“Health care is in the midst of a historic refocusing and clinicians of all types are wondering what their roles will become.” I came across this quote which aptly summarises a number of topics that I have been pondering on as NZSA President.

The quote comes from Lee Fleisher, the University of Pennsylvania’s Department Chair of Anesthesiology and Critical Care. Fleisher’s quote is timely, highlighting evolving changes affecting medical practice around the world.

Confusion and refocusing has been manifest in a number of guises:

- Whether it’s a member questioning the current relevance of the society.
- Whether writing a submission in response to proposed new policies or legislation such as:
  - non-medical professionals, such as dieticians, being able to prescribe
  - discussing the pros and cons of nurse sedation to support the nationwide bowel screening programme planned for 2017
  - or whom is the most appropriate person to be the assistant to the anaesthetist – a nurse or technician.

“How do we ensure a thriving and sustainable profession, bolstered by a thriving and sustainable member society?”

What is our role as doctors and medical anaesthetists? And what is the role of the NZSA? How do we ensure a thriving and sustainable profession, bolstered by a thriving and sustainable member society?

The NZSA has made significant strides in supporting the professional interests of our members, and we have new initiatives and networks which demonstrate our proactive work on your behalf. We have developed a Health and Safety manual (see p.3) to help you comply with new legal requirements. We also hosted a forum in July to update you on a range of topical issues affecting your practice. We brought together speakers to share their knowledge across H & S, e-prescribing, the Commerce Act, ACC changes and assistant to the anaesthetist, and more. This was a valuable opportunity to meet members and openly discuss issues that you would like us to be more engaged in. We thank members for their support of the Society, which in turn enables us to fund an increasing number of activities. You can read more about the diverse work we are doing across different areas, such as private practice (p.4) supporting trainees (p.5), and obstetrics (p.18).

Returning to the issues I have raised relating to changes affecting medical practice and our role, I confess there are times where rather than grapple with these high level concepts I would prefer to be in the pain clinic considering the best way forward for a distressed patient or in the middle of a massive blood transfusion – the cause of which is irrelevant. I was trained to do the latter clinical tasks rather than the former intellectual tasks. I do not feel qualified or trained to be making these calls. Or so I thought, until I sat down to write this column and realised that part of my role as a medical professional is to try and address these issues. In fact, this is embedded in the ANZCA curriculum under the CanMEDs umbrella and in the current climate of rapid change has never been more relevant. It is part of what we do as anaesthetists and as a Society, advocating and championing issues on our members’ behalf.

Looking at the ambiguity of health professionals’ roles there is no shortage of essays and books on this topic. I found the following etiologies:

- The increasing number of women in medicine.
- The increased availability of education, both to patients and postgraduate nurses.
- The computerisation of medical records,
which has spurred increases in the need for physician extenders to support practices.

- Cost-containment considerations.
- The erosion of the doctor as an ultimate authority figure and the rise of patient autonomy.

To summarise, I think it is a mix of history, technology and economics. I recently read Atul Gawande’s book "Being Mortal" which looks at the difficult decisions we and patients need to make as the end of life approaches – I found it an insightful read. He comments on the development of systems we now take for granted such as social security, pensions, hospitals, retirement – all made possible due to both prosperity and technology. However, the driving force of technology has surpassed prosperity meaning that we are struggling to afford the treatments that technology has made possible.

So, to the economics: there is a huge drive to make healthcare affordable and doctors are expensive commodities. So as a policymaker a simple solution is to task substitute, i.e. where we can use less expensive options such as facilitating non-medical prescribing, non-medical endoscopists and non-medical administration of sedative drugs. Therefore, all practitioners are now working more “at the top of their scope.” This statement rolls off the tongue nicely but in reality, and for those of us at the coalface, I am not sure it’s ideal.

What do doctors bring to the table that other health professionals don’t? I have referred to an NZMA document Consensus Statement on the Role of the Doctor:

- Doctors accept their ethical responsibilities to act in the best interests of their patients.
- Doctors work in partnership with patients in the delivery of their healthcare.
- Doctors work effectively as leaders.
- Doctors are advocates for improved population health.
- Doctors have diverse roles, within and outside of the health sector.

