‘Gassing’ with Mercy Ships

Dr Tony Diprose spends 17 days working on board the Africa Mercy hospital vessel

Fit for Surgery – Fit for Life
A new, innovative programme to improve perioperative patient care and safety

PLUS:

Meet Dr Kerry Holmes
Paediatric anaesthesia network
Charting and hospital certification
Second Seal Technology
The elongated cuff facilitates the upper esophageal seal.

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The only laryngeal mask that combines a pharyngeal chamber and dual gastric drainage channels, designed specifically to channel gastric content away from the airway.

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The airway tube and cuff are 100% silicone, phthalate free and designed to conform to the anatomy. Silicone cuffs have been shown to reduce risk of sore throat\(^1\) and achieve higher seal pressures.\(^2\)

Cuff Pilot Technology
An integrated cuff pressure indicator for single use airway management devices that enables continuous cuff pressure monitoring at a glance and facilitates easy, accurate adjustment when necessary.\(^3\)

References:

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Contributions and feedback

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

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It’s hard to believe it’s already December. The year seems to have gone quickly and it’s fair to say it’s been a momentous one for the Society; we have seen a continued increase in NZSA membership, we hosted two forums to update members on key issues, we produced a comprehensive Health and Safety resource to assist our members to comply with the new legislation, and we have rebranded the Society. I trust that you like our new look magazine and the other resources we have updated, such as our E-Newsletter and social media platforms.

Earlier this year, I had the privilege of representing you at the Common Interest Group (CIG) meeting, hosted by the Australian Society of Anaesthetists.

Once again, despite our small size, the other members of the CIG made the NZSA feel most welcome and valued. While there are geographical and cultural differences, our organisations share many common issues, which we are grappling with including:

- Workforce and task substitution
- Electronic records
- Revalidation, and
- Member welfare and wellbeing.

The theme of value proposition was a recurring one in our discussions on these issues, and resonated strongly with me. Why is Britain exiting the EU? Because 51% of Britons did not believe it brought them value. I suspect that value proposition is a global phenomenon right now and we need to avoid it becoming too clichéd. However, it behoves us to apply this principle to our daily activities, whether in public or private, as medical practitioners and anaesthetists, and as an organisation which represents our specialty.

Value proposition is not a new concept. Anaesthetists and anaesthetic departments have been adding value to hospitals since 1846. Anaesthetists have been leaders in safety and quality improvements. Not only have we held portfolios within our departments but hospital wide, both in public and private. What may have changed is the need for us to quantitate our value to others. This concept has become particularly relevant to our US colleagues with the potential for independent practice by nurse anaesthetists, known in the US as Certified Registered Nurse Anaesthetists (CRNAs). It is hard to quantitate the increase in value a medical practitioner brings to the table. If we look at the CRNA advertising, there is no added value in paying for an anaesthesiologist. Anecdotally, there are many examples to the contrary. The recently appointed President of the American Society of Anesthesiologists Jeff Plagenhoef speaks to this view clearly and passionately.

Michael Porter, a Harvard Professor of Economics, advocates a very sophisticated value measure but this involves data collection and analysis which I suspect will not be available in New Zealand or probably anywhere, for some time.

The CanMEDs physician competency framework provides a comprehensive template to audit our value proposition but it’s exhausting and highly unlikely that many practitioners are experts in all the stipulated competencies. It is however worth referring to from time to time. (www.CanMEDS 2015 Framework_EN_Reduced.pdf)

What is the value proposition of the NZSA? Like Professor Porter’s value measure I think this is multi-tiered.

The NZSA’s historical publication “Safety Through Knowledge” provides an excellent overview of our Society’s original aims and value proposition:

- To improve the status of anaesthesia in NZ
- To promote education in anaesthesia
- To facilitate the exchange of ideas between anaesthetists
- To encourage research into questions pertaining to anaesthesia
- To encourage the publication of articles on anaesthesia.
We have modified these only slightly almost 70 years on as they remain highly relevant to what our role and value are:

1. **Advocacy:** The NZSA can bring a distinctly New Zealand outlook to advocacy. We collaborate with the National Committee of the College and discuss differing viewpoints if necessary. The items this year included comment on the Medicines Act review, funding for Malignant Hyperthermia testing, and the Maternal Clinical Information System.

2. **Education:** Organising meetings and other educational events is a constant background rumble for us. Keeping in touch with organising committees and all the various bodies that run educational activities is critical. The NZAEC is the prime mover for this.

3. **Sustainability:** Sustainability is very important and dependent on strong membership – without a high membership the purpose and voice of the Society would be significantly diminished.

4. **Representation:** This ties in well with advocacy. I hope our Link Person Network will enable increased communication amongst our anaesthetic community.

5. **Welfare:** This was not explicitly stated in the NZSA’s original purpose but has become increasingly important. Mental health issues are very close to home for many of us in the anaesthetic community. This issue has also been discussed at the CIG meetings I have attended. The ASMS report on the high levels of burnout among senior medical officers reinforced how widespread the problem is, and highlighted the potential effects on doctors’ wellbeing, as well as the risk of undermining the safety and quality care of our patients. The NZSA supports the Welfare Special Interest Group but our activities in relation to welfare are limited. The Association of Anaesthetists of Great Britain and Ireland has a mentoring scheme, which is well utilised and very successful. I am interested in members’ thoughts as to whether the NZSA needs to be more strongly involved in welfare issues, and if so, what can we be doing.

“I am interested in members’ thoughts as to whether the NZSA needs to be more strongly involved in welfare issues, and if so, what can we be doing.”

Working collaboratively with our stakeholder organisations, and combining our resources and knowledge, will strengthen our ability to progress the issues to enhance the professional and personal wellbeing of our specialty.

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**Acknowledgements**

I am very grateful to our President Elect Kathryn Hagen who has represented the Society at the Combined Scientific Congress in Melbourne, and at both the ASA and ANZCA Council meetings in September. Kathryn is a very strong advocate for the Society and I have greatly appreciated her support throughout the year.

I would like to acknowledge Dr Ted Hughes, our former NZSA President, who has resigned after 11 years of service to the committee. The contribution that Ted made over the years has been considerable, and we appreciate his commitment to stay on as an NZSA Link Person.

I would also like to thank Drs Tomas Goscinski and Kate Romeril for their time on the NZSA Executive and wish them well in their future endeavours.

