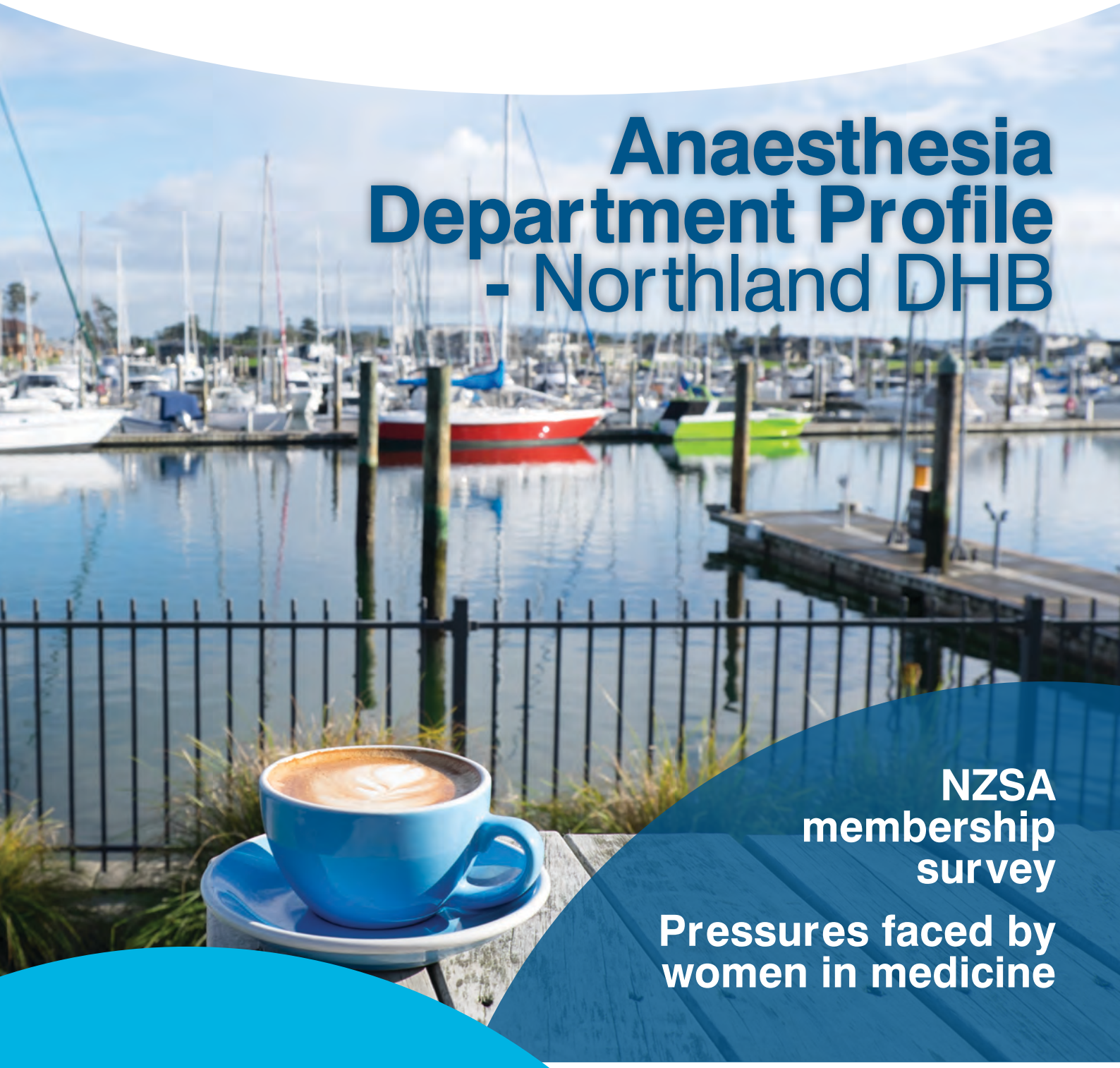
NEW ZEALAND
# Anaesthesia

THE MAGAZINE OF THE NEW ZEALAND SOCIETY OF ANAESTHETISTS • APRIL 2019



## Anaesthesia Department Profile - Northland DHB

## NZSA membership survey

## Pressures faced by women in medicine

**PLUS:**

BWT Ritchie Report from Canada

Annual Scientific Meeting 2019

A chat with an executive member - Nicole Vogts

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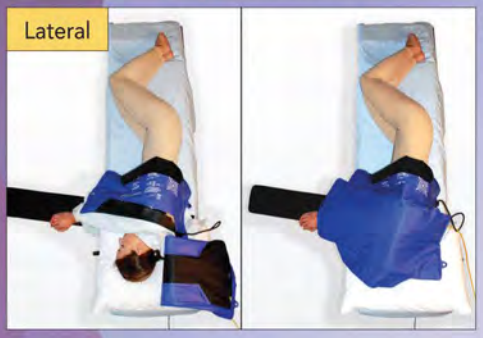

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## Special features








## APRIL 2019
## ISSUE 53


### 2019 publication dates and deadlines are:

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|---|---|
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| November 10 | December |

### Contributions and feedback

We welcome your comments on the magazine. If you would like to contribute ideas and/or an article please contact editor, Daphne Atkinson: comms@anaesthesia.nz

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# President's column

APRIL 2019

## Kia ora koutou

**I would like to begin by acknowledging the horrific events in Christchurch on 15 March. Unwanted and unwelcome anywhere, the terrorism that struck Christchurch seemed doubly wicked; has not the city, its citizens and healthcare workers suffered enough? Clearly and sadly well placed to deal with mass casualties, the theory is not something anyone wishes to put into practice. We praise and salute the dedication, exceptional work and professionalism of our colleagues in Christchurch who have been working hard. Our heartfelt thoughts are with the victims and their families, and the wider Muslim and Christchurch communities. We have seen the best of humanity since this tragedy unfolded; diversity, inclusiveness and unwavering generosity, compassion and support offered to those affected.**

Almost all of you will have been impacted by the recent, ongoing industrial action by the RDA. Thank you to those SMOs who undertook on-duty requirements to allow RDA members to exercise their right to withhold services. Well done to those RMOs who have had to live with the impact and stress that such tense negotiations bring despite studying for and sitting exams, among other stressors. I hope that by the time this goes to print there will have been a resolution that is mutually agreeable to both the RMO group and the DHBs. The development of an alternative union for RMOs has certainly changed the playing field for these negotiations.

The need for a strong collective voice to protect hard earned gains is critical in many situations. In areas where the NZSA advocates strongly on your behalf, we work hard to maintain our close links with related organisations such as ANZCA, so that we can effectively present a message or position that advances New Zealand physician anaesthetists and improves patient safety. The sharing and cross-pollination of ideas that occurs at Executive and Council meetings, as well as our official combined meeting with the NZNC in the middle of the year, go a long way to ensuring we can complement each other's messages and avoid contradiction. I am a proud member of my College and my Society and I was incredibly impressed by the release of ANZCA's Gender Equity Position Statement on 8 March, International Women's Day. I commend ANZCA for taking a leading and bold stand on Gender Equity.

***...a strong collective voice to protect hard earned gains is critical in many situations.***

In terms of the NZSA, office staff have been busy managing and supporting our member subscriptions, subspecialty networks, submissions and most recently collating and reporting on our membership survey. Thank you to those who took the time to feed back to us; like any membership organisation, we need to know your opinions and thoughts on relevant matters so that we can make our collective voice as strong as possible.

The results of our membership survey, and the many comments received, has reinforced that members view the NZSA's key role as advocacy for New Zealand anaesthetists, across a range of areas, including private practice (meetings with ACC and private hospitals and insurers rated highly) and more widely in terms of raising awareness of the contribution of anaesthetists to our health system to Government, officials and the wider public. In terms of the key issues, members consider workforce to be critically important and there is strong support for the NZSA to continue, and bolster, its advocacy for environmental sustainability and the welfare and wellbeing of anaesthetists. I encourage you to read the article on the member survey in this issue of the magazine, which includes a selection of member comments. Thank you again for your support. One member's words of encouragement were greatly appreciated: "Carry on chaps, you're doing a great job." We certainly intend to! The message which resonated most strongly from the survey was the need for the NZSA to keep up the momentum and stay focused.

***...there is strong support for the NZSA to continue... its advocacy for environmental sustainability and the welfare and wellbeing of anaesthetists.***

The beginning of the year is a good time to take stock and plan the year ahead; the issues that we are actively working on in 2019 include a review of the Relative Value Guide by the Private Practice Committee as well as:

## Advocacy:

Active participation in NZNC's PHARMAC Advisory Group. Supporting the New Zealand Anaesthetic Technicians' Society as their workforce negotiates its educational future and we also seek to bridge the anaesthetic assistant shortage affecting some parts of the country.

## Community:

Sponsorship of trainee events, both the Part 3 course in Auckland in December and various Anaesthesia Trainee Collective Events being organised by Rotational Trainee groups around the country; and supporting our networks – Airway Leads, Obstetrics (shared with NZNC), Paediatrics, and the newly established Acute Pain Network.

## Education:

Promotion and support of our combined ASM with NZNC and AQUA in Queenstown. A review of the Visiting Lectureships, and a review of the criteria for the BWT Ritchie Scholarship, both administered by the New Zealand Anaesthetic Education Committee.

***...there are many ideas, theories and counter arguments about the causes of burnout and exhaustion, and how to counter them.***

Physician Wellbeing and Welfare remain extremely topical, and as already mentioned, members would like us to continue our focus on this. We are cognisant of how difficult it is for our anaesthesia community, especially since we are small, when we experience the sudden death of a colleague. We are profoundly affected and want to better support our colleagues, and ensure there is help available.