There are two big ticket items in my opinion:

1. The buck stops with the doctor. From day one as clinicians we take responsibility for diagnosis, ordering tests, interpreting tests, initiating treatment and planning follow up. We accept responsibility for developing our clinical acumen and judgment. This is not to say we don’t make errors. There is also the occasional bad egg for which we need to take responsibility.

2. Doctors have traditionally enjoyed a special status in society and a high level of trust. We are seen as role models for the general public, in matters of health but also morality.

Anaesthesia has a very strong culture of research and quality improvement. We stand on the shoulders of giants. The current health of our own specialty reflects this.

So with this overview and the quote by Lee Fleisher in mind, what is our future role?

“We need to apply our unique experiences and knowledge, both in intensive care and pain management.”

Fleisher encourages us to “be proactive and forward looking” and to focus on outcomes and efficiency. As a specialty we have excelled in this regard and we should look to how we could (and should) continue into the future. He says our natural tendency will be to hunker down in theatre and focus on performing many high standard procedures. This goes without saying but he also encourages a strong emphasis on perioperative care; so optimising patients’ preoperative experience including their time, need for tests and even the appropriateness of surgery. Current examples include the perioperative surgical home, and ERAS (enhanced recovery after surgery). Likewise, in the postoperative phase we need to apply our unique experiences and knowledge, both in intensive care and pain management. This is interesting as in Australasia we have moved to split these skills into separate specialties. Perhaps we need to reclaim them?

Michael Porter, a Harvard Professor of economics, has turned his attention to “central value,” an overarching concept that matters to patients and would unify all parties. Value is defined as health outcomes per dollar spent. Outcomes are condition specific but multidimensional. He describes a three tiered outcome measures hierarchy tool. However, to determine value a rigorous and disciplined system of measurement is required. So we come back to the same old issues:

- Increasing demand
- Decreasing resource
- Increasing standards
- Data, data and more data.

The theory is somewhat complex and cannot be easily described in a short article but I would refer you to these references for a more detailed explanation.

https://hbr.org/2013/10/the-strategy-that-will-fix-health-care
NEJM. 363:26 Dec 23,2010 p.2477 What is value in Health Care?

**ANAESTHESIA VALUE CURVE**

I came across the concept of an anaesthesia value curve. I think this ties together the refocusing that Lee Fleischer refers to, the central value that Michael Porter wants, and what we as medically trained professionals can add to a patient’s perioperative journey. The detailed explanation of the value curve is on page 12. In short, we need to ensure that not only are we functioning at a high level, i.e. operating on the dark curve, but also that the differential in quality is measured and recognised. Quality for our patients will always be at the heart of what we do as a specialty and as a Society.

On a final note, if you are attending this month’s Annual Queenstown Update in Anaesthesia (AQUA) I look forward to seeing you. I trust you enjoy reading this magazine and we welcome your comments on the issues raised.

**President’s Blog**

David writes a regular blog which covers a diversity of issues affecting the profession and patient safety. His latest focuses on the welfare and wellbeing of anaesthetists, and strategies to promote good mental health. The blog comes out every four to six weeks and is posted on the home page of our website. We also promote it through our regular E-zine newsletter. We always welcome your feedback on David’s blogs at president@anaesthesia.nz
NZSA News

New Health and Safety Resource

The NZSA Health and Safety Manual is a new member resource available on our website (under the resources tab on the home page). You’ll find instructions on how to use the manual, health and safety information and forms, an online educational component with two short videos, links to key websites, and a hazard register.

Evaluation of NZSA, our brand and strategy

The NZSA is a forward looking organisation focused on increasing its visibility, profile and influence to better represent the interests of anaesthetists and the safety of our patients. To do this we need a growing and engaged membership. As part of our work to achieve these goals we are evaluating our brand alignment to our strategy. Does our brand effectively communicate what we stand for as a society? As a profession/specialty? Does it enhance or hinder our digital profile? How are we perceived by external stakeholders – society? As a profession/specialty? Does it enhance or hinder our visibility, profile and influence to better represent the interests of anaesthetists and the safety of our patients?

The NZSA Forum - platform to promote NZSA advocacy and member engagement

The NZSA is committed to supporting the professional interests of its members, both advocating on your behalf and keeping you informed on topical issues. On 30 July the NZSA hosted “Behind the Scenes: A Forum Covering National Issues That Impact On Your Practice” at the University of Auckland. This forum was organised to provide a platform for members to meet our executives, understand the issues NZSA has been championing and to provide us with feedback on areas members would like to see more engagement in. The Society is expanding the work we do and our membership is tracking upwards. We do believe that every anaesthetist should be a member of the Society. It’s your membership that gives us the mandate and resources to advocate and champion issues that affect NZ anaesthesia.