Finally, thanks to our hard working and dedicated Executive for what has been a very successful year, our CEO Renu Borst, and the rest of the NZSA office staff.

Our President welcomes your comments. Please email president@anaesthesia.nz

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**Seasons greetings**

I wish all our members a wonderful holiday season and look forward to continuing to represent the NZSA and our specialty in 2017.

The NZSA office will close on 23 December 2016 and reopen on 4 January 2017.
NZSA news

New Executive Committee members

We have welcomed four new members to our Executive Committee – Dr Gareth Harris from Nelson, Dr Ian Williams from Christchurch, and Drs Nick Lightfoot and John Burnett, both from Auckland. We appreciate their enthusiasm and commitment to help the NZSA with its work and look forward to profiling them in future issues of New Zealand Anaesthesia.

Advocacy

The NZSA has filed the submissions below since July this year. All our submissions can be read on our website.

- Increasing rates of deceased organ donation (Ministry of Health, July 2016)
- Feedback on additional medical device categories (PHARMAC, Sept 2016)
- Feedback on tramadol hydrochloride oral solution in DHB hospitals (PHARMAC, Oct 2016)

Health and Safety resource

The NZSA health and safety resource was developed earlier this year to help members comply with the revised health and safety legislation, whether working in public or private practice. A reminder to members that this resource is a member only benefit and can be found on our website homepage. You must log in to access this. Please note that this is a living document and regularly updated.

Medicines Act update

A new regulatory regime to regulate all therapeutic products - the Therapeutic Products Bill - is being developed by the Ministry of Health to replace the Medicines Act. The new regime will include medical devices and cell and tissue therapies which are currently not fully regulated in New Zealand. It is proposed that controls on prescribing authority will sit under the Health Practitioners Competence Assurance Act 2003 and that the Act be amended to include mechanisms for the prescribing authority to be part of a health practitioner’s scope of practice which would be determined by the relevant regulatory authority.

Consultation on the Exposure Draft of the Bill was anticipated in 2016 but owing to the large scale of this project and detail required, MOH has advised that consultation will now occur in 2017. Ahead of formal consultation next year, engagement with stakeholders continues to inform the work. The NZSA will be making a submission and will seek members’ input to develop its draft. The Government aims to pass the new Bill in 2017.
The NZSA’s biennial cocktail function, at the Art Exhibitions Gallery of Fine Art in Wellington, was a wonderful opportunity to host our stakeholders and the breadth of attendees reflected the Society’s strong relationships to advance anaesthesia and patient care. Stakeholders included the NZ Medical Association, ANZCA NZNC, the NZ Private Surgical Hospitals Association, the Medical Council of New Zealand, ACC and the NZ Anaesthetic Technicians Society. We formally launched our new brand on the night and thanked members and stakeholders for their input. In his speech NZSA President Dr David Kibblewhite outlined key advocacy issues and thanked our stakeholders, executive and staff for their dedication and hard work over the year. He emphasised the need to continue to work together in partnership to enhance healthcare. “In a time when our health sector, and the needs and expectations of our patients are changing so rapidly, there are great challenges but also opportunities, and a collective commitment is essential in our endeavours.”
From left: New Zealand Anaesthetic Technicians’ Society (NZATS) Outgoing Registration Exam Coordinator Nicola Smith-Guerin and NZATS Chairperson Angela Dewhirst.

From left: NZMA Manager Policy and Stakeholder Relations Dr Sanji Gunasekara, NZMA Operations Manager Anna Phipps, ANZCA NZNC Communications Manager Susan Ewart and NZSA Communications Manager Daphne Atkinson.

From left: Health Funds Association Executive Director Roger Styles and New Zealand Medical Association CEO Lesley Clarke.

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NZSA Private Practice Committee Chair Dr Mark Featherston writes that it’s in the interests of patients and our specialty, to educate patients and funders on the value that anaesthetists contribute to healthcare.

When I first embarked into the world of private practice, a senior and respected colleague told me it was important to understand that there would be “rough and smooth.” Not surprisingly after 10 years of part-time private practice I have a better understanding of what he means.

There is a great deal of satisfaction to be gained from working regularly with the same surgeons, nurses and anaesthetic technicians, in a familiar environment with a reasonably predictable work schedule. Early on you realise that you are providing a service and that patients do not come to you to be anaesthetised, rather they seek out a surgeon for a procedure and assume the anaesthesia will occur with the surgery. In the typical private hospital provision of surgical procedures is the economic driver; if the anaesthetist is away another must be found, however if the surgeon is away there does not seem to be the same imperative to find a surgeon to fill the gap.

At the NZSA’s private practice forum held in Auckland earlier this year and the condensed version of our forum presented at AQUA, presentations on the rules around negotiating fees for anaesthesia services generated much interest from attendees. Essentially, the vast majority of anaesthetists in private practice are independent contractors in competition with each other and as such cannot collectively negotiate or set fees for services. This behaviour is deemed anti-competitive and falls foul of the Commerce Commission. There is a significant imbalance of power where funders of the services, through the surgical hospitals, can effectively present a schedule of fees on a take it or leave it basis which means the individual contractor has few options. The Commerce Commission website has a useful page spelling out this situation, which explains why District Health Boards and ACC are exempt from anti-competitive rules.

Rather than get into conflict with the funders over the rules and landscape that exists, I think in the interests of patients and ourselves we are better served if we inform and educate patients and funders of the value that anaesthetists provide.

The NZSA promotes the broad, diverse role and value of anaesthetists and meets regularly with the Health Minister, ACC, and the NZ Private Surgical Hospitals Association to advocate for patient safety and quality care. The NZSA is a membership based organisation and its effectiveness is based on the number of financial members and the activities of our members. Successful advocacy depends on not only the NZSA’s advocacy however but the actions of NZSA members. It is important that individual anaesthetists make the effort to engage with hospital management and establish how fees are determined, and to enlighten them on the amount of work that goes on behind the scenes to ensure the smooth running and safe delivery of surgical procedures. The efforts at an individual and Society level will help to raise awareness about the role of anaesthetists in advancing patient care and health outcomes.

**RELATIVE VALUE GUIDE (RVG)**

The NZSA RVG 2015 provides guidance to assist NZSA members who work, or are considering working, in private practice.

Available on our website home page www.anaesthesia.nz under the Resources Tab. You’ll need to log in as it is a NZSA member only benefit.

