NEW ZEALAND
Anaesthesia

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

ASM + AQUA highlights

Financial advice for trainees

Advancing the welfare of anaesthetists

PLUS:

Anaesthesia care in developing countries - Mercy Ships

Meet Executive Member Catherine Caldwell

News from the World Federation of Societies of Anaesthesiologists

New Zealand SOCIETY OF Anaesthetists

Contents

Special features

SEPTEMBER 2019
ISSUE 54

2019 publication dates and deadlines are:

Copy due by:	Published:
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

Connect with your audience - advertise with New Zealand Anaesthesia!

Our advertising rates are very competitive and advertising is available in our magazine and on our website. Find out more by contacting Pam Chin: pam@adprint.co.nz

Magazine advertising is available on both standard and premium pages. Options include full page, half page and quarter page. Complimentary advertising is also included in our E-Newsletter (E-Zine) – conditions apply.

Level 1, Central House
26 Brandon Street, Wellington 6011

PO Box 10691, The Terrace,
Wellington, 6143

Phone: +64 4 494 0124
Fax: +64 4 494 0125

www.anaesthesia.nz

@theNZSA
New Zealand Society of Anaesthetists

New Zealand SOCIETY OF Anaesthetists

President's column

SEPTEMBER 2019

Firstly, congratulations and thank you to the Auckland Organising Committee for their work in curating the outstanding Annual Scientific Meeting + AQUA in Queenstown last month. Truly a mammoth effort to get it all off the ground (and safely into Queenstown!). I know all attendees appreciated the stimulating scientific content, the scenery and the skiing. For those who had to stay at home, we have provided some highlights in this issue of our magazine, including a selection of photos. In Queenstown I was also able to say a final goodbye to Heather Ann Moodie and an inaugural greeting to Kiri Rikihana, who has replaced Heather Ann as the General Manager of ANZCA's National Committee NZ.

NZSA networks

I would like to take this opportunity to highlight some of the new areas of member support that the NZSA has been progressing over the last six months or so. We have two new networks, which are clinician driven initiatives advancing one of our core missions – connecting and supporting the anaesthesia community across New Zealand. Dr Michael Foss from the Waikato department has formed a national Inpatient Pain Network, as well as organising the network's inaugural meeting to be held on Friday 22 November in Auckland. All members of acute pain teams (nurses included) are invited to attend. It will be a wonderful opportunity to network (pun intended), to meet colleagues and to share ideas. Registration is available through the NZSA website www.anaesthesia.nz. You can read more about the network on p.20.

...most of us are seeking to lessen the impact we have on the waste and pollution created by each operation.

Our other new network is the Environmental and Sustainability Network, chaired by Dr Rob Burrell from Counties Manukau DHB. Again, this seeks to connect practitioners across the country, as well as harness and share the good ideas that are coming to fruition in New Zealand hospitals. I feel that most of us will have a personal connection with this initiative. I doubt there are any operating room personnel who are not shocked at the amount of waste produced daily, and the lack of personal choice around every single item moving to 'single use only' is vexing. Although not long in the tooth compared to some, in the 13 years since I began practising anaesthesia, the amount of equipment that is now NOT sterilisable is ever growing.

I think most of us are seeking to lessen the impact we have on the waste and pollution created by each operation, but information telling you what can safely, securely and sensibly be done on an individual basis is often lacking. I believe that by connecting enthusiasts and exchanging ideas we can improve NZSA members' access to this information. There are some folk in New Zealand who are contributing to the global community effort in this area. Some notable examples which we can be inspired by include:

- Drs Rob Burrell and Matt Taylor from Middlemore Hospital, working with the University of Auckland to capture volatiles and then safely destroy them (more details on our news page).
- Dr Paul Currant from Christchurch, who has been exploring the measurement of anaesthetic agents in wastewater due to their likely aquatic toxicity.
- Dr Matt Jenks from Dunedin, who devoted his sabbatical to calculating the carbon footprint of Southland DHB and gave a great presentation on his findings at the ASM in Queenstown.

We have the why; we now need the how, and the funds to turn these ideas into actions. We are hoping to have a regular 'Sustainability Tips' section in our magazine (which you can choose to receive electronically by emailing membership@anaesthesia.nz) to offer you practical solutions to use in your hospital.

Whether you are organising potato starch trays for your OR drugs, driving e-bikes and cars, moving back to using Proseal LMAs, increasing your use of TIVA, recycling in the operating room, reducing your desflurane use, removing desflurane vaporisers from the backbar, considering flying less, walking more, taking public transport, selling the SUV, buying the Tesla – whatever you are able to manage in your daily lives, there will be other people around the country who are interested in how you are doing it and the benefits of the changes you've made. So please be in contact with the NZSA (via president@anaesthesia.nz) with your sustainability ideas and/or to join our newest network.

Our other networks continue to thrive and strengthen connections in our anaesthesia community; NOA, the Network of Obstetric Anaesthetists, which the NZSA co-supports with National Committee NZ, is chaired by Dr Aidan O'Donnell. NOA hosted a joint meeting with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and the New Zealand College of Midwives in mid-August. These multidisciplinary meetings enable discussion of issues affecting the whole of New Zealand's maternity services and guide our advocacy work at ministerial level. It is a high level, cross sector engagement and a strong anaesthesia voice at this table is crucial to improving maternity care in New Zealand.

PANNZ, the Paediatric Anaesthetist Network of New Zealand, is chaired by Dr Jason Henwood and remains very active – especially this year with ANZCA consulting on PS29 Guideline for the Provision of Anaesthesia Care to Children. PANNZ works with the Society for Paediatric Anaesthesia in New Zealand and Australia, SPANZA, to support an Annual Update Meeting. This meeting is aimed at every anaesthetist who anaesthetises children in New Zealand, not just those at tertiary centres. The 2019 meeting was well attended and included workshops on airway management. It was located under the America's cup! (thank you to Dr Kate Brunette for convening and to the Royal NZ Yacht Squadron for their hospitality). Organisation of the 5 April 2020 Update Meeting in Rotorua is well underway, and registrations will open this November (visit the NZSA website for more information).

...effective mentoring can foster strong connectivity and support for colleagues.

Our other network that I'd like you to be aware of is the Airway Leads Network, chaired by Dr Paul Baker of Auckland. The initiation of this network stemmed from NAP 4, and an Australian initiative has commenced, promoted by ANZCA. Although New Zealand is small and remote, which has its disadvantages, we do have the benefit of being able to easily connect and communicate with almost our entire anaesthesia community – a tremendous boon. The complexity of the Australian hospital landscape (e.g. the number of institutions and the geographical diversity are just the starting factors) makes this sort of initiative more difficult to get off the ground compared to New Zealand. One of the areas that the Airway Leads Network is playing a critical role is medical device procurement by PHARMAC. This is an enormous undertaking but having an established and connected network of experts to advise both the NZSA and NZNC to inform our feedback to PHARMAC is essential. Thank you to all those who have contributed in this area.

Welfare and Wellbeing

An area which the Society has been very focused on is looking at how we can support the welfare and wellbeing of our anaesthesia community. It is well recognised that effective mentoring can foster strong connectivity and support for colleagues. Dr Emma Patrick, who holds the wellbeing portfolio on the NZSA Executive and sits on the Wellbeing SIG executive committee, has organised a mentoring training day for anaesthetists. This will be in Auckland on Monday 4 November (visit the NZSA website under Events to register) or access our latest E-Zine for the details.

Dr Sue Nicholl from Canterbury DHB presented on her welfare journey at the Queenstown ASM + AQUA and one of her suggestions for assisting in the development of wellbeing among trainees, is for departments to train their willing SMO staff in effective mentoring. Sue chaired the ANZCA NZNC inaugural Welfare Officers Network meeting earlier this year and the NZSA is actively working with the NZNC to improve access to initiatives that can positively impact on your wellbeing. There are more great ideas in the Wellbeing SIG's *Long Lives, Healthy Workplaces* toolkit designed for anaesthesia departments.

Scientific Meetings including CSC2020

Once again, thank you to all our members who supported the NZSA, ANZCA NZNC, and JAFA ASM + AQUA by coming to Queenstown. Without delegates there would be no successful meetings. Hats off to those of you who put time aside to organise these meetings and of course to my colleagues who run workshops and present their work – a great deal of effort goes into delivering a successful scientific meeting.

Looking to the future, I look forward to seeing you at the Combined Scientific Congress, which the NZSA is jointly organising with the Australian Society of Anaesthetists (16-19 October 2020, Wellington). There will also be Obstetric and Neuro Anaesthesia Satellites attached to this meeting, so put your leave in early. Keep an eye on NZSA communications, including our social media platforms Twitter and Facebook, for ongoing updates of the programme and social activities.

