New Zealand Anaesthesia

Te Kotuku Rerenga Tahi

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The newsletter of the New Zealand Society of Anaesthetists

INSIDE ISSUE:

Dr Tin Lun Chiu

Dr Sheila Barnett

Dr kerry Holmes

Dr Rick Acland

The New Zealand Anaesthesia's newsletter design includes the NZSA's logo (safety through knowledge) and the symbol on our constitution. The Kotuku, a white Heron, represents the physical person, its shadow represents the spirit. Te Kotuku can be translated as 'safe' and Rerenga Tahi as 'journey'. The flight and return home of the Kotuku, is likened to a patient's experience under anaesthesia.

President's Column

Greetings Colleagues!

What have you planned for February next year?

Schools will be back, summer holidays over, and it will be time to get back to work.

Can I suggest a week of superb education (and fun) in the city of sails? I'm talking about the Asian Australian Congress of Anaesthesiology (AACA) combined with the Australasian Society for Ultrasound in Regional Anaesthesia (ASURA) meeting to be held at Auckland's Sky City in mid-February.

Neil MacLennan, Martin Misur, Darcy Price, Simon Mitchell and their teams have been toiling to organise a super conference for us.

This will be preceded by the first-ever "Pacific Super Conference" organised by Alan Goodey and Ted Hughes – where all three Pacific Anaesthesia Societies (the Pacific Society of Anaesthetists, the Melanesian Society of Anaesthetists, and the Society of Anaesthetists of Papua New Guinea) will meet together for the first time. The Combined AACA/ASURA website is up, and registrations are open. Have a look at the website and the programme. You won't need me to promote the meeting; the programme and speakers speak loudly enough for themselves. There are world leaders coming – leaders acknowledged not only for their research and knowledge, but also, especially, for their teaching and speaking ability.

The AACA is a WFSA meeting – like an Asian-Australasian mini World Congress, and ASURA is the 2-yearly meeting of the Regional Anaesthesia Special Interest Group. There will be something for all interests. Get on-line, get your study leave organised, and get registered!

By the time you read this, another AQUA meeting will have come and gone in Queenstown. This year promises to be slightly smaller than last, however I fully anticipate the quality to be superb as always. A small meeting of interested participants, taught by acknowledged experts in a beautiful setting has much to recommend it! Our thanks go to Kerry Gunn, Martin Misur, Neil MacLennan and Karen Patching for their great organisation in bringing us this meeting.

Meanwhile in Dunedin, Campion Read and his team are finalising preparations for the 2013 NZ Anaesthesia Annual Scientific Meeting to be held in the newly-renovated Town Hall in the second week of November. This is going to be a gem, and I have enjoyed attending some of their planning meetings by Skype. They are superbly organised, and their excitement is infectious. They are planning something a little bit "edgy" and political, which will challenge us all. This will be education in its broad sense – including ethics, teamwork, compassion and the "disruptive colleague". Registrations are open, and going well. The closing day of the conference is also the day for the "Part Three" course – aimed at post-fellowship senior trainees who are about to step into consultant roles. Annick Hood and Julian Dimech at Middlemore have very successfully run this for the last couple of years, and this year they are bringing their course to Dunedin to round out the ASM. This will be a great day, and I would warmly encourage senior trainees to attend this as we cover topics and issues that do not appear in text books or tutorials, but which have real importance to our lives as senior anaesthetists.

Southern Cross Affiliated Provider Scheme

In my column in our last newsletter I talked of Southern Cross Healthcare expanding their Affiliated Provider Scheme to include common general

Continued on page 4

Obituary ~ Dr Hugh Timothy Spencer

On 5th July 2013, New Zealand anaesthesia lost one of a rare breed. Hugh Spencer was a gentleman in every sense of the word: Educated, cultured, polite, refined, humble. And gentle.

Hugh was born in London in 1941, arriving in New Zealand with his parents as a young man of twelve. He had been a Boy Chorister in London, and had a love of Church Music. He kept a slight English accent, and had an ongoing passion for the music of Bach. He went to high school in New Plymouth and then Oamaru, before studying for an MA degree in history at Canterbury University where he met Margaret, and they married in 1963.

He soon heard the call of medicine, and studied at the University of Otago, where he excelled in Obstetrics and Gynaecology – his love of Obstetrics continuing throughout his career. His initial calling was to General Practice, and to Hugh this included being able to give a safe anaesthetic, so in the early 1970s he packed up his family – Margaret, Geoff and Penny, to Lincoln where he undertook the Diploma in Anaesthetics, and then the first part FFARCS. In 1974 he returned to New Zealand. He popped into Waikato on the off-chance of an anaesthetic registrar job, passed the FFA in 1977, and remained at Waikato for the rest of his career.

His exploits are legion: He took over from Paul Kempthorne as Director in 1986 and continued moulding a united and cohesive department. He led huge expansion in anaesthetic and surgical services with sub-specialisation, development of the Pain Clinic and Pre-assessment Clinic and recognition and development of the Anaesthetic Technician profession.

His work in the Pacific is similarly the stuff of legion: He worked tirelessly to help train our colleagues from the Pacific, and there was always a Pacific Trainee Anaesthetist (and often Anaesthetic Technician) in our department. Hugh would arrange and often pay for flights, visas, accommodation, and warm clothing for trainee and family. He would pick them up from the airport, and shelter a bewildered and COLD Pacific family as they found their feet in a strange land. He did locums in the Pacific so local anaesthetists could attend conferences. He taught in the Pacific. He taught in Australia and was the Australasian Visitor for the ASA in 1992, and was made an honorary member of the ASA that year. He was made a life member of the South Pacific Society of Anaesthetists in 1993.

He served our new College for many years – as a member of the New Zealand Regional Committee from 1994 to 2004, and as NZ Education Officer from 1994 to 2002.

He received an ANZCA Citation in 2004.

In 2008 he was recognised by NZSA with Life Membership.

In 2010 he was recognised nationally with the ONZM for his services to Medicine, particularly in Anaesthesia.

He drove a blue Peugeot 504.

Hugh was resourceful and practical. If there was a need, he set about supplying it. He became a self-taught neonatal anaesthetist. He became a self-taught pain specialist, and with Luc Chin he started the Pain Service at Waikato, as they saw patients in their lunchtimes. He was an expert thoracic and vascular anaesthetist. He was a pioneer of anaesthesia techniques – and his trainees still talk not of "Low Flow Anaesthesia", but of the Spencer technique of "No Flow Anaesthesia". We love the Goldman vapouriser thanks to Hugh Spencer. He had an ability to combine very sound, innately and intuitively safe practice with innovation and an alternative perspective that somehow turned to brilliance. He had a charm and insight with patients and colleagues that in a few minutes allowed him clear insight into a person and their predicament, and instilled total confidence. He loved people, and he loved science, and he loved medicine. He was excited by anaesthesia. He considered it a privilege to provide comfort to his fellow in time of need.

Following his retirement in 2005 Hugh and Margaret spent several years doing locums on either side of the world, enjoying a perpetual summer. He delighted in his family, and took enormous pride in their achievements. His battle with cancer was as you'd expect: fought with grace, honesty, humility and courage.

Hugh's funeral was a feast of music, tribute and reunion.

When his family had immigrated to New Zealand, the Bishop of Waikato had accommodated them for a time. Hugh had always been an "enquirer", including in matters of faith, and for many years he and Margaret attended Quaker Meetings together. He felt it "cheeky" to ask to have his funeral at Waikato Cathedral, yet in a way he was completing the circle, and coming back to his first home in New Zealand.

I know that Dean Peter Rickman loved visiting Hugh in his final weeks, and felt it a privilege to get to know a man of such humility, courage and faith in humanity.

Many of us are grateful to Hugh for many reasons, and many were relayed at his funeral – he had faith in us and employed us; he helped us in our careers; he taught us and inspired us, and was our mentor.

Mostly I think he was an example – of commitment, respect, sound practice, innovation, good nature and humanity, of how to be a good doctor and a good person. He showed us what a privilege we have in our profession and in our ability and obligation to serve.

Rob Carpenter
President, NZSA

Dr Spencer receives the insignia as an Officer of the New Zealand Order of Merit for his services to Medicine, particularly in Anaesthesia from the then Governor-General Anand Satyanand.

Why you should register now for the 2014 Combined AACA and ASURA...

Although it has a complicated name, the 2014 Combined AACA and ASURA is actually pretty simple. It's not the world congress (WCA). And it's not the ANZCA ASM or the ASA. But it is arguably the most important anaesthesia meeting in NZ since the AACA was held here back in 1986. Think of it as an Asia-Pacific version of the WCA with a large extra dose of regional anaesthesia.

The best reason for a Kiwi anaesthetist to consider attending the meeting is the quality of the scientific programme. Although it is only a four day meeting, we have packed an awful lot into it. First, we have 8 international keynote speakers. And these guys are really good. Second, all your favourite speakers from around Australasia will be there to complete the programme. Third, we have a really big PBLD and workshop programme with the opportunity to get some small-group teaching with your favourite faculty.

Sure, we will throw in a great dinner on the waterfront and it will be an excellent chance to catch up with your friends and colleagues, but the highlight is the programme.

So, go to the website (www.aaca2014.com) and register now before all the good workshops are taken.

Keynote Speakers

Vincent WS Chan MD FRCPC
Professor, Department of Anesthesia, University of Toronto, Ontario, Canada

Lee A Fleisher MD
Robert D Dripps Professor and Chair, Department of Anesthesiology & Critical Care, Professor of Medicine, University of Pennsylvania, USA

Admir Hadžić MD, PhD
Professor of Anesthesiology Department of Anesthesiology, St. Luke's-Roosevelt Hospital Center, New York

Paul Myles MBChB MD
Professor/Director, Department of Anaesthesia & Perioperative Medicine, Alfred Hospital and Monash University, Melbourne, Australia

Mark F Newman MD
Merel H Harmel Professor and Chair, Department of Anesthesiology, Duke University Medical Center, North Carolina, USA

Warwick Ngan Kee MBChB MD
Professor and Director of Obstetric Anaesthesia, Department of Anaesthesia and Intensive Care, The Chinese University of Hong Kong

Steve Shafer MD
Professor of Anesthesiology, Columbia University New York, USA

Ban Tsui MD, PhD
Professor, Department of Anesthesia and Pain Medicine, University of Alberta Hospital Edmonton, Canada

ACECC

President's Column Continued…

surgical operations, and joint replacements. Some members have expressed concern at the implications of this development, however open discussion is hindered by the requirements of our Commerce Commission – where providers of services who are in competition with one another (e.g. anaesthetists in private practice) are forbidden to discuss terms or conditions for fear of colluding. In essence, it is "each person for themselves" and we are unable to negotiate on your behalf, nor to advise you. We have however commissioned a legal opinion, and this is available through our office upon request. I must tell you that this opinion is legally privileged information, and should not be shared with non-NZSA members.

Assistants to the Anaesthetist
Many colleagues will be aware that the Perioperative Nursing College of the New Zealand Nurses' Organisation published a consultation document in May:

"Proposal of formalising the role and education pathway of the Registered Nurse who is providing anaesthetic assistance to the Anaesthetist within the perioperative continuum."

We spent some time writing a submission responding to this consultation document which you can read at http://www.anaesthesia.org.nz/health-sector/submissions. We made several points:

There is already a pathway in place for training anaesthesia assistants in New Zealand – The Anaesthetic Technician programme through Auckland University of Technology produces excellent graduates for whom we have great respect and trust.

There is already provision within that programme for Registered Nurses to train as anaesthetic technicians, with their previous training recognised, and training time reduced.

The existing programme trains anaesthetic technicians to the high standards of College Document PS8 2012, and we would not accept a lesser standard of training.

The consultation document did not go into much detail of training, nor the syllabus of training, and we urged the authors to liaise with ANZCA, the Auckland University of Technology, the New Zealand Anaesthetic Technicians Society, and the Medical Sciences Council if/as they contemplate such a programme.

Early this month we received a second round consultation document from the Perioperative College of NZNO and we are working on a response to this as I write.

I know that around the country there is wide variation in the "human resources" available to help the anaesthetist, and that idealism must be balanced by realism. Your thoughts and comments would be welcomed!

The Common Issues Group
In June I went to Canada with two objectives: To attend the Common Issues Group (CIG) meeting in Banff as an observer; and to attend the Canadian Anesthesiologists' Society Annual Scientific Meeting in Calgary.

The CIG meeting was superb. I met the Presidents, Vice Presidents and CEOs of the Australian, UK, American, and Canadian Societies of Anaesthetists. The President of the South African Society of Anaesthesiologists was also invited as an observer. We spent a day in formal meeting, and it was not enough. It was truly enlightening to be at the same table as these leaders of anaesthesia of the developed, English-speaking world. We discussed "Common Issues" of which there are a great many – ranging from drug shortages, drug labelling, drug preparation, to the effects of anaesthesia on the infant brain, to workforce issues, to CPD. A "Mandate" of the CIG was discussed.

I think it is fair to say that while there are many Common Issues affecting our groups, there are also Different Issues – most obviously that of Nurse Anesthetists in the US. Jane Fitch is the ASA President Elect, and she is fascinating to listen to. As a former Nurse Anesthetist, she is well qualified to discuss this issue. I can't hope to get close to understanding all the issues, let alone try to summarise. Suffice to say this is a vexed issue, which makes me very glad to live and work in a quiet, functional, respectful, backwater country named New Zealand.

Not only were some of the issues different, but some of the responses were different: The UK has developed a different approach to CPD, where the value of a CPD activity is entirely personal, and that personal value is recorded, before being discussed and validated by a colleague. Formal lectures are becoming less regarded as CPD activities, and yet UK conferences are becoming more and more popular. There was considerable discussion around the idea of offering discounted registration to conferences for members of the Anaesthesia Societies of allied CIG member countries. There was considerable, almost unanimous support for this idea, and it died…..

What of the future, and the place of NZSA in the Common Issues Group?

I would fully support NZSA's attendance at this meeting in the future. To be able to meet and talk and get to know these people was a great experience, and one which will benefit NZSA in ways I don't yet fully appreciate. Of course the negative is cost, and full membership of this group does carry some commitment. The four "wealthy" members of this group appreciate that NZSA and the South African Society of Anaesthesiologists may not have the resources they have, and I believe an alternative to full membership of this group is under discussion. Of course, NZSA are not party to that discussion. I will keep you posted!

My second objective was not so successfully achieved! That is another story!

Office
Work continues in our Office to establish our database, and improve the IT functionality of the office. Part of this will include a renewal of our tired and outdated website. You will see the results soon.

Lifebox
NZSA has now sent 80 Lifebox Pulse Oximeters to Vietnam. This is something we should be proud of. However, there are 90 million people in Vietnam, so our work is far from over! Maurice Lee leads a delegation of New Zealand anaesthetists to Vietnam during the 2nd week in October this year to teach and introduce more Lifeboxes. He has several volunteers, but needs two more. This will be a challenging and fulfilling week doing great work. If you are interested, please contact the NZSA Office for details and to volunteer.

I hope this Newsletter finds you well, happy and fulfilled.

With Best Wishes

Rob Carpenter
President

World Federation of Societies of Anaesthesiologists Update

In February 2014, it will be Auckland's turn to host the four-yearly meeting of the Asian Australasian Regional Section of the WFSA. This will be the fourteenth Asian Australasian Congress of Anaesthesiologists and the meeting will be combined with the Australasian Symposium on Ultrasound and Regional Anaesthesia (ASURA).

The WFSA is administratively divided into a number of regional sections – Asian Australasian, South Asian, Pan Arab, African, European and Latin American. Regional sections each have their own congresses in addition to the four-yearly World Congress of Anaesthesiologists, next being held in Hong Kong in 2016.

Over the next few months, the WFSA will be supporting a number of important regional meetings, including the CLASA meeting (Latin America) in Asunción, Paraguay, and the Pan Arab meeting in Beirut, Lebanon. Nigeria is also hosting a meeting of West African societies, and the Democratic Republic of Congo is the venue for a major meeting of French-speaking African anaesthetists.

The WFSA has helped to find a number of speakers for these meetings. The WFSA also helps young anaesthetists from poorer countries to attend the meetings through the WFSA-Baxter scholarship programme. The scholarships are advertised on the WFSA website (www.anaesthesiologists.org) and successful applicants present a lecture or poster during the conference. At present, we are processing applications for the CLASA and Pan Arab congresses, and scholarships for the Combined AACA and ASURA are currently being advertised on the congress website (www.aaca2014.com).

I will be attending the CLASA congress in Paraguay as a representative of the WFSA. I am looking forward to face to face meetings with my Education Committee colleagues, Juan Carlos Duarte (Venezuela) and Dr Getulio de Oliveira Filho (Brazil), as well as people involved with WFSA training programmes in Colombia, Brazil and Chile.

During the CLASA meeting, I will also be helping to run an interactive workshop called Essential Pain Management (EPM), which gives doctors and nurses a framework for recognising, assessing and treating pain. Last year, I visited Honduras and helped to train a group of EPM instructors from Central America. The new instructors have run more courses in Honduras, Mexico and Panama, and the course in Asunción will be the first step in a planned roll-out in South America.

The Combined AACA and ASURA in Auckland will be an exciting meeting. The organisers have been working tirelessly to attract delegates from throughout the Pacific and Asia, as well as further afield, so we are expecting a truly international congress. Please register early!

A very special satellite meeting, the Pacific Super Meeting (PSM), will precede the congress. The meeting will be open to members of the three Pacific societies (the Pacific Society of Anaesthetists, the Society of Anaesthetists of Papua New Guinea and the Micronesia Anesthesia Society) and will provide a once-in-a-generation opportunity to get together to learn and discuss issues of mutual concern.

Professional isolation and difficulties relating to transport and communication are major problems for Pacific anaesthetists. The three Pacific societies usually hold individual meetings but this will be the first combined meeting, made possible by Auckland's role as a transport hub for the Pacific. The PSM will include case presentations by delegates, a session on disaster management, and practical workshops. Members of the NZSA Overseas Aid Subcommittee are working hard to enable our Pacific colleagues to attend the meeting.

On another note, the WFSA has been around since the 1950s and now has over 120 member societies representing anaesthesiologists in over 140 countries. We have historically run things on the "smell of an oily rag", but the need to update our fundraising approach, governance structure and communications strategy has become increasingly apparent over the last few years. We have decided to appoint a Chief Executive Officer – more details in the next newsletter.

Dr Wayne Morriss
Chair, WFSA Education Committee

Guest Article ~ *Australian and New Zealand Anaesthetic Allergy Group (ANZAAG)*

It is well known to anaesthetists that anaphylaxis during anaesthesia is a life-threatening crisis. It is a subject that is frequently discussed with patients prior to anaesthesia as a possible risk.

Busy anaesthetists need readily available information regarding acute anaphylaxis management and referral centres for patients that have had an anaphylaxis to ensure subsequent anaesthesia is safe.

Furthermore, anaesthetists involved in the subsequent episodes of care need clear guidelines regarding appropriate anaesthetic agents which can safely be used. The Australian and New Zealand Anaesthetic Allergy Group (ANZAAG) resolved to focus on these challenges.

ANZAAG met for the first time on 10 May 2010. The group arose from a concept of collaboration developed by New Zealand anaesthetists involved in the management and investigation of patients who experienced anaphylaxis during anaesthesia. The New Zealand group first met in the early 1990s. The benefit of a network of specialists including anaesthetists, immunologists and technical/laboratory specialists involved in this area of care throughout New Zealand became apparent. It was then a logical step to extend the network throughout Australasia.

Since the initial meeting the group has grown and consolidated. Current membership of ANZAAG totals 86, comprising 66 anaesthetists, 17 immunologists, two technical laboratory specialists and one perioperative physician. All of these members are involved in one of the 39 testing centres throughout Australia, New Zealand and Hong Kong. The group has become an incorporated society in New Zealand and agreed upon a constitution.

The aims of the group are as follows:

1. To work towards best practice and safety in relation to the treatment, investigation and prevention of anaesthesia related anaphylaxis, working with other agencies nationally and internationally.
2. To foster information exchange, standardisation of practice and good working relationships between anaesthetists, immunologists, allergists and technologists involved in the follow up and investigation of patients who experience perioperative anaphylaxis in Australasia.
3. To foster critical inquiry and other research in the area of perioperative allergy and in the long term, to support these endeavours by establishing a research database of anaesthetic related allergy within Australasia.
4. To provide and maintain web-based resources including Australasian guidelines for the management and investigation of anaesthesia related anaphylaxis and to advise on referral and investigations after such an event.
5. To seek opportunities to keep anaesthetists, immunologists and allergists updated regarding the subject of anaesthesia related anaphylaxis.

The key achievements thus far have included the development of the ANZAAG website, www.anzaag.com and the resources that are now available on that site. The website is hosted by ANZTADC (the Tripartite Anaesthetic Data Committee) which is jointly funded by the Australian and New Zealand College of Anaesthetists (ANCZA), the New Zealand Society of Anaesthetists (NZSA) and the Australian Society of Anaesthetists (ASA).

An annual educational symposium of general interest to all anaesthetists and immunologists has been established and the next symposium will be held from 16 to 17 August 2014 in Sydney.

Early planning is underway for the 2015 symposium which will be held in Christchurch.

Dr Peter Cooke
Consultant Anaesthetist
Auckland

WebAIRS Update

The Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) has made good progress with website development over the past six months, and has released results in the form of presentations and publications as well.

This article covers:

- Recent and future presentations and publications
- Recent alerts
- Website development
- The release of the Australian and New Zealand Anaesthetic Allergy Group (ANZAAG), and website hosted by ANZTADC.

Recent and future presentations and publications

There are currently 56 registered sites using WebAIRS and at the end of June 1685 incidents had been reported and analysed.

Data from these incidents were used in a recent presentation at the College's Annual Scientific Meeting in May 2013. Topics discussed included errors associated with contingency drugs, management of anaphylaxis, and the potential for the use of mobile apps for crisis management. This presentation may be viewed from the logged in user area of the WebAIRS website. WebAIRS interim data has also contributed to a paper titled 'The introduction of pre-filled metaraminol and ephedrine syringes into the main operating theatres of a major metropolitan centre'. This invited paper has been submitted to *Australian Anaesthesia*[1]. A further invited paper has been submitted to *International Anesthesia Clinics* titled 'Incident Reporting at the Local and National Level', as a joint effort between ANZTADC and the Anesthesia Quality Institute[2].

Lessons learned from Critical Incident Reporting

At the 2013 NZSA Annual Scientific Meeting from 6-9 November in Dunedin there will be a WebAIRS presentation in the 'Where have all the data gone' session on Friday afternoon. This will include the interim analysis of data from the WebAIRS database along with some practical examples of how to improve clinical care. On Thursday there will be a WebAIRS PBLD where the WebAIRS system will be used to record, present and discuss some unusual de-identified cases.

WebAIRS Update Continued...

Recent Alerts

Alerts reported include:

1. A case of severe hypertension (systolic 240 mmHg) in a young, fit and healthy patient which developed in the recovery unit approximately 25 minutes after regaining consciousness following a short oral surgical procedure. Fortunately the outcome resulted in only a temporary disability as well as an unplanned admission to intensive care. However, in the short-term there was complete loss of consciousness and the next day, although consciousness had returned, there was still loss of power and sensation in the one arm and the shoulder. Initial CT and MRI scans were normal as were the follow-up CT scan, MRI scan and EEG. The case was quite puzzling and although the initial differential diagnosis had been that this might have been a sudden intracranial event such as ruptured cerebral aneurysm, this was subsequently excluded on investigation. Possible causes of hypertension during anaesthesia include pre-existing hypertension, light anaesthesia or awareness, airway problems, drug errors and surgical factors[3]. Causes during recovery from anaesthesia might include pain, urinary retention, hypoxia, hypercarbia and anxiety[4]. However, none of these diagnoses appeared to be the problem, especially as neurological symptoms persisted to the next day. Other rare and uncommon causes of severe sudden hypertension during anaesthesia include phaeochromocytoma, hyperthyroidism, malignant hyperthermia, raised intracranial pressure or fluid overload3. None of these seemed likely, however, and most of these potential causes would have been likely to present earlier and probably during the case rather than postoperatively. The final diagnosis was a transient ischaemic episode. The cause of the episode was not clear but one possible explanation suggested in the report was that there may have been an accidental intra-arterial injection when the local anaesthetic, which contained adrenaline, had been injected during the case. The symptoms appeared approximately 55 minutes after the local anaesthetic injection, so if this was the cause it was also a late presentation. It would be interesting to know if any readers have experienced a similar case.

2. Another alert related to an operating table extension that detached during a urological procedure. A loud click was heard when the extension was engaged into the slots in the body of the table. However, it was later observed that theatre extensions are not self-locking and require the locking pins to be twisted into place. This alert emphasised the need for training as well as familiarity with the specific

requirements of each piece of equipment in the operating theatre.

3. A known drug user was absent for a short period of time from a birthing suite and returned showing signs of fluctuating consciousness. She later required spinal anaesthesia for an urgent caesarian section which was performed without adding opioids to the local anaesthetic due to concerns regarding illicit recent drug use. Postoperatively a 'pain buster' local anaesthetic infusion was used for wound analgesia. Ten hours later the reservoir was empty and there were signs of tampering with the reservoirs. The patient was warned against the dangers of ingesting or injecting local anaesthetic. The reporter noted that intralipid should be considered if a known drug user has a fit or cardiac arrest in similar circumstances. Another precaution is to always have a high index of suspicion that known drug users may tamper with infusions or cannulae, or self administer while in hospital.

Acknowledgements

WebAIRS thanks the reporters for these interesting alerts. We plan to release more de-identified alerts in future WebAIRS reports. ANZTADC will be grateful if future, unusual reports are flagged as alerts when reported. As this is the first issue where alerts have been published, there is backlog of alerts reported to WebAIRS which will be published in future issues of the ASA News.

Website development

The WebAIRS website now has a link to a demo program[5], so users can try out the system before registering. There are also links to assist with registration and to answer frequently asked questions. Other news includes the release of the ability to use a single username (email address) to log into multiple registered sites. Previously registration required one email address per registered site. Other improvements include additions to the morbidity and mortality reporting tool.

Left: Jim Troup. Right: Martin Culwick.

Australian and New Zealand Anaesthetic Allergy Group

ANZTADC is also hosting the ANZAAG website on the WebAIRS server. There are great synergies with this arrangement with reduction in cost for ANZAAG, as well as the possibility of sharing of information relating to anaphylaxis data. One of the early benefits for WebAIRS is the ability to link to the ANZAAG resources for anaphylaxis management. ANZTADC appreciates the excellent voluntary work that both Mr Patrick Crilly provided in programming the web pages, and Dr Helen Crilly performed in coordinating the collection and presentation of the anaphylaxis resources. ANZTADC has assisted with creation of the master page, authentication of users, the menu system and the website framework, as well as setting up and providing the website hosting. As a result of this cooperation between ANZTADC and ANZAAG, anaphylaxis management cards and other anaphylaxis resources are available from the public area of www.anzaag.com[6] with links from the WebAIRS website.

References

1. **The introduction of pre-filled metaraminol and ephedrine syringes into the main operating theatres of a major metropolitan centre.** Dr Nathan Goodrick, Dr Torben Wentrup, Dr Geoffrey Messer, Patricia Gleeson, Adj Prof Martin Culwick and Dr Genevieve Goulding. Submitted to Australian Anaesthesia.

2. **Incident Reporting at the Local and National Level.** Patrick J. Guffey, Martin Culwick, Alan F. Merry. Submitted to International Anesthesia Clinics.

3. **Crisis management during anaesthesia: hypertension.** A Paix, W Runciman, B Horan, M Chapman, and M Currie. Qual Saf Health Care. 2005 June; 14(3): e12.

4. **Hypertension in anaesthesia.** Dr Antonia C. Mayell. Royal Devon and Exeter Hospital UK. http://www.frca.co.uk/article.aspx?articleid=100656

5. **WebAIRS Demo.** http://www.anztadc.net/Demo/IncidentTabbed.aspx

6. **ANZAAG resources.** http://www.anzaag.com/Mgmt%20Resources.aspx

Adjunct Professor Martin Culwick, FANZCA, MIT

Medical Director

ANZTADC

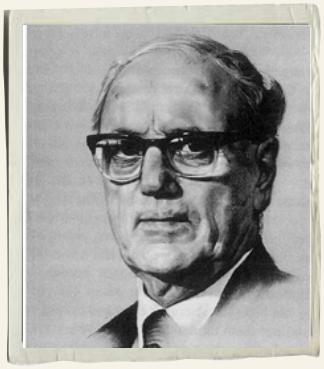
NZSA Prizes and Awards

Auckland University of Technology Prize Giving

The Society has once again supported the School of Applied Sciences at Auckland University of Technology by providing the prize for the Most Outstanding Graduate in the Diploma in Applied Science Anaesthetic Technology. We thank Dr Cedric Hoskins, President of the Society from 1978 to 1979 and in 1980, for presenting the prize for a second year on behalf of the Society to Julianne Bergemann, this year's winner.

Newly graduated Anaesthetic Technician, Julianne Bergemann, and Dr Cedric Hoskins who presented her prize on behalf of the NZSA.

NZSA Ritchie Prize Session at the Dunedin ASM 6-9 November 2013



Ritchie Prize Session

The Ritchie Prize Session is a named plenary session at the Annual Scientific Meeting (ASM). If there are insufficient entrants the balance of the session should be made up with other submitted free papers. The format of the presentations is a 10 minute oral presentation with 5 minutes for questions.

The winner of the John Ritchie Prize will be invited to apply for the NZSA Ritchie Prize Research Grant. Receipt of the Research Grant is not automatic.

Applications invited by 30 September 2013

Winners of the following prizes receive a certificate and a cash prize.

The John Ritchie Prize

The John Ritchie Prize was established in 1983 by the New Zealand Society of Anaesthetists.

Guidelines for the John Ritchie Prize

1. The Prize shall be awarded annually to the presenter judged to have the best paper at the Ritchie Prize Session which is held at the Annual Scientific meeting organised in whole or in part by the NZSA and at which the Society's Annual General Meeting is held.
2. Any questions relating to eligibility for the Prize shall be referred to the President of NZSA for discussion by the Executive Committee. The Executive Committee's decision will be final.
3. Three adjudicators for the Prize will be appointed annually by the Executive Committee. The judges will not themselves be eligible for the prize while acting in that capacity.
4. An award will only be made if, in the opinion of the judges, there is a paper of sufficient merit.
5. Selection of papers: Selection for the session is made by the Scientific Convenor of the ASM in consultation with the NZSA Education and Research Officer or deputy. To be accepted for the session the abstract and the work described in it must be of a suitably high standard.

Declaration

- Entrants must declare compliance with the following conditions:
- Work presented in the session must have been carried out predominantly in New Zealand.
- The presenter should be the lead researcher and must have played the major role in the conduct of the study and preparation of the presentation.
- The presenter must be a member of the NZSA.
- The work must not have been presented at a major Australasian or international meeting. (Note that presentation at a New Zealand meeting would not normally preclude later presentation elsewhere).
- Receipt of appropriate Ethics Committee approval.

NZSA Trainee Prize

The NZSA Trainee Prize will be awarded for the best presentation by a Trainee in the award section of free papers. The applicant should have made the dominant contribution to the work for the prize and be a member of NZSA.

1. Three adjudicators for the prize will be appointed annually by the NZSA Executive Committee. The judges will not themselves be eligible for the prize while acting in that capacity.
2. An award will only be made if, in the opinion of the judges, there is a paper of sufficient merit.

NZSA Poster Prize

This prize was introduced in 2011. Posters were put on display at the Annual Scientific Meeting. Last year there were 50 entries in this category and there were five winners.

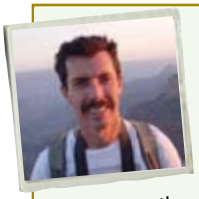
NZSA Registrar Prize for Best Quality Assurance/Audit Paper at the Annual Registrars Meeting

Entrants for this prize are also eligible for the NZSA Trainee Prize so long as they are members of the NZSA.

How to apply for the prizes

Applicants for these prizes must be members of NZSA. To apply contact your Head of Department or NZSA nzsa@anaesthesia.org.nz. To become a member of the Society please complete an application form which is available on the NZSA website here http://www.anaesthesiasociety.org.nz/anaesthetists.

Applications should be forwarded to NZSA, PO Box 10691, Wellington or to nzsa@anaesthesia.org.nz by 30 September 2013.



Trainee Corner ~ Introducing Dr Kerry Holmes – NZSA Trainee Representative

After several years in the role Kathryn Hagen will be travelling overseas on Fellowship at the end of this year and I have taken over as Trainee Representative in what has been a relatively bloodless transition of power. Anybody who has worked with Kathryn knows what an incredibly effective job she has done in this role, and she leaves behind a mighty pair of boots for me to try and fill. Kathryn will remain as a co-opted member so her wisdom, enthusiasm and hard work will continue to be available to the Executive Committee.

I am an ATY2 trainee at Auckland Hospital and have taken a course more winding than usual to get here. After an initial year of training in Tauranga I worked for the Flying Doctors in Alice Springs (which was awesome) then for the AMREF Flying Doctors in Nairobi (which was even more awesome). After that I was accepted onto the Radiology training scheme in a career move that still completely baffles me.

I'm looking forward to being more involved with the speciality in the Trainee Rep role, and am being brought up to speed by both Kathryn and Kate Romeril (who continues to impress in her role as Deputy Rep despite studying for her Part One's). These remain interesting times for trainees with the changes that are happening to training and the challenges facing those coming through, such as the tight job market.

It remains important for Trainees to have a voice in committees throughout Anaesthesia and to be kept abreast of issues that will affect them. Please let me know of any Trainee related questions or issues you may think of at docholmes@gmail.com.

Improving your chances in the tight job market

The job market in Australasia is tight and getting tighter. There are fewer and fewer Metropolitan jobs, and many more trainees coming through. Now is the time to be thinking about getting your CV looking great and standing out from the crowd.

An interest in Research is a clear bonus. Apart from actually getting something published there are plenty of scientific meetings and conferences to get things presented at. This is something that can definitely go in the CV and can give you cheap (or even free) conference entry. Performing and presenting research will give you the chance to win some of the prizes on offer for Trainee research such as the NZSA Trainee prize or even the Ritchie Prize.

Quality assurance is another obvious area well regarded by employers. Getting some decent audits on your CV, especially with follow up demonstrating changes in practice stemming from your audit will serve you well.

New curriculum and the Part 0 course

The new curriculum offers the Post Graduate Diploma in Clinical Education as an option to complete the Scholar requirement. On top of getting more letters after your name (you need more incentive than that!?) it shows that you are someone with more than a passing interest who will also go the extra mile. The Part Zero course coming up in December also offers an opportunity. We're currently recruiting teachers so get in touch with Dr Nav Sidhu now on nzpart0course@gmail.com - you'll get to teach the newest trainees a thing or two which will help your CV.

ASM Dunedin 2013

I want to put a quick plug in for the ASM in Dunedin. NZ trainees traditionally have an aversion to spending their own money on their training, but there's good reason to be attending conferences during your trainee years. Apart from seeing what the latest 'thing' is in Anaesthesia these are wonderful opportunities to meet and form networks with future colleagues and employers in New Zealand. These conferences are not only organised by our best and brightest, they also feature the leading lights of Anaesthesia. You can do some tremendous things with your FANZCA and conferences are a great place to see where you can take it. On top of this, if you are an Advanced Trainee conferences are opportunities to use your CME funding allocation that, after all, is a concession as part of your salary.

Dr Kerry Holmes
Trainee Representative
NZSA Executive Committee

Teaching Opportunity for Senior Trainees

The organisers of the 3rd NZ Anaesthesia Part 0 Course would like to invite senior ANZCA trainees based in New Zealand to apply for positions as facilitators. Teaching on Day 2 of the course (the Basic Introduction to Clinical Anaesthesia [BICA] Day) is delivered via small-groups and a practical skills session. As facilitators, senior trainees will be given a handbook on small-group teaching and practical skills teaching prior to the course, and be required to formulate and submit a teaching plan. During the course, teaching sessions will be observed by peers and feedback given using a structured checklist. A short written reflection on their experience of 'learning how to teach' will be required to be submitted a few weeks after the course. The BICA Day will take place in Auckland on Saturday 14 December 2013, with facilitators required to be in attendance from 0730-1800.

Senior trainees may submit an expression of interest with the following details: reasons for wanting to be involved, work history, previous teaching experience, other qualifications/ experience of relevance. Please submit all applications or any queries to Dr Nav Sidhu, Consultant Anaesthetist, North Shore Hospital. Email: nav.sidhu@waitematadhb.govt.nz

Dr Tin Chiu in the Big Apple

Dr Chiu in Times Square, the busiest part of NYC. The statue is of Father Duffy, a decorated chaplain and soldier from WW1

When I underwent my training as an anaesthesia registrar in the Auckland training programme I had always been particularly interested in regional anaesthesia. Thinking back I think it was because of the great teaching for peripheral nerve blocks by regional enthusiasts I had at Middlemore Hospital while doing case after case of hand surgery. Also it was fun to be able to use a 'toy/tool' such as the ultrasound scanner to see exactly where the local anaesthetic goes and also getting a buzz out of seeing how well they work.

I had the fortune of meeting Dr Andy Cameron also as I was training. He had just returned from a regional fellowship at the Hospital for Special Surgery in New York to be a Consultant at Middlemore Hospital. He described the experiences he had at HSS and I knew that was the type of fellowship I would also like to do some day. In my ATY3 year Dr Andy Cameron kindly offered to organise a hospital visit for me to HSS. When I visited I was fortunately able to spend that time with another New Zealander, Dr Richard King who is a Specialist Anaesthetist at HSS. He showed me around his hospital and provided me with a great introduction to HSS. I was able to talk to present fellows and they also described the experiences they were having. Finally, during that visit I met the Director of Anaesthesiology, Dr Greg Liguori and we had an informal interview. He encouraged me to put in an application for a fellowship position, but they have a very competitive fellowship programme and there are no guarantees of getting a spot. I returned home to NZ, placed my application and commenced a fellowship for liver and vascular surgery in Auckland. I was lucky enough to be offered a fellowship position later that year at HSS.

I have now been in New York doing the Regional Fellowship for 4 months. One word springs to mind when describing this fellowship - fun!

HSS is an orthopaedic elective surgery hospital in the Upper East Side of Manhattan. They have almost 40 operating rooms that do upper limb, lower limb and spine surgery. They have a culture of doing primarily regional anaesthesia and sedation for all surgery unless a general anaesthetic is required, such as for spine surgery. Around 85% of surgeries in HSS are done with regional anaesthesia without general anaesthesia. The fellows get to experience a lot of peripheral nerve blocks and neuraxial blocks in the 1 year fellowship. Also the fellows are always doubled up with a Specialist Anesthesiologist in the theatre, so there is always one to one teaching of nerve blocks. The working days are long however. Fellows are expected to set up the operating room for surgery at around 0630 (there are no Anaesthesia technicians) and there are usually journal clubs or grand rounds from 0700-0800. Patients are assessed prior to coming in to the OR at 0800. The finish time each day is 1800, but occasionally the list finishes early and that is a bonus. Also fellows are expected to participate in research, teaching of residents and to help with demonstrations of regional anaesthesia workshops in conferences. The anaesthesiology department is very supportive of fellows and provides great clinical teaching. They also have informal functions to welcome new fellows and farewell dinners for the departing ones.

The other fun aspect to the fellowship is the fellows you get to meet. The current anaesthesia fellows come from all around the USA and also internationally. Currently there is a fellow from Brazil and a couple of Australian orthopaedic surgical fellows also. The fellows tend to socialise a lot as a group so even though I didn't know a lot of people in NY, it was so easy to just fit in. The fellowship is a great way to make new friends and make contact with other anaesthetists from around the world.

And of course New York is a fun city in the days off. This is the city that never sleeps and there is always something happening. There are some of the best restaurants, bars, shows, attractions and cultural events in the world all within walking distance or a cab ride away.

Arranging a fellowship in the USA is not easy. I would encourage anyone interested in an overseas fellowship to start organising it early. Unfortunately there are a lot of barriers along the way. Our medical qualifications are not recognised in the US and completing the United States Medical Licensing Exam (USMLE) is a requirement for medical registration. It consists of 3 parts, each part is a 8 or 9 hours multi-choice exam. The 2nd part has an oral exam which can only be done in the US. As a New Zealand citizen, obtaining medical registration and a US working visa is a slow and burdensome process that requires many hours of paperwork, and a sponsorship from the New Zealand government is needed. The other downside to doing a North American fellowship is the low remuneration, a lot lower than NZ or Australia. It is certainly a financial burden, especially for people with families, mortgages or student loans.

However, I feel all the sacrifices have been worth it for this once in a lifetime experience. This is a fellowship that is unique and is not something that can be replicated locally in Australasia. I am having a fantastic time so far and I plan to make the most of the time I have left. I look forward to returning to NZ after this fellowship.

Dr Tin Chiu
Regional Fellow at the Hospital for Special Surgery in New York

BWT Ritchie Scholarship For 2012
Interim Report from Dr Sheila Barnett June 2013

I am now six months into my year's fellowship in paediatric anaesthesia at the Royal Children's Hospital in Melbourne.

I have moved over with my engineer husband and two preschool aged kids and, halfway through, we are feeling a bit more settled. Moving two jobs and two children has been quite a challenge, even if it is just over the ditch!

I have arrived into an anaesthetic department that is friendly, approachable and very active (both in and out of work!). There is a core of full time specialists but also many visiting anaesthetists who often do much of their work in private too. The consultants are enthusiastic teachers and there is something to learn from every list. Certain lists are reserved for us fellows (assisting the consultant), including craniofacial surgery, neurosurgery and cardiac surgery. Neurosurgical lists include the IMRIS system. This is an in-theatre MRI that sounds quite cool until everyone else clears the room and you are the only person left in there for the long scan! It is also the National Centre for Epilepsy Surgery with cortical mapping performed in theatre. Cardiac surgery lists give great hands on experience with tiny babies, central and arterial lines, and for understanding complex congenital heart disease. What could be considered our 'service provision', lists as fellows often provide great learning too. There are daily radiotherapy lists off site that we often anaesthetise for. These children come every day for several weeks so do not get intravenous access routinely. The 'labs & lines' list often has central venous lines for insertion. Even 'routine' lists like gastroscopies often have a curve ball, such as a baby with liver failure.

There are around 11 fellows and most are Australian trainees. We have a very friendly, down to earth group who get on well. We include those who have quite a bit of paediatric experience and those (like me) who are fifth year registrars. The department has been very welcoming and supportive of this mixture of experience levels. However, on a personal basis, in the early weeks I would have been much more comfortable with a previous paediatric fellowship! Our only fellows' complaint would be that we are perhaps too protected! Not too much of our work is out of hours (one 15-hour night shift every 3 weeks and one weeknight on call shift each fortnight) and, as a result, we may sometimes miss out on some interesting acute work. The department recognises this and it is set to change! We are well supported and are encouraged early to choose a mentor in the department to help discuss our goals for the fellowship.

The hospital is co-located with the Murdoch Children's Research Institute. There are several large and well-known trials such as the GAS study and PIMS study that the anaesthetic department leads or takes part in. There are also smaller studies going on all the time. Getting started on research or projects is easier as the systems are already in place to, for example, gain ethical approval, and there are people around to ask. For example, I have just attended one of the sessions on how to set up an Epidata database. The departmental teaching is strong, as I would have expected. What I have been surprised by is the number of opportunities for education within the hospital as a whole. I've taken part in a weekly evening session 'Teaching as you go' to improve my clinical teaching. There are many more opportunities for senior trainees such as introductions to research or management but these often clash with theatre times.

I am aiming to report on our outcome and safety data for cardiac MRIs. I have also co-written a Clinical Practice Guideline on laryngospasm. These guidelines are peer reviewed within the hospital and are then made freely available on the hospital website. I have recently travelled to Wellington to teach on the Final Exam viva course. I attended the Melbourne ASM in May and spoke at the Welfare SIG session on our New Zealand experiences of setting up a trainee welfare system. I am planning to attend SPANZA later this year too. We have five hours non-clinical time per week that includes our fortnightly fellows' teaching so this time is easily filled!

It feels like a genuine privilege to be working here. I think this is, in part, because unusual cases or techniques you only read about for exams are part of day-to-day practice. There is also a strong work ethic. It is unusual to cancel any cases and very usual to squeeze in an acute case at the end of a list. There are strong support services such as the play therapists that we will often work with. There is also the hospital itself. It is only a couple of years old now and is quite impressive in many of its facilities for children and their families. There is even a 'mock' MRI scanner to see if kids will manage without a general anaesthetic. Our own kids have really enjoyed seeing the meerkats enclosure, playing on the 'big ipad' and visiting the aquarium that spans two floors and keeps the kids waiting in ED entertained.

Both my husband and I work fulltime and our children come with me to the hospital. Theatre lists do run late and it means I am often picking them up at 6:30 pm then rushing home for the evening routine. The kids love the preschool and we have found it a great way to make friends in the hospital. I am also able to spy on them a little from the corridors on the third floor. Weekends are our own and we do lots with the kids. We explore the beaches of the Mornington Peninsula; we are members of the zoo and all the museums. We live on the 38th floor of the tallest residential building in the Southern Hemisphere. It sounds unusual but it is right in the middle of the city and there is so much to do on our doorstep. The nearest green spaces are the garden of the National Gallery or the Botanic Gardens so we head over there most weekends. We've had plenty of visitors and expect more to come. Melbourne is the kind of city that everyone seems to travel through or come and visit. We've finally bought a car after it became too dark and cold in the winter to be out at the tram stop with the kids at 7 am! It will be even more useful next summer as many of the trams aren't air-conditioned and the temperatures are often over 30 degrees. We are planning Christmas in a holiday house in a small town down the Great Ocean Road.

Next week I start my 3 months in NICU, then back to anaesthetics for the last 3 months of the fellowship year. I plan to stay on for a further 6 months in PICU. I would like to thank the Ritchie family and the NZAEC for their support in giving me the opportunity to make the most of my time here.

Dr Sheila Barnett

BWT Ritchie Scholarship Recipient 2012

Dr Barnett and family.

Inside the Royal Children's Hospital in Melbourne.

New Zealand Anaesthesia Education Committee (NZAEC) BWT Ritchie Anaesthesia Scholarship Applications

New Zealand-born anaesthetist Dr BWT Ritchie and his family set up the BWT Ritchie Anaesthesia Scholarship to enhance the experience of trainee New Zealand anaesthetists. The scholarship is intended as a grant in aid to allow New Zealand-based trainees obtain experience in other countries for one year during or immediately following their final year of training and, if appropriate, for one further year.

The scholarship is open to trainees or Fellows of the Australian and New Zealand College of Anaesthetists (ANZCA) who have passed the final examination for ANZCA Fellowship and are eligible to proceed to Training Year 5; or who wish to take a further year of study outside New Zealand in the year following completion of their ANZCA Fellowship (FANZCA).

It is also open to those who have completed their FANZCA and are also studying for a Fellowship in intensive care medicine or pain medicine; and who have passed the final examination for Fellowship of the College of Intensive Care Medicine of Australia and New Zealand or ANZCA's Faculty of Pain Medicine Fellowship, or who wish to take a further year of study outside New Zealand in the year following completion of either of those Fellowships.

The 2013 scholarship is valued at up to $25,000, depending on the programme of the successful applicant/s.

Candidates for the scholarship must be nominated and supported by their training department.

For further information, including details on how to apply, please contact Rose Chadwick at the New Zealand Anaesthesia Education Committee (NZAEC), nzaec@anaesthesia.org.nz

Applications should be sent to Rose Chadwick, NZAEC, PO Box 25506, Featherston Street, Wellington 6146 by **31 October 2013.**

New Zealand Society of Anaesthetists (Incorporated)

New Zealand Anaesthesia Visiting Lectureship 2013

The New Zealand Anaesthesia Education Committee (NZAEC) established the New Zealand Anaesthesia (NZA) Visiting Lectureship in 2008 to promote sharing knowledge and experience among anaesthesia departments and practices through outstanding presentations.

This year's visiting lecturers have continued the tradition of presenting stimulating and informative talks which have been much appreciated by their audiences. Dr Rachel Williamson presented on the topic of "Christchurch Quake: New Zealand's Darkest Day" at Nelson and at Rotorua. Dr Simon Scothern from Rotorua reported that Dr Williamson spoke at the hospital grand round to a packed floor of staff from all disciplines, and her talk was universally well received.

This year saw a new initiative in the lectureship programme, whereby two visiting lecturers were invited to attend a regional meeting. Dr Nigel Waters came up with the idea following the successful visit of 2012 Visiting Lecturer, Associate Professor Tim Short, to Palmerton North. Dr Waters considered that a regional meeting would enable more anaesthetists to benefit from the expertise of the visiting lecturers while also strengthening regional collaboration.

Dr Mike Miller from Wanganui Hospital agreed to host the meeting on July 5th, and anaesthetists were invited from five lower North Island Hospitals (Hutt, Hawke's Bay, Masterton, Palmerston North, and Wanganui) to hear a range of topics presented by Professor Brian Anderson and Dr Matt Taylor. (Prof Brian Anderson: Pharmacology in the Young: Anaesthetic Implications; Paediatric Total Intravenous Anaesthesia; and Paediatric Intensive Care; and Dr Matt Taylor: ERAS for Anaesthetists; Fluids and Goal Directed Fluid Therapy; and Intraperitoneal Local Anaesthetic). Dr Waters described the talks as informative, thought provoking and absolutely geared for the target audience. The presentations were filmed and the NZAEC intends to make the talks available to all hospital departments in New Zealand later this year.

Professor Anderson's second visit was to Wairau in Blenheim and Dr Taylor's second visit will be to Taranaki Base Hospital in New Plymouth.

Nominations for Visiting Lectureships for 2014 close on October 31, 2013. Heads of departments and practices are invited to nominate a member of their staff who has given an outstanding presentation at a continuing medical education session and who is willing to travel to two other centres in New Zealand to present their lecture/workshop in 2014. The anaesthetist awarded the lectureship will receive an award of $500, and NZAEC will pay for the travel costs associated with the visits. Departments who would like to host a visiting lecturer in 2014 can also contact NZAEC. The *NZA Visiting Lectureship Nomination Form* and the *Expression of interest in hosting a New Zealand Anaesthesia Visiting Lecturer Form* are available on the Visiting Lectureship page of the newly launched NZAEC website: http://www.anaesthesiaeducation.org.nz/ Information about previous NZA Visiting Lecturers can also be found on this website. An article about the new website is on page 14.

Prof Brian Anderson and Dr Matt Taylor presenting at Wanganui

Dr Rob Whitta – New Clinical Director, MidCentral DHB

I was born on Niue Island. My father, John, who died in 1997, was a third generation New Zealander, of English immigrants from Cornwall. My mother, Tepaeru, is a Cook Islander, who trained as a nurse, and who at 89 years old is living an enjoyable retirement in Rarotonga.

We migrated to New Zealand when I was 9, planning to live permanently in Auckland. However, my parents accepted a job back in the Cook Islands as I was about to start high school so I attended boarding school at Auckland Grammar, and stayed on in Auckland for Medical School.

I had wanted to study medicine since I was a child, and General Practice was always my preference. When I set off overseas in 1986, it was with the intention of returning to South Auckland General Practice in two years.

My work experience, firstly in Australia, then subsequently in England, led me to rethink my career, and I accepted a job opportunity in Anaesthesia. My 2 year OE turned into a 12 year odyssey which was revealing, exciting and satisfying.

My training in Anaesthesia took in several District General Hospitals in southeast England, as well as tertiary hospitals in London, including a research fellowship at the Royal Free Hospital, a pre-requisite for Senior Registrar positions. From this I took up locum consultant positions.

I had met my wife, Charlotte, whilst working in England. She trained as a nurse and then moved to the pharmaceutical industry. We travelled extensively, when we could, mainly in Europe and Africa. We redecorated a Victorian flat, and then house together, whilst starting our family. As work, time and commuting in London began to take its toll, we decided to move to New Zealand in 1998. This was to Gisborne initially, but after a year we moved to Palmerston North. The job here has had a lot more to offer, in terms of the range of clinical work and it has been a great place to raise a family.

We have chosen to live in the country for the lifestyle and have three teenage children who are all at high school now. We have enjoyed redecorating this house too, and enlarging it for our growing family. Landscaping and maintaining the property including a large vegetable garden, raising chickens, pet sheep and border collie dogs add to the pace of our lives.

I have always maintained an active outdoor life, playing tennis, rugby to my early forties, I have run for 30 years, fitted in a few mini-triathlons and a half marathon, scuba dive when I visit the tropics, ski/snowboard in winter and play golf year round.

My preferred music is rock, edging to country and blues. I love to read history and crime fiction, I am passionate about the environment and even more about the All Blacks.

The position of Clinical Director will be challenging, but we have a terrific department, a lot of collegial support, and an excellent reputation for the work we do and the teaching and training we provide. My aim is to help maintain and hopefully enhance these achievements.

Dr Rob Whitta
Clinical Director
MidCentral DHB

Dr Marco Meijer– New HOD Whanganui DHB

Anaesthetists Marco Meijer (left) and Mike Miller share a 'moment' before Mike handed his role of Head of Department of Anaesthetics over to Marco at the end of July.

Mike said after holding the position for 26 years, he felt it was time for his younger colleague Marco Meijer to step up.

Marco joined the Anaesthetics Department four years ago with a special interest in ultrasound guided blocks. Trained in Holland, he is responsible for teaching trainee anaesthetic technicians and earlier this year he was awarded his Australasian Fellowship.

Mike says Marco's proven leadership skills will be of great value to the department which over the past 10 years, has grown so much that it has nine highly trained anaesthetists on staff.

In the meantime, Mike will continue his role as a WDHB anaesthetist doing all he can to support Marco in his new role.

Relieved of his HOD duties, Mike intends to spend more time trout fishing, tramping and travelling to exciting places.

The WDHB HOD double - Drs Mike Miller and Marco Meijer

New NZAEC Website Launched

Interested in applying for fellowship opportunities to study overseas? Want to host a lecture in your department or nominate a colleague for a visiting lectureship? The new website (http://www.anaesthesiaeducation.org.nz/) launched on 5 August by the New Zealand Anaesthesia Education Committee (NZAEC) is the place to find out more.

For example, this website contains information for anaesthetists and trainee anaesthetists about the process of applying for BWT Ritchie Scholarships and NZ Anaesthesia Visiting Lectureships which are administered and awarded by the Committee each year. Links to information about courses of interest related to developing a career in anaesthesia and techniques in the management of anaesthetic emergencies are also provided. Read also about the experiences of past recipients of the scholarship and the topics and centres visited by lecturers.

The NZAEC is a joint committee of the New Zealand National Committee of the Australian and New Zealand College of Anaesthetists (NZNC) and the New Zealand Society of Anaesthetists (NZSA). In addition to overseeing scholarships and lecturerships the Committee co-ordinates and supports meetings and other continuing professional development (CPD) anaesthesia events, particularly the NZ Anaesthesia Annual Scientific Meeting, on behalf of the NZNC and the NZSA. These two organisations take turns to nominate a new chair every 2 years. The current NZNC nominated Chair is Dr Kerry Gunn and the Chair-elect is Dr Graham Roper who will be the NZSA nominated Chair for the next 2 years when his appointment is ratified in November. Previous Chairs have been Drs Ross Kennedy, Don Mackie, Brian Lewer, and Ted Hughes.

Applications for the BWT Ritchie Scholarships and for Visiting Lectureship nominations close on 31 October 2013.

Dr Rick Acland - Reflections on My Career in Anaesthesia

Dr Orderly: What Anaesthetists can do when they retire.

Approximately 36 years ago I embarked on my anaesthetic training. I had done a house surgeon run in Christchurch, went solo after 2 weeks, and thinking this was for me, was encouraged by Chris Evans and Gerald Moss (in particular) to consider an anaesthetic career.

One of my first cases as a registrar in Christchurch in 1978 developed severe halothane hepatitis. John Gibbs presented the case at a hospital clinical meeting stating that the incidence was equivalent to one case of halothane anaphylaxis in the practicing lifetime of an anaesthetist; well, at least I got mine out of the way early on!

I did seem to get my share of anaphylaxis; the most memorable being to thiopentone at caesarian section, whilst training as a registrar at Middlemore Hospital. By sheer coincidence I was doing the teaching presentation that very evening on the management of anaphylaxis (the mother and baby survived!).

Middlemore also presented me with a case I shall never forget; a laparotomy for unexplained diarrhoea which subsequently turned out to be a case of thyrotoxicosis. Apart from uncontrollable hypertension and sweating, the red rubber ETT cuff herniated over the end and created huge inflation pressures; a case totally out of my control and sadly the patient succumbed weeks later in thyroid storm!

Handcycle wheelchair for the retired anaesthetist who has plenty of time on his hands

In 1978, as a first year registrar, I attended the NZSA ASM, held at the Rutherford Hotel in Nelson: a memorable meeting. The guest speaker was the urbane Dr Pollard from Sydney. I was introduced to the Auckland 'Powerhouse'; Tony Newson gave a presentation on 'Units of Measure' (why should I remember that?!), new boy David Rawlings presented on thoracic epidurals (a really big deal), and Dr (Jack) Watt was a towering presence amidst a lovely mix of GP and specialist anaesthetists.

I had had a very fulfilling career at the new North Shore Hospital (I arrived when it opened on 1 April 1984, also the day the road toll ceased on the bridge). I was on the staff for 10 years. We had a happy team, not only in the department, but also in private, setting up Anaesthesia Associates (thank you Christchurch for the name) and working along side some incredibly diligent North Shore GP anaesthetists. I am forever grateful to Bob Boas for giving me wise counsel throughout these times, not least in managing difficult pain patients.

One of my big anaesthetic moments in that decade was sighting oximetry for the first time; August 1986 to be precise. NZ Oxygen and Gas introduced the Ohmeda portable oximeter at $10,000; a steal! I decided that I had to have it, so I bought the first one in New Zealand. I well remember my colleagues being astounded that someone would waste so much money on such a gimmick. Sure, from that moment with the advent of microprocessors, the price gradually declined (Balclutha Hospital bought the second oximeter). The rest is history. I never regretted my purchase, at least it was tax deductible and in those days the rate was hovering at 60%.

In the 20 odd years that I was in anaesthesia, I was privileged to witness many amazing changes: the introduction of all those new induction agents, non depolarising relaxants, inhalational agents, analgesics, the combination monitor, the LMA (Archie Brain, you gem!) and the demise of reusable items.

In 1998, on my retirement, I was given a fond farewell by the Christchurch anaesthetic technicians. In my watch as Clinical Director their numbers had increased exponentially. I was a great supporter of their role in the operating suite, however it does concern me that they seem to have a limited career pathway.

I ceased anaesthesia at the end of 2000. Why? I became quite involved in the Burwood Spinal Unit, soon after I had moved back to Christchurch in 1995; anaesthetising for the spinal fixations and upper limb tendon transfer work, and consulting in pain. I was invited to come and work in rehabilitation and I thought why not, interesting challenge!

Anaesthesia teaches doctors to appreciate the functional limitations of patients. For me the transition to rehabilitation, where one attempts to maximise function, seemed reasonably straightforward.

Anaesthesia remains risk averse: balancing risk is challenging, as we strive for best outcomes. I am concerned that ICU and Pain seem to be no longer part of the career packages of the modern day anaesthetist.

I now revel in neuromodulation (Spinal Cord Stimulation and Intrathecal Baclofen Therapy) and travel in the upper North Island doing spinal clinics.

I also enjoy the challenges of being on the Medical Council (thank you for your votes). I think I may have been the first 'anaesthetist' elected on to Council. Of course there are many anaesthetists whom we hold in high regard for their political roles; in particular Bill Pryor, Grahame Sharpe and Alan Merry in his important role as chairman of the Quality and Safety Commission.

I have never regretted my decision to 'do anaesthetics". I have always appreciated its facilitative role in surgery. I now enjoy the challenges of my redirected career. The big question now is: when do you retire?!

Rick Acland
Rehabilitation Consultant
Clinical Senior Lecturer
Christchurch

Did you know that:

In 1986 a portable pulse oximeter cost $10,000.

76,000 hospitals worldwide lack these life-saving machines.

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From the Archives ~ Forty Years Ago!

The August 1973 Newsletter contained 56 pages, beginning with Pen Brown's Editorial, "Safe Dental Anaesthesia and Sedation". This gave a brief history of dental anaesthesia and described the Society for the Advancement of Anaesthesia in Dentistry (SAAD) which was founded in 1958 in England. A New Zealand Society for the Study of Anaesthesia in Dentistry (NZSSAD) began in 1961 to encourage and improve dental anaesthesia in this country. Newer agents were then described as were hazards and complications, including arrhythmias. Sedation rather than anaesthesia was also discussed.

Articles entitled Piped entonox for dental anaesthesia (JC Barrett), Entonox for anaesthesia in dental surgery (GA Moss), Developments in dental anaesthesia in Britain (WN Rollason, visiting lecturer), Diazepam and fentanyl (in conservative dentistry, JG Horton), Methoxyflurane (in operative dentistry, NKF Harris), Dr Prys-Roberts on althesin, the patient at risk (JI Clayton), Drugs: use and abuse in patient management (DH McClymont), Cardiorespiratory responses to intravenous diazepam in the dental chair (RA Boas), Fentanyl in oral surgery (Z Isenberg), Intravenous techniques - what do you tell your patients? (P Armstrong) and Althesin in the dental chair (JB Warren).

The Correspondence section continued the dental theme: NZ Society for the study of anaesthesia in dentistry (NA Ross), Sedation in dentistry (D Bambery), Anaesthesia in dental rooms (NA Ross) and Ketamine in dental procedures for children (RM Fergusson). There was also an article on Epiglottic cysts in adults (JB Lauritz and AF Cameron), a short description of the Meditek dental anaesthetic machine, notices on the VI World Congress of Anaesthesiologists to be held in Mexico City in April 1976, and audio-digest tapes on anaesthesia, sponsored by the Anson Memorial Foundation (WJ Watt).

Society News included reports from Auckland and Wellington (this included highlights from Dr C Prys-Roberts' visit from Oxford). The Faculty of Anaesthetists gave notice of the ASM (with its programme) to be held in Christchurch in September, and a new film was reviewed, "Blepharoplasty and rhytidectomy under hypotensive anaesthesia". There were the usual advertisements.

Also listed were anaesthesia articles in the New Zealand Medical Journal and the New Zealand Dental Journal of 1973 also contained a few of interest. They were:

Barclay JK. A survey of dental extractions in New Zealand. 69, 261-271.

Macalister AD. Adverse drug reactions and local anaesthesia. 69, 31-34.

Newcomb GM. Contra-indications to the use of catecholamine vaso-constrictors in dental local analgesics. 69, 25-30.

There were book reviews:

Allen GD, Everett GB, Meyer RA, Tolas AG. Dental anaesthesia and analgesia. 69, 133-134 (by PH Caldwell), and Whitehead FI, Local anaesthesia in dentistry. 69, 221-222 (by AD Macalister).

So the August 1973 issue of New Zealand Anaesthesia covered a vast field of dental anaesthesia, which perhaps our local journals had neglected in the past.

Dr Basil Hutchinson

Life member

The Dunedin ASM – historical perspectives

In our Society book, *Safety Through Knowledge*, it appears that the first AGM of the Society held in Dunedin was in 1955, but that was not a Conference. In those early days, the AGM tended to be held at the centre where the Executive resided, and those office bearers (and their city) changed every two years. Most Scientific Meetings were North Island and South Island meetings, held in Wairakei and Timaru, respectively, until about 1974. These were the half-way points in each island for car travel!

Dr Tony Newson brought us into the modern age with the first all-New Zealand conference (apart from our 21st Anniversary in Wellington in 1969) held in Auckland in 1974. This was the start of the CANZ Meetings, though that title took a couple of years to get going.

So the first CANZ Meeting held in Dunedin was in 1980, followed by another in 1992 and the 50th Jubilee Meeting was in Dunedin in 1998.

But perhaps the most important fact about the NZSA and Dunedin is that at the 1946 BMA Conference in Auckland, when the Section of Anaesthesia was revived (post-war), there was a definite proposal to form a New Zealand Society of Anaesthetists and Drs Eric Anson (Auckland), Alf Slater (Wellington), Tim Taylor (Christchurch) and John Ritchie (Dunedin) began preparations for this. During 1947, local societies were formed in Wellington and Christchurch, and at the BMA Conference in 1948 in Dunedin, a meeting was held and it was agreed to set up the "New Zealand Society of Anaesthetists", and officers were appointed (Dr Anson - President). So Dunedin is really where the NZSA was born! (in 1948). The first Newsletter was sent out that year.

Dr Basil Hutchinson
Life member

Dunedin 2013

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Carbon Dioxide Formation and Elimination – Another Perspective

Anaesthetists have a special interest in carbon dioxide – we spend much of our time contemplating its formation and dissolution in the body and in observing its appearance as a gas. Small wonder then that some of us are fascinated by CO2 when it appears elsewhere, and what better example than in the production of champagne.

The 'unique' feature of champagne is the addition of sugar to a wine that has already undergone the primary conversion of grape sugars to alcohol and carbon dioxide to initiate a secondary fermentation which, 'contained' in a bottle, causes the gas to remain under pressure in solution.

The appearance of bubbles during primary fermentation has been recognised for hundreds of years. However, the first description of the gas being contained until the wine was drunk did not appear in south western France until 1531. Some believe the 'Blanquette de Limoux' produced by Benedictine monks in the abbey of St Hilaire near Carcasonne was simply the result of storing the wine in tightly sealed casks before the primary fermentation was complete. The earliest recognition of effervescence in wines from Champagne probably occurred when they were sent incompletely fermented to England, bottled during the winter and with the coming of spring the primary fermentation began again. The first clear written description of adding more sugar to a fermented wine to reinitiate fermentation and make the wine more 'brisk and sparkling' appeared in 1662 in the transactions of the fledgling Royal Society. On17 December of that year a physician, Dr Christopher Merret, presented a paper entitled *'Some Observations concerning the Ordering of Wines'.*

Oddly another of Dr Merret's interests was glass manufacture which was a critical second component in the development of bottle fermentation. In the first half of the seventeenth century England rapidly moved from the use of charcoal to coal, in part to conserve its oak forests. The higher temperatures in coal furnaces, along with 'experimentation' on the components of the glass resulted in bottles that were heavier and stronger than any produced in France. A third component was English vintners' rediscovery of cork as a bottle closure – although it was used widely in the classical world, by the sixteenth century bottles had 'reverted' to being sealed by devices such as cloth wrapped wooden plugs which were unable to contain gas under pressure.

At first the French could not understand the English attraction to bottle fermented bubbling wine drunk from shallow glasses but eventually the taste spread to mainland Europe and the Champenoise began work on producing sparkling wine with less risk of exploding bottles or shooting corks demolishing their cellar stocks! Most famously, at the Abbey de Hautvillers, Dom Perignon changed tack and instead of trying to halt fermentation in his bottled wines he began development of what has now become known as the 'méthode champenoise'.

So what is it about the bubbles in bottle fermented wines? For a sensualist there is the visual appeal of long strings of fine, flavour laden, bubbles swirling to the surface to erupt, tickle the nose and tongue and gratify the olfactory senses….. For scientists such as ourselves the evolution and fate of the bubbles is equally fascinating. Research by Dr Liger-Belair at the University of Reims (where else??) has shown that when a bottle of champagne containing dissolved CO2 with a partial pressure in excess of 500kPa (equating to 5 litres at STP) is poured into a glass it begins to diffuse into bubbles of air greater than 2 microns in size trapped inside any cellulose fibres left in a champagne glass after it has been dried. When the expanded bubble reaches an average of 25 microns diameter it becomes buoyant enough that it detaches and begins to ascend in the glass leaving behind another micro bubble which once again serves as a 'nucleation site' for the dissolved CO2. During their ascent the bubbles expand to almost a millimeter in size, gather up aromatic molecules from the depths of the glass and cause motion within the fluid. Within 100 microseconds of reaching the surface the bubble's exposed surface thins and ruptures causing its side walls to collapse in, hit the bottom of the collapsing bubble and droplets to be propelled a few centimeters above the surface at a speed of several metres per second. In the process the surfactant compounds carried up on the bubbles accumulate on the champagne's surface and promote greater retention of bubbles in an uncollapsed state. For serious drinkers the champagne flutes with a number of laser etched dimples (ideally about 20) on the bottom of the glass are spotlessly cleaned to eliminate cellulose fibres. A central column of bubbles arising from these nucleation sites produces stable vortices within the flute which circulate the wine and provide a near perfect visual and olfactory experience.

Needless to say the unique characteristics of different types of bubbling wine such as cremant, cava, prosecco and sekt are influenced by the mode of production and partial pressure of CO2, viscosity and solutes (especially surfactants). However, other than bubbles what they all have in common with champagne is alcohol – which takes us from physics to pharmacology.

Folklore would have us believe that champagne and other carbonated alcoholic beverages are associated with more rapid uptake of the alcohol into the blood stream. Socially, such drinks are more often consumed before meals and without the presence of food in the stomach to slow transit time into the small bowel. However, when controlling for such factors, drinking 'degassed' champagne nevertheless results in significantly slower alcohol uptake albeit with significant inter individual variation. The most likely explanation is an increase in the rate of gastric emptying due to pressure exerted by ingested gas.

So anyone caught dropping a sugar cube into a champagne coupe they believe was modelled on Marie Antoinette's breasts may not be a decadent sensualist – they're just inducing efficient decarbonation and attempting to ingest carbohydrate with their alcohol…….

Dr Malcolm Futter

Consultant Anaesthetist

Auckland

New Zealand Business Struggles to Identify Drivers of Growth

New Zealand businesses seem as confused as a losing All Black coach when it comes to identifying factors that would dramatically drive their business forward, according to the recent Grant Thornton International Business Report (IBR).

When asked in the survey "what is the one thing that would dramatically drive their business forward in 2013", the expected responses were the current topical issues such as an improvement in the exchange rate, skilled staff, technology improvements or research and development incentives. Instead, Greg Thompson, partner, Grant Thornton New Zealand, said that the staggering fact was that there was no consensus as to what makes a difference. Only 'More Capital' and 'A Tax Break' garnered 8% support for a solution, with all other suggestions receiving less than 5%, and 74% of the respondents picking "some other factor" rather than those suggested.

"What this really indicates is a country without direction when it comes to building a stronger economy, with businesses' views being extremely varied. It would appear we are going round in circles rather than forward.

"What is drastically needed is strong leadership to define actions that will make a difference, and then make that happen. This is probably a job that should fall to the Government as the one organisation in New Zealand than can galvanise a wide group.

"There was some hope that the last Budget would give that clear direction, but this was not the case. With next year being an election year, there is little chance of improvement in this area.

"For the sake of New Zealand's prosperity and future, leadership and direction has become the number one priority. If the All Blacks were as confused and rudderless as New Zealand business, change would occur quickly.

"Unfortunately, New Zealanders take their rugby far more seriously than business, otherwise the rudder would now be fixed," he said.

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Notes to editors:

Opinions expressed in this column are general in nature and are not intended as a recommendation or guidance to any individuals in relation to structuring their tax or finances. Readers should not rely on these opinions and should always seek independent professional advice specific to an individual's circumstances.

Trauma Insurance ~ Under The Microscope

Known by many names in the Life Insurance industry, such as Trauma, Critical Conditions or Living Assurance and various depths and breadths of cover, this benefit provides the Life Insured with a lump sum payment when diagnosed with a specified illness, injury or condition.

What does it all really mean, and are you receiving the policy benefits that best suit your needs?

- This benefit provides you with a lump sum payment of your chosen sum insured. The payment can be used for whatever you wish - such as specialised medical treatment, covering leave without pay for you and/or your family support, reducing/clearing mortgages, taking a family 'recuperation' holiday or knocking things off your bucket list. When you're trying to recover from a serious illness, the last thing you need is financial stress and worries.
- All policies are not alike. It's important to read your policy wording and see what illnesses and conditions are covered, and what limitations could apply.
- Trauma insurance can be sold as a stand alone cover, or attached to a Life Insurance policy. If cover is 'accelerated', which means it's attached to your life cover, the life insurance sum insured reduces by the amount of your Trauma claim. To ensure you maintain the level of Life Insurance cover you need, talk to your Insurer or Adviser about 'Stand Alone' cover.
- Did you know that some insurers provide a benefit that allows you to reinstate your Trauma cover 12 months after a claim is paid?
- Some policies provide an advanced percentage of the sum insured, at the initial stages of diagnosis, for instance you could receive 10% of your sum insured if a melanoma is under the Grade 3 limit that would trigger the full trauma benefit payment.
- Your chosen sum insured can stay the same, or increase with a CPI adjustment each year.
- And did you know you can also protect your children, with a specialised Children's Trauma cover, providing you with a lump sum payment to enable you to be with your child during their recuperation and cover the associated costs as needed. Cover can be transferred to an adult policy, with no further medical evidence.

If this has made you think about your insurance covers, and it's been awhile since you reviewed them fully, contact BNZ Partners to talk with one of our Life Insurance Managers, to give you comprehensive advice and recommendations on all your insurance needs.

Arlene Oliver
Life Insurance Sales Manager
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August 2013 | Issue 35

We Thank All of Our Contributors For Their Stories

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These rates are subject to review for the 2014 year.

All of the above include complimentary advertising for a limited period in NZSA's online Ezine members' newsletter.

Publication dates in 2013/14

The copy due dates for publication of advertisements and articles in *New Zealand Anaesthesia* and the online membership newsletter, the *Ezine* are as follows:

New Zealand Anaesthesia

2013

Copy due by	Published in
15 Nov	December

2014

Copy due by	Published in
14 Feb	March
2 May	May
25 Jul	August
14 Nov	December

Ezine

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