*Developed by the NZSA Private Practice Sub Committee and the RVG Working Group*
As I write this article the Resident Doctors’ Association (RDA) remains at odds with the District Health Boards regarding contract negotiations. Issues of fatigue and safe rostering have made the headlines as junior doctors talk of struggling with 12-day stretches and seven-night runs. For me, as an anaesthetic trainee nearing provisional fellowship, deciding whether to take part in industrial action was not easy.

I consider myself fortunate to train in New Zealand departments which recognise the importance of trainee welfare and acknowledge that fatigue can be dangerous. Anaesthetic rosters for trainees are by no means easy but they are appropriate. Thankfully, I have not had to endure 36-hour plus stretches on-call like my Irish counterparts or my surgical colleagues. While nightshifts and long days do take their toll, my personal view is that a reduction in working hours as an anaesthetic trainee would limit clinical exposure and add to the years in training. I still feel “under-cooked” in some areas in terms of volume of practice.

Despite my personal experience I decided it was important to support my colleagues. Having graduated from medical school in 2006, I no longer know what it is like to work as a house officer and I am removed from the experiences of registrars in other areas of the hospital. For now, I am part of a wider group of junior doctors who consider this an important issue. I have benefitted from the hard work of others and will support the goal of striving to do better for the collective.

The theme of striving for better was apparent at a recent Trainee Summit held by the New Zealand Medical Association’s Doctors-in-Training Committee. Trainees from all specialties gathered for this daylong event to hear leaders from across the health sector discuss improvements in health systems, innovation and training. The audience was asked to consider how global “mega-trends” such as the rise of the consumer, big-data and artificial intelligence technology will impact on healthcare in the coming decades. Whilst I was pleased to hear artificial intelligence is currently making less inroads in anaesthesia than radiology, my key takeaway was to remain adaptable and look for opportunities to constructively incorporate these trends.

A highly relevant issue to vocational training highlighted at the summit was patient consent and the trainee. The tension between how best to care for patients and how best to meet the needs of trainees is not new, but a decision in 2015 by the Health and Disability Commissioner in a loss of sight complication is having ramifications for some surgical trainees. Consultants are now required to explicitly ask patients for consent for a senior trainee to do the operation. Dr Amanda Dalton explores this further in her article on the next page “Consent and Training.” I hope it stimulates some conversation at the water cooler.

Kate Romeril  Trainee Representative

From the archives - forty years ago!

October 1976 saw the third Newsletter for the year and Bill Peskett’s Editorial looked at the pros and cons of routine pre-operative antacids. Interestingly, further on in the journal, was a letter to the editor from Bill Pryor of Christchurch who had experienced patients going into laryngeal spasm after use of antacids!

The major article by Gerald Wong was an account of his visit to China on a doctor and nurses Study Tour. This allowed him to make an assessment of acupuncture anaesthesia which had become a topic of great interest. This was followed by Cost of Agents Used by Anaesthetists, written by Cedric Hoskins. We had been debating this topic, and there were comments by Tony Newson, Basil Hutchinson, Jack Watt and Bill Peskett, particularly relating to cost differences between general and regional anaesthesia, and how costs had changed over the years.

The Educational Section comprised a set of Anaesthetic Multiple Choice Questions (followed by the answers!) and then Society News, which contained the minutes of the Society’s AGM held in Hastings at the time of our local conference in August, and a general report on that meeting. Ted Ward was the able organiser of that conference. There were news reports from the Wellington, Hawkes Bay and Christchurch divisions. The Combined Meeting of the Australian Society of Anaesthetists and NZSA to be held in Christchurch in August 1977 was notified. The NZIG-Medishield Essay Prize for registrars and house surgeons was advertised, and there were the usual anaesthesia advertisements.

Basil Hutchinson  Life Member
A naesthetist Dr Amanda Dalton says that trainees need to learn and gain clinical experience by treating patients, while not subjecting patients to undue risk. But can the tension between learning new skills and safeguarding patient safety be resolved?

We go to work to help our patients. We are conditioned to believe that we can improve their lives and that patients will not suffer because of what we do. This belief comes with a weight of expectation on modern medical practitioners – the expectation that things will go well, that we will not make mistakes, and that complications will not happen. But they do. Nearly every procedure we perform comes with a risk. Somehow trainees are expected to make the transition from novice to expert seamlessly, with no serious harm to our patients along the way. But the fact is that trainees cannot learn without exposing their patients to at least some increased level of risk.

The concept of using patients as our learning tools is so entrenched we might not take the time to consider that a person’s body and life are in our hands. The ethics of using patients as subjects is complex. We are taught to do no harm. But when a partially trained professional performs a procedure while they’re still learning, are we not exposing that patient to a greater level of risk? When a trainee causes a dural puncture while performing their first ever epidural on a woman in labour, are we acting in her best interests by using her as a learning tool?

We justify practising on our patients because there is a clinical need. We need future specialists and trainees are essential to New Zealand’s public health system. Without junior doctors our health service simply cannot function. On that basis, we may accept that plunging a large needle into the back of a patient for their first time is justified because we simply have to learn. This is a form of utilitarianism – the greatest good for the greatest number. It may not be ideal for that individual patient to be a practice run, but using patients as learning tools leads to a better overall healthcare system. But this argument does not assign much weight to the individual rights of our patients. As Immanuel Kant would say, ‘we are using our patients as a means to an end, and not as an end in themselves.’

In June 2015, the Health and Disability Commissioner found a senior trainee in breach of the Code of Health and Disability Services Consumer’s Rights when a patient suffered permanent visual loss due to an adverse event while he was operating. The Commissioner found that the trainee “did not explain sufficiently that he was a trainee and that he would be carrying out the surgery on her, and did not inform her of any increased risks resultant from having such delicate surgery performed by a trainee.” This finding is troubling. The Commissioner has openly acknowledged that when a trainee performs a procedure the patient may be exposed to more risk. This is true, yet there is another problem. If trainees are explicit in informing patients of this added risk can we expect patients to willingly consent to having trainees involved in their care? Perhaps in this case the patient would have declined to have the trainee operate on her if she had clearly understood he was still learning. But how can we expect trainees to master technical skills and become safe medical specialists if patients refuse their involvement? How can we prevent a similar finding against an anaesthesia trainee? This case clearly highlights the tension between promoting and encouraging trainees to learn while also striving to provide patients with the best and safest care possible.

There is no easy solution to this problem. We need to ask how successful we are as a group at enabling trainees to learn potentially harmful procedures without subjecting our patients to undue risk. Increasingly our training programme seeks to evaluate the procedures being performed and to what standard, and yet there are no formal guidelines on how we can safely teach trainees. There is no mutual understanding as to when and at what stage it is appropriate for trainees to be performing procedures on patients and when it is not. Trainees sometimes feel unsupported and out of their depth. Sometimes supervisors think carefully about how to teach and under which circumstances and other times there is little thought or planning. Patients are also left in the dark, and while we may assume they understand the implications of seeking care in a teaching hospital, it’s often not the case.

It is easy to focus the discussion on the obvious victim – the patient – and to forget that there is another victim. For trainees, being involved in an adverse event can be devastating. It can have a significant impact on confidence and job satisfaction and lead to a spiral of negative emotions and poor performance.

In striving for a safe, considered and moral approach to teaching we are likely to better achieve our educational objectives, while also making hospitals a safer place for our patients.

Dr Amanda Dalton, originally from Wellington, undertook her anaesthetic training in Melbourne and received her FANZCA in 2015. During her time as an anaesthetic trainee she completed a Masters in Ethics from Monash University. She currently works at Starship Children’s Hospital.
The hospital is well resourced with five operating theatres, a post-anaesthesia care unit or PACU, an intensive care unit with adjoining high dependency unit (with the ability to ventilate post-operative patients), four post-operative wards, full laboratory services including transfusion – you have to love warm, whole blood when the suction bottle has reached the seven-litre mark – and radiology, including CT, ultrasound and plain film. Post-operative physiotherapy and extended-duration hand therapy was available.

From an anaesthetic perspective the theatres had Mindray anaesthetic machines, circle systems with Iso and Sevo volatile agents, oxygen/air mix, end tidal agent monitoring and the capacity for invasive monitoring in selective cases. A range of fibre-optic scopes were available along with C-MAC and Air Trac. Ultrasound was easily accessible for regional anaesthesia. Every theatre had an anaesthetic consultant and trained anaesthetic assistant.

The surgical pathology over my stay was varied, the sub-speciality surgery being dependant on the specialist skills of the surgeon who was onboard the ship at the time. I did plastics lists with lots of burn contracture-release surgery, removal of massive facial neurofibroma, MaxFax cases of ameloblastomas the size of watermelons requiring awake fibre-optic intubation (AFOI), subtotal mandibulectomy and plate reconstruction, lots of hernia repairs, and lumps and bumps. There was a mix of adult and paediatric cases.

There were plenty of times that I wished I had paid more attention during fourth form French classes but translators were readily available throughout the patient journey. Local people were multilingual and one could always communicate with patients in one of their own languages including at induction and emergence.

The surgical wards were a very communal affair. It was common to see a patient for the next day’s list, to ask questions about their past anaesthetic exposure, allergy or surgical pathology only to have those questions answered by the patient in the next bed with advice from visitors across the room. One notable general surgical list had three adjacent patients with four hernias between them. Much discussion ensued as to who had the biggest hernia, the stonemason, the fisherman or the jailer-turned-security assistant.

It has been suggested by some that the reason I went to Cotonou, Benin, West Africa was to avoid the annual, college educationalist update at the Supervisors of Training (SOT) meeting in Wellington. On the contrary, I spent 17 days of my sabbatical from the Hawkes Bay District Health Board (DHB) working in theatre on board the Africa Mercy, a hospital vessel operated by Mercy Ships. The timing of the SOT meeting was a happy coincidence.

Benin, a small West African country between Togo and Nigeria, has severe resource constraints and a population of 10 million with limited access to health care. Mercy Ships will be in Benin for 10 months providing a range of surgical specialities: plastic and general surgery, gynaecology (fistula repairs), ophthalmology, orthopaedics, limited neurosurgery (specifically encephalocele cases), and dental and maxillofacial surgeries.

I found the Mercy Ships set-up to be very welcoming, professional and well equipped. Long before the ship had arrived in the country patients had been screened for suitability.

Initial screening took place in both metropolitan areas and in isolated rural villages with teams from the ship travelling far into the interior. The ship offers elective surgery for only benign disease and only where the course of treatment can be completed over the course of the ship’s stay.

Prior to their arrival on the hospital wards, patients had been checked by an experienced rural Australian GP, who had arranged for their blood tests, ECGs and radiology. Severe hypertensives were postponed and started on treatment. Time had been spent counselling the patients in their own language about what was being offered, and expectations and likely outcomes. Final surgical consent was obtained the night before surgery, often with an inked thumb print.

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The surgical pathology over my stay was varied, the sub-speciality surgery being dependant on the specialist skills of the surgeon who was onboard the ship at the time. I did plastics lists with lots of burn contracture-release surgery, removal of massive facial neurofibroma, MaxFax cases of ameloblastomas the size of watermelons requiring awake fibre-optic intubation (AFOI), subtotal mandibulectomy and plate reconstruction, lots of hernia repairs, and lumps and bumps. There was a mix of adult and paediatric cases.

There were plenty of times that I wished I had paid more attention during fourth form French classes but translators were readily available throughout the patient journey. Local people were multilingual and one could always communicate with patients in one of their own languages including at induction and emergence.

The surgical wards were a very communal affair. It was common to see a patient for the next day’s list, to ask questions about their past anaesthetic exposure, allergy or surgical pathology only to have those questions answered by the patient in the next bed with advice from visitors across the room. One notable general surgical list had three adjacent patients with four hernias between them. Much discussion ensued as to who had the biggest hernia, the stonemason, the fisherman or the jailer-turned-security assistant.
In the end the ward decided the fisherman was the victor given that he was scheduled for a bilateral hernia repair, but no one believed his account of the size of the fish he caught. The stonemason clearly had the toughest hands – mine were pronounced to be like a young girl’s – and the security guard laughed that the very people he was paid to keep in, he was now paid to keep out! It was certainly a unique pre-admission clinic!

With help from Mercy Ships and through contacts with the World Federation of Societies of Anaesthesiologists (WFSA) - thank you Wayne Morriss - I was able to spend two days observing at two local university hospitals. I was made very welcome by the two professors who patiently showed me through their institutions and allowed me access to the theatre complex. In Benin, medicine is a seven-year fee-paying course, and most graduates endeavour to specialise as soon as possible after completing the course.