It is interesting to note that there are many ideas, theories and counter arguments about the causes of burnout and exhaustion, and how to counter them. Although we hear about resilience and how its learned skills can help physicians prevent or avert actual burnout, the implication can also be that simply by increasing resilience, we are back to "Physician heal thyself." Essentially, the risk of this is to place the 'blame' or onus for not being resilient enough onto the doctor. Another way of looking at this is that we are affected by Moral Injury – a notion that Immediate Past President David Kibblewhite previously highlighted in a blog post.

***Our systems need improvement... to support the development of personal resilience and work fulfilment.***

Our systems need improvement as well, to support the development of personal resilience and work fulfilment. One way for our systems/DHBs to show they are walking the talk of improving wellbeing would be by ensuring the overwhelming narrative through industrial negotiations with all doctors – SMOs or RMOs – is that we are a valued workforce whose working environments and contractual obligations should enable, enhance and facilitate the work that we do. Hearing messages that we are too expensive, too demanding, too entitled and having to constantly fight MECA clawbacks can be phenomenally demoralising; quite the antithesis of resilience building!

Once again, thank you to those who took the time to complete our member survey. We will be spending some time to evaluate and reflect on the results to help shape our priorities and direction.

Naku te rourou nau te rourou ka ora ai te iwi
*(With your basket and my basket the people will live).*

***Kathryn Hagen, NZSA President***

# Private Practice Network establishment - nationwide representation sought

**The NZSA held its first Executive Committee meeting for the year in March and discussed how we can more effectively advocate for anaesthetists working in private practice.**

We would like to establish a communication Network to discuss and comment on issues affecting Private Practice in New Zealand. Your role as a regional representative would involve commenting on what is going on specific to your region in the private hospitals as well as informing the NZSA executive about how new initiatives might affect your region. The commitment would involve one or two face-to-face meetings a year as able, a couple of videoconferences and letting us know what you think. Thank you to those who have already come on board with the Relative Value Guide review. We need more voices for the ongoing issues facing private practice! If you would like to be involved and/or have any questions please email president@anaesthesia.nz

# News in brief


Dr Mike Ng

## New Executive Committee members

The NZSA has welcomed two new members to the NZSA Executive Committee: Dr Catherine Caldwell is an Anaesthetist at Wakefield Hospital and a Consultant at Capital Anaesthesia & Associates Ltd in Wellington. Catherine will be taking over as NZSA Treasurer after the NZSA AGM to be held at the NZ Anaesthesia ASM + AQUA 2019 Meeting in August.

Dr Mike Ng is an Anaesthetic Registrar at Capital & Coast DHB and our new NZSA Deputy Trainee Representative. He is working closely with our Trainee Representative Dr Nicole Vogts who is based in Auckland. Michael has an interest in the welfare of anaesthetists and trainees; and improving the transition from trainee to specialist.

## Therapeutic Products Bill

The NZSA is developing its submission in response to the Therapeutic Products Bill, which will replace the Medicines Act 1981. We believe the Bill potentially has far reaching implications for the specialty and the wider health sector. The Bill sets out the proposed legislative, principles-based framework for the new regime, which will cover all therapeutics (except natural health products for which there will be a separate consultation). Our submission will be focused on the medicines section of the Bill in areas such as product approvals, prescribing, labelling, and unapproved drugs (Section 29). The NZSA is concerned about the possibility of restricted access to Section 29 medicines, which will impact clinicians and patients. We are also concerned about extending prescribing scopes of practice. Members of our Executive have been looking closely at the Bill, and collating information, including attending briefings by the Ministry of Health and speaking with key stakeholders. The submission is due 18 April 2019. The Bill is the start of a lengthy process involving further Government decision-making, the passage of the Bill into law, and then a further two years to write the Regulations and Rules. Read all NZSA submissions on our website www.anaesthesia.nz (click the About tab/Advocacy)

## How can we reduce our carbon footprint?

Members have expressed interest in learning how to reduce their carbon footprint as anaesthetists and following a member's suggestion, we will be publishing a regular feature to share ideas from DHBs across the country. If you'd like to contribute the initiatives taking place in your DHB please email us at comms@anaesthesia.nz

## BWT Ritchie Scholarship

The BWT Ritchie Scholarship assists New Zealand-based anaesthesia, pain medicine and intensive care medicine graduates to gain overseas experience, which they can use on their return to New Zealand. Applications for the 2020 award of scholarships will close on October 31, 2019. Read the report from our 2017 Scholarship recipient Dr Oliver Brett on pp.20-22. More information on applying at https://www.anaesthesiaeducation.org.nz/bwt-ritchie-scholarship

New Zealand Society of Anaesthetists

ANZCA Australian and New Zealand College of Anaesthetists

## Visiting Lectureships 2019


Dr Matthew Drake

Dr Matthew Drake (Auckland DHB) and Dr Jane Thomas (Starship Hospital) have been selected for this year's Visiting Lectureships. Dr Drake was nominated by Dr Andrew Warmington, Service Clinical Director, Auckland City Hospital, for his presentation 'What's New in Obstetrics?' which reviews the most relevant and interesting publications in Obstetric Anaesthesia. It gives an excellent overview of recent developments and ideas in this subspecialty, which features in most anaesthetists' work. Dr Kerry Holmes, NZAEC Chair, nominated Dr Thomas for her presentation 'Paediatric Pain Management.' The lecture covers a very broad view of this topic with practical and pragmatic tips on dealing with tricky paediatric cases. This talk is focused on practical tips of use to all those anaesthetising children, from one of the national experts on the topic.


Dr Jane Thomas

Rotorua and Northland Hospitals have been chosen to host these talks. Dates to be confirmed soon – we will keep you updated in our E-Zine.

*The New Zealand Anaesthesia Education Committee established the Lectureships to share knowledge and experience from outstanding presentations among anaesthesia departments and practices. Each year, heads of departments nominate members of staff who have given an outstanding presentation at a CME session.*

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# NZSA membership survey - members have their say

Renu Borst

**Members have expressed overwhelmingly strong support for the activities and direction of the NZSA in our biennial member survey, even more so than our last survey in 2017. NZSA CEO Renu Borst says that she believes this is in part because the NZSA took on board the comments from that survey to increase face-to-face member engagement (establishing and running the NZSA forum, regular visits to hospital departments) and to more clearly communicate the value of NZSA membership.**

Ms Borst says that the survey is invaluable in helping to shape the Society's priorities, including new initiatives, and allocation of resources. "Two areas that have emerged strongly since our last survey are the importance for members of the NZSA working to improve the welfare and well-being of anaesthetists, with a range of suggestions including mentoring programmes; and having a stronger voice in advocating for environmental sustainability. Another marked finding was growing support for our sub-specialty networks e.g. obstetrics, paediatrics." Ms Borst says that the Society is doing work in all these areas but will be exploring how it can have a greater impact across these activities. Advocacy continues to be viewed as our core function, and meeting with the Health Minister, health officials and private practice stakeholders, such as private hospitals, rated most highly.

### *Are you happy with the overall direction of the NZSA?*

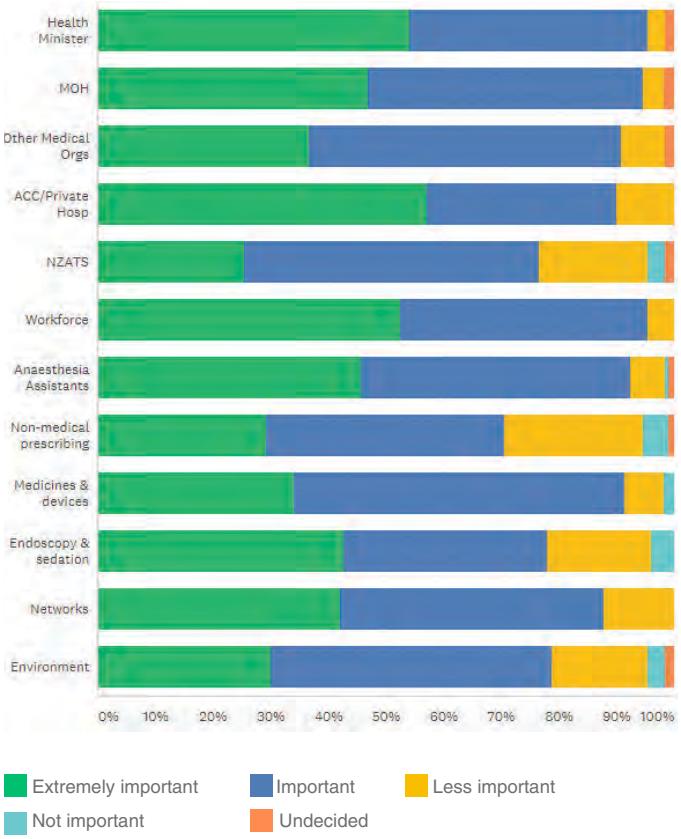

NZSA membership is tracking steadily upwards, and the survey showed a significant increase since 2017 (about double) of members in the 25-34-year-old age bracket. She commends the work of NZSA Executive, particularly our trainee representatives, for raising awareness of the Society amongst trainees. "They have been championing the Society, especially by presenting at trainee events, and taking the time to speak to trainees regularly."

Ms Borst says member engagement is vital to the Society's effectiveness.

"We are grateful to members who completed the survey and expressed their views. We do appreciate the many positive comments, and take on board suggestions for improvement, such as refining our website. We will continue to keep members updated on our work across advocacy, education and the community."