Ngā mihi nui

Kathryn Hagen, NZSA President

President's blog

Kathryn writes a regular blog which covers a diversity of issues affecting the profession and patient care. Her latest blog explores cultural competence and safety, and health equity. The blog is published in our E-zine newsletter. Kathryn welcomes your comments on her blogs and columns at president@anaesthesia.nz

News in brief

Pacific Society of Anaesthetists (PSA) 30th Annual Refresher Course

The PSA's 30th Annual Refresher Course, held in late August, served as a reminder of how much work our small community of doctors do throughout the Pacific. The region's low resources and high morbidity rates make it challenging for our Pacific doctors to train as a group, which means the annual course is always highly anticipated. Thank you to the NZ and Australian locums who made this meeting possible. We also thank Dr Indu Kapoor for her hard work behind the scenes with PSA reps to organise the biggest number of locums yet! The meeting was held over five days, with two days of plenary sessions and a day of workshops. The last two days focused on PSA member countries presenting updates and the AGM where the new President Dr Kartik Mudliar was appointed.

Australian and NZ anaesthetists presented talks, and for the first time we welcomed ANZCA President Dr Rod Mitchell and ANZCA Vice-President Dr Vanessa Beavis to this meeting. NZSA sponsored trainee speaker Dr Marcus Lee spoke about the life of an ANZCA trainee 'the good, the bad and the ugly,' which was very well received.

The NZSA offers free associate membership to PSA members and this year we had a large number sign up. This membership helps the NZSA to maintain an ongoing relationship with the Pacific and to support the PSA in their work. Thank you to the PSA for their outstanding hospitality and a huge congratulations to the PSA Organising Committee.

Minister of Health, Dr Ifereimi Wagainabete opens the PSA 30th Annual Refresher Course.

NZSA advocacy

The NZSA's advocacy aims to provide a strong voice for New Zealand anaesthetists on proposed policies and legislation affecting the specialty and patient care. In addition to the PHARMAC medical devices consultation detailed below, other recent NZSA submissions include feedback on the Climate Change Response (Zero Carbon) Bill, the Therapeutic Products Regime Bill (replacing the Medicines Act 1981), and the Medicinal Cannabis Scheme. NZSA submissions are published on our website www.anaesthesiasociety.nz

PHARMAC medical devices

Input from anaesthetists into PHARMAC's consultation on medical devices is critical as it will impact the everyday practice of anaesthesia across many areas of health services. PHARMAC has sought feedback to develop its approach and framework to manage the national medical devices list. Our submission included recommendations on how PHARMAC can best access expert advice relating to anaesthesia, including the formation and composition of advisory committees. We also highlighted the need to consider the environmental lifecycle of all devices in determining decisions on procurement. PHARMAC has been analysing all submissions and is due to provide a summary of feedback this month. There will be further consultation on the proposed approach and operational detail with ongoing opportunities for feedback. We will keep members updated on developments.

Anaesthetists call for solutions to anaesthetic waste

The University of Auckland is undertaking research to transform New Zealand's pharmaceutical waste disposal system, including anaesthetic waste, following an approach from Middlemore Hospital Anaesthetists Rob Burrell and Matt Taylor. They expressed their concern that surgery and anaesthesia is a polluting industry and sought NZ solutions to the problem. Dr Saeid Baroutian, who leads the Waste & Biomass Processing Group at Auckland's Faculty of Engineering, said solutions would likely be driven by anaesthetists, who are "vocal and persuasive" senior doctors. The main anaesthetic gases sevoflurane and desflurane, are usually administered with oxygen and nitrous oxide, or a mixture. Liquid anaesthetics can be used and reduce carbon emissions but have their own problems with up to 50 per cent of liquid anaesthesia drug waste being sent to landfill. The University, along with Counties Manukau Health and Interwaste, a NZ medical and clinical waste disposal company, are working to develop a process to treat anaesthetic gases. These gases would be captured in the operating theatre and treated with high pressure hot water to break the anaesthetic compounds into safe and inert compounds, mainly water and organic acids such as acetic acid. It is hoped that this research will lead to forming a pilot programme.

DEVICE TECHNOLOGIES

VYGON
Value Life

VASCULAR ACCESS

Extended Dwell

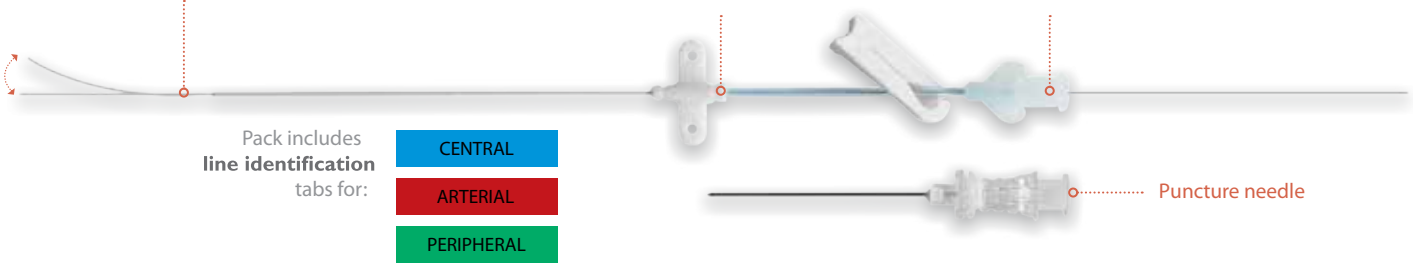
leaderflex

Universal catheter for peripheral, arterial & central catheterization

Flexible guidewire
Reduces risk of vein trauma.

Integral extension with wings
Permits secure catheter fixation, reducing the risk of mechanical phlebitis.

Seldinger insertion technique
Allows access to smaller palpable/fragile vessels.



Pack includes **line identification** tabs for:

- CENTRAL
- ARTERIAL
- PERIPHERAL

Puncture needle

For further information:
Device Technologies Ltd
P: 0508 DEVICE (338423)

W. www.device.co.nz **E. sales@device.co.nz**

World class ASM + AQUA 2019

Queenstown was a spectacular, sunny backdrop for our highly successful NZ Anaesthesia Annual Scientific Meeting + AQUA last month. This success was built on the dedication and hard work of our Organising Committee, led by Convenor Dr Kerry Holmes. During the welcome we were told the programme would be informative, stimulating and 'at times challenging', and that is exactly what we were privileged to experience. The conference theme 'Aspirations into Action' strongly resonated with attendees who were keen to learn, question, and seek answers on how we can further improve anaesthesia safety and quality, patient care and population health.

Our world class speakers engaged delegates and encouraged them to reflect on their own practice. There was certainly a lot of animated discussion during the breaks. Topics covered, some of which are highlighted in this issue of the magazine, included the role of evidence and ethics in quality improvement initiatives, the prevalence of scientific fraud in medical journals, the importance of countering health misinformation online, the value in using the surgical checklist, and quality care for those at the end-of-life.

'Aspirations into Action' strongly resonated with attendees who were keen to learn, question, and seek answers...

We have many to thank for such an outstanding and memorable event: our Organising Committee, our speakers (especially those who travelled from Australia, the UK and the US), our PCO, Outshine, for their consummate professionalism, along with workshop facilitators, trade industry partners and all those that contributed in some way.

The NZSA would also like to acknowledge our partners and co-hosts of the ASM + AQUA – the ANZCA New Zealand National Committee and JAFA (Joint Anaesthesia Faculty of Auckland). Next year we will be bringing you another exceptional conference alongside the Australian Society of Anaesthetists: the 2020 Combined Scientific Congress, in Wellington.

Dr Kerry Holmes told delegates their experience would be "the best of ASM and AQUA combined." He also said that keynote speakers had generously donated their speaker fees to the Mental Health Foundation.

The conference opened with a pōwhiri, including waiata

ANZCA NZNC Chair Dr Jennifer Woods, Dr Kerry Gunn from JAFA, and NZSA President Dr Kathryn Hagen welcomed delegates and speakers, including keynote presenters who had travelled from Australia, the UK and the US.

ASM + AQUA highlights

"Anaesthesia royalty" Professor Alan Merry


Alan Merry

The Alan Merry Oration was launched at the ASM + AQUA in honour of Professor Alan Merry's towering contribution to anaesthesia. All future ASMs jointly hosted by ANZCA NZNC and NZSA will open with this oration, which will focus on themes of patient safety and quality. Dr Kerry Holmes welcomed Professor Merry to the stage, describing him as "anaesthesia royalty." In his talk Professor Merry described incredible advances in providing safe anaesthesia and surgery at home "New Zealand is one of the safest places in the world to have anaesthesia" and abroad. This could largely be attributed to the "very high standing of our specialty, which affords us the ability to recruit the best trainees and to influence funders and employers." He explained that this high standing reflected the specialty's professionalism, underpinned by unwavering commitment to excellence in clinical practice through training and continuing professional development, teamwork, research, incident reporting and audit, as well as engaging with the wider challenges confronting healthcare. He also commended the College and Society "working in an aligned way for a common good, which has been a very successful approach."

Delegates heard about the history of anaesthesia including New Zealand's first anaesthesia on 27 September 1847, administered by a Mr Marriott who had no medical background! The specialty's modern-day success was based on a range of quality and safety initiatives, including the WHO Surgical Safety Checklist, the distribution of pulse oximeters by Lifebox, and incident reporting run by webAIRS.