For this reason, we invited speakers to provide valuable insights to our members on current topical issues, including Barrister Hanne Janes who has had significant experience in health and commerce, and Keith Robinson who has been our health and safety consultant on the legislative changes. Our forum covered a broad range of topics including the Medicines Act review, privacy issues, e-prescribing, training of assistants to the anaesthetist and the Maternity Clinical Information System. We thank all speakers for giving up their time to update our attendees on these issues.

Joint NZSA and ANZCA NZNC Meeting

We held our joint annual meeting at the end of June and the main issues discussed included the anaesthesia workforce (the key challenge remains maldistribution with greater difficulty attracting anaesthetists to the smaller centres), training of assistants to the anaesthetist (see NZSA President David Kibblewhite’s article on p.10), and sedation training for endoscopy. We have made good progress on these issues and are working collaboratively with the College to advance the interests of the profession and the safety of our patients.

NZSA Executive Update

Welcome to our new executive committee member Morgan Edwards (Deputy Trainee Representative) and welcome back to Kerry Holmes (nominated Education Officer) after his year in Bristol. The other executive committee members are NZSA President Dr David Kibblewhite, Dr Ted Hughes (Immediate Past President), Dr Malcolm Stuart (Treasurer), Dr Mark Featherston (Chair Private Practice sub-committee), Dr Kathryn Hagen (nominated Incoming President), Dr Kaye Ottaway (private practice), Dr Yvonne Wagner (submissions, obstetrics), Dr Tomas Goscinski, Dr Sheila Hart (nominated Secretary) and Kate Romeril (Trainee Representative). You’ll find examples of the executive’s work, and their strong commitment to the specialty and the Society, throughout this magazine.

Submission on increasing NZ’s deceased organ donation rates

The NZSA expressed its strong support for a national strategy to increase New Zealand’s deceased organ donation rates. We provided feedback to the Ministry of Health in response to their consultation document and said a multifaceted approach was needed. We covered a range of areas including the need for a national coordinating body with a mandate to increase rates, a strong focus on raising public awareness through the media and social media, putting structures in place through our driver licensing system to facilitate conversations between individuals and their families, and the need to address complexities around cultural considerations. Our submission is on our website home page under the About tab, advocacy.
The NZSA Private Practice Committee has made good progress to maintain effective channels of communication with both ACC and the New Zealand Private Surgical Hospitals Association (NZPSHA).

We met with ACC in May to discuss a number of issues, including the redesign of Elective Services and the current Clinical Services contract. There are no immediate changes to the current contract system; the Elective Services project proceeds at a glacial pace and we expressed our strong interest to be part of the redesign process. We continue to advocate for a change to the way telephone consultations are recognised and reimbursed, and are suggesting to ACC that patient assessments can made before ARTPs (Assessment Report and Treatment Plan i.e. approval for surgery) are processed. The current Elective Services contract is being rolled over with some changes, including that hospitals will be required to provide more information about patients and procedures. Of note for anaesthetists is that the time that antibiotics are administered will be collected.

The NZSA has resumed regular meetings with the NZPSHA, which have been very productive and strengthened our relationship. We met with NZPSHA President Dr Ian England and Executive Director Rose Geden and discussed issues of common interest including Affiliated Provider Schemes, ACC and RNAAs (Registered Nurse Assistants to the Anaesthetist). We have invited the NZPSHA to write an article for this newsletter (p.13) and I have accepted an invitation to speak at the NZPSHA conference in September. We will continue regular meetings with NZPSHA to advocate for anaesthetists in the private hospital setting.

The new Health and Safety at Work Act 2015 (HSWA) came into effect in April, along with the majority of the first phase of regulations to support the Act. Anaesthetists practising in private hospitals who are not in an employment relationship are regarded as PCBUs (Persons Conducting a Business or Undertaking). The Health and Safety at Work (General Risk and Workplace Management) Regulations 2016 mean PCBUs have duties to ensure, so far as is reasonably practicable, that the workplace is without risks to the health and safety of any person. This is an obligation that cannot be insured against or contracted out of. The NZSA has released a resource for members (on our website under resources tab) that provides advice and guidance on how to comply with these new regulations.