## Advocacy

### *How would you rate the importance of current NZSA advocacy activities below?*




### *Comments on advocacy:*

*"Advocate for all the important aspects of our role that may be affected politically or by other organisations from both a NZ perspective and representing the ethos of our college."*

*"Environmental, climate change issues should be the main population health issue."*

*"Advocacy is the most important function."*

*"NZSA is the only NZ anaesthesia focused professional organisation to put forward the interests of NZ anaesthetists."*

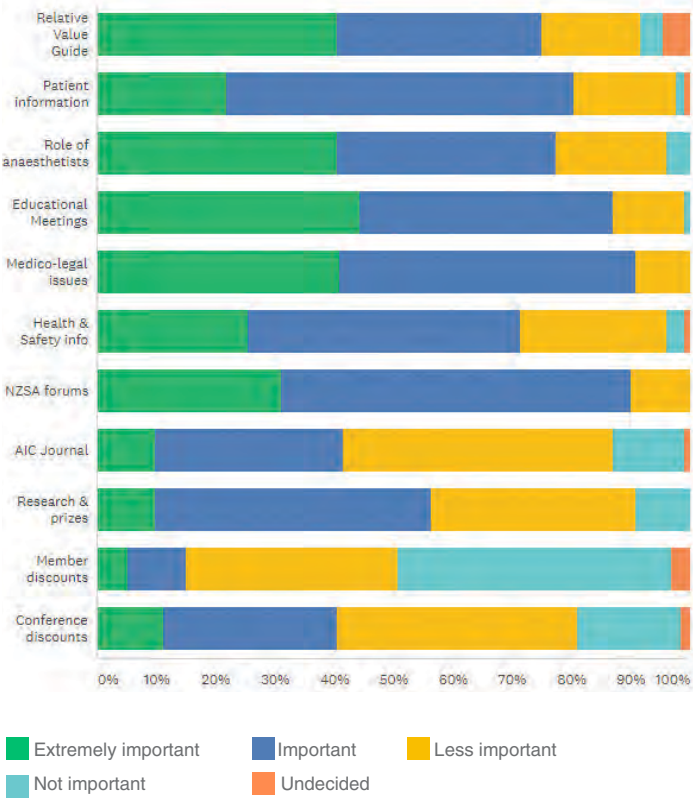
*"We need the Society to meet with politicians to educate them on who we are and what we do…the Society's good efforts must continue."*

*"We need stronger advocacy on environmental sustainability."*

*"Working with ACC to accept a more modern version of the RVG would be the single most important activity."*

## Education

### *How would you rate the importance of the following NZSA educational and financial activities?*




### *Comments on education:*

*"Education on the role and value of anaesthetists is critical."*

*"Visiting lectureships are an excellent initiative. The ASM goes from strength to strength."*

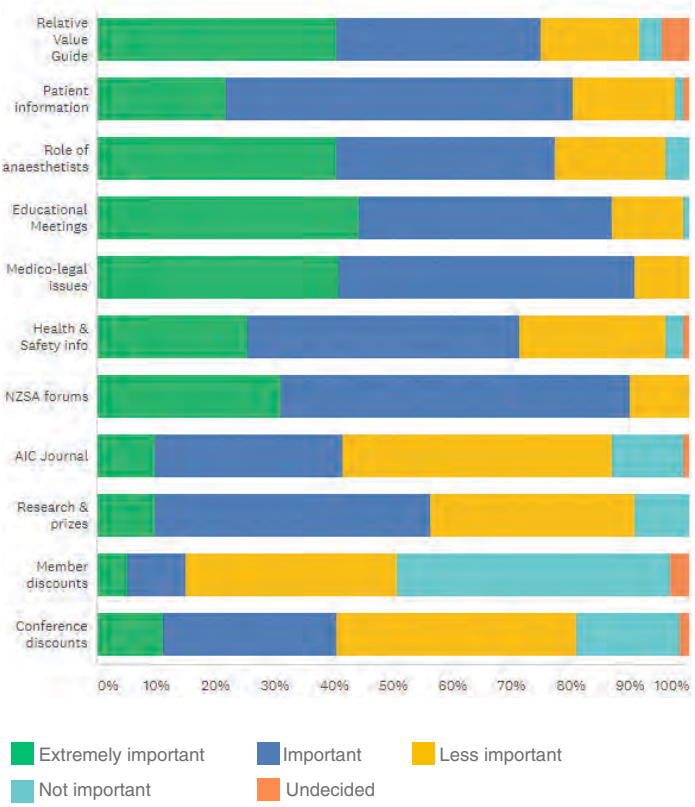
*"Local CME opportunity needs to be as strong as possible to reduce the need for anaesthetists to travel overseas (expensive and environmentally damaging).*

*"Suggest discounted rates for affiliate attendance e.g. techs nurses and trainee members."*

*"Prefer that NZSA stays away from hosting bigger, potentially risky conferences."*

## International activities

### *How would you rate the importance of the following NZSA international activities?*




### *Comments on international activities:*

*"Overseas aid and development need to be strengthened. More financial and logistical support for a set of pre-identified core activities that best meet the needs of our colleagues in the Pacific."*

*"WFSA membership allows a NZ voice at the international level."*

*"NZSA should maintain strong relationships with the WFSA and other world bodies in anaesthesia to raise the profile of NZ anaesthesia."*

*"NZSA is our voice internationally!"*

## Communications

Members access information about the NZSA through a range of communication channels, and our publications remain widely read. The President's blog continues its increase in readership. About 98% of members were happy with the frequency of communications. Some members expressed that they are not interested in our social media channels, such as Facebook, but concede that others will want to have these available.

## Website

Some members expressed the need for website improvements and support NZSA redeveloping its website. There were suggestions about content, including having a page on environmental sustainability. The most frequently visited parts of the site are events, news and updates, and private practice information such as the Relative Value Guide.

## Other comments

*"Unless we are valued, other groups will try to assume the functions we provide. Enhance and defend that."*

*"I don't want to be an anaesthesiologist!"*

*"Going from strength to strength, thanks to current leadership and secretariat!"*

*"Please progress the discussion on Anaesthetists vs Anaesthesiologists."*

*"Carry on your great work. Welfare is vital. Eradication of bullying is vital."*

*"How about some discussion on retirement, approaching the end of one's career – dealing with reduced social contact that that entails."*

*"There are a few mentoring initiatives being developed and I would like to see better sharing of resources and a joint initiative for this."*

# More News in brief

## Part 3 Course

The NZ Anaesthesia Part 3 Course is designed for provisional fellows and senior trainees who will be making the transition to SMO in the near future. Part 3 is limited to 28 participants to maintain the personal and interactive nature of this course. CV and interview workshops and plenary sessions included. To register, visit www.anaesthesia.nz and click on the education and events tab on homepage. Please contact NZSA Membership Manager Lynne Wood membership@anaesthesia.nz, 04 494-0124 if you have any queries.

## NZSA Health and Safety Resource

If you are an anaesthetist working in private hospitals you are considered a Person Conducting a Business or Undertaking (PCBU) with obligations to comply with health and safety regulations. The Health and Safety at Work Act (HSWA) 2015 shifted the focus from solely monitoring and recording health and safety incidents to proactively identifying, preventing and managing risks. The NZSA has a resource for members only – NZSA Health & Safety manual – (you must be logged in to access this on our website) to help you comply with the Act, and avoid incurring significant fines. This resource includes instructions for using the manual, an online educational component with two short videos, links to key websites with H & S information, and a hazard register.

# **Women's work** - pressures faced by women in medicine

*Nicole Vogts, NZSA Executive Trainee Representative*

**A recent Australian newspaper article raised the issue of sexism in the medical workplace, with a female surgical registrar reporting crippling workloads and discrimination.[1] This is a not a new problem, but recently it has certainly attracted more commentary.**

The gender composition of our medical workforce is changing. Data from the Medical Council of New Zealand shows that the number of female doctors is steadily increasing, and that women now outnumber men amongst new graduates and house officers.[2] This is not bad news for patients – a recent study has shown reduced mortality and readmission rates for patients treated by female doctors.[3] However, alarmingly, international statistics show that women in medicine report higher levels of stress, burnout and mental illness than their male counterparts. Our ANZCA trainees are not immune: the 2017 Welfare Survey undertaken by the College found that female trainees have double the rates of distress, anxiety and depression than those reported by males.[4] So, what makes a medical career that much more challenging for women?

This question prompted Dr Charlotte Chambers from the Association of Salaried Medical Specialists to begin her qualitative research into the pressures faced by female doctors in the New Zealand workplace. Her 2016 report on burnout in the senior medical workforce in New Zealand found it far more prevalent in female specialists, and almost ubiquitous in the 30-39 years age bracket.[5] Dr Chambers' recent study consists of interviews with female specialists, including anaesthetists, and the review of their stories in search of common patterns and themes. She believes that medicine's hidden gender bias has roots in its history as a 'traditionally male enterprise.'

***...the view of medicine as an all-consuming profession is still held by our medical colleagues and is internalised by women themselves.***

"There is an assumption," she told me "that medicine will occupy a lot of your life – and that you will generally work full-time." This assumption originates in the historical image of the dutiful young doctor pacing the hospital corridors at all hours, occupying his free time with textbooks, usually with the luxury of a wife at home to look after family and other responsibilities. Society has changed, but the view of medicine as an all-consuming profession is still held by our medical colleagues and is internalised by women themselves. Conflict arises when these same women feel forced to choose between their career and raising children; the traditional 'women's role.' It's easy to understand how burnout is a consequence of this.

A proposed answer is part-time work, but availability and feasibility of this is dependent on many factors – geographical location, type of specialty and, for trainees, stage of training and flexibility of your department and training college.

Anaesthesia has traditionally had a reputation as a 'family friendly' specialty but the reality varies between departments. ANZCA supports part-time training, but leaves negotiations around this to the trainee and their employee. For many this means finding another trainee with whom to job share. And even when part-time work is possible, there are other issues. Some doctors interviewed in Dr Chambers' study felt that they were viewed as "a bit of a slacker" by colleagues when they decided to work part-time. It's not hard to see where these feelings originate, as any article written on the 'feminisation of the medical workforce' offers the opinion that women taking time off work and then electing to work part-time will lead to poorer outcomes for patients. This view is largely unchallenged, despite data suggesting that part-time doctors report better mental health, and that their patients report increased satisfaction with their care.[6]

***The first step is recognising we have gender bias.***

So how do we address the issues affecting female specialists? "The first step is recognising we have gender bias," says Dr Chambers. As with all important issues, conversation around this problem is key to creating long-term change. We have to question the views held by colleagues, by society, and maybe even held by ourselves, consciously or subconsciously. We need more research on the rates of poor mental health and burnout in women, and their possible solutions. We need a workforce which offers more options for flexibility.