His talk also raised the issue of addressing Māori health disparities. The Health Quality and Safety Commission report "A window on the quality of Aotearoa New Zealand's health care 2019 – a view on Māori health equity", looked at the major impact of personal and institutionalised racism on Māori health outcomes. He was hugely supportive of ANZCA's Indigenous Health Strategy, and the need to undertake research on the experiences of Māori in our healthcare system, to help achieve health equity.

Professor Alan Merry is an anaesthesiologist at Auckland City Hospital. He is Deputy Dean, Faculty of Medical and Health Sciences at the University of Auckland, Chair of the NZ Health Quality and Safety Commission and serves on the boards of the World Federation of Societies of Anaesthesiologists and Lifebox.

Professor Mary Dixon-Woods


Mary Dixon-Woods

Healthcare is rife with challenges and understandably there is a huge urge for quality improvement to provide solutions, said Professor Mary Dixon-Woods, who presented on the integral role of high-quality performance measurement in quality improvement initiatives. Professor Dixon-Woods is the Director of the UK's Health Improvement Studies (THIS) Institute at the University of Cambridge and has been described as the patient safety workaholic. The Institute was launched in January 2019 and aims to strengthen the evidence base for improving healthcare. In her talk, Professor Dixon-Woods said that the findings of 3,000 plus trials had found that the results of 396 trials were questionable – a huge concern when flawed data is used to develop practice. The onus was on individuals and organisations to be accountable and transparent, and it was critical to "evaluate projects" and to "align the goals of improvement and evaluation." It was unfortunate that "enthusiastic endorsement of measuring outcomes of clinical trials hasn't happened, and we lack an evaluative ethos."

She urged caution in quality improvement initiatives, especially when some reforms are advocated as having to succeed, overridden with "optimism bias." Some improvement programmes did not work and did not "withstand scrutiny." While an initiative may look sensible, an evaluation trial may show that it had no impact in improving areas such as cost savings, reducing workload, or ED admissions. But some may have trouble seeing flaws in their creation with Professor Dixon-Woods likening it to the "lovely baby problem" in that it can be immune to criticism or evaluation, when "sometimes the baby's just ugly!"

Professor Bruce Spiess


Bruce Spiess

Anaesthesiologist Dr Bruce Spiess, Associate Chair for Anesthesiology at the University of Florida School of Medicine, has been described as an outspoken proponent of patient blood management (PBM). He credits PBM with saving lives, reducing complications after health surgery and improving cost. PBM was not happening enough in his view but the World Health Organisation had defined it as a "systemised, evidence-based individual patient-focused methodology to optimise transfusion appropriateness and management. They have also determined it is a good quality treatment, ensuring the best health care in terms of safety and efficiency." He described the three pillars of PBM as: optimisation of red blood cell volume, minimise bleeding and blood loss, and perioperative optimisation of the anemia tolerance.

Dr Bruce Spiess has focused his research career on blood: its critical oxygen capacity, oxygen therapeutic pharmaceutical development, risks of blood transfusion, and the development of monitoring technologies.

Doctors need to counter health misinformation online

Dr Ed Mariano

Doctors need to be active on social media and other communication platforms to counter online pseudo-science and health misinformation, according to Dr Ed Mariano, a Professor of Anaesthesiology from Stanford University.

As one of the most trusted professions in the world, doctors have a "moral imperative" to stand up to the vocal online anti-science community, and to promote science and evidence-based treatment.

It concerns him greatly that many people access misleading health information from the internet, which spreads quickly and then becomes hard to combat. Doctors need to "offset the noise" by joining the conversation.

...doctors have a "moral imperative" to stand up to the vocal online anti-science community.

Dr Mariano is certainly a role model for what he promotes – he is ranked as one of the world's top 10 anaesthetists on Twitter.

He says that there are far reaching benefits for doctors' knowledge and learning, as social media provides an excellent avenue to keep updated with the latest research and new treatments.

"The benefits to me as an academic physician have been invaluable."

He cites the exponential growth of regional anaesthesia as just one example.

"We have more tools at our disposal. New blocks are being performed and described every month and it's hard to keep up with the literature. Social media allows you to be part of a learning community made up of people who have similar interests."

These "curated learning communities" have also led to fruitful collaborations. "I've had interesting conversations on Twitter that have developed into projects. Engaging in social media gives physicians a worldwide community of colleagues who can help curate the vast and ever-growing amount of information available today."

In his talk Dr Mariano asked delegates how many engaged in social media and the show of hands was reasonably small. Many took up the challenge to join Twitter and by the time the ASM was over, the conference had generated over two million impressions and 595 tweets (that's about six tweets on average per hour)! The NZSA also hit the 700 plus mark for Twitter followers.

His messages to fight pseudo facts resonated with the media and he did two long-form radio interviews urging the medical and scientific communities to embrace social media and to see it as an opportunity. But he cautioned that the information doctors provide needs to be in a language the general public can understand.

Interviewed on Radio NZ's Jesse Mulligan Show he said, "We may publish a new research study but the words we use aren't the words an average person can understand so that type of attention usually doesn't last very long."

...the information doctors provide needs to be in a language the general public can understand.

"I think as scientists and physicians, part of our vocation or calling is to really improve the health of the community and the only way to do that is to really speak in the language that people understand."

"The only way to do that is to arm patients with information … and when they have questions about some of these therapies they read about online they have to feel comfortable going to a physician and asking about it and having a real discussion about why or why not it may make sense for them."

ASM + AQUA highlights

Dr Andrew Klein

How can the medical research community counter the rise of fake medical data?

The extent of scientific fraud was laid bare by Cardiothoracic Anaesthetist Dr Andrew Klein, who cited his first-hand experience as Editor-in-Chief of the UK medical journal, *Anaesthesia* – which is uncovering scientific fraud at the rate of one in 40 papers submitted for publication. In the last few months, the journal has been requesting an investigation every fortnight.

Scientific fraud includes plagiarism, made up data, duplicate publication, and image manipulation. This is undermining the credibility of medical research and patients may be harmed as a result of treatment based on false medical evidence.

Dr Klein is a strong believer in routinely checking for fake data. He outlined a statistical analysis computer programme used by *Anaesthesia*, known as the Carlisle method, which was developed by UK anaesthetist and "data detective" Dr John Carlisle. The Carlisle tool helps to uncover whether data has been manipulated or fabricated. It detects "unlikely" distributions of data in randomised control trials and has revealed a high prevalence of scientific fraud, exposing some high-profile studies, including the trial of Mediterranean diets, which was marked as unlikely to be genuinely randomised.

Anaesthesia has been using the Carlisle method since 2017 to check all randomised control trials submitted for publication, and recently the *New England Journal of Medicine* followed suit.

Dr Klein urged the medical research community to protect patients by working together to "clean up the scientific record" and he hoped more medical journals would adopt the Carlisle method.

Dr Kate Grundy

How do we improve quality care at the end of life? Palliative Medicine Physician Dr Kate Grundy, from Canterbury DHB, began her presentation with two quotes: "We cannot define success as beating death, because death cannot be beaten" and "Hope is not a plan!"

Dr Grundy explored how quality care at the end of life might be measured. In terms of how we define a good death, this had to go beyond managing symptoms and physical cares. Treatment needed to match the goals and preferences of each individual, "attending to the whole person and to their family/whānau." Ideally, she said, we would ask the patient what they want and provide care in line with the patient's preferences.

Measuring quality dying could include assessing clinical documentation for evidence of quality care based on best practice. This in turn could help to guide education and support, drive up standards, and set system expectations.

Current initiatives to help improve individual quality care at the end of life includes a guidance document Te Ara Whakapiri – care in the last days of life, which is based on an extensive evaluation of the available literature and is informed by local research. This ensures it is applicable to the unique context that is Aotearoa New Zealand. It includes a set of checklists, flowcharts, tools and patient resources, and is based on the Te Whare Tapa Whā model (the four or sides of Māori health) of good physical, mental, spiritual, and family/whānau health.

The Serious Illness Conversation Guide was another initiative and enabled "shared decision-making" (developed by the NZ Health Quality and Safety Commission).

Dr Grundy said that "the earlier we have the conversations, the less the complexity of the dying."

Article continued on page 24

ASM + AQUA highlights

Dr Richard More, Dr Richard Collins and Dr Han Truong

Dr Mary Dixon-Woods and Dr Kerry Holmes

NZSA Vice President Dr Sheila Hart, Dr Peter Peres, Dr Louise Speedy, Dr Joe Dieterle

Graham Tyson, NZSA CEO Renu Borst, Dr Claudio Alarcon

ANZCA NZNC Chair Dr Jennifer Woods and NZSA President Dr Kathryn Hagen present Dr David Choi the ANZCA Trainee Prize and the NZSA Ritchie Prize

Dr Aruntha Moorthy and Dr Ben Van Der Greind

Margaret Blakely, Past NZSA President Dr Ted Hughes, ANZCA President Dr Rod Mitchell, Sue Mitchell

Dr Jennifer Woods and Dr Kathryn Hagen present Dr Nicholas Lightfoot the prize for best poster presentation (jointly awarded by ANZCA and NZSA)

Meet an NZSA Executive Member

Dr Catherine Caldwell

Dr Catherine Caldwell is a Consultant Anaesthetist who works in public and private practice in Wellington. She is one of our newest Executive members and sits on the NZSA Private Practice Sub-Committee.

