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Anaesthesia
THE MAGAZINE OF THE NEW ZEALAND SOCIETY OF ANAESTHETISTS • DECEMBER 2020

New NZSA President

NZSA 2020 Conference coverage

PLUS:

COVID-19 - values, behaviour and lessons learnt

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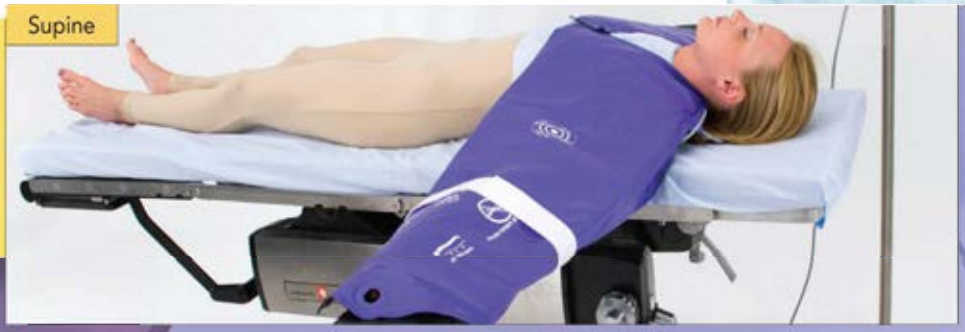

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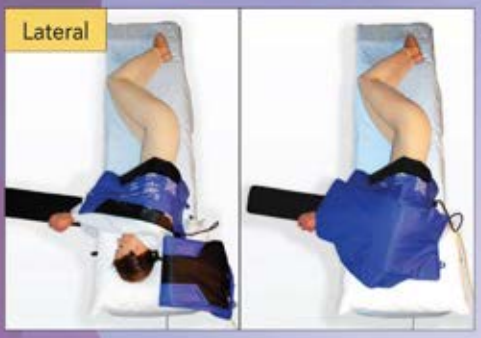

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President's column

DECEMBER 2020

So here it is, my first President's column! Taking on the role of President at our AGM in October was in the pipeline for some time, even so it still feels a little surreal that the time is now.

I have been on the NZSA Executive Committee since 2015, and early on the President at that time, Dr David Kibblewhite, was very keen to have a succession plan. His plan has come to fruition and I think it has been a great strategy to strengthen the society. I'd like to thank David for that foresight, and his hardwork over his three year term. And then of course, Dr Kathryn Hagen, who held the reigns for the last two years. Her organisation and focus have added to the growth of our Society and we now have a sound membership platform, which is fantastic, especially as most membership based societies like ours are struggling to maintain their membership numbers.

As we fast approach the end of the year and reflect, the words I have heard most often to describe 2020 are – uncertain, unpredictable, unprecedented, and tumultuous. While this was especially the case for those on the frontline of health, no one was unaffected by the COVID pandemic.

I thank our Executive Committee, subcommittees, and networks, as well as our staff, for their commitment to our anaesthesia community. This commitment and hard work enabled us to sustain the momentum of building a strong, connected anaesthesia community. Our NZSA Conference is just one notable example of this commitment – even through the uncertainty of lockdown levels and case numbers, and not being sure what the future held, members of our Executive Committee stepped up to offer our members a conference experience (well aware that they only had four months to turn it around). The reasons for forging ahead were twofold: to give members an opportunity to gather CME points in a year where CME options were seriously curtailed; and more importantly to give anaesthetists and the wider anaesthesia community the opportunity to meet up. These objectives aligned strongly with the NZSA's wider strategic goals of supporting the profession and building a connected community. I thank them for their sterling effort.

We have seen steady NZSA membership growth

In such a disruptive year, I am proud of the NZSA's progress across our three pillars of work – advocacy, community, and education. We advocated on COVID issues to the Health Minister and the Ministry of Health, continued, and in some cases increased the frequency of our sub-specialty network meetings, and kept members informed of COVID news and research.

We have seen steady NZSA membership growth, which I think can in part be attributed to our ongoing engagement – especially through our sub-specialty networks, and hospital department visits. The latter enabled our Executive Committee to speak to colleagues about the value of being a member and supporting the distinct, and integral role that the NZSA has as an independent voice on issues unique to New Zealand anaesthesia.

Here is a snapshot summary of some of our key work and achievements through 2020.

Advocacy

COVID has shaken the foundations of our globalised world and shown us that we need to change how we do things to ensure human survival; the status quo is no longer an option and we recognise there needs to be a new normal. This year we asked ourselves, how can we contribute to the new normal?

Our advocacy provides a strong collective voice, which is evidence based and considered. This was arguably never more apparent than this year. We continued to strengthen our relationships with ACC, the NZ Private Surgical Hospitals Association, and the Health Ministry. We look forward to communicating our advocacy work to the new Minister of Health Andrew Little in the coming months. We assisted the Ministry of Health through the initial phase of the COVID response and liaised with health officials over the uncoordinated procurement and distribution of Personal Protective Equipment (PPE). We were also in regular contact with PHARMAC on supply of core anaesthesia drugs and will continue to engage with them on their medical devices procurement project as they seek expert advice. PHARMAC presented to our Executive meeting in November, providing an update on the plan to manage medical devices. The bones of the plan are still the same, but of course the landscape that this may be applied to will change as the Simpson report recommendations are implemented.

This was a quieter year for submissions, however we provided input on issues such as professional behaviour of doctors, medicinal cannabis, anaesthesia assistant shortages and training (an area where we are working within a large stakeholder grouping led by the government agency TAS), and proposed changes to RMO training start dates.

The NZSA supports anaesthetists working in the private sector. In addition to our stakeholder meetings we provide updates, and resources to members on issues relevant to private practice. In the latter half of this year we made good progress on our revision of the Relative Value Guide and also released an introductory guide to working in private practice.

Community:

Fostering and supporting a strong anaesthesia community is integral to the NZSA's vision and mission. Our subspecialty networks have raised their profile, and there is growing recognition of their value to individual practitioners, the Society and patient care. They are a forum for the dissemination of ideas, protocols, guidelines, and evidence-based medicine. We have PANNZ (paediatrics), NOA (obstetrics), airway leads, private practice and the Global Health Committee (formerly NZSA Overseas Aid Committee). In the last year we formed and supported the formation of new networks, the Environmental and Sustainability Network and the Inpatient Acute Pain Network. Our networks met frequently during COVID to share information e.g. what level of PPE we should be wearing in droplet or airborne precautions for labouring women.

Our networks are a way of connecting newly qualified and more experienced anaesthetists which creates the opportunity for the retention of institutional knowledge and less reinvention of the wheel – meaning more initiatives are likely to succeed.

We have strong global connections with our overseas society counterparts – particularly through the Common Issues Group (CIG). We met regularly with the CIG this year and shared our experiences of COVID, and resources such as webinars, which we made available to members. Our involvement in the WFSA was further strengthened with the election of Dr Wayne Morriss as WFSA President elect, and the successful candidacies of Dr Sue Nicoll (wellbeing committee) and Dr Indu Kapoor (paediatrics committee).

Supporting the wellbeing of anaesthetists remains a priority and it has been a tough year placing many of us under more stress. Wellbeing is a complex and challenging issue, however we continue to work towards improving understanding of mental ill health triggers (individual and systemic), and to provide support e.g. Long Lives, Healthy Workplaces resource, tailored to NZ anaesthesia departments.

Our trainees have been ably supported by our trainee representatives in such an uncertain year of exam changes. We had an excellent response from trainees who attended the social function after the Part 3 course we hosted, as they appreciated the opportunity to socialise and touch base, and NZSA has continued to support trainee events such as the Annual Registrars' Meeting.

Our Global Health Committee supported our Pacific colleagues and launched a new initiative seeking the support of all NZSA members to fund trainees in the Pacific – the equivalent of donating just one coffee a week to help us achieve a sustainable anaesthesia workforce in the Pacific (learn more at https://anaesthesia.nz/community/global-health-committee/donation/). I know that under the helm of Dr Indu Kapoor the GHC has many other plans for 2021 (e.g. locum support) to build on the assistance we offer our Pacific colleagues.

Education:

In 2020 many of our educational offerings, such as the Combined Scientific Congress and AQUA, were either cancelled or postponed. However, many of us took part in webinars and other online offerings. Our NZSA conference was obviously a highlight, which included a mini Part 3 course as part of the workshops program. As the magazine goes to print, many of us are travelling to Queenstown to attend AQUA, which fortunately is going ahead this month, having been postponed from when it is usually held in August. Another great opportunity for CME and meeting up with colleagues – and the skiing part of AQUA has been replaced with other adventurous endeavours such as mountain biking.

We now look forward to 2021's Annual Scientific Meeting with ANZCA NZNC to be held in Christchurch. Certainly, an event to look forward to, and I hope to see many of you there!

Sheila Hart, NZSA President

The NZSA wishes members and health sector colleagues a very happy festive season. We hope you have an opportunity to enjoy a restful break with family and friends. It has been a tough year and many of us will no doubt be counting down to the holidays. With the summer weather and sun (we live in hope) enjoy New Zealand's majestic beauty whether on the beach, hiking trails or your own backyard.
Happy New Year and see you in 2021!

NZSA stakeholder function

The NZSA's biennial stakeholder function was a wonderful opportunity to connect and thank the organisations we work closely with to support our anaesthesia community and patients. In her speech to attendees, then NZSA President Dr Kathryn Hagen emphasised how fortunate we were to host a face-to-face event. Here is an abridged version of her speech.

"It has been a privilege to serve as President – but what a very different world we find ourselves in to the one we inhabited two years ago when I began my term. I recall in late 2018 asking our then President Dr David Kibblewhite, what his focus had been over his three-year term and he replied 'survival.' I now know what he means, although I did not expect my presidential term to coincide with such a literal threat to our survival!