*Article continued on page 25*

# **Aspirations into Action** - Annual Scientific Meeting 2019

*Dr Kerry Holmes Convenor*

**New Zealand's ASM for 2019 will be one for the ages. Not only are we combining with the legendary Annual Queenstown Update in Anaesthesia (AQUA) meeting for a unique 'AQUA on steroids,' but you will be blown away by the array of international and local speakers joining us.**

Ever been to a conference and thought "now there's a great speaker"? Well, they're probably coming to Queenstown!

Our keynotes are Prof Mary Dixon-Woods and Dr Andrew Klein from the UK, and Prof Ed Mariano from the US.

Our invited speakers are Prof Bruce Spiess from Florida, A/Prof Alicia Dennis from Melbourne, and our very own Prof Simon Mitchell. We also have Prof Alison Phipps from Glasgow, Prof Martin Culwick from Australia, and NZ Green MP Gorliz Ghahraman, plus many extremely talented New Zealand speakers. Last, but not least, local legend Prof Alan Merry will be giving a very special opening address.

***...our aim is to generate plenty of takeaway points that will make you think...***

Our overarching theme this year, *Aspirations into Action*, is one of striving for improvement, and our aim is to generate plenty of takeaway points that will make you think, and that you can implement back at your workplace.

What can you expect? Day One will open the conference with two inspirational speakers showing us what we have done as a profession, and what we can do. Further sessions cover Quality Improvement at home and abroad, how we can improve ourselves through communication, and we'll finish with a nod to the usual AQUA update sessions with local Hot Shots.

The Day Two opening session on Morbidity and Mortality is designed to be eye-opening and thought provoking. Then we have world leading speakers on refugees, Green MP Gorliz Ghahraman and Prof Alison Phipps from Glasgow. We will look at why we need to be talking about refugees to New Zealand, and some practical lessons on intercultural communication.

Also, because it is a Scientific Meeting, we will be holding the Ritchie Prize session for original research. This session has been going from strength to strength over the last couple of years and should be great.

You will not want to sleep in after the Gala Dinner, because Day Three comes out of the gates running. We have three immense intellects speaking on the use and abuse of evidence, and we guarantee you won't be looking at journals the same after this.

***We have three immense intellects speaking on the use and abuse of evidence...***

We then close the meeting with a bang. Two international speakers talking on topics close to their hearts, then Prof Simon Mitchell presenting original research, and sharing background knowledge, from the Thai cave rescue.

We have a great range of workshops planned, that we hope will have appeal for everyone. On the Wednesday before the conference opens, we have the usual CPD workshops, as well as BATS on Ice. On Saturday afternoon we have our keynotes and local experts running through a range of options that we're sure will pique your interest.

And if all that wasn't enough, then wait till you see the social program. Every night we will have a function to maximise this opportunity to catch up with friends and colleagues – from the opening drinks on Wednesday night and wine tasting at the Industry evening, to the Gala Dinner at the top of the gondola, and of course the Coronet Peak family BBQ with night skiing that has become a staple of all AQUA events.

We have it on good authority that there has been an unprecedented level of demand for tickets already for this conference, so get on and get yours secured (registration is open).

We're looking forward to seeing you there!

***Dr Kerry Holmes – Convenor***

**On Behalf of the Organising Committee:**

**Drs Tom Fernandez, Olivia Albert, Neil MacLennan and Kerry Gunn**

# Aspirations INTO Action 2019

COMBINED NEW ZEALAND ANAESTHESIA ASM + AQUA

**EARLY BIRD REGISTRATION CLOSE: 14 JULY 2019**

**AUGUST 21–24, 2019**
MILLENNIUM & COPTHORNE HOTELS
QUEENSTOWN, NEW ZEALAND

The New Zealand ASM is joining this year with the Annual Queenstown Update in Anaesthesia (AQUA) to provide a stimulating conference in one of the world's alpine wonderlands. The theme is "Aspirations into Action" and the organising committee have put together an aspirational and wide ranging program with an exceptionally fine array of local and international speakers. As well as the usual AQUA update sessions on a number of topics, you can expect to be challenged to ensure your practice is the best it can be.

## INTERNATIONAL KEYNOTE SPEAKERS

**DR ED MARIANO**
Professor of Anaesthesiology,
Perioperative and Pain Medicine
Stanford University School of Medicine
USA

**PROF MARY DIXON-WOODS**
Director
The Health Improvement Studies Institute
University of Cambridge
United Kingdom

**DR ANDREW KLEIN**
Cardiothoracic Anaesthetist
Editor-in-Chief, Anaesthesia
Royal Papworth Hospital
Cambridge, United Kingdom

**ABSTRACT SUBMISSION CLOSE**: 7 JULY 2019

#NZASM19 #AQUA19

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# A chat with an executive member - Nicole Vogts

*Nicole Vogts, NZSA Executive Trainee Representative*

## What led you to choose anaesthesia as your specialty?

I love Anaesthesia because it's a collaborative specialty. We work with so many other groups in the operating theatre and perioperatively. We also collaborate with the patients themselves; planning a good anaesthetic is about determining the patient's priorities, and negotiating a plan that will work for you, for them and for the type of surgery they're having. I've also always been interested in Pain Medicine, and the fact that pain management is part of Anaesthesia is a bonus!

## How would you describe your training path, and where did you study?

My path has been quite traditional, with a bit of time off here and there. I studied Medicine at the University of Auckland and then worked for two and a half years as a house surgeon. During this time I took a few months off for travel. I then started Anaesthesia training. One of the best things about working in Auckland is the number of different departments and hospitals – and I've been lucky to visit them all during my training. That included time in Whangarei Hospital, as Northland is part of the Auckland training rotation.

## Who/what was most influential during your training?

I found a mentor as a house surgeon and they've been a big support over the past six years. I know I can call them when I need a coffee and a debrief on work or personal matters.

I also think that having a strong peer group is really important. Even over the relatively short time that I've been training there's been a growing awareness of this. Trainees have always been good at organising study groups but there's now a lot more focus on social support. Registrars are establishing messenger groups discussing work and social matters. The Anaesthesia Trainee Collective events are growing across the country. We're all trying to take better care of each other. There are some trainees who have had a huge influence on me during the most gruelling parts of my training.

***It used to be embarrassing to ask for help – now it's almost expected.***

## Where do you work?

I've recently started my Fellowship at National Women's Hospital in Auckland.

## What is the most satisfying aspect of your job?

At the moment, it's helping women to have a safe and meaningful birth. Obstetric anaesthesia is so complicated – there are many different disciplines involved in the childbirth process, there are complex physiological changes of pregnancy which can present a real challenge where there is also pathology present, there are hair-raising emergency situations, and in the middle of all this there's a woman and her support people/whānau who are having this hugely important life experience.

## What is the most challenging aspect of practising medicine/anaesthesia?

For me, I think it's the emotional and psychological stress of the situations we find ourselves in. We're protected from some parts of that as anaesthetists because usually we don't follow patients for the duration of their illness – we miss out on many of the heart-breaking complications and decisions and end-of-life care. However, we find ourselves in acutely stressful situations more often than other specialties; we are trained to manage critical events and emergencies. Traditionally, medical culture has underplayed the importance of this stress – there's been a real 'harden up' approach. But I find it challenging, and I think it wears away at you over time, especially if you're not getting much work-life balance.

## What are the key issues for anaesthesia trainees in New Zealand? How can we best address them?

The big issues that have come up over the past few years have been the same as those the consultants are raising: the stressful nature of our jobs, the growing desire for more focus on well-being, the need for self-care and job flexibility. We know that trainees have high levels of stress, and that the major causes are examinations, shift work and the desire to do a good job and not make mistakes. So how do we address this?

For starters, giving trainees a voice. The NZSA introduced the trainee rep role a decade ago and they've been inviting us to raise our concerns directly with the committee ever since. ANZCA similarly has a trainee committee, and we work closely with them. There has been real progress made in the areas that have been brought forward. The problem is it can be difficult to get trainees to engage and speak up. I think that this happens for many reasons:

lack of time and energy, lack of access to channels available to them and perceived pressure to 'keep your head down and get on with it.' This is a puzzle that I think about a lot – how to best capture the issues that are meaningful to trainees. I'm open to ideas!

## There's a growing emphasis on wellbeing which is taking a bigger picture approach to look at what improvements we can make on a system level, and how the profession itself can better support colleagues. Are we beginning to make progress?

I think the new emphasis on welfare and wellbeing is fantastic. We are making progress – there is a clear culture shift happening in medicine. It used to be embarrassing to ask for help – now it's almost expected. People are talking openly about seeing a psychologist, their GP, taking time off, having a mentor. Personally, I've done all of these things at one time or another. The Society has been a vocal supporter of improving anaesthetists' wellbeing. They're trying to keep the conversation going and to understand how to best support anaesthetists. There've been too many casualties along the way for us to remain quiet on this.

*Nicole and her husband Sam.*

## Why did you volunteer to work with the Society?

I first heard about the Society as a very junior trainee and I thought it was for consultants only – a common misunderstanding! Later, John Burnett who was the previous Trainee Representative filled me in on what I was missing. It's been a real eye-opener to hear about the complex issues facing anaesthesia in New Zealand, and how NZSA, ANZCA, NZATS and many other groups work together on these.