What led you to choose anaesthesia as your specialty?

It was a serendipitous accident. I originally wanted to do ophthalmology but had a six-month gap before I could get onto that training program. I wanted to do something "useful" for those 6 months that would give me a few good clinical skills. I had always seen anaesthesia as a proper hands-on sort of job as a junior doctor and thought it would be good to do. Six months later when my other training position came up, I realised I loved what I was doing and didn't want to change.

Where did you study and how would you describe your training?

I studied at the University of the Witwatersrand in Johannesburg, South Africa. Most of my clinical training was at Baragwanath Hospital in Soweto. I went straight into anaesthesia after my house officer years. The training length and exam set-up was very similar to NZ. In Johannesburg you move around the public hospitals in the city, spending most time at your base hospital. Baragwanath and the Johannesburg General Hospital (now the Charlotte Maxele Johannesburg Academic Hospital) were the huge tertiary hospitals I mostly worked at. The case mix of my training was quite different to NZ though, with a huge trauma, acute and obstetric load. There was much less theatre space for ordinary elective work – I barely anaesthetised a joint replacement in my six years of training! Also, the pathology we saw was often very late stage and severe by the time the patient got onto an operating list. We were also not quite as carefully fostered as junior doctors and vocational trainees and had to "woman up" from a tender age. Another stark difference was the lack of properly trained assistants to the anaesthetist. I was amazed when I arrived in New Zealand that somebody else was employed to check my machine and equipment, run through my arterial lines etc. and for example reliably knew what cricoid pressure was! We forget how fortunate we are here with the excellent assistance we get.

Who was most influential during your training?

There were several women who made my training special. As brand new trainees we were handed to a senior trainee to buddy us for four weeks. Then we were released off independently on our own. Shocking I know! But my buddy was a wonderful, practical woman who instilled enough skills into me in those four weeks that, terrified as I was, I managed on my own. There was another woman anaesthetist there, bordering retirement, who had seen and done it all. She instilled in me a sense that this job was achievable, fun and satisfying. I also had some lovely friends training with me that made our sometimes almost comically insane work environment enjoyable.

What is the most satisfying aspect of your work?

I often think how incredibly fortunate we are taking people through an often frightening and potentially painful experience and making it manageable for them. Patients are often so relieved and grateful that the experience they were dreading turns out so much better than they expected. We also don't really carry the burden of our patients with us like surgeons have to. At the end of the day (or a few days later anyway) we can typically hand them over and let go. I'm not sure we realise how freeing this is. I love the mix of academic and practical aspects to our work – it's very satisfying.

What is the most challenging aspect of practising medicine?

Medicine will always have its stresses. It's a busy and demanding life. I think trying to mould it into the working expectations of younger generations will change it; in some ways for the better and some not. Making a medical career work as a mother (or mothering work with a medical career more accurately) demands huge compromise and support systems. And guilt! I wonder what the future of our speciality holds. Having become so safe, anaesthesia is now seen as "easy" and open to non-medical practitioners. That would make our job as medical anaesthetists a lot less satisfying.

What are the key challenges for anaesthetists working in private practice?

We don't drum up the work or "bring in the money" and can sometimes be treated a bit like necessary, but annoying second-class citizens. We need to work together to make sure our needs and concerns are appreciated by the more powerful players (surgeons and hospitals). The NZSA's strength is that there is a chance for our collective voice to be heard.

Catherine Caldwell in Botswana

Article continued on page 23

Money, money, money!

Dr Michael Ng , NZSA Executive Trainee Representative

NZSA Deputy Trainee Representative Dr Michael Ng delves into what can be a perplexing area for the uninitiated – finance – and provides information to help you navigate financial literacy, during anaesthetic training and beyond.

As doctors, we go through years of study and training, acquiring knowledge to become specialists. During this time, we receive little (or no) education on money. We're often left wanting when it comes to financial literacy. We leave medical school and are suddenly thrust into the top income tax bracket, needing to make important financial decisions.

By New Zealand law, this article CANNOT give specific financial, personal or investment advice. Only a qualified financial advisor can do that (see below on how to find one). I have endeavoured however to provide some basic information on finances, jargon, and maths(?!) as a starting point for those who perhaps haven't thought much about their financial situation; so that if you decide to talk to a professional advisor, you are familiar with some of the language and concepts.

Below are some topics a financial advisor may bring up:

Disposable Income versus Discretionary Income

Disposable income is the take home pay after tax and ACC deductions. It's what you get in your bank account on pay day.

Discretionary income is what you have left after paying for bills/ the essentials (rent/mortgage, electricity/gas, school fees, petrol).

The "Cash flow" bunny

Earning more than 70k per year puts you in the top 21% of earners in NZ; and more than 100k per year puts you in the top 9%. (1)

So even as junior doctors, we have a relatively high disposable and discretionary income (depending on bills and expenses).

Therefore, it's all too easy to fall into the trap of "money goes in; money goes out" (i.e. "Cash flow bunny" – a term courtesy of Dr Cooper) and not keep track of where our money goes.

If you plan on coming back to NZ, find out if it's possible to bring your superannuation contributions from overseas back to NZ.

Why does this matter?

- The impact of financial mistakes is masked because "we can afford it." We don't suffer the financial consequences or burden that others might, and therefore are less likely to learn from them.
- So what? The danger is that when it happens regularly, it can add up to a lot!

During training

It's a stressful time during vocational training...it can be difficult to manage our finances during this time.

It's a stressful time during vocational training, with shift work commitments, college requirements, and exams. It can be difficult to manage our finances during this time.

Luckily in NZ, if you are an RMO on a union contract, our training is subsidised and some of the costs of training, relocation, and mileage for work are reimbursable.
It is always worthwhile going over the MECA to know what you're entitled to, and keep track of those reimbursements. This is money that is yours!

Many of us will be looking at going overseas for fellowships to complement our training. Each country has its own taxation and superannuation funds. Talk to those who have been to your country of interest, and ask about how easy/hard it was to get a tax number, bank accounts, likely cost of living and expenses.

If you plan on coming back to NZ, find out if it's possible to bring your superannuation contributions from overseas back to NZ (and if it gets taxed/if fees are involved.

Consider other means of financial aid, including the BWT Scholarship offered through the Aotearoa New Zealand Anaesthesia Education Committee.

Currently, there seems to be inconsistencies with the salary band scale that you start on when you return to NZ as an SMO. This is being addressed in the ASMS MECA update in 2020.

The easiest way to avoid headaches is to get vocationally registered in NZ **before** going overseas.

If you get vocational registration in NZ **after** spending time as an SMO overseas, make sure you clarify with your employer if your time overseas as an SMO will count when they decide what band scale you start on when you commence employment in NZ.

Retirement planning – some basic information

When talking to a financial advisor, they may go through what sort of life you want to lead when you retire. Based on this, they can give a rough estimate of how much you would need to save to achieve that.

On average, we usually need enough to last 20 years after stopping work! (if you plan to retire at the current retirement age of 65 and survive until the average NZ life expectancy – 79 for men; 83 for women. (2)

The current pension in NZ is $21,380 gross per annum ($411/week) for a single person living alone; and $32,892 gross per annum ($633/week) for a couple who both qualify.(3)

For many of us, that amount may not be enough to maintain the sort of lifestyle we're used to!

Regardless of what that amount is, it's important to start saving early for retirement. Time is money. Literally. Here's why:

...it's important to start saving early for retirement. Time is money.

Compound interest is the addition of interest to the principal sum, and then earning interest on the new sum total. The same concept applies to any earnings you make on investments, which you then reinvest. This is called **compounding.**

The Doubling time in finance is the time taken to double your investment value provided you are reinvesting the interest, therefore experiencing compound interest.

To figure this out, you need to know how much your investment is improving by, in percentage terms.

Divide 72 by the percentage (aka the "rule of 72")

- For example, if you had $100, and invested in something that was going to give you 10% gain, the amount of time taken to double the value of your initial investment of $100 would be:
- 72/10 = 7.2 years

If you start early, you have more "doubling time" experiences and therefore a higher end result.

Other things you may want to bring up with a financial advisor include establishing a **trust**, and a **will** (especially if you have dependents, or assets such as a house).

Resources, and finding a financial advisor

This article only scratches the surface of what to consider when managing our finances.

There are plenty of good resources online for more information, including sorted.org.nz. especially the "tools" and "guides" sections.

Talk to your accountant, the Medical Assurance Society or broker for a reputable advisor.