This resource was presented at the NZSA event “Behind the Scenes: A Forum Covering National Issues that Impact on Your Practice” in Auckland at the end of July, which was organised to update our members on a range of topical issues, including the Commerce Act, ACC and e-prescribing.

On a final note, the opinions and concerns of NZSA members are valued and sought, and we encourage you to contact the NZSA office to share these with us.

Mark Featherston
Private Practice Committee Chair

A new simulation course for New Zealand anaesthetists and their operating room colleagues is an international first and paves the way for New Zealand to lead the way in patient safety. MORSim (Multidisciplinary Operating Room Simulation) is a national team training programme for full surgical teams, aimed at improving the safety and efficiency of patient care. The course is being delivered by the University of Auckland, funded by ACC, and is being supported by the Health Quality and Safety Commission.

MORSim involves realistic simulated surgical cases that challenge communication and co-ordination between members of operating room teams. It is multidisciplinary, training surgeons, anaesthetists, nurses and anaesthetic technicians to work together more effectively. Surgical models have been integrated with full-body computerised manikins. When placed in a realistic surgical environment this promotes active engagement in decision making and clinical tasks relevant to each of the four professional groups. MORSim has around eight hours of face-to-face training, covering simulations, debriefs, and communication skills stations. The cases are designed for the largest surgical disciplines (general, urology, orthopaedics, ORL, plastics).

MORSim was developed by the University of Auckland. The project team includes Associate Professor Jennifer Weller, Professors Alan Merry and Ian Civil and Dr Jane Torrie. It has been piloted across three DHBs with over 130 general surgical staff. Evaluations consistently showed positive gains in teamwork and communication, and the potential for a reduction in the risk of patient morbidity and mortality.

ACC is funding simulators and simulation models, instructor training and delivery of MORSim courses. This funding will enable the course to be delivered to all DHBs, making New Zealand the first country to implement nationwide team training in healthcare. The programme will proceed stepwise through four cohorts (five DHBs in each).

As local instructors are trained, DHB staff will take over the training for ongoing delivery, with central co-ordination and support from the University team. Training for those interested in becoming MORSim instructors will begin three months prior to MORSim commencing at each DHB.

Associate Professor Jennifer Weller says the training aims to achieve safer surgery for patients through improved team communication, optimal care co-ordination and fewer preventable complications.

“Resources saved treating preventable harm can be reinvested in more healthcare. Simulation based team training is known to be effective, but hasn’t been attempted on this scale before.”

Training begins in February 2017. For more information visit www.morsim.ac.nz
Trainee Corner

How do you navigate the challenges of pregnancy and parenthood in training? Morgan Edwards, our new Deputy Trainee Representative, provides some practical and insightful advice.

Hello everyone! As I come to the end of advanced training I find I have more spare time (no more exams!) and it is a real honour to spend some of this time being involved in the fantastic work the NZSA does. Both Kate Romeril (Trainee Representative) and I are really keen to work further with our fellow trainees to provide you with support and assistance where we can.

Trainees face a unique set of challenges, and at times it seems that when one hurdle is leapt, another presents itself right away.

Speaking of which, as a parent to a two-year-old, I well know the challenges of pregnancy and parenthood while training. Our son was born nine months after the Part 1 Vivas, and I sat the Part 2 a week after his first birthday. It might sound like this made for a hectic few years, and let me tell you – that is an understatement! However, as I’m sure any parent will tell you, it is absolutely worth it. I was given some sage advice at my own Part Zero course about planning for children in training ("there is no right time!") and I thought I’d share a few thoughts I’ve had about planning for pregnancy and training.

1. There really is no right time. The person who said this to me could not be more right. Making the decision to have children is an intensely personal one, but there really is no magical moment at which everything will be easier. Instead, the timing when you do start your family will end up being the perfect time for you, because you will make it so. Waiting to sit your exams, focussing on getting through training, or ensuring you’ve secured a consultant position – these may seem like important life events to tick off prior to starting a family. However, there will always be another milestone to achieve or another hurdle to leap. Fertility is not forever. And having children in training does have its benefits.