## What does the Society offer trainees?

I've learnt so much about what the Society does over the past year and I really encourage trainees to get involved early. The NZSA represents trainees on many local and international issues that directly affect their daily work – or will do as they move into consultant roles. Through the website, Facebook page and newsletters it keeps members up to date with progress on these issues. It links New Zealand to other anaesthesia societies internationally, and supports our colleagues in the Pacific. It is a major supporter of many trainee events, research days, and important national events such as the NZ ASM. It awards the BWT Scholarship, which helps a New Zealander fund their overseas fellowship. And on top of this, membership is completely free for trainees!

## What career would you have chosen besides medicine?

I'd love to be a food and wine critic – how good would that be?

## What do you like to do/are your interests outside of work?

My newest interest is Te Reo Māori lessons. I've finished my first semester through AUT and am just starting my second. I thoroughly recommend it. The classes are focused on spoken language, with an emphasis on daily practice and conversational skills. I've learnt a lot about Māori culture along the way, which is a bonus. I'm finding it really challenging but a lot of fun. There's nothing like finishing the working day by belting out an off-key waiata in a room of strangers!

## What was the best holiday you've ever had and why?

My husband is an anaesthetic trainee as well. After our primary exams, we took two months interrupted training, rented a car and drove around Europe. We had a rough plan only and were often booking accommodation en route to the next town. We lived on a diet of wine, cheese and gelato. It was total freedom!

# Anaesthetic Department Profile - Northland DHB

**Our April issue kickstarts a regular new feature profiling anaesthetic departments from throughout the country. Dr Joanna Coates writes about the Northland region and DHB, and says they're delighted to share with NZSA members the joys and challenges of working in Northland.**

## Northland region and DHB – an overview

***by Dr Joanna Coates***

Sitting at the top of the North Island, in the so-called 'winterless north,' covering some of the most remote and deprived areas of New Zealand, Northland DHB is a mid-sized organisation providing health care to a rapidly growing and aging population. The DHB has a catchment population of approximately 175,000 and growing. We are one of the fastest growing regions of NZ, and have the most rapid increase in those over the age of 65; this population is rising by 8% year on year. This rapid growth brings a sense of a thriving community, but also presents challenges to the region's infrastructure, not least its health care system.

The population is very mixed, with a high level of rurality and deprivation. Twenty eight percent of our population are Māori, bringing a strong traditional cultural influence to our care. There are also large numbers of people who originate from other countries, including various European nations as well as an increasing Asian population. Diversity is definitely one of Northland's assets, although, again, it can also be a challenge.

The DHB has its base hospital in Whangarei, with satellite hospitals in Kawakawa (Bay of Islands), Dargaville and Kaitaia. Of these, surgery is only undertaken at Whangarei and Kaitaia Hospitals, but all centres have inpatient and outpatient facilities and an ED. It is 150km and a 2-hour drive between Whangarei and Kaitaia; the hospital charters a daily flight to transport doctors and other staff between these two sites, and there is a very busy HeliMed service to transport patients around the region.

### Anaesthesia and ICU in Northland

There is a small surgery unit at Kaitaia Hospital, which has its own full-time Specialist Anaesthetist. Cases undertaken there are usually ASA 1 and 2 patients undergoing minor (usually day-case) surgery, together with some interventional pain procedures and endoscopies. Most elective surgery and all emergency surgery and Intensive Care activity takes place at Whangarei Base Hospital, in central Whangarei. At the base hospital, we have a team of 20 Specialist Anaesthetists, 4 MOSS-grade anaesthetists, 7 registrars and an SHO in Anaesthesia, and 7 ICU registrars. Five of our anaesthetic registrars rotate up from the Auckland training rotation, and the ICU has just been given accreditation for training, too, allowing them to recruit registrars from the ICU training scheme.


We are well supported by Anaesthetic Technicians, Pain and Pre-assessment Clinical Nurse Specialists, PACU, theatre and ICU nurses and a wonderful office with 2 very helpful admin staff (the atmosphere in any department is determined by the roster administrator, and ours is superlative, having the nickname "Mother Theresa"!). Our pre-assessment service was pioneering in developing the role of Nurse Specialists in pre-assessment, and many of our patients undergo nurse assessment alone in preparation for their surgery, only meeting an anaesthetist on the day (which is cost-effective but can make for a busy and stressful time for the anaesthetist on the morning of surgery!).

We have 6 operating theatres, an endoscopy room (in which the occasional GA is given), and an ICU which can accommodate up to 4 level 3 patients or 8 level 2 patients (dependent on nursing staffing, which is a recurrent problem). We undertake most types of surgery, including General Surgery, Gynaecology, Urology, Orthopaedics, ENT, Eye and Dental surgery. We do all but the most complex procedures from within these specialties; Ivor-Lewis and Whipples procedures in district hospitals are things of the past, thankfully.

***Our pre-assessment service was pioneering in developing the role of Nurse Specialists in pre-assessment...***

We also have visiting Maxillofacial, Plastic and Paediatric surgeons. There is an evolving Chronic Pain Service, which is slowly growing to meet the enormous needs of our aging population. We have a Delivery Suite which offers an Obstetric Epidural service, with a relatively low Caesarean Section rate of around 15%. The trauma service is particularly busy, especially over the summer months, when the population swells due to the influx of NZ and overseas tourists.

Out of hours, we have a (resident) registrar on call for theatres, backed up by an on call consultant, and there is a similar arrangement for ICU. The Specialists split themselves onto one of the 2 rosters, so for 'pure anaesthetists' the call frequency is currently 1 in 12, for the 'intensivists' (who are all anaesthetists) it is 1 in 8. Both are reasonably busy, with the usual culprits of obstetrics, post-tonsillectomy bleeds and critically unwell patients keeping the teams up overnight. The "life or limb after midnight" rule is well adhered to.

We are desperately short of operating theatres, and struggle to keep up with demand, especially when the emergency service is busy. Patients in Northland are frequently co-morbid, elderly and obese, and often present very late in the clinical course of their disease, meaning that both the surgery and the anaesthesia can be complex and time-consuming. We have been given funding by the Ministry of Health for a separate Endoscopy Suite and two further operating theatres, but planning is long and painstaking, and, meanwhile, our waiting lists grow. It is not uncommon for patients to have deteriorated so much whilst waiting for their surgery that the surgery is no longer deemed worthwhile or appropriate when they finally come for it. This is far from ideal, and it can be very frustrating for patients, anaesthetists and surgeons alike to feel that their hands are tied by an inadequate system. This seems especially true for our patients with poor health literacy, and those who don't have relatives to advocate for them in what is an increasingly complex system to navigate.

***...Northland isn't just a great place to work; it's a great place to live!***

On the positive side, it means that there are anaesthetic challenges every day, be they very large patients, very sick patients, very young or very old. In general, the atmosphere in theatre is convivial, and the teamwork is superb. When the chips are down, everyone pulls together to get the job done.

Whilst our facilities are outdated and way too small, our equipment is up-to-date and functional. We have a brand new monitoring system which allows us to see monitoring in theatre from any computer in the hospital, and state-of-the-art technology that allows us to do telehealth clinics, allowing Whangarei-based doctors to 'see' patients who live up to 200km away in the Far North without wasting time and expense on travel. In addition, these facilities are set up in all our ED resus areas throughout the district, so that the ICU team can 'review' critically unwell patients in the outlying hospitals and give real-time advice to the rural medicine specialists treating them whilst transfer to Whangarei is planned and arranged. These videoconferencing facilities are also useful for joining meetings elsewhere in the DHB or even other parts of the country.

There are many young and dynamic specialists driving services forward. Of note, within the Anaesthetic department, we have developed an Echo Clinic, enabling patients to have an anaesthetic assessment combined with an echocardiogram performed by the anaesthetist, as a 'one-stop-shop' visit. We also run a High Risk Clinic, in which patients who are at high risk of perioperative morbidity and mortality can have an extended risk discussion and benefit from shared decision making before committing to surgery. Interestingly, about half the patients coming through this clinic choose not to proceed with surgery. This is an area I see as very likely to expand as we start to consider more often what is appropriate for patients who are 'in their twilight years.'

## Private Practice

There is a small Private Hospital in Whangarei providing surgery for most of the specialties covered in the public service. The work is a mixture of ACC-funded, privately funded (either by insurance or by the patient themselves) and some DHB cases which are 'out-sourced' to the private system because of a lack of capacity within the DHB's facilities. There is also a stand-alone private Orthopaedic Day-Stay surgery unit. Work is plentiful, and we are seeing more patients fund their surgery themselves due to the long waiting lists (and high thresholds) for surgery within the DHB. In addition, there is a rapidly increasing population of retirees from Auckland to the Bay of Islands, who have health insurance. They are surprised not to have a hospital providing surgery closer to their homes; I suspect that this will happen in the future.

What attracts most people to Northland, however, is not monetary gain, but lifestyle and enjoyment of the Great Outdoors. Hence, for the remainder of this article, I will focus on the non-medical attractions of our region!

## Family Activities

We are seeing an increasing trend of people who were born and raised in Northland coming back to raise their own families. Many have left as young adults to travel, study at university or progress their career, but return as they, too, want to settle down, buy an affordable house with some land, and bring up their children in a safe, clean environment.

As well as the ubiquitous sporting opportunities, Whangarei alone has 36 children's playgrounds, scouts and girl guides groups, skateboard parks, traditional Māori dance classes, horse riding lessons, glow worm caves for young explorers, youth theatres, sailing for teens, surf schools, abseiling, surf life saving clubs and courses, toy libraries, indoor playgrounds, interschool sports tournaments, calf clubs, disc golf courses, and more. For obvious reasons, most activities are centred on the outdoors, but, when it does rain, the library and aquatic centre offer particularly good facilities for a city of Whangarei's size.