Qualified financial advisors – you can check if they're appropriately qualified by law at https://fsp-register.companiesoffice.govt.nz/ (Ministry of Business, Innovation and Employment).

Special mention to Dr Jeremy Cooper for his contribution and advice for this article.

References:

1. *Treasury.govt.nz*
2. *Stats.govt.nz*
3. *Sorted.org.nz*

The welfare of Anaesthetists

How can we better support the welfare and wellbeing of anaesthetists? Dr David Kibblewhite, NZSA Executive Member and Immediate Past President, outlines a range of avenues including different forms of peer support and a mentoring course for NZSA members.

Welfare and wellbeing within our speciality, and the wider medical community, are topical areas of discussion and increasingly a focus for action. We are seeking to raise awareness of triggers leading to mental ill health and subsequently looking at support mechanisms to enable early intervention and prevention.

Officially, we now refer more to 'wellbeing' than welfare, and the Welfare Special Interest Group recently changed its name to the Wellbeing SIG. Although wellbeing is important, I still think the concept of welfare has relevance. This became more apparent to me when attending the recent Combined SIG meeting in Manly (which brought together the Wellbeing, Management and Leadership, and Communication and Education SIGs). Welfare was a major theme at this meeting and the talks were thought provoking and very insightful.

Anaesthetist welfare aligns strongly with the NZSA's focus of fostering a strong anaesthesia community, and community is one of the three pillars of the NZSA's work. (Education and Advocacy are the other two).

For the last two years the NZSA Executive has been discussing ways of adding to the available resources in welfare. The NZSA Forum in Christchurch last year was devoted to this topic and included the unveiling of the *Long Lives Healthy Workplaces* toolkit, designed by anaesthetists for anaesthetists. The toolkit, comprehensive and all encompassing, was released by the Wellbeing Special Interest Group, in association with Everymind (an Australian institute dedicated to the prevention of mental ill health and suicide). We were fortunate to have ASA President Dr Suzi Nou go through the toolkit with us, and in recent months Dr Joanna Sinclair of Middlemore Hospital has revised some of the resources so that they are New Zealand specific. (The toolkit is available on the NZSA website and is highly recommended for individuals and departments to help assist in the development of an action plan).

Another initiative we would like to highlight is the ANZCA National Committee Welfare Network group, which had its inaugural meeting earlier this year and comprises of welfare advocates from anaesthesia departments throughout the country. The College has also been developing in parallel, resources such as the 'Mentoring Modules' available on its website.

So, there is a lot happening in this space which is very positive as welfare and wellbeing are complex and require a multidimensional approach. This was well highlighted in the US Air Force report in 1996 in response to an unprecedented suicide rate of airmen (and women).

Dr David Kibblewhite, NZSA Executive Member and Immediate Past President

An avenue the NZSA would like to promote and foster as part of this multidimensional approach is peer support. I think that as an Executive we did not initially fully appreciate that there are many forms of peer support; each of which will have variable relevance at different times in our practice and working lives. Here is a summary of peer review avenues:

Grassroots peer support

In essence local groups of mates or colleagues who meet regularly. The composition and look of these groups would vary depending on the individual make up. For some this may be a regular forum to discuss difficult cases, i.e. case discussion. For others it may be a semi-formal social occasion over drinks. The underlying principle is to establish regular contact and to build relationships with colleagues. Hopefully, regular contact would facilitate discussions and rapport so that supportive relationships are already in place in the event of a stressful event.

Supervision

Some are finding it useful to establish formalised professional support. This principle is well established in psychiatry, psychology and more recently in the police force. The College has recognised the benefit of such relationships and practice, and CME points

The underlying principle is to establish regular contact and to build relationships with colleagues.

can be accrued from these meetings. This is perhaps the Gold Standard.

Mentoring network

A local and potentially national resource of trained coaches and mentors. The aim is to provide a skilled sounding board for end users to enable them to work through dilemmas, crossroads in career, future planning etc. It is envisioned that this is not primarily for acute crisis management, but appropriate for assisting in workplace difficulties and conflicts where a neutral third party (Mentor) can help to navigate the situation. It is important to emphasise that this is not a counselling service.

Critical incident de-brief

Possibly a more local support group but not necessarily. Following a critical incident, a professional debrief service is available. Formal training is required and indeed this service is already in place at some institutions.

Buddy peer support

Both local and national buddy support for those undergoing a formal/legal process. The absolute ideal would be to have a small group of experienced, trained anaesthetists who have knowledge of the Health and Disability Commission/Coroner process and who would be available nationally for those who need a 'buddy' outside of the Medical Protection Society (MPS) to help support them through the process.

Although a multi-tier system was not our initial goal, it reflects the multipronged US Air Force's original 11-point plan concept. (Subsequent to its introduction, the suicide rate for Air Force personnel has fallen by 75%).

As your national professional body, we encourage you to reflect on, and be involved in the above processes. We can provide guidance and help with setting up tiers 1, 2 and 3. We would like to recruit volunteers for levels 3 and 5.

Dr Emma Patrick, our welfare representative on the NZSA Executive, is spearheading the mentor project. She has explored mentor training options with a professional mentor training organisation, and we are now offering this course to NZSA members on 4 November (see right-hand column for all the details). We hope to interest a small but dedicated group of colleagues to do this training.

I have been looking at how we can offer buddy peer support and have discussed this with MPS, the HDC Commissioner Anthony Hill, and the Wellbeing SIG. All are supportive. If you wish to be involved in any of the above initiatives or would like to share your views, please be in touch via the NZSA office.

Universal access to safe anaesthesia

Your WFSA – news updates

As an NZSA member you are automatically a member of the World Federation of Societies of Anaesthesiologists (WFSA) (www.wfsahq.org). The WFSA, whose secretariat is based in London, has 135 member societies representing anaesthesiologists in 150 countries worldwide. Most societies, like the NZSA, represent one country, but some, like the Pacific Society of Anaesthetists, represent anaesthesiologists in a number of countries.

The WFSA President is Dr Jannicke Mellin-Olsen from Norway. There are currently two New Zealanders on the WFSA's Board of Directors: Professor Alan Merry, who is the Treasurer and Dr Wayne Morriss, the Director of Programmes. The other Board members are Dr Gonzalo Barreiro (Uruguay), Professor Adrian Gelb (USA), Dr Berend Mets (USA), Dr Daniela Filiipescu (Romania) and Dr Philippe Mavoungou (France/Democratic Republic of Congo).

The WFSA's vision is "universal access to safe anaesthesia." This is an aspirational goal in many resource-poor parts of the world. The 2015 Lancet Commission on Global Surgery found that five billion out of the world's seven billion population do not have access to safe and affordable surgical care and anaesthesia when needed. The WFSA is heavily involved in advocacy and educational initiatives to improve access to safe anaesthesia worldwide. This article highlights just three examples of the WFSA's work.

...five billion out of the world's seven billion population do not have access to safe and affordable surgical care and anaesthesia when needed.

Advocacy at the World Health Assembly

A WFSA delegation attended the 72nd World Health Assembly (WHA) in Geneva in May 2019. The WHA is the main policy-making meeting of the World Health Organisation and is attended by all 194 WHO member countries. The WFSA has an official liaison role with the WHO and is therefore able to make statements at the WHA on behalf of anaesthesiologists worldwide.

This year's WHA was notable for a greater emphasis on surgery and anaesthesia than in previous years. The meeting began with an address by Dr Richard Horton, the Lancet's Editor-in-Chief, who listed "investment in surgery and anaesthesia" as one of his top five global health priorities. In many low-and middle-income countries (LMICs), development of surgical services has fallen behind development of other areas of medicine. In 2015, the WHA passed a resolution WHA 68.15 calling on member states to strengthen surgical care and anaesthesia as a component of universal health coverage (UHC) and there is increasing

At the World Health Assembly, from left: Annabel Higgins (WFSA Advocacy and Communications Officer), Prof Adrian Gelb (WFSA Secretary), Jannicke Mellin-Olsen (WFSA President), Wayne Morriss (WFSA Director of Programmes), and Julian Gore-Booth (WFSA CEO).

recognition that UHC will only be possible if there is appropriate resourcing of anaesthesia and surgery.

This message was front and centre during an official WHA "side event" entitled "Safe and affordable surgery in small island developing nations," organised by the governments of Fiji, Tonga and Palau, along with the Maldives. This side event provided a forum for in-depth discussion of the challenges relating to development of surgical services in countries with limited resources. Anaesthesia was not forgotten and the Fijian Minister of Health, Dr Ifereimi Waqainabete, stated (and restated) that "there cannot be safe surgery without safe anaesthesia."

The WFSA organised and co-hosted, along with Lifebox and the International Committee of the Red Cross, a well-attended side event entitled "Surgery and anaesthesia: conflict, poverty and development." The delegation also made statements to the General Assembly on issues important to anaesthesiologists everywhere: access to medicines, the role of surgery and anaesthesia in the management of non-communicable diseases, workforce, and patient safety.

Training Teachers and Leaders: WFSA Fellowships

The WFSA offers about 50 short subspecialty attachments per year for young anaesthesiologists working in LMICs (www.wfsahq.org/wfsa-fellowship-programmes). Most fellowships are for six or 12 months, and span 14 countries, 22 hospitals and cover eight subspecialty areas of practice. Examples include the Paediatric Anaesthesia Fellowship in Nairobi, Kenya, the Ganga Hospital Regional Anaesthesia Fellowship in Coimbatore, India, and the Obstetric Anesthesia Fellowship in Medellin, Colombia.

The aim of the fellowship programme is not to just train excellent clinicians, but to also train teachers and leaders. Almost all fellows return to their home countries and many are now playing pivotal roles as teachers and leaders. The Bangkok Anesthesia Regional Training Center (BARTC), which was established in 1996, has trained many anaesthesiologists in the Asian region including a large cohort from Mongolia. Many of the latter now fill leadership roles in Mongolia and have been at the forefront of an impressive upscaling of surgical services in the last 10 years.

Almost all fellows return to their home countries and many are now playing pivotal roles as teachers and leaders.

The fellowships are relatively low cost and funded in part by donations through the Fund A Fellow programme (www.wfsahq.org/get-involved/as-an-individual/fund-a-fellow). We are very grateful for the donations from individuals and institutions, and the many contributions from New Zealand and Australia.

Join us at the next World Congress of Anaesthesiologists

You are all invited to the Anaesthesia Olympics! The World Congress of Anaesthesiologists (WCA) is the flagship meeting of the WFSA – held every four years. The next one is in Prague, Czech Republic, 5-9 September 2020. Registrations are now open (www.wcaprague2020.com).

There really is no other event like the World Congress. The 17th WCA promises to be an outstanding event, with speakers and registrants from all over the globe. The Scientific Committee and WFSA are finalising the programme, and, at last count, there will be speakers from around 80 countries. Don't miss the diverse range of topics, which cater for anaesthesiologists working in low-resource and high-resource settings, and different geographical regions.

Prague, the capital of the Czech Republic, is known as the "City of a Hundred Spires." The city's historical centre is on UNESCO's World Cultural Heritage list and sights include the Old Town Square with its astronomical clock, the imposing Prague Castle, and Charles Bridge over the Vitava River.

The WFSA runs a scholarship programme to give young anaesthesiologists from LMICs the opportunity to attend a major meeting. At the 2016 WCA in Hong Kong, approximately 50 scholars from around the world received sponsorship, including a group of Pacific anaesthesiologists generously sponsored by the NZSA, Australian Society of Anaesthetists, and ANZCA. The WFSA is working hard to ensure that a similar number of scholars will be able to attend the 17th WCA in Prague.

The NZSA is a relatively small society in global terms but a highly valued and important member of the WFSA – your WFSA! We thank you for your ongoing support and look forward to seeing you in Prague.

Dr Wayne Morriss
Professor Alan Merry

NZSA Inpatient Pain Network

The formation of the Inpatient Pain Network is a clinician led initiative which aims to improve inpatient pain services (IPS) in New Zealand.

Dr Mike Foss from Waikato DHB established the Network late last year to connect clinicians and departments across New Zealand to discuss issues and share information on inpatient acute pain care. The Network will hold its first event in Auckland this November (details below).

The Network aims to address the challenges facing IPS in New Zealand, including an increasingly complex patient population, a low resource health environment with limited access to pain psychology, psychiatry and drug rehabilitation/CAD's services, poor access to novel pharmaceuticals, production pressure from theatre managers to reduce IPS staffing, and a fairly insular DHB health system that reduces opportunities for formal collaboration.

Essentially the Network aims to provide New Zealand solutions to New Zealand problems by strengthening collaboration and communication. The group's discussions with inpatient pain clinicians, in person and via email, revealed gaps in the NZ anaesthetic scene, and these gaps were especially noticeable in the smaller centres, where services seemed to be in crisis and in need of support.

The Network has representatives from the majority of DHBs and for now will focus on inpatient adult acute pain.

The NZPS, ANZCA's Faculty of Pain Medicine and the Acute Pain Special Interest Group have all endorsed the formation of the Network. The Network will liaise closely with these groups and send an annual report to the Acute Pain SIG.

Advocacy will be a key focus of the network, including advocating for PHARMAC to fund novel analgesics for use in the inpatient and transitional settings, and assisting NZPS, FPM and ANZCA in their advocacy for increased government funding for pharmacological and non-pharmacological treatments in the inpatient pain population.

What's next? Inaugural Network Event

The Network is holding its inaugural event on 22 November 2019 at the Jet Park Hotel, Auckland. The focus will be on adult pain management and improving IPS by strengthening cooperation between specialised pain nursing and acute pain physicians. From the outset of announcing this event, there has been significant interest and steady registrations. There are still places available for this full-day event. View the program and register via the NZSA website www.anaesthesiasociety.org.nz/ (via the home page menu tab education and events)

For queries contact Lynne Wood membership@anaesthesia.nz or 04 494-0124.

The multifaceted nature of inpatient pain management

- Routine post-operative rounding
- Perioperative medical outreach to complex patients after operations
- Managing vulnerable and frequently admitted patients with pain problems
- Hospital based opioid stewardship and oversight of pain therapies in the transition from hospital to community
- Procedural sedation for painful interventions e.g. burns dressings
- Management of acute, severe pain problems such as CRPS, phantom limb pain, and acute neuropathic pain in the initial inpatient phase

Lasting impact on anaesthesia care in developing nations

Consultant Anaesthetist Dr Hilary Lapham writes about her experience volunteering for Mercy Ships, a not-for-profit, faith-based charity providing surgical services and training in developing nations.

Dr Hilary Lapham

Each year the 16,000 tonne Mercy Ship spends 10 months in an African port, at the invitation of the local government and in collaboration with the Ministry of Health, providing surgical specialities that are not available within the nation. The hospital ship has five operating theatres, five wards, and the axillary services required to fully rehabilitate their patients. The specialties include burns and plastics, paediatric orthopaedic, obstetric fistula, maxilla-facial, ophthalmic and paediatric general surgeries.

Alongside the provision of essential surgery, upskilling and mentoring local health care professions is Mercy Ship's focus in the developing nations it serves. The courses provided include essential surgical skills, primary trauma care, essential pain management, SAFE Obstetric Anaesthesia, SAFE Paediatric Anaesthesia, sterile processing and biomedical training.

As part of Medical Capacity Building (MCB) projects, the Mercy Ships Safe Surgery team visited 16 hospitals around Guinea in 2018 and 2019. They provided a five-day course which included the WHO Safety Checklist, recognition and treatment of hypoxia, teamwork and how a good team means better treatment for the patient.

My most recent role with Mercy Ships was on the Safe Surgery follow-up team. Over three weeks we travelled 'upcountry,' away from the Mercy Ship in the capital's port, returning to Guinea's remote regions visiting hospitals where the courses had previously been conducted.

Our team of four formed a close bond as we worked and travelled in some challenging conditions. The doctors and medical personnel in the district hospitals we visited have enormous challenges. The resources, including equipment and drugs, are very limited. Some hospitals do not have running water. Often there is no electricity. The staff work long hours in extreme heat and some of the hospitals are very isolated. There is incredible poverty in the population, and the staff themselves often struggled to make basic ends meet.

The resources, including equipment and drugs, are very limited. Some hospitals do not have running water.

We lived, ate and worked together 24/7 during our follow up visits. This meant that a lot of planning occurred at our mealtimes. On a typical day we ate breakfast together at around 8am. This gave us time to gather the equipment for the day, or to pack the car if we were leaving that day for another town.

Each follow-up occurred over 48 hours. On the first day we routinely observed a surgical case. If no operation was scheduled, we conducted a simulation. The areas that were being taught during the Safe Surgery course were observed, and notes taken for feedback during the debrief process. As observers we did not take part in the management of the patient unless he/she was compromised.

...participants completed feedback to indicate how the training had impacted their practice and hospital.

Our team met with the course participants straight after the surgery. During the debrief our team leader Anita noted what had been done well, the changes that had taken place leading to safer outcomes and identified issues where there seemed to be some difficulty. The participants completed feedback to indicate how the training had impacted their practice and hospital. We also identified a single topic which participants wanted to have presented again the following day. Interestingly in all cases this was the Ketamine Lecture.

On the second day we spent four hours doing follow up training with the participants.

Topics specifically covered included all WHO surgical safety checklists, surgical scrubbing and gowning, appropriate theatre attire, principles of sterility, antibiotic administration, human factors and safe anaesthetic practice.

Before the team left each hospital, a donation of essential equipment was made which included Lifeboxes, ambubags, stethoscopes and thermometers.

Nurse Anaesthetist Sandouno Finda works at Mamou Hospital, a large town towards the middle of Guinea. She did not participate in the first part of the Safe Surgery program earlier in the year as she was away receiving training in the capital city. However, she noticed some changes on her return and agreed to let me share her thoughts.