2. Ask for help. As anaesthetic registrars we tend be a fairly collegial bunch and always keen to help each other out, but asking for help doesn’t come so naturally. We feel guilty calling in sick, even when our head is in a toilet bowl, or admitting defeat with the call roster even though our MECA mandates that we stop working nights at 28 weeks. As someone who experienced a difficult pregnancy, I felt incredibly supported by my Supervisor(s) of Training, fellow registrars and head of department – but asking for help was fairly guilt inducing. At the end of the day, you’re no use when you’re sick or exhausted, and your department can plan much better with more notice.

3. Take all of the time you need. This is the piece of advice I needed to hear myself, and didn’t do that well, so do as I say, not as I do. It is incredibly difficult to plan to step off the training treadmill. To fall out of sync with your cohort. To step out of the spotlight and watch a gap grow in your CV. I deeply regret not having more time at home with my son. Be kind to yourself and your new baby, and take all of the time you need at home. Work will always be there. You will finish training. You will pass the exams. But your baby is only a baby for such a fleeting time. Enjoy every minute. I promise you won’t regret it!

4. There are benefits to having parental leave in training! Taking time out of training seems daunting. But having a guaranteed training job to return to that comes with clinical and professional supervision is a wonderful thing. Returning to clinical work after an extended period of baby talk, feeding and nappies can be quite unnerving. Furthermore, government paid parental leave is currently at 18 weeks and there are some fantastic additional benefits as per the MECA.

Most importantly, I think it’s reassuring to realise that you are not alone. Having children during training is a well-trodden path, and I’m yet to meet a medical parent who isn’t willing to offer support or a listening ear. If anyone would like to get in touch and discuss further, swap war stories, or meet up for a play date please email me at morgankellyedwards@gmail.com.
Bike packing (lightweight self-supported cycle touring) was a term I had never come across until 2015 but then I spent most of a year eating, sleeping and breathing it!

Having recently returned from my fellowship year in Toronto, I had headed to Taupo to ride the Great Lake Trail with a group of friends. Ted from Tread Routes was our shuttle driver, and as he was driving us home he said ‘have you heard of Tour Aotearoa? If you enjoyed that trail you should have a look at that.’ This was a 3000km ride being arranged by Jonathon Kennett, from Cape Reinga to Bluff, taking in many of the new national cycleways, with 30 days to complete it. It included off road riding as well as on road, and was an ideal route for bike packing. Jonathon was hoping this would become the route used for cycling the length of the country, in the same way the Te Araroa is for walking. In effect we would be test riding the route. I got my name on the list, and didn’t think too much about it until July 2015, when I decided I should start training and planning. But first I needed a bike, and there are many opinions on what the best bike is for this type of ride. I decided on a 29er hard tail (big wheels, front suspension, a bit more in the comfortable rather than fast end of the spectrum) and then all the kit that goes on it. Seat bags, frame bags, handlebar bags, dynamo hubs, lights, water holders. It just seemed like an endless list, and boy did the credit card take a hammering!

“I just had to ensure that at least two of the three B's were in good form (Bike, Body and Brain, although maybe backside deserves a spot!) at any one time and I'd get to Bluff.”

By December my set up was complete, and allowed me to just concentrate on riding the thing. I have never been a fast rider, more of a steady but can keep going type, but I was quite amazed at how slow I was on the loaded bike, and my set up was light compared to many! But apparently slow and steady is the key to this type of riding. The training was fun, getting me out around the country exploring, heading away for weekends, overnighting so I could practise using all my kit before it came to D-Day. It was good to do some long solo rides, as I envisioned lots of time riding on my own during the Tour.

Finally, it was almost February. I was comfortable on the loaded bike and had spent many hours on the trails around Wellington getting used to the different handling when loaded. I thought I could be fitter, you always can, but the beauty of a long event like this is that you can ride yourself fit!

I headed up north excited and apprehensive, all the ‘what ifs’ filling my mind. I just had to ensure that at least two of the three B’s were in good form (Bike, Body and Brain, although maybe backside deserves a spot!) at any one time and I’d get to Bluff.

Around 120 of us started from the Cape on Sunday 21 February, with two further waves heading off over the next couple of days, about 240 riders in total.

The route took us from top to bottom, not the most direct, but as direct as possible, with the least amount of riding on the busy highways. We took in delights such as 90 Mile Beach, Hauraki Rail Trail, Waikato River Trail, Timber Trail, Bridge to Nowhere Trail, Great Taste Trail, Waiutu and Big River Trails, and the West Coast Wilderness Trail. The route was just spectacular.