The NZSA feels very grateful to have so many of the organisations and individuals here tonight, which we have worked with over so many years. There is strong collegiality, and genuine partnerships. It goes without saying that it has been a tough year and we appreciate the goodwill and generosity of spirit in sharing information and resources and being able to support each other.

Where does one begin to describe 2020? It has been a year of uncertainty and unpredictability, and it has led to considerable stress, especially for those on the frontline of health. We have stepped up admirably as a country and community in our response to COVID. Our organisations have been deeply committed to patient care and to our wider health system in incredibly challenging times. COVID has shaken the foundations of our globalised world and shown us that we need to change the way we do things to ensure human survival; the status quo is no longer an option and we recognise there needs to be a new normal. This year we all asked ourselves, how can we contribute to the new normal? As we forge ahead, working collectively will be more important than ever.

In terms of a connected health community working towards common goals for our patients and healthcare system, the relationships we have with organisations such as those here tonight are vital – and they are certainly enduring. Thank you for all your hard work this year. We are now better prepared, and may we not forget the lessons we have learnt in 2020."

From left: Medicines NZ CEO Graeme Jarvis, NZ Orthopaedic Association CEO Andrea Pettett, and Pharmacy Guild CEO Andrew Gaudin

From left: Medical Technologies Association of NZ CEO Faye Sumner and NZ Medical Association CEO Lesley Clarke

From left: Alastair Franklin, NZSA Executive Committee members Dr Renee Franklin and Dr Jonathan Panckhurst

From left: TAS Director of Workforce Services Alison Plumridge, NZSA CEO Renu Borst, NZ Anaesthetic Technicians' Society Chair Kirstin Fraser

From left: ASMS President Professor Murray Barclay, ASMS Director of Policy and Research Dr Charlotte Chambers, and ASMS Vice-President Dr Julian Fuller

From left: Chief Medical Officer Southern Cross Dr Stephen Child and Chief of Healthcare Partnerships Southern Cross Rebecca Ogilvie

New NZSA President Dr Sheila Hart

Building on the NZSA's steady rise in membership and continuing to strengthen New Zealand's anaesthesia community are key priorities for new NZSA President Dr Sheila Hart.

Dr Hart, who took over the Presidential role in October at our AGM, is a Consultant Anaesthetist at Capital and Coast DHB, and Deputy Clinical Director of the Anaesthesia and Pain Department at Wellington Hospital. She has represented the NZSA on various advocacy issues since joining the Executive five years ago and is currently a member of the NZSA's Airway Leads Network, and the Network's Secretary. She is also the co-convenor of the ASA/NZSA 2022 Combined Scientific Congress (planned for 2020 but postponed due to COVID).

Originally from the UK, Dr Hart came to New Zealand after completing her first year as an SHO at a time when she was feeling disillusioned with life as a medic. "I was unsure what my planned year in New Zealand would achieve, but I longed for a change of scene and a break from the low morale that seemed to plague the NHS. I hoped to rediscover my passion for medicine." What she did not expect, but her close friends predicted, was that she totally loved her new life in New Zealand.

Her first role in New Zealand was at Waikato Hospital with colleagues Scott Robinson and Cam Bennett, both anaesthesia trainees who at the time were doing their ICU run. "They were so passionate about anaesthesia that it inspired me and made me realise you could be happy in medicine if you found the right specialty." She secured an anaesthesia training position at Waikato and says she is grateful for the incredible training experience, which rekindled her enthusiasm for a career in anaesthesia.

After her time in Hamilton she arrived in Wellington, fell in love with the city and has lived here ever since. She describes the Wellington anaesthesia department as very collegial, however "the reality is that anaesthetists practise in relative isolation and to maintain wellbeing, whether in the face of professional or personal challenges, I think it's really important to be involved in supportive activities which provide face to face interaction such as education sessions and peer groups."

Keeping fit and active are also a big part of maintaining her own wellbeing, and Dr Hart is a keen cyclist. In a previous NZSA magazine, we profiled her Cape Reinga to Bluff 3000km cycling adventure!

She has since revisited some of the national cycle trails that were part of that trip. In future she is keen to walk some of the trails in New Zealand, exploring on two feet rather than two wheels. She is also a yoga enthusiast and has taken part in yoga retreats in New Zealand and overseas. Also keeping her busy is a new family member – adorable puppy Molly ("gorgeous").

From left: NZSA Immediate Past President Dr Kathryn Hagen, NZSA Past President Dr David Kibblewhite (2015-2018) and new NZSA President Dr Sheila Hart.

Dr Hart is excited about what the next two years will bring. "While the health sector has many challenges, the NZSA is a strong, connected organisation that is well placed to have influence, work collaboratively with others such as ANZCA NZNC, and raise the profile of anaesthesia.

"I think we will have an expanding role in perioperative medicine with a greater involvement in pre- and post-op care, and I think this is a good thing. Steering this within our specialty will be important.

In terms of our wider health system, the Health & Disability system review may lead to major structural changes such as in the composition and number of DHBs, however what came across most strongly in that review was the serious disparities in health outcomes and the need to improve health equity across groups such as Māori, Pacific and rural populations. This will be a major focus for our new Health Minister, and we are keen to have input in any way we can.

Additionally, PHARMAC's procurement of medical devices is a huge, complex, long-term project and we have provided input and will continue to engage as this work moves more from a high-level principles framework stage, to operational. They are looking to set up a range of sub-committees, and anaesthetists will need to be represented across a range of committees as befits the breadth of our roles across healthcare."

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1. Dr Peng (Paul) Wen, *Australasian Physical & Engineering Sciences in Medicine* 2012; 35, 389–392

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NZSA's 2020 conference

Dr David Kibblewhite
NZSA 2020 Conference Convenor

Emerge, Reflect and Reconnect certainly lived up to its name - an engaging and stimulating program to encourage delegates to reflect on what it means to be an anaesthetist in 2020 and beyond, and a rare opportunity in such an uncertain year to reconnect with colleagues. We also provided a virtual option, which was an opportune test run on how to offer an effective hybrid conference. We received many positive comments, in person and via social media and our survey. We thank attendees for all your support.

The dates of our conference coincided with some of the busiest of the 2020 calendar – on the first day of the conference (16 Oct) we marked World Anaesthesia Day, National Anaesthesia Day, Pink Shirt Day (anti-bullying), World Start a Heart Day and of course on 17 October our long-awaited General Election.

There are many to thank – my colleagues on the Organising Committee – Morgan Edwards, Renee Franklin, and Michael Ng, as well as office staff including NZSA Communications Manager Daphne Atkinson, for their hard work in turning around a conference in just four months. Your commitment delivered a superlative and diverse program (COVID, trauma, bias, culture, wellness, perioperative medicine and more) and a truly memorable #support local conference dinner.

Thank you also to those who contributed to our conference - especially our speakers and those who led or assisted in running our pre-conference workshops. We were also very fortunate to work with PCO Conference Innovators who were the epitome of professionalism and kept us on track at all times!

Thank you to all our sponsors for their tremendous support – especially as they were approached at short notice but enthusiastically came on board.

We are also grateful to WellingtonNZ and Tourism NZ for their financial support and to Havana Coffee who teamed up with us to provide a donation to the children's charity Variety.

In one of her last official duties as NZSA President Dr Kathryn Hagen welcomed attendees.

Organising Committee, from left: Convenor Dr David Kibblewhite, Daphne Atkinson, Dr Morgan Edwards, Dr Michael Ng and Dr Renee Franklin.

NZSA staff at conference booth from left: CEO Renu Borst, Membership Manager Lynne Mulder-Wood and Communications Manager Daphne Atkinson.

COVID-19 – values, behaviour and the lessons learnt

Director-General of Health Dr Ashley Bloomfield headlined our NZSA 2020 Conference plenary session and spoke about New Zealand's COVID response from the outset "when we could only see a dark tunnel whenever we looked at what was happening overseas, especially in Northern Italy and realised we needed to take decisive action." The Government's open communication with the public from the very beginning was "by far our best health intervention" as it built trust and confidence which encouraged New Zealanders to act collectively to abide to lockdown rules.

The core drivers of New Zealand's response were predicated on the government accepting that it was responsible for upholding the health and safety of its citizens; the need to protect our health system (both health workforce and access to the full range of health services New Zealand offers); and that New Zealand was responsible for protecting the Pacific region from COVID – "at the forefront of our minds was the last measles epidemic and the tragedy that unfolded, and avoiding being a source of COVID in the Pacific."

Dr Bloomfield summarised the six key lessons learnt from our COVID response:

- The call to collective action and its implementation – "we can replicate this for future issues"
- People value being safe and looked after
- New Zealand has a fantastic public service, and our work was visible (this included the wage subsidy offered to employers)
- The need to slow down. "What was profound about our enforced pause during lockdown was that we had to slow down. It gave us time to reflect – what do I fill my life up with each day? Am I spending quality time with my family?"
- The need to keep reviewing and learning (to be ahead of the virus); and
- In a situation with so much outside of our control, we can control our behaviours and how we respond. "Our behaviours should be an expression of our values."

Delegates appreciated Dr Bloomfield sharing the personal toll of the COVID response as the relentless day-to-day pressure and intensity of the situation built up. He said he recognised the need to focus on his own mental wellbeing, which culminated in taking breaks when he could and spending time with his family. Unexpectedly his children returned home during COVID and having that time together over dinner to talk and doing activities in the evening, such as board games, had been a huge help.

The take home message was "resilience is when you know you are stressed and anxious and you take deliberate steps to manage it. Keep being kind to yourself, and to others."

Award winning scientist Dr Siouxsie Wiles told delegates that COVID marked the end of an era. "We cannot go back to the lives we had in 2019."

Dr Wiles is an Associate Professor at the University of Auckland and the head of the Bioluminescent Superbugs Lab, which seeks to better understand how infectious microbes make us sick. Her contribution to the country's COVID response has been, and continues to be immense – as a regular media commentator she has been prolific in countering misinformation (especially via social media) and clearly explaining the science of the pandemic. Dr Wiles spoke about the actions we all need to take to retain our high level of confidence that we have eliminated community transmission of COVID. "Don't be complacent. Use the app. Model this behaviour. Even if you have a sniffle, get a test. We know that rapid testing, tracing, and isolation work!" Strong collective action was needed quickly "and you do not take your foot off the brake."

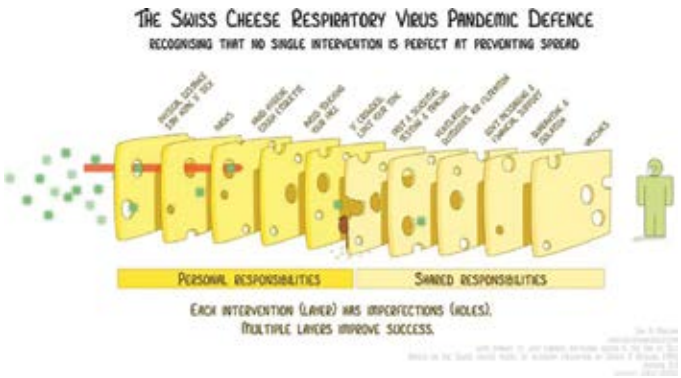
Conference Organising Committee members from left: Dr Renee Franklin, Dr Morgan Edwards and Dr Michael Ng, pictured with Dr Ashley Bloomfield and Dr Siouxsie Wiles

Dr Ashley Bloomfield speaking to delegates

Dr Siouxsie Wiles presenting to delegates.

Dr Siouxsie Wiles with Conference Organising Committee Dr Renee Franklin, Dr Morgan Edwards, Dr Michael Ng and Dr David Kibblewhite (Conference Convenor)

Below is the swiss cheese model graphic she shared – each layer has its imperfections so success is reliant on implementing all the multiple layers (which involve us all).



"New Zealand has shown the world it can act really fast and make a dramatic difference. We now need to rebuild to face future pandemics which we know will happen."

Dr Wiles urged everyone to join the many thousands who have signed up to the John Snow memorandum (www.johnsnowmemo.com) to "show a groundswell of support as no one is safe until we are all safe." John Snow is considered one of the founders of modern epidemiology and devoted much of his life to promoting public health. The memorandum is the work of a group of international researchers with expertise spanning areas such as public health, epidemiology, infectious diseases and medicine, who felt moved to deliver a clear and simple message on how to manage the COVID-19 pandemic.

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The concurrent use of aspirin and a NSAID does increase the risk of serious gastrointestinal (GI) events. ***Hypertension:*** NSAIDs can lead to onset of new hypertension or worsening of pre-existing hypertension, either of which may contribute to the increased incidence of CV events. Use NSAIDs with caution in patients with hypertension. ***Congestive heart failure and oedema:*** Fluid retention and oedema have been observed in some patients taking NSAIDs. ***Gastrointestinal effects: risk of ulceration, bleeding, and perforation:*** Serious GI toxicity such as bleeding, ulceration, and perforation of the stomach, small intestine or large intestine, can occur at any time, with or without warning symptoms, in patients treated with NSAIDs. Minor upper GI problems, such as dyspepsia, are common and may also occur at any time during NSAID therapy. Therefore, physicians and patients should remain alert for ulceration and bleeding, even in the absence of previous GI tract symptoms. Studies have shown that patients with a prior history of peptic ulcer disease and/or GI bleeding and who use NSAIDs, have a greater than 10-fold higher risk for developing a GI bleed than patients with neither of these risk factors. Pharmacoepidemiological studies have identified several other co-therapies or co-morbid conditions that may increase the risk for GI bleeding such as: treatment with corticosteroids, treatment with anticoagulants, longer duration of NSAID therapy, smoking, alcoholism, older age, and poor general health status. Most reports of spontaneous fatal GI events are in elderly or debilitated patients. To minimise the potential risk for an adverse GI event in patients treated with a NSAID, use the lowest effective dose for the shortest possible duration. ***Serious skin reactions:*** NSAIDs can cause serious skin adverse reactions such as exfoliative dermatitis, Stevens-Johnson Syndrome (SJS), and toxic epidermal necrolysis (TEN), which can be fatal. These serious events may occur without warning. ***Pre-existing asthma:*** Maxigesic® IV is contraindicated in patients with aspirin-sensitive asthma and should be used with caution in all patients with pre-existing asthma. ***Ophthalmological effects:*** Blurred or diminished vision, scotomata, and changes in colour vision have been reported with oral ibuprofen. ***Hepatic effects:*** Borderline elevations of one or more liver tests may occur in some patients taking NSAIDs. These laboratory abnormalities may progress, may remain unchanged, or may be transient with continuing therapy. Notable elevations of ALT or AST (approximately three or more times the upper limit of normal) have been reported in small numbers of patients in clinical trials with NSAIDs. In addition, rare cases of severe hepatic reactions have been reported, including jaundice, fulminant hepatitis, liver necrosis and hepatic failure, some with fatal outcomes. ***Renal effects:*** Long-term administration of NSAIDs has resulted in renal papillary necrosis and other renal injury. Patients at greatest risk of this reaction are those with impaired renal function, heart failure, liver dysfunction, those taking diuretics, ACE inhibitors, or angiotensin receptor antagonists, and the elderly. Caution is also recommended in patients with pre-existing renal disease; Maxigesic® IV has not been studied in patients with advanced renal disease. ***Aseptic meningitis:*** Aseptic meningitis with fever and coma has been observed in patients on oral ibuprofen therapy. Although it is probably more likely to occur in patients with systemic lupus erythematosus and related connective tissue diseases, it has been reported in patients who do not have underlying chronic disease. ***Haematological effects:*** Anaemia may occur in patients receiving NSAIDs. This may be due to fluid retention, occult or gross GI blood loss, or an incompletely described effect on erythropoiesis. NSAIDs inhibit platelet aggregation and have been shown to prolong bleeding time in some patients. ***Masking inflammation and fever:*** The pharmacological activity of ibuprofen in reducing fever and inflammation may diminish the utility of these diagnostic signs in detecting complications of presumed non-infectious, painful conditions. ***Anaphylactoid reactions:*** As with other NSAIDs, anaphylactoid reactions may occur in patients without known prior exposure to ibuprofen. Maxigesic® IV is contraindicated in patients with the aspirin triad. ***Patients receiving spinal or epidural analgesia:*** As potential bleeding around the spinal cord has serious consequences, caution should be exercised when treating patients undergoing spinal and epidural analgesia. ***Special precautions:*** In order to avoid exacerbation of disease or adrenal insufficiency, patients who have been on prolonged corticosteroid therapy should have their therapy tapered slowly rather than discontinued abruptly when products containing ibuprofen are added to the treatment program. ***In-house compounded solutions:*** Maxigesic® IV has been specifically formulated to provide a stable solution of paracetamol and ibuprofen. Commercially available formulations of each active ingredient alone should not be mixed together in order to produce a substitute for Maxigesic® IV, as precipitation may occur. ***Effects on laboratory tests:*** Using current analytical systems, paracetamol does not cause interference with laboratory assays. Paracetamol in therapeutic doses may interfere with the determination of 5-hydroxyindoleacetic acid (5HIAA), causing false-positive results. ***Use in pregnancy:*** There are no adequate, well-controlled studies in pregnant women. As there is insufficient information on the use of Maxigesic® IV during pregnancy, its use during pregnancy or in patients planning to become pregnant is contraindicated. ***Use in lactation:*** It is not known whether ibuprofen and/or its metabolites are excreted in human milk. Because many drugs are excreted in milk and because of the potential for serious adverse reactions in nursing infants from IV ibuprofen, Maxigesic® IV is contraindicated for use in nursing mothers. **INTERACTIONS WITH OTHER MEDICINES AND OTHER FORMS OF INTERACTION:** ***Aminoglycosides:*** NSAIDs may decrease the excretion of aminoglycosides. ***Anticoagulants:*** e.g. warfarin - users of both warfarin and NSAIDs together have a higher risk of serious GI bleeding than users of either drug alone. ***Antidiabetic medicines:*** interact with ibuprofen. ***Aspirin:*** reduces ibuprofen's protein binding, although the clearance of free ibuprofen is not altered. The clinical significance of this interaction is not known; but concomitant administration of NSAIDs and aspirin is not generally recommended. ***Busulfan:*** concomitant use with paracetamol may result in reduced busulfan clearance. ***Cardiac glycosides:*** NSAIDs may exacerbate cardiac failure, reduce glomerular filtration rate and increase plasma cardiac glycoside levels. ***Chloramphenicol:*** paracetamol may increase chloramphenicol plasma concentrations. ***Combination use of ACE inhibitors or angiotensin receptor antagonists, anti-inflammatory drugs and thiazide diuretics:*** NSAIDs may diminish the antihypertensive effect of ACE inhibitors and beta-blockers, with possible loss of blood pressure control. The combined use of the three classes of drugs all at the same time increases the risk of renal impairment. ***Corticosteroids:*** increased risk of gastrointestinal bleeding. ***Cyclosporine or Tacrolimus:*** increased risk of nephrotoxicity when used with NSAIDs. ***Diflunisal:*** increases paracetamol plasma concentrations and this may increase hepatotoxicity. ***Diuretics:*** ibuprofen can reduce the natriuretic effects of frusemide and thiazides in some patients. During concomitant therapy with NSAIDs, observe patients closely for signs of renal failure, as well as to assure diuretic efficacy. ***Enzyme-inducing agents*** *(such as barbiturates, isoniazid, anticoagulants, zidovudine, amoxicillin + clavulanic acid, carbamazepine and ethanol):* induction of metabolism of paracetamol from enzyme inducers may result in an increased level of hepatotoxic metabolites. ***Herbal extracts:*** Ginkgo biloba may potentiate the risk of bleeding with NSAIDs. ***Lithium:*** NSAIDs have produced elevations of plasma lithium levels and a reduction in renal lithium clearance. ***Methotrexate:*** NSAIDs may enhance the toxicity of methotrexate. ***Mifepristone:*** NSAIDs should not be used for 8-12 days after mifepristone administration as NSAIDs can reduce the effect of mifepristone. ***Phenytoin:*** may result in decreased paracetamol effectiveness and an increased risk of hepatotoxicity. Phenytoin may also interact with ibuprofen. ***Probenecid:*** causes an almost 2-fold reduction in clearance of paracetamol by inhibiting its conjugation with glucuronic acid. Probenecid may also interact with ibuprofen. ***Quinolone antibiotics:*** NSAIDs can increase the risk of convulsions associated with quinolone antibiotics. ***Zidovudine:*** increased risk of haematological toxicity when NSAIDs are given with zidovudine. There is evidence of an increased risk of haemarthroses and haematoma in HIV (+) haemophiliacs receiving concurrent treatment with zidovudine and ibuprofen. **ADVERSE EFFECTS (UNDESIRABLE EFFECTS):** Clinical trials with Maxigesic® IV have not indicated any undesirable effects other than those for paracetamol alone or ibuprofen alone. In a phase III study in 276 patients undergoing bunionectomy surgery, the most common treatment emergent adverse events (TEAEs) were gastrointestinal disorders (38.8%), followed by nervous system disorders (28.6%). TEAEs observed in ≥5% of any treatment group (Maxigesic® IV, paracetamol, ibuprofen, or placebo) were nausea, vomiting, dizziness, infusion site pain, pruritus, somnolence, constipation, headache, hyperhidrosis, infusion site extravasation, decreased appetite, muscle spasms, hot flush. TEAEs are consistent with the postoperative setting and the use of paracetamol or ibuprofen for analgesia. The incidence of TEAEs was comparable between the Maxigesic® IV, ibuprofen, paracetamol and placebo groups, with the exception of vomiting which was significant for the comparison between Maxigesic® IV and ibuprofen or placebo (but not paracetamol), suggesting that the vomiting reported by patients in the Maxigesic® IV group is attributable to the paracetamol component of the combination, rather than an effect unique to the combination. **SPECIAL PRECAUTIONS FOR STORAGE:** Store below 25°C. Do not refrigerate or freeze. Protect from light. **NATURE AND CONTENTS OF CONTAINER:** Maxigesic® IV is supplied in 100 mL clear glass vials, closed with a grey rubber stopper and an aluminium flip-off cap, in a pack size of 10 vials. **MEDICINE SCHEDULE:** Prescription Medicine (Schedule 4). **SPONSOR:** AFT Pharmaceuticals Ltd, Level 1, AC Nielsen House, 129 Hurstmere Rd, Takapuna, Auckland 0622. Phone: 0800 423 823. **PATENT NUMBERS:** 552181/609727/604009.
DATE MATERIAL PREPARED: July 2020.

maxigesic® IV

Paracetamol 1000 mg and Ibuprofen (as sodium dihydrate) 300 mg in 100 mL solution for infusion

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*Based on time-adjusted SPID[48], calculated from VAS pain intensity scores recorded up until the time of consumption of the first dose of rescue[1]. **According to VAS pain intensity, Pain Intensity Differences and Pain Relief scores at the majority of scheduled time points over a 48 hour period. Dosed as one vial every 6 hours over 48 hour period[1]. ***Based on the total oral Morphine Milligram Equivalent (MME) dose of all rescue medication over the full 48 hour study period[1].

Reference: 1. Daniels, S.E, Playne, R., Stanescu, I., Zhang, J., Gottlieb, I.J, Atkinson, H.C. (2019). Efficacy and safety of an intravenous acetaminophen/ibuprofen fixed-dose combination after bunionectomy: A randomized, double-blind, factorial, placebo-controlled trial. Clinical Therapeutics 41 (10): 1952-1965. Research sponsored by AFT Pharmaceuticals.

AFT Pharmaceuticals Ltd, Auckland. TAPS PP6110

Ambitious 2030 goals for global surgical and anaesthesia services

Dr Alan Goodey, NZSA Global Health Committee member and Immediate Past GHC Chair, writes about how the NZSA can better support our Pacific colleagues towards developing a sustainable anaesthesia workforce to deliver on ambitious surgical and anaesthesia goals set by the Lancet Commission on Global Surgery.

Challenging goals for monitoring universal access to safe, affordable surgical anaesthetic care were set by the Lancet Commission on Global Surgery in 2015. Ambitious indicators to be achieved by 2030 are: a minimum of 80% coverage of essential surgical and anaesthesia services in each country and 100% of countries having a minimum of 20 SAO (specialist surgeons, specialist obstetricians and specialist anaesthetists) per 100,000 population.

In the South Western Pacific region many of these populations are well under 100,000 and in these circumstances one surgeon and one anaesthetist may well provide sufficient capacity to achieve the intended goal of 5,000 operations per 100,000 people. For these islands, the issues are maintaining competency and engagement, and retention of health practitioners. However, for the larger Pacific Island countries achieving the target of 20 SAOs per 100,000 population by 2030 remains largely aspirational. At the current rate of workforce training and turnover I doubt it is achievable without significant extra training resources.

I believe that the majority of NZSA members would want to see the NZSA actively involved in assisting our Pacific colleagues to make progress towards these goals. The NZSA can assist in three strategic ways to increase the capacity of the anaesthetic workforce in the Pacific, as outlined below:

I believe that the majority of NZSA members would want to see the NZSA actively involved in assisting our Pacific colleagues

To train as an anaesthetist at Fiji National University (FNU), the trainee must have a medical degree for entry and generally must apply for a scholarship to have their tuition fees paid (F$16.5K per year). The course is divided into a one-year diploma course, and then for those interested a further three years to complete a Masters degree in medicine specialising in anaesthesia. At the end of the four years the trainee has a degree roughly equivalent to our ANZCA Fellowship and is considered a Consultant or Specialist Anaesthetist. Their training enables them to have a major impact on the development of anaesthesia wherever they end up working. As such, the ongoing training of anaesthetists to this level will be critical to enable training other anaesthetists in their home countries, and to develop robust support services needed to deliver high quality anaesthesia and critical care.

The one-year diploma course offers a quick way to produce anaesthetists who can provide basic level care and is an affordable means of expanding the workforce. There are obvious limitations of trainees' knowledge if they only complete the diploma, and limits on their ability to develop as future leaders and educators. It may be an appropriate level of training for doctors from some of the smaller populated islands, especially if the practitioner has also completed a second or third diploma in another specialty to enhance their general skills.

Until the last two years, all formal anaesthesia training towards the FNU qualifications occurs in Fiji. Fijian trainees need to obtain funding for their university fees, however, can live on their

STRATEGY	ISSUES	ACTIVITIES FOR NZ ANAESTHETISTS
Retain and maintain the current workforce	• Small numbers of practitioners lead to risk of burnout, fatigue, ill health • A vulnerable workforce • As soon as the new trainee qualifies the older doctor moves on	• Mentoring • Providing locum cover to allow leave for CME and holidays • Sponsor Pacific colleagues to attend CME events
Train the future workforce	• Relatively expensive • Centralised training in Fiji results in loss of workforce in home countries and Fiji over reliant on foreign doctors	• Assist the movement to more formal training in home countries • Advocate for more funding for training. • Anaesthetic groups sponsoring training
Assist development of support structures to make anaesthesia safer	• Issues related to medical workforce the same or worse for all other health workforces • Regular failure of supply chains, equipment, maintenance issues • Over reliance on donated, expired, or old equipment/ pharmaceuticals	• Support current physician workforce to advocate for support structures, funding, and staffing • Assist training of biomedical engineers, anaesthetic technicians, anaesthetic nurse assistants and recovery nurses

1. *Recommended further reading on the Lancet's Commission Goals https://globalsurgery.ucsf.edu/media/8065752/Overview_GS2030.pdf)*

available local resources. For trainees from the rest of the Pacific, they not only have to get support towards their university fees, but to also obtain sponsorship to support them while they live in Fiji. Although they make up a significant portion of the trainee workforce in Fiji, they are not paid for their clinical contribution in Fiji by Fiji's Ministry of Health.

While Fiji clearly benefits from this increase in workers at minimal cost, their workforce is also made vulnerable by the sudden decrease in numbers of doctors during the Christmas/summer break, and this year during the COVID crises when many doctors returned to their home country.

For these non-Fiji based trainees a huge personal and financial sacrifice is made to complete the MMED training. In addition, the home country loses a trained medical professional for the time of their training, which puts an additional pressure on the limited staff resource in the home country. Some of the trainees eventually put roots down in Fiji and become a loss to their country of origin.

Despite these significant problems there are good reasons to continue to support the current training in Fiji rather than try to create a new training regimen. The benefits include building a support network of anaesthetists with a common centralised experience of training. Pacific anaesthetists not only share the common issues of providing anaesthesia in relatively low resourced settings in a Pacific Island context, but get to know each other sitting exams together, sitting through shared tutorials and solving common issues through the training program.

The program, developed over the last 40 years, has high standards and expectations of students and the faculty. To try and recreate an alternate program would be expensive and likely result in an inferior product in the short term. By having a program specifically aimed at developing an anaesthetic specialist workforce in the Pacific context, trainees are better prepared for working in their own environment than if we were to offer the ANZCA curriculum for example. It also remains important to have a not directly transferrable qualification from the Pacific to Australia and NZ as this would undoubtedly result in a "brain drain" and limit the ability to build a sustainable workforce in the Pacific.

For 2019 and 2020 FNU, with assistance from the ASA and NZSA, has moved towards offering some of the training for non-Fijian trainees in their home country. The major prerequisite is that there is at least one and preferably two FNU MMED qualified anaesthetists in the home country to supervise the training. We have been working to get anaesthetists from Australia and NZ to do some supervision in the home country to bolster supervision, although this has been severely limited this year due to Covid-19 travel restrictions.

In 2019 Tonga led the way with Dr Siale Hausia, beginning his second year of training at home. He was able to be trained by two fully qualified MMED anaesthetists Dr Selesia Fifita, and Dr Apaitia Goneyali. Also, Dr Meg Walmsley and Dr Justin Burke from Australia visited and provided additional in theatre training for Siale. The year went very well and possibly provided a higher level of supervision for Siale than he would receive in Fiji.

Siale started this year in Fiji to do the bulk of the academic work and sit the main exams of the course. The hope at the start of the year was for this to be completed in Fiji and for Siale to return to Tonga for his final year, complete a formal research or audit in Tonga and complete his Masters program.

Some of the trainees eventually put roots down in Fiji and become a loss to their country of origin.

In 2020 we have attempted to commence a similar scheme for Dr Cecilia Vaai in Samoa. Cecilia has completed her Diploma and has been waiting for an opportunity to complete her Masters program. Samoa is a little different from Tonga in that there is currently only one MMED graduate, Dr Lamour Hansell. In addition, the Samoa medical administration seems less interested in developing the anaesthetic workforce. Presumably, they feel they have other even less resourced specialties. Apart from Dr Hansell, the senior anaesthetic workforce is made up of Dr Pesa Une, a diploma qualified anaesthetist who is heading towards the end of his career and has had some recent health issues and Dr Yew, a Chinese anaesthetist provided by the Chinese Government. Samoa is funding one other trainee, Dr Mua, in her third year of training. Due to Covid, she is back in Samoa and this is the year in the spoke and model system in which she is supposed to be in Fiji sitting exams (the issue is yet to be resolved).

Samoa's population in the 2018 census was 196,130 which based on the Lancet targets suggests that they should have a minimum of 10 physician assistants. They currently have three consultants. If the trainees are included, the numbers go up to eight, all of whom are working at the main hospital on the island of Upolu. There are 46,000 Samoans living on the larger island of Savaii. There is no surgical service available to these people and a trip to the main hospital in Upolu is at least half a day away, making the Commission's timely access to essential surgery within two hours target impossible.

FNU Training Scheme

YEAR OF TRAINING	COURSE CONTENT	OLD SYSTEM PRE 2019	SPOKE AND WHEEL TRAINING 2019 ONWARDS
Year 1MMED (Diploma)	Basic one-year training	Fiji	Fiji
Year 2		Fiji	Home country
Year 3	Main exit exams	Fiji	Fiji
Year 4	Formal project	Fiji	Home country

Samoa also has aspirations to provide intensive care services for their population. Dr David Galler was instrumental in setting up a high quality service for a few years – and it received a lot of publicity when the Chief's Assistant Rugby Coach Andrew Strawbridge became unwell, which helped with funding and development. Unfortunately, there were insufficient numbers of anaesthetic trained or intensive care trained doctors to cover the roster needed for a standalone unit. I highly recommend this presentation https://youtu.be/MJtM1qKB1gk given by Dr Dina Tuitama to the World Congress of Intensive Care to reflect on the issues our colleagues in the Pacific experience. Dr Tuitama is a highly talented doctor who has (at least for now) been lost to our combined specialty of anaesthesia and intensive care. Sadly, at the present time I worry that she will not be the last who can no longer continue. Specialist doctors are expensive to train and must be valued and retained.

The lesson from this experience is that while it is desirable to develop intensive care as a specialty in the Pacific, the current effort should be to train combined anaesthetist/intensive care specialists to cross cover the demanding rosters.

Main barriers to training more anaesthetists

The barriers are funding and total numbers of doctors being trained. It is clearly a significant cost to fund the training in Fiji, and not surprisingly the health administrators who administer the limited number of scholarships try and share these out evenly amongst the different medical specialties. However at the current rate of scholarship approval for anaesthesia in Samoa, the experiences that forced Dr Tuitama out of hospital medicine, and the small existing workforce, I don't see much progress being made on building a sustainable anaesthetic workforce in Samoa let alone achieving the Lancet Commission's targets.

And this is not just a problem for anaesthesia. Every other specialty also needs to build its workforce and struggles with funding. The problem is they are all competing for the same small pool of money. It seems self-evident that the answer is to expand the funding pool. The NZSA can do this by either advocating to other funders such as the NZ Ministry of Foreign Affairs and Trade or by finding the funds ourselves to sponsor training anaesthetists, across the Pacific. If we move into the funding and purchasing side of the equation, we are also in a better position to start advocating for a better deal when it comes to fees etc. NZSA members have the capacity to raise funds. I liken such an arrangement to the WFSA Fund a Fellow project where individuals and anaesthetic groups sponsor anaesthetists from developing countries to obtain further specialist training.

The barriers are funding and total numbers of doctors being trained

Following on from this aim, my colleagues on the NZSA Global Health Committee have created the Pacific Anaesthesia Collaborative Training (PACT) initiative as a way for NZ anaesthetists to directly contribute to sponsoring more Pacific trainees to train as specialist anaesthetists. Please visit the PACT webpage https://anaesthesia.nz/community/global-health-committee/donation/ to donate the equivalent of a coffee a week to support growing the anaesthetic workforce in the Pacific.

In the meantime, the NZSA Global Health Committee has cautiously dipped its toes in the water, part sponsoring the training of Cecilia Vaai this year. We are still working on how we might get ongoing sponsorship to continue Cecilia's training for next year with the added expenses of being in Fiji.

The 68th World Health Assembly in 2015 passed a resolution for the first time recognising that surgical and anaesthetic care are essential components of Universal Health Care. Five years later, amidst a global pandemic, it is interesting to reflect on progress made towards providing safe, effective obstetric, surgical, and anaesthetic care for the South Western Pacific. The Lancet Commission published a series of KPI's the same year as the WHA resolution. It is probably time to assess how our region is performing on the KPI's and the Commission's targets for 2030.

Until the Covid-19 pandemic the surgical capacity in the Pacific was significantly increased thanks to regular surgical teams visiting from Australia and New Zealand. While it may be impossible to eliminate the dependency on these visiting teams for more specialised surgery, the pandemic reinforces the need to strengthen the workforce so that it is less vulnerable. A Covid-19 outbreak would quickly overwhelm a Pacific Island health service.

The risk of losing key members of the health response team could lead to a major long term set back in improving access to surgical services. Ironically at the very time travel is limited, funding for expensive surgical trips could be diverted to the expansion of training Pacific health professionals.

As fellow anaesthetists we are in a unique position to advocate for our colleagues in the Pacific. Even if the Lancet Commission targets are ambitious, we have an opportunity to advocate and to assist to achieve stronger anaesthesia, intensive care, and surgical care in the Pacific.

Editor's addendum: New information has come to hand as we are going to print, that funding for new Specialist training in Fiji is likely to be suspended due to the current financial situation. Those currently training will continue. The GHC are closely monitoring the situation.

News in brief

Support our Pacific colleagues – new initiative

By donating the equivalent of just one coffee per week ($5) you can help fund a Pacific anaesthesia trainee through their three-year Masters program at the Fiji National University. PACT (Pacific Anaesthesia Collaborative Training) is a new initiative from the NZSA Global Health Committee to support a sustainable anaesthesia workforce in the Pacific. If just 77 people donate one coffee per week to our PACT fund, we can provide the entire cost of a Pacific Island trainee's education through the Masters program. Join colleagues who have already signed up and help us reach our target. Learn more https://anaesthesia.nz/community/global-health-committee/donation/

NZSA 2020 conference recorded sessions

Attendees at the NZSA 2020 Conference *Emerge, Reflect and Reconnect* provided very positive feedback on our two-day program of talks. These diverse and thought-provoking presentations are now available to all NZSA members. You can access recordings on the NZSA website in our members only section (you will need to be logged in). Hear sessions on COVID, wellbeing, culture, trauma, bias, research, and perioperative medicine.

PHARMAC medical devices update

PHARMAC representatives provided an update on its medical devices procurement project, which aims to provide fairer access to medical devices throughout the country, at the NZSA Executive meeting last month. An expert advice framework approach is being developed, which will include forming sub-committees and sub-groups to provide strategic, operational, and user advice. The NZSA Executive recommended PHARMAC access existing groups in the sector for advice such as the NZSA's subspecialty networks, as well as anaesthetic technicians. NZSA will have input on the configurations of committees that affect anaesthesia, and the areas anaesthetists work in. PHARMAC is now setting up a strategic advisory group to guide engagement with DHBs and more consultation is planned for early next year on operational details. Keep updated on the medical devices project at https://pharmac.govt.nz/hospital-devices/

PANNZ Update Meeting 2021

The Paediatric Anaesthetist Network of New Zealand (PANNZ) Update Meeting will take place 5-6 March 2021 in Rotorua. A one-day course suitable for anaesthetists with an interest in paediatric anaesthesia and other staff (nursing/technical) wanting to upgrade their knowledge of current paediatric anaesthetic management. The main aim of PANNZ is to maintain two-way collaboration and communication between paediatric anaesthetist services within regions, and with colleagues in different regions, of the country. Registrations now open https://willorganise.eventsair.com/pannz-2021/

NZSA Best Anaesthetic Technician Speaker awards

The NZSA was very pleased to sponsor the 2020 Best Anaesthetic Technician Speaker awards at the NZ Anaesthetic Technicians' Conference in November. The prize winners were:

1st - Elise Hemmingsen – 'How did you possibly miss that?'
2nd – Terry Leftley and Greg Mann – 'Reflective Practice'
3rd – Ian Boxsell – 'Human Factors'

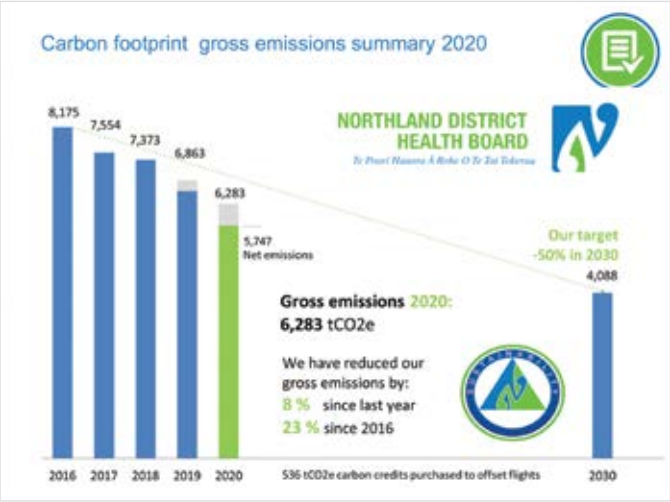
NZSA Best AT Speaker Elise Hemmingsen (L) with NZATS Chairperson Kirsten Fraser (R)

Sustainability at Northland DHB

Dr Jenny Henry, Anaesthetist at Whangarei Hospital, and member of the NZSA's Environmental and Sustainability Network writes about advances in sustainability at Northland DHB.

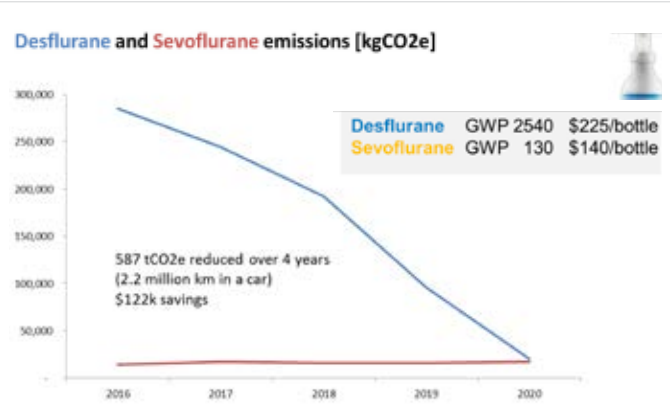
We are fortunate in Northland to have an extremely motivated and well informed Sustainability Officer, Margriet Geesink, who has driven a great deal of change within our DHB to reduce CO2 emissions and reduce our environmental impact. Since 2016 our DHB carbon footprint has reduced by almost a quarter as shown in the graph below.

This has been achieved by measures including reducing petrol cars in the DHB fleet and replacing them with electric vehicles, including e-bikes; no longer using diesel for heating; switching to an electric supplier that is 100% regenerated power; the purchase of carbon credits for hospital flights by all staff; using NZ credits only; and SMOs being able to claim for carbon offsetting when purchasing flights for CME. And a great deal more too.

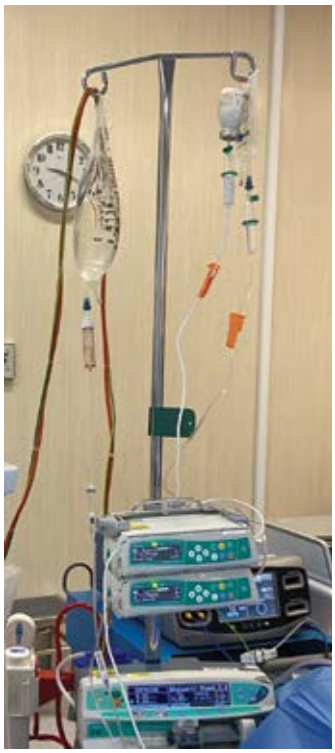


We have played our role in anaesthetics and theatres also:

Desflurane: The greatest achievement is a massive reduction in desflurane use to the extent that we have now, as a department, decided to stop using it altogether and will no longer purchase any. The graph below illustrates this:



Propofol TIVA: There has been a big uptake of propofol TIVA and we have purchased 10 Braun TIVA pumps which are programmed for both propofol and remifentanyl TCI. The biggest advantage of them over the Alaris infusion pumps is that 1 giving set is used which is attached directly to the propofol bottles and hence negates the multiple 50 ml plastic syringes we have been using. The Braun pumps are also about a quarter of the price of the Alaris pumps and much smaller and more compact. They are also very user friendly. We are also now using 100 ml bottles of propofol as well as the 50 mls. Below is a photo of the setup.



The Braun pumps are also about a quarter of the price of the Alaris pumps and much smaller and more compact.

Recycling: We have recycling set up at our anaesthetic end as much as is possible within the confines of what our region will provide. Sadly very few medical products have a recycling number on them so there is very little plastic recycling and Northland only provide for recycling 1 and 2. We do however sort the non-broken glass vials including propofol, antibiotics and paracoxib, Baxter fluid bags and packaging, paper and cardboard. We use the vegetable sourced drug trays.

Carbon offsetting of CME flights: All SMOs in the DHB can claim to carbon offset their flights using CME money.

I am fortunate to be a member of the NZSA Environmental & Sustainability Network which has been a great way to share information. Thank you to my colleagues as I have learnt so much from being on the Network.

Featured session NZSA 2020 Conference

How gender bias affects wellbeing and how to make positive change

"More than ever we are recognising the toll that stress, fatigue, burnout and workplace bullying can have on our professional and personal lives," said Dr Emma Patrick, in her introduction to the wellbeing session at the NZSA conference. Dr Patrick is an anaesthetist from New Plymouth and NZSA Executive Committee member who holds the wellbeing portfolio. Our first speaker for this session was Dr Charlotte Chambers, the Director of Policy and Research at the Association of Salaried Medical Specialists (ASMS).

Dr Chambers has undertaken considerable research for ASMS on wellbeing issues affecting senior doctors and dentists, including presenteeism, burnout and bullying. Her research has consistently found that female specialists are disproportionately affected. Essentially the role of gender perpetuates 'minor inequalities' in medical careers, which cumulatively build up and shape the experiences and wellness of women in medicine. She described gender stereotypes as a complex interplay of societal and cultural expectations, biases and learned behaviours. "These gender norms/biases are often unrecognised, and the onus is often on women as individuals to decide whether and how to address these behaviours."

Dr Chamber's talk 'One step behind – exploring the lived experiences of women in the senior medical workforce' focused on the gendered nature of the medical profession and the impact this has on the wellbeing of female doctors. In her research Dr Chambers interviewed 14 female specialists in depth, which provided great insight on how gender bias is manifested in their daily encounters with patients and staff.

It's hard to be assertive but not to be perceived as aggressive

"What I found most interesting was this invisible line of comportment that had to be traversed regarding how they were supposed to look and behave. Traversing this divide was mentally exhausting." She provided an example where a doctor had received feedback on her appearance for being "too mumsy" and had been left perplexed and angered that she had been subjected to this comment. As for how female consultants are perceived by patients and colleagues there were myriad examples included that they were more likely to be questioned about their clinical skills or judged by nursing staff "which they definitely wouldn't say to guys." Other quotes she highlighted were around how to behave, with one consultant lamenting "It's hard to be assertive but not to be perceived as aggressive."

The role of gender perpetuates 'minor inequalities' in medical careers

A major finding of the research was the perception that female specialists are less committed to medicine as they are more likely to work part-time to balance career and family commitments. Dr Chambers highlighted news articles and medical journal articles such as one by a UK surgeon titled 'Why having so many women doctors is hurting the NHS.' Medicine, and many other professions, are predicated on having the 'unencumbered worker' who does not have commitments outside of their professional duties.

In her talk Dr Chambers outlined the strong correlation between hours worked and the absence of breaks, to burnout. "Some of the temporal norms in medicine are harmful to our health. What I found particularly concerning in some of the interviews I did was that many of the women had internalised that working part-time was risky for career progression. Some of the comments they made were "If you don't work every day they don't think you're a participant, you're not interested, you're not helping out," and "you don't want to be seen to be slacking off… so when I'm at work I don't say no to any requests because you are already

Dr Charlotte Chambers

feeling guilty." There was a prevalent fear of being judged by those not working part-time and being perceived as only "dabbling in medicine" rather than fully committed. One interviewee pointed out that some of her male colleagues worked part-time in the department, with the remainder of their hours worked in private – this was viewed as legitimate, whereas part-time hours looking after children was not. Some felt that working part-time was risky as it could mean being overlooked for promotion and/or being excluded from involvement in projects. "Society needs to change so that the responsibilities of parenthood are viewed as affecting both men and women, rather than a woman's/mother's issue."

Dr Chambers highlighted that studies have consistently found that household responsibilities such as childcare, coordinating schedules and other domestic tasks are deeply gendered – and women are much more likely than men to scale back on work commitments to fulfil these responsibilities. When men found it difficult to balance the two, they tended to cut back on family time. Inevitably the two competing areas are in tension and one interviewee described burnout "as the emotional overlay of managing the two roles." For reasons of self-preservation some women then lean out of their careers, while the careers of their male colleagues accelerate and progress, including being involved in management and decision making for their department.

For reasons of self-preservation some women lean out of their careers

Dr Chambers said awareness of gender bias and the power of gender stereotypes is the starting point because this awareness serves to help us understand the reasons why women's wellbeing is disproportionately affected by issues such as burnout. Awareness is the precursor to reflection and action. So, what can we practically do to address the issues?

Read: There are many articles that evaluate gender bias. Dr Chambers recommended an article published this year about the veterinary profession, which highlighted how gender bias was perpetuated by those who didn't think it existed e.g. allocating a higher starting salary to men (Science Advances Journal 2020 C.T Begeny).

Take the Harvard implicit bias test: www.implicit.Harvard.edu This could prove revealing and surprise many with their individual results – we all have inherent bias and it may be stronger than we assume.

Place a gender lens on what you say: Reflect on what you may say to a woman and how it would sound if you said it to a man, such as questions about taking time out of one's career for parental leave, or comments on appearance.

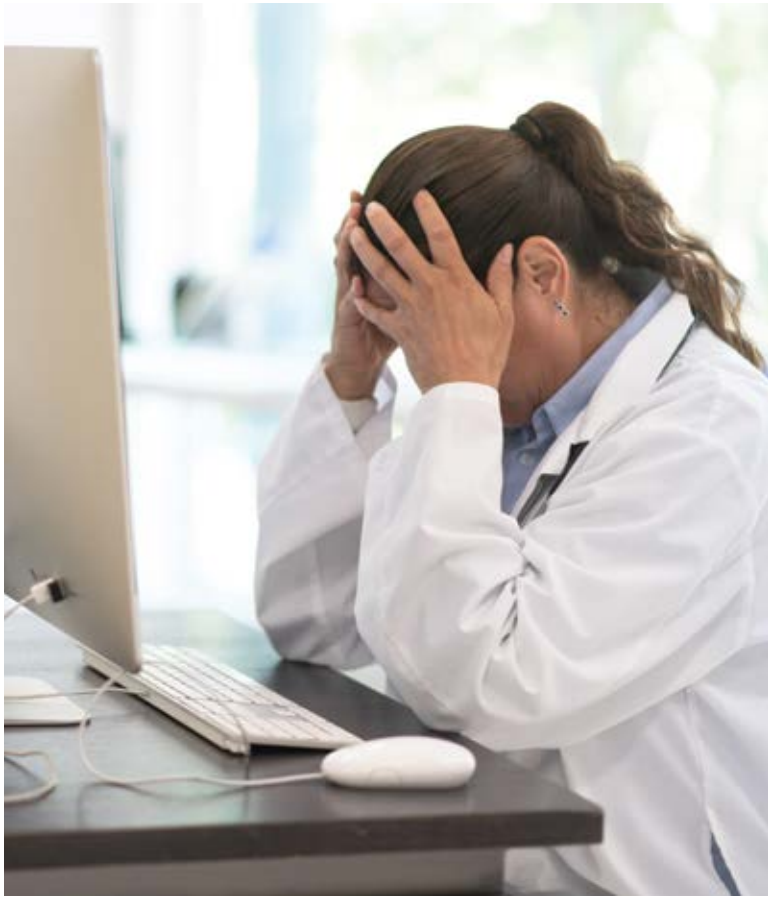
Go for amplification: Amplify a comment or suggestion a woman may make by repeating it and drawing attention to it.

Recognise micro-aggressions: Cumulatively gendered words, behaviours and actions add up

As the union for senior doctors, Dr Chambers said ASMS recognised that cultural change needed to be accompanied by changes to employer practice, working conditions and a sector that is adequately resourced.

"Managers need to develop a culture of work-life integration and family friendly policies (promoted to both genders), such as normalising family related breaks, along with strategies such as equal access to opportunities and providing effective mentors. These kinds of changes will enable medicine to be practised by a new generation – men or women with a partner and children, sharing joint responsibilities."

1. *https://www.asms.org.nz/wp-content/uploads/2019/11/Health-Dialogue-Making-up-for-being-female-WEB.pdf*



Featured session NZSA 2020 Conference

Unconscious bias and how to mitigate it – a long-term process

Dr Michael Ng, a member of our conference organising committee and a provisional fellow at Middlemore Hospital, chaired our session on bias which he said would be "challenging." The session began with a talk exploring how unconscious bias affects medical practitioners' interactions with patients and colleagues, and practical measures to mitigate bias.

Associate Professor Angela Ballantyne, a Visiting Senior Research Fellow at the National University of Singapore, who also holds a permanent position at the Department of Primary Health Care and General Practice at the University of Otago Wellington, gave attendees much to reflect on.

"There is systemic racism and pervasive sexism in our health sector, and we must do better," she said, in her opening remarks. "We judge people on physical measures such as their appearance, ethnicity, gender, and this influences our behaviour and how we treat them e.g. decisions we make about recruitment and promotion. Research extensively illustrates that these 'physical' factors outweigh an individual's potential and competence so we should be sceptical about notions of meritocracy." She emphasised that unlearning bias is a long-term process and making changes to our assumptions and behaviour requires the same kind of commitment as you would make to undertaking a project "such as learning a new language, which for most takes time" – in fact she points out that the older we are, the more likely that attaining fluency will be a life-long project.

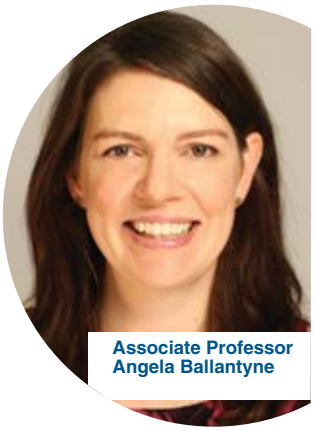
A/P Ballantyne highlighted a range of examples of gender bias in medicine:

- Patients in general do not interrupt a doctor unless the doctor is female, in which case both male and female patients are more likely to interrupt.
- Female patients who report pain are more likely than men to be perceived as being emotional.
- (Orthopaedics) 61% of women were asked illegal interview questions e.g. plans for family, versus 8% of men (O'Connor 2016).
- Female surgeons in Ontario earned 24% less per hour while operating (Dossa et al 2019) – and female surgical registrars had "their surgical training wheels kept on for much longer than their male counterparts."

Men are overrepresented in the highest paid, most prestigious roles in medicine such as neurosurgery and thoracic surgery, whereas family medicine which is one of the lowest paid specialties is predominantly female.

In terms of ethnic bias in medicine, this influences how patients are treated e.g. less likely to be referred for specialist follow up.

Graham Cameron



Associate Professor Angela Ballantyne

Bias is particularly problematic if we are committing to progressive goals such as health equity, anti-racism, and gender equality in the workplace. Recognition and awareness of bias are not enough on their own to effect change - practical tactics are needed to mitigate bias, such as data collection "enormously important as it means we can stop circular debates about what is true in the workforce and relying on our subjective perceptions and instead have baseline measurements to see how much we are improving" as well as blind review, key performance indicators, targets and quotas, for example representation on boards and panels. She cited the policy from the University of Otago that aims to have the ethnicity of those selected for medical school mirror New Zealand's community. These kinds of actions are successful as they are "visible and transparent," and people can be held accountable for the progress being made.

Next steps: Visit biasinterruptors.org, which outlines an evidence-based model that provides checklists and other tools to counter bias in the workplace, enabling workplaces to be "more diverse and perform better. "

Our bias session also featured Graham Cameron, who as the Pou Tikanga in Māori Health Gains and Development at the Bay of Plenty DHB is the lead support for the Board and Executive in their iwi relationships. He has supported the BOPDHB Māori Health Rūnanga (a representative body of 17 iwi in the BOP) to develop and implement Te Toi Ahorangi, a wellbeing strategy grounded in the aspirations of Māori communities in the Bay of Plenty and endorsed by BOPDHB. He described the strategy as unique, as prior strategies have all been written by the Crown – "whereas Te Toi Ahorangi is an articulation of what Māori want to achieve and what an authentic health partnership looks like." Their definition of equity is "the purposeful investment of resources that transforms pathways of disadvantage to advantage." Success is measured by equity of access, quality and/or outcomes. "These are bold aspirations in the face of today's health system, in which Māori are less likely to be referred to secondary and tertiary care, and when they are in those institutions they receive fewer interventions, experience longer hospital stays and are more likely to die there."

NZSA 2020
Emerge, Reflect & Reconnect Conference
#support local dinner

An amazing evening of conviviality and showcasing our support local theme, including the divine food and drinks, the beautiful flowers, the arty lights, and the brilliant music performed by The Relatives (the dance floor was not empty for long!)

Trainee Column

Michael Wadsworth
NZSA Trainee Representative

This is my first trainee column for the NZSA magazine having taken over from the exceptional Mike Ng. Given we are finally about to escape the year that keeps on giving, I thought I would do a quick review of 2020 and then we can all turn our focus to a better 2021. But first, a little about myself.

I am coming towards the end of AT two and am halfway through my part two exam. I am one of the members of the cohort that is sitting the written and viva nine months apart. Currently all the facts I crammed into my head before the written are dripping out in a slow leak, but I will endeavour to plug the leak as best I can and relearn them all again next year before the viva in May.

I began my training at Waikato Hospital but am now based in Wellington, completing a six-month stint at Hutt Valley DHB before returning to CCDHB next year to begin my provisional fellow year. I am married to a medico-lawyer who argues with me about informed consent and have a six-year-old daughter and five-year-old twin boys.

Now that 2020 review:

Well in short, I have heard from a number of trainees that 2020 has well and truly been a below par year. The pandemic has had an unprecedented impact on all trainees throughout New Zealand, but I commend you all for your unrelenting dedication to your patients, support for your colleagues, and your hard work and professionalism. Particularly so during lock down periods when many of you volunteered to help on intensive care escalation rosters, missed study and teaching opportunities and generally were available to your respective departments and hospitals. Although it may not always feel like it, I know these sacrifices are appreciated.

Exam uncertainties have had the most impact for trainees, including myself, with all sittings being majorly disrupted in some way. Mike Ng and I have advocated on your behalf through the ANZCA NZ Trainee Committee and directly with the college to ask them to improve transparency and communication with affected trainees. I applaud those of you who have passed despite such trying circumstances. I am hoping that the college's hurdles can be overcome and there will be no further delays or cancellations in the coming years, despite COVID-19's continued rampage.

Right, time for some good news; the NZSA conference committee managed to host an amazing conference this year, which was well attended and a highlight for those trainees able to attend. Also, a mini Part 3 course was put together, and I understand on good authority that it was well received by all (I was a receiver!). I encourage all of you to try to attend this course when you are coming towards the end of your training, it is invaluable. Many thanks to Mike Ng for putting it together.

I would also like to introduce Dr Mikaela Garland who is signing on as the new Deputy Trainee Representative for the NZSA Executive. She is based in the Midlands region and will be working at Waikato Hospital next year as an AT two, so feel free to contact her with any questions, concerns or comments that we may be able to help you with if you are from that neck of the woods.

Finally, it is a real privilege to represent NZSA trainees on the Executive. Please feel free to get in touch with us so we can represent your views and advocate for your issues and wellbeing. I wish you all the best for 2021!

Michael Wadsworth
NZSA Trainee Representative

The pandemic has had an unprecedented impact on all trainees throughout New Zealand

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webAIRS news

Cardiovascular incidents during anaesthesia among the first 8000 reports to webAIRS

ANZTADC reached an important milestone in May 2020 with 8000 reports submitted. A breakdown of the main categories is shown live on the webAIRS website and the results for the first 8000 are shown in the table below.

MAIN CATEGORY	PERCENT
Respiratory/Airway	29.4%
Medication	16.5%
Cardiovascular	16.1%
Medical Device/Equipment	11.3%
Neurological	5.8%
Assessment/Documentation	4.7%
Infrastructure/System	4.6%
Other Organ	2.0%
Miscellaneous/Other	7.5%
Not Specified	2.2%
Total	**100%**

Interim results of first 8000 reports shown as a percentage. Please note that the figures above are approximate and might change slightly because of data cleansing during the detailed analysis that will be performed by ANZTADC before final publication.

The most common category of the incident reported was respiratory and airway (29.4%). A detailed analysis of difficult and failed intubations among the first 4000 reports has been accepted by the peer reviewed journal Anaesthesia and Intensive Care (AIC), and should be published by December 2020. A further analysis, which includes the respiratory and airway events amongst the first 8000, is also underway. The second most frequent category was medications (16.5%). The anaesthetic incidents relating to medication amongst the first 4000 reports have been analysed, and a paper is in the process of being submitted to the AIC Journal for peer review.

Critical incidents involving the cardiovascular system were the third most common category and are an important cause of anaesthetic morbidity and mortality

Critical incidents involving the cardiovascular system were the third most common category and are an important cause of anaesthetic morbidity and mortality. A selection of cases to illustrate examples of the above categories have been added to the ANA – Alerts on the webAIRS website.

A formal systematic analysis of the incidents listed above is being planned. This will include a narrative search using key words and an automated database search to return additional reports that may be relevant. The narrative search will augment the original coding by the reporters that is shown in the table above. Data cleansing will also be performed to cross check that the reports were correctly coded by the original reporters. These additional checks might result in small changes to the percentages shown.

SUB-CATEGORY CARDIOVASCULAR	PERCENT
Other (including anaphylaxis)	22.90%
Arrhythmia (other than cardiac arrest)	19.70%
Hypotension	17.90%
Cardiac arrest	16.00%
Myocardial Ischaemia/Infarction	7.00%
Blood loss	7.40%
Embolism	3.10%
Hypertension	2.80%
Cardiac failure	2.10%
CVS trauma (unintentional surgical)	0.60%
Disseminated Intravascular Coagulation	0.20%
Electrolyte/Metabolic disturbance	0.20%
Total	**100%**

Interim results of the subcategories of the cardiovascular reports amongst the first 8000 reports shown as a percentage. Please note that the figures above are approximate and might change slightly because of data cleansing during the detailed analysis that will be performed by ANZTADC before final publication.

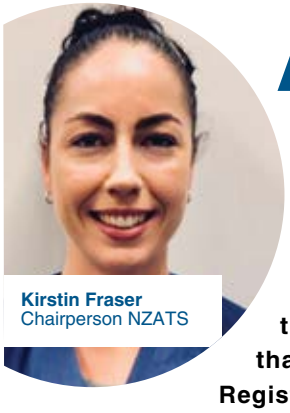
At present we have a small number of teams analysing the incidents and ANZTADC is looking for more analysers and teams to assist with this analysis. Although the number of reports in each main category is high, each individual subcategory associated with the main categories has a smaller number of reports usually numbering between 100 and 300. All the reports are already codified according to the following parameters, which assists in the analysis. To view the full dataset collected visit https://www.anztadc.net/demo/IncidentTabbed.aspx and select all of the tabs on the web page.

The ANZTADC Publications group is looking for volunteers to assist with the analysis of the data. The volunteers will be formed into teams to analyse the various subcategories. Please contact anztadc@anzca.edu.au to register your interest and indicate the main category that you are interested in analysing.

To view the latest ANA-Alerts go to the webAIRS website and login or register at https://www.anztadc.net

New Zealand Anaesthetic Technicians' Society

NZATS column



Kirstin Fraser
Chairperson NZATS

As I began to write this column, I reflected on the AGM report I wrote a year ago, and that the messages still apply today: "It is incredibly disappointing as an Executive to see the countless hours we put into the profession with the seemingly little interest from the wider workforce. In saying that, there are a core group of Registered Anaesthetic Technicians who are immensely passionate about their profession and are engaged at every step, they know who they are, and we thank them." This includes our executive members, our regional representatives, our examiners, registration examination volunteers, and those passionate individuals who engage with NZATS through our many forums.

On behalf of the executive, I would like to extend our thanks to NZSA. We greatly appreciate your support, especially in what has been such a challenging year. Those challenges have been either emotional, physical, and/or financial. COVID-19 has changed the world as we know it and we need to adapt to the new normal. As always, anaesthetic technicians will continue to get on with getting on.

NZATS was delighted to hear reports from around the country about how anaesthetic technicians did their profession proud in their preparation and response to COVID-19. We still hope to have articles published in the NZATS newsletter showcasing examples. Traditionally we have been a modest profession, but it is time we change that and collectively celebrate our successes!

Of the ~840 Anaesthetic Technicians on the Medical Sciences Council (MSC) register, we have: seven associate members and 290 qualified members. It is important to be aware that there are professions that would happily see the end of the existence/advancement of the anaesthetic technician profession. There is no other body other than NZATS that tirelessly work to prevent that from happening.

The priority of the MSC, as the regulatory body for ATs, is to protect the public from the potential harm an Anaesthetic Technician may cause. However, ensuring we have a strong, viable and sustainable profession along with optimal patient care is the core role of NZATS. We ask that you go back to your workplaces and implore your AT colleagues to become NZATS members. Without higher membership we are limited in our ability to speak as the voice of the profession.

A summary of achievements and issues from the previous 12 months:

- National Anaesthetic Technician Day was celebrated across Australasia on 10 March. It will always be on the second Tuesday in March meaning that 2021 will be celebrated on the 9th.
- The profession has been represented by NZATS at multiple taskforce meetings on workforce shortages and the training program progression.
- With the publication of the December newsletter, NZATS will have delivered an additional newsletter in 2020 to previous years.
- NZATS has engaged key people to review our machine check guidelines to ensure they are valid and fit for purpose.
- An inaugural team leader/charge anaesthetic technician forum was held in Auckland (between lockdowns) and it was so successful that a follow-on event will be held in 2021.

At the forefront of people's minds may be the transition of AT training from a diploma to a degree. COVID impacted the planning stages so currently it is looking like the degree program will commence in 2022. AUT has recently sent a proposed degree program out for consultation and generally NZATS supports the proposal, although we do hold concerns stemming from the discrepancy between the limited clinical hours achieved in a degree program and the number of hours suggested in ANZCA's PS08 Statement on the Assistant for the Anaesthetist. NZATS would like to explore the possibility of MSC, AUT and NZATS working together with the current accredited training hospitals (and others if they wished to apply) to provide an opportunity for students to work clinically outside of university term time, with hospitals utilising the current funding i.e. students could be in paid employment. An example of this could be students working after their exams in November/December, have Christmas off, and then return the second week of January to work through to the start of the academic year. This could potentially be advantageous to students in attaining clinical hours and of benefit to hospitals, which could use the placements as a means of pre-employment screening.

NZATS feel that the proposed degree program goes too far to the thinking practitioner side and potentially has gaps in preparation needed to becoming a professional and functioning practitioner.

We are excited about the majority of the proposed degree program – however, NZATS feels it must reflect the needs of the profession, and move towards future proofing a flexible workforce as current demand is high and will only increase in the future.

Ngā mihi,

Kirstin Fraser
NZATS Chairperson
Acting Communications Officer

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1. Dr Peng (Paul) Wen, *Australasian Physical & Engineering Sciences in Medicine* 2012; 35, 389–392

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