

# NEW ZEALAND Anaesthesia

THE MAGAZINE OF THE NEW ZEALAND SOCIETY OF ANAESTHETISTS • JUNE 2020



webAIRS and  
COVID-19  
Peer Supervision

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## President's column

JUNE 2020

**H**ow times have changed. In the original April edition of our NZSA magazine (which we had to defer due to COVID-19), we had advertisements for upcoming events; the Combined Scientific Congress in Wellington in October and the WFSA's World Congress in Prague in September. But eight short weeks later I have an entirely different focus in 2020, with travel largely off the cards and red lines through most of my calendar.

Instead of continued discussions with PHARMAC about the acquisition of medical devices and consultations with Government on the Therapeutics Products Bill, we have been liaising with the Ministry of Health and PHARMAC on issues such as shortages of Personal Protective Equipment (PPE) and propofol. After several years of working on improving our practices with an environmental slant, we are now urging the restriction of propofol use, leading to an increase in the use of volatile agents again. This is sustainability, but with a different outcome in mind in the short-term.

We have been extremely fortunate in New Zealand to have chosen to 'go hard and go early' and to see the success of lockdown measures such as social distancing – we have benefitted from strong leadership and I hope that we continue to do so over what will be tough financial times ahead for many. Our leaders have taken a science-based approach and listened to the experts from the Ministry of Health and wider scientific community. As a country we have acted on their advice and shown solidarity and commitment to stamping out COVID-19. We have all heard and read about the consequences of different actions taken in the UK and the US, for example. It is hard to imagine working in hospitals that are so overwhelmed and have such a huge volume of critically ill patients; an anaesthesia trainee friend of mine from Cork, Ireland – which has not been overwhelmed with COVID patients – said the most depressing aspect was knowing that those in the units being ventilated have such dismal outcomes. It is understandably demoralising.

There are many clinicians across the globe who have been left broken and hurting by these events; especially in situations where they have felt abandoned and unsupported by their governments. I feel deeply for our American and British colleagues who have suffered so much in some regions. The daily briefings by Dr Ashley Bloomfield and Hon Jacinda Arden, among others, have provided New Zealanders with the benefit of clear, concise and transparent answers to most questions and has certainly added to the confidence that we have taken the right course. How things will play out in the future months and years with respect to vaccines, treatments, herd immunity and international travel is uncertain and remains to be seen.

Some of the goals we need to strive for in the future are very clear, however; a robust and well-funded public health service, which is critical to shutting down any future pandemics and being adequately prepared to respond to healthcare needs. Integrated and up-to-date systems for contact tracing and isolation must be developed and maintained. Our infectious diseases and occupational physician colleagues have played a critical role in developing guidelines (alongside others) and making sure both patients and staff remain safe with the appropriate PPE, a rapid testing turnaround and good risk stratification pathways. It's been interesting to see that the new celebrities on our radio stations and other media outlets are professors of epidemiology and Infectious disease specialists. The new public heroes are ICU nurses, cleaners and other essential workers.

Other changes that we would like to see include an improvement in the way information and equipment is cascaded through health services with a more centralised, coordinated approach, e.g. in areas such as PPE and how it should be worn and by whom, or who should be tested and how. Ideally, we would have a much better handle on what equipment is kept in stock in New Zealand, the volume of this stock, and how to provide it to frontline clinicians in a timely way. We must treat this episode of COVID-19 as the first event, and not the only pandemic we are likely to see in our lifetimes and continue to build a strong platform to be well prepared.

The centralised nature of PHARMAC has meant New Zealand has been able to be alerted early to drug shortages and we have been shielded to some degree by a national agency whose role is to procure and provide all public hospitals across the country with medicines – DHBs are not pitted against each other, or region against region with respect to medicines. With PHARMAC taking over the procurement and supply of medical devices, there will be similar protection for that equipment – perhaps it should be the same for PPE such as masks, goggles etc?

*We have been extremely fortunate in New Zealand to have chosen to 'go hard and go early'*

And now is the time for the release of the Simpson Health and Disability Review, so that any changes we might consider because of COVID-19 can be evaluated and made alongside this review. If one of the positive outcomes of this pandemic is a change to our health and disability sector that improves access, planning, coordination, and equitable treatment of all patients, that would be an incredible result. Māori and Pacific Island communities would have suffered disproportionately had COVID taken hold in New Zealand, as they have with most other acquired and infectious diseases. When a health system is under pressure it inevitably exacerbates existing inequity. We need to work together as a sector to address entrenched health inequity and bridge the gaps in the social determinants of health, treatment and health outcomes.

**When a health system is under pressure it inevitably exacerbates existing inequity.**

We will also need to work cohesively in the coming months as we continue to ramp up elective surgeries to clear the backlog that has built up during the restrictions of the pandemic, as well as other health services such as scans and diagnostic tests. The high level of demand will have our health sector, both public and private, under pressure and working beyond full capacity for some time.

## NZSA office

The NZSA staff have been working from home since mid-March (at the time of going to press they are planning their return to the office) and have done admirably well to continue with business as usual as much as possible. Thank you to those of you who have paid the 2020 subs; with postponed events such as PANNZ, MOET and the CSC, membership retention is a more critical factor than ever in ensuring our society remains in a sound financial position. Although naturally all things Coronavirus related have dominated our communications, our team and Networks, we are working on other projects including our website and database redevelopment (read our CEO's column about this on p.14 ) and we are considering future CPD opportunities for the end of this year.

## CSC and WFSA World Congress

The postponement of the Combined Scientific Congress is a sad consequence of COVID-19, and I know that the Regional Organising Committee, headed by Drs Sheila Hart and Mark Featherston, had a hard decision to make. We are very excited that they have agreed to stay on, as most of the ROC has done, so that we can bring you a sterling CSC in October 2022. The WFSA World Congress has also been postponed, but just for one year, so will take place in September 2021 in Prague. We have three New Zealanders who have been nominated for committee positions (Dr Wayne Morriss for President, Dr Indu Kapoor Paediatrics and Dr Sue Nicolls Welfare), and information about how and when the elections for these positions will occur is to come.

## Continuing professional development

Opportunities for CPD have clearly been curtailed in 2020, and the Medical Council's decision to effectively push 2020's CPD requirements into 2021 was welcomed. The College has increased online opportunities for CPD attainment, and clearly most of us could claim a multitude of hours and emergency response credits with all the training and preparation undertaken for COVID patient care. We are hoping that as New Zealand moves down the COVID alert levels, we might have opportunities for local and national CPD events; perhaps AQUA, perhaps in Waitangi with the ANZCA-NZNC meeting, and the NZSA is considering hosting an event in place of the CSC later in the year. So, keep a look out for CPD opportunities over the coming months.

## Welcome to new ANZCA President

The NZSA extends a warm congratulations and welcome to Dr Vanessa Beavis, who is the new ANZCA President. Dr Beavis is also an NZSA member and NZ based, so we are particularly proud of her achievement. It was wonderful to witness via Zoom as Dr Beavis became ANZCA's first 'virtual' President at the first ever ANZCA virtual AGM. We look forward to continuing our collaborative partnership with ANZCA and thank previous ANZCA President Dr Rod Mitchell for his outstanding vision and leadership.

## Thank you

I'd like to conclude by thanking you all as frontline workers, or frontline support workers. Although not yet overly used, we had anaesthetists and intensivists trained, ready and prepared to risk their own lives for our patients. We had skilled people to write protocols, produce simulations, develop walk-throughs and MERIT teams. We had people who sacrificed their family time and their private incomes in order to use the time we had to get ready. So, thank you all for your contribution, and the collective commitment in supporting our health system, patients, and colleagues.



**Kathryn Hagen,  
NZSA President**





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# Optimising peer supervision



Angela Dewhirst

**A**ngela Dewhirst is a Registered Anaesthetic Technician who works at Southern DHB in a district wide clinical governance role. One of her responsibilities as the Professional Development Facilitator for Allied Health, Scientific, and Technical, is to facilitate courses on clinical peer supervision. She shares her personal insights into what she believes good supervision is, and how to develop an optimal supervision relationship.

## Peer Supervision

Clinical peer supervision is utilised extensively by allied health practitioners to optimise professional development through transformative reflection. This methodology challenges and investigates apprehensions through a safe and structured relationship. Supervision provides critical in-depth reflection to explore the clinical environment and support someone to think differently in order to address their concerns. It is the delivery of skilled guidance to progress clinical practice, enhance work-related knowledge and skills, increase well-being and resilience, and improve patient outcomes. This occurs through non-judgemental, transparent sessions between qualified colleagues. While mentoring is a more broad based technique, which concentrates on developing areas such as career progression, scholarly achievements, and personal development, supervision is about empowering people to be the best they can be. A good supervision relationship will enhance role clarity, accountability, and efficiency, which in turn will improve well-being and decrease the risk of burnout.

To be an effective supervisor, you need to know your values and what you bring to the session. You must have insight into your own learning style, so you don't inadvertently push your style onto your supervisee. You will also need to take time to learn your supervisee's learning style. All of this will help ensure that together you're a good fit. Strengths people bring as a supervisor include experience, empathy, and the ability to empower. Being an active listener who is present in the here and now, with a desire to encourage self-reflection, rather than provide solutions, is also desirable. A good supervisor will work out which questions they need to ask to help the supervisee find the answers they need to grow as a clinician. They will be skilled in communication and

*...it is good to meet each other before committing to a contract, so you know your compatibility.*

motivational interviewing and are not there to give all the answers. A supervisor should not expect things of the supervisee that they themselves are not willing to share. An 'A grade' supervisor is available, approachable, and able (clinically and as a teacher).

Both the supervisor and the supervisee need to be organised to alleviate time pressure. Each supervision session lasts for one hour at a monthly frequency. It is a formal process so should occur in a protected time at an appropriate location. It is important to talk about potential power issues. That is, supervision needs to be 'safe', so make sure you aren't supervised by your boss. To facilitate the sessions, it is useful to use a framework initially; an appropriate 'recipe' to follow until you become familiar with the process and can use your tacit knowledge to go with the flow. These frameworks take you through a reflective process to help you know how to address a problem effectively. The supervisee will bring a real issue to supervision and prepare a summary of the issue for discussion. A supervision contract can be helpful to clarify what you are going to be focusing on. However, it is good to meet each other before committing to a contract, so you know your compatibility. Start with a three-month contract and then review this for up to a year. This way you can check it works before committing long-term.

