NEW ZEALAND
Anaesthesia
THE MAGAZINE OF THE NEW ZEALAND SOCIETY OF ANAESTHETISTS • DECEMBER 2021

Whakaora (To Heal) – ASM highlights

NZSA sustainability audit

PLUS:

Māori health disparities

Hyperconnected medics

NZSA President's Award

Optimising anaesthesia research

New Zealand SOCIETY OF Anaesthetists

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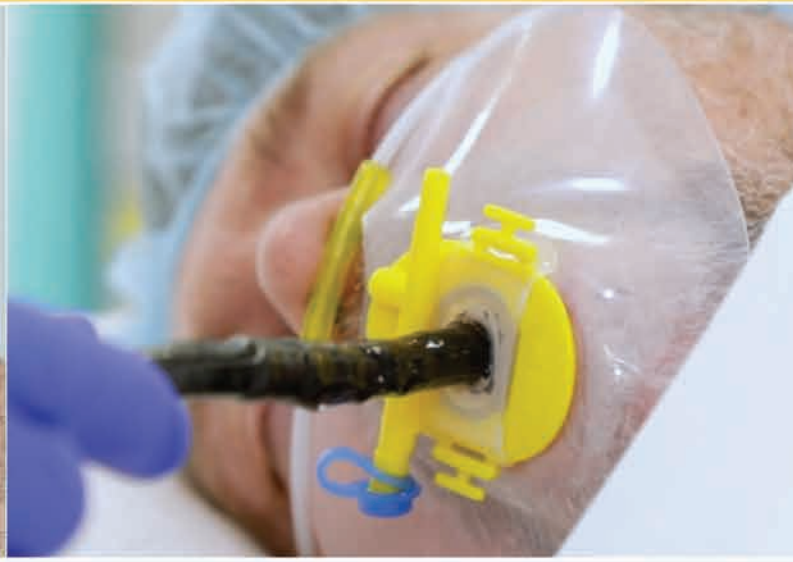

SAM Safety Shield with Bite Block and Valve for use during aerosol generating procedures such as endoscopy, bronchoscopy, and trans oesophageal echo, assists to reduce aersolisation of secretions.

Scan to see how SAM Safety Shield works

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PRESIDENT'S COLUMN

As we approach the end of 2021, it is a good opportunity to reflect on the year and what the NZSA has achieved in that time.

We set some top priorities for 2021:

- **Ensure new office staff settle in, without them we cannot do anything!**
- **Look at our Society with the principles of Te Tiriti o Waitangi in mind and through this lens grow our Society and its values in the right direction.**
- **Continue to be an active voice, alongside ANZCA, on important issues likely to affect our members.**
- **Connect with our members and engage, including planned hospital visits.**
- **Award the inaugural President's Award to a well deserving anaesthetist!**

So, how have we progressed?

The office

Michele Thomas, our CEO, joined us in April. She has grabbed the bull by the horns to ensure our office policies and processes are up-to-date and robust. She has worked hard to meet our key stakeholders, having over 180 meetings since she arrived! Rebecca Nodwell, our Networks Administrator and EA, similarly, has unbounded enthusiasm and lots of new ideas on how to improve our IT systems and network support. Along with Daphne Atkinson, our Communications Manager and Lynne Mulder-Wood, our Membership Manager, who have been with us for a number of years, the office has an excellent team. This is essential for the smooth running of the NZSA, especially as we face some uncertain financial times. This was the first year for a long time that the Society had a deficit due to the impact of COVID on events, one of our significant revenue generators. We are looking at alternative revenue streams to ensure we remain solvent.

Advocacy

One of our key goals was to develop a plan to integrate the principles of Te Tiriti o Waitangi into the NZSA and its activities. We have begun this process with the development of the NZSA Te Tiriti o Waitangi Policy Statement. This was put together with consultants Jim Berry and Cheri Ratapu-Foster, who will also be running an eight-week te reo and tikanga training course for the NZSA and ANZCA NZNC offices early in 2022. We have a very long way to go, this is just the beginning.

We continue to work alongside ANZCA NZNC to be a joint voice for anaesthesia. Both organisations (along with NZMA and others) recently submitted on the changes to the list of drugs pharmacy prescribers can prescribe as we felt strongly that NMBAs should not be on that list. Unfortunately, despite our strong feedback, they have been listed. ANZCA NZNC Chair Dr Sally Ure and I plan to meet with the Pharmacy Council to discuss this; the justifications given do not readily apply to the New Zealand context.

Community

This year we have visited anaesthesia departments in North Shore, Tauranga, Palmerston North, Wairarapa, Wellington, Blenheim, Dunedin, and Timaru and have a visit planned to Gisborne before the end of the year. These visits are a great opportunity to connect with our members. We are planning a full calendar of visits for 2022.

Our networks continue to enable discussion and collaboration across the country. Recently we established a COVID network to share policies and ideas, again fostering collaboration and minimising duplication of efforts. It would have been desirable to have more national level guidance from the Ministry of Health on many issues related to COVID planning, but as a substitute this aims to assist with policy and planning across our anaesthesia departments. This coincided with the initiation of a national COVID forum set up by Network Z (the ACC funded MDT simulation program). This is multidisciplinary and they have held several forums to foster similar collaboration. I am acutely aware of the number of networks/forums/groups/committees our members are asked to contribute to, and am forever grateful to those who do put their hands up. As you can see in the infographic summarising key NZSA highlights for the year, we have a huge number of volunteers, and the hours put in are a testament to the dedication of those in our specialty.

A positive development this year has been the inaugural President's Award, which was established to recognise the sustained efforts of our members. It was awarded to Dr Indu Kapoor (read more on p. 17). Congratulations Indu!

Education

COVID thwarted a number of our events, including AQUA which was intially postponed, then cancelled. We were fortunately able to deliver the Aotearoa/New Zealand Anaesthesia ASM, however had to pivot to a fully virtual format at short notice. We are planning the NZSA/ASA Combined Scientific Congress for October next year in a hybrid format. I would also like to draw your attention to the Auckland City Symposium on 1 April.

We are developing some Part 3 resources that will be accessible on our website throughout the year, rather than just at the annual Part 3 Course (which was cancelled this year).

2022

The new year will still bring a degree of uncertainty, but we may get a glimpse of what the new normal may look like.

As a Society we will continue to foster activities under our key pillars of advocacy, community and education. We will be reviewing our strategy early in 2022 to ensure we remain current and relevant to our members.

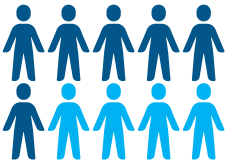
The health and disability system reform will be a major focus of our advocacy in 2022 – the magnitude and reach of the Pae Ora (Healthy Futures) Bill and the plans and strategies that fall under this will be profound on the health workforce, patients and population health. We must have a sound, robust platform if we are to effect meaningful change in areas such as preventive health, integrating primary and secondary care, and more equitable health outcomes. A strong clinical governance framework is crucial and must be prioritised. There will be ongoing opportunities to engage and provide input in 2022 and we will be asking for members' views to inform our feedback.

In what has been a particularly tough year, I hope you will be able to have a break over summer and have some free time to recharge and do what you enjoy. As our ASM wellbeing session conveyed so strongly – looking after yourselves needs to be a priority so you are able to look after others. I'll end my column with these wise words on wellbeing posted by Australian surgeon Dr Eric Levi on Twitter:

"Wellbeing is more than just physical and mental health. We've got more than two compartments. Health is physical, mental, social, emotional, intellectual, cultural, even spiritual. Nurture them all."

Sheila Hart, NZSA President

NZSA 2021 Highlights



Membership

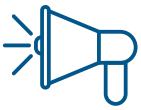
We have a total of 752 members made up of:
507 Full members
157 Trainee members
16 Associate members
6 Honorary members
14 Life members
23 Retired members
29 Pacific members

Networks & Committees

Our committees have been actively growing during 2021 with 140 members volunteering their time and energy.

Submissions During 2021

This year we've made **11** submissions to Parliament advocating on issues affecting anaesthetists in Aotearoa.



Stakeholder Meetings

Approximately **300** stakeholder meetings have been attended by our President, Vice President and CEO during 2021.

Looking Ahead to 2022

We have some incredibly exciting initiatives in the pipeline for 2022 including: launching our environmental impact audit, Treaty of Waitangi/Tikanga training, additional member resources and benefits, as well as a brand new NZSA website. Email us with your thoughts, suggestions or requests - nzsa@anaesthesia.nz

We've got 506 followers, and our post engagement has increased by 49.6%!

We've got 1193 followers, that's 147 more than last year. @thenzsa

We launched our LinkedIn page - be sure to give us a follow and share with your networks!

Publications

We have put out magazines in April, August and December this year! We've also sent out regular E-Zines each month.

The NZSA wishes members and health sector colleagues a wonderful festive season, time with family and friends, and a restful break. Thank you all for your support.

Happy New Year and we look forward to seeing you in 2022!

NEWS IN BRIEF

Theatre caps

We're excited to launch our NZSA branded theatre caps! Personalise with your name and choose from a range of styles. We'd also appreciate receiving photos with the new look – individual or a team one so we can put them up on our website. Studies have shown that wearing theatre caps make it easier to identify others in the team by name, which improves communication in the OR and leads to better patient outcomes. View the styles and purchase at: https://bit.ly/3omp2KM

NZSA President Dr Sheila Hart with the adorable Molly.