Whoever planned the weather did a good job as it was the most magical weather. A few days of rain down the West Coast, but it wouldn’t be the West Coast if we didn’t have rain!

As for the logistics…I had invested in a fancy lightweight tent, so I could stop where I wanted and not be dictated to by where the...
accommodation was. It turned out that on the
route you were never far from a backpackers/
motel or some kind of bed. And it became
apparent quite early into my adventure that I did
rather prefer a hot shower and bed at the end
of the day, over a patch of grass in a field! So
my trusty tent was only used for three nights in
the end, but it gave me piece of mind that I had
shelter if I needed it.

Many have asked what I ate. Anything and
everything and lots of it. Guilt free indulgence
at every opportunity. For the first time in my
life I would seek out the most calorie laden
items to eat and carry. Lots of café stops,
lots of coffee and cake, my staple of eggs
on toast, and a lot of cereal bars. I was able
to carry enough food to last me for about 48
hours, although I never went more than a day
without a town to resupply items. And due to
the proximity of towns I did not take a stove,
relying on my time passing through towns to
grab a hot meal.

Many people have also asked me what the best
bit of the tour was. It’s hard to pin this down to one thing.
The things I loved were:

1. The country – I rode in some of the most beautiful parts of New
Zealand. If I had to pick the best part of the route I would say
the few days in the central North Island, linking the Timber Trail
with Bridge-to-nowhere; that was pretty special.

2. The company – I had thought I would spend a lot of time on
my own during the tour, and wondered how I would cope with
my own company for such long periods. But I wasn’t often
alone. In the North Island, I virtually had company every day, for
some part of it, or when I stopped for the night. And everyone
was like minded, all super-excited about this riding opportunity.
Interspersed with this were times of content solitude taking in
the fantastic riding, enjoying the rhythm of turning the peddals,
with just the free hub and cicadas to break the silence.

3. The atmosphere of the event – we all had spot trackers, and
you could follow each rider’s progress on a website. This
meant that friends and family could follow your progress, and
many became hooked at dot watching. I hadn’t realized how
regularly people were following, until one afternoon early on I
had to take a detour into Rotorua to fix a broken wheel, and
I received a frantic text from a friend, worried that the speed
with which my dot was moving meant I could be in an
ambulance (I was in a taxi).

4. The local support – the tracking system meant that local owners
of eateries and accommodation could also watch the trackers,
and stay open later to accommodate an approaching rider who
was riding late into the night. There are endless stories of the
locals going above and beyond to help a tour rider. Bike shops
along the route bent over backwards to accommodate short
notice repairs – you just mentioned you were a tour rider, and
the queue, what queue? Many people would stop and have a
chat about what we were all up to.

5. The physical challenge – this was not supposed to be a
race, but an event that introduced bike packing to many
in New Zealand. But as you can imagine, for many the
challenge was in riding as quickly as possible. The first
finisher was in Bluff in 10 days, the last in 30 days. I took 20
days, and think I balanced the ‘race’ component versus the
‘holiday’ component very well. It was hard not to feel a little
competitive, watching who was around you and who was

passing you in the night. Knocking out big days covering big
distances became surprisingly addictive! My shortest day was
35km (had a mechanical) and my longest 203km.

What did I not enjoy? That it was only 20 days. I had such a fun
time that I felt I could have lived that life forever. It really does rank
as one of the best things I have ever done.

However, so as not to create an illusion of utopia, there were days
when I felt tired, the legs felt heavy. They always came right as
long as I kept it steady. And it was so easy to lose myself in the
riding that any low patch was relatively short lived. I would be lying
if I said the body didn’t suffer a little; there was a small issue with
the saddle. It was good for the first seven days, but then it did
get a bit uncomfortable. For that reason, I was just a little
relieved to get off the bike once I reached Bluff. It was all good
though after a day off the bike and the issue with the saddle was
promptly forgotten.

Jonathon Kennett will be publishing a book later this year about
the route for those who feel inspired to give it ago, called Tour
Aotearoa, or check out www.touraotearoa.nz. And if you want to
ride it with a bunch of other like-minded riders, the next organised
ride will be in February 2018.