There is no universal health care; patients pay for medical treatment. Consequently Obstetrics and Gynaecology is the most popular choice given the young population and high birth rate. Specialist training takes four years and during this time the registrars receive no salary for their work.

The anaesthetic workforce statistics reported to me were staggering. Consistent with most of sub-Saharan Africa, Benin, with 10 million people, has 22 medical anaesthetists, and not all of them are in clinical practice. There are 250 nurse anaesthetists who do the bulk of the clinical work. The nurse anaesthetist school in Cotonou has trained 200 of the 250 but has been closed for the last two years.

Part of the role of Mercy Ships in Benin is to assist with medical capacity-building and education, as well as clinical care. Accordingly they are running courses in sterilisation techniques, promoting the WHO Surgical Safety Checklist – which is not widely used – and promoting the need for a surgical count at the end of surgery to ensure all swabs and instruments are accounted for—also not used in the theatres I observed. Local surgeons and anaesthetists also spend time working along expatriate specialists in the theatres on board the Africa Mercy.

While in this environment, as a husband and father it was hard not to wonder what life would be like for my loved ones should the place of their birth have been different. It was a privilege to be able to make a small contribution to the lives of some very vulnerable people.

For more information visit www.mercyships.org.nz
Video link: https://vimeo.com/171768893 The Mercy Ships response to Global Surgical Need (three minutes)
“Little patients traumatised by burns come onto the Mercy Ship so scared and scarred. It’s beautiful how their personalities blossom under the love they receive. They become beautiful little people with new hope of a brighter future.”

Tertius Venter, plastic surgeon.
Meet executive member Kerry Holmes

The Munros above Glen Coe in Scotland

What led you to study anaesthesia?
I realised early on I didn’t enjoy working on the wards, and general practice wasn’t for me. I did my fourth year selective in the Waikato Anaesthetic Department, and enjoyed working with the people there. They looked so in control in situations that looked terrifying to me, and they all had interests outside of medicine. That was enough to nudge me along the path.

How would you describe your training path, and where did you study?
I left Anaesthetics after a year and did some retrieval and aid-type work. Then I got onto the Radiology training scheme, but soon decided that wasn’t for me. I sat the Emergency Medicine Part 1 exam, and did that for a while in Sydney. I made it through to Advanced Training and then realised that I would burn out in that career. I did a run in ICU as part of my Emergency training, and was again impressed with the Anaesthetists there. I moved back to NZ and got back on the scheme in Auckland.

Who/what was most influential during your training?
There have been loads of people that looked terrifying to me, and they all had interests outside of medicine. That was enough to nudge me along the path. I also really enjoy being able to make a material difference to people. This can be as simple as seeing someone in pre-assessment clinic who’s pain is poorly managed. Having the time to listen to them, and tweak things that will make a difference to their life is really satisfying.

What is the most challenging aspect of practising medicine/anaesthesia?
I think you have a lot of self-belief coming out of training and after finishing a fellowship, and that takes a pretty serious dent when, as a Consultant, things don’t go as smoothly as planned.

You did overseas aid work earlier in your career. What were the highlights?
I made it through to Advanced Training and then realised that I would burn out in that career. I did a run in ICU as part of my Emergency training, and was again impressed with the Anaesthetists there. I moved back to NZ and got back on the scheme in Auckland.

What is the most satisfying aspect of your job?
The variety. No two weeks are the same. I also really enjoy being able to make a material difference to people. This can be as simple as seeing someone in pre-assessment clinic who’s pain is poorly managed. Having the time to listen to them, and tweak things that will make a difference to their life is really satisfying.

What would you like to achieve for the Society?
An important role for the NZSA is being able to react quickly to anything that might affect Anaesthetists. This means keeping well versed on many different things, and having input from all over the country. I’d like to maintain our capacity to provide submissions, and give our opinion on issues, while also getting more input from our members.

What career would you have chosen besides medicine?
My application to the School of Music in Wellington to do a BMus was apparently viewed favourably! I played Tenor Sax at college, and was the lead tenor for the NZ High Schools Jazz Band. I thought I might be a famous jazz musician, but looking back that was never going to happen, so I’m glad I got into med school!

What do you like to do outside of work?
Surfing and ocean swimming. I’ve surfed in places as far away as Morocco, the Outer Hebrides and the Shetland Islands, right through Lake Malawi. I also really enjoy walking, and miss the pub walks my wife and I did through the British countryside while we were away on my fellowship in Bristol.

What’s your ideal holiday destination?
Somewhere warm, with a beach and uncrowded waves, and preferably good local food. We had our honeymoon in Vietnam, and that would be up there, as would Hawaii.
The Australian Society of Anaesthetists (ASA) National Scientific Congress (NSC, 17 – 20 September 2016) was a hive of webAIRS activity and many members of the New Zealand Society of Anaesthetists (NZSA) attended this conference in Melbourne.

Medical Director, Dr Martin Culwick, along with colleague, A/Prof Kersi Taraporewalla, hosted two webAIRS workshops. They gave an overview of the capabilities of webAIRS and its usefulness in the clinical setting. On the final day of the congress, a session was dedicated to error reduction strategies and how we can learn from the examination of incidents. In an engaging two hours, chaired by Dr Gregory Deacon, attendees learned about the analysis methodology known as the bowtie diagram, responding to crises and how the human brain responds in a high stress situation such as an unexpected serious operating theatre incident. Dr Culwick closed the session with further evidence of how incident reporting can provide a unique opportunity for learning and practice improvement. There are several webAIRS presentations and workshops planned for conferences in 2017, which will include the NZSA annual scientific meeting in Rotorua, the ANZCA ASM in Brisbane and the ASA NSC in Perth.

webAIRS has now collected more than 4000 incident reports by the hundreds of Anaesthetists registered in the system. Most users choose to connect their registration with a site. This allows for de-identified, local level data to be accessed, displayed and discussed at local M&M meetings – one of webAIRS most useful features in the clinical setting.

Every report submitted to webAIRS is contributing to the process of bi-national quality improvement through data analysis and reporting. In early 2016, ANZTADC formed a Publications Group to oversee the examination of data and subsequent publication of articles. A series of reports derived from the first 4000 incidents is planned for 2017. The analyses will include the four big A’s – awareness, anaphylaxis, aspiration and airway. Mortality data, hypotension and medication errors are also being investigated.

Did you know that reporting in webAIRS earns you two CPD credit points in the practice evaluation category? The end of the triennium for continuing professional development is 31 December 2016. If you are not already registered in webAIRS, and earning CPD points, this is easily done so via link on the webAIRS landing page. There are different registration options for individuals and organisations, be they hospitals, day surgeries or private practices. All reports are de-identified and are a valuable contribution to this important, anaesthesia specific, quality assurance activity.

Need further information about webAIRS?
Follow the links on the home page (www.anztadc.net) to download an information brochure and register online, or contact ANZTADC at anztadc@anzca.edu.au
Audits by the Ministry of Health have highlighted concerns regarding standards for charting anaesthetic drugs. NZSA Executive member Kaye Ottaway outlines the areas of non-compliance, the remedial actions taken, and urges compliance with MOH hospital accreditation requirements.

The standard of drug charting has been one of the focuses of the MOH’s Hospital Accreditation audits this year.

The NZSA was contacted by a Dunedin anaesthetist in April enquiring about the standard of charting for anaesthetic charts. There had been much criticism of the charting of medications, in particular:

1. Failure to use the full name of the drug administered
2. Failure to write the units either in full or at all
3. Failure to chart the time of administration
4. Charting of antibiotic administration especially the time of administration.

Following this audit, further audits in Auckland private facilities highlighted other areas of concern to the Ministry of Health. These included:

1. Standing orders – the format of and the failure to countersign these by the prescriber
2. Anaesthetic charts once again
3. Postoperative charting – failure to write full drug names, units, times of administration, indications and 24-hour drug limits.

I undertook random audits of hand written records at two different hospitals and found that no records fully complied with what the auditors required.

The ANZCA professional document PS06 The Anaesthetic Record. Recommendations on the Recording of an Episode of Anaesthetic Care is a useful resource, as well as the documents recommended in the CPD workbook relating to auditing of anaesthetic records from the RCA.

Electronically generated anaesthetic records do fulfil the auditors’ requirements but standing orders and postoperative medication charting are areas of concern. Whilst there are no standards for anaesthetic charts per se they are considered an administration record.

If the National Medical Chart (NMC) is used, as in the Southern Cross Hospital group, the format is such that, if filled in as per the Medication Charting Standard, charting would comply with the MoH auditors.

This may seem to be a minor issue but one facility was in danger of losing its accreditation due to the number of failures to comply with these standards. This required the following remedial actions:

1. A complete update of the format of standing orders and actions to make sure they were signed
2. Revising the anaesthetic chart to incorporate more pre-printed drug names written in full along with units written in full beside the names
3. Revising the section for antibiotic administration
4. Revising the section for timing of administration of local blocks along with the drugs used
5. Introduction of the Day and Long Stay NMC with education regarding the charting of drugs and access to the Standards.

Allergies and Alerts also need to be completed as do the VTE risks and prophylaxis – hence the alerts on such systems as Safer Sleep. In addition, prescribers need to remember to fill in their name, signature and Medical Council registration number. Auditors, in the past, have allowed lists of regular prescribers to be available in private hospitals but this situation may change in the future.

The ACC also requires that its Lead Providers provide ASA data for their audits. The ASA needs to be completed by anaesthetists either on the electronic record or hand written record.

Please assist the hospitals you are credentialled to work in to comply with the MOH accreditation requirements.
Fit for Surgery - Fit for Life

Anaesthetist Dr Marco Meijer writes about a new, innovative programme to improve perioperative patient care and safety. Engaging with the primary healthcare sector and patients to address the risk factors of obesity for surgery have been key to achieving a ‘culture shift.’

In 2015, a Whanganui DHB surgical team witnessed an event that led us to design a programme to address chronic conditions in the primary healthcare sector before patients are referred for surgery.

A patient had died two days after an uneventful orthopaedic procedure under spinal anaesthetic. Apart from a Body Mass Index (BMI) of more than 40 he was relatively healthy and active, with controlled hypertension but the autopsy diagnosed that a massive myocardial infarction had occurred causing his death.

While we reviewed the case and found several learning points for improvement, I kept asking myself: Why is no-one mentioning his weight? We’re adapting to bigger patients, with better equipment and bigger operating tables but what are we doing to stop society’s worst health threat, the obesity epidemic?

Shortly after this incident, it was World Anaesthesia Day and that year’s theme was Obesity Complicates Anaesthesia so we used this opportunity to further educate our senior medical staff, as well as the public, on the dangers of surgery for obese patients. We hosted a workshop run by Ko Awatea, a health quality improvement initiative, and formed a core group to launch a multi-disciplinary, community-based weight reduction programme, using the principles of co-design which enables consumers to provide input into the design of a programme from the start.

We then began to lay the foundations for the project, which began with a literature search, and looked at various models, mainly from Europe, to model our own. We decided to use our elective hip- and knee joint replacement patients as a trial group for our programme, and mapped the current patient journey from referral to surgery. This was not easy, as patients have several routes to access secondary services (private and public). We wanted to identify all the potential contact points with patients, and understand the patient journey from referral to surgery.

To identify possible stakeholders, we mapped the current funded community projects; several patients who are obese were interviewed to help us establish relationships and to learn from their stories; and data regarding mortality and morbidity for hip and knee joint replacements from the previous year was collected from our hospital database. While the numbers were small, we noted that there were more ICU admissions for obese patients in our sample.

When we began engaging with representatives from primary healthcare, it became apparent that GPs had no information on ‘Fit for Surgery’ guidelines being used by the Anaesthetic Department. Additionally, patients did not have information available in primary healthcare on what it means to be ‘Fit for Surgery’ and why these criteria are important.

We are now developing a patient information booklet to distribute to primary healthcare providers which has detailed information for patients, explaining what ‘Fit for Surgery’ means for them, the importance of managing chronic conditions prior to surgery, and addressing obesity as a risk factor for surgery.

Primary healthcare has adopted an approach using collaborative clinical pathways under the Map of Medicine model and software so it was decided that a ‘Fit for Surgery’ pathway would be established as part of the solution. Weight reduction was incorporated into these guidelines, with a link to a proposed weight reduction programme. Chronic conditions that need to be optimised include hypertension, asthma, atrial fibrillation, diabetes, anaemia and ischaemic heart disease. Our philosophy is that these chronic conditions are better dealt with in primary healthcare before referral to the secondary healthcare sector for surgery. These conditions need time to optimise, and it is often too late when patients are seen in the anaesthetic pre-admission clinics. This leads to cancellations and patients being taken off the waiting lists, which is inefficient, and very disruptive to the patient.

It took several months of hard work, and moments of deep frustration, to reach the point of engagement with the primary healthcare sector. Although it didn’t feel that we’d made much progress, we did succeed in establishing a framework for our weight reduction programme to fit into, which linked the primary and secondary healthcare sectors. Most significantly, we achieved a culture shift. Obesity became a recognised risk factor for any anaesthetic, and anaesthetists and surgeons realised change was needed. We also had buy-in from management which created momentum, and strengthened our negotiations with primary healthcare.

“What are we doing to stop society’s worst health threat, the obesity epidemic?”

“Most significantly, we achieved a culture shift. Obesity became a recognised risk factor for any anaesthetic.”
Challenges in addressing obesity

During the initial discussions with medical staff, we identified the need for greater education amongst health professionals to raise the topic of obesity with patients and a need to improve the integration of the various government-sponsored programmes in the community.

Our next challenge will be to engage with primary healthcare, patients and representatives to understand the various treatment options that are available to help us design a robust, multi-disciplinary, evolving weight management programme. Patients will need to be assessed holistically, and monitored during their weight reduction journey. Our main challenges are integration, follow-up and review of patient progress through the journey, collecting data on the effectiveness of the programme, and creating avenues for feedback so we can continually improve the programme. Patients will be key to this process and co-design will see patients providing guidance on the programme’s structure.

I’m reasonably confident in saying that we are moving toward achieving our goal of establishing holistic, patient-centred evaluation and management of chronic conditions in the community, before patients are referred for surgery in the hospital. Weight management will be an integral part of this process, with a focus on multi-disciplinary, community-based programmes.

Central to our vision is a self-help philosophy that sees patients able to take control of their own health. ‘Fit for Life’ and ‘Fit for Surgery’ when needed. We are confident that this approach will improve patient safety perioperatively.

Dr Marco Meijer is a Consultant Anaesthetist, born in South Africa. He did his Anaesthetics training in Rotterdam, the Netherlands, and arrived in Whanganui eight years ago. He is the current Head of the Anaesthetic Department at Whanganui DHB. He says that he, his wife and two children love New Zealand, and love living in Whanganui. If you would like to send Marco feedback or any comments his email is: marco.meijer@wdhb.org.nz
NZSA President Angela Dewhirst provides an update on recent activities from the Registered Anaesthetic Technician domain.

The Medical Sciences Council (MSC) is reviewing the scope of practice (SOP) for registered anaesthetic technicians. A stakeholder forum was held earlier in the year in Wellington and the context of the Council’s review was explained and the future configuration of our scope was discussed. The potential opportunities and threats to the profession were identified and explored. We did a group brainstorm to review what we may need to change to realise any proposed revisions to our scope. For example, wording such as ‘working in the appropriate team environment’ rather than ‘under the direction of,’ was thought to better reflect our current and future practice. It was a very positive and productive day where many folks from all around the country had the opportunity to share their views and contribute their thoughts. We looked at ways that we could modify our scope to better serve the New Zealand public safely, while also keeping our practitioners engaged. This meeting however was just one in what is a long and involved process to ‘get it right’ with our SOP review.

Representatives from the MSC presented at our NZATS conference in October to update us on where they are up to with this big piece of work. The review is currently in the early stages and there will be an opportunity for practitioners to feedback their feelings to council when the consultation document is sent out. Nothing at this stage is set in concrete and all input will be listened to and valued. I have encouraged the Registered Anaesthetic Technician profession to provide feedback when the opportunity arises.

We were thrilled to receive a good number of entries in both the trainee – Basil Hutchinson Award and the qualified – Medtronic Award this year. The generous prize of $1,000 for each winner was provided by Medtronic NZ. The standard of entries was outstanding. I commend all participants on their fine effort. The winner of the qualified Registered Anaesthetic Technician research prize (Medtronic Award) was Heather Godfrey from Whangarei Hospital with her entry “The Case of the Bubbling Rotameter.” The winner of the trainee Anaesthetic Technician research prize was Laura Jackson from ADHB with her entry “Inter and intra hospital transport of the critically ill patient – a case study, review of the literature and recommendations for Anaesthetic Technicians.”

We are grateful for the continued support of the NZSA sponsoring the Best Anaesthetic Technician Speaker Prizes at this year’s NZATS Conference, which was held at the Ellerslie Events Centre in Auckland. The high standard of presentation from the speakers made this difficult for our three judges but the first prize of $500 was presented to Brenda Knowles and Julie Bromley for their Workshop “What’s your Rhythm.” Second place was awarded to Ian Boxall with his paper, “Automation: The Way Forward. So What’s the Problem?” and in third place with a prize of $100 we had Kaylene Henderson with her presentation on “MOR Sim for Techs and Teams.”

I was privileged to attend a reception at Parliament to celebrate the 20th anniversary of the Code of Health and Disability Services Consumer Rights. Through the speakers’ musings I reflected on the 30+ years since I began working in healthcare and just how far we’ve come. Although a long way from being perfect, we largely work in a culture now where we would feel supported in speaking out if we see an error or injustice. Our patients can feel assured that their healthcare team genuinely has their best interests at heart. The Code arose from the ‘Unfortunate Experiment’ at National Women’s Hospital in the 1980s. The Cartwright Report and its recommendations then followed. So, it was fitting that our retired Governor General Dame Silvia Cartwright was present to share her reflections.
The Paediatric Anaesthesia Network of New Zealand (PANNZ) is a collaborative network of anaesthetists providing anaesthesia care to children in New Zealand. PAAZN Chair Indu Kapoor, from Capital and Coast District Health Board, says that the network believes that communication and cooperation will ultimately help to provide universal high quality anaesthesia services to all children in the country, irrespective of their geographical placement.

The network’s main aim is to establish and maintain two-way collaboration and communication between anaesthetists providing paediatric anaesthesia services within regions, with colleagues in different regions of the country, as well as with Starship. The proposal for a collaborative network was raised by Indu Kapoor in 2014 and the network was formed by the NZSA and the Society of Paediatric Anaesthesia in New Zealand and Australia (SPANZA), following an open forum held at the SPANZA ASM in Auckland in October 2015. The concept of a paediatric network received unanimous support.

A face-to-face meeting followed in Wellington in October 2016, with representatives from 14 DHBs and apologies from three. This meeting approved the terms of reference for PANNZ and confirmed the network’s objectives and governance structure.

The national level governance is coordinated by a National Coordinating Group (NCG) which is made up of a representative (link person) from every DHB, as well as a Private Practice Group representative and representative each from the NZSA and SPANZA.

The NZSA is providing administrative support as well as hosting a PANNZ webpage on the NZSA website (www.anaesthesiasociety.org.nz/about/networks/paediatric-anaesthetic-network-of-new-zealand). You will need to log in to access this page as it is members only.

The network’s terms of reference and the minutes from its last meeting can be found on this webpage. It also contains contact emails for link people as well as a contact email for the whole group.

In addition to collaboration and sharing information, the network will be a conduit for developing other collaboration pathways including regular QA sessions via videoconferencing, a cloud based online community for real time communication, facilitating observer-ships/secondments and peer reviews, advice from special interest groups for high risk/complicated paediatric cases (e.g. paediatric pain, kids with congenital cardiac conditions or syndromes and children with burns) and will provide assistance with quality assurance activities, national level audits and external advocacy.

The network will also organise an annual Paediatric Anaesthesia Update meeting which will rotate through the country. The next update meeting will be held in Wellington on 11 March 2017 and is being supported and co-hosted by SPANZA. The programme for the meeting is on the PANNZ webpage and on the SPANZA website on its home page www.spanza.org.au

We are still waiting to hear from Whanganui, Masterton and Greymouth DHBs. We look forward to them joining the network.

Feedback/more information:
If you would like to discuss the network or want to know more, please contact pannz@anaesthesia.nz or indu.kapoor@ccdhb.org.nz

Universal high quality anaesthesia for children

2017 SPANZA PANNZ Update Meeting
11 March 2017
Wellington Hospital, Newtown, NZ
www.spanza.org.au
The value proposition WITH the patient, not FOR the patient

Carolyn Canfield is an honorary lecturer at the University of British Columbia in the department of family practice. In 2014 she received the Canadian Patient Safety Champion Award. When accepting her award Carolyn said “Participation and activism in healthcare improvement is an act of citizenship.”

Carolyn’s article for New Zealand Anaesthesia is adapted from a talk she gave at the Australian Society of Anaesthetists pre-conference on the Perioperative Surgical Home in Melbourne in September.

In 2010 Michael E Porter and Thomas H Lee advanced a startling expression of the value proposition for healthcare in two linked NEJM articles. Lee wrote, “As is often true in medicine itself, the critical first step is measurement. Provider organisations need to capture data on the outcomes that matter to patients, as well as the costs for a patient over meaningful episodes of care.”

The value proposition can be expressed as:  
Outcomes (Quality + Safety + Satisfaction) 
Value = Cost

To apply such a powerful reformulation with patient defined terms to perioperative assessment would transform improvement along the lines in the BMJ editorial of 14 May 2013, with its compelling cover featuring a militant patient’s raised fist: “Let the Patient Revolution Begin”

…the mission of healthcare requires urgent correction. And how better to do this than to enlist the help of those whom the system is supposed to serve—patients? Far more than clinicians, patients understand the realities of their condition, the impact of disease and its treatment on their lives, and how services could be better designed to help them.

Suddenly it’s apparent that this new value proposition could not remain the domain of clinical leads and operations managers. Benefit and cost is not only reoriented to a patient focus, but it’s individualised. The patient is the only one who can define what matters to him or her, and is also the only one who can assess definitively whether or not that therapeutic goal has been met. Externalities that affect a patient’s perioperative or post-perioperative well-being are now included as costs.

Do we have a mechanism to accomplish that? Let’s follow at least the first few steps of a patient-led collaborative surgical care that supports the new value proposition.

Building the therapeutic relationships of reciprocal trust in the surgical context will span a multitude of interactions and clinicians. Initially however, expertise lies solely with the patient’s capacity to monitor and interpret their own symptoms within self-knowledge from lived experience. The patient may weigh many options on whether to seek further assistance, or not, judging which paths seem prudent, premature, unwarranted, simply unknown or frightening.

At the start, a patient encounters the medical system when life with symptoms is no longer tolerable, or perhaps screening tests indicate that there may be cause for concern. A family practitioner or a specialist may lead in diagnosis and lay out preliminary care options. The episode of care has surely begun, although no surgical treatment may yet have been proposed. At least in retrospect, this is where the clock starts ticking on a perioperative episode of care that has meaning for the patient.

Sensitive and courageous conversations with clinicians may build trust and dispel fear by delineating what’s known and what isn’t, naming rescue and futility, describing “living with” disease, the certainty of eventual mortality, making sense of fears. Effective strategies to avoid over-testing, over-diagnosis and over-treatment are rapidly emerging with a focus always on outcomes that match patient values and preferences. As shared decision-making is deeply respectful of both evidence and patient values, the exchange naturally builds reciprocal trust.

Patient hopes and aspirations may evolve into care goals that direct the entire arc of perioperative planning towards surgery. It is the patient who elects elective surgery, not the surgeon, after all. Following their co-created plan, patients contribute to a likelihood of success in “pre-hab” preparation before surgery.

A perioperative plan oriented to patient-identified recovery goals seems likely to raise plan adherence and convey a sense that clinicians are respected partners more than lofty experts. Self-reportable integrative measures identified in advance by patients might include reading the newspaper, cooking dinner, returning to work. Those workers involved with building trust with patients may experience less burnout as closer ties with patient experiences may validate the rewards of clinical life, earning greater public trust for their institutions.

Porter and Lee have proposed a patient-led formula for care evaluation that could transform perioperative care for patients and practitioners alike. You will know whether what I suggest rings true, or possibly ignites your imagination. Let me know your ideas on how patents can lead the value proposition for better perioperative success and culture transformation.
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Reversal of profound neuromuscular block from rapid sequence induction using rocuronium

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References:

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- Contraindicated e.g. IHD, morbid obesity, COPD
- Partial residual block after conventional reversal
- Unexpectedly difficult airway that cannot be intubated and requires rapid reversal of anaesthesia and neuromuscular block

Adverse Reactions:
- Dysgeusia