Trainee PACT fundraising initiative

PACT (Pacific Anaesthetic Collaborative Training) is an initiative which helps to fund the training of anaesthetists in the Pacific region and was launched last year by the NZSA Global Health Committee. Dr Jennifer Ross, anaesthesia trainee at Wellington Hospital, organised a fundraiser screening of 'Bond - No Time to Die' to raise money for PACT. NZSA GHC Chair Dr Indu Kapoor says that this was a trainee run event, with some consultants joining "because who can resist Bond? It was a massive success and raised $750 towards PACT." She encourages trainees in other locations around New Zealand to also get on board and think of creative ways to fundraise for PACT. If you have any questions, contact Indu Kapoor indu@icloud.com

New degree for Anaesthesia Assistants

The BHSc degree in Perioperative Practice will become the new training pathway for anaesthetic technicians in 2022 and will be offered by the Auckland University of Technology. It is a level seven qualification of 360-points (three years full-time). Graduates will be eligible to apply for registration through their registration body, the Medical Sciences Council. DHBs have been very supportive of the degree and partnerships between DHBs are forming to progress clinical placements. The first cohort of graduates will enter the workplace in 2024.

Immediate NZATS Past-Chair Kirstin Fraser

The NZSA would like to wish the Immediate Past Chair of the New Zealand Anaesthetic Technicians' Society (NZATS), Kirstin Fraser, all the best for the future and to thank her for her contribution. Kirstin, who completed her term at the end of October, joined the NZATS Executive in 2014 as the AUT Liaison Officer taking on the Chair role in 2017. We appreciated Kirstin's hard work in advancing her profession and continuing to foster a strong collaborative relationship with the NZSA. We look forward to working with new NZATS Chair Matthew Lawrence.

NZSA new Deputy Trainee Representative

The NZSA welcomes Dr Aidan Ward as our new Deputy Trainee Representative. Aidan is an AT1 who is moving from Tauranga to Waikato Hospital at the next registrar changeover. He will be working closely with NZSA Trainee Representative Dr Mikaela Garland. Aidan has recently made the switch from road to mountain biking and is always trying to keep up with his physiotherapy partner Zara.

ASM education prizes

Judges were highly impressed with the calibre of entries. Congratulations to all the winners, which were announced at the ASM.

NZSA John Ritchie Prize ($2500) to Dr Stephen Roberts from Canterbury DHB for 'Coolsense® versus EMLA® for peripheral venous cannulation in adult volunteers: a randomised crossover trial.' Dr Roberts is also able to apply for the $5000 John Ritchie Prize Research Award.

ASM Poster Prize from NZSA and NZNC ($500) to Associate Professor Ross Kennedy from Canterbury DHB for 'EEG power and frailty - A preliminary investigation.' There was also an honorable mention for Mr Taehoon Kim from the University of Auckland for his paper 'The association between quality of recovery metrics and postoperative opioid use following elective total knee arthroplast.'

NZNC Trainee Prize ($1000) to Dr Jignal Bhagvandas from Whangarei Hospital, Northland DHB for 'The effect of Remifentanil PCA vs Epidural in labour - maternal and neonatal outcomes.'

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Aotearoa New Zealand Anaesthesia Annual Scientific Meeting

Whakaora (To Heal)

Our ASM (with 400 plus registrations) proved to be an engaging and interactive event, boosted by the enthusiasm and support of delegates who embraced the fully virtual format. It was a privilege for the NZSA to co-host the ASM with ANZCA NZNC and NZATS.

We were thrilled to see 'watch parties', including in Tāmaki Makaurau Auckland and Whanganui-o-Tara Wellington. There were opportunities to participate in event engage experiences to collect points and be in the draw to win prizes – it certainly spurred on the competitive streak in many!

We were fortunate to be able to broadcast some of the event from the Christchurch Town Hall, with a small group attending in person, which included the Organising Committee (OC) from Christchurch Hospital and some of the speakers. It was a fantastic conference with diverse, thought-provoking talks that challenged our practice and ways of thinking across many issues. The OC put together a program that reflected the biggest issues facing our hospitals and surgery, with sessions that included: equity in medicine in Aotearoa, how the Christchurch earthquakes led to positive changes in healthcare delivery, how research is changing surgical treatment for patients, climate change and the health emergency it will create, and what doctors can do to look after each other and themselves during change and uncertainty. The program exemplified the thinking, research, innovation, and planning that is underway to make healthcare safer in these challenging times of COVID, and leading into the health reforms next year.

We thank the scientific convenors Drs Christian Brett and Veronica Gin for their work in developing such an outstanding scientific program.

A big thank you to the Organising Committee, led by Dr Ben van der Griend. Your positivity and adaptability in the face of COVID restrictions enabled us to deliver an incredible virtual experience. The ASM theme Whakaora (To Heal) 'Our patients, ourselves, our city, our planet' was timely and poignant, and the Ōtautahi Christchurch ASM session was a testament to resilience and outstanding patient care in times of crisis.

We also extend our thanks to all speakers, session and workshop chairs and moderators, our industry supporters who play such an essential role in enabling us to hold a conference, and of course all attendees for your support. We thank our PCO Outshine for your professionalism and for working so collaboratively with the OC and parent bodies.

Aotearoa New Zealand Anaesthesia ASM Organising Committee.

From left on screen: NZSA President Dr Sheila Hart, ANZCA NZNC Chair Dr Sally Ure, and NZATS then Chair Kirstin Fraser welcomed delegates to the conference. On stage, Dave Brennan from Ngāi Tahu.

Christchurch Town Hall.

Aotearoa New Zealand Anaesthesia ASM Organising Committee.

Professor Carol Peden.

We began our ASM with a welcome from Dave Brennan from Ngāi Tahu, followed by convenor Dr Ben van der Griend, and a joint welcome from NZSA President Dr Sheila Hart and ANZCA NZNC Chair Dr Sally Ure. They said that the ASM program reflected the dynamic times we live in and would pique curiosity and keep delegates informed and entertained. The OC was praised for "pivoting to a completely virtual platform."

Colleagues in Tāmaki Makaurau were acknowledged for doing it tough in an extended lockdown and contending with the effects of COVID in their workplaces. Chair of NZATS Kirstin Fraser also welcomed delegates and thanked the OC for their work in these challenging times.

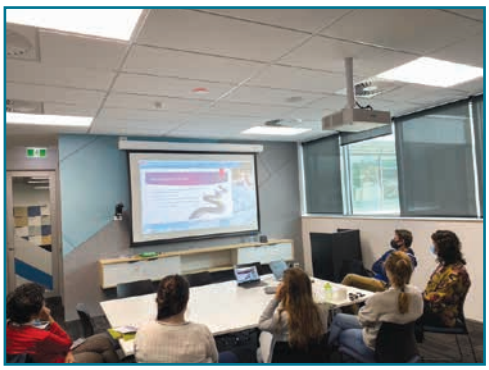
Alan Merry Oration

"We found that the more strategies you used, the more likelihood of success."

Our opening plenary theme was 'A focus on quality' and commenced with the Alan Merry Oration (established at the 2019 ASM), delivered by Professor Carol Peden, an Adjunct Professor of Anesthesiology at the University of Southern California and the University of Pennsylvania.

Professor Peden presented on 'The UK National Emergency Laparotomy Audit (NELA): A quality improvement journey from audit to ERAS guidelines.' NELA aims to improve quality care for patients undergoing emergency laparotomy, by providing high quality comparative data from all providers of emergency laparotomy. Professor Peden said great progress had been made in addressing the wide variation in outcomes and adherence to best practice since 2011-2012, although "there was still a lot of work to do." She attributed improvements in data collection to: securing buy in from those in the system including CEOs; setting standards; and developing quality improvement tools, checklists, bundles and pathways. She emphasised the importance of sharing stories about patients, as a personal approach was more likely to motivate changes in healthcare treatment. "That's about getting the why, and the emotion of why we need to do things differently." A story she had recounted about a patient called Ruby a decade ago still resonated all these years later, with many telling her that it was Ruby's story that led to their involvement in laparotomy work.

The Enhanced Peri-Operative Care for High-risk patients (EPOCH) study, published in the Lancet in 2019, led to improvements in 279 out of 800 processes, and teams were encouraged to use tools such as stakeholder meetings, data analysis, and run charts. "We found that the more strategies you used, the more likelihood of success." Ethnographers were part of the study looking at physician engagement and its influence on successful teams. The teams that did best in making changes were those that engaged best socially and reached out to others in the hospital such as radiographers and surgeons. The impact of these "corridor conversations" made a difference.



Left and centre: Whanganui-a-Tara/Wellington watch party.
Right: Tāmaki Makaurau/Auckland watch party.

The next big thing was the Emergency Laparotomy Collaborative, which scaled up ELPQiC with defined metrics and NELA data to develop a standardised pathway. This study learnt from EPOCH and increased its focus on the elderly, on sepsis and held regular plenary meetings as this was a collaborative rather than randomised controlled trial. Bringing people together meant they could be "synergistic in their work." Coaching and change leadership were the focus of later meetings and local teams developed their own resources, including webinars.

Bringing people together meant they could be "synergistic in their work."

The baseline was over 5,500 patients – results included the crude mortality rate falling from 9.8% at the beginning of the Collaborative to 8.7%, while length of stay decreased by 1.3%. There was regular data and feedback to the teams, and regular engagement with CEOs and academic networks to ensure the project was supported.

Prof Peden highlighted that while making change is hard, sustaining it is even harder due to factors such as staff turnover or a sense of complacency as people think "we cracked this, we don't have to think about it anymore." She recommended having an audit built into electronic records.

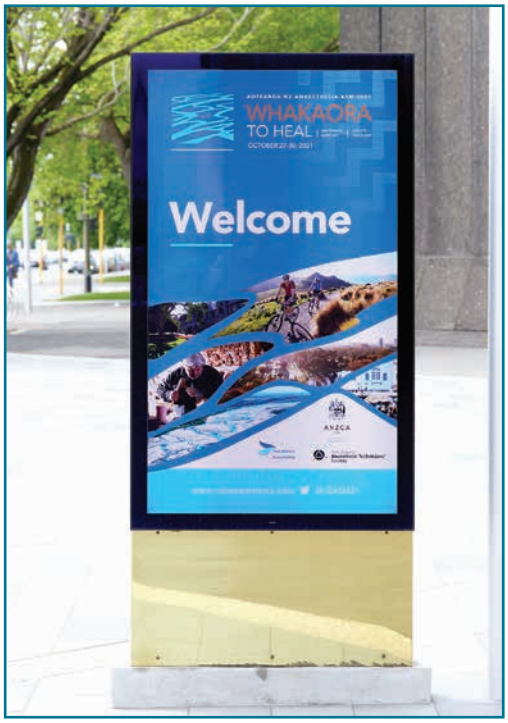
The guidelines for perioperative laparotomy for ERAS were published in the World Journal of Surgery in May 2021 to help reduce mortality, morbidity, and length of stay.

We were fortunate to welcome other international guest speakers at our conference: Professor Dan Sessler, Professor Bernhard Riedel and Professor Victoria Brazil. Professor Brazil's talk on hyperconnected medics is featured in this issue of the magazine, along with articles on NZ speakers Dr Doug Campbell (NZSA sponsored speaker) and Dr Jason Gurney.

Delegates can watch the ASM 'on demand' until 31 January 2022

ASM social media

In the seven days leading up to and including the conference, the ASM Twitter account had ~78,000 impressions. We would like to thank Dr Ross Scott-Weekly for tweeting from this account with such aplomb and to all who tweeted and retweeted to promote the ASM.



Top: Welcome sign outside the Christchurch Town Hall
Bottom: WFSA President Elect Dr Wayne Morriss from Christchurch Hospital presented on quality and safe anaesthesia from a global perspective as part of the quality session.

Optimising research in our anaesthetic departments

NZSA sponsored ASM speaker, Dr Douglas Campbell.

Specialist Anaesthetist Dr Douglas Campbell from Auckland City Hospital says that partaking in clinical research is one of the foremost ways to improve clinical practice through new methods, techniques, and investigations.

Dr Campbell, whose research interests include large, collaborative, multi-centre clinical trials, was the NZSA sponsored speaker at our ASM.

"Research advances our specialty and makes us better clinicians. All anaesthetic departments in the country are striving to improve the quality of care they provide to their patients, and research is a core part of this. However, unlike teaching and education, research is not quite as embedded in our hospital departments and often sits outside the mainstream of the core activities," he said.

He presented data from the UK's NHS to show that the higher the volume of research funding, the lower the one-month post-surgery patient mortality rate.

He outlined some of the obstacles to doing more research, including inadequate research infrastructure in hospitals – strong infrastructure is needed to support trainees, early career researchers and specialists.

"Having support from hospital and departmental management, and colleagues makes a huge difference."

He says that every department will have clinicians involved in research who have faced various obstructions. A key piece of advice is to employ someone who can focus on research, such as an audit and nurse research coordinator, with suitable office space, to support clinicians involved in research. New Zealand's ethical regulatory environment is robust, and Dr Campbell says he relies on his audit and research nurse coordinator to help him meet the requirements, which includes adhering to privacy laws and Māori data sovereignty. "This expertise is invaluable to have for every department doing research, but you need a reliable funding stream to cover the salary sustainably in the long-term."

"Funding is fundamental to advancing research and requires having a departmental research plan in place."

Ideally, mentorship and provision of data should be part of the equation and are also contingent on adequate funding – New Zealand's DHBs do not provide enough funding into research, with most funding secured from external sources.

While applications for funding can be hit and miss, the adage "you've got to be in, to win" certainly applies. He recommends applying and securing multiple funding streams to reliably cover financial research commitments, including employee salaries and other costs such as site set up and publishing fees.

"A department's business plan needs to include applying for funding through grants – with practice you get better at doing these applications and honing your case for funding."

How do we develop an environment that is supportive of research? "Departments need to prioritise research and recruit people who are either involved in research or willing to participate in it in some way and develop career pathways which include a research component."

He recommends that departments align their research to their clinical goals "investigating problems which are of clinical interest" and "triaging" research projects according to how the department views the importance and feasibility of the research.

Dr Campbell says that an advantage of New Zealand's research environment is that there is great collaboration between centres in the country, and from across the Tasman, such as ANZCA's Clinical Trials Network, which has a high track record of success and allows all DHBs to be involved.

He believes our research should focus on areas in which New Zealand excels and can make the biggest difference, such as NMDs (national minimum datasets) and the cancer registry. "We can produce world-leading research that can be done easily and cost-effectively."

Looking to the future departments must prioritise training the next generation of researchers by involving trainees and those early in their careers in doing more research. "This is incredibly important as key people approach retirement age, we need to have successors in place to carry on the high quality research we are doing."

Future directions – NZSA's sustainability audit

Rebbecca Page, Greenstart Director and Principal Consultant.

The NZSA has been working with Greenstart, a consultancy which supports organisations on their sustainability journey to become financially, environmentally and socially resilient.

Rebbecca Page, Greenstart Director and Principal Consultant, provides an overview of the process and what genuine sustainability looks like.

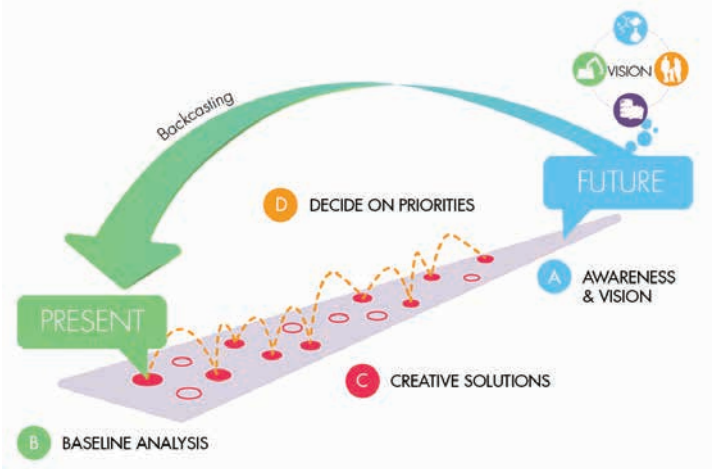
What do you think of when you hear the word sustainability? It wasn't so long ago that when we talked about sustainability in the workplace, it meant a recycling bin, or a sideways glare if you weren't pulling your weight with the double-sided printing. One person in the team would be allocated the task of coming up with and implementing the Sustainability Strategy for the organisation; the unified eye-rolls as the delegate could be seen heading your way to ask, "have you been turning the lights off?"

How do I know this? Because I was that delegate, although fortunately I am a tenacious wee soul and enjoy a challenge. There was a stigma attached to being a sustainability professional; a wary look would come over people's faces as though there was a fear I might try to wrap them in hemp and teach them the words to Kumbaya. It has been more than a decade now, and I have watched the rapid transition in attitudes regarding sustainable practice, development and the experts who implement the systems. If an organisation, an individual even, is ignorant about sustainability, they are vulnerable. It is the language of today – our youth are conversant in it and expect our behaviour to reflect the action to reflect the words.

"Sustainability goes beyond resource management and consumption."

Sustainability goes beyond resource management and consumption. It's also important to consider all four pillars of sustainability: human, social, economic and environmental. It is well recognised that organisations now see sustainability as a long-term investment rather than a cost, evolving from a fashionable trend to a business imperative, and society expects it.

So, how does an organisation identify sustainable practice; claim the good, tie a ribbon around the work to be done and make a plan; avoid the dreaded greenwashing, and perhaps most importantly, engage folk (like you) who are going drive the change? Having buy-in from top management at NZSA has been the critical element at the beginning of this process. By creating a baseline of environmental and sustainability impacts for the NZSA's operational arm (Wellington Head Office), I worked with the team to identify the gaps (which can also be described as risks and opportunities) in the journey towards a more sustainable and resilient future.



Following the assessment, recommendations were made for the NZSA to improve their sustainability where the immediate and higher risk gaps sit; followed by looking to the horizon to identify the larger and more audacious goals for themselves and the NZSA members who are looking for guidance.

As B Corp measures an organisation's entire performance, from transparency and carbon footprint to supply chains and inclusion, it's widely considered the "gold standard" of environmental and social certification. B Corp aligns strongly with the UN Sustainable Development Goals (SDGs), a unique opportunity to rally around a shared global agenda to end poverty, protect the planet, and ensure that all people enjoy shared and durable prosperity. It is also a powerful storytelling tool to share what you are doing to create a better world for tomorrow. Implementing the B Corp assessment recommendations that help advance the SDGs will likely improve trust among stakeholders; strengthen their license to operate; reduce legal, reputational and other business risks; and build resilience to costs or requirements imposed by future legislation.

The team answered a range of audit questions tailored to the NZSA's size, sector, and geography. These include a detailed investigation into NZSA practices around governance, community, workers, environment, and potentially sensitive industries, practices, outcomes, or fines/sanctions. The process enabled the NZSA to assess their sustainable practice and ethical practice authentically.

By implementing the recommendations, it is anticipated that NZSA will become an exemplar for its members on practical implementation and better awareness of the operational impacts that an industry carries.

It is not always a simple or easy process; however, it's how we build a better tomorrow.

Michele Thomas, NZSA CEO.

NZSA CEO Michele Thomas explains what the NZSA is doing to demonstrate its commitment to a resilient and sustainable future.

It has been a privilege to meet such wonderful people since joining the NZSA as CEO and I am so impressed by the incredible work of our NZSA networks to support our anaesthesia community.

The NZSA's Environmental and Sustainability Network is very active and engaged, aiming to reduce the environmental impact of anaesthesia and our wider healthcare services nationally. It has taken a strong leadership role in advocating for sustainability (most recently COP26), as well as educating our members on how to reduce their hospitals' carbon footprint. To support and strengthen the aims of the E & S Network, we decided to audit the operational arm of the NZSA. We also wanted to ensure the best possible environmental and working processes for our organisation to 'walk the talk.'

I had worked with Rebbecca Page from Greenstart in a previous role and she immediately came to mind to help NZSA undertake this work. NZSA's commitment to a resilient and sustainable future means reviewing all our policies and processes to evaluate how they rate in terms of environmental sustainability.

"Society's most challenging problems cannot be solved by government and non-profits alone."

Greenstart recommended an assessment audit against the B Corp standards as Rebbecca has outlined. Undertaking a B-Corp audit helps business to meet the highest standards of verified social and environmental performance, and to demonstrate public transparency. It also redefines success in business practices to attain a more inclusive and sustainable economy. In their own words:

"Society's most challenging problems cannot be solved by government and non-profits alone. The B Corp community works toward reduced inequality, lower levels of poverty, a healthier environment, stronger communities, and the creation of more high quality jobs with dignity and purpose. By harnessing the power of business, B Corps use profits and growth as a means to a greater end: positive impact for their employees, communities, and the environment." https://bcorporation.net/about-b-corps

What are environmental and sustainable practices? It's much more than recycling your coffee grounds and lunch packaging – it's about putting real thought and purpose into every tier of the business to ensure sustainable practices now and into the future.

Rebbecca met with the team and NZSA President Dr Sheila Hart, to go through the survey together and gather the information we needed to complete the audit questions. As a registered health auditor myself, it was not unlike undertaking a healthcare audit, representing a snapshot in time of the organisation to create a baseline for practice improvement and change. As a team we reflected on our working practices and brainstormed ideas on how to make improvements – we realised that some changes could be made quickly (what Rebbecca described as the low hanging fruit) while others need more time. Rebbecca rated the NZSA's audit results favourably (e.g. minimal waste, reduced travel with more virtual meetings, good use of public transport, less printing as more online resources, governance that has high female representation) so we have a great platform from which to keep strengthening the NZSA's performance. She made the process easy and continues to support the team as we start implementing her recommendations.

I look forward to keeping members informed of our progress and welcome any questions you may have.
Email: ceo@anaesthesia.nz

More information

https://bimpactassessment.net/
(https://www.sdgactioncampaign.org/resources/)

B Impact Assessment™

Anaesthetist's harrowing COVID ICU experience in the UK

New Zealand anaesthetist and intensivist Dr Ryan Salter shares his experience of working in the UK at the height of the COVID pandemic. He was based at Royal Papworth Hospital in Cambridge, a cardiac surgical centre and the UK's leading heart and lung hospital where patients are referred for last-resort treatment on ECMO [1] (extracorporeal membrane oxygenation). The hospital received more ECMO referrals in just one month, than they had for an entire year pre-COVID.

Ryan has recently returned to New Zealand and is working at Wellington Hospital.

When Ryan arrived in the UK in July last year with his young family, the country's first wave of COVID was subsiding. There was a feeling of optimism that the worst was over, and people could return to their normal pre-COVID lives. Optimism was short lived however, as a second wave of COVID hit and the UK was put into a one-month lockdown, followed by the country easing restrictions ahead of Christmas. By January, case numbers had skyrocketed to about 30,000 a day and hospitals were soon overwhelmed.

Papworth began to receive referrals from other hospitals that were struggling. The hospital is funded to provide about 35 ICU beds – but soon reached double capacity with 80 patients either ventilated or on ECMO. Ryan arrived in the UK as a cardiac anaesthesia fellow, however in December of last year Papworth appointed him as an ECMO/ICU/anaesthesia consultant.

Ryan says that the intense pressure Papworth was under necessitated change to the nursing patient ratio so that instead of a 1:1 nursing/patient ratio, the model became one ICU nurse per two or three patients.

While it was a difficult working environment for all staff, Ryan says he particularly felt for the nurses who were under immense strain, with each looking after three patients, as well as supervising bedside carers. He emphasises the importance of treating ICU nurses well, describing them as "our best asset" in treating endemic COVID.

The standard at Papworth was to have two specialists looking after one ECMO patient but as demand surged, with ICU specialist nurses also becoming unwell with the virus, the ratios became compromised. At one stage it was about one ECMO specialist for six patients.

The strain on ICU staff meant that the hospital had to recruit non-ICU staff from throughout the hospital to assist, such as anaesthetists, nurses and even heart and lung transplant physicians. Space in the ICU reached capacity and other parts of the hospital, such as the surgical day ward and theatre recovery rooms, had to be used for the ICU COVID response.

In terms of bringing anaesthetists into the ICU, Ryan explains that in the UK anaesthetists and ICU are more closely linked, with many anaesthetists already doing some work in intensive care.

Non-ICU nurses and Operating Department Practitioners took on bed care support roles.

The vast majority of COVID patients Ryan saw at Papworth were unvaccinated. He says recent cohort studies show that under normal circumstances around 5 to 10 per cent of people who get COVID will end up in ICU, but that this falls to about 0.5 per cent for those fully vaccinated.

"we had seriously ill patients under the age of 30, and many couldn't be saved."

The concerns voiced by doctors and nurses in New Zealand that community and hospital services could become overwhelmed by COVID are well justified, he says. "I agree with the concerns expressed by so many of my colleagues that our health system is under-resourced for the anticipated critical care demand and does not have the capacity to manage a COVID crisis. Our best protection is to get as many people vaccinated as possible and to achieve high vaccination targets."

Papworth's cardiac service was significantly scaled back due to COVID, and cardiac services only continued for the highest priority cases. A high proportion of elective surgery was put on hold.

"The need to ration and compromise the care of some patients was a huge emotional strain and burden for staff."

Notably, the number of ECMO referrals the hospital received in one month exceeded the referrals it received in one year pre-COVID.

At the peak of the second wave, Papworth had 26 patients on respiratory ECMO, of which 25 had COVID. Most patients on ECMO were in for the long haul.

"In fact, being on ECMO for under two months was considered a short time, with some not turning a corner in their recovery until about day 80." He recalls one patient being on ECMO for about 140 days before his lungs began to finally recover.

1 ECMO is a very specialised, last resort treatment for life support. The ECMO machine pumps and oxygenates a patient's blood outside the body, allowing the heart and lungs to rest. It is for people who are unable to get oxygen in and carbon dioxide out, even with a ventilator.

The team at Papworth following an oxygenator change out in a severely unwell patient. Photo credit: Lynsey Addario.

The number of referrals for ECMO became so high that ECMO had to be rationed to who was deemed to be fit enough to survive this highly invasive treatment. A 'risk of death' score was used for receiving ECMO care, which included considering a patient's age – many patients over the age of 50 were not provided ECMO care.

"In January we had just short of 350 ECMO referrals, most of whom we declined for ECMO. The majority of those we declined subsequently died."

The need to ration and compromise the care of some patients was a huge emotional strain and burden for staff. He says many experienced burnout, and it is also likely some had PTSD from seeing so many patients die and the cumulative day-to-day pressure of rationing patient care. "It became apparent that the illness does not only affect the elderly and/or those who are immune-compromised – at Papworth and other hospitals we had seriously ill patients under the age of 30, and many couldn't be saved."

Ryan says that in his time in the UK, even between the second and third waves, there was no reprieve as major pressure mounted to scale up theatre work to clear the massive backlog of surgical patients. And cardiac surgery also required post-surgery ICU care, at a time when ICUs were already struggling with COVID patients.

Ryan left the UK a week after 'Freedom Day,' in which the nation lifted most COVID restrictions – masks were no longer legally mandated, and social distancing rules and limits on indoor gatherings were removed. In his last fortnight at Papworth the workload increased again with more referrals coming through. He says that while there was much talk about impending freedoms in the media, it felt like a "real disconnect from what staff were experiencing at Papworth and it certainly led to further angst for those working in the health system."

Some health care workers became infected with the virus. Ryan says he heard anecdotally of consultants who became unwell with COVID and some ICU nurse specialists. There was also the fear of bringing the infection home to your family. Ryan took personal precautions such as having a shower as soon as he got home from the hospital, and says his family hunkered down with minimal outside contact.

Since Ryan's return to New Zealand, he has spoken to various media, including Kim Hill's Saturday program. He has sounded a warning that we need to reach high levels of vaccination, support public health measures to minimise intensive care admissions, and look at addressing ICU resourcing.

Having experienced the dire situation in the UK, he feels strongly that we need to work collectively to avoid the impact COVID has had on the UK's health system, health workforce and population.

Anaesthesia Visiting Lectureships

Nominations are open for the 2022 Visiting Lectureships.

Heads of departments are invited to nominate members of staff who have given an outstanding presentation at a continuing medical education session and who are willing to present this again as part of our virtual visiting lectureships – we held our first virtual lectureships event this year. In the past, two regional centres were visited, however with COVID disruptions and the motivation to reach a wider audience, we switched to a webinar format in 2021.

The Aotearoa New Zealand Anaesthesia Education Committee (ANZAEC) established the NZ Anaesthesia Visiting Lectureship to promote sharing knowledge and experience through outstanding presentations among anaesthesia departments and practices.

More information on the ANZAEC website:

https://www.anaesthesiaeducation.org.nz/visiting-lectureship

Study reveals stark disparities in perioperative outcomes for Māori

Epidemiologist Dr Jason Gurney (Ngāpuhi), director of the Cancer and Chronic Conditions (C3) Research Group at the University of Otago, led a team of researchers, including anaesthetists, which compared 30-day and 90-day mortality rates across elective and acute surgeries for Māori and non-Māori patients. The study of almost four million surgeries across all ethnic groups in Aotearoa New Zealand (2005-2017), showed glaring disparities of survival for Māori compared to non-Māori patients.

In his talk at this year's ASM, Dr Gurney provided a comprehensive outline of the study *Disparities in post-operative mortality between Māori and non-Indigenous ethnic groups in New Zealand* (funded by the Health Research Council and published in the New Zealand Medical Journal) which found that Māori are more likely to die post-operatively even when adjusted for factors such as age, socioeconomic deprivation, and co-morbidity.

"We really need to dig deep to understand what is driving these disparities."

He describes the evidence as "compelling and substantial" and provides an example where a Māori patient is twice as likely to die within 30 days of an amputation even after you control for the possible differences between them and European patients and the complexities of their conditions.

The study found disparities were higher in elective surgery, in part because there are more opportunities in an elective/waiting list setting for differential access to best-practice care prior to surgery, which then has a greater impact on outcomes. "This includes disparities in access to prehabilitation before surgery and access to primary care to treat existing conditions."

Earlier in 2017, the C3 Group was alerted to warning signs of disparity after undertaking a study on postoperative death 30-days and 90-days following minor and major amputations of patients with diabetes. The finding that Māori with diabetes are *substantially* more likely to die postoperatively following either major or minor lower limb amputation – even after adjusting for factors such as age, deprivation, and co-morbidity – was a "wake up call" and prompted the group to begin asking whether these results were solely linked to diabetes or part of a wider problem. It was around this time that the C3 Group came across a 2016 paper by the Perioperative Mortality Review Committee (POMRC), which found Māori were 20% more likely to die following acute procedures. The difference was even more stark for elective/waiting list procedures – 60%.

Epidemiologist Dr Jason Gurney led the study that revealed stark disparities in postoperative survival for Māori. Photo credit: STUFF Ltd.

Following the release of its report, the POMRC called for further investigation to understand why Māori had worse perioperative outcomes.

The research group took up the challenge, and successfully applied to the Health Research Council to fund a national audit study. In his talk to delegates, Dr Gurney focused on two projects undertaken as part of this audit – 'Setting the scene – stocktake of postoperative mortality following GA', and 'The Deep Dive – Comprehensive evaluation of ethnic disparities.'

The results showed that Māori are the only group in New Zealand to have substantially worse perioperative mortality than the majority European population, even when adjusting for factors such as age, socioeconomic deprivation, comorbidity, and the risk profile of various specialist procedures.

Breaking it down to reveal disparities by procedure, the research found Māori were:

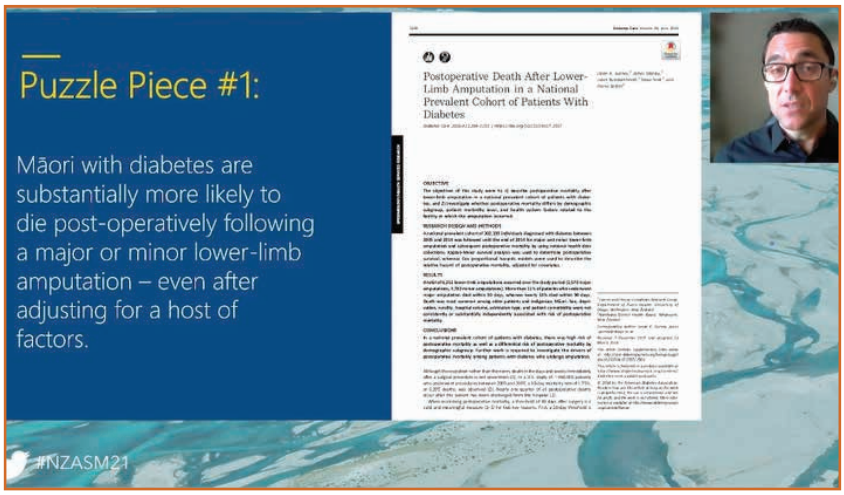
- 40% more likely to die following valve repair/replacement
- 50% more likely to die following CAGB (Coronary Artery Bypass Graft)
- 90% more likely to die following SI/bowel resection
- More than twice as likely to die following lower-limb amputation.

"These results are appalling. We really need to dig deep to understand what is driving these disparities."

According to data, socioeconomic deprivation and co-morbidity are important factors but are only partly able to explain the differences. "The extent of the disparities suggests a multi-factor cause," he says.

To dig deeper, Dr Gurney presented a slide titled 'Peeling the Equity Onion,' which looked at structural factors such as the intergenerational effect of colonisation and institutionalised racism "which means the system has been set up to work better for some groups than others, and the system also perpetuates inequities in the social determinants of health."

The structure influences the system, including the health sector, and impacts areas such as access to primary care and prehabilitation, which have a profound influence on perioperative outcomes. Dr Gurney says that we need to spend the vast majority of our time looking at these structural factors and how they impact the patient.



On a positive note, Dr Gurney says that there is time to better prepare Māori patients for surgery so they are as ready and "fit for surgery" as European patients.

Dr Gurney says that New Zealand's healthcare system requires transformative change to be more responsive to the needs of Māori. "A system wide approach that addresses all facets of healthcare, from decisions on funding and policy, through to patient care covering access, diagnosis and treatment."

The study called for systematic audits of perioperative care for Māori "built into our business-as-usual reporting at a national level" which could look at issues such as access to specialist surgical teams. Additionally, exploring and addressing cultural competence and bias, including unconscious bias, is imperative.

"Monitoring surgical care at a systems level should be part of ongoing quality assurance to help us move towards more equitable surgical outcomes."

Dr Gurney says he is optimistic that the newly formed independent Māori Health Authority, able to commission health services as part of the Government's health system reforms, will drive meaningful change and shake the system up, "on the proviso it is adequately funded and resourced."

Excerpt below and link to NZMJ article

"These disparities are in breach of the United Nations Declaration on the Rights of Indigenous Peoples, which states that Indigenous peoples have both the right to good health and the "right to access, without any discrimination, all social and health services."

https://journal.nzma.org.nz/journal-articles/disparities-in-post-operative-mortality-between-maori-and-non-indigenous-ethnic-groups-in-new-zealand-open-access

NZSA President's Award

The inaugural NZSA President's Award was presented to Dr Indu Kapoor, a paediatric anaesthetist in Wellington, at this year's ASM. The award is for an NZSA member who has provided a specific or sustained contribution towards the specialty of anaesthesia and the NZSA.

Indu formed the NZSA's Paediatric Anaesthesia Network of New Zealand (PANNZ) to support the wellbeing of those doing paediatric anaesthesia and to improve information sharing throughout the country's hospitals. She was the first Chair of PANNZ and continues to be part of the network. Indu set up and continues to be involved with Pacmac, and simulation courses for anaesthetic crises in paediatric anaesthesia. She was a member of ANZCA NZNC committee for 12 years, which included holding the education portfolio. She is actively involved in SIMG processes and workplace-based assessments. Indu has a passion for assisting our Pacific neighbours and is the Chair of the NZSA's Global Health Committee. She has been instrumental in organising locum cover for Pacific anaesthetists so they can attend their annual conference hosted by the Pacific Society of Anaesthetists.

She most recently helped to set up the PACT initiative, where for the equivalent of a coffee a week donors can support the costs of training anaesthetists in the Pacific region." Find out more about PACT on the NZSA website www.anaesthesia.nz.

Hyperconnected medics – helpful or not?

Professor Victoria Brazil champions doctors having an online presence as it benefits learning, collaboration, and career advancement. In her talk to delegates at the ASM, she promoted the value of having a 'digital identity,' avenues for engagement and how to navigate the potential downsides of social media.

Professor Brazil, a Professor of Emergency Medicine and the Director of Simulation at the Gold Coast Health Service, and at the Bond University medical program, can certainly attest to the power of social media with 11.7k followers on Twitter (@ SocraticEM). She is also the co-producer of Simulcast and hosts the Harvard Macy Institute Podcast.

She is a big believer in the benefits of social media to advance education and continuing professional development to improve clinical practice and patient outcomes; whether as a consumer, collaborator, or creator.

What impact has COVID had on online and social media activity? "There is no doubt that it has amplified some of the negative aspects, with misinformation and disinformation prevalent. There are times when you'll need to switch off and disengage from certain conversations."

She says that for some social media is seen as a "narcissistic playground" having observed celebrities using it to promote themselves. However, this is far from the case for doctors who are sharing and disseminating their knowledge with colleagues throughout the world. "They are sharing research so that it has the impact that it deserves, and this sharing is an adjunct to the great work, and findings, they are producing."

What of the negative behaviour we see on social media, such as personal attacks and trolling, which discourages many from engaging on these platforms? "I think we're more aware of the traps these days. Fortunately, platforms have more safeguards than they used to. A lot of it is common sense – not engaging in negative conversations. Not going down rabbit holes that don't look authentic."

Professor Brazil points out that there are guidelines to follow, such as the Mayo Clinic's simple 12-word social media policy: Don't lie, don't pry, don't cheat, don't delete, don't steal, don't reveal. Essentially your online behaviour should be guided by integrity and ethics.

She favours keeping it very professional online – while she knows others who post personal material about their lives, she has found it easier to only maintain a professional persona and keep those boundaries in place.

In today's digital world, we face information overload – how can we best deal with this? Professor Brazil says that essentially it is our failure to "filter" information which is the real problem. Top tips to ensure your inbox is under control and you're receiving the relevant information you want include: RSS feed aggregators to enable you to filter the information you receive; subscribing to journal table of contents that you automatically set to go a particular inbox folder; and being considered about what and who you follow.

In terms of collaboration and creation, Professor Brazil outlined an example of a published paper she co-wrote on how to improve team performance through simulation. The publication of this paper could have followed the traditional route of just being published and gathering a few citations, which would have limited its access to those core followers strongly interested in simulation. However, the team decided to aim for a wider reach and posted about it on Twitter using techniques that maximise your audience such as including a photo, links and tagging individuals with Twitter handles who were involved in simulation. Their social media activity was essentially guided by the 'community' they wanted to reach – so in this case, no TikTok! (a video focused media platform) or Facebook, as they were targeting academic groups – and Twitter is the best social media platform for this. They also did a podcast via Dr Brazil's Simulcast.

"Don't lie, don't pry, don't cheat, don't delete, don't steal, don't reveal"

She concedes that being a creator does take a lot of time and effort and understands that some may choose not to go down this path.

On a personal level, she has found it beneficial and enjoyed the experience of having an active online presence as a consumer, collaborator and creator, the latter in a myriad of ways including writing a blog, maintaining her own website, and presenting her podcast.

"I've found it very rewarding. I did have to quickly learn about the technical aspects and how to present a podcast – and I think the quality of the podcasts has improved over time.

"From an educational perspective, I've learnt so much about healthcare simulation by doing podcasts, especially as I get to interview leaders in this field, to explore the research in more depth. As an interviewer, I've learnt to listen carefully. I've learnt how to take the theory and translate it more effectively to make it more understandable for those working in the coalface of delivering healthcare simulation."

Her final words of advice – use social media to add style to the substance and make sure it's intentional.

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Environmental sustainability

Environmental sustainability was at the forefront of this year's ASM, including a session 'There is no plan B' and a climate change workshop. Members of the NZSA's Environmental and Sustainability Network were among those who presented talks and chaired sessions for these events.

Network members are leaders in reducing their DHBs' carbon footprint and advocating for sustainable alternatives. Their expertise has been invaluable in enabling the NZSA to respond to environmental consultations e.g the Emissions Reduction Bill, and providing advice in our magazine with regular articles on how to lower our carbon footprint. We look forward to featuring an in-depth article about the Network's influence and activities in future.

NZSA E & S Chair Dr Rob Burrell, from Middlemore Hospital, introduced the workshop, which looked at how we can reduce carbon at an individual and systemic level. He defined sustainability as the actions which maximise co-benefits, minimise harm to patients and our environment, and make us better ancestors.

Setting the scene, Dr Burrell said 7 per cent of New Zealand's carbon footprint is from healthcare, with anaesthesia making up 5 per cent of this figure. He is a strong believer in anaesthetists being ideally placed to drive change in their hospitals through their leadership and conflict resolution skills.

Positively, we have seen a raft of environmental legislation in recent years to enable an organisation's environmental performance to be scrutinised as readily as its other operations, such as finance and governance. For example, the Government's Carbon Neutral Program (CNP)[1] seeks to reduce emissions within the public sector. CNP requires organisations to reduce and measure their CO2e emissions by December 2025. Anaesthetic gases are within this scope, as well as consumables e.g. single use devices.

Featured workshop talk – From health sector waste minimisation towards a circular economy

ESR Senior Environmental Scientist Dr Annette Bolton presented on a Ministry of Health funded project *'From health sector waste minimisation towards a circular economy,'* which collected information to support national guidance for DHBs to reduce waste, including waste going to landfill, greenhouse gas emissions and unnecessary procurement costs.

Dr Bolton said that a reduction in waste would deliver financial, environmental, cultural, health, wellbeing, and social benefits.

The Government has stated its intention that Aotearoa shift from a linear model (currently this model overwhelmingly dominates, with 81% of waste going to landfill) to a circular model that avoids landfill by maximising reuse and recycling. A quote she came across which strongly resonated, is that the

concept at the heart of the circular economy is to "ensure we can unmake everything we make."

The project undertook literature reviews, informal interviews and a survey on waste volume and audit.

A more circular healthcare waste economy can be created through a systemic change in the healthcare sector and more widely across the waste sector. The report identifies areas in which the health sector can make changes including the adoption of higher procurement standards, product stewardship schemes, uptake of reusable items and medical equipment, innovation to reduce waste streams reaching landfill, reduction and replacement of single use items, and using technology to reduce waste." For example, Dr Bolton says technology could be used to reduce food waste by forecasting the amount of food to purchase and prepare based on trend information of actual patient meal orders.

An Australian study is referenced in the report, which found a quarter of all hospital waste was from theatres with up to 25% derived from anaesthetic services (McGain et al 2019). The same study also found that about one quarter of OR waste could be recycled. Per tonne recyclables are half the cost of general waste, so increasing recycling capability will save DHBs waste related costs.

Dr Bolton said DHBs differed in what changes they could make depending on their internal and external infrastructure such as the ability to compost organic or green waste. The variation in DHB resources was also a factor in what each DHB can deliver.

The report's recommendations to achieve a circular economy include collecting national healthcare waste data, mandatory reporting mechanisms, and developing a national procurement standard. It also reiterated calls which have been made by our E & S Network to create sustainable development units, as exist in the UK, to drive policy, legislation, innovation, regulation, and initiatives for the health sector.

The report can be read on the ESR website https://www.esr.cri.nz/assets/HEALTH-CONTENT/20210716-DHB-Waste-Report-FINAL-1.pdf

Further reading:

https://ellenmacarthurfoundation.org/circular-economy-diagram

1 https://environment.govt.nz/what-government-is-doing/key-initiatives/carbon-neutral-government-programme/

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Guest Q & A

Michael Naera - Māori mental health specialist

Michael Naera began working as a Māori health practitioner at Rotorua Hospital in 1997 in the newly formed Hunga Manaaki service team. He describes it as a "momentous occasion" for the iwi, as Te Arawa had fought long and hard to ensure Māori entering the hospital were treated with respect and dignity from admission through to discharge. He speaks to NZSA about his work to address mental health issues and high suicide rates for Māori.

Can you tell me more about your work at Rotorua Hospital working in Māori mental health? What motivated you to become an advocate for change?

I interacted with whānau affected by suicide, suicidal behaviours, and psychological concerns. Four years after starting at the hospital, we started receiving more calls to support whānau bereaved by suicide, self-harm, and mental distress. I started to learn about Māori models of practice, which I really enjoyed because I didn't learn this at Polytechnic. I thought it was philosophical and out-of-the-box thinking. However, little did I know, it was leading me down this path of suicide prevention and mental health.

From 2000-2002, Te Arawa was hit by a spate of suicides. My hapū of Ngāti Pikiao was heavily affected. Six young dads, with families and prosperous sporting careers, had all died to suicide. Our hapū was in a state of flux. The DHB, schools, community and local sporting bodies struggled to deal with the aftermath. It was at this time I became involved in advocating for change at grassroots, clinical, policy and national level.

What I didn't know is that something was about to change my life. I was doing my normal ward visits when I got a call that a male had taken his life and was in the morgue. Like any other call, I knew the drill: Organise tea, coffee, and sandwiches. On arriving at the morgue, I was greeted by my uncle. I said, "Hey uncle, what are you doing here?" He said, "Your uncle took his life." Then he hit me with my uncle's name. As I walked into the morgue viewing room, my whānau were waiting. As I neared where uncle lay, I lost the plot and sobbed like a baby. My mentor, my kaitiaki and our whānau pou was gone.

My mahi has been full on since my uncle's death. In 2006, I received a scholarship from Te Rau Puawai to start a Bachelor in Psychology and Māori studies at Massey University.

I sat on multiple groups across the DHB before leaving after 12 years working for my iwi. I then shifted to Te Rūnanga o Ngāti Pikiao Trust as a Kia Piki te Ora Project Lead. I worked across Lakes DHB delivering a Kaupapa Māori Public Health and Suicide Prevention programme. I spent 10 years working for my hapū and loved it.

Today I am continuing to study, doing my PHD in Philosophy (Māori Studies). I was told you get more recognition doing psychology than Māori studies. My reaction was, "Yeah maybe, but when I get my PHD I can tell psychologists to change their practices to reflect Māori concepts."

The high rate of suicide in New Zealand affects all facets of society across age, socioeconomic background, ethnicity, etc, however there are glaring disparities with suicide rates more prevalent for Māori. What are some of the reasons for this huge difference?

We don't know why, and we shouldn't speculate or oversimplify. What I can say from years of working and studying in this area, is that relationships are probably at the core of suicide and suicidal behaviours. I'm talking about the relationship you have with yourself, whakapapa, the environment you live and work in, with others, your current circumstances, and even with the intangible world. If multiple things are not aligned over prolonged periods of time, then suicide becomes the solution to end the problem.

What we do know is that Māori are less likely to seek help and when they do, it's usually when they're at crisis point. By then, they are subjected to a mental health system that throws the book of conditions at them. If you don't meet the criteria, you're sent home with a self-care brochure and told to sleep, remove the knives from the drawers, drugs from medicine cabinets and to stay off alcohol and illegal substances. If you do meet the criteria, you might come under the Mental Health Act and be secluded. The difficulty is, there are multiple entry points to access help such as community, schools, police, corrections, and self-referral. There

Left: Māori mental health advocate Mike Naera.

are flaws to access help. But there are some great frontline workers who dedicate their lives to helping our whānau.

We often talk about the determinants of physical and mental health (housing, education, income). What are the key factors impacting Māori suicide rates? How much of a factor is drug and alcohol addiction? The impact of colonisation and displacement for generations?

These are interesting questions, and they all tie into each other:

1) The poor determinants of health are a cause of colonisation, racism, and historical trauma. As Moana Jackson puts it: "Racism is a bastard child of colonisation."
2) Sir Mason Durie says: "Suicide is complex, there is no single cause."
3) Māori are the highest users of alcohol and substance abuse.
4) Racism, historical trauma, unresolved grief and loss are all part of colonisation. Colonisation still exists today. It's bigger now given capitalism, globalism, communism and neoliberalism contribute to whānau stressors.

I read that Māori suicide rates are very much an issue for rangatahi, rather than older Māori.

Coroner's statistics show rangatahi Māori (15-25 years old) are two and a half times more likely to die by suicide. However, if you decipher the statistics, you'll find Māori suicide rates fluctuate across the 25-45-year age groups. They are not as high but should be identified as a growing concern. Notably, our kaumatua are low in the suicide stats and our kids under 15 years and some as young as 9 years are starting to show in the stats. My work focuses across the lifespan.

"we must take care of the people whether we have the money or not."

You were part of organising the first World Indigenous Suicide Prevention Conference and youth summit in 2016 – what were the drivers behind this?

The global conference was ignited by our Ngāti Pikiao kāumatua. They met with a small group of us and told us to organise a national conference in Aotearoa. We had six months to fulfil their wish of running this conference in Rotorua in 2015. We called the conference, Tūramarama ki te Ora National Suicide Prevention Conference and the theme was suicide prevention starts from conception. About 200-300 people showed for the three-day conference.

Not long after this, our kaumatua met with us again and told us we needed to invite our indigenous brothers and sisters from across the globe. We had no idea how to organise a national conference let alone a global gathering! But we got on with it and our small tribal team jumped in boots and all. In 2016, 500-600 indigenous peoples arrived on our doorstep for a three-day Youth Summit and World Indigenous Suicide Prevention Conference. It was magnificent! But I also need to say, we ran out of kai and had a small debt to pay after. Our kaumatua said to us, 'we must take care of the people whether we have the money or not.' So, we welcomed them and fed them regardless.

Keynote speaker, Sir Mason Durie, presented the Tūramarama Declaration which was endorsed by the congregation. This declaration has travelled the globe and is still referred to today. Since then, Australia hosted the conference in 2018 and Canada hosted this year online.

A common theme that has emerged at these conferences as key to suicide prevention is the importance of being connected to your culture and spirituality. Could you elaborate on this?

In all my time in suicide prevention, our rangatahi know who they are as Māori regardless of how little or how much they know their culture. I want to say that societal attitudes, conditions, and expectations are what impinge on their wairua (spirit).

Culture must be seen as a healing tool and protective factor. When suicide prevention commentators say, suicide is not a Māori issue it's a New Zealand one I say, too right it is! My argument is, then why do we default to psychological evidence as opposed to culture to heal? Why are kaupapa Māori pathways the least funded? Why, do we continually push our whānau to another culture rather than utilise our own to heal?

Our ways of reigniting the spirit are just as valuable as the medicalised pathway. I would argue that it is more than the medical model because it connects us back to the intangible world through whakapapa.

When Māori reconnect with their whakapapa what are the changes you've seen in them?

When our people attend wānanga on mental health and suicide prevention you see their wairua lift as we talk about the stuff non-Māori exclude. Things such as te whare tapa whā[1], and poutama[2]. These are inbuilt in us through whakapapa. I liken it to the movie, Avatar. Once you connect the natural world through wairua and whakapapa, you soon receive the spiritual kick you've always wanted. You'd probably need someone like me to support their journey of discovery though.

Is New Zealand's mental health strategy giving enough voice and focus on Māori mental health?

Since He Ara Oranga: The Government's Inquiry into Mental Health and Addiction Report was released in 2018 it's been slow, even though I applaud the work the Government's been doing. The Government released Every Life Matters; He Tapu te Oranga o ia Tangata Strategy[3] and Kia Manawanui. There's a lot of aspiration but not enough detail to achieve mental wellbeing nationwide.

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1 Te whare tapa whā is a model of the four dimensions of wellbeing developed by Sir Mason Durie in 1984 to provide a Māori perspective on health... aha tinana (physical wellbeing) taha hinengaro (mental wellbeing) taha wairua (spiritual wellbeing) taha whānau (family wellbeing). The Whare Tapa Whā was developed as a response to research by the Māori Women's Welfare League in the late 70s. Rapuora, the piece of research which had uncovered health issues and barriers amongst Māori, included a lack of spiritual recognition and issues of structural racism.

2 The Poutama (**stairway to heaven**) pattern is found in Māori weaving and plaiting. Poutama has significant spiritual and educational meanings. The stepped pattern symbolises levels of attainment and advancement and the growth of man, striving ever upwards and for betterment.

3 https://www.health.govt.nz/system/files/documents/publications/web3-kia-manawanui-aotearoa-v9_0.pdf

What are some current projects/initiatives you are involved in to address Māori suicide rates?

- I'm on the Global Indigenous Group for the World Indigenous Suicide Prevention Conference.
- I chair Te Mana Hauora o Te Arawa Trust. We were successful in receiving a Te Rau Ora Community Suicide Prevention Grant. We rolled out a programme called Te Ao Kapurangi Wānanga and rongoā Māori across Te Arawa.
- I do a lot of media interviews, predominantly for Māori mediums.
- I'm a board member on Piringa, residential facility for our tāngata whaiora.

We have come along way with mental health – less stigma, more korero and awareness. Where have we seen the most progress? What do we need to do to continue to make progress (as individuals, organisations)?

I think Māori advocates have pushed for change and yet they are not recognised for their mahi – Moe Milne, Naida Glavish, Dr Hinemoa Elder, Sir Mason Durie, Arama Pirika, John Vercoe, Hapi Winiata, Pihopa Kingi to name some.

I think we are past suicide and mental health awareness campaigns. We need to embed mental health 101 into everyday conversations. It's time we make the abnormal, normal. At the moment, mental health is for someone else to do. The notion behind this, is based on the fear of not knowing. Just think, if we take the 5 million - all in this together message and entrench it into our core living standards, how much we could change a person's life.

Mental health is not a project or part of a rule book. It's ugly and it's a buzz kill. But the people I have helped survive and live to tell their story which is priceless. We talk about the death rates as if these people don't exist. We need to keep in our minds that our whānau who have passed to suicide are brothers, sisters, sons, daughters and so forth. No one ever talks about the people we save but the ones that fell through the net.

What is your advice in how we can approach someone who we are worried about in terms of their mental health?

Do your best. You are not a psychologist or psychiatrist, you are a mum, dad, sister, brother, friend. Just be there in that capacity. Confirm you are listening and try not to contradict their story. But make sure you are safe and they are safe first and foremost.

You've spoken at indigenous conferences on suicide in recent times. What were some of the themes that came through?

Never forget your culture has the answers. Never think your culture is the problem. Never doubt the gifts given to us by our ancestors. Once doubt enters your thinking and vocabulary you've strayed from thousands of years of knowledge.

webAIRS NEWS

ANZTADC – a reflection on its history and contributors

webAIRS
Anaesthetic Incident Reporting System from ANZTADC

The Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) represents and is funded by the Australian Society of Anaesthetists (ASA), the New Zealand Society of Anaesthetists (NZSA) and the Australian and New Zealand College of Anaesthetists (ANZCA).

NZSA founding members of ANZTADC

Professor Alan Merry
(ANZTADC 2006-21, Chair 2006-2014)

Dr Graham Sharpe
(ANZTADC 2006-7) NZSA President

Dr Michal Kluger
(ANZTADC 2006-11) NZSA Representative

At the last ANZTADC meeting for 2021 in November, Professor Alan Merry retired from the Committee after 15 years of service. Around 2005, following the findings of the ANZCA Safety and the ANZCA data taskforces, it was decided to form a tripartite committee, to re-establish an anaesthetic craft group, bi-national incident reporting system in Aotearoa/New Zealand and Australia. The Committee was named the Australian and New Zealand Tripartite Anaesthetic Data Committee and its aim was to improve the safety and quality of anaesthesia for patients in Aotearoa/New Zealand and Australia by providing an enduring capability to capture, analyse and disseminate information about incidents (de-identified) relative to the safety and quality of anaesthesia in Aotearoa/New Zealand and Australia.

The first meeting was held in September 2006 with Professor Alan Merry as the inaugural Chair, and attended by the NZSA founding members (photos shown above except photo unavailable for Ms Phillipa Bascand, NZSA CEO 2006-2013), and founding members from ANZCA and the ASA. Since then Alan and Michal have both contributed substantially to the establishment of webAIRS, presentations that included webAIRS data, the recent analysis of the data, and publication of the results in peer reviewed journals. Ms Cherie Wilkinson was the inuagural ANZTADC Executive Officer. Dr Martin Culwick was appointed Medical Director of ANZTADC in November 2007 and contributed to the design and programming of the webAIRS website. In May 2010 Dr Heather Reynolds was appointed as the ANZTADC Data Analyst. ANZCA and ASA committee members will be listed in the December 2021 editions of the ANZCA Bulletin and the ASA Australian Anaesthetist magazines, respectively. All of the founding members from all three organisations have worked hard and succeeded in re-establishing a craft group specific anaesthetic incident reporting system in Aotearoa/New Zealand and Australia.

The other ANZTADC Committee members representing the NZSA, in addition to the founding members listed above, were Dr Andrew Warmington (2008-9) NZSA President, Dr Nigel Waters (2009-10) NZSA President, Dr Robert Carpenter (2010-13) NZSA President, Dr Russell Rarity (2012-Current) NZSA Representative, Ms Renu Borst (2013-20) NZSA CEO, Dr Ted Hughes (2013-15) NZSA President, Dr David Kibblewhite (2015-18) NZSA President, Dr Kathryn Hagen (2018-20) NZSA President, Dr Sheila Hart (2020-Current) NZSA President and Ms Michele Thomas (2021-Current) NZSA CEO.Dr Yasmin Endlich has been elected as the new Chair of the Publications Group from September 2021, following Professor Alan Merry's retirement. We apologise if we have omitted any members who filled in at various meetings for other members or for members who served for less than a year. We also thank the many guests at our meetings over the years who have provided their expertise and advice.

Under the guidance of Alan, ANZTADC members strongly contibuted to the success of webAIRS - from collecting a substantial number of reports to the numerous publications which are listed on the website.

All ANZTADC members have contributed to incident reporting and patient safety during their time on the committee.

Professor Alan Merry chaired the Committee from 2006 to 2013 and chaired the ANZTADC Publications Group from 2013 to 2021. ANZTADC has published peer reviewed articles since 2011 and currently has 25 publications, three of which

are currently in press. These can be viewed from links on the webAIRS website. In addition, ANZTADC publishes eight to 12 magazine articles per year in the parent bodies' publications: ASA Australian Anaesthetist, the ANZCA Bulletin and the NZSA magazine New Zealand Anaesthesia.

Professor Alan Merry has also made significant contributions to patient safety, both nationally and internationally, with a focus on medication error. He recently published a book *Medication Safety during Anesthesia and the Perioperative Period* in conjunction with Professor Joyce Wahr (University of Minnesota). Alan's contributions to all facets of anaesthesia and medicine are too sizeable to list in this article, however some highlights to draw your attention to: the Lifebox Foundation, which provides pulse oximeters to lower income regions of the world, and his contributions to the World Federation of Societies of Anaestheiologists. These achievements and many others, as well as the people who he collaborated with, were described by Alan in the Inaugural Alan Merry Oration, which he delivered at the combined AQUA/ASM in Queenstown in 2019. This oration is now given annually at Aotearoa/New Zealand Anaesthesia Annual Scientific Meetings. We wish Alan many pleasurable moments pursuing his hobbies in retirement, which include skiing, golf and sailing.

ANZTADC thanks Alan and all past committee members for their contributions. We thank all of our founding members for setting up ANZTADC and creating webAIRS, and the webAIRS members and sites for submitting over 9000 reports which has made possible the numerous publications and presentations listed above.

ANZTADC Case Report Writing Group

Note – this is an abridged article and the full version can be read on the NZSA website www.anaesthesia.nz

Are you contributing to quality anaesthesia? Log in or register **ANZTADC Home Page for WebAIRS**
For further enquiries contact anztadc@anzca.edu.au

Obituary

Elaine Langton

29 April 1952 - 17 August 2021

Elaine went to Medical School in Auckland and undertook her anaesthesia training in Lumsden, Greymouth, Christchurch, with a fellowship at Liverpool Hospital in Western Sydney. She was a trailblazer for women and completed her anaesthesia training as a new mother of three children. It was no mean feat to gain a specialist qualification as a parent then, a gruelling four years, studying and 70-plus-hour working weeks. With this experience Elaine became a staunch advocate for part-time training and where we are today is in no small part due to the steadfast efforts of women like Elaine.

Elaine worked as a specialist anaesthetist in Palmerston North Hospital, where she became involved in Obstetric Anaesthesia and Malignant Hyperthermia (MH). She continued these roles after commencing at Wellington Hospital in 2002. Over the years she became a world-wide authority on MH, that expertise will be sorely missed.

Elaine had an unwavering commitment to continually improving the health and safety of women and their babies. She was passionate not only about providing high quality care to our patients, but also educating the next generation of anaesthetists. Among many roles, she was the clinical lead of Obstetric Anaesthesia in Wellington for many years. She was a MOET instructor – a course for Obstetricians and Anaesthetists managing obstetric emergencies – and she frequently taught on these in New Zealand, Australia, and even Manchester on a couple of occasions. She was also instrumental in developing the multi-disciplinary in-situ PROMPT course in Wellington, a course which encourages teamwork and communication across craft groups to ensure the best outcomes for patients in Birthing Suites. This work led to her being invited onto several important committees, including the National Maternity Monitoring Group.

Elaine had a gradual and gracious retirement process, and she moved out of theatre to utilise her skills in pre-assessment clinic where she spent much of her time in latter years. She planned to keep busy after she retired in March, continuing her role with the Citizens Advice Bureau, and taking up a role doing COVID vaccinations, and of course enjoying time with her family, especially her grandchildren. She was content to have moved on from medicine after so many years of dedicated service to the specialty of anaesthesia.

She will be sorely missed.

Tribute by Dr Sally Ure,
Clinical Director, Department of Anaesthesia,
Wellington Hospital

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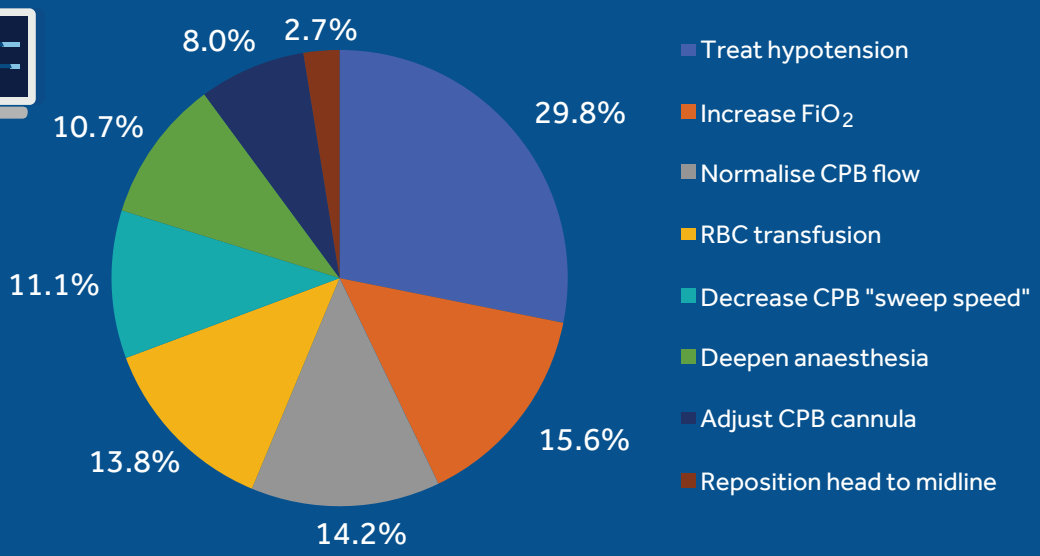

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1. Based on internal white paper #11-PM-0232(1). Cerebral oximetry is frequently a "first alert" indicator of adverse outcomes. April 2016.
2. Subramanian B, Nyman C, Fritock M, et al. A multicenter pilot study assessing regional cerebral oxygen desaturation frequency during cardiopulmonary bypass and responsiveness to an intervention algorithm. Anesth Analg. 2016;122(6):1786–1793.

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