## Geography and Climate

Northland is New Zealand's northernmost region and the first one to be settled by Polynesians and European explorers – and those who choose it as their home now will appreciate why! Northland and especially the Bay of Islands are one of the most popular tourist destinations in the country, offering an abundance of ancient forests, historical sites and world class beaches – there are over 100 beaches in Whangarei District alone.

Northland is also home to giant sand dunes and Kauri trees, an exciting range of wildlife, huge areas of green and productive farmland and fruit orchards. On the West coast, one beach alone is 110 kilometres long, all set between big city Auckland and the magic of Cape Reinga. Our native species abound, from Kiwi to Orca; they all live here.

The beautiful landscape and coastline are the result of a very interesting combination of extinct volcanoes, raised sea floor with limestone formations and ancient Gondwana rock. For those who prefer to be on or in the water, the opportunities here are endless – sailing, diving, spear-fishing, surfing, stand-up paddle-boarding, big-game fishing, and plain old ocean swimming are accessible to all.

Northland has the highest average annual temperature in New Zealand, but it is never extreme. In summer, day temperatures range between 22°C and 26°C while in winter night-time minimums may drop to around 7°C. Light frosts are possible in sheltered areas but are not common and snow is unheard of in low regions.

Annual sunshine hours average about 2,000 in the region, often rain showers mixed with sunshine. Annual rainfall is around 1,500 - 2,000 mm, but approximately one third of that falls in the winter months of June, July and August, which definitely feels like a winter, even if the locals try to pretend there isn't one!

## Events, Dining and Nightlife

While Whangarei is more renowned for its natural life than its nightlife, there is a lively bar scene, with websites dedicated to events and live music venues.

The artistic community also continues to add creative events and venues throughout the year, while the Council sponsors free concerts, festivals and open air cinema.

Exciting events are spread throughout the year, for example Māori festivals, agricultural field days, rodeos, boat fairs, fun walks, rally championships, Scottish highland games, open air cinema, flower shows, horse and dog races and shows, music festivals, fishing tournaments etc.

And for those who enjoy the bright lights of the big city, Auckland is only a two hour drive away, meaning that concerts, West-End shows, opera, ballet and fine dining can be enjoyed for the occasional evening.

In summary, Northland isn't just a great place to work; it's a great place to live! We welcome enquiries from prospective anaesthetists – give us a call or pay us a visit!

# National Obstetrics Anaesthesia (NOA) Network - update

*Dr Aidan O'Donnell*
*NOA Chair*

**The NOA network is a national group comprising Obstetric Anaesthetists from nearly all of New Zealand's 20 DHBs. NOA aims to achieve best practice by sharing guidelines, providing support for clinical practice in difficult cases, and encouraging and supporting members to foster training and education. NOA Chair Dr Aidan O'Donnell took over from founder, Dr Douglas Mein, in mid-2018. He reports on the last 12 months and the broad range of issues NOA has covered.**

The group meets three times a year, and one of these meetings includes a lengthy plenary meeting with comparable groups in Obstetrics and Midwifery, allowing the three main stakeholders in women's health to come together to tackle our shared issues. Forging and nurturing links with other professional groups is a core NOA objective.

A main focus of activity has been the national Maternity Clinical Information Service (MCIS) introduced by the Ministry of Health. Early versions of the software were ill-suited to anaesthetic requirements. Lengthy and detailed consultation between the development team at Clevermed, and several NOA members, including Deputy Chair Dr Matthew Drake, has substantially improved the applicability of the MCIS system to anaesthetic practice. NOA will be closely involved in the future evolution of MCIS.

In addition to MCIS, Matthew has been involved at a national level in the development of the national maternity early warning system and vital signs chart, which is being rolled out across the country this year.

NOA provides collegial support for members and is particularly helpful to those working in more isolated areas. Between meetings there is also plenty of email exchange between members. NOA members can draw upon the experience and wisdom of the group to help address issues and concerns arising in their practice.

Our most recent meeting was held in March 2019. Sixteen members attended the meeting, which opened with a reflection of the recent Christchurch shooting. One of our members was working on the front line in Christchurch Hospital, and gave the group a moving, impromptu description of his role in caring for the victims.

The meeting continued with discussions of MCIS; the Perinatal and Maternal Mortality Review Committee and Maternal Morbidity Working Group; epidural infusion regimes; the NOA group Terms of Reference; the national monitoring of adverse events associated with the use of tramadol in breastfeeding women; sphenopalatine ganglion blockade for dural puncture headache, and national studies of outcomes of care in childbirth in New Zealand. This was followed by a fascinating discussion of a successful case of spinal anaesthesia in a woman with Marfan syndrome. People with Marfan syndrome often have ectasia of the dural sac, which means that both spinal and epidural techniques are frequently unsuccessful. Dr Nigel Skjellerup came up with a novel approach which has been published in the International Journal of Obstetric Anaesthesia.

One of the most valuable aspects of NOA, as attested by feedback from members, is the opportunity to have informal discussion as part of our meetings. The agenda is deliberately slightly loose to allow for discussion to take place on a range of topics.

- NOA is supported by the NZSA and ANZCA National Committee, with both organisations sharing the costs of hosting the face-to-face network meetings. The NZSA provides secretariat services for the network and updates to the membership.
- To keep up-to-date on NOA's work please visit the NZSA website and click on About > Networks tab on the Home Page.

# BWT Ritchie Scholarship

*Dr Oliver Brett*

**Dr Oliver Brett was awarded the BWT Ritchie Scholarship in 2018 and is doing his general clinical 'anesthesiology' fellowship at Vancouver General Hospital. He reports on his experiences since July 2018.**

The holiday period is over, rain has set in, and I am just entering the second half of my general clinical 'anaesthesiology' fellowship at Vancouver General Hospital (VGH).

VGH is a major tertiary/quaternary referral centre for British Columbia. The surgical suite consists of 18-20 ORs and performs around 16,800 surgical cases per year. A second hospital, University of British Columbia Hospital, performs further elective and day case surgery. VGH via the University of British Columbia offers fellowships in cardiothoracics, neuroanaesthesia, perioperative medicine, and general clinical anaesthesia.

The general clinical fellowship is designed for the fellow to gain further experience in a wide range of clinical specialties, while allowing development of specific areas of interest. It is a flexible fellowship, with the ability to pick and choose good lists, cases and specialties as you see fit. To date I have had blocks of major hepatobiliary, vascular, ENT, urology, spine and neurosurgery. Due to the volume of cases it is easy to gain valuable experience rapidly. For example, in the hepatobiliary room it is normal to do a Whipple's followed by a liver resection or similar most days of the week. Urology is usually major retroperitoneal lymph node dissections and robotic prostatectomies. ENT has a huge amount of major head and neck work, but also some excellent airway lists with rapid turnover of microlaryngoscopy cases. The rest of my year will be made up of a perioperative rotation, regional anaesthesia and perhaps some further hepatobiliary and ENT.

The working week is designed so that I have two "fellow" days where I am rostered with a 'staff' anaesthesiologist in my area of interest, and two service days where I cover staff while they perform non-clinical duties. One day per week is non-clinical, where I am expected to partake in research or further learning. In reality, the days are similar with most of the staff happy to leave you to manage the lists. They don't all have access to regular non-clinical time, so will use the days they have a fellow to catch up on their administrative tasks. Having said this, they are always available to help at the start of cases, or if any problems arise. It is an extremely supportive department and all staff are very approachable.

Most of the operations at VGH are major cases, so it would be unusual to do more than 10 cases per week. I have put in perhaps three LMAs during my first 6 months, and am yet to do a laparoscopic appendicectomy orcholecystectomy.

Canadians pride themselves on their free public healthcare system, and this results in an interesting mix of patients. I recently had an ENT list where the first patient was a billionaire philanthropist, with part of the hospital named after him!

It has been relatively easy to settle into work in Vancouver. The clinical side of things is similar to New Zealand, with a few exceptions. The most difficult thing to get used to (other than being at work at 0645) has been the scarcity of anaesthetic technicians. It takes longer to get ready for a case when you need to check the machine, set up your own arterial line set, fluids lines and prepare for an epidural/central line. On a number of occasions, I have come to intubate and reached for my endotracheal tube only to realise that it was still in the drawer…

A nurse will be assigned to assist in intubation, but as soon as there is any slight deviation from the routine it is quite obvious that you do not have highly skilled help. The upside to this is that I have become better at dealing with routine equipment issues, and my communication and planning has had to improve to ensure I am prepared with other options should plan A fail to succeed. Another major clinical difference is the widespread use of thoracic epidurals. The department has a robust pain service, and ward nurses are very comfortable with managing epidurals. It has been useful to become comfortable with this technique, and anecdotally one can certainly appreciate the value of a working thoracic epidural over systemic multimodal analgesia. There may yet be a renaissance in the use of the thoracic epidural, and I am glad to have had the opportunity to master the skill. There are some regional enthusiasts in the department, and I have learned a block called the Erector Spinae Plane block, which may be a useful alternative to the epidural and particularly good for rib fractures, thoracics, and breast surgery.

One of the most interesting features of the anesthesia service at VGH is the "IPACU." This is a designated portion of the recovery area where patients can be booked to stay overnight. It is manned by ICU level nurses, and a supervising anaesthesiologist. This is particularly useful for patients who require an extended PACU stay but are unlikely to require ICU level care for more than one day. For example, the major head and neck cases who are at risk of requiring re-intubation, or patients on low level vasopressors. It is easy to book patients in to this area, and I have found it really cuts down on the number of patients who require routine ICU admission. The IPACU is a new and relatively unique initiative, and a good example of how robust multidisciplinary involvement can lead to gains in healthcare. It is a concept that could be replicated in other hospitals and it is something I would like to bring back for discussion in my department on my return to New Zealand.

In terms of non-clinical work, the department is active academically and is keen for fellows to participate in research projects. I am one of the principal investigators in a study looking at pain following laryngeal surgery. This comes with the added advantage of being regularly rostered on some interesting airway lists. On my most recent list, the least complicated patient had recently undergone a heart transplant! VGH employs some renowned airway experts, and I am fortunate to have worked with them and gained some valuable insights and new techniques.

I am part-way through an online diploma in transthoracic echocardiography via the University of Vienna. In the next six months, I plan to use some of my non-clinical time to gain more hands-on experience in scanning. I am also involved in a research project looking at using transthoracic echocardiography in the recovery room for assessment of hypotension. I have had the opportunity to use an artificial intelligence program that is being designed to allow novice scanners to gain good images which can then be reviewed by experienced clinicians.

***...the department is active academically and is keen for fellows to participate in research projects.***

Life in Vancouver has been busy, but fun, and my family has definitely made the most of the experience so far. The summer was glorious and the famed rains of October and November mostly stayed away. We are now in the depths of gloomy winter, but know that rain in the city means snow in the mountains! We live in Kitsilano, which is a nice beach-side suburb with plenty of expats. We have got to know several of the other fellows and their families, and my wife is part of a "fellow's wives" group who provide great support and social interaction. There are lots of things for the kids to do, including drop-in play sessions, music classes, multiple excellent playgrounds and an amazing aquarium.

Coming to Vancouver for a fellowship has required a couple of years of careful planning and budgeting. Vancouver is an expensive city, with a noticeably high cost of living. Rental payments make up 77% of my take-home income, resulting in quite a deficit once food and bills are paid. Overall, I estimate the cost of the year will be in the $50-$70,000 range.

The BWT Ritchie Scholarship has made this year financially possible, and I would like to express my sincere gratitude to the committee for granting myself and my family this opportunity. Outstanding clinical experience in a department with a progressive approach to perioperative medicine, coupled with the life experience of spending a year in North America has made any sacrifices more than worthwhile.

***I am excited to bring some new ideas and skills back to my department.***

After finishing in Vancouver, I have arranged a relieving locum role at Rarotonga Hospital in the Cook Islands for a couple of months before heading back to Christchurch where I will be taking up a senior medical officer position. I am excited to bring some new ideas and skills back to my department. If anyone would like any further information, I am very happy to be contacted regarding fellowships in Vancouver.

# Book Review

*Sir David Skegg*

## The Health of the People, Sir David Skegg

***(Published by Bridget Williams Books Limited, 2019)***

We neglect public health at our peril, writes Sir David Skegg in his new book The Health of the People, in which his message is clear and unambivalent – New Zealand must invest more in public health and have the political will needed to oppose the forces that damage health. While preventative public health programmes save governments money in the longer term, he argues that politicians are continually lobbied by and influenced by vested interests, such as the tobacco and alcohol sectors.

Sir David, is an epidemiologist and public health physician who has chaired many government bodies, including the Health Research Council and the Public Health Commission (PHC). He has also been an adviser to the World Health Organization in Geneva for more than three decades.

The serious bacterial infection that struck 40 per cent of Havelock North residents in 2016, with 45 people hospitalised and at least three deaths, brought starkly to light the weaknesses in this country's health infrastructure he writes. A government enquiry into the contamination produced a scathing report which found that there was "a complete failure of leadership and stewardship by the Ministry of Health." But he believes that a lack of central leadership is not confined to the provision of safe water. "The Ministry's had a long-standing policy of…hardly ever using their legal powers and just turning a blind eye to groups that flout the regulations."

The turning point for public health was 1996 when the Public Health Commission was axed and public health leadership was compromised "which helps to explain why the health status of New Zealanders is slipping behind that in other comparable countries."

This is a lean, pulling no punches, straight forward read that strongly argues its case that a national health system has two basic and related, but distinct functions: to provide access to sound personal health services (which he believes we do quite a good job of providing) and to improve the health status of the community. The book provides an overview of New Zealand's health sector history and the trajectory that has brought us to the current day of a neglected public health system. As he describes it: "There is lip service to the importance of health promotion and disease prevention, but these activities are given far too little attention."

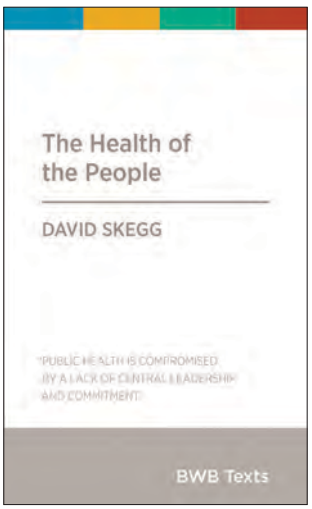
He calls for the Ministry of Health to be better resourced to greatly strengthen its expertise in public health, but also advocates for re-establishing a separate public health agency. Together they must be strong, impartial voices advocating for public health, able to withstand the pressures of interests such as tobacco, alcohol and some food manufacturers – pressures which he clearly observed when he chaired the PHC. "An experience that gave me an uncomfortable insight into what goes on behind the scenes."

Politicians and short term thinking due to our three-year electoral cycle also get a hammering, as the focus is on short-term gains such as reducing surgical waiting lists or funding new cancer drugs, rather than committing resources to preventive measures which would ultimately produce greater benefits – and long-term cost savings. A notable example he gives is lack of action on meaningful alcohol reform in 2010 after the Law Commission issued a landmark report on the regulatory framework for the sale and supply of liquor.

But the issues go beyond the failures of politicians and the Ministry of Health for Sir David who laments our nation's tendency to accept complacency.

"…People just tend to accept our mediocre performance, it's funny we don't accept it in sport, but we do in health."

The Health of the People is a wake-up call to counter this complacency and the "perilous fragility of our public health capacity."

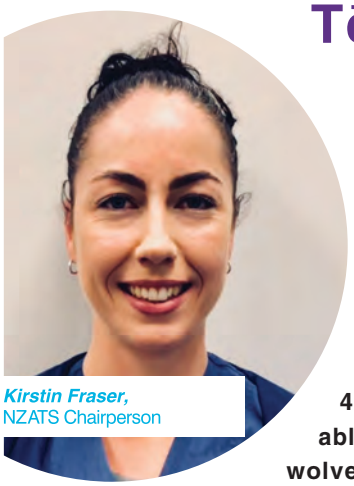



***Review by Daphne Atkinson, NZSA Communications Manager***

*Photo credit: University of Otago*

New Zealand Anaesthetic Technicians' Society

# Tēnā koe



*Kirstin Fraser,*
NZATS Chairperson

**Our profession was created by Dr Basil Hutchinson after he recognised the need to have well trained assistants during the induction, maintenance, and emergence of anaesthesia, but almost 40 years on we barely seem able to keep the metaphorical wolves from the door as far as the Anaesthetic Technician (AT) profession and workforce is concerned. Our profession and public safety are constantly under threat from the political superpower that is the New Zealand Nurses Organisation (NZNO), Registered Nurse Anaesthetic Assistant programs (RNAA), and our own apathy towards career progression.**

It has recently come to our attention that ATs were not included in a list of key stakeholders being consulted on proposed changes to the national standards for inter-hospital transfers (IHT). ATs competently and professionally participate in IHT around the country. We are warmly welcomed by our medical colleagues for our expert technical knowledge as well as our ability to manage critically ill patients. The skills required for IHT are part of our competency standards as set by the Medical Sciences Council. Unfortunately, it has also come to our attention that NZNO has made a submission on the proposed changes expressing their fierce opposition to ATs participating in **any** IHT. The NZNO submission is available online should you wish to read it. NZATS is actively investigating this situation and endeavouring to protect the vital IHT role and contribution of ATs.

***NZATS are greatly appreciative of the unwavering support of the NZSA...***

NZATS was notified late last year that a major public hospital intended to commence a RNAA training program. NZATS was relieved to find this is only in addition to its AT training program, and not a replacement course. We are disappointed that a public hospital is pursuing an unproven program when there are several proven pathways to becoming a Registered AT. NZATS welcome Registered Nurses to become Registered ATs or to practice as a RNAA so long as there is an exit exam guaranteeing equivalent standard. Our concern has been, and will always be, public safety.

Our tertiary provider, the Auckland University of Technology, says that they are currently not progressing a degree program for ATs and are unsure whether there is demand for such a course. We have been informed they intend to recommence a RNAA program in either July 2019 or March 2020.

NZATS has created a condensed "how to" guide for any hospital that is thinking about becoming an MSC accredited training hospital. We also wrote to our members alerting them to an article in the MSC October newsletter, which communicated that if a hospital department can prove it has an operational need and is able to generate a pathway for an extended scope of practice for Registered ATs, then MSC will consider this.

***NZATS will continue working towards strengthening and advancing the AT workforce.***

With the many challenges our profession faces, it is especially disappointing that NZATS membership consistently sits at less than half the Registered AT workforce. If we are to be the voice of the profession, then we need Registered ATs to be members. You may ask what benefits each individual receives. Is the protection of a career and scope of practice not enough? Is being a voice at the discussion table about areas of practice not enough? Is providing regular educational and networking events not enough either? I have implored our members to consider whether they will let other professions dictate the future of our workforce, or if they want to stand together with NZATS to move the profession forward with strength in numbers.

NZATS are greatly appreciative of the unwavering support of the NZSA and our close working relationship with ANZCA New Zealand National Committee.

NZATS will continue working towards strengthening and advancing the AT workforce.

Until next time, heoi anō tāku mō nāianei.

***Kirstin Fraser***
***NZATS Chairperson***

# Financial Success

MFAS Medical Financial Advisers

*Sue Stewart, Financial Advisor*

**It is human to make mistakes. This article provides some ideas on how to minimise errors in the financial world, how to ring-fence downside and how to make your money work.**

Often neglected by the busy medical profession, the accumulation of money should start with a Financial Plan personalised to your needs and objectives. Winston Churchill, in one of his many mantras, states that those who fail to plan, plan to fail. This adage resonates strongly in the investment world.

After many years assisting health professionals through a myriad of market conditions, our observation is that the most important criteria for success is financial discipline. As an example of the importance of discipline, statistics tell us that in the boom decade from 1990 to 2000 the US sharemarket produced about a 10% year on year return. Yet the same statistics tell us the average investor over the same period achieved 3-4% in annual growth. Why the deficit?

The negative outcome came through our propensity to follow the two predominant investment emotions of fear and greed. Through that 90s decade, while overall it was spectacular for investment, there were several Gulf War flare ups, Asian flu and a US budget crisis with government shutdown, Clinton/Lewinsky scandal/ impeachment proceedings, Y2K bug threats and a plethora of other headline events that inexperienced investors tried (and failed) to second guess. They went in and out of the market as fear overwhelmed, and then inevitably re-invested only when the media reported the world was good again……with most of the rebound gains having already been banked.

The return outcome however was significantly better for investors that adhered to a Financial Plan because a good plan (and a stoic investor) concentrates on long term outcomes and ignores the "noise." Your best defence is to remain committed to your regular saving/investing programme through market circumstance. It imposes discipline and consistency and takes the guesswork away.

So what is a Financial Plan, what should it encompass and why does it have relevance to you?

Your Financial Plan will help you to achieve financial independence, whatever that may look like for you. This requires balance between enjoying your current lifestyle and setting aside sufficient funds for your future. Being in a position to stop work when you are ready to do so, or work less hours than currently, requires you to have sufficient resources available to provide income.

Your Financial Plan is that one document that you continually refer back to for guidance. It mandates and quantifies your objectives, and the steps that have been identified to ensure these goals are achieved. With a Financial Plan you will have clarity and confidence as you make your future financial decisions, putting you in control of your finances.

A Financial Plan is also a "living document" that needs to be regularly reviewed and updated appropriate to your "age and stage" to ensure your evolving thoughts and objectives are captured and allowed for.

Your Financial Plan will provide a tailored investment strategy covering:

- What is important to you – your lifestyle, your objectives, your adventures along the way.
- Risk – personal to us all your risk profile is pivotal to proper investment structure.
- Timeframe – what do you want to achieve in the short term as well as the long term?
- Identifying how much is enough? Know what your financial target is so you know if you are on-track and when you have succeeded.
- How to build assets that will help you to fund your objectives – KiwiSaver and hospital Superannuation may underpin your position but what further steps are required for you to achieve your goals?
- Insuring your income and wellbeing – your future income is your largest asset, not your house!
- Measuring, monitoring and reviewing both financial progress and relevance of your Plan over time.
- Allowing flexibility for the curve balls that life challenges us with from time to time.

## Some Golden Rules:

Always hold a buffer equivalent to 3 months of your income requirements. These funds should be in a bank deposit (or a line of credit) and will provide you with breathing space so you can make rational decisions during times of turmoil.

***Think of your Financial Plan in the same way as the Health Plan you prepare for each of your patients.***

Procrastination is an anathema to the successful. We all know that the best time to save and invest is when you are young in order for compound interest to work to your full advantage. If you were to save $100 per week from age 25 to age 65, this would give you $900,000. If you wait until you are 45 to start saving, you will need to save $450 per week to get to the same position. At any stage of life however you are always better off starting your savings today rather than leaving it for another tomorrow!

Your future income is your largest asset. While you are in the accumulating stage of life you need to have the right level of protection in place to replace your income if you were unable to work for an extended period. Get good personal advice in this regard as you are unique and so too are your needs. Also as you build your wealth, review your insurances to ensure you aren't over-insured!

Get professional advice. While there is plenty of information available on the internet in regard to investing and investments, as you set your Plan you need to know what is the best solution for you, your risk propensity and timeframe. While stocks (equities) will provide long-term positive returns this is not achieved without volatility as market returns are rarely average! It is how you react to each negative (and positive) market event that will determine your ultimate success which is where your fortitude and outside guidance will help save you from biased behavioural decisions we are all prone to make.

Think of your Financial Plan in the same way as the Health Plan you prepare for each of your patients. They all have different requirements depending on the operation, their size, their allergies, their health history and your Plan will be tailored to each and every patient. Yes, your processes will be similar but the exact prescription of drugs or how these are combined are individualised.

With a financial strategy in place you will no longer be stressing about money as you will have a good understanding about what you need to do to achieve your financial success. Once in place you will need to regularly monitor and measure progress and update as necessary using the framework of your Financial Plan. As such, the abstract concept of retirement becomes demystified... and the journey there a whole lot more pleasurable!

***Sue Stewart, MFAS, AFA, CFP$^{CM}$***

# **Women's work** - pressures faced by women in medicine

continued from page 11

"What advice would you give to a young woman starting medical training?" I asked the New Zealand Women in Medicine Facebook page, a platform for female doctors to network and discuss both work and non-work topics. The answers were laden with the same themes raised in research: the need to find balance, the need for a strong support network, including female role models, and the pursuit of part-time work. These responses were incredibly heartening, suggesting widespread understanding of the challenges ahead for a young female doctor and a strong feeling of support amongst colleagues who had faced the same challenges.

As I start my fellowship year, looking back on my training and forward to the approaching challenge of balancing the demands of a new baby with those of work, I can't help but feel touched by many of the replies. "Cultivate a habit of self-belief," one doctor said, "You are likely to be good enough in all your roles – others are undoubtedly looking at you in awe." Another advised, "Be realistic about what you can achieve, try to avoid sacrificing yourself or your family for your work….and be kind to yourself as you try and work it all out along the way." And perhaps the aspirational, but what we all strive towards: "Keep a big, fat life outside of medicine… Write, talk. Story is powerful. Look after your physical and mental health."

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# webAIRS news

**The webAIRS incident reporting database of de-identified incidents is a tool for quality improvement, enabling us to learn from unexpected or potentially hazardous events.**

Susan Considine joined us in January this year as the new ANZTADC Coordinator. She has a wide range of experience in Health Information Management and Clinical Coding, and has previously worked at Geelong Hospital, the Melbourne Clinic, the Peter MacCallum Cancer Centre and Cancer Council Victoria.

The webAIRS strategy for 2019 is to increase feedback to users with a number of initiatives that include increasing the number of safety alerts and incident case reports in the NZSA magazine.

An incident reporting database relies on the richness of the data that is captured and within each incident reported in webAIRS there is a provision to enter more than one Coding Category and Sub-category.

The green buttons on the home page enable users to obtain a brief description of the features and their functionality, and are outlined as follows:

- Incidents: view the webAIRS data dashboard and a summary of the numbers of incidents reported by main category, select a link to enter a new incident into the database, or modify an existing incident and trial a demo incident.
- News: recent news and alerts.
- Events: links to upcoming webAIRS presentations at annual scientific meetings and congresses.
- Publications: links to articles that incorporate webAIRS data and which have been published in a peer reviewed journal.
- FAQ: Frequently asked questions assists users with information about the system which may be useful to new and regular users.

'Registering a new site' is a recent addition that guides new users with the process of registering a new site.

WebAIRS is considering the publication of an individual webAIRS newsletter several times a year, which would include case reports, and we would value your feedback on the usefulness of this information. This would be in addition to the current arrangement of articles within the e-news and NZSA magazine.

Please email your feedback to anztadc@anzca.edu.au

More information:
ANZTADC/WebAIRS: https://www.anztadc.net/

# From the archives - 40 years ago

**NZSA's first Newsletter for 1979 (Volume 26, Number 1) was published in March and contained 40 pages. The editorial described accidental arterial injection, a rare but serious problem, and how to deal with it. A guest editorial on Anaesthetic Technicians by Jim Clayton of Dunedin followed. He was highly involved in the introduction of these essential assistants to our fraternity.**

An audited statement of accounts for the Society to 31 December 1977 was presented and minutes of the AGM were summarised. Forty-six members attended this meeting held in Nelson on 16 September 1978. The question of antistatic flooring in operating theatres was discussed, as was anaesthetic technician training. Sponsorship of Newsletter by NZIG Medishield was announced and ICI Tasman thanked for their support over the previous eight years. The president welcomed our guest speaker from Australia, Dr Brian Pollard, who was the NZSA's first speaker sponsored solely by the Society. In the past we had shared speakers with Australia.

The Society's membership was reported to be 273, including 12 honorary members, and our finances were in order. Dr Jon Broad of Hamilton was appointed vice president, Gerald Moss of Christchurch was to continue as newsletter editor and Trevor Dobbinson as secretary/treasurer.

Dr Semesa Seruvatu of Suva, Fiji, presented a detailed account of the first general anaesthesia in Fiji in 1876. Dr Tony Newson announced that the Sixth Asian-Australasian Congress of Anaesthesiology would be held in Auckland in February 1982. This would be the largest meeting of any medical specialty ever held in New Zealand!

Sadly, there was an obituary for our life member -- Dr Joseph (Joe) Simcock of Opotiki.

Divisional reports were received from Wellington, Christchurch and Waikato/Bay of Plenty and there was a report from the Anaesthetic Mortality Review Committee chaired by Dr John Gibbs. There were advertisements by our sponsor, NZIG Medishield.

***Basil Hutchinson,***
***NZSA Life Member***

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**References: 1.** Blobner M, Eriksson LI, Scholz J, et al. Reversal of rocuronium-induced neuromuscular blockade with sugammadex compared with neostigmine during sevoflurane anaesthesia: results of a randomised, controlled trial. Eur J Anaesthesiol. 2010;27(10):874–881. doi:10.1097/EJA.0b013e32833d56b7. **2.** Jones RK, Caldwell JE, Brull SJ, et al. Reversal of profound rocuronium-induced blockade with sugammadex: a randomized comparison with neostigmine. Anesthesiology. 2008;109(5):816–824.

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