Lake Waiuku
**Strong connections: The NZSA and anaesthetic technicians**

The NZSA and NZ Anaesthetic Technicians’ Society (NZATS), the professional body representing registered and trainee anaesthetic technicians in New Zealand, enjoy a long-standing and mutually supportive relationship. This has been a basis for developing and maintaining the NZSA and NZATS memorandum of understanding.

**The role of NZATS**

NZATS provides high quality continuing professional development opportunities, trainee education, advocacy and support to its members. It advocates for excellence in high quality patient care in collaboration with other health care professionals and organisations, such as the NZSA.

**Anaesthetist and NZSA support for anaesthetic technicians and NZATS**

For over 20 years anaesthetists have been involved in developing and supporting anaesthesia technician training in New Zealand to help ensure consistently robust competency standards, to support medical anaesthetists. NZSA Executive member Dr Malcolm Stuart was involved in developing the curriculum and as an examiner for anaesthetic technicians for many years, and was the ANZCA representative on the NZATS executive until 2014. He says the main goal has always been to deliver high quality, optimally safe patient care and many anaesthetists have contributed to this.

“New Zealand is fortunate to have very high calibre anaesthesia technicians”

A shortage of anaesthetic technicians and the cost of training have seen the development of new pathways for assistant to the anaesthetist (read our President’s article on the registered nurse to the assistant role p.10). NZSA President Dr David Kibblewhite says that New Zealand is fortunate to have very high calibre anaesthesia technicians. “Their skills are world class and standards are consistently high. We have worked to ensure this is the case for anyone undertaking anaesthesia assistant training and to ensure it is comparable to the anaesthetist technician training.”

**The NZSA-NZATS Memorandum of Understanding**

In 2009 NZSA and NZATS signed a MOU, outlining the roles of each organisation to cement our working relationship. A revised MOU was agreed in February 2013.

In addition to the MOU, NZATS also have a service agreement contract where the NZSA provides focused and dedicated administrative support for NZATS. This involves 10 hours of weekly support to assist with general membership queries, the membership subscription renewal process, provision of membership statistics and information, e-newsletter mail outs, examination support in the form of receipting and printing of certificates, and other projects as they arise. The administrative support also includes special projects related to membership drives and involvement in the current website redevelopment. The NZSA welcomes being able to share some of its own experiences and insights as a membership organisation with NZATS, which has a similar number of members and faces some similar issues.

NZATS Chairperson Angela Dewhirst says that the team in the office are a fantastic asset. “They often go above and beyond the call of duty to support NZATS. It’s clear they share our passion and vision for the future.”

The NZSA is also represented at the NZATS Executive Committee meetings with NZSA Immediate Past President Dr Ted Hughes the NZSA representative. This has provided a strong channel of two-way communication. This role will be formally assigned to Incoming President Dr Kathryn Hagen at the NZSA’s AGM in August.

NZSA sponsor a “Best Anaesthetic Technician Speaker” at the NZATS annual conference. NZSA also support the prize for top student at the Registration Examinations.

**A brief history of the anaesthetic technician role**

In 2012 anaesthetic technicians gained recognition as a regulated profession under the Health Practitioners Competence Assurance Act. The NZSA was very supportive throughout this application process, viewing this as a key measure to achieve optimal quality of perioperative care, says Dr Stuart. The regulation of the profession came after many years of work, particularly from the anaesthesia profession.

A pilot scheme to train assistants to the anaesthetist began in Christchurch and Greenlane in 1977, with the first examination held in 1979. The course was 24 months of in-hospital training with 150 hours of theory and practical instruction. Funding for training ceased in 1992 and the Anaesthetic Technicians’ Training Board was dis-established after resolving that all future training would comprise distance learning at a polytechnic institute. It was replaced with an interim board which eventually became the New Zealand Anaesthetic Technicians’ Society (NZATS). The registration body for anaesthetic assistants, the Medical Sciences Council (MSC), took on the role as regulatory body for Registered Anaesthetic Technicians in 2012 with NZATS currently contracted to run the registration examination as an agent of MSC.

NZSA Life member Dr Basil Hutchinson was involved promoting the concept of a trained anaesthesia assistant, along with other anaesthetist colleagues. He was a member of the Anaesthetic Technicians Training Committee from 1983-1992, the Committee’s Chairman from 1986-1992, and Chief Examiner 1985-1988. In 1992 NZATS awarded him life membership. NZATS provides an annual award to trainee anaesthetic technicians, which is named after Dr Hutchinson.

Angela Dewhirst, Chairperson of NZATS, says a major reason behind the development of the anaesthetic technician role was frustration by anaesthetists at a lack of specific anaesthetic assistance training to ensure they’d have quality support.

She says the role of anaesthetic technician didn’t always enjoy the respect it does today but there is now a realisation of how specialised the role has become.

“The calibre of candidates entering the Anaesthetic Technician field has increased significantly in recent years.” She adds that many trainees that do the diploma course, a three-year course taught through AUT, do this after gaining a degree qualification.
NEW ZEALAND ANAESTHESIA
EDUCATION COMMITTEE (NZAEC)

Applications for the 2016 BWT Ritchie Scholarship close on 31 October 2016

The BWT Ritchie Scholarship provides financial assistance to New Zealand-based anaesthesia trainees who have passed the final examination for fellowship of ANZCA and are eligible to proceed to training year 5, to gain overseas experience and bring it back to New Zealand. It is also open to those who wish to undertake a further year of study outside New Zealand in the year following completion of their ANZCA fellowship (FANZCA); and to anaesthetists with FANZCA who are also training in pain medicine or intensive care medicine and who have reached a similar stage for those fellowships. Applicants must be nominated and supported by their training departments.

Currently, the scholarship fund available for disbursement is up to $15,000 per year.

To find out more about the scholarship and how to apply, please go to the BWT Ritchie page of the NZAEC website: anaesthesiaeducation.org.nz

BRIDGING THE GAP - BECOMING A CONSULTANT AND BEYOND….

NZ PART 3 COURSE

19 NOVEMBER 2016
AT WAIPUNA HOTEL, AUCKLAND

A one day course for advanced trainees, with workshops, small group discussions and interactive presentations

Places are limited. For further information visit: WWW.ANAESTHESIASOCIETY.ORG.NZ
REGISTERED NURSE TO THE ANAESTHETIST (RNAA)
AN UPDATE FROM NZSA PRESIDENT DAVID KIBBLEWHITE

The RNAA role has raised significant concerns for our members and our technician assistants.

A BRIEF BACKGROUND:
This issue first came to the attention of ANZCA-NZNC and the NZSA in mid-2014 when we were asked to assist in the development, oversight and teaching of a pilot course, at the Auckland University of Technology (AUT), aimed at upskilling nurses who were currently in this role. At the time this amounted to about 65 nurses around the country, mainly in smaller centres and private hospitals, who had been performing the role of assistant to the anaesthetist for many years but had no formal course and qualification.

Our initial response was to point out the existing training pathway which many nurses have previously used and continue to, i.e. AUT Technician’s Graduate pathway. In addition, students are required to pass the technician exit examination to ensure a common standard. The Perioperative Nurses College opposed the need for this, saying that the group that the new course was intended for were already registered and did not need to complete a second registration exam. As this group has been practising for many years they did not believe such an intense course was needed.

The professional document PS08, relating to the anaesthetic assistant, was revised at that time and focused on competencies rather than specific training requirements, such as duration of training. With this in mind, NZSA and ANZCA-NZNC agreed to support the AUT pilot course. Our primary aim was for those doing the course to achieve the same high standards and competencies as for the technician course.

The NZSA worked with AUT, ANZCA-NZNC, the New Zealand Anaesthetic Technicians Society, Health Workforce New Zealand and the NZ Nurses Organisation (NZNO) to have ongoing input into the course, including anaesthetists being involved in teaching and examination of the pilot year. NZSA executive committee member Kathryn Hagen deserves special mention as she spent considerable time ensuring that the curriculum and examination, including the technical aspect of checking the machine, achieved the standard of PS08 and PS31. AUT did an audit and mapping exercise for the course. While the course fulfilled its objectives, as in any process there are some loose ends and confounding factors:

1. One candidate was accepted who did not fully meet entry criteria in terms of previous experience. This candidate has required additional tuition and time to gain the required competencies.
2. The course has not been repeated this year due to lack of applicants.
3. If this course is to be marketed in future to those without previous experience then a one-year course does not meet the objective of a competent fully trained assistant.

There are a number of other confounders, as well as stakeholders which add complexