA female representative. Stephanie's position has been filled by Charlotte Allen. Chris Hoffman is now the Chief Examiner and will take over from Sue Stott.

Thank you to all those who volunteer their time to contribute to the Board.

Tim Gregg
Chair SOTB

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Education Committee Report

Dawson Muir
Chair

Once again, it has been a busy year in Education. The Trainees overall are progressing well and it is heartening to see them support each other and engage with learning.

Surgical supervisors, including the Education Committee, work hard to monitor and maintain standards in education which helps promote excellence in Orthopaedics. Like most roles in the NZOA, these positions are seldom remunerated and I am very grateful for their help. I am also well aware of the many hours of teaching provided by a large number of our general Membership. In recognition of this commitment, we have established a new NZOA award for Service to Education which will be selected by the Education Committee and announced at the Gala dinner.

Prue Elwood continues to provide excellent 'no-nonsense' support to Trainees, the Committee and the Specialty Orthopaedic Training Board. This is a particularly busy role within NZOA management. Prue now has some additional support from Elaina Fellows who started in 2022.

Training Events (in chronologic order)

The 2022 SET 2-5 Spring Training Weekend was held in Dunedin on 11-12 November and hosted by David Gwynne-Jones. The new Dean of Otago Medical School and mana whenua, Joanne Baxter, provided a warm welcome. Steve Frick, a highly respected Paediatric Orthopaedic surgeon and educator from Stanford, gave great talks on 'who gets the knife' (a guide to Trainees about the required knowledge before supervising surgeons can reasonably allow them to perform the surgery) and lessons in fracture management. Hamish Deverall followed this with an excellent and very personal talk on burnout. Some fairly mediocre Curling was followed by one of the best Saturday evening training dinners that I have ever attended – enhanced by the Black Ferns winning during the evening.

The 2022 SET 0/1 Training Weekend in Nelson on 18-19 November was meticulously organised by Perry Turner – right down to the Nelson produce gift packs. The local faculty with some from Wellington and one from Christchurch did a great job hosting this introductory event with a focus on history and exam processes. Hopefully the Trainees don't forget Richard Peterson's technique for how to exam the hip. Not surprisingly, Perry arranged a team building event that involved so much physical exertion that even Hamish Leslie battled.

The Mock Exam was also held in November in Timaru. Our thanks to Sean Van Heerden, ex-examiners Tim Lynskey and John Matheson and the team at Timaru Hospital. Another important event that sets us apart from other Specialties.

The SET 1 Training Weekend was held in Gisborne for the first time on 3-4 March 2023. Local convener Duncan Cundall-Curry and the local faculty hosted a great event. Quality talks were followed by a good patient mix and practical stations focusing on knee and shoulder arthroscopy and external fixation. They were supported by additional faculty from Tauranga who enjoyed the hospitality of Muir's senior. Waka ama was the Friday afternoon team building event. Fortunately, no one drowned but worrisome incoordination meant it was a near thing. The residual effects of cyclone Gabriel were very evident on the river.

The SET 2-5 Autumn Training Weekend was held at Middlemore Super Clinic and convened by Alpesh Patel. The event kicked off with an excellent pōwhiri. As he did in Dunedin, the previous year, it was great to have the President speak during the introduction once again and emphasise the key role of education in the NZOA. Art Nahill, a semi-retired physician from Middlemore and Catriona Doyle, District Court Judge and Member of our Specialty Orthopaedic Training Board, combined to give an informative and thought-provoking symposium on bias. Not surprisingly, the Middlemore faculty were outstanding and brought along an array of great patients.

The May Pre-Exam Course was held in Auckland and convened by John English. This has become a large event and the hardest to host. It is also one of the best features of our approach to the FRACS exam and one of the reasons why our pass rate exceeds that of Australia. In order to provide the best clinical exam experience we rely heavily on the help of the local department to provide time and patients. We also lean on ex examiners to increase the authenticity of the experience. We had a large cohort of SET 5 Trainees this year and this demand will increase if we want to maintain the high standard of this event in the future. The Trainees and Committee are very grateful to those who contributed to the course.

Fellowship Exam

Congratulations to those of our SET 5 Trainees who successfully passed the Fellowship Exam in May 2023, a huge amount of work to get here and a well-deserved result.

Kenan Burrows, Dulia Daly, Rob English, Joshua Knudsen, Lewis Mackenzie, Jess Mowbray, Bryden Nicholas, Lloyd Roffe, Rachel Price, Vahe Sahakian, Mustafa Saffi, Richard Storey, Ruth Tan and Neil Stewart.

SET Selection

Interviews were held at Boulcott Hospital on 30 June 2023 and we once again thank them for hosting the day. The mihi whakatau was led by Mr Ken Te Tau. We received a total of 43 Applicants, including 18 female and 25 male. Nineteen Trainees were selected (12 female and 7 male). Additional training posts have been established in private in Wellington, Christchurch and Waikato. One successful applicant has deferred to 2024 to complete a master's degree in Boston, so a candidate from a reserve list was offered and accepted the position on the programme. Of 4 Māori Applicants, 3 were successful.

We were happy with the calibre of the candidates selected and continue to refine the selection process. Congratulations to Cherelle George, Michael English, Luca Killick, Vik Gupta, Patrick Bekhit, Abby Heath, Will Caughey, Sophie Wilton, Zoe Wells, Jess Lynch-Larkin, Erynne Scherf, Darina Gilroy, Chynna Gleeson, Alex Boyle (deferred), Kenrick Rosser, Martin Coia Jadresic, Kat Sim, Jess Leary, Anna McDonald, Gina Kioa.

Increasing training numbers will lead to some changes in the structure of our training events but more importantly, we as an organisation need to do all we can to ensure that there are more jobs in TWO hospitals for these aspiring surgeons.

Trainee Information and Management System (TIMS)

There is improved understanding of the use and utility of TIMS. However, this is not universal and all Supervisors and Trainees need to continue to engage with the process. I would like to emphasise that it is a vital part of Trainee education and especially relevant in our contracted elective surgery environment and will become the platform for any transition to a competency-based training programme in the future.

There is a plan to upgrade the platform that TIMS sits on. The goal is to give users great functionality, specifically with creating reports and ease of adjustment and upgrade.

We have had to place one Trainee on TIMS Probation, which involves additional and more frequent run assessments. If an individual fails their TIMS probationary period they will be deemed to have failed the run and need to repeat six months.

Online Learning (VLE)

These sessions have continued each fortnight post COVID and remain supported by Trainees. However, they have been variably attended which has dented the enthusiasm of many to contribute. Salil Pandit and Jonny Sharr have worked hard to encourage contributors, all of whom have put a great deal of effort into providing outstanding teaching. The Trainees assure me they watch the recorded sessions if they zoom in at the time. Whether we continue to provide this will be determined by the Committee. It is possible that we provide the sessions monthly in future.

Education Committee

With increasing experience on the Committee, there is more confidence in consistency with supervision and selection. We continue to have strong governance from the Specialty Orthopaedic Training Board and support for education from Andrea Pettett.

I would like to thank the leaving Members Ian Galley and Steph van Dijck for their contribution. James Aoina (Tauranga) and Charlotte Allen (female representative on Specialty Orthopaedic Training Board and Committee) join in 2024.

Dawson Muir
Chair

NZOA ACC & Third Party Liaison Committee Report

Peter Robertson
Chair

"*To Tread Water*" – when someone is treading water, it means that they are in an unsatisfactory situation where they are not progressing but are just continuing doing the same things.

The above sentiment could well be used to describe the experience of this Committee in its principal role – the quarterly meeting with ACC.

The good news is that we have moved off from unsatisfactory online meetings with ACC, and the face-to-face meetings have recommenced. The bad news is that the outcomes of these meetings seem to mirror the commonly held current viewpoint of the public service in Wellington – much lofty aspiration delivered with management speak but bugger all delivery despite excellent feedback from the practitioners at the coalface (Us!).

A recent meeting with the new CEO of ACC, Megan Main, allowed us to express concerns around engagement, noting that the NZOA sends 6-7 Sub Specialty leaders to the meeting, whilst ACC send Middle Management and it is increasingly rare to see full attention of Medical Officers or Upper Level Management.

With the above provisos, the key issues this year (continue to) include increasing delays in ARTP processing, unreasonable declines by a senior CAP member, introduction of 'non approval' codes to allow decongestion of trauma lists in public, Integrated Care Pathways MSK, and coding and pricing reviews.

ACC processing of ARTPs is getting very slow due to understaffing at the ACC end. Delays at CAP relate to coding changes (e.g. 'lumbar sprain' changes to 'lumbar disc prolapse'), gathering of old medical information, and 'limited data'. From the NZOA perspective we should be very descriptive in our 'Causal Link' explanations and avoid submitting requests where we do not believe that there has been a PIBA.

A well-known Senior CAP member has a perceived high decline decision rate, a perceived high rate of 'change of decline decision to acceptance', a perceived high rate of sudden acceptance of ARTP request for surgery at the final hour before a review hearing, and a perceived high rate of overturn of decline at review. These above high rates are perceived by all NZOA Sub Specialty representatives although true rates are unknown as total ARTPs assessed along with acceptance rates are unknown. The declines often seem to not take account of the 'Consideration Factors' that the NZOA have worked on over the last few years. We have clearly indicated our concerns to ACC and requested a Dashboard outlining CAP members performance in terms of raw numbers of ARTPs reviewed, accepted and declined.

There appears to be a way forward to decongest acute services by the introduction of 'non approval codes', where clear trauma could be performed in the private sector. Current delays to the introduction of these management options relate to questioning whether funding occurs through PHAS or an Elective Surgical Contracts.

Integrated Care Pathways (formerly Escalated Care Pathways) have now been trialled for four years, although unfortunately this did occur through the COVID periods of reduced activity. By concentrating of specific diagnoses in Knee/Shoulder/and Spine, integrated care including preoperative assessment, surgery, rehabilitation, wrap around services and planned return to work, has demonstrated improved outcomes with earlier return to work, reduced reinjury and significant cost savings – according to ACC. The ACC Board have approved a full roll out of the programme and will commence contracting soon. In general, this Committee has been kept at arm's length thus far due to 'commercial sensitivities'. We have expressed many concerns including alterations in referral pathways, and ownership by overseas interests.

Continued work on coding refinement is occurring across the Sub Specialties. ACC have introduced price increases for contracts which have been disappointing – in that they in no way match either inflation or medical inflation. The Private Surgical Hospitals Association have received similar limited increases in contract pricing that threaten the viability of some procedures. We have made vigorous representations to ACC on these matters, and they fall back on process/reviews/benchmarking/indexing and other management speak to justify their unsatisfactory approach. There is a real risk that some procedures my become non-viable for some surgery contract holders.

In other matters the NZIIR campaign to obstruct surgeon shareholding of radiology practices is quiet at present with their failure, at judicial review, to limit ACC contracting with radiology practices with surgeon shareholders.

Interaction with insurers has been very limited in the last twelve-month period.

Thank you to the current Members noting their sacrifice of significant time involved in the work of this Committee (Bruce Twaddle (Knee), Alex Malone (Shoulder and Elbow), Sandeep Patel (Wrist and Hand), Warren Leigh (Hip), Tony Danesh-Clough (Foot and Ankle), Antony Field (Spine) and John McKie (Presidential Line Rep).

Peter Robertson
Chair

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Senior Examiner's Report

The disruption to the FEX caused by COVID-19 is slowly diminishing to be replaced by the College's financial difficulties.

Dr Chris Hoffman
Chief Examiner

My first task in taking over from Sue Stott in June as NZ Senior Examiner was to assist Alison Taylor and the other Australian Senior Examiners to convince the College Leadership that the Fellowship examinations are core business and should continue relatively unaffected. I am pleased to report the preparation and delivery of the FEX will continue as before, with the focus on producing an examination of high quality.

The May Fellowship exams ran in Wellington and Brisbane. The examiners welcomed the return of patients for one of the clinical vivas, with the clinical video format retained for the other. This hybrid model will continue as it allows a wider range of conditions to be presented and helps with providing standardisation over the examination.

In Wellington, local coordinator Woosung Kim put together a great set of clinical cases, as well providing superb organisational support. There was a minor disruption with a computer screen failure during the clinical video viva but this was managed well by the examiners and candidates involved with a time adjustment made and no negative affect noted. There were 17 candidates in Wellington, one of whom was from Australia, and 15 candidates were successful (88%) with two unsuccessful. In Brisbane there were 41 candidates, of whom 32 were successful (78%), and I thank the contingent of NZ examiners who travelled over to assist.

The FEX exam in Australia in the second half of the year will be held in Adelaide in September. There are 38 candidates sitting and my thanks to the four NZ examiners who will travel to assist.

The Orthopaedic Principles and Basic Sciences OPBS MCQ exam (the old Part I) continues to run twice a year and is coordinated by Simon McMahon with the assistance of an Australian examiner. Simon is looking to retire next year and his input here will be missed.

The timeline for decoupling the written from the viva exam is not clear yet but will be further discussed at the RACS examiners strategy meeting in November this year. The rationale for this is compelling, as very few candidates who fail this section will ultimately pass overall.

In Wellington, we welcomed four new examiners - Dave Templeton, Helen Rawlinson, Gordon Beadel and Brendan Coleman. With increasing numbers of Trainees being selected the Court will need to continue to expand. The Court is looking for diversity across regions, provincial vs large centre, Sub Specialities, gender and ethnicity. There were many strong applicants last year and the Court will again call for applications in due course.

We also farewelled Kevin Karpik and Sue Stott. Both are thanked for their significant contributions. Sue is to be congratulated with her appointment as Deputy Chief Examiner of the Full Court.

Dr Chris Hoffman
Chief Examiner

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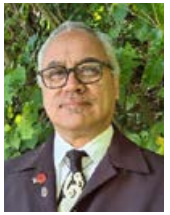
Cultural Advisor Report

Te Kāhui Kahurangi

Our Treasured People
Our Shining Stars



Ken Te Tau
Pou Tikanga/Cultural Advisor

As the Matariki constellation began its reappearance in the heavens this year, our annual Orthopaedic SET Selection Applicants gathered in the chilled early morning air at Boulcott Hospital in Te Awakairangi/ Lower Hutt.

Remembering back to our very first mihi whakatau in 2018, I vividly remember delivering my whaikōrero/ speech whilst gripping the mere pounamu gifted to the NZOA in 2016 by Prof Jean-Claude Theis and his wife, Virginia. There was a great sense of occasion at this inaugural mihi whakatau of appreciable achievement and positive progress for NZOA in regard to embracing the principals of Te Tiriti o Waitangi and introducing Māori culture into the SET Selection process. We have since continued to honour this Māori engagement ritual; however, something has been constantly bugging me in the dim recesses of my mind, which we will arrive at later in the piece.

The conch shell sounded the beginning of the proceedings, and the karanga/call echoed in the hallway and summoned the Applicants to ascend the stairway into the Hospital; the mere pounamu once more slipped into my hand. This year our NZOA Kaikaranga was my cousin, Anihera Carroll, mātua Tim Gregg, and I spoke on behalf of NZOA, responding Kaikaranga was Cherrelle Ormsby with mātua John Mutu-Grigg speaking on behalf of the Applicants.

'He Korokoro Tūī' is a Māori metaphoric term for someone whose throat produces such magnificent tuneful sounds likened to that of our native Tūī bird, each year I try and elicit such vocal enthrallment from our surgical interview panellists as we sing 'haere mai'. It was wonderful to hear this year's Applicants in full voice singing 'hutia te rito o te harakeke' a waiata/song that warns us about the damage that can occur when one extracts the juveniles at the centre of the flax plant, to do so would mean the eventual death of the aforementioned plant. The flow-on effect of the dead flax, the Kōmako/Bellbird would have nowhere to alight and sing, and there would be no future generations of that flax bush to succeed their flaxen elders. The beautifully sung waiata echoed the phrase uttered by mātua John Mutu-Grigg, one that you may have heard of before, "He aha te mea nui o te ao, māku e kii atu… he tangata, he tangata, he tangata". "What is the most important thing in the world? I say, it is people, it is people, thrice… it is people".

This phrase led me to consider who are the most important people at SET Selection; I say, it is the Applicants, it is the Applicants, thrice I say…the Applicants. This next generation of surgical stars at the centre of our Orthopaedic world have their hearts and minds set on surgical careers like their consultant forebears; however, with the interview selection process looming, will they, with joyful song, enter the training programme or with no place to land, be extracted.

Back to my bothersome dilemma, I have struggled with the term 'Applicants' This cold and heartless name, I felt, didn't correctly describe this gifted and intelligent, competitive cohort that tirelessly studies and vigorously strives to advance their medical careers in Orthopaedics. Further, the term 'Applicants isn't a very captivating and mana-enhancing personal identifier for the beauty of who they are, what they mean to their whānau, and the mana that they bring to their communities who have nurtured their success to date.

Sleepless in travail the night before the SET Selection, the disturbed sleep provided me with the name 'Te Kāhui Kahurangi' – 'Our Treasured People – Our Shining Stars' as a name for the SET Selection Applicants.

This Māori proverb says: **Ahakoa he iti, he pounamu – even though it is small, it is greenstone**. Pounamu/ Greenstone is intrinsically valuable; for NZOA, this means that every Applicant is unique and, like Pounamu, regardless of size or stature, is of immense value to us.

Te Kāhui is a word that refers to a constellation or a group of stars.

Kahurangi is the name of a light green, translucent variety of greenstone without flaws or spots - a highly valued variety.

Kahurangi also means prized, precious, honourable, distinguished, and treasured possession.

Another Māori proverb says: **'He kahurangi ia, he matahīapo i te iwi - She/He is a darling, a treasure of the people'**—an apt reference for our 'Applicants' who are the treasured people of their whānau and communities.

This final Māori proverb: **'Whāia e koe te iti kahurangi; ki te tuohu koe me he maunga teitei'**, urges us to pursue our treasured aspirations; however, it concludes by saying, 'if you falter, let it be only to insurmountable difficulties.

Mātua Tim Gregg concluded the SET Selection mihi whakatau with the words, "He aha te mea nui o te ao? māku e whakaae, he tangata, he tangata, he tangata – what is the greatest thing in the world? I agree... it is the people, it is the people, thrice I say… it is the people".

Te Kāhui Kahurangi, 'Our Treasured People, Our Shining Stars'. Whether or not they succeed in acquiring a training position at SET Selection is immaterial because each of them is already a shining star, and when it comes to stature and status, they are all treasured like pounamu.

Speaking of treasured people, at the conclusion of the formalities I took the opportunity to acknowledge our Education and Training Manager, Prue Elwood and gift her a piece of kahurangi pounamu stylised in the pikorua/twist shape. Prue is an integral part of the Training programme and is tireless in her efforts to ensure that we are all cared for and informed.

Nāku noa nā Ken Te Tau

Pou Tikanga/Cultural Advisor

Ngāti Kahungunu me Rangitāne i Wairarapa

Ngāti Porou, Ngāi Tahu

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Smaller Centre's Report

A huge amount of time and effort was expended on the Rural Health Equity plan.

Andrew Meighan
Orthopaedic Surgeon
Smaller Centre Representative

In Australia this led to funds being awarded from the federal government for FATES (Flexible Approach to Training in Expanded Settings) which aims to broaden the skills of the specialist workforce and encourage more specialists to work in rural areas. In New Zealand there is no funding available to continue the programme, nor staff support to seek a similar funding stream and so despite the wishes of many on the National Committee it seems likely there will be no further progress on this project. Hopefully the rural health network will continue to be developed.

The smaller provincial centres continue to struggle to recruit SMOs, relying on SIMGs and locums to keep their services running. I believe much of the issue is that few New Zealand Trainees rotate through these units, despite many of them offering excellent opportunities for public and private surgical experience. The Education Committee representatives tell me that there are currently insufficient numbers to get Trainees through the smaller centres. With Private/ACC hospital training of registrars now agreed, that could be an excellent way of funding Trainees to these rural areas.

Clinical networks are now being established by TWO. Hopefully this will improve trauma pathways to the bigger centres. In many small centres there is still very limited access to imaging out of "working" hours and at weekends.

There are considerable differences in access to elective surgery with large variations in CPAC scores accepted for surgery. We hope that having a centralised health service will reduce some of these disparities and improve access for those in rural areas.

Andrew Meighan
Orthopaedic Surgeon
Smaller Centre Representative

Trainee Representative Report

It's been a pleasure to be in this role for about six months now having taken over from Dulia Daly at the last training weekend.

Teriana Maheno
New Zealand Orthopaedic Trainee Representative

Many thanks to Dulia who filled this role for the past several years and is now enjoying her post FRACS existence – well deserved.

The training landscape remains largely unchanged over the last year with elective experience and significant challenges at the College level predominating over this time.

As many will already know the College is in significant financial strife at the moment resulting in substantial financial changes at both the pre-SET and SET level. Pre application courses, the GSSE, clinical exam and application fees for SET selection are all due to increase. Alongside that Trainees are likely to see a fees' increase in the realm of 32% for the next training year. Having attended many zoom meetings at the RACTSA Committee level it would appear that these fiscal changes are inevitable but the consequences to Trainees, especially our counterparts in Australia, have the potential to be very large. From an equity stand point increasing the cost of both preparing and applying for training poses a significant issue, making your ability to become a Trainee, and then subsequently training to be a surgeon, significantly based on your financial standing.

After substantive conversations with the College I remain underwhelmed at current suggestions to mitigate this although am optimistic that some of the suggested NZOA changes, which may include invoicing our training fees directly to the DHBs, may lighten some of the burden for our kiwi registrars.

Elective operating still remains a concern for many Trainees with both staffing shortages and trauma load in many centres becoming prohibitive for elective experience. Personally, having now had COVID as a feature for the entirety of my training the consequences of elective volume has been a concern for some time now. Hopefully the planned establishment of private rotations over the next 6-12 months in centres such as Wellington and Waikato helps improve the current Trainee experience, although is unlikely to replicate the elective experience our predecessors of even 5-10 years ago would have had.

Selection this year was a big one, with the introduction of 19 new Trainees into the fold. While we are excited about welcoming our new colleagues, concerns about placements, training experiences for current trainees and SMO jobs at the end of training have all been raised over the past several months. While the need for an increasing workforce has been raised at a Ministry level, in an environment where things such as training experiences remain scarce the concern about further diluting the training experience remains a real one- something that remains on the agenda for further discussion at our next Trainee meeting.

On a lighter note as I sat at APOS in Perth (23rd-26th August 2023) I was reminded of how lucky we are to train in New Zealand in an environment where every Trainee knows one another. It's a unique feature of New Zealand training that cannot be understated and, for those of us heading into exams, provides a huge support base to be able to connect with your colleagues (even internationally) over shared misery. The reputation of New Zealand training remains high overseas and that's a testament to the quality of not only the Education Committee Members and Specialty Orthopaedic Training Board but also to the support and education we receive on a day to day basis, in the centres we all work in. Our sincere thanks.

Teriana Maheno
New Zealand Orthopaedic Trainee Representative

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Wishbone Orthopaedic Research Foundation of New Zealand Report

It is with much anticipation that I write this year's report. The Trust is in a good position with over one million dollars of funds.

Wishbone Orthopaedic Research Foundation of New Zealand

Richard Keddell
Chair

Since its inception, the Trust has relied on the "Joint Effort" walks to raise money but more recently, especially during the COVID period, these have become more and more difficult to organise. Step up Perry Turner and Ian Galley who have turned Perry's desire to walk the length of New Zealand into the Wishbone Relay. Perry and Ian supported by the wonderful team of Vanya and Nikki, have met online every week to put this fantastic fundraising and promotional event together. You will all now be aware of the details of this walk, cycle, golf and Gala Ball extravaganza, but this group, now expanded by numerous regional organisers, will provide us with a novel way to raise funds but more importantly, a promotional event which will highlight our professions support of Orthopaedic Research in New Zealand.

On behalf of the Trust Board, I wish to express special thanks to Andrea, Vanya and Nikki, Perry and Ian, and all the regional supporters. Our thanks also to all the Members and their families who take part in the Wishbone Relay.

You will see from the financials that the Trust now has grown to a fund of $1,074,749. The fund has grown by a $10,000 donation from the Foot and Ankle Society, $11,000 from the Tauranga Orthopaedic Research Society, $23,000 from Member donations and $2,000 from the Maunsell Estate Bequest. It has also grown $71,000 from investments.

Again, my thanks to Members who have donated to the Trust directly. Our aim is to continue to grow this fund to allow a sustainable source of financial support for good Orthopaedic Research in New Zealand. My thanks again to Andrea, Vanya, and the team at NZOA head office for their support of the Wishbone Trust.

Richard Keddell
Chair

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NZOA Wishbone Orthopaedic Research Committee Report

Wishbone Orthopaedic Research Foundation of New Zealand
Orthopaedic Research Committee

Gary Hooper
Chair Wishbone Orthopaedic Research Committee

The Wishbone Orthopaedic Research Committee is responsible for promoting research within the NZOA. One of its primary roles is to assess Applications for research funding.

Members

Gary Hooper
(Chair, Editorial Secretary)

Tom Sharpe
(Education Representative)

Sue Stott, David Gwynne-Jones, Paul Monk, Dawson Muir
(Committee Members)

Funding in the past has been made available by the NZOA Council from the surpluses from the Annual Scientific and COE meetings. However, funding is always difficult to generate despite all the best intentions of the NZOA. This year and early next year a major National fund-raising event has been organised by Perry Turner and Ian Galley, the Wishbone Relay, which will involve a bike ride from the South to the North of the country, with multiple fund-raising activities along the way. The primary aim of this event is to raise the profile of Orthopaedic research within the country and to raise sufficient capital to make funding this research self-sustainable. Both of these surgeons should be celebrated for giving up their precious time to organise and participate in this event. These surgeons recognise the importance of this research in New Zealand and it is important that the rest of our Members get behind them and show the country that both collectively, as an Association, and individually we believe it is vital to support this initiative.

We also recognise that several of the Sub Specialty Societies have also committed to contributing to this research fund and the Committee thanks them for this initiative which will allow significantly more Orthopaedic focused research to be funded nationally. An opportunity exists for the Committee to develop "named" grants to recognise these contributions which will be discussed at future meetings.

This year we have 17 applications for funds which will be assessed in early October.

Finally, I would like to thank Bernice O'Brien for her dedication and energy in the administration of the Committee.

Gary Hooper
Chair Wishbone Orthopaedic Research Committee

Wishbone Orthopaedic Research Reports Summary

Wishbone Orthopaedic Research Foundation of New Zealand

Improving Patient Selection in Total Knee Arthroplasty (TKA)

Yush Zhou

Objective

Our research aimed to develop and test a user-friendly tool named the "SMART Choice" which would empower patients with knee osteoarthritis to predict their quality-of-life improvement after undergoing a total knee arthroplasty (commonly known as a knee replacement surgery).

What Makes SMART Choice Different?

Unlike existing solutions, the SMART Choice tool is entirely patient-centric. It uses simple inputs that a patient can provide, like their age, gender, and how severe their symptoms are. What is exceptional about this tool is its accessibility. The simplicity of the predictive inputs means patients can benefit from the tool early in their knee osteoarthritis journey, a crucial time when they're weighing up their treatment options. This promotes well-informed decision-making and fosters a shared decision-making process between clinicians and patients regarding surgery.

Research Method and Outcomes

We recently concluded a randomised controlled trial to test the efficacy of the SMART Choice tool. The results were genuinely encouraging:

- The tool reduced the willingness of patients to undergo surgery, particularly among those who the tool predicted wouldn't gain significant benefit from a total knee replacement.
- It diminished patient uncertainty regarding knee osteoarthritis treatment choices.
- It lowered patient preference for surgery, which is a favourable outcome. A significant portion of patients who might not reap the full benefits of knee replacement are those in the early stages of the condition. For them, non-surgical treatments, like physiotherapy and lifestyle adjustments, could be more beneficial.

Conclusion and Implications

The SMART Choice tool signifies a significant advancement in patient empowerment, giving them the autonomy to make informed decisions about their health. By allowing them to evaluate the potential benefits of surgery early in their osteoarthritis journey, we hope to promote treatments that align best with their individual needs and potential outcomes. This, in turn, can result in improved patient satisfaction and optimal utilisation of medical resources.

Acknowledgement

I deeply appreciate the generosity and vision of the Wishbone Research Trust Foundation in facilitating this research through their generous grant. Together, we are paving the way for a more patient-centric healthcare landscape.

Transfer Validity of an Augmented Reality Supracondylar Humeral Fracture Simulator

Phil Blyth

This project involves the development and testing of an Augmented Reality simulator for use by advanced Orthopaedic Trainees. This simulator enables practice of image guided pinning of a fracture by replacing the Fluoroscopy unit with a custom-built app on an iPad. By removing the radiation hazard, Trainees can practice the procedure outside the confines of the operating room. Usage in controlled environments such as a training weekend allows comparison between Trainees, as well as monitoring of progress of individual trainees. By having a simulator located in their local hospital, Trainees can upskill immediately before a case, rather than months before.

The technology also provides an opportunity to investigate different skills within surgical technique such as interpretation of angulation and the learning curve associated with different surgeries.

Development

BonedocAR Simulator

The simulator uses a custom-made anatomical model of an elbow, a standard drill and K-wire, an iPad and Bluetooth footpedal. The BonedocAR app uses optical tracking to calculate the exact location and poise of the bone and drill and hence produce fluoroscopic (X-ray) images, as well as track the position and trajectories of all wire passes. Results from the procedure are stored locally on the device and can be uploaded anonymously to a secure server. The use of TestFlight technology allows easy upgrade of the app.

Distribution

The simulator sets were distributed around New Zealand to all SET-1 Trainees for use between training weekends.

Training Weekends

There was significant disruption to the training weekends caused by COVID-19, which delayed testing and deployment. Finally in August 2022 the first training weekend testing for SET 1 Trainees went ahead in Whanganui. Unfortunately, 5 of the 14 Trainees were unable to attend this weekend, due to COVID-19 isolation requirements. Individual instruction for those Trainees was undertaken, which illustrates the resiliency which simulation via a mobile platform such as Bonedoc allows. The second weekend in Auckland was again impacted with one of the researchers unable to attend.

Figure 1a) Simulator in use on training weekend. b) Physical bones drilled. c) Overview of simulator. d) Virtual rendering of all wires (green) and errors (red) from training weekend.

Results

All Trainees operated on both weekends and provided quantitative feedback on the simulator. The amount of practice on the simulator by Trainees between weekends was variable, as was the number of real-world procedures performed. Due to Covid-19 delays in acquiring locality approval (despite HEDC ethics approval), comparison between real world outcomes and simulation is still underway. Interviews with Trainees are currently underway.

Construct validity testing, measuring the difference between medical students, Trainees and Surgeons is currently being completed.

Face validity testing, measuring the extent to which the simulator reflects the real world surgery, based on surgeons opinion is nearing completion.

Future Work

Feedback from the advanced Trainees has suggested they would like to use the BonedocAR simulator to teach their basic registrars/house officers. Due to not wishing to bias future sample gathering, our current policy is for this not to occur. However, it is appreciated that early practice could have potential benefits both for patients, as well as increasing the attractiveness of Orthopaedic surgery to junior doctors. Consequently we are planning to allow this to occur, once final data analysis is complete.

Approaches from surgeons as to how they can access the simulator in Ireland and India have been received.

The simulator has been developed to allow software upgrades via WiFi. Current development work is focussed on modelling of vertebrae to allow practice of pedicle screw placement. Further modelling of scaphoid fractures is also being investigated.

Hypochlorous Acid: A Novel Surgical Sterilisation Agent

Jack Parker

What questions are you seeking to answer with your research?

Funding was sought from the Wishbone Orthopaedic Research Foundation of New Zealand to support a Masters research project titled "Hypochlorous Acid: A Novel Surgical Sterilisation Agent". More specifically, the questions asked are is neutral hypochlorous acid (HOCl) delivered as fog an effective way to decrease bacterial colonisation within Orthopaedic operating theatres, and is HOCl an effective topical sterilisation agent?

What progress has been made?

We have been successful in demonstrating that hypochlorous acid could be used as a whole operating theatre sterilisation agent. This has been achieved through trials of delivering hypochlorous acid via a fogging machine in an animal operating theatre at the University of Otago, Christchurch campus. There are a number of parameters to control for and adjust to achieve this, which have been worked through since the grant application to achieve success. Firstly, humidity in the room needs to be between 70-90% to get reliable distribution. This is measured via multiple humidity meters in the room. Initial trials were attempted with the room HEPA filters left running, but they cycle too frequently to gain the desired humidity. 70-90% humidity is achievable with the HEPA filters switched off. When the grant application was submitted, we had demonstrated that HOCl delivered as fog could reduce the total amount of bacterial colonisation in an environment.

The next step was to show efficacy against specific bacteria, namely Staphylococcus aureus and Escherichia coli. Initially, this was attempted by inoculating a known number of bacteria onto sheep blood agar plates in the laboratory, before placing them in our animal theatre.

No difference was shown after exposure to HOCl fog, including with repeat experiments. The impression of our clinical microbiology support was that the conditions were likely too favourable for the bacteria.

A trial of inoculating S. aureus and E. Coli onto empty Petri dishes, leaving for an hour with no HOCl exposure, before swabbing the dishes, followed by spread plate technique was completed. Pleasingly, this showed good survival of bacteria as a positive control. After repeat of this, we then proceeded with our refined protocol, outlined below.

Before starting the experiment, HEPA filters are switched off. Petri dishes are placed throughout the theatre at different locations, four at each point. Two are inoculated with S. aureus, and two with E.coli. All dishes are then left for 60 minutes. Two dishes are sampled via swabbing at the 60 minute point to assess the effect of desiccation on the bacteria. Following this, the plates are exposed to HOCl fog with an effective concentration of 4ppm at a designated volume for the room (50ml/m3). This takes 80 minutes. At the concentration delivered via this method, HOCl requires a contact time of 120 minutes to be effective. To achieve this, the dishes are left for a further 40 minutes after fogging is completed and the exposed plates are then swabbed.

In our experiments with the above protocol, ten Petri dishes for each bacteria were inoculated at five points throughout the room (one control and one exposed at each location). The concentration of the inoculum is 1.2 x 108 CFU/ml for E. Coli and 1.2 x 108 CFU/ml for S. aureus.

All control dishes returned confluent growth. Of the exposed dishes, one each was exposed to concentrated liquid HOCl (500ppm) for 80 minutes whilst the fogging machine was running. For both S. aureus and E.coli, no growth was measured from these dishes. Three of the four remaining dishes were placed directly in line with the fogging machine at distances of 2, 3 and 5 metres. The remaining dish was at a 90 degree angle to the direction the fog is projected. Of the E. coli and S. aureus dishes exposed to HOCl fog, all sustained at least a 3-log reduction (99.9%) in numbers, which is cited routinely as the minimum standard for sanitising and cleaning agents.

There is a slight increase in survival in plates further from the fogging machine, but this trend does not reach statistical significance. These results have been consistent in repeat experiments.

What conclusions have been drawn from your research?

These results demonstrate strong efficacy of HOCl fog within an animal operating theatre. The results seen in our testing show reductions of S. aureus and E. coli that exceed infection control standards. It is of particular importance to control humidity and airflow in the room to achieve this.

Identify any further work you are planning as a result of the research

As stated in the application, this research is a Masters project, which assesses the effect of hypochlorous acid as a novel sterilisation agent. The Masters thesis is in the final drafting stage before submission.
Further work to come from this project will involve translation to human operating theatres for confirmation of its efficacy.

If your research has been published or presented at an Orthopaedic meeting how have you identified that funding has been awarded by the Wishbone Orthopaedic Research Foundation of New Zealand?

The fogging component of the research has been presented at the NZOA Registrar Paper Day 2022 and at the combined NZOA/AOA ASM in November 2022. Funding was acknowledged verbally and on the presented slides.

TIFF Trial (Steroid versus PRP Injection For Frozen Shoulder) Report

Warren Leigh

The study set out to answer the question is platelet rich plasma injection is as effective as corticosteroid injection in treating patients with Frozen Shoulder (FS).

Current guidelines (e.g. ACC) recommend a corticosteroid injection (CSI) as being effective if given early. However, the evidence for CSI lacks long term follow up and corticosteroids have a short duration of therapeutic benefit. They are also responsible for multiple adverse effects such as hyperglycaemia, infection and tendon rupture. The use of Platelet Rich Plasma Injection (PRPI) for frozen shoulder has been studied in four recent randomised controlled trials all demonstrating equal or superior efficacy compared to other non-operative treatment modalities such as corticosteroid injections. However, these studies had small sample sizes and various epidemiological errors including patient selection criteria, blinding technique and short follow up.

We have set up a double blinded randomised control trial aims to test if PRPI is as effective as CSI in treating patients with adhesive capsulitis referred from the Auckland region. This study will be the largest RCT comparing PRPI to CSI. It will also have the longest follow up period of any in the literature. Patients will be followed up for one year and we will measure their outcomes including pain, function, disability and any adverse outcomes.

We so far have 36 participants who have received a blinded injection of either a CSI or PRP. Patients have been followed up every 6 weeks over a phone consultation, asking about their shoulder pain, rehabilitation plan, sleep, medications and any adverse effects since the injection. 22 patients have been followed up for over 6 months so far.

Study participants are referred from Auckland and Northland by Orthopaedic surgeons, musculoskeletal physicians, sports physicians and rheumatologists.

Patients will then receive the injection under ultrasound guidance by radiologist Dr RD (Radiologist) who is also blinded and has no further study data collection participation in the study. No complications or adverse events have occurred.

At 50 patients a preliminary statistical analysis is to take place to ensure there is no identifiable statistically significant difference between study groups (to maintain clinical equipose).

The study is still ongoing and therefore will likely require more study participants to draw a conclusion, we used 200 patients to power a statistically significant result.

NZOA Trust Report

The Trust assets are secure and growing at a very satisfactory rate. The international financial situation has obviously been challenging, but despite that, reasonable returns are still being achieved.

Richard Street
Chair
NZOA Trust

As a result of our earlier review of Trust performance, the decision was made to split the Trust assets between Simplicity and JBWere. This decision was made after a fairly rigorous process of getting RFPs from investment providers, shortlisting those and then interviewing the most attractive candidates. After a lot of work, the decision was made to use the two investment vehicles, with Simplicity having a slightly lower fee structure but less day-to-day management and JBWere having a proven track record of return. The redistribution of funds took several months.

The Trust continues to fund the President's Best Registrar prize and the Orthopaedic Registrar Research prize. It contributes to the cost of the ABC Fellow as well as a number of other visiting short-term Fellowships including the Trans-Tasman Fellowship and the ASEAN Fellows. There has also been a contribution from the Trust to NZOA to cover the cost of the computer requirements for training and other activities.

The Chairmanship of the Trust will pass to Haemish Crawford at the NZOA ASM, after I finish a five-year term. The new Trustees at that stage will also include the incoming NZOA Secretary and Treasurer as well as a change of one of the other Trustees.

Richard Street
Chair
NZOA Trust

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New Zealand Joint Registry Trust Report

NEW ZEALAND JOINT REGISTRY

Gary Hooper
Chair

Over the last twelve months, the Joint Registry Trust has continued to facilitate and monitor the Joint Registry. The Committee has met on one occasion this year and do not anticipate any barriers to continue to obtain satisfactory performance appraisals from ongoing reviews.

Current Trustees

Gary Hooper
(Chair)

Rod Maxwell, Richard Keddell, Angus Wickham
(NZOA Honorary Treasurer)

Andrew Graydon
(NZOA Honorary Secretary)

Ex officio members

John McKie
(Supervisor of the NZJR)

Andrea Pettett
(Chief Executive)

The previous accounting problems have been resolved and now the Registry aligns with the other entities within the NZOA, ensuring that our Charitable status is maintained.

Jinny Willis has done an exceptional job in organising and generating the 2023 Registry Report. The new format is designed to give a better snapshot of the current position of arthroplasty in New Zealand. Change is always open to criticism and the Registry is happy to take comments and suggestions from the Membership.

Our Chief Executive, Andrea, continues to work hard in generating funding from various Government agencies and this year has been successful in gaining commitments for future funding although these are often precarious and require constant negotiation. Getting Government agencies to commit to funding the NZJR has been a constant challenge and our Chief Executive should be congratulated for her skill and perseverance. Maintaining a good funding stream is vital to enabling the independence and robustness of the Registry.

In 2025 we will be hosting the International Societies of Arthroplasty Registries. This is a significant honour for the Association and it is a recognition of the esteem our Registry is held worldwide. This will be a significant meeting and all surgeons and researchers are encouraged to prepare Registry based papers which can be presented to this meeting.

I wish to thank all of the Trustees who give up their time to ensure that the NZRJ remains robust and viable and all the Registry staff who work tirelessly to maintain your Registry. Finally, a big thank you to Andrea and the office team for their continued support.

Gary Hooper
Chair

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New Zealand Joint Registry Management Committee Report

NEW ZEALAND JOINT REGISTRY

John McKie
Joint Registry Supervisor

This year has been another year of transition and development for the Registry.

After the delays caused by COVID, the Registry celebrated a belated 21st birthday celebration at the Combined NZOA AOA ASM in Christchurch. It was great to be able to include the Registry's Inaugural Supervisor and driving force in its development, Alastair Rothwell to the Registry plenary session. Delegates voted this session the best plenary of the conference.

The Annual Report has undergone a major refresh with a move to a fully digital interactive format. This enables large volumes of data to be included in appendices while keeping the core or the report more concise and easier to navigate.

The changes to the Report have involved a large amount of work from the Editorial Committee for which we are very grateful. Ongoing work continues for further improvements in the Report and continuous review of data and auditing any spurious or questionable entries.

In line with International Registries, we are now reporting surgeon performance on a rolling ten-year average. This is generally a more sensitive measure of variation in outcomes, both with improving and declining performance and should provide surgeons with an improved audit tool. The whole of Registry outcome data with still be used for surgeons' individual results on the registry funnel plot, but the snail trails represent the outcomes of primary arthroplasties performed in the preceding ten-year period.

John McKie and Jinny Willis represented our Registry at ISAR (International Society of Arthroplasty Registry's) ASM in Montreal in May this year. This is an excellent meeting that brings together surgeons as well as Registry statisticians. This meeting outlines the power of Registries to distil clinically valuable information out of big data.

New Zealand has been awarded the hosting of this meeting in 2025, which is the first time in the southern hemisphere. It will be held in Christchurch in February 2025.

This represents a great opportunity for kiwis to present quality research at a major international meeting held down under.

A proposal is being put to raise the surgeon levy to fund the Registry. This has been $25 for over a decade, and we now struggle to cover costs.

It is proposed that the fee move to $30 for next year, then move at approximately CPI moving forward as our Association subscriptions do.

I'd like to thank the Registry staff for all their hard work running the Registry and enabling the new format Report to be produced. We look to continue to innovate and may the data of more value to surgeons. To that end, any suggestions on changes or improvements are welcomed. Can I also encourage surgeons to continue to check forms for accuracy when signing them in theatre and encouraging your local coordinators to forward forms promptly, especially as we move to the annual cut off in December. This will enable timely data entry and statistical analysis to facilitate earlier delivery of surgeon reports for audit and prompt presentation of next year's Annual Report.

John McKie
Joint Registry Supervisor

New Zealand Hip Fracture Registry Trust Report

The Australian New Zealand Hip Fracture Registry (ANZHFR) is a Binational Registry for patients 50 years of age and older who suffer a low velocity fracture of the proximal femur, that is from the top of the femur to a point 2.5cm distal to the lesser trochanter.

Mark Wright
Chair

The Registry collects both patient level data and facility level. The 2023 Annual Report includes the eighth patient level report and the eleventh facility level report.

The Report is made possible by the extraordinary efforts of the teams involved in hip fracture care in both countries and, particularly in New Zealand by the devoted work of Nicola Ward, the New Zealand Fracture and Fragility Fracture Registry Coordinator and Sarah Hurring Geriatrician the Clinical Lead, who are supported by Andrea Pettett and the NZOA staff.

Unlike the Joint Replacement Registries, the ANZHFR focuses on performance compared to a set of Clinical Care Standards for hip fracture care. This performance is measured against quality and indicators e.g. time to surgery or opportunity to be full weightbearing immediately after surgery. In this year's report there are improvements in domains, including pre-operative assessment of cognition and assessment of delirium, early recognition of which reduces the risk of other hospital required complications. The use of nerve blocks remains high with 92% of patients receiving a block prior to surgery.

Conversely there are areas which have seen little or no improvement over the last five years. For example, average length of stay in ED and average time to surgery increased in both Australia and New Zealand in the last five years. Also, the proportion of patients whose surgery did not occur within 48-hours of admission has increased. These data are broken down to hospital level and can be seen in the full report (ANZHFR.org/registry-reports) which also highlights drivers for surgical delay and potential hospital level and systems level improvement strategies.

First day walking remains low with fewer than half of patients taking a step the day after surgery. Given the challenges associated with early mobility a sprint audit examining acute rehabilitation was performed in 2022. A summary of the key findings is available at ANZHFR.org/sprintaudit/. The ANZHFR has just completed a Sprint Audit on fasting practices prior to surgery. The Sprint Audits require the collection of additional data and the ANZHFR greatly appreciates the efforts of participating teams in this endeavour.

2022 saw the return of face-to-face Hip Festivals with the New Zealand Hip Fest in Wellington and a Binational Hip Fest in Melbourne. The Hip Fests are a great opportunity to hear the latest multidisciplinary approach to hip fracture care. At the festival the Golden Hip is presented to the best performing hospital. North Shore Hospital won this for the second year running and Hutt Hospital won a prize for the Most Improved.

The New Zealand Implementation Committee and Hip Fracture Registry Trust greatly appreciate the work by Andrea Pettett and the NZOA team for managing particularly the financial aspects of the ANZHFR in New Zealand.

Thanks to their efforts with support from the NZOA ACC & Third Party Liaison Committee the funding for the Registry is settled for the next few years. Further, our financial records and auditing requirements are managed very efficiently by the NZOA.

Not only is the Registry Binational but it is also multi-disciplinary with the major partner being the geriatric services in both countries. Roger Harris, a Geriatrician from Auckland who instigated the original Auckland City Hospital Orthogeriatric Service has been involved with the Registry from its inception, over a decade ago, and is now retiring from his post as Co-Chair of the New Zealand Implementation Committee and the ANZHFR Trust.

His vision, commitment and good humour have added immensely to the implementation of the Registry in New Zealand. He was the initial Clinical Lead in New Zealand and liaised directly with and visited all New Zealand Hospitals to allow funding for each hospital's primary investigator and data collector. He was also fundamental in the effort to achieve an opt off consent, without which comprehensive data collection would be very difficult. Although Roger remains involved, particularly with the Fragility Fracture Registry and with an interest in periprosthetic fractures, on behalf of the NZOA Members I would like to express our deep appreciation for all that he has done to make the ANZHFR an excellent audit tool, a conduit for research and education and especially, as a mechanism to improve the care for hip fracture patients.

It is difficult to over-estimate the importance of data comprehensiveness, completeness and accuracy. In other words, we must try to catch all patients with hip fractures, make sure that all data points are collected and that the data are accurate. For example, our description of the diagnosis and operation undertaken must be accurate so that the data collectors are correct when they enter the data. The inconsistencies that may be seen between the diagnosis and treatment at a hospital level in the Registry can reflect these inaccuracies.

On behalf of the ANZHFR Implementation Committee and the Trust I would like to thank all Members of the NZOA, including the Council and Andrea's team for the support and assistance provided in the last year. I recommend that you look at the full report on ANZHFR.org/registry-reports and see how your services compared to those of other hospitals in New Zealand and Australia.

Mark Wright
Chair

NZOA Health Technology Committee Report

The NZOA Health Technology Committee is a new Committee which started in 2021.

Mark Clatworthy
Chair

Our brief is evaluate new technologies in Orthopaedics and to determine training requirements for surgeons to use these technologies. The initial Members of the Committee were predominantly arthroplasty surgeons however we now have Representatives from each Sub Specialty Society.

The Committee Members are

Mark Clatworthy – *Auckland (Chair)*
Matthew Walker – *Auckland*
Paul Monk – *Auckland*
Nicholas Lash – *Christchurch*
John Scanelli – *Dunedin*
Anand Segar – *Auckland, New Zealand Orthopaedic Spine Society Representative*
Michael Flint – *Auckland, Hip Society Representative*
Marc Hirner – *Whangarei, Shoulder & Elbow Society Representative*
Allen Cockfield – *Christchurch, Society for Surgery of the Hand and Paediatric Orthopaedic Society of New Zealand Representative*
Chris Birks – *Dunedin, Foot & Ankle Society Representative*

Our first project has been to set the Guidelines for Robotic Total Knee Arthroplasty which has shown significant adoption by knee arthroplasty surgeons in New Zealand. The same Guidelines have been set for Robotic Hip and Spine surgery.

The document states:

NZOA ROBOTIC TKA SURGEON TRAINING REQUIREMENTS FOR SURGEONS, IMPLANT COMPANIES AND HOSPITALS

1. Introduction

The New Zealand Orthopaedic Association (NZOA) Health Technology Committee has recently finalised surgeon training requirements for Robotic Assisted Knee Surgery.

The NZOA recognises that most current robotic systems are in effect advanced navigation systems utilising varying levels of robotic assistance. Consequently these guidelines recognise surgeon experience using navigation platforms.

TO PEFORM ROBOTIC TKA SURGERY THE FOLLOWING TRAINING MUST TAKE PLACE

2. Education Session/s

The NZOA requires that surgeons must participate in at least one company led education session. Computer simulations and app based learning with an emphasis on case examples is considered extremely useful. Saw bone workshops must be included as part of the education session.

3. Cadaveric Lab

A cadaveric lab is considered to be most useful for those surgeons inexperienced with navigation. Surgeons experienced in navigation (more than 25 cases completed within the last 2-years) do not need to do a cadaveric lab, but it is encouraged.

Those not experienced in navigation must undertake a cadaveric lab.

4. Surgeon Visitations

A visitation with a surgeon experienced in Robotic Assisted Knee Surgery is mandatory. This may lead onto a reverse visitation (proctoring). Whilst this is not mandatory, the NZOA strongly encourages surgeons to partake in a proctoring process.

5. Peer Reviewed Audit

The National Joint Registry will report a separate category to surgeons using TKA Robotics to identify outcome and revision rates. This information must be presented at peer reviewed audit meetings annually.

6. Implant Companies Obligations and Certification Document

As all current TKA robots to date are TKA implant specific the training requirements will be provided by the implant company. A certification document must be given to the surgeon, NZOA and hospital CMO on completion of the training.

7. Surgeon Obligations

Surgeons cannot perform robotic TKA until they have completed the training requirements and the certification document has been received.

If a surgeon has already started using a TKA robot prior to this document being circulated on the 1st June 2023 they have eight weeks to complete their training requirements.

Future Direction

Our next project is to audit that the Guidelines have been followed by asking the implant companies to provide us with confirmation that surgeons have completed their training requirements and the training certificate has been given to the surgeon and their hospital CMO.

The Hip and Spine Society have adopted the same training Guidelines

Mark Clatworthy
Chair

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Ladies in Orthopaedics New Zealand Report (LIONZ)

The past year has been a roaring success for LIONZ. We had a fabulous time at our LIONZ forum adjacent to the ASM in Christchurch in October with a fantastic turnout of medical students, junior RMOs, Trainees and consultants from around the country and a few from even further afield.

Nikki Hooper & Georgina Chan
Chairs LIONZ

The morning sawbone workshop allowed medical students and house officers an insight into true orthopaedics with plenty of opportunities to get their hands on some power tools! This was followed by an afternoon forum with some inspirational female surgical leaders from around the world and incredible speakers. We especially loved seeing a number of our male allies in the room, including the Carousel and Presidential Line. We are grateful for the continued support from Haemish Crawford and the rest of the Presidential Line.

We followed on from the success of this event with a subsequent forum in June in Wellington with another sawbone workshop in the morning followed by dual afternoon sessions including an interview preparation session for the registrars approaching interviews and an introduction to private practice session run with the help of Southern Cross Hospitals. Again, this was extremely well recieved with a huge turnout of LIONZ and supporters.

Later that month we were excited to see the results of the SET Selection interviews, which saw 12 (63%!!) incredible wāhine selected. We are truly heartened by this result, with the incoming Trainee year set to have a majority of women for the first time in the history of our training programme! This is a fantastic step forward in promoting and increasing diversity – something that our LIONZ Council representative, Josie Sinclair, has been working hard on with the NZOA diversity plan.

We also held our inaugural AGM in June and as a result have achieved Incorporated Society status and expanded on our plans for the future of LIONZ. We are in the early stages of planning next years' event with a similar format incorporating sawbones, interview prep and a forum as well as continuing to work with Southern Cross Hospitals to try to remove barriers for women in the private sector. We have also continued our regular newsletters for subscribers (please email vanya@nzoa.org if you wish to join the mailing list), expanded our facebook group to over 200 members and started our instagram page (follow us @lionzortho). Look out for the proud pride around your hospital – you can easily identify them by their hot pink LIONZ lanyards.

LIONZ 2023 Meeting in Wellington

LIONZ 2022 Meeting in Christchurch

Nikki Hooper & Georgina Chan
Chairs LIONZ

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Ngā Rata Kōiwi (NRK) Report

The power of the status quo.

John Mutu-Grigg
Ngā Rata Kōiwi
Representative

The status quo is a powerful thing. The status quo is what we consider to be 'normal'. Any movement away from this is considered 'abnormal'. The status quo in New Zealand is that NZ Europeans receive more and superior healthcare than others. This has been shown in almost every single field in New Zealand, from GP referrals, prescriptions, investigations and tests, surgical referrals, joint replacements and cancer care to name just a few. These numerous 'small' advantages means that NZ Europeans will be significantly advantaged overall with a total gain in life expectancy of 7.5 years over some others. It is interesting that socioeconomic status does not change this advantage. This has been the status quo for some time and few of us question this, fewer still try to rectify it, because we accept this as 'normal'.

Unfortunately, when we do try to change things, even in a small way such as within our surgical wait lists, this change is perceived as 'abnormal' and causes defensive behaviour. By some, it is considered to be unfairly advantaging a particular group, even though statistics repeatedly demonstrate that this group has the worst outcomes across our health system. This is the power of the status quo. It normalises inequity, and therefore maintains it.

NZ Europeans have an odds ratio of developing knee OA that is 0.81 that of Māori yet receive TKJR at a 24% higher rate. They receive 28% more THJR. Our Joint Registry shows that at every age group European NZer's receive more TKR than Māori. For THRs, European and Māori had similar utilisation rates in the under 55 and 55-64 age groups, where the rate of arthritis is significantly higher in Māori, but European NZer's had significantly higher utilisation rates in all other age groups. This has not changed over time.

Through ACC, NZ Europeans are more likely to be both referred for surgery and to receive surgery. NZ Europeans are twice as likely to be referred for physio compared to other ethnicities. NZ Europeans are also more likely to receive acupuncture, chiropractic services, hand therapy, occupational therapy, osteopathy, and podiatry than other ethnicities.

This ethnic disparity is not unique to New Zealand. Multiple studies in the United States have shown significant inequity in the utilisation of joint replacement. Indigenous populations around the world have shown this as well. Indigenous Australian men receive 1/3rd the hip and ½ the knee replacements of non-Indigenous, for women the rate is 1/5th and a 1/3rd.

In an editorial published in the JBJS it was said "fundamentally, we must face the possibility that disparities in utilisation and outcome persist stubbornly because they reflect fundamental economic and sociocultural challenges of living as a member of a minority group." However, what must be acknowledged is there is a striking similarity in inequity of access to orthopaedic care in minority and indigenous populations throughout the world. Importantly, it is increasingly recognised that health care professionals themselves are a contributing factor to this. In the United States, the Institute of Medicine identified "provider bias and stereotyping as key determinants of unequal treatment".

I believe that we all agree, ethnicity should play no role in the delivery or reception of healthcare. Unfortunately, however the data proves that ethnicity does indeed play a role, and it is significant. Knowing this, the question then becomes what are we going to do about it?

There was a large amount of misinformation and disinformation spread about the recent 'equity adjustor tool'. The entire function of this tool was to adjust for various 'risk factors' that hospital data had identified as contributing to unfair advantages and/or poorer surgical outcomes. All of the risk factors identified were given different weighting. The most significant was clinical priority. This means the adjustor would have made virtually no difference on P1 and P2's and mainly affected P3 and P4's. When these factors were accounted for, data then showed that once on the wait list every group was waiting the same time. It is necessary to recognise here that many people waiting on that list, had already been waiting significantly longer due to inequity of access further downstream. It is also important to note that ethnicity was but one of the adjustors, yet it was the only one that made people angry and galvanised media focus. We should think about that.

The tool has now been put on hold and correspondingly NZ Europeans will now again, be significantly advantaged over all other ethnicities. This is the status quo. I want to know if all of those who were particularly vocal about the unfairness of any particular ethnicity being advantaged, are now going to stand up and say we cannot have the status quo, as it is completely unfair. I fear however, they will not. I wonder how many of those voices have read any of the hundreds of papers about equity and bias?

I believe that the vast majority of Orthopaedic surgeons want the best for all of their patients. They do not actively promote certain ethnicities over others. The concept of inherent bias however is now well understood and we do discriminate against our patients, especially those that are not like us. We all do this. None of us are immune. The data actually shows that unless you make a conscious decision to treat those that are not like you differently, the results of your actions will be to discriminate against them. This is an unconscious decision. If you, as an orthopaedic surgeon feel that you treat all your patients the same, then the data shows that you specifically are in fact discriminating against certain groups. The more that we fight against this concept the longer our own patients will suffer. If we disagree with this well-established and researched concept, study your own data. Record the ethnicity of your patients, the treatment they get and the outcomes they achieve. I encourage all of us to do this, in every hospital and practice. We need solid data from which to make our decisions and policies. There is a world full of this data now for those who choose to look.

Another significant factor driving inequities is institutional racism. This is not an interpersonal issue, it is a design issue. This is a system that is designed for certain groups to prosper, but not all. All of us know the issues we have getting certain groups into our clinics or operating theatres. We all understand that certain groups do not engage freely within the current system, we understand that when they do engage there can be a reluctance. This is because these groups see the systems in which we operate as foreign. Systems that are not designed by them or with them in mind. Systems that do not care if they are left behind or excluded. A system that has no concern if they have higher complications rates, higher mortality rates or that they die much younger than all others. And they are right to be reluctant because we don't care. While we maintain the status quo, we demonstrate our lack of concern for their suffering.

We know that we as surgeons hold significant power in the delivery of Orthopaedic surgery in this country. We also know that there are biases in both the institutions and in our own decisions. We now know that this means that in this country we currently provide significant privileges to certain subgroups of society. This is unfair and unjust but is also the status quo. Therefore, if we are to provide equitable care we need to account for these biases. This step is difficult because to those with privilege, equality feels like oppression.

Our current scoring system for surgical waitlists has given us the results that we now have. Stacked heavily in one ethnicity's favour. That may not have been the design of the system, but that has been the result of it. The NZOA's absence of support of a tool that adjusts for the inequities we know exist is therefore by design or by negligence supplying racially divided care to the country. I do not believe that as a knowledgeable society that we should allow this. We must change it.

Imagine if we can, a system that has no ethnic groups that have worse outcomes, complications and mortality. No particular group that is difficult to engage with. A system that all groups can have the same outcomes as any other. To me, that sounds like a fantastic system. It is however, not the current one. I am regularly saddened when I remember that although I have worked hard and continue to work for the advancement of my whānau and hapū and have attained great education and prosperity, my family will still die 7.5 years earlier than others. I dream of a system where my family do not have to suffer longer and die sooner. This is why I fight the status quo.

John Mutu-Grigg
Ngā Rata Kōiwi Representative

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New Zealand Foot and Ankle Society Report

Chris Birks
Secretary

Finally, a year not affected by COVID (well not too much)! Fourth time was a charm for our Annual Meeting and AGM, finally able to be held face to face in Wanaka 22nd-24th September 2022.

This was well attended by clinicians and trades. The meeting was a great success and our thanks go Wesley Bevan and Tanya Turchie for their patience and good humour in re-organising this event multiple times. The meeting made a small profit.

Our involvement in the recent formation of the Southern Federation of Foot and Ankle Society (SFFAS) as the Fifth Chapter of the International Federation (IFFAS), is beginning to bear fruit. This has given us access to a wider range of speakers and provide a "seat at the international table" going forward. As part of this Southern Federation, the South African Society have, for the first time, been invited to this year's combined meeting. Thus, culminating in the Inaugural Meeting of the SFFAS.

For twenty years the New Zealand and Australian Orthopaedic Foot and Ankle Societies have combined, with a meeting every third year. An arrangement which has been very successful. It is very exciting to now include the South African Foot and Ankle Society at this meeting. This provides a new opportunity to mingle, develop networks and educational opportunities.

Our thanks also to Tony Danesh-Clough who continues his tenure on the NZOA ACC & Third Party Liaison Committee. From a Foot and Ankle perspective there is ongoing work around the pricing structure for procedures as well as streamlining approval for certain acute and semi acute procedures. Chris Birks continues as Secretary.

A huge thank you to Rhett Mason who has done an outstanding job as current President and has been instrumental in helping to establish the Southern Federation and fifth chapter of the IFFAS. We think the benefits of this relationship will be seen for many years to come. Rhett is planning to step down at the next AGM and nominations for President would be gratefully accepted (please forward to me).

Pleasingly the last few years have seen a steady growth in our Society with an increase in the number of Trainees completing Foot and Ankle Fellowships and subsequently returning to consultant positions. The country overall is now well served with Foot and Ankle specialists, able to service most of our urban and peripheral centres. We have Charitable status as well as a relatively healthy financial position and are therefore able to offer funding for Foot and Ankle research projects subject to approval from our NZOA Wishbone Orthopaedic Research Committee.

Chris Birks
Secretary

New Zealand Hip Society Report

Matt Boyle
President

Executive Committee

President:	**Matthew Boyle**
Secretary:	**Nicholas Lash**
Treasurer:	**Nicholas Gormack**
Immediate Past-President:	**Jacob Munro**
Immediate Past-Secretary:	**Vaughan Poutawera**

AGM and Future Meetings

The Hip Society looks forward to contributing to the upcoming combined NZ Hip Society and NZOA Annual Scientific Meeting in Nelson, where we have a combination of international and local expert surgeons contributing and we will hold our AGM.

Charitable Status

Charitable status was achieved by the Hip Society in 2022. The Society however notes recent changes within the NZ Companies Office which requires repeat registration for incorporation in this regard. The Hip Society looks forward to working with the NZOA Executive on this process over the coming year.

Finances

The Hip Society's financial status remains satisfactory. The Society maintains a desire to provide a regular, significant contribution to the New Zealand Wishbone Orthopaedic Research Foundation which we believe is the best mechanism through which we can support the funding of Orthopaedic research in New Zealand.

Matt Boyle
President

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New Zealand Knee & Sports Surgery Society Report

Bruce Twaddle
Immediate
Past President KSSS

The Knee and Sports Surgery Society has had a busy year after a period of frustrations during the COVID affected period as noted in our previous report.

The Combined Meeting with the Australian Knee Society before the NZOA AOA Combined ASM Meeting in October 2022 was a great success with about 100 attendees and very high quality of presentations. Ironically the restrictions of COVID had enable people to concentrate on consolidating their research projects of both sides of the Tasman and this was their first opportunity to present the results of their labours with some very high-quality research being performed in Australia and New Zealand. Romain Seil from Luxembourg and Andy Williams from the UK were excellent guest speakers. Adding an extra day to have a CME type day to make up for what was missed due to cancellations during the COVID period was well supported and felt to be an excellent addition to the meeting by both New Zealanders and the Australians.

We also had our 2023 Annual Meeting in association with the Bledisloe Cup test in Dunedin in August and again a very enjoyable meeting. Due to the relatively small number of attendees with restrictions on when the meeting could be held and it following on soon after the ISAKOS meeting, the format was a case presentation and discussion format. All participants were encouraged to present a case with plenty of time allocated for discussion and the variety of cases and challenges covered was very worthwhile. Thanks to Peter Myers for coming from Australia as the guest speaker, with his insights on being a team and stadium doctor for 40 years being an ideal warmup to the test.

A new President for the Society was elected at this meeting with Simon Young accepting his successful nomination for this position for the next three years.

We have worked through changes and recommendations with our radiology colleagues on Imaging guidelines, particularly in an effort to prevent some of the more unnecessary recommendations on reports for further investigations and studies without clinical support. How these affect actual practice only time will tell.

The meetings with the NZOA and ACC have continued and in the last year seem to be more open and candid, particularly on ACC's part. Hopefully this will result in much better dialogue regarding changes ACC are planning in the future such as the new ICP process and ongoing decisions around in room procedures such as ultrasound guided injections and minor procedures being performed.

The Guidelines for X-rays after Joint Replacement surgery have been updated as well, again in consultation with our radiology colleagues and moving forward these Guidelines have been changed so that X-Rays after 12 months should only be performed if clinically indicated up until at least the five year mark.

We look forward to taking part as one of the Sub Specialty meetings in association with our Annual Scientific meeting next year in New Plymouth and looking further ahead we are due to host the next COKS (Combined Orthopaedic Knee Societies Meeting) which will be outside a year the ISAKOS meeting would be held so likely to be 2026.

Bruce Twaddle
Immediate Past President KSSS

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New Zealand Shoulder & Elbow Society Report

Alex Malone
Immediate
Past President NZSES

This year we held a very successful meeting in Fiji thanks to Richard Lloyd and Tanya Turchie from TSquared Events, who navigated the complexities of organising an international meeting in the school holidays and delivered an outstanding event enjoyed by all.

Carl Jones was our European Travelling Fellow and presented during the meeting on his travels to Ireland, Belgium and France.

Richard Lloyd has been recently appointed as the next Fellow for 2024, he will be joined by Fellows from Australia and for the first time from South Africa. There is also an extra Fellowship for 2025 available.

The NZSES contributed to a shoulder session at the Combined NZOA/AOA AGM in Christchurch in 2022 and will do so again for the AGM in Nelson later this year.

The Society recently gained Charitable Status and made its first donation of $10,000 to the Wishbone Orthopaedic Research Foundation. We look forward to seeing how this funding can support Upper Limb projects in the future.

We held our first virtual AGM in 2022 in order to approve some constitutional changes and fulfil obligations in our Constitution to have yearly AGMs.

Marc Hirner is our new President from 2023-2025, Warren Leigh has kindly agreed to stay on as Secretary to provide continuity. Andrew Stokes is our President Elect from 2025.

It has been an honour to serve the Members of the Society as President and Secretary for some years previously. I will continue to advocate for our upper limb patients as a Member of the NZOA ACC & Third Party Liaison Committee, meeting regularly with ACC.

I feel confident that the Society is in a great pair of hands in Marc and Warren and look forward to watching it go from strength to strength.

Alex Malone
Immediate Past President NZSES

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New Zealand Society for Surgery of the Hand Report

Chris Lowden
President NZSSH

We live in interesting times as some may say. As the global pandemic seems to be abating the constraints that came with it are relaxing, we are fortunate to once more be able to take part in the collaboration and sharing of information through international travel and conferences, however the landscape has definitely changed.

Executive Committee

President	**Chris Lowden**
Secretary/Treasurer	**Robert Rowan**
President Elect	**Jeremy Simcock**
Secretary/Treasurer Elect	**Allen Cockfield**
Immediate Past President	**Tim Tasman-Jones**
Immediate Past Secretary/Treasurer Elect	**Sandeep Patel**

For our part Wellington hosted the biennial meeting for the New Zealand Society for Surgery of the Hand in combination with the New Zealand Association of Plastic Surgeons. The Joint Scientific Meeting was convened in Wellington in December 2022, and I would like to congratulate Ilia Elkinson as the Orthopaedic convener for the meeting. Anthony Berger was an excellent international speaker and Greg Bain and Dominic Power provided some quality presentations via Video link with an excellent local faculty.

In May of this year I was fortunate enough to be able to attend the FESSH meeting in Rimini and later this year Tim Tasman-Jones will represent our Society at the IFSSH meeting in Toronto. These meetings continue to provide stimulus and innovation while also highlighting different approaches and challenges to patient management and healthcare delivery.

The tail-end of the pandemic and its effects on the economy and staffing levels of the health service continue to pose challenges for our hospitals. Surgery planning particularly in Te Whatu Ora continues to require prioritisation towards the treatment of acute injuries, infections, tumours and other critical conditions. From local anecdotal experience I would estimate that we are still at less than 50% of the elective surgical volumes that we were prior to COVID. As waiting lists grow, outsourcing and continued development of the Public/Private partnership models continue to be required and this may require novel approaches and flexibility to help our patients waiting for treatment.

The institutional changes associated with Te Whatu Ora continue to add challenges to our routines and 'change management' becomes an important skill which we have to learn, adapt to and contribute to helping our ever-changing management colleagues.

As we enter a new post-COVID era, the global influences of conflict and recession will add to the uncertainty of health funding and as I write this we face the prospect of Nursing strikes and Senior Medical Officer stop-work meetings.

Additional financial worries within our over-arching professional body do suggest that having excess of funds becomes a liability rather than an asset.

Care pathways and contracts with different health providers continue to make patient management more complex under the edict of streamlining and rationalising patient care. With the evolution of these generic pathways it is even more important that we do not forget the individual patients. I have no doubt the next few years will continue to involve negotiations between ourselves, hand therapists and health funding providers.

The NZOA COE meeting (Hand and Wrist) August 2023 is being held in Queenstown with international guest speakers Don Lalonde and Randy Bindra. This will hopefully provide both practical and specialist knowledge for Registrars and Consultants of all stages in practice. I would like to thank Tim Tasman-Jones and Sandeep Patel for organising this meeting and cordially invite all our NZOA colleagues to what promises to be an excellent conference.

Chris Lowden
President NZSSH

New Zealand Orthopaedic Spine Society (NZOSS) Report

New Zealand Orthopaedic Spine Society

Angus Don
President NZOSS

The Annual meeting was held in Dunedin in November and was well attended. It was a great occasion for reconnecting with colleagues and presented a chance for lively debate and interactions.

Following the meeting the NZOSS has become an Incorporated Society, and well advanced to reach Charitable Status.

The hard work that Bruce Hodgson and Kris Dalzell have done on recoding and revaluating spinal procedures has come into effect, with very satisfactory advances being made.

We have set up two working groups. The first led by Alpesh Patel to establish more formal guidelines for Spinal Fellowships in New Zealand, to give us a framework to optimise Fellows experience and learning. The second group led by Anand Segar and Peter Robertson is looking into lumbar disc arthroplasty, with regard to outcomes, indications, and monitoring guidelines to be fed back to the Society for discussion at the AGM, so that this can give recommendations to the insurance companies.

Two Members have joined NZOA Committees to advance the Society's voice. Anand Segar on the NZOA Health Technology Committee, and Antony Field on the NZOA ACC & Third Party Liaison Committee.

We have an exciting AGM coming up in Nelson, with Dr Mike Vitale out of New York contributing his insights. This is the first time we have linked with other Societies to have our meeting around the NZOA, which will offer a chance to interact with our other Orthopaedic colleagues.

Angus Don
President NZOSS

New Zealand Orthopaedic Spine Society

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The Paediatric Orthopaedic Society of New Zealand Report

The first thing I would like to do is thank the previous president Haemish Crawford for leading the Paediatric Orthopaedic Society of New Zealand over the last three years.

James Donovan
President POSNZ

He has done a fantastic job and has continued this theme with taking on the Presidency of the NZOA. He has a great contact list of international colleagues who are world leaders in Paediatric Orthopaedics, and who contribute extensively to our meetings. He also readily contributes to these meetings himself, despite his busy workload, and I would like to thank him and Dawson Muir for their help with organising this year's meeting.

We are looking forward to holding our Annual Meeting, in association with the NZOA Annual Scientific Meeting, in Nelson in November this year. This will be alongside the Hip and Spine Society meeting, combining with the Hip Society for the Saturday morning. We have some great speakers coming, including Professor Vitale from Columbia, New York, Professor Stuart Weinstein from Iowa, and Dr Jimmy Chong Paediatric Rehabilitation specialist from Starship. These alongside presentations, research and case discussion from Members who continue to volunteer to contribute to their Society meeting for which I am truly grateful. I would encourage you to register if you haven't already.

POSNZ is looking in to following other Sub Specialty Societies and moving to an Incorporated Society. We appreciate the NZOA's assistance with this. Ian is the Chairperson of the current Trust and continues to do a great job running this and is working with the NZOA to make the changes required. The Society is planning a further donation to the Wishbone Orthopaedic Research Foundation and is contributing towards funding for Pacific Island surgeons to attend the ICL meeting in Australia.

By the time you read this, the annual POSNZ/APOS instructional course lecture series will have been held in Fremantle. These are always an excellent educational experience and, followed on by the APOS ASM, a worthwhile attendance for Trainees and consultants.

It is a privilege to be nominated President of POSNZ. It hasn't helped my fear of others figuring out that I really don't know what I am doing, but I will endeavour to follow the lead of those before me.

James Donovan
President POSNZ

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New Zealand Orthopaedic Trauma Society

On Friday 23rd of June, in Auckland and via Zoom, and coinciding with our most recent AO course, a meeting was had by some of our NZ Orthopaedic Trauma surgeon community.

Jonny Sharr
President Trauma Society

The purpose of the meeting was to ratify a Constitution for our Society and appoint the office holders. The inaugural appointments were Alex Lee as Secretary, Mark Huang as Treasurer, Jonny Sharr as President for an initial two year term, Angus Jennings as President Elect, and fulfilling the role of "Past President", Gordon Beadel.

With Trauma contributing a significant workload to every Orthopaedic department around the country, the formal establishment of this Society is long overdue. We are likely all aware, that there are many challenges affecting the provision of Orthopaedic Trauma care throughout the country. We believe having the NZOA Trauma Society established, may allow for better advocacy and more coordinated responses, in addressing some of those challenges.

We are all excited by the potential positive influence our Society may have in Orthopaedic Trauma care in New Zealand. I encourage anyone with an interest in Orthopaedic Trauma to take up Membership with your newest NZOA Society when next provided the opportunity to do so.

I wish to acknowledge the assistance of the NZOA office and Andrea in getting the Society functional and Alex Lee for putting in the groundwork to establish our constitution and our registration with the NZ Companies office.

Jonny Sharr
President Trauma Society

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New Zealand Sarcoma Society

On the 18/19th of March 2021 a National Sarcoma meeting for clinicians, nurse specialists and Allied Health Professionals (AHP) who are involved in the treatment of Sarcoma in New Zealand was organised in Auckland.

Andy Johnston
Sarcoma NZ

We had 57 attendees from across the country. This meeting was very successful and included a guest speaker in the form of world renowned sarcoma pathologist Adrienne Flannagan, who talked to us about genetics in Sarcoma and the 1000 genomes project. This inaugural meeting produced support for a National Ewings Sarcoma MDM, which started in the November of the same year, and led to the second meeting, held in Christchurch in 2022.

The meeting in Christchurch led to the agreement that a National Society should be incorporated to help formalise the national approach to Sarcoma care, treatment and research. The New Zealand Sarcoma Society was formally Incorporated on the 6th of July 2023, and the Charitable Trust application has also gone in.

An interim set of office holders were selected to allow this process to happen and these positions will be formally voted on in September this year, and it is envisioned that a meeting will take place every 2 years, with the board meeting annually. I have included a list of the interim office holders, and the interim inaugural President Mr Michael Flint, will be in touch with those people who have attended the previous 2 meeting to organise a formal vote.

We look forward to helping improving care and outcomes for patients and families in New Zealand with bone and soft tissue cancer.

President – Michael Flint, Orthopaedic Oncologist
Treasurer – Isaac Cranshaw, Surgical Oncologist
Secretary – Josh Kempthorne, Orthopaedic Oncologist
Research Officer – Joanna Connor, Medical Oncologist
President Elect – Clement Korenbaum, Medical Oncologist
Treasurer Elect – Hedley Kravitz, Radiation Oncologist
Secretary Elect – Virginia Pringle, Sarcoma Clinical Nurse Specialist

Andy Johnston
Sarcoma NZ

Orthopacifix Charitable Trust

As we emerge from the fog of COVID, it has been our pleasure to resume regular activities in the Pacific and it has been a busy year involving several visits to the Pacific.

We are very grateful to the 67 NZOA Members who this year contributed a little over $23,000 in donations to the Trust. Industry also contribute and we thank Pioneer Medical who continue to strongly support the Trust with regular donations. Stryker have also continued to support the charity and provided stipends for two registrars to experience orthopaedic practice in the Pacific Islands in 2023. Several other companies have also contributed to the Trust.

In 2023, the Trust has again supported the Pacific Islands Orthopaedic Association's (PIOA) training modules. The module in March was attended by Jason Donovan and Tim Gregg and Tauranga Rheumatologist, Tracey Kain. James Aoina, Soti Leilua, Hamish Leslie and Suren Senthi will all be teaching on the PIOA training module and David Bartle will be assisting with registrar examinations in Suva in September. Vaughan Poutawera and Richard Cowley will work at the main hospital in Suva to facilitate the local surgeons attendance at the lectures and practicums.

The Trust has assisted with two other visits to Samoa involving surgical assistance for several complex cases including a major pelvis trauma case and two cases of congenital tibial pseudoarthrosis.

One of the major ongoing projects of the Trust is a to refurbish the operating theatre in Rarotonga. The Tauranga orthopaedic surgeons group have donated $150,000 and the Orthopacifix Trust has donated a further $100,000 in honour of Andrew MacDiarmid who volunteered his services in the Cook Islands for more than 40 years. The first site visit has been undertaken with Opritech to plan the improvements and further planning and fund-raising activities continue to help raise the anticipated cost of approximately one million dollars.

In addition to these activities, the Trust has also facilitated the delivery of various Orthopaedic supplies to the islands this year. Finally, we have been able to support Dr Naseri Aitaoto from Pago Pago who has been working as a registrar at Tauranga Hospital for the past year.

We welcome any enquiries from NZOA Members who may be interested in teaching and working in the Pacific Islands. We encourage Members to consider whether their hospital department may be able to accommodate a Pacific surgeon in a non-trainee registrar role. Please contact any one of us to discuss any of the above or with other queries.

Further information on the trust can be found online via the NZ Charities Commission website (Trust number CC53594). Updates on Trust activities are posted on our website www.orthopacifix.kiwi and on our Facebook page.

Vaughan Poutawera, Andrew Vane, David Bartle, James Aoina
Trustees Orthopacifix Charitable Trust

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Orthopacifix Pacific Islands Ambassador

Dr Thomas Kiele
Orthopacifix Pacific Islands Ambassador 2022

Summary

The Orthopacifix Charitable Trust is the sponsor of the prestigious Pacific Islands Ambassador programme enabling a PIOA trainee to attend the NZOA scientific meeting which was combined with the AOA ASM this year. This was held in Te Pae, Christchurch.

In addition to attending the conference, I was able to participate in a 2-week long observership period at the Tauranga Public hospital attached with the orthopaedic department. Both experiences were highly rewarding with a lot of lessons to take back.

NZOA/AOA Combined Annual Scientific Meeting – Christchurch

Participating for the first time in a high level medical specialty meeting with possibly 200 plus orthopaedic surgeons from Australia and New Zealand (including others) in attendance. It was a challenging yet very fulfilling experience to participate and listen to a wide variety of talks. Topics from environmental conservation in orthopaedics to cutting edge developments in cartilaginous regeneration out of Melbourne University, to the exorcism of hip resurfacing surgery. One of introductory presentations touched on the spirit of exploration that was remembered in the story of Ernest Shackleton's trans-Antarctic expedition on the Endurance.

The qualities of Commitment (& Courage), Leadership, Resilience, Innovation and Teamwork that made Shackleton's story stand out to me. In a comparable way, but by a much less degree, is the prospect of improving orthopaedic services in PNG and the Pacific. Where it seems the last 300 years of orthopaedic history and development is being played out over the last few decades in PNG's medical professional development.

Photo taken with Tim Gregg, Vaughan Poutawera, David Bartle and Stephen Kodovaru after presenting in the outreach programme at NZOA/AOA ASM.

During the outreach session Stephen (PIOA President) and I were both able to give presentations. Stephen gave an update of the PIOA training with the impact of COVID. My talk was on the use of prophylactic antibiotics in PNG.

Attending such a big conference is a whole new experience, the biggest benefits from observing the different presentations was not only the content of their talks but also the manner they were structured. Each talk was strictly kept to time yet efficiently presenting their key ideas. Having experienced this now I can at least have an idea on how to present in future scientific meetings if the opportunity arises.

Observership at Tauranga Hospital

The observership period was a two-week period in which I was able to shadow Naseri as well as some of the final year registrars Tom and Ollie in the operating theatre. Observing and assisting in theatre.

For this my focus was not just on observing surgical procedures but also just the general workings in OT, the etiquette, sterility practices, patient positioning and use of adjuncts like traction and spine tables, as well as c-arm positioning for specific cases and many more aspects.

All in all, I observed 24 operative cases with take away lessons from each. I found that the entire team were only happy to explain their procedures and practices. It was clear why Tauranga was known to be a highly sought after teaching hospital by its emphasis on training by the team of consultants. I was only happy to interact with nurses, anaesthetists, residents and company reps which were even more enthusiastic to share their knowledge and expertise.

Another observation was the manner in which daily operations were scheduled which is very different from our local practice. The manner in which patients are scheduled for major surgery walking in on the day and being discharged afterwards is an approach not done in PNG. Although I see the benefit of this practice in reducing inpatient care – it would require changes not only in practice but in theatre design and hospital planning.

There were also a lot of opportunities to ask questions with the OT nurses. It was good getting more informed about the preparation of the bone cement, their preference on what types of IM nailing system that they found was simplest and straight forward to learn. Another interest of mine was the VAC dressing system which Cindy and her colleagues were only happy to explain. I greatly valued their explanations recommendation.

Also talking to company reps which I found who were very approachable and knowledgeable not just about their products but the procedural steps involved. I was able to get some of their contacts in the event that my local practice changes.

One of the challenges in my setting is that in implementing new techniques and procedures, I could not solely focus simply on the procedure. I've had to consider and try to understand other things such as designing OT rooms with laminar airflow and positive pressure rooms which are significant in minimizing infection, especially in arthroplasty procedures. Not only that but the specific set ups – patient position, setting up traction tables, the C-arm positioning, the anaesthetic considerations, even the leg pumps and DVT prophylaxis which would be completely new practices to implement if my own setting were to introduce such operations.

One of the main takeaways for me is that – doing arthroplasty was possible. With a very limited concept of it, now having seen the surgery being performed, I, at least have a general sense of what needs to be implemented to accomplish this level of surgery in my own setting. Which I believe is an achievable goal.

Recommendations

The two week observership period in my opinion is great. It gave me enough time to get a good understanding of the day to day work flow.

It was also ample time to really settle in and become comfortable in participating and interacting more especially in theatre.

The advantage with having a fellow PIOA member who previously did attachment in Tauranga (Shaun and Areta) and having Naseri currently there also played a large part in it being more enjoyable as well as much easier to integrate with the team.

Apart from this maybe the only recommendation I can suggest is maybe future observership can be made to coincide with the local New Zealand Orthopaedic (junior) Registrar Training week programme. Maybe that can give PIOA students further insight into the NZ orthopaedic programme and help bridge the two training programmes.

But again, this suggestion is just in addition to what's already a 3-week programme already packed with activities.

Dr Thomas Kiele
Orthopacifix Pacific Islands Ambassador 2022

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NZ Artificial Limb Services Report

Peke Waihanga's new state-of-the-art $6m centre in Christchurch had its official opening in June 2023.

Sean Gray
Chief Executive Officer

Peke Waihanga's new state-of-the-art $6m centre in Christchurch had its official opening in June 2023.

Located near Burwood Hospital, the centre in Christchurch replaces the old one which Peke Waihanga Board Chair George Reedy describes as being "no longer fit for purpose" and that a facility was required that was "empowering and one that the people we care for deserve".

A feature of the new building is the stylised tree in the reception area. Peke Waihanga Cultural Advisor Ken Te Tau says the tree represents the legend of Tane Mahuta who, through his persistence and determination, provides inspiration for amputees because he boldly and bravely "pushed onwards and upwards to allow light into the world and lifeforms to flourish". It also represents Peke Waihanga determination to "move heaven and earth to support our amputees and patient community to achieve independent and productive lives".

Board Chair Mr Reedy commended the Government for funding the centre saying that regionally the centre is part of the ongoing revitalisation of the community and nationally it sends a positive message to amputees and whānau needing orthotic support. "The services we provide are world class and now we have the building that says that too," he says.

Local amputee Mark Bruce says the "purpose-built centre will positively change service delivery for amputees" especially since it has been built with design input from both staff and amputees ensuring it has a user-focus.

Peke Waihanga physiotherapist Kate May says patients are really enjoying the centre's warm and modern space. "We often hear 'wow' from the patients when they walk in and see the tree and the reception area. As a health professional it's a lovely space to work," she says.

Inequity in Prosthetic Service Funding

We are observing an increased level of frustration within the amputee community due to the ongoing inequity in prosthetic services and the funding for our national contracts. In 2022 Te Whatu Ora[1] amputees got 47% less technology and services than ACC[2] amputees with the same need.

This is difficult for our clinicians to manage as they believe in many cases an improved prescription and service could deliver substantially better outcomes. This challenge is further complicated, as in reception and clinical spaces we have these amputees sitting next to each other, specifically they can see the inequity right in front of them every day.

Note: this situation creates and contributes to Health and Safety issues for Peke Waihanga.

For example, the following are risks from our Health and Safety register:

Risk Identified	Risk Category	Potential Harm	Controls
Increased risk of patient falls when we cannot prescribe an optimum device e.g. microprocessor knee for above knee amputees, due to funding limitations	Frequent risk (people are exposed frequent or for long durations).	Patient suffers injury or further disablement; Patient unable to work due to immobility; Mental health issues; leading to substance abuse/self-harm or suicide; Patient gets angry and abusive to staff.	Rehabilitation services provided to ensure patient can safely use their prescribed device.Ongoing contract negotiations in an effort to improve prescription.

Sean Gray
Chief Executive Officer

1. Te Whatu Ora amputees including diabetes and vascular (amputee services are prescribed from a bulk funded amount for all, which is insufficient to meet actual need).
2. ACC (amputee services are prescribed based on needs).

Tributes to Past Members

Denis King

24 February 1930 – 4 July 2023

It was with great sadness that Denis' wife Joan recently informed me of Denis' recent passing after a battle he had with malignancy. Denis was 93 years old and had lived in the Tauranga area for a good number of years. He was courageous to write his own obituary which he has specifically requested was sent to the NZOA and I understand it will be included in the proceedings of the AGM later in the year.

My earliest contacts with Denis were through my time at Middlemore Hospital as a Registrar when Denis was part of the team structure at the hospital maintaining probably the busiest acute day of the week being Thursday. My clear recall of Denis has been what a gentleman he always was, being very polite and somewhat quietly spoken, and these qualities persisted right through his retirement years.

As you will note he had many and varied interests outside of orthopaedics including his work with art and in various sporting pursuits. The 1960's at Middlemore saw the commencement of the modern regime of hip and knee joint replacement and Denis was instrumental in being part of that revolution at the time.

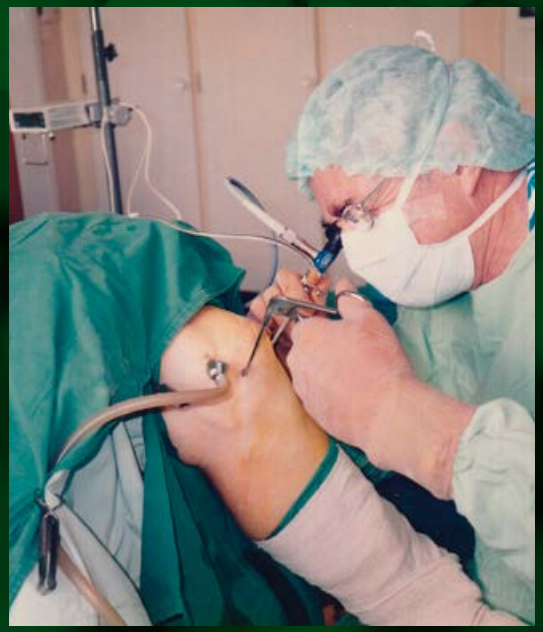
Those of us who were about in that era will recall the plaster room based adjacent to the operating theatre suite at Middlemore, to have a considerable list of patients belonging to each team on their particular day, having total contact casts for their tibial fractures, this mode of treatment pre-dated the evolution of intramedullary nailing for fractures of the tibia.

My more recent contacts with Denis have been largely through his wife Joan who in herself has put up with a number of medical issues and throughout Denis has been very supportive of and well supported by Joan. On meeting with Joan through a number of appointments, Denis appeared to have read up on the condition so his mind clearly was active throughout his latter years.

The photograph of Denis at work doing an arthroscopic knee procedure is also a reminder that he was very instrumental in the early development of arthroscopic surgery at Middlemore and I would guess in his private practice.

Denis was very keen that his obituary would be forwarded to the NZOA and I am grateful for Andrea including this in the newsletter. I am sure many of you reading this will have fond memories of Denis and indeed our hearts would go out to his wife Joan and their families.

Acknowledgement: *Bryan Thorn*
Orthopaedic Surgeon



Denis King "on his last leg!!"

Tributes to Past Members

Denis King Obituary

Born 24.2.30 in Palmerston North – Parents – Father Cyril King Surgeon at Palmerston North Hospital and Mother Rena King and Registered Nurse. A sister Robin Mary was born in 1932. Early education was by home schooling together with younger sister then Huntly Preparatory School Martin 1940–42 and Whanganui Collegiate School 1943–47 where active in athletics and swimming and a member of the 1st XV. Form 6 prize awarded in 1947.

Mother passed away in 1942 and father remarried in 1944. A son Christopher was born in 1945. From 1937 family holidays were usually at the bach in Taupo with introduction to swimming, boating and trout fishing.

In 1948 passed the medical intermediate exam and was accepted into the Otago Medical School. Member of the University rowing 8 and qualified MBChb in 1954. Travel between Palmerston North and Dunedin was mainly by motorcycle and ferry and most vacations spent working in manual unskilled jobs. Then two years 1954 and 1955 spent working as a House Surgeon at Palmerston North hospital.

Early in 1956 travelled to the UK to pursue further medical studies as Ships Medical Officer on the MV Imperial Star. There over a 5-year period and worked as a Casualty Officer or Surgical Registrar in a number of London hospitals and obtain fellowships of the Royal College of Surgeons of Edinburgh and England. Met and married Norma Cook a Registered Nurse from New Zealand and lived for much of the time close to Hampstead. A daughter Amanda was born shortly before returning to New Zealand in 1960 to take up the position of full time Orthopaedic Surgeon at Middlemore hospital, Auckland. A second daughter Diana was born in 1961. Unfortunately my wife Norma became unwell with numerous admissions to hospital. Became a part time Orthopaedic Surgeon at Middlemore and entered private practice in Auckland in 1966. Passed the examination for the Royal Australian College of Surgeons in 1962. Read many papers in scientific meetings and published in surgical journals. Offices held included President of the Auckland Orthopaedic Society and Editorial Secretary of the New Zealand Orthopaedic Association. Norma passed away in 1970 and later Amanda developed a serious mental illness and tragically took her own life in 1981 at the age of 20. Diana took a 3-year course in legal studies and became a legal executive. She has remained in full time employment with a legal firm in Auckland. Continued in private practice and at Middlemore hospital being involved in the introduction of hip and knee replacement surgery, arthroscopic menisectomy and below knee total contact casting for tibial fractures.

In 1982 I met Joan (nee Pettman) originally from the UK, became engaged and married in 1984 in the UK, staying with Joan's parents in Billericay. Then lived in Meadowbank Auckland while continued working at Middlemore and in private practice with Joan as receptionist. Resigned from position at Middlemore in 1987 and travelled to Saudi Arabia with Joan and we both worked at a hospital in the Asir Province for 18 months enjoying particularly trips to the Red Sea coast for camping, swimming and snorkelling often with friends. Returned to New Zealand to take up a position at Gisborne hospital and in private practice there until 1990. Then moved to Rotorua living on the northern shore of the lake. From there after a trip to the South Island took up a position as part time visiting Orthopaedic Surgeon at Whakatane hospital. During this time enjoyed several overseas trips and Pacific Island holidays. From 1995 four years did part time work for a medico legal firm in Australia which involved travel along the East coast from Cairns, Sydney and Melbourne to Tasmania.

We moved to Lake Tarawera and had a new home built by the lake where we established our own Art Gallery and Handcraft centre. Was able to expand a long term interest in Art and painting with inspiration from the local scenery and did painting trips to the Coromandel and South Island becoming a well-known landscape artist with paintings in several galleries. I also took part in Art displays and markets with Joan in her work as a card designer.

At Tarawera other main interests included gardening, tramping, trout fishing and entertaining many visitors. In 2004 moved to a lifestyle block in Rotorua being able to continue with many interests and activities despite health issues which included prostate cancer. In 2010 moved with Joan to a residence close to the beach in Papamoa, Tauranga.

Survived by my wife Joan, my daughter Diana and my brother Christopher (Kester). Robin (my sister) passed away 2021 after a long illness.

NZOA Council & Committees: Composition

NZOA Council 2021 – 2023

President	Mr Haemish Crawford
First President Elect	Mr Simon Hadlow
Second President Elect	Mr Khalid Mohammed
Immediate Past President	Mr John McKie
Honorary Secretary	Mr Andrew Graydon (elected 2019)
Assistant Honorary Secretary	Mr Joe Baker (elected 2022)
Honorary Treasurer	Mr Angus Wickham (elected 2019)
Executive Committee	Mr Richard Peterson (elected 2019)
	Mr Stephen McChesney (elected 2019)
	Mr Jonny Sharr (elected 2021)
Small Centres Representative	Mr Andrew Meighan (elected 2020)
Editorial Secretary	Mr Gary Hooper (elected 2019)
Specialty Orthopaedic Training Board	Mr Tim Gregg (co-opted 2022)
Education Committee	Mr Dawson Muir (elected 2021)
CPD and Standards Committee	Mr Edward Yee (appointed 2015)
NZOA ACC & Third Party Liaison Committee	Mr Peter Robertson (co-opted 2022)
Ngā Rata Kōiwi Representative	Mr John Mutu-Grigg (appointed 2020)
LIONZ Representative	Ms Josie Sinclair (co-opted 2021)
Orthopaedic Representative to RACS Council	Mr Greg Witherow Australia Orthopaedic Association (elected 2016)
Chief Executive	Ms Andrea Pettett

Specialty Orthopaedic Training Board

Mr Tim Gregg (Chairperson) (appointed 2017)

Ms Dulia Daly (appointed 2021)

Dr Margy Pohl (appointed 2018)

Mr Andrew Graydon (elected 2019)

Mr Ken Te Tau (appointed 2018)

Professor Sue Stott (appointed 2021)

Mr Robert Rowan (appointed 2021)

Mr Dawson Muir (appointed 2017)

Mr David Bartle (co-opted 2019)

Ms Stephanie Van Dijck (co-opted 2021)

Mr John Mutu-Grigg (appointed 2022)

Ms Andrea Pettett (Chief Executive)

Ms Prue Elwood (Education & Training Manager)

Education Committee

Chairperson	Mr Dawson Muir (appointed 2021)
Education Secretary	Fiona Timms (appointed 2023)
Auckland	Mr Adam Dalgleish (appointed 2021)
	Mr Alpesh Patel (appointed 2023)
North Shore	Mr Dean Schluter (appointed 2020)
Whangarei	Mr Lyndon Bradley (appointed 2021)
Waikato	Mr Hamish Deverall (appointed 2021)
Hawkes Bay/Tauranga	Mr Ian Galley (appointed 2019)
Wellington/Hutt	Mr Roy Craig (appointed 2019)
Wellington	Mr Robert Rowan (appointed 2019)
Taranaki	Mr Salil Pandit (appointed 2021)
Christchurch	Mr Jonny Sharr (appointed 2021)
Dunedin	Mr David Gwynne-Jones (appointed 2021)

Invercargill	Mr Pierre Navarre (appointed 2021)
Smaller Centres Representative	Mr Martyn Sims - (appointed 2020)
Co-opted Female Representative	Ms Stephanie Van Dijck (co-opted 2021)
Ngā Rata Kōiwi Representative	Mr John Mutu Grigg (co-opted 2021)
Chief Executive	Ms Andrea Pettett
Education & Training Manager	Ms Prue Elwood

Continuing Professional Development and Standards Committee

Mr Edward Yee (Chairperson) (appointed 2015)

Mr Michael Flint (appointed 2023)

Mr Julian Ballance (PVP Chair) (appointed 2018)

Mr Richard Lander (appointed 2015)

Mr Grant Kiddle (appointed 2019)

Ms Andrea Pettett (Chief Executive)

Ms Bernice O'Brien (CPD and PVP Coordinator)

NZOA ACC & Third Party Liaison Committee

Mr Peter Robertson (Chairperson – 2022) (appointed 2015)

Mr Bruce Twaddle (appointed 2021)

Mr Alex Malone (appointed 2021)

Mr Tony Danesh-Clough (appointed 2022)

Mr Warren Leigh (appointed 2022)

Mr Sandeep Patel (appointed 2021)

Mr Antony Field (appointed 2023)

Mr John McKie – Presidential Line Representative (appointed 2021)

Ms Andrea Pettett (Chief Executive)

Membership Committee

Mr Andrew Graydon (Chairperson) (appointed 2019)

Mr Dawson Muir (Chair of Education Committee) (appointed 2021)

Mr John McKie (Past President) (appointed 2022))

Ms Andrea Pettett (Chief Executive)

NZOA Related & Associated Entities: Composition

NZOA Trust

Mr Richard Street (Chairperson) (appointed 2018)

Mr Andrew Oakley (appointed 2019)

Mr Simon Dempsey (appointed 2019)

Mr Andrew Graydon (NZOA Hon Secretary) (elected 2019)

Mr Angus Wickham (NZOA Hon Treasurer) (elected 2019)

Mr Wayne Hughes (Independent Trustee) (appointed 2019)

Ms Andrea Pettett (Chief Executive)

Wishbone Orthopaedic Research Foundation Trust

Sir Bryan Williams (Patron) (appointed 2013)

Mr Richard Keddell (Chairperson appointed 2019) (appointed 2011)

Mr Andrew Graydon (NZOA Hon Secretary) (elected 2019)

Mr Angus Wickham (NZOA Hon Treasurer) (elected 2019)

Mr Haemish Crawford (appointed 2016)

Dr Helen Tobin (appointed 2016)

Ms Andrea Pettett (Chief Executive)

Wishbone Orthopaedic Research Committee

Professor Gary Hooper (Chairperson elected 2019) (appointed 2008)

Mr Angus Wickham (NZOA Hon Treasurer) (elected 2019)

Mr Paul Monk (appointed 2019)

Assoc Prof David Gwynne-Jones (appointed 2015)

Professor Sue Stott (appointed 2016)

Mr Dawson Muir (appointed 2018)

Ms Andrea Pettett (Chief Executive)

NZOA Joint Registry Trust Board

Prof Gary Hooper (Chairperson) (appointed 2018)

Mr Angus Wickham (NZOA Hon Treasurer) (elected 2019)

Mr Andrew Graydon (NZOA Honorary Secretary (elected 2019)

Mr Rod Maxwell (appointed 2018)

Mr Richard Keddell (appointed 2018)

Ms Andrea Pettett (Chief Executive)

NZOA Joint Registry Management Committee

Mr John McKie (Supervisor) (appointed 2018)

Mr Simon Young (appointed 2016)

Mr Peter Devane (appointed 2008)

Mr Andrew Graydon (elected 2019)

Mr Matt Debenham (appointed 2021)

Mr Brendan Coleman (appointed 2017)

Prof Chris Frampton (appointed 2017)

Mr Tony Lamberton (appointed 2019)

Mr Vaughan Poutawera (appointed 2021)

Mr Hugh Griffin (appointed 2010)

Mr Philip Kearney (Arthritis NZ) (appointed 2020)

Dr Jinny Willis (Coordinator)

Ms Andrea Pettett (Chief Executive)

Hip Fracture Registry Trust

Mr Mark Wright (Chairperson - appointed 2019) (appointed 2016)

Ms Sarah Hurring (appointed 2020)

Mr Roger Harris (appointed 2016)

Ms Helen Tobin (appointed 2019)

Ms Andrea Pettett (Chief Executive)

Hip Fracture Registry Implementation Committee

Mr Mark Wright – Co-Chair Implementation Committee and Chair of Hip Fracture Registry Trust (appointed 2016)

Mr Roger Harris – Co-Chair Implementation Committee, ANZHFR Board & Fracture Registry Clinical Lead (appointed 2015)

Ms Sarah Hurring – CDHB & ANZHFR Clinical Lead (appointed 2020)

Ms Min Yee Seow – ANZSGM/WDHB (appointed 2020)

Mr Pierre Navarre – NZOA Orthopod Southland DHB (appointed 2021)

Ms Kim Ferguson – FLNNZ (appointed 2019)

Ms Colleen Dunne – MOH (appointed 2021)

Mr Harminder Gill – ACC (appointed 2023)

Ms Caroline Juniot – ACC (appointed 2022)

Ms Leona Dann – HQSC (appointed 2021)

Ms Christine Gill – Osteoporosis NZ (appointed 2015)

Mr Stewart Fleming – SO3 IT Consulting (appointed 2015)

Ms Jenny Sincock – Orthogeriatrics Nurse CDHB (appointed 2019)

Ms Rebbecca Lilley – Research Otago University (appointed 2019)

Ms Jessie Snowdon – Physiotherapy NZ (appointed 2019)

Ms Sharon Russell – New Physiotherapy NZ Rep (appointed 2023)

Ms Caroline Miller – Consumer Representative (appointed 2021)

Ms Ngarangi Naden – Consumer Representative (appointed 2021)

Mr Vaughan Poutawera – NZOA Ngā Rata Kōiwi (appointed 2021)

Mr Frazer Anderson – Geriatrician Northland and Fragility Fracture Registry Liaison Clinical Lead (appointed 2023)

Ms Bridget Kerkin – Te Whatu Ora (appointed 2023)

Ms Andrea Pettett (Chief Executive) – NZ Orthopaedic Association

Ms Nicola Ward (National Coordinator) (appointed 2019)

NZOA Health Technology Committee

Mr Mark Clatworthy (Chairperson - appointed 2023) (appointed 2021)

Mr Michael Flint (appointed 2021)

Mr Nicholas Lash (appointed 2021)

Mr Paul Monk (appointed 2021)

Mr John Scanelli (appointed 2021)

Mr Matthew Walker (appointed 2021)

Mr Marc Hirner (appointed 2021)

Mr Anand Segar (appointed 2023)

Mr Chris Birks (appointed 2023)

Mr Allen Cockfield (appointed 2023)

Orthopaedic Representative to RACS Council

Mr Greg Witherow – Orthopaedic Surgeon from Australian Orthopaedic Association (appointed 2016)

NZ Artificial Limb Services Board (appointed by the Assoc Minister of Health)

John McKie (appointed March 2023)

The Inaugural Meeting

The inaugural meeting held in Wellington on 17 February 1950 decided to form the New Zealand Orthopaedic Association. The first Annual General Meeting was held in Christchurch on 20 September 1950. Mr Renfrew White was made Patron.

The following is a list of Foundation Members:

Mr M Axford
Mr G C Jennings
Mr R Blunden
Dr G A Q Lennane
Mr J K Cunninghame
Mr A MacDonald
Mr R H Dawson
Mr S B Morris
Mr J K Elliott
Mr G Williams
Mr H W Fitzgerald
Mr J L Will
Sir Alexander Gillies

Past Presidents of the New Zealand Orthopaedic Association

1950-51	Sir Alexander Gillies
1952-53	Mr J L Will
1954-55	Mr M Axford
1956-57	Mr H W Fitzgerald
1958-59	Mr A A MacDonald
1960-61	Mr J K Elliott
1962-63	Mr R Blunden
1964-65	Mr W Parke
1966	Mr R H Dawson
1967	Mr W Parke
1968-69	Prof A J Alldred
1970-71	Mr B M Hay
1972-73	Mr J R Kirker
1974-75	Mr H G Smith
1976-77	Mr W A Liddell
1978-79	Mr A B MacKenzie
1980-81	Mr P Grayson
1982-83	Mr O R Nicholson
1984-85	Mr C H Hooker
1986-87	Mr G F Lamb
1988-89	Mr V D Hadlow
1990-91	Mr P D G Wilson
1991-92	Mr J C Cullen
1992-93	Mr J D P Hopkins
1993-94	Professor A K Jeffery
1994-95	Mr C J Bossley
1995-96	Mr G F Farr
1996-97	Professor A G Rothwell
1997-98	Professor D H Gray
1998-99	Mr A L Panting
1999-00	Mr M C Sanderson
2000-01	Mr G D Tregonning
2001-02	Mr A E Hardy
2002-03	Professor J G Horne
2003-04	Mr B R Tietjens
2004-05	Mr R O Nicol
2005-06	Mr R J Tregonning
2006-07	Mr M R Fosbender
2007-08	Mr J Matheson
2008-09	Mr D R Atkinson
2009-10	Mr J A Calder
2010-11	Assoc Prof G J Hooper
2011-12	Mr B J Thorn
2012-13	Mr R O Lander
2013-14	Mr M S Wright
2014-15	Mr Brett Krause
2015-16	Prof Jean-Claude Theis
2016-17	Mr Richard Keddell
2017-18	Mr Richard Street
2018-19	Mr Rod Maxwell
2019-20	Mr Peter Robertson
2020-21	Mr Peter Devane
2021-22	Mr John McKie

Compendium of Awards

Gillies Medal Recipients

1965	Prof A J Alldred
1966	Mr G B Smaill
1969	Prof A J Alldred
1971	Mr O R Nicholson
1974	Mr H B C Milson
1974	Mr S M Cameron
1977	Mr V D Hadlow
1978	Mr C H Hooker
1979	Mr H E G Stevens
1980	Prof D H Gray
1982	Mr A W Beasley
1993	Dr N S Stott
2001	Mr S J Walsh
2008	Assoc Prof Sue Stott
2009	Mr O R Nicholson
2016	Tim Lynskey

ABC Fellows

1956	Mr O R Nicholson
1962	Mr J B Morris
1968	Mr A R McKenzie
1972	Prof A K Jeffery
1976	Prof D H Gray
1980	Prof A G Rothwell
1982	Mr A E Hardy
1984	Mr B R Tietjens
1986	Mr A J Thurston
1988	Mr R O Nicol
1990	Mr G J Hooper
1994	Mr M J Barnes
1996	Mr P A Robertson
1998	Mr P A Devane
2000	Mr K D Mohammed
2002	Mr H A Crawford
2004	Mr C M Ball
2006	Mr M M Hanlon
2008	Mr P C Poon
2010	Mr D C W Muir
2012	Mr G P Beadel
2014	Mr B Coleman
2016	Mr Andrew Graydon
2018	Mr Michael Rosenfeldt
2022	Mr Joe Baker

President's Award

2005	Professor Alastair Rothwell
2006	Mr David Clews & Mr Allan Panting
2007	Professor Keith Jeffery
2008	Mr Chris Dawe & Mr John Cullen
2009	Mr Ross Nicholson
2011	Christchurch Orthopaedic Surgeons
2012	Mr Richard Street
2013	Mr Kevin Karpik
2014	Mr Richard Lander
2015	Mr Tim Lynskey
2016	Mr James Burn
2017	Professor Alastair Rothwell
2019	Mr Edward Yee
2022	Mr Chris Hoffman
2023	Mr Michael Barnes

Hong Kong Young Ambassador

1993	Alastair Hadlow
1994	Peter Devane
1995	Peter Devane
1996	Stewart Hardy
1997	Kevin Karpik
1998	Geoff Coldham
1999	Hugh Blackley
2000	Matthew Tomlinson
2001	David Gwynne-Jones
2002	Terri Bidwell
2003	Ian Galley
2004	Perry Turner
2005	Angus Don
2010	John Ferguson
2011	Vaughan Poutawera
2012	Matthew Debenham
2013	Alpesh Patel
2014	Phillip Insull
2015	Godwin Choy
2017	David Bartle
2018	Michael Wyatt
2019	Matthew Boyle
2023	Ryan Gao

ASEAN Fellowship

2013	Prof Jean-Claude Theis
2015	Mr Richard Lander
2017	Warren Leigh
2019	Rupesh Puna

Korean Orthopaedic Association Travelling Fellow

2018	Seung-Min Youn
2023	Anand Segar

ANZAC Travelling Fellow

2016	David Kieser and Jillian Lee
2017	Hogan Yeung

ANZAC Fellow

2016	Simon Young

Trans-Tasman Fellow

2019	Anthony Maher
2023	Mustafa Saffi

ESR Hughes Award – RACS

2015	Chris Dawe
2017	John Matheson
2019	Peter Robertson

The Mary Roberts BMW Award

2021	Bruce Hodgson
2022	Dr Tim Woodfield

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Awards and Memorabilia of the NZOA

Presidential Jewel

The jewel of the office is worn by the President at meetings of the New Zealand Orthopaedic Association and on other official occasions. It was presented to the Association by Her Majesty Queen Elizabeth, the Queen Mother, at the Combined Meeting of the English Speaking Orthopaedic Associations in London in 1952. In view of the intrinsic value of this jewel a replica is worn by the President when attending meetings overseas.

Replica of Presidential Jewel - made by Leslie Durbin who created the original - donated in 1987 by Mr & Mrs G F Lamb.

Presidential Miniatures

Miniature jewels are worn by the Past Presidents. These are made from a die prepared from the American Orthopaedic Association's Presidential jewel and are presented to the President at the end of his terms of office.

President's Wife's Brooch

A brooch modelled on the tree of Andre is worn by the wife of the President during their term of office. This brooch is kept to be worn at future events.

Sterling Silver Bleeding Bowl

This was presented by the British Orthopaedic Association on the occasion of the Pre-Conference Meeting in Auckland before the Fifth Combined Meeting of the English Speaking Orthopaedic Associations in Sydney in 1970.

Sterling Silver Paul Revere Jug

This was presented by the American Orthopaedic Association on the occasion of the Pre-Conference Meeting in Auckland before the Fifth Combined Meeting of the English Speaking Orthopaedic Associations in Sydney in 1970.

Minute Book

This was presented by the Canadian Orthopaedic Association on the occasion of the Pre-Conference Meeting in Auckland before the Fifth Combined Meeting of the English Speaking Orthopaedic Associations in Sydney in 1970.

London Emblem

This symbolic sculpture of the tree of Andre was presented by the British Orthopaedic Association to each of the Presidents of the Associations at the Sixth Combined Meeting of the English Speaking Orthopaedic Associations in London in 1976.

Wall Tapestry

This was presented by the South African Orthopaedic Association on the occasion of the Seventh Combined Meeting of the English Speaking Orthopaedic Associations in Cape Town in 1982. This measures approximately 1.5 x 2m in size and represents the jewel of office of the Association.

Sterling Silver Salver

A sterling silver salver was presented to the Association by Dr and Mrs Leonard Marmor in 1973 when Dr Marmor was guest speaker at the Annual Meeting.

Gavel

This was made by Mr R Blunden (President 1962-63) and presented by him at the Annual General Meeting in 1977.

New Zealand Orthopaedic Association Golf Cup

This was presented to the Association by Sir Alexander Gillies (President 1950-52) for annual competition.

Kirker Salver

This was presented by Mr J R Kirker (President 1972-73) as a trophy for the winner of the annual Ladies Golf Competition.

Thomson Memorial Trophy

This was presented by Mrs E H Thomson in 1983 to be presented annually to the winner of the Trout Fishing competition.

Hadlow Trophy for Tennis

This was presented by Victor and Cécile Hadlow in 1989 at the conclusion of two years as President of NZOA and is competed for at the Annual Scientific Meeting and presented to the winner of the Tennis Competition in the format the meeting organizers arrange.

Black and White Paintings (x 4) by Ansel Adams

These were presented by the American Orthopaedic Association on the occasion of the 10th Combined Meeting of the English Speaking Orthopaedic Associations in Auckland during February 1998.

Harold Lane Painting

This was presented by the Australian Orthopaedic Association on the occasion of the 10th Combined Meeting of the English Speaking Orthopaedic Associations in Auckland during February 1998.

Silver Bowl - Scottish Quaich

This was presented by the British Orthopaedic Association on the occasion of the 10th Combined Meeting of the English Speaking Orthopaedic Associations in Auckland during February 1998.

Wood Carving

This was presented by the South African Orthopaedic Association on the occasion of the 10th Combined Meeting of the English Speaking Orthopaedic Associations in Auckland during February 1998.

Wood Tapestry - Kokanee

This was presented by the Canadian Orthopaedic Association on the occasion of the 10th Combined Meeting of the English Speaking Orthopaedic Associations in Auckland during February 1998.

Wood Tapestry - High Air Selkirks

This tapestry was presented by the Canadian Orthopaedic Foundation on the occasion of the 10th Combined Meeting of the English Speaking Orthopaedic Associations in Auckland during February 1998.

Old Bison Bone

The Old Bison Bone was presented by the American Academy of Orthopaedic Surgeons on the occasion of the 10th Combined Meeting of the English Speaking Orthopaedic Associations in Auckland during February 1998.

Pounamu Mere

The Pounamu Mere was donated to the NZOA in 2016 by Prof Jean-Claude Theis and his wife Virginia in recognition of their Presidential year. It is to be handed over by the outgoing President to the incoming one at the time of the transfer of the Jewel of Office. A Mere symbolises the authority of a Maori Chief and it is appropriate to recognise the New Zealand Maori culture as an integral part of our Association.

NZOA Annual Scientific Meeting Awards

Sir Alexander Gillies Medal

This medal was presented to the Association in 1964 by the New Zealand Crippled Children's Society in recognition of the work of Sir Alexander Gillies. The Gillies Medal is presented to the author of the best paper presented at the NZOA Annual Scientific Meeting on crippling conditions of childhood. The Paper should be substantially the work of the person presenting the paper although some outside assistance is permissible. The Paper must be read at the Annual Scientific Meeting.

Trainee Prizes (Funded by the NZOA Trust)

- Presidents Prize for Best Overall Trainee
- Research Prize for Best Research for a final year Trainee

David Simpson Award

– for best exhibit at ASM Industry Exhibition

Trainee Awards

2009	**Michael Rosenfeldt**, Best Scientific Paper
2009	**Simon Young**, Paper of Excellence at the ASM
2009	**Andrew Graydon**, President's Prize
2009	**Jacob Munro**, Research Prize
2010	**Albert Yoon**, President's Prize
2010	**Fraser Taylor**, Research Prize
2011	**Simon Young**, Research Prize
2011	**Nicholas Lash & Simon Young**, Joint President's Prize
2012	**Matthew Boyle**, Research Prize and President's Prize
2013	**Stephanie van Dijck**, President's Prize
2014	**Nicholas Gormack**, President's Prize
2015	**Gordon Burgess**, President's Prize
2015	**Rupesh Puna**, Research Prize
2016	**David Keiser**, President's Prize and Research Prize
2017	**Tom Inglis**, President's Prize
2018	**Paul Phillips**, President's Prize
2018	**Neal Singleton**, Research Prize
2019	**Matthew Street & Carrie Lobb**, Joint President's Prize
2020	**Otis Shirley**, President's Prize
2020	**Lizzie Bond**, Research Prize
2021	**Tim Roberts**, President's Prize
2021	**Ryan Gao**, Research Prize
2022	**Matt Fisk**, President's Prize

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