To keep it fresh, try not to have the same supervisor for more than two years. The supervisor thinks about the format of the session, to frame the issue and select the reflective model of choice. They then respond, observe, and support, through a process of facilitation. The range of supervision models offer tools to select from so that you may frame the question the supervisee brings, to achieve a meaningful outcome. Although the ability to provide support, praise and encouragement is an important part of being a supervisor, the supervisor is not there to provide 'therapy.' It's okay for the supervisee to inform the supervisor of life stresses, e.g. bereavement, divorce etc., but if they require support with these issues, they need to look elsewhere, such as an employee assistance programme.

*Strengths people bring as a supervisor include experience, empathy, and the ability to empower.*

Self-disclosure can be valuable if it assists the supervisee but be careful that it remains helpful and not indulgent. When someone constantly comes into a supervision session with the same issue, such as time management, ask yourself what is going on in other areas of their practice, and how these issues could be addressed. A supervisor is a great support as a safe person to role play with and provide care around life's challenges. Legitimate topics to discuss in supervision sessions may include: quality assurance, professional issues, reflection on self-skills/knowledge/attitudes, professional development needs, service wide requirements, and relationship dynamics between colleagues and within the team.



When structuring a supervision session, it can be helpful to utilise the first five minutes with 'what's on top?,' meaning a debrief, to get what's on your mind out of the way and seal off what you were doing previously to get yourself into the right space. The agenda can be loosely structured to begin with by paraphrasing the supervisee's comments, in order to confirm understanding and to clarify what the issue is. Once established, ascertain why they are bringing this issue into supervision and what the supervisee wants to get out of the session, then help them figure out how they can achieve that. Finish by reflecting on how the process went; what worked well, and what might be done differently next time. Plan some actions to revisit at the beginning of your next supervision session.

*Plan some actions to revisit at the beginning of your next supervision session.*

There are several models that supervision sessions can be based around. Once familiar with these, a supervisor can mix and match to suit the situation. Below is an overview of two models:

## John Heron's six categories of intervention

This looks at the most common reflective styles, to establish which supervision approach is most useful for you. The value of this model is that you can be selective with the type of response you give in the situation. The styles of this model are predominantly facilitative, and occasionally need to be authoritative.

They are:

**Prescriptive** – telling them what to do.

**Informative** – providing suggestions or the benefit of your experience.

**Confronting** – exploring what the supervisee has tried already. Consider what else might you do.

**Cathartic** – exploring feelings and questions such as, 'how do you feel about your relationship with this person?'

**Catalytic** – Have you considered their point of view? Have you considered sharing your knowledge?

**Supportive** – Seeing the strength in their resolve to deal with the issue. Acknowledge their first step and ask them what they would like to do next.

## The solution focused supervision model

This works well for people who have good insight. Developed by two social workers in the 1980s, this model believes that identifying competence is more likely to increase professional confidence than a preoccupation with deficits and mistakes. It is based on the premise that people construct their own reality and know the solutions to their own problems. It relies on good communication techniques, where the supervisor acts as a curious enquirer, who seeks to validate the supervisee. I like this model, as it is very outcomes focused and concentrates on positives and strengths, rather than dwelling on the negative. This approach analyses what has worked before and looks to apply this to the current issue. It takes the view that if we optimise our success, then challenges and weaknesses can be overcome.

Being a peer supervisor is not an easy role, but it is rewarding, and will facilitate growth and development of both yourself and your colleague. Clinical supervision is mandated in several allied health professions; it is encouraged in other health professions. I would recommend you give it a go.



# Personal insights on clinical supervision



Dr David Kibblewhite

**N**ZSA Executive members Dr David Kibblewhite and Dr Renee Franklin write about their personal experiences of clinical supervision and offer practical advice on how to access supervision and make it work to your benefit.

## Dr David Kibblewhite

I have taken up the challenge of clinical supervision and found it to be very worthwhile so far. You may well be asking why, and what is the point?

Supervision is a difficult concept for medics. We are taught to be self-sufficient and indeed are expected to be, so the notion of developing a long-term relationship with someone to talk to about difficult cases, and being somewhat vulnerable is the complete antithesis of our training and role modelling. This is especially the case for a middle-aged, white male. However, there is a dark side to this model which we tend not to openly acknowledge and if we do it is often (I think) lip service. I am referring to depression, lack of self-worth, sadly sometimes suicide; and last, but not least, lack of respect for others – more commonly referred to as bullying (although I personally don't like the term bullying as I think it is too blunt and an extreme form of what often is quite subtle behaviour). On a more positive note, I think that many of us have unwittingly or unknowingly developed informal supervision type relationships with colleagues and for many this works very well. However, the evidence suggests that a more formal process is beneficial.

I was privileged to be involved in discussions on these topics during my time as NZSA President. I spoke with colleagues, anaesthetic leaders from around the world, the police and the Health and Disability Commissioner – so an extremely rich and fertile ground for ideas. In addition, with my pain physician hat on, I frequently work alongside psychologists so am familiar with the concept of, and reasons for clinical supervision. Both are summarised brilliantly in the accompanying article in this issue of the magazine by Angela Dewhirst.

Why did I embark on clinical supervision? The straw that finally pushed me across the line was being asked by junior colleagues to provide mentorship and supervision. I thought I need to 'walk the talk,' not just 'talk the talk.'

How do you choose your supervisor? People will often choose someone in the same profession. I chose a slightly older male I had worked with at the Auckland pain clinic. He is someone whom I respect very much, whose company I enjoy and whose opinion I value (I think this is mutual). He just happens to be a very well-respected psychologist and probably knows all there

is to know about clinical supervision.

Clearly however, he cannot really help me reflect on my anaesthetic practice but can in my pain medicine practice. Having said this, where the rubber hits the road for me in clinical supervision is not so much the 'clinical' part but the softer interpersonal interactions, and personal growth and development. Even though we have only had two sessions so far, they have covered many topics.

*...so I find myself looking forward to the session and enjoy that they are unpredictable.*

The real value for me has been having someone (other than my life partner) that I can trust and reflect openly with on a range of topics. These have included: clinical governance (and as a result I have put my hand up to be a Supervisor of Training), what clinical supervision entails and how to pursue it, pain management issues (so yes, sometimes clinical), and general life issues.

I confess that I do feel a little nervous before each session as I'm never quite sure where the conversations will go. I'm taken out of my comfort zone but never in a malicious or judgemental fashion. However, I find myself looking forward to the session and enjoy that they are unpredictable. We have not followed protocol with session frequency and meet every two to three months.

Arguably, this is not strictly clinical supervision however it has certainly been an interesting and worthwhile experience. Has it made me a better doctor or person? Hard to say, but it certainly has not done any harm.

## Dr Renee Franklin

Two years ago, I was sitting in the office of my then GP Dr Melanie Johns when she told me she had decided to step back from her general practice to become a professional supervisor. I remember thinking many things all at once. I was really going to miss having Melanie as my family GP as I respected and trusted her, and I was nervous about finding someone else to fill her role. I also felt excited, as I had given some thought to professional supervision over the years but had little idea (or had been a bit lazy) about how to get started. Here it was landing in my lap – the opportunity to give it a go.

Other specialties in our DHB were already accessing supervision using CME funds and it had recently been discussed at our departmental meeting. When I checked with our clinical director there was no issue getting approval to use my CME funds to begin seeing Melanie in her new role.

In all honesty I was a little nervous about beginning this journey.

I thought I would need to come to each session with a plan about what I wanted to get out of it. At this stage I did not feel overtly distressed by work – I was busy, but not distressed. Melanie reassured me that she could direct me as much or as little as I needed/wanted. In the end, all it took was a few open questions and we quickly acquired a list of topics to discuss. To start with we decided to meet every four to six weeks and 18 months later we are meeting every six to eight weeks at a cost of \$172.20 including GST per session (this rate is lower for registrars who are generally unable to access funding).

Melanie has helped me with a wide range of work-related issues, including career development (for example, whether to accept a position on the NZSA Executive, and the Perioperative SIG Executive), when to say no, difficult relationships with colleagues, what my perceptions of my strengths and weaknesses are, and understanding my unconscious bias.

With Melanie's guidance, I have learnt so much about myself and how I function at work. Often, I come to conclusions on my own by talking about an issue. I feel I can "offload" work related stressors to Melanie in a similar manner that I might have previously done to a close colleague. I don't however feel any guilt or stress about "dumping" my issues on Melanie as it is her job to listen. For me, one thing we have not needed to discuss so far are clinical cases. I feel well supported already in this area of my work – which may always change in the future.

Supervisors can have many different backgrounds but personally I find it very helpful that Melanie is a doctor. While it's been many years since she worked in a hospital setting, she is very insightful about the unique issues faced in hospital medicine.

Melanie and I discuss our goals for supervision yearly. She regularly checks with me that my needs are being met and I would feel comfortable letting her know if I needed something different.

The very valuable aspect of supervision for me is that when something happens at work, which inevitably it will, I can think "that's something for me to take to Melanie when I see her next." Previously that difficult interaction with a colleague or patient, or that stressful event would have gone around and around in my head for days (at least). Funnily, now when I see Melanie and relay an event, I find it's no longer as big an issue as it first seemed.

I have recommended Melanie to friends and colleagues of all specialties and levels of training for a myriad of reasons and almost all have found her helpful.

I have always loved my job but now it is so much better. I have learnt to pay attention to the aspects I enjoy and have found new ways of coping with the challenges.

If you would like to give supervision a go, rest assured you do not have to be distressed or have a specific issue to discuss. Supervision can still help in your everyday work life and if/when something major comes up, you will already have a process in place to manage it.

**Have a think about what you would like to get out of the sessions.**

## Practical steps to starting supervision:

### 1. Find a supervisor

- Begin by asking colleagues at work – it is likely some are accessing supervision.
- Supervision is more commonly accessed by certain work groups – mental health colleagues/social workers/counsellors who may have a contact.
- Phone local psychologists.

### 2. Discuss funding with your department. I believe some departments have separate funding for supervision (not CME); some fund it through CME and some choose to self-fund.

### 3. Have a think about what you would like to get out of the sessions. Consider:

- What are the things about work that I pick over in my mind?
- Why is a certain person (patient/colleague etc) bugging me?
- Has there been a time when my emotions were inappropriate at work?
- What makes me frustrated and negative about work?
- Am I good at managing work-life balance?
- Am I good at saying no when I should say no?
- Have I had discussions about my work issues that haven't gone well? Have people not heard what I was trying to say? Do I choose appropriate people to talk to?
- What things have I simply not had time to think through and sort out?
- What are the challenges in my professional life that seem too big to consider?
- Where am I in my career? Where do I want to get to? Am I in the right job?

### 4. Remember that you are not signing up forever and can change your supervisor if the first one is not the right fit for you.

### 5. Go for it!



**I have always loved my job but now it is so much better.**

## Disruption to anaesthesia services due to COVID-19

The COVID-19 crisis has led to heightened anxiety and levels of fatigue for frontline staff working in anaesthesia within New Zealand and Australia. In the past few months, webAIRS has received reports with concerns for protective personal equipment availability, guidelines for use, staff unfamiliarity with procedures and equipment, staff and equipment shortages, and suggested changes to routine practice, that are all related to COVID-19 precautionary measures. There is a chance that a second wave of COVID-19 positive cases will appear in New Zealand and Australia, and we will continue to monitor the webAIRS incidents that are reported in relation to COVID-19 and add these as an ANA-Alert to the webAIRS website.

WebAIRS has received a number of incident reports where COVID-19 or PPE related issues have been a contributing factor in the environment surrounding the incident.

## Personal Protective Equipment (PPE)

- PPE was not available or inadequate. This could lead to procedure cancellation where aerosolisation might occur such as ear nose and throat (ENT), maxillofacial and endoscopy procedures.
- The type of PPE was unfamiliar with a risk of not wearing it correctly.
- Fogging of the protective goggles led to difficult visualisation during intubation.
- Interpretation of the guidelines for use of PPE were reported as inconsistent.

*Interpretation of the guidelines for PPE were reported as inconsistent*



## Equipment

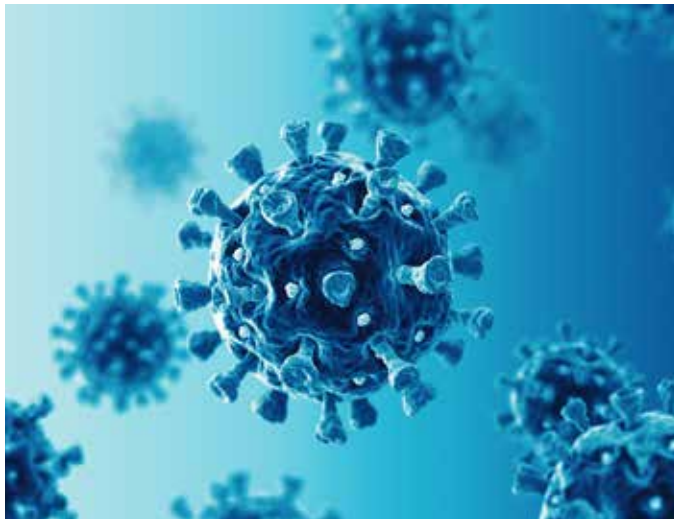
- Lack of the anaesthetic trolley present in the room led to delays with emergency drug availability.
- Equipment was unfamiliar to anaesthetic staff who do not usually work in the emergency department. This in turn led to difficulties with patient management.
- Bag mask ventilation (BMV) equipment for COVID cases was unfamiliar to anaesthetists and assistants.
- An endotracheal tube (ETT) failed on two occasions during a planned fiberoptic nasal intubation.

A patient with no known risk factors for COVID-19 presented with pain and limited mouth opening for incision and drainage of an abscess. After assessment and consent, an awake fiberoptic nasal intubation was planned. The intubation was successful but associated with a large leak and inability to inflate the ETT cuff. A tube exchange was performed with an airway catheter but there was still a large leak from the ETT. Ear nose and throat (ENT) surgical assistance was requested and a decision made to proceed to surgical tracheostomy. However, the ENT team was concerned about aerosolisation and insisted that a powered air-purifying respirator (PAPR) be worn by each of their team. There was a delay as a result, but there was no desaturation despite the large leak from the ETT. This case illustrates the heightened awareness of the possibility of undiagnosed COVID-19 cases in the community and how this impacts on surgical practice. The patient had the procedure and recovered well after the procedure, without any harm as a result of these events. There was however a prolonged period where the patient airway was not completely secured as a result of COVID-19 concerns, which means that the patient was exposed to an additional hazard.

## Staff/facilities shortages

- Lack of personnel present in the room led to a delay in obtaining a replacement piece of equipment that was requested when the original ETT encountered a leak.
- A patient suffered anaphylaxis and after successful management the procedure was postponed. It was planned that the patient would have skin testing and after the results were available the patient was to be rebooked. However, COVID-19 preparation had resulted in the closure of elective allergy testing facilities. The procedure was not urgent but was required within weeks. At the time of reporting it was not clear whether the clinic would reopen in time, or the procedure would be required in the absence of formal testing of the agents previously used.
- ICU bed delays and shortages occurred due to COVID preparations.

- Operating room entrances were not clearly marked that PPE precautions were in place.



- Difficulty deciding whether an emergency case merits full COVID precautions especially with ENT, Maxillofacial, endoscopy and any other procedures where aerosolisation might occur.

We encourage anaesthetists to report any incidents with COVID-19 patient management and will provide regular notifications of issues via the ANA-Alerts.

Please login or register: webAIRS website and select the ANA-Alerts menu option.

### **ANZTADC Case Report Writing Group**

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3. <https://www.safetyandquality.gov.au/covid-19>
4. <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-information-specific-audiences/covid-19-personal-protective-equipment-workers/personal-protective-equipment-use-health-care>
5. <https://www.health.gov.au/sites/default/files/documents/2020/04/guidance-on-the-use-of-personal-protective-equipment-ppe-in-hospitals-during-the-covid-19-outbreak.pdf>
6. <https://www.mz.co.nz/national/programmes/saturday/audio/2018745813/vanessa-beavis-how-nz-hospitals-prepared-for-covid-19>
7. [https://www.nzherald.co.nz/nz/news/article.cfm?c\\_id=1&objectid=12330280](https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=12330280)

## Unexpected events

- Drugs were left unattended following an intubation in a negative pressure room. The patient was transferred to intensive care accompanied by the anaesthetist and the anaesthetic assistant. When the anaesthetist and the assistant returned to the negative pressure room it had been cleaned and there were no staff present. The anaesthetic drugs were left on a tray outside the room and were left unattended due to no clear plan for drug disposal. This raises two issues, firstly, the drugs and tray were potentially infected, and also controlled drugs were left unsupervised and unlocked which contravened the state regulations.
- Difficulty ventilating a patient occurred during an emergency gastroscopy. After a difficult visualisation of the larynx, it was determined that a bougie was required and there was a longer than usual delay before it was produced. During the delay it was difficult to ventilate the patient. The anaesthetist reporting suggested that if COVID precautions are in place, it would be a good idea to routinely preload a bougie into the ETT during intubation.
- A patient suffered what appeared to be a severe bronchospasm, following an intubation with COVID precautions in place. The patient had a history of TB and it transpired that there was a tension pneumothorax present, either prior to intubation, or as a result of the high ventilation pressures required. It was difficult to diagnose a pneumothorax, perform initial chest decompression, and insert a chest drain in these circumstances as the usual equipment required was not in the room.

## Heightened tension and anxiety

- Difficulty managing patients with difficult airway anatomy, which is difficult even in normal circumstances, but is much more difficult where there is potential for the spread of a COVID-19 viral infection.

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*for updates between magazines*



**facebook.com/thenzsa**



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# Environmental Q & A – carbon offsetting

**T**he NZSA Environmental and Sustainability Network writes a regular Q & A for our magazine to provide guidance and advice on how to mitigate climate change. In this issue, network member Dr Campbell Bennett, from Lakes DHB, writes about carbon offsetting.

## What is carbon offsetting?

Carbon offsetting is a means of compensating for the inevitable carbon dioxide and other greenhouse gases (GHGs) emitted into the atmosphere by our daily activities. Everyday fossil fuels are burned to transport, power and feed us. Food production and wastage generate additional GHGs. Collectively, these are measured or quantified as carbon dioxide equivalents (CO<sub>2</sub>e) and are the drivers of climate change.

Reducing individual and collective emissions needs to be at the forefront of our goals, however carbon offsetting enables us to compensate for the GHG emissions we cannot avoid. The principle is to invest in projects that represent a sufficient reduction in emissions to balance out the emissions we're creating. Simply, we pay some cash which is used to either increase uptake of or reduce the production of atmospheric carbon.

Examples of offsetting include:

- Planting new, or preserving existing forestry
- Investing in renewable energy alternatives to fossil fuels
- Energy efficiency projects aimed at reducing overall energy use and therefore carbon emissions.

For offsetting to be legitimate, projects must be permanent (the lifespan of some GHGs is 100 years!) and additional i.e. created by the offsetting investment which would otherwise not have happened.

## Why should I do it?

As individuals we are typically high emission producers – but we do have the means to measure, reduce and offset.

Our work-related emissions from nitrous oxide, desflurane and air travel are visible on the top 10 list for all DHBs undertaking the Toitū Envirocare carbon emissions measurement and reduction scheme. Long haul business air travel is the second highest operational GHG for Auckland DHB and approximately 20% of their total emissions. Most other DHBs that measure their carbon footprint are similar. Many DHBs are now trying to measure, mitigate and in some cases offset their operational carbon emissions (see Toitū table below) so it makes sense for us to do the same.

The stance of the Association of Salaried Medical Specialists (ASMS) is that carbon offsetting is a legitimate travel claim for CME related travel. As this is not explicitly written into the MECA though, variable interpretations exist. Given the Health

Minister's letter of expectation to DHBs to minimise and mitigate GHG emissions, it seems very reasonable for SMOs to offset and claim for CME related travel.

## How do I do it?

There are various accredited online voluntary carbon offsetting schemes. Accreditation of the schemes ensures the validity and legitimacy of projects. It's quick and easy to calculate your emissions estimate and cost to offset – all you need are a few of your household bills and knowledge of your lifestyle and eating habits. For air travel it's important to include radiative forcing in your offset as this accounts for all the Greenhouse Gas Emissions (GHGe) from the jet engines rather than just CO<sub>2</sub>.

- Toitū Envirocare (formerly Enviro-Mark Solutions): provides offset calculators and programs for individuals and businesses, as well as certification programs for businesses (including DHBs) wanting to go carbon neutral. It's a subsidiary of a government-owned crown research institute with a background in the science of carbon accounting. Toitū Envirocare has the highest level of accreditation for their carbon offsetting schemes and allows you to choose the scheme you want from a range of options. Examples include: reforestation projects such as the Hinewai project on Banks peninsula; renewable energy projects such as a wind farm in China; a solar plant in Mexico; and energy efficiency projects in China where traditional coal cooking stoves are being replaced with solar cookers. The Toitū projects have an additional improvement focus added to the carbon science. Examples of this include biodiversity improvements in Hinewai and a reduction in air pollution with the energy efficiency project.

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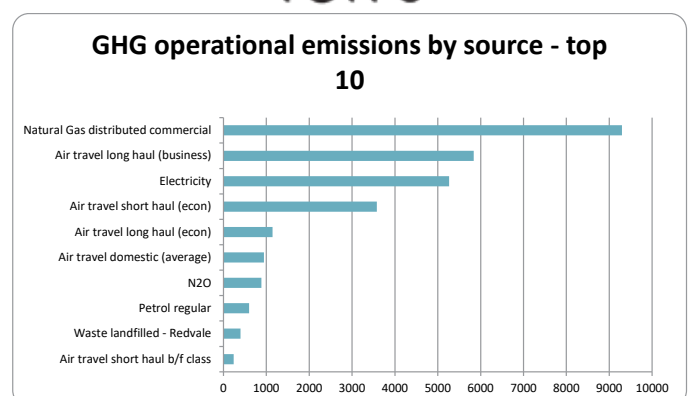


Figure 1: GHG emissions by emissions source

- Ekos: provides carbon offsetting for individuals and businesses. It's a New Zealand based non-profit enterprise which develops, pilots, and then scales up self-sustaining forest carbon projects. Their projects are locally owned, collaboratively developed and as much as possible locally delivered. They have a very user-friendly website and their offsets are accredited to a high standard. Ora Taiao (the New

Zealand Health and Climate Council) has partnered with Ekos for their carbon offsetting (my family also uses Ekos for our carbon offsetting). All their projects are forest conservation projects in New Zealand and the South Pacific. Many mountain bikers and frequenters of the Tasman area will be familiar with Project Rameka, which is reforesting marginal farmland with native bush in the Rameka track area of Golden Bay. Other Ekos projects protect mature rainforest from logging, which include the Rarakau rainforest conservation project in South Westland and areas in the Solomon Islands, Fiji and Vanuatu. To offset the emissions for my family of four last year, which included an overseas holiday, cost around \$400.

- Air New Zealand carbon offsets: the calculator they use is backed by Toitū. Offsets purchased are half from permanent forest sink initiative projects (run by the Ministry for Primary Industries) which promote replanting new forests on private land in New Zealand, such as Mangarara Station in Hawkes Bay. The other half are offshore biodiversity and sustainable energy accredited projects.

## Take home messages

If you want to minimise climate change the best thing you can do is reduce your GHGe's. Attending a videoconference will always be better than flying to the other side of the world from an environmental perspective.

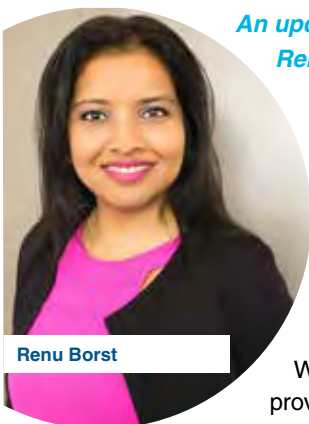
I would encourage everyone to consider carbon offsetting and explore your options. It's a positive environmental opportunity to compensate for the GHGe's you can't avoid and the process of identifying your GHGe's will show you where your opportunities to reduce lie. It's great to see some of the work being undertaken by offsetting organisations. Why not begin by checking carbon calculators on the links below:

<https://calculator.toitu.co.nz/?calculator=household>

<https://ekos.org.nz/lifestyle-calc>



# NZSA website upgrade



Renu Borst

## An update from NZSA CEO Renu Borst

Easy to find information, interactive and dynamic content, visual appeal and an easy member login process will all be features of the new NZSA website. Work on rebuilding and modernising our website is well underway following research, discussion and scoping.

We are upgrading the website to provide members with an excellent go-to source of information about the NZSA and wider specialty, and to help ensure members are able to easily access this information.

An important part of upgrading the website is to allow for more engagement across the many areas of value for members – whether accessing information about our subspecialty networks, opportunities to work in the Pacific, resources and guidance on private practice, our submissions in response to health legislation and policy, our member news, and much more. We are also redeveloping our company database to meet the operational needs of the organisation, including better collection of individual member data, which will enable us to be more responsive to member needs.

The layout of information on the site will be simplified and streamlined. Most information and resources will be categorised under advocacy, community or education, as these are the three key pillars of our work.

When I refer to a dynamic website, this is in relation to having regular new content – from highlighting CPD events, to changes in medicines access.

We are working closely with our Executive, and other members, to help ensure that the information we have on the website is relevant and of interest to members. Rest assured that our website upgrade will also enable you to access information which is well laid out across different desktop and mobile devices, as well as different browsers.

We are using a Wellington based company to develop and manage our website and they are working closely with office staff and members of our Executive to deliver this project.

A major priority is to provide you with an easy, efficient member joining and renewal process. We know from past member surveys, and direct contact with members, that this is an area which needs improvement and we are committed to delivering this. Robust security and privacy protocols will also be in place.

While our priority audience for the website is our members, we are also aware of the need to provide easy to understand, accessible information to our patients about anaesthesia. We are expanding and refining our patient information section with input from our Executive and subspecialty networks (including obstetrics and paediatrics).

We look forward to offering our members a more informative and dynamic website, and plan to launch the new website later this year. In the meantime, we will provide regular website project updates through our member communications, including our E-Zine.

# NZSA Trainee Column



Dr Michael Ng  
NZSA Executive Trainee  
Representative

**N**ZSA Trainee Representative Dr Michael Ng writes about factors to consider if you need to relocate to a different training region and provides an excellent guide on how you can make the transition as smooth as possible.

Anaesthetic training has many challenges – getting onto a training scheme; primary and final exams; work-based assessments; and projects. In New Zealand, we are fortunate that one stressor is largely removed. Our allocations to hospitals and institutions to meet training requirements are generally seen to when we're accepted onto an ANZCA Rotational Training Scheme. However, life can throw curve balls. For various reasons whether family, personal, ANZCA training requirements, or simply a change in scene, we may need to relocate to a different training region. You can find the list of Rotational Training sites on the ANZCA website<sup>1</sup>.

Having been through the relocation process mid-way through training myself, and speaking to others who have also changed Rotational Training Schemes, here are some tips and factors to consider:

## Before moving

Choose a destination. If there is a relocation for family or personal reasons, sometimes the location is already decided. However, for those needing to move due to ANZCA training requirements this will be something you will need to consider. Most of our tertiary hospitals are accredited for 156 weeks (three years) by ANZCA for training. If you've spent the first three years of training in one of these tertiary centres, and not completed all 'specialised study units' and 'volumes of practice' that are only available at a tertiary centre, you will likely have to move to another tertiary centre to get them completed. Factors which may affect your decision could be family, cost of living, or commuting distance if you're planning on long distance with your partner or family.

If you know anyone that is (or has been) training in the region you're interested in, have a chat to them. Find out how they're finding the training there, and lifestyle, and see if it fits in with what you're after. You may wish to consider the collegiality and culture of the departments and trainees; and any potential training issues that may affect your training (e.g. accreditation).

## Let your current employer know of your intentions

It's always helpful to let your Rotational Supervisor know that you're planning to leave a Rotational Training Scheme. They would have usually made plans for your training requirements (as well as the other registrars!), well in advance. Letting them know early helps them prepare for not having you there so they can fill your position. It also helps not to burn any bridges!

You will also need to let your DHB employer know about your intention to leave. Ask what happens to your annual leave, lieu days, and sick days. Some DHBs will transfer them to your new DHB employer; others will only pay them out. If you want to transfer your leave, you should check that both the DHB you're leaving AND the DHB you're moving to are happy to do this!

## Make contact

Once you've decided on a place, or if you've narrowed your choices down and can't decide, contact the Rotational Supervisors to let them know of your interest in moving. A list can be found on the ANZCA website<sup>2</sup> on who the Rotational Supervisors are for each region.

Once you've let them know your intention, it often pays to book a visit to the hospital so you have the opportunity to see the hospital, ask questions face-to-face, and have a look at the city you're moving to. They'll probably be curious to know your reasons for the move – and you can explain your reasons in a more relaxed, informal manner before you apply.

It's also worthwhile finding out who the welfare representative is for the department; and if there is a mentor and/or buddy system. Moving can be a very stressful time, and even if you never use them, it's helpful knowing you have people to touch base with for advice, to help get into social activities, or debrief with when needed.

## Formal application and interview

Once you've decided on where you're going to apply, find out the application dates. Most New Zealand Rotational Training Schemes have interviews early in the year for a December start. However, registrars often rotate every four or six months throughout the year, and you may be able to start during these changeover periods. It may be worth asking this question to the Rotational Supervisor when you meet them, especially if you needed to negotiate an appropriate start time that works for you and your future employer.

*It's also worthwhile finding out who the welfare representative is for the department; and if there is a mentor and/or buddy system.*

# COVID-19 impacts on trainees

**T**he COVID-19 global pandemic has brought about an unprecedented level of uncertainty, anxiety and stress for trainees in all medical specialties, including anaesthesia.

The outbreak led to government-enforced travel restrictions, self-isolation requirements, limitations on meetings/gatherings, postponement or modifications to exams, and changes to rosters and hospital rotations. Teaching has been modified, or in some cases cancelled due to the educators being prioritised to help manage and run their hospital's COVID response.

On top of this has been the need to quickly adapt and learn the new protocols and processes, and in some cases take on new COVID-related responsibilities such as mask-fitting.

Employment issues have been raised, such as the type of leave deducted for the mandatory 14-day quarantine, and the repercussions especially in those contracts where there are a limited number of sick-days allocated per year.

These disruptions will have consequences on training progression, especially for trainees waiting to sit exams or specific courses to progress onto advanced training, provisional fellowship, or consultancy. Some may need to go into extended training because of it.

At the time of writing, New Zealand is in a very privileged position. We can look forward in the near future to some normalcy, unlike other countries overseas. For trainees, details on exams, training requirements and any future changes due to COVID-19 are constantly updated online. Here are some key website links: <http://www.anzca.edu.au/training/frequently-asked-questions/covid-19-trainee-information> and <http://www.anzca.edu.au/training/frequently-asked-questions/covid-19-impacts-on-training>. Your Supervisor of Training is also a helpful resource for questions you may have.

For employment issues, STONZ and RDA have been keeping their members informed about employment issues.

Currently, work is still underway by the ANZCA Education Committee to decide on whether exams will go ahead in the second half of the year. Should they proceed, a big factor for New Zealand trainees would be the potential need to self-isolate for 14 days if the current government rules were to remain unchanged (with no Trans-Tasman "bubble"), which could have repercussions on the remaining workforce.

*Article continued on page 23*

The interview often involves questions that you would have come across when you initially applied for the training scheme, so there shouldn't be too many surprises here. The interview panel may ask why you're changing Rotational Training Schemes, so be prepared to explain your move (again!); and what your remaining requirements are for your training. This will help them factor you into the Rotation's registrar jigsaw puzzle!

## Not-work stuff

Finding a place to live can be stressful, especially if you have to factor in other people. Figure out your non-negotiables – does it have to be a house, or can it be an apartment? Does it have to be near public transport? Daycare/schools? Near the hospital you'll be working at? You may also be in a position to think about whether you want to buy versus rent.

Where you decide to move may also affect what you do with your current home or living situation (e.g. rent out your home or sell). Consider what you're going to do with your home in your current location, and factor in the time you need to sort this out before you move.

## Starting your new job

Once you've secured your position on the new Rotational Training Scheme, the hospital will give you a mountain of forms, most of which will hopefully be completed before your first day.

Your department will often give you an orientation day (or days) before you start clinical work. You may be introduced to the chief resident, who will often be your "go-to" for most things. Ask about departmental orientation booklets/guidelines; teaching days (depending on what exams you're sitting); and if there is a whatsapp/messenger/email/social group you should join. You may need to enquire about the annual and education leave process, how reimbursements are requested, and claiming for public holidays.

Having a mentor and/or buddy is very useful during this time. Contact the welfare representative at your department to organise this as they may have a list of suggested people or have pre-allocated you someone. Try to meet regularly in the first few weeks even if it's a quick five-minute chat to make sure things are okay. A mentor/buddy isn't just useful at the beginning, but throughout your training. If you find you don't gel with a mentor/buddy, you can find another – just let your welfare representative know.

Despite the challenges, moving Rotational Training Schemes is possible with some forward planning. And before you know it, you'll end up being part of the established crew, and a go-to person being asked to buddy someone yourself.

### Footnotes:

1. ANZCA Rotation Training Sites - New Zealand. <http://www.anzca.edu.au/training/rotations-and-training-sites>. Accessed May 20, 2020.
2. ANZCA Rotation Supervisors and SOTs - <http://www.anzca.edu.au/training/supervisory-roles>. Accessed May 20, 2020.





# Meet an executive member



Dr Jonathan Panckhurst

**A**naesthetist Dr Jonathan Panckhurst works at Nelson Hospital and joined the NZSA Executive at the beginning of this year, keen to provide stronger regional representation. He is a previous Chair of the ANZCA NZ Training Committee and has taken over the NZSA Education portfolio from Dr Kerry Holmes.

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

I was always drawn to critical care and I spent a lot of time working in ED and ICU as a junior doctor. I soon realised that the aspects of medicine that I really loved in these jobs were considered the bread and butter of anaesthesia. I had my interview with the Northern Region panel whilst working in Haiti. It was the first time in an interview that I felt the panellists were genuinely interested in the broader me, rather than the stock interview questions. This was important to me as it portrayed a culture I could identify with. I haven't looked back.

## Where did you study medicine and what training path did you take?

Growing up in Timaru it was a natural progression to head to Otago where I undertook the dreaded health sciences first year course. I completed my training in Christchurch after a year of research to complete a BMedSci Honours and headed to Wellington and the Wairarapa for my house officer rotations. After an overseas stint, my wife and I returned to the Auckland region so I could undertake Anaesthesia training.

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

Aside from my wife, who provided amazing support, I am indebted to the consultants who took the time to teach and guide me, support my research, and come in on a day off to take a viva practice – the list could go on. The cool thing now is that these people have become my friends and I really appreciate them for that. By them setting this example it also means that I try my best to pay it forward with the trainees that we have rotating through my hospital. I am also grateful to my training colleagues from across Australasia for their friendship, developed mostly in the throes of exam preparation (and subsequent celebration).

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

As an anaesthetist who works in a regional centre, I really enjoy the variety offered by the broad range of patients and presentations that we are required to care for.

## What in your view, are some of the key issues for anaesthetists working in New Zealand? How can we best address them?

I rate welfare, equity and sustainability highly. One thing at the forefront of our department's mind is being simply viewed as a service provider. It is exceptionally difficult, I find, to be constantly defending standards of care and added value that can't always be quantified by an immediate cost saving. I think the challenge that faces us, and perhaps what we can learn from others in our position, is how to be more effective when engaging with those that are the financial decision makers. I think NZSA has an instrumental role in facilitating discussion amongst anaesthetists throughout the country to ensure sharing of valuable institutional knowledge.

## What motivated you to join the NZSA Executive?

I have had roles throughout my training on the ANZCA Training Committee. Through my involvement on this committee I saw the great work that NZSA does to advocate for, inform and support its members. As an anaesthetist from a regional centre I want to ensure ongoing regional representation and joining the executive was, for me, the next logical step.

## What would you like to achieve for the Society?

Building on the great work that is quietly achieved year after year I would like to add to the regional voices on the executive and I look forward to progressing the education role.

## What career would you have chosen besides medicine?

Given I now consider myself a Nelsonian I have taken on the local activities. Namely mountain biking and beer brewing (but really, apart from surf, the options are limitless here). I figure given the amount of learning I have saved myself on the brewing front by doing my part one anaesthesia exam (Poussille's law, specific gravity, Henry's law, overpressure, infection control...) this would be the next career option off the rank. However, given limitless resource, I think stay at home Dad would be my preferred option.

## What has been your best travel destination?

Although we went for work rather than for a holiday, our recent family trip to Rarotonga was amazing. What was given up in time at the hospital and being on call from a family perspective was more than made up for by the way the hospital staff took us all in and gave us a truly local experience. My young daughter still dresses up and dances in her ei katu, and talks about going back to visit.

# BWT Ritchie Scholarship - Paediatric Anaesthesia Fellowship

**D**r Chris Badenhorst was one of the 2019 BWT Ritchie Scholarship recipients and moved to Vancouver with his wife and three daughters to undertake a one-year paediatric anaesthesia fellowship. In his interim report, Chris writes about his experience including the differences he encountered between Canadian and New Zealand hospital systems.

I chose to undertake a fellowship outside of Australasia as I felt our training and my subsequent practice in New Zealand is very comparable to Australia. My hope was that working in a completely different health system would provide a different perspective to anaesthesia practice and healthcare delivery and potentially allow the acquisition of a different set of skills and practice to benefit our paediatric population in New Zealand.

British Columbia Children's Hospital (BCCH) is a highly regarded specialist paediatric hospital, which services the wider province of British Columbia and the Yukon. Hospital facilities are state-of-the-art following a recent \$676 million upgrade. Anaesthesia is provided for all aspects of paediatric surgery including cardiovascular, transplant, general, ENT/airway, urology, orthopaedic and neurosurgery. BCCH is affiliated with the Women's Health Centre, the tertiary care obstetrical hospital for British Columbia, which is the largest maternal-fetal-newborn clinical service in Canada, hence the considerable volume of newborn surgery. A busy Paediatric Intensive Care Unit with over 20 beds and a 50 Neonatal Intensive Care Unit are also situated within the hospital.

Each year there are only two paediatric anaesthesia fellows at BBCH in contrast to the program at Sick Kids in Toronto where there are 10 fellows. As such, the clinical exposure and immersion is fantastic. A normal general anaesthesia week is Monday to Friday, 0700 to ~1700. Fellows do one 24-hour call shift per week, as well as a 1:6 weekend call. Every 6-8 weeks, for one week, you cover the pain service as well as out of theatre minor procedures e.g. radiotherapy, chemo, burns etc. During the general anaesthesia blocks you are rostered to each of the subspecialties. However, because there are only two fellows if there is an interesting case in another OR you are encouraged to swap lists. Outside of the general anaesthesia rotation you are allocated to cardiac anaesthesia for six weeks and a PICU rotation for four weeks.

When I began my fellowship there was close supervision from consultants, but over time this supervision has diminished and I'm now independently managing and running lists. The initial close supervision is multifactorial. Firstly, there's a requirement to ensure a degree of competence of the fellow, and secondly due to the "fee for service" funding structure consultants need to be onsite when any case is in the OR in order to bill for their time. Lastly, the medical training system is very different in Canada compared to New Zealand. After four years of medical school you directly enter your chosen specialty program. Anaesthesia is a four-year program, which has constant level 1-2 supervision. The first time many of the residents run a list independently, without a consultant in the OR, is after they've completed their training.



*Stunning Vancouver*

Also, residents may have only been exposed to one to three months of paediatric anaesthesia throughout their entire training because, unless you live in a remote location, adult anaesthetists do not anaesthetise children under the age of 16 unless in the case of an emergency.

My clinical exposure has been broad and varied ranging from routine cases (e.g. T&A's, hernia, simple orthopaedic procedure) to rarer cases either involving children with complex syndromes I had only come across in textbooks or complex surgeries e.g. tracheo-oesophageal fistula, congenital diaphragmatic hernia, congenital cardiac surgery, major scoliosis surgery, complex airway and neurosurgical procedures etc. My six weeks in the cardiac theatre was extremely valuable in finetuning procedural skills, such as caudally thread epidurals, invasive lines and vascular access. Despite feeling reasonably confident with US guided vascular access pre-fellowship, I have been shown useful tips and techniques which have come in handy when obtaining access in microprem babies weighing only 450g.



*British Columbia Children's Hospital*

Gaining further experience with neonatal anaesthesia was a priority for me on this fellowship as this experience can be difficult to obtain in a smaller country. Here in Vancouver, I've had a variety of neonatal cases ranging from the simple ROP laser to the more complex critical congenital tracheal stenosis, severe CDH, laparotomies for necrotising enterocolitis and PDA ligations. Due to the relatively high neonatal case load, the anaesthetic department is often exploring techniques which avoid airway instrumentation, minimise large haemodynamic changes and postoperative apnoeas in this fragile population. An example of this, which has recently been published by this department, is neonatal laparoscopic inguinal hernia repair. Here a caudal anaesthetic is administered, and the neonate is kept sedated with a low dose dexmedetomidine (+/- low dose propofol) infusion whilst maintaining spontaneous ventilation with supplemental O<sub>2</sub> via nasal prongs. The surgeons work with low insufflation pressures and low flow which often means ventilation is minimally affected. The neonate appears to tolerate the pneumoperitoneum well with no significant desaturations, increased work of breathing or haemodynamic swings. The NICU has welcomed this technique as it negates the need for airway augmentation and subsequent ventilatory weaning in fragile neonates who may

have only recently been extubated and weaned from a respiratory perspective. Patient selection is a key determinant in the success or failure of this technique. To date, the outcomes have been reassuring although with further case numbers the potential drawbacks of this technique may become more evident.

Outside of clinical theatre time I have a post call day devoted to research and non-clinical activities. Being an active research group with staff frequently publishing in major paediatric journals, there is an expectation that fellows should submit, or make significant progress towards, a research publication during their fellowship. I am involved in two research projects and a quality improvement project. One of the research projects is an extension of a survey colleagues and I conducted in Australasia, which explored current views and practices surrounding cricoid pressure amongst adult and paediatric anaesthetists. The second project is comparing a novel bronchial blocker, designed by staff at BCCH, to existing methods of bronchial blocker placement in the paediatric population. We hope to present an abstract of this study at a conference in San Francisco in May. My quality improvement project involves developing a distraction free induction and extubation environment. I am enthusiastic about this project because these are two critical times where the anaesthetist's full attention is required, however, for the rest of the theatre staff this is the time they are engaged in other activities such as setting up instruments, dictating operation notes and discussing patients, all of which can cause major distraction to the anaesthetist. If we can develop a working model this project could reduce distractors and improve patient safety and clinician satisfaction in many other hospitals in Canada and New Zealand.

***Gaining further experience with neonatal anaesthesia was a priority on this fellowship as this experience can be difficult to obtain in a smaller country***

There have been clinical and non-clinical differences at BCCH compared to my previous experiences back home, which I thought would be interesting to reflect on.

The role of the Anaesthesia Assistant (AA) in Canada is different to Anaesthetic Technicians in NZ. Most have an undergraduate degree in "respiratory therapy" followed by a further three years of specific training to become an AA. In Canada, respiratory therapists manage all patients who require some degree of respiratory support i.e. Non-invasive ventilation on the wards and ventilators in PICU/NICU. AAs perform all the valuable tasks of an anaesthetic technician, but most are also competent at intubation, vascular access, and arterial lines. Despite being such an asset there are only three to four anaesthesia assistants on site on any given day.

*Article continued on page 22*



**Kirstin Fraser**  
Chairperson NZATS

**T**ēnā koe,  
NZATS and NZSA, together with other key stakeholders, were engaged in a working party to transition the AT training pathway from the diploma program to a degree program. Initial thoughts were that the degree would likely commence in the second half of 2020. Due to the disruptions of COVID-19 development of the degree has not progressed and the degree has now been pushed back. NZATS was immensely relieved when AUT announced they will now offer a diploma intake in 2021 to ensure there is no year with no graduates.

Anaesthetists and Anaesthetic Technicians must be proud of our achievements and the work we completed in recent months. This pandemic has shown us that we are an admired and valuable workforce, not just in the operating theatre but throughout the hospital.

Around the country, anaesthetic departments quickly mustered troops in response to the COVID-19 pandemic. There was a collaborative approach to preparing equipment, procuring appropriate PPE, designing protocols and processes for infective patient flow, and upskilling for patient care. Simulations for PPE donning/doffing, intubation of the acutely unwell, and management of the Covid-positive/suspected patient for the operating theatre were designed and run. Research into best practice for aerosol generating procedures (AGPs) were scoured, as was infection control modalities and practices. In many hospitals this preparation covered areas extending outside the operating theatre, for example the emergency department and the intensive care unit.

**Around the country, anaesthetic departments quickly mustered troops in response to the COVID-19 pandemic.**

NZATS would like to extend our thanks to all Anaesthetists and Anaesthetic Technicians for stepping out of their comfort zones. We are grateful for their flexibility in the restructuring of their rosters to cover the anticipated influx of patients requiring our expert care. We are grateful for the Trainee Anaesthetic Technicians who trained in mask-fit testing so that our registered professionals could go about their business safely. We are grateful for the registered Anaesthetic Technicians and Anaesthetists who became experts in infection control practice. We are grateful for team members who gave their own personal time to participate in activities so that our teams could be safe in the context of PPE and AGPs; there are many resources including videos available online to be referenced now and in the future. We are grateful to those who looked after the welfare

of our teams. The risk of burnout was high and the isolation experienced by some was untenable.

I would like to reflect personally on how grateful I am to be in the profession I am. Continuing to go to work released me from my home that would have otherwise been a prison for seven weeks, unlike many of our fellow citizens whom without their sacrifice we would not be in the positive position we are in. I also consider myself fortunate for the opportunity to utilise my clinical skills. I was the primary Anaesthetic Technician involved in the airway management of an extremely unwell Covid-positive patient requiring intubation. As it was called in our hospital, the high risk intubation team began their PPE preparations at 19:30, entered the patient's room at approximately 21:00 and began exiting the patient's room approximately 21:45 after intubating the patient and inserting both a urinary catheter and central line. The doffing process, decontamination and restoration of equipment took until 00:30. As is often the case with a novel process, procedural issues were identified although this did not affect the clinical care of the patient. The patient spent over a week on a ventilator in ICU and has since been discharged from hospital. Whilst only two consultant Anaesthetists and myself entered the isolation room of the patient, we would not have been successful without the support of numerous staff outside (additional consultant Anaesthetist/Anaesthetic Technician/ICU nurse, as well as the many observers). This is a crucial reminder that we are a team.

**We are grateful to those who looked after the welfare of our teams.**

May we safely go forward into the next stage as we return to our full hospital capacity caring for our population, whilst we carefully watch for any signs of a resurgence of positive cases. Kia kaha.

Heoi anō tāku mō nāianei.

**Kirstin Fraser**  
NZATS Chairperson



# New Zealand anaesthetists offer training in Cambodia

**A**naesthetists Maurice Lee and Indu Kapoor travelled to Cambodia's capital Phnom Penh late last year to run training workshops. The first was on essential pain management, offered under the auspices of the Australian Society of Anaesthetists (ASA), as well as the Cambodian Society of Anaesthesiology, Critical Care and Emergency Medicine (SCARMU). ASA President Dr Suzi Nou approached Drs Lee and Kapoor to participate and was also part of the teaching team.

The course provides pain management education in developing countries and attracted about 100 attendees, comprising of doctors, nurses and students. The course was developed by Drs Roger Goucke, Wayne Morriss and Linda Berger, and is now also offered at undergraduate level in New Zealand medical schools. "The course has an excellent reputation," says Dr Lee. "It provides highly interactive, multidisciplinary workshops to give doctors and nurses a framework to recognise, assess and treat pain."

Course participants were assessed at the end of training and issued with course certificates.

Cambodia has good access to a range of drugs, says Dr Lee, not too dissimilar to what is available in New Zealand. In terms of issues they encountered teaching the course, he says that there was "reticence among participants to use morphine, as there is a fear about addiction. We had questions about morphine and risk of addiction, so we aimed to allay those concerns and to show that there are situations where it is the appropriate medication option for patients."

In terms of other challenges, Dr Lee says that most participants had only a basic grasp of English, so interpreters were used to ensure course content was well understood.

A component of the training is to train the trainers to promote self-sufficiency in local pain management.

Following the EPM Course, Drs Lee and Kapoor, Dr Nou and the ASA's Overseas Development and Economic Committee members ran a one-day CPR and safety defibrillation workshop



*CPR workshop certificates awarded by Dr Suzi Nou ASA President. Visiting ASA and NZSA faculty in the background.*

for SCARMU delegates. This was held the day before their conference and involved six stations on a rotational basis, alongside lectures and demonstrations.

Drs Lee and Kapoor are members of the NZSA's Overseas Aid Sub-Committee (OASC), with Dr Kapoor recently having been appointed OASC Chair. They are committed to raising awareness about the avenues available for New Zealand anaesthetists to become involved with assisting low-and-middle income countries, including volunteering their time to teach and/or locum relief to enable local anaesthetists to attend conferences, or take a break from work.

## Interested in Pacific engagement opportunities?

The NZSA OASC coordinates and leads many overseas aid engagement opportunities for NZSA members, including volunteering to be a locum in the Pacific and applying for the NZSA Trainee Grant to attend the Pacific Society of Anaesthetist's Annual Refresher Course. We encourage you to visit our website at <https://www.anaesthesiasociety.org.nz/about/outreach/oas-bulletin-board/> to keep updated on the Committee's broad activities and the opportunities for you to become involved. This page is regularly updated and well worth bookmarking.



*Essential Pain Management (EPM) workshop being conducted by local Cambodian faculty with support from visiting faculty (Indu Kapoor, NZSA OASC)*



*Relaxed and happy participants after completing the CPR and safe defibrillation workshop*



Chris and family experiencing the great outdoors of British Columbia.

*continued from page 19*

AAs are spread across the 14 ORs and four procedural rooms at the hospital. Beyond a full machine check in the mornings and being available for complex cases, they are not involved with routine operating lists. It is up to the anaesthetist, in between cases, to set up the anaesthetic machine, circuit, airway and vascular access equipment and all monitoring equipment for each case. For induction you are mostly alone; occasionally a nurse is available however they are often a circulating nurse with no specific anaesthesia skill or experience. I learnt this the hard way in my first week. After a routine gas induction, I asked the nurse if she would hold the face mask whilst I placed a cannula. She replied, "I've never held a mask before, but I can hold the patient's hand back towards you so that you can perform your cannulation." It was awkward but worked, surprisingly! Despite this I am in no hurry to incorporate this technique into my regular practice and am more appreciative of anaesthetic technicians back home. This arrangement has not been all bad. Having to be more self-sufficient has meant I am now much more vigilant and better prepared for each case. The lack of an ever-present AA forced me to evaluate the entire process from the moment the patient enters the room until they leave for the PACU. Through this process I have developed, and finetuned a safe system that works when I am by myself.

Another point of difference is in the predominant anaesthetic technique. The default technique at BCCH is an awake intravenous induction followed by TIVA for maintenance. This contrasts to previous hospitals I have worked at where the predominant routine technique was gas induction followed by placement of a cannulae. BCCH's statistics from last year showed that over 72% of

***Having to be more self-sufficient has meant I am now much more vigilant and better prepared for each case.***

cases had an awake IV cannula placed, followed by an IV induction and TIVA maintenance and a less than 6% premedication rate.

As a trainee I recall that paediatric IV induction always seemed to be a high anxiety situation for all involved. However, the system at BCCH works extremely well. Considering that you are often working unassisted, this technique makes more practical sense over an inhalational technique. I believe the system is successful here because a) families arrive with the expectation that "Plan A" is an IV induction, b) topical local anaesthetic is applied as soon as the child enters the department, c) play therapists run through the IV routine prior to the child arriving in the OR and, d) there are great distraction tools in the OR.

***I have found parental expectations to be a significant factor which can influence the type of anaesthetic you deliver.***

I have found parental expectations to be a significant factor which can influence the type of anaesthetic you deliver. There is a perceived fear by parents that having a cannula placed is far more traumatic than a face mask. I respect that there will be differences in opinion but personally I think it is far more traumatic having someone apply a mask and "forcefully" prevent you from removing it compared with having a small cannula placed. The above is especially true if you have a system that works as well as it does at BCCH where most children are hardly aware the cannulae has been placed as the local anaesthetic cream has ample time to work, the child has some idea what to expect and is distracted, and the parents are on board with the plan. After my experience, I prefer the practice of an awake IV insertion and induction, unless there is a clear indication for a gas induction.

Other clinical differences I briefly alluded to previously is that of procedural sedation with spontaneous breathing +/- nasal prongs.

Procedural sedation is by no means a new technique and most anaesthetists are comfortable with it. The differences I am referring to, here at BCCH, is procedural sedation for procedures which I would have previously performed under general anaesthesia in children in New Zealand. Some examples, unless contraindicated are: most upper GI endoscopies (starting at the neonatal age), ophthalmology procedures such as ROP laser and congenital cataract surgery in neonates, cardiac catheterisations, imaging procedures e.g. MRI, ultrasound/CT guided interventions.

An area where procedural sedation has impacted waitlist times for British Columbia has been in the MRI suite where less than 10% of children receive a general anaesthetic.

The system here involves a preop simulation MRI experience with a child play therapist. If tolerated, they proceed with a non-sedated MRI. If sedation is required children receive an intranasal dose of dexmedetomidine 30-45 minutes pre-procedure which is successful most of the time. If further sedation is required a low dose dexmedetomidine or propofol infusion is started and spontaneous ventilation maintained with nasal prong O<sub>2</sub>. It would be uncommon for an LMA or endotracheal tube (ETT) to be inserted. Prior to leaving Wellington this was not our routine practice and most children would have a general anaesthetic with either an LMA or ETT. Clearly, this is not as simple as just adopting a different anaesthetic technique and there will be logistical and infrastructure differences which will contribute to this process being successful in a different institution. However, this topic will be worth exploring on my return to Wellington as it has potential benefits for patients in avoiding a general anaesthetic and for our hospitals to reduce waitlist times and improve access to high demand technologies.

With regards to non-clinical differences the healthcare model in Canada is paternalistic. This may be different in an adult hospital, however, in the children's hospital, it often appears that patients and families are less involved in decisions surrounding their care. Also, there is no separate consent for anaesthesia as occurs in New Zealand. Anaesthetic consent is implied based on the patient signing a surgical consent with the surgeon. I have found this has mostly negative effects with patients misinformed or ill-informed of potential risk and complications associated with the anaesthetic. It undermines the role of the anaesthetic team in a patient's care when the anaesthetic may pose more risk than the surgical procedure being performed. Obtaining the perspective of the patient and their family and involving them in decision making is something we do very well in New Zealand.

My six months in Vancouver has not been all work and no play. We have explored what Vancouver and British Columbia have to offer during weekends and public holidays. Sampling some of the world class mountain biking in the North Shore and Whistler has been a highlight. Vancouver is a multicultural city and we have felt

very welcomed by people in our neighbourhood. Our children are enjoying school but also missing family and friends back home.

I am very appreciative of the opportunity to undertake a fellowship at BCCH. Many of my senior colleagues here are at the forefront of paediatric anaesthesia in North America and it's been invaluable being able to benefit from their expertise and skills. The department has a genuine interest in providing the best possible care to patients and this is evident in the enthusiasm they bring to work on a daily basis. This enthusiasm, along with the skills and knowledge I am acquiring, will be returning with me to Wellington Hospital, where I will be taking up a paediatric anaesthetist role at the completion of my fellowship. I am acutely aware that without the financial assistance of the BWT Ritchie Scholarship, this year would have been substantially more difficult and potentially not even possible. Vancouver is a beautiful city but also significantly more expensive than Wellington. Thank you to the Ritchie family and the ANZAEC for this opportunity. It is my hope and intention to return as a more competent clinician, researcher and member of the wider paediatric anaesthesia community.



*...the healthcare model in Canada is paternalistic.*

*- continued from page 16*

## Trainee well-being

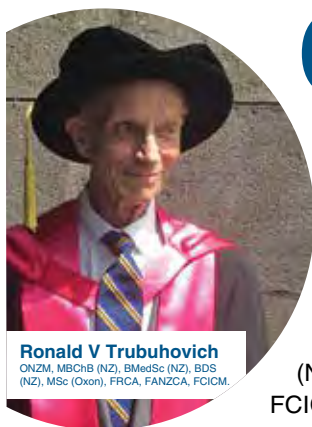
With the ongoing uncertainty, it is important to keep looking out for each other. For trainees and Anaesthetists, there is a well-being section on the ANZCA website: <http://www.anzca.edu.au/resources/doctors-welfare>.

The New Zealand Mental Health Foundation addresses mental health specific to COVID-19. Their website can be found here: <https://www.mentalhealth.org.nz/get-help/getting-through-together/>

Despite these tough times, COVID-19 has brought out some of the best qualities in our colleagues. Many trainees have covered shifts at short notice or taken on extra duties. As trainees we have seen why anaesthesia is such a great profession, as demonstrated by our SMOs. We have seen anaesthetists across our hospitals pull extra hours and sacrifice time away from their families to help do research, write up protocols from scratch, do extra presentations, simulations and intranet/website updates. This has helped ensure theatre complexes, and in fact entire hospitals, are safe and ready for the pandemic. As trainees, we have seen our anaesthetic consultants as confident leaders in hospital-wide responses, and as role models to emulate in the future.

Hoping everyone stays safe for the remainder of the pandemic. Kia Kaha.

# Ronald V Trubuhovich ONZM awarded Doctor of Medicine degree



**Ronald V Trubuhovich**  
ONZM, MBChB (NZ), BMedSc (NZ), BDS (NZ), MSc (Oxon), FRCA, FANZCA, FCICM.

**O**n 29 November 2019 Auckland University capped one of Australasia's early intensivists with his MD degree for a thesis on Resuscitation and the Origins of Intensive Care / Critical Care Medicine.

Ronald V Trubuhovich ONZM, MBChB (NZ), BMedSc (NZ), BDS (NZ), MSc (Oxon), FRCA, FANZCA, FCICM, currently the oldest living Fellow of the College of Intensive Care Medicine of Australia and New Zealand, was the recipient of this degree by examination. His thesis was the result of many years research into the history of the development of resuscitation techniques, particularly for endotracheal intubation and artificial ventilation. Such developments led to changes in the treatment for diphtheria, respiratory poisoning and neonatal resuscitation in the latter part of the 19th century, and then later to radical changes in the treatment during the poliomyelitis epidemics of the first half of the 20th century culminating in the landmark intervention in Copenhagen in 1952 for treating poliomyelitis with endotracheal intubation and intermittent positive pressure ventilation. This advance was relatively quickly adopted around the world for treating patients afflicted with respiratory insufficiency from any cause. These management methods also included the sequestration of such patients in specialized areas in hospitals with equally specialized medical and nursing staff to care for them, and which then became known as intensive / critical care units.

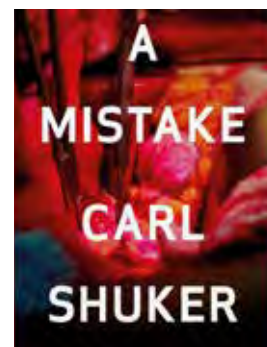
Dr Trubuhovich's Thesis presents much of his own original research into how these historical events built on one another to create this advance in therapy and is a magnificent historical heritage for all those who practice the vital modern-day specialty of Intensive Care Medicine. A copy of his Thesis is lodged with the College Library and one also at ANZCA. The College of Intensive Care Medicine salutes Ron Trubuhovich for his achievement at the age of 90 years, and for his dedication to the research required to set down the development and early days of our specialty, to say nothing of his own dedication as a practitioner for over 50 years to fostering the specialty and thus the care of the many patients who have benefitted from his clinical care.

**AB Baker AM**  
Emeritus Professor  
University of Sydney

## Book Review

### A Mistake by Carl Shuker

In 'A Mistake' the lead protagonist is surgeon Elizabeth Taylor, who excels in her specialty but whose life begins to spiral out of control.



The story centres on the repercussions of a patient's death just hours after surgery, against the backdrop of tension following the Health Minister's announcement that he will launch a system of open public reporting of the results of New Zealand doctors and surgeons – the fates of their patients, or in bureaucracy speak 'outcomes.' While Elizabeth battles with Wellington Hospital's management over culpability of the patient's death, she is also in a war of words as she pens an article opposing public reporting of surgeons' results in a leading medical journal. She laments the many drawbacks, including surgeons avoiding difficult operations to ensure impressive league table results and asks a colleague, "what incentive is there for me to let my registrar try anything challenging if it turns to custard and goes against my stats?" And then there are the internal battles as she reflects on her life's choices and motivations, from career to relationships.

Addressing themes of guilt, fallibility, responsibility to patients, self-conviction and loyalty, this is a riveting read which highlights the complexities of medicine – it is ultimately risky no matter the advances in learning, research and technology because clinicians need to make choices in a pressured environment where the results are not always predictable. Refreshingly, Elizabeth's character is not particularly likeable: she's abrasive, coldly clinical at times, and hardened by fighting the male hierarchy of medicine and hospital management. But she is also intelligent, pragmatic and advocates for her patients, while also weighing up the cost of her decisions at every turn; the fateful surgery, her interactions with a vulnerable surgical registrar; her conflict with senior colleagues; her personal relationships. Ultimately, will a mistake (whether she is to blame or not) undercut a successful career she has dedicated her life to?

Author Carl Shuker is a former editor at the British Medical Journal and has a very strong understanding of the medical profession and health system. He has written a book that is credible and convincing, alongside well-developed characters, sharp dialogue and a story that feels like a procedural thriller, building momentum from the first page. Missteps? The analogy of the Challenger disaster, which is interspersed throughout the book, breaks up the compelling narrative and the two situations (while both 'mistakes') are not similar.

A Mistake will stay with you and you will want to tease it out, dissect it, and talk about it with others. Doctors can read this lean, succinct novel in a day, while laypeople like myself will take longer having to look up medical terminology (which is abundant)!

**Reviewed by**  
**Daphne Atkinson, NZSA Communications Manager**  
(Published by Victoria University Press)





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## From the archives - 40 years ago



**T**he first Newsletter for 1980 was the March issue containing 40 pages. It began with an important Guest Editorial on Medical Registration and Anaesthetists – this at a time when anaesthetists ranged from highly trained specialists to GPs who gave a few anaesthetics. John Gibbs reported on the work of the Anaesthetic Mortality Review Committee. David Woolner won the NZIG

**Medishield Trainee Prize for 1979.**

Following the untimely death of Jon Broad, NZSA Vice-President Cedric Hoskins became Acting President until the next AGM. David Wright was elected Vice-President and was President Elect. CANZ 1980 was to be held in Dunedin in August.

Condolence letters were received from the Australian Society of Anaesthetists for the death of Jon Broad. Names and brand-names of drugs on ampoules and how this varied was raised by Gwenda Lewis. Thoughts on a "three-tier" specialist register came from Joe Petoe while there were two on the costs of our annual subscription, and one from Pen Brown on Medical Misadventure and ACC.

The Faculty of Anaesthetist's RACS's "Recommended Minimum Facilities for Safe Anaesthetic Practice in Non-Teaching Hospitals" was reproduced and NZSA Office Bearers and Regional Officers were listed. Membership came to a total of 261.

News was received from Auckland, Waikato/Bay of Plenty, Wellington and Canterbury regions.

There were several advertisements and the Newsletter was sponsored by NZIG Medishield. A Society tie was still on people's minds.

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

# History of anaesthesia shows the way forward

**D**r Andrew Walpole is the Chair of the History of Anaesthesia Special Interest Group (HA-SIG). He says our careers are often determined by doors opening, and chairmanship of the HA-SIG has opened a new door for him. We speak to Dr Walpole about his career highlights, his interest in anaesthesia history, and the value of the HA-SIG.

Tell us about your medical training and the path that led to anaesthesia, and how you became interested in the history of anaesthesia.

I was born in North East Victoria, graduated in medicine from the Royal Melbourne Hospital in 1979, and then worked as an intern and junior RMO in Wangaratta. The Wangaratta Hospital was a regional hospital in transition to a specialist-based service. There was one specialist anaesthetist, Dr Sandy Bell, originally from Southend-On-Sea in Essex, UK and several general practitioner anaesthetists. Dr Bell arrived in Australia as a General Practitioner with a Diploma of Anaesthesia, later completing specialist training in Melbourne. I learned the basics of anaesthesia and medical politics from Dr Bell. My plan was to enter rural General Practice; he encouraged me to seek an SHO anaesthesia post at Southend and offered to provide a reference.

He opened the door to the UK. The UK department was founded by J Alfred Lee, recognised as the principal author of Synopsis of Anaesthesia. From the 1950s to the 1970s the Synopsis was known as the bible of anaesthesia and a history section was a key feature of the Synopsis.

When I arrived in the UK, Lee was 76 years old. He was compulsorily retired from the NHS at the age of 65 but maintained an association with the department. I worked with Lee and provided dental chair anaesthesia using the McKesson Apparatus, a Goldman Vaporiser and Halothane. I recall Lee speaking in 1983 about Karl Kohler and August Bier. The centenary of the first use of local anaesthesia with cocaine was in 1984.

In 1983 another door opened in the Western Australian Anaesthesia Training program and I qualified FFA RACS in 1987. I joined a specialist practice in Mildura in 1988. In 2000 the Mildura Base Hospital closed and was replaced by a private hospital of the same name. I then worked in Launceston, Shepparton and Ballarat until relocating to Melbourne in 2011. Initially I worked at Box Hill Hospital and later Royal Victorian Eye and Ear Hospital.

In 2012 I joined Eyes for Africa as a volunteer anaesthetist. We completed around 200 cataract surgeries using eye blocks. I was asked if we could operate on five children with congenital cataracts, which required general anaesthesia. The hospital had a range of anaesthetic equipment including Boyles Machines and vaporizers for Ether and Halothane. Since the mid-1990s I had not used Halothane. There was an electrocardiographic monitor but no electrodes. So, I looked to history to help me make this happen. The children all had an IM premed of atropine and I used a pre-cordial stethoscope for continuous cardiorespiratory monitoring and administered Halothane in oxygen (there was no nitrous oxide and no piped air).

At the International Symposium on the History of Anaesthesia in Sydney in 2013 I heard a very enlightening presentation by Johan Sebastian Poll titled "The Emergence of Anaesthesia as a Medical

Specialty in the British Versus the German Empire." One point I took away from this was that the establishment of the NHS was marked by an attempt to put anaesthetists on a lower pay tier than other doctors. This was rejected and all doctors are treated equal in the NHS. J. Alfred Lee was involved in these negotiations, the results of which have provided the foundation for our specialty as it exists today in Great Britain, Australia and New Zealand.

## What does the HA-SIG encompass?

It includes the history of anaesthesia, as well as related fields such as intensive care medicine, pain medicine, resuscitation, equipment and drug history. It is inextricably linked with the history of medicine in general.

## What is the value of being knowledgeable about the history of anaesthesia?

History is fascinating but more importantly if you know where you have come from, you will know which direction is forward and which doors to open and which to close.

For example, this year we know the value of quarantine. Quarantine was named from the Italian for 40 (days). Quarantine was developed in the 14th century in Mediterranean states to prevent plague entering trading ports by ship with serious economic repercussions.

We also remember the polio epidemic in Copenhagen in 1952. People kept coming. They were dying of respiratory failure. Doctors and nurses stood by, unable to help without sufficient equipment. Desperate for a solution, the chief physician of Blegdam Hospital called a meeting. Asked to attend was Bjørn Ibsen, an anaesthesiologist recently returned from training at the Massachusetts General Hospital in Boston, who had a radical idea. It changed the course of modern medicine. This marked the start of intensive-care medicine and the use of mechanical ventilation outside the operating theatre — the care that is at the heart of abating failure to quarantine COVID-19.

*(Reference for this section: Nature 3 April 2020. <https://www.nature.com/articles/d41586-020-01019-y>)*

## What are some upcoming activities for the HA-SIG?

This year has become a tremendous opportunity to reflect and regroup. In 2021 there will be sessions at the ANZCA (Melbourne) and ASA (Cairns) meetings. I will also be attending the Tenth International Symposium on the History of Anaesthesia in Kobe, Japan. I hope you can be there too.

The HA-SIG is a special interest group governed by the Anaesthesia Continuing Education Committee (ACE) which promotes and coordinates combined CME activities and related disciplines on behalf of ANZCA, the NZSA and ASA. Find out more about the HA-SIG <http://www.acecc.org.au/>

**POSTPONED TO 2022**  
*See you in Wellington!*



Prof. Denny Levett



Prof. Steven Shafer



Prof. P.J. Devereaux

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References: 1. Blobner M, 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 Oct;27(10):874-81. 2. BRIDION Data Sheet 2 April 2019.

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