Significantly, Sandouno said that Checklist sign-in was now routinely used. IV antibiotics were being given before 'knife to skin,' and pre-anaesthetic consultations were being performed. She stated that previously the consultations were either briefly conducted when the patient was already on the table, or not done at all. Now, she explained, consultations were being routinely undertaken as soon as the patient was considered for surgery. This meant she could now postpone the surgery if necessary, for the patient to receive appropriate medical therapy to reduce the risk of the anaesthetic. Sandouno said that one of the participants from the initial training had shared the information in a presentation on the checklists and counting sheets.

Sandouno now felt able to 'speak up,' and that she experienced better teamwork due to improved interactions and contributions from all team members.

During the follow up sessions we observed one surgery at each hospital. We then spent time in follow-up training, consolidating the principles previously taught and encouraging the positive changes. I gave a lecture on ketamine at two of the hospitals at their request.

It was encouraging to see that some participants had really grasped the principle of sharing forward the information and training that they had received. They were committed to positive changes being kept alive and further improved upon, once the Mercy Ships MCB team left.

They were committed to positive changes being kept alive.

Having grown up in Zimbabwe, my favourite thing about serving with Mercy Ships is being able to return to the continent and people I love, and to come alongside the Mercy Ship crew on sustainable projects such as this which is a support and encouragement to our colleagues in the nations we serve. Every blessing was met with joy, and every challenge with courage.

The British Medical Journal recently published a Global Health Supplement about the medical capacity building work of Mercy Ships http://gh.bmj.com/content/2/Suppl_4

Video Link: Mercy Ships responses to global surgical need https://vimeo.com/215942979

Find out more about donating or volunteering www.mercyships.org.nz

Biography

Hilary Lapham has been a Consultant Anaesthetist at Tauranga Hospital for two years. She completed her undergraduate medical degree in Zimbabwe, then her Anaesthetic specialisation (Fellow of the College of Anaesthetists) in Cape Town in 1996. She worked in Cape Town from 1997-2016 in public and private healthcare. Between 2008-2016 she travelled to Togo, West Africa on five separate occasions for medical missions.

Dr Lapham first volunteered with Mercy Ships in Benin, West Africa for a three-week volunteer project. She provided an anaesthesia service for the free surgeries conducted on board the hospital ship Africa Mercy, in 2009. Her work with Mercy Ships changed focus in 2016 when she returned to work with the hospital ship's Medical Capacity Building team, conducting a week-long Safe Obstetric Anaesthetic course in Madagascar's capital city. She returned to West Africa earlier this year to continue her volunteer work in the area of equipping local anaesthesia staff, this time in Guinea.

A snapshot of the 10-month field service in Guinea, West Africa

- 1,099 attended medical training courses
- 155 professionals participated in medical mentoring
- 2,442 free surgeries were provided
- 41,000 dental patients received free treatment
- Of the 1260 volunteer crew members onboard, 35 were Kiwis

The next port of call is Dakar, Senegal.

Meet an NZSA Executive Member – Dr Catherine Caldwell

continued from page 13

What advice do you have for anaesthetists considering working in private practice?

Make sure you ask the advice of a colleague who has experience in private to guide you before you start – the NZSA has some resources on this too. Don't take on anything you wouldn't in a more supported environment, like public. You can be quite isolated in a private hospital. Pick your surgeons carefully! Don't make plans or appointments for the time you expect to finish!

What motivated you to join the Society's Executive?

I was asked by a colleague too nice to say no to! More seriously though, I think we all owe a bit of time to our profession. We get so much out of it that we should all take a turn to give back. The Society does a lot of good work and our colleagues are sacrificing their time (and income) to contribute. I'm happy to do my part.

As our newest Executive member, what are your impressions of the Society now that you've had the experience of seeing the work it does up close?

There is so much more to what goes on behind the scenes than I ever realised! I really appreciate the time and thought put into the submissions the Society produces. I'm so proud I belong to a Society of such hard-working and well-meaning people.

What career would you have chosen besides medicine?

Wild animal vet…as a medical student my plan was to become the doctor for the Kruger National Park in South Africa. Not sure how I ended up in Wellington, New Zealand! But the more I think about it, the more I like the idea of being a vet there instead.

What are your interests outside of work?

With my job and busy family life there is precious little time for idle pursuits. I like to try to keep fit. I enjoy producing crafty things. Cooking (and eating!). I adore being in the African bush and bird or game watching when I get the chance.

The three best things in life

Loved ones, nature, and coffee.

What has been your best travel destination?

There is only Africa for me. I am fortunate enough to go "home" nearly every year to visit my family and spend some time in the African bush. That is my true happy place.

ASM + AQUA highlights

continued from page 11

Professor Simon Mitchell

The WHO Surgical Safety Checklist was lauded by Professor Simon Mitchell for improving team communication among OR members and the substantial reduction in patient mortality and complications. The Checklist had made a huge difference to positive patient outcomes when implemented as part of a strategic roll out plan and when performance monitoring has been in place.

Professor Mitchell, a Consultant Anaesthesiologist at Auckland City Hospital and Professor of Anaesthesiology at the University of Auckland, said that despite the checklist's success it did have ongoing challenges. These included the need to ensure everyone in the OR was engaged, that the checklist was clearly visible (putting checklists on wall posters in the OR for example), that there was vigilance to avoid a "tick box mentality," plus countering attitudes such as "the hero model of medicine" which describes the attitude of the self-assured expert that believes they're unlikely to make an error and see the Checklist "as a bit of a threat."

Professor Mitchell showed delegates simulation footage of checklists being used to illustrate examples of the checklist being properly handled and implemented by the team, which included "lots of conversation, especially about risks."

In his presentation he held up aviation as a profession that uses checklists diligently and has a very positive attitude about the process. "We need more of that culture."

Professor Mitchell also delivered a very inspiring talk about last year's acclaimed Thai Cave Rescue, after 12 young soccer players and their team coach became trapped in the Tham Luang Cave in northern Thailand. Torrential rain and rising water levels forced the team to withdraw deep into the cave where they became trapped by approximately 1.6 kilometres of flooded cave. They were found nine days later by British cave divers who quickly realised the untrained boys would not cope with diving out through the technically difficult cave passage in zero visibility. Australian anaesthetist and cave diver Richard "Harry" Harris assumed the enormous responsibility for deeply sedating the boys prior to them being individually dived out of the cave by a member of an international rescue team of cave divers. This strategy contravened international guidelines which recommend against trying to manage the airway in unconscious divers underwater. Even though there were no palatable alternatives, undertaking this anaesthetic intervention was an extraordinarily brave act on Dr Harris' part. As a cave diver himself and good friend of Dr Harris, Professor Mitchell highlighted just how extraordinary the planning and bravery of the rescue was, and described some experiments (in collaboration with Dr Harris) being undertaken to determine whether the full face masks chosen for use by the boys during the rescue really do maintain CPAP throughout the respiratory cycle as the manufacturer claims. This talk was truly enlightening and humbling!

Professor Simon Mitchell

webAIRS news

Distractions in the operating theatre

Introduction

Distractions in the operating theatre are believed to be one of the many contributing factors that may cause clinical incidents in the perioperative period. While there have been no randomised controlled trials in an operating theatre environment of which we as authors are aware, this principle is generally accepted in the community where activities such as texting on mobile phones whilst driving are believed to cause road accidents.

Cases reported

In the webAIRS database, a search performed on 13 July 2019 revealed 24 reports where the word 'distraction' was used in the narrative and an adverse event or a near miss occurred as a result of the distraction. Seven of the reports were associated with a drug error, which included two cases where the drug given was of the same class as the intended class, four where it was of a different class and one case where double the dose was given resulting in an overdose.

User error with a medical device occurred in nine cases. These were varied and included lost guide wires with Central Venous Pressure CVP insertion, the use of a chlorhexidine impregnated catheter where a patient had recorded an allergy to chlorhexidine, failure to connect or turn on various devices, and a wrong site block.

Distraction is known to increase the chance of error in the aviation industry and, as a result, code 135.100 has been issued under the US Government code of regulations.

There was a failure to notice something important in six cases, which included deterioration of the patient, a TIVA leak, an oesophageal intubation and a retained throat pack. In addition, there were two cases where failure of a piece of equipment caused distraction, making it difficult to monitor the patient but no adverse event occurred.

Discussion

Distraction is known to increase the chance of error in the aviation industry (1) and, as a result, code 135.100 has been issued under the US Government code of regulations. It is commonly known as the sterile cockpit rule and states that no flight crewmember may perform any duties during a critical phase of flight that is not required for the safe operation of the aircraft. There are specified critical phases of flight such as take-off and landing, and any other time as directed by the flight captain.

All the incidents in this series occurred at a critical phase of anaesthesia. Most of them occurred either immediately before induction of anaesthesia or within the first 10 minutes of anaesthesia. A small number were associated with restoration of circulation and ventilation after coming off cardiopulmonary by-pass. The American Society of Anesthesiologists issued a statement on distraction in 2015 (2) and this contains recommendations that could be worth implementing in Australia and New Zealand.

Dr Martin Culwick ANZTADC Medical Director, Ms Susan Considine ANZTADC Coordinator, and the webAIRS case report writing group

References:

1. *Electronic Code of Federal Regulations section 135.100. Flight Crewmember Duties. e-CFR data is current as of July 11, 2019, https://bit.ly/31Rbo5s.*
2. *Statement on Distractions. Developed By: Committee on Quality Management and Departmental Administration American Society of Anesthesiologists, https://www.asahq.org/standards-and-guidelines/statement-on-distractions*

More news in brief

Part 3 course

As a senior trainee, how do you successfully transition to SMO? Register for the Part 3 Course (5 December 2019, Auckland), which includes CV and interview small-group workshops in a supportive and collegial environment. Limited to just 28 participants, the course is highly interactive with a Q & A session which will feature a panel of senior anaesthetists, and opportunities throughout the day for informal discussions. An outstanding line up of speakers will discuss how to secure a consultant post and provide insights into the working lives of anaesthetists. Program and registration https://www.anaesthesiasociety.org.nz/education/part-3-2/

BWT Ritchie Scholarship

The BWT Ritchie Scholarship assists NZ-based anaesthesia trainees who have passed the final examination for fellowship of ANZCA and are eligible to proceed to training year 5. It is also open to those who wish to undertake a further year of study outside NZ in the year following completion of their ANZCA fellowship; and to anaesthetists with FANZCA who are also training in pain medicine or intensive care medicine, who have reached a similar stage for those fellowships. Applications close 31 October 2019. Visit www.anaesthesiaeducation.org.nz/

UK survey of fatigue

The extent and impact of fatigue on consultants in anaesthesia and intensive care medicine in the UK and Ireland has been revealed in a survey undertaken by the Association of Anaesthetists. The Association's Fight Fatigue campaign is raising awareness of the issue and has developed a range of resources for hospitals to encourage changes, including the need for rest facilities. It says that while progress has been made, there is still a lot of work to be done. Some key results from survey respondents were:

- 91% of consultant doctors experience work-related fatigue and 50% of them reported this had a moderate or severe impact on health, wellbeing, work and home life.
- 45% admitted to either having a car accident or near miss when commuting whilst fatigued.
- Only a third (34%) said they have access to a private rest facility when on-call.
- 84% of respondents contribute to a night on-call rota (including weekends) and 37% also work regular weekend days.
- For about one third (32%) the longest period of on-call duty is 48-72 hours and 32% are on call every eighth day or more frequently.
- 62% did not feel supported by their organisation to maintain their health and wellbeing.

More information and resources:
www.anaesthetists.org/Fight-Fatigue

From the archives - 40 years ago

In 1979, four Newsletters were published. I will describe the June and September issues in this article. Elizabeth Maycock wrote a guest editorial which surveyed health problems in anaesthetists and the possibilities of these being passed onto our children. G Myburgh described Anaesthesia in South Africa, comparing it with New Zealand practice. Anthea Hatfield wrote a progress report on the upgrade of facilities in the theatres of Vaiola Hospital in Tonga and Dr Kester Brown of the Royal Children's Hospital, Melbourne, gave notice of a course to be held in Adelaide in October; Dr N P Singh of New Delhi advised of a conference on Critical Care Medicine in November, while Bill Peskett gave information on Maternity Benefits claims and there was a letter relating to Nosworthy record cards.

Dr Jack Watt was congratulated on becoming a Knight of Grace in the Order of St John.

News from Divisions saw contributions from Christchurch and Taranaki, the latter containing details of Professor Barry Baker's visit. There was also a section describing the conference in Nelson in September. Dr Brian Pollard from Sydney was our visitor and together with local speakers dealt with anaesthesia for burns, head injuries, faciomaxillary injuries, multiple trauma, emergency anaesthesia in obstetrics, paediatric surgical emergencies, regional anaesthesia in trauma and many other topics, including malignant hyperthermia.

Membership of the NZSA reached 272 members. Bruce Cook's editorial in the September issue looked at anaesthesia in the Pacific region and discussed our obligations there. Outpatient anaesthesia featured and a questionnaire for patients coming to day-stay anaesthesia was presented.

Ninety anaesthetists and more than 30 associates attended the winter conference in Hamilton in August. Dr John Paull of Melbourne was guest speaker and spoke on computers and O & G anaesthesia.

Professor Ian Anderson told us about veterinary anaesthesia and demonstrated with a horse! The historical section presented the landmark paper on Cardio-Respiratory Resuscitation by D S Cole and W J Watt published in the New Zealand Medical Journal of 1960. There was regional news from Auckland, Waikato/Bay of Plenty, Wellington and Canterbury. George Downward was presented with the Cecil Gray Medal (1978) and David Woolner with the NZIG Medishield Prize.

Basil Hutchinson
NZSA Life Member

CSC2020
COMBINED SCIENTIFIC CONGRESS
NZSA & ASA • WELLINGTON NZ
16-19 OCTOBER 2020

SAVE THE DATE
16-19 October 2020
WELLINGTON, NEW ZEALAND

INTERNATIONAL INVITED SPEAKERS

Professor Denny Levett

Dr Levett joined UHS in July 2015 as a consultant in critical care and perioperative medicine. She's also clinical lead for cardiopulmonary exercise testing and surgical high dependency, and co-lead for perioperative medicine. Dr Levett is experienced in diagnostic and perioperative cardiopulmonary exercise testing, perioperative fluid management, enhanced recovery after major surgery and looking after high risk surgical patients.

Professor Steven Shafer

Professor Shafer is professor of Anesthesiology, Perioperative and Pain Medicine (Adult MSD) at the Stanford University Medical Centre. His professional interests are the clinical pharmacology of intravenous anesthetic drugs. This has led him to clinical studies of many of the intravenous opioids and hypnotics used in anesthetic practice. However, his passion is not the drugs themselves, but rather the mathematical models that characterise drug behaviour.

Professor P.J. Devereaux

Dr Devereaux is the Director of the Division of Cardiology at McMaster University. He is also the Scientific Leader of the Anesthesiology, Perioperative Medicine, and Surgical Research Group at the Population Health Research Institute. Dr Devereaux is a full Professor and University Scholar in the Departments of Health Research Methods, Evidence, and Impact (HEI) and Medicine at McMaster University.

For all enquiries please contact

Denyse Robertson • E: drobertson@asa.org.au • Tel:+61 2 8556 9717

www.csc2020.co.nz

EXPERIENCE THE BRIDION EFFECT.

PREDICTABLE.[1] COMPLETE.[2] RAPID.[2]

BRIDION provides complete reversal from neuromuscular blockade.[1,2]

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.

Bridion® (Sugammadex) is a Prescription Medicine, fully funded under Section H of the Pharmaceutical Schedule from 1 June 2013. Indications: Reversal of neuromuscular blockade induced by rocuronium or vecuronium. **Dosage & Administration:** Immediate reversal of intense block. 16.0 mg/kg IV, three minutes following administration of rocuronium (1.2 mg/kg) in adults, (including: elderly, obese patients, patients with mild and moderate renal impairment and patients with hepatic impairment). Routine reversal of profound block 4.0 mg/kg IV following rocuronium- or vecuronium induced block when recovery has reached 1-2 post-tetanic counts; in adults. Routine reversal of shallow block. 2.0 mg/kg IV following rocuronium- or vecuronium-induced block when recovery has occurred up to reappearance of T2; in adults; 2.0 mg/kg IV following rocuronium in children and adolescents (2-17 years). **Contraindications:** Hypersensitivity to sugammadex or to any of the excipients. **Precautions:** Repeated exposure in patients; respiratory function monitoring during recovery; use for reversal of neuromuscular blocking agents other than rocuronium or vecuronium; coagulopathy; severe renal impairment; severe hepatic impairment; marked bradycardia, use in ICU; hypersensitivity reactions (including anaphylactic reactions); pregnancy (Category B2); lactation; infants less than 2 years of age including neonates; prolonged neuromuscular blockade (sub-optimal doses) and delayed recovery. **Interactions**: Potential identified with toremifene, hormonal contraception. Could interfere with progesterone assay and some coagulation parameters. **Adverse Reactions:** Dysgeusia, prolonged neuromuscular blockade, anaesthetic complication (restoration of neuromuscular function), hypersensitivity reactions varying from isolated skin reactions to serious systemic reactions (i.e anaphylaxis), bronchospasm and pulmonary obstructive events. Severe hypersensitivity reactions can be fatal. Events associated with surgical procedures under general anaesthesia. Isolated cases of marked bradycardia and bradycardia with cardiac arrest. **Marketed by:** Merck Sharp & Dohme (NZ) Ltd., Newmarket, Auckland. Based on Medsafe-approved Data Sheet, prepared 22 February 2016, available on www.medsafe.govt.nz. ® BRIDION is a registered trademark. ANES-1208494-0002. First issued July 2017. DA1735MW essence MSD8467

MSD

bridion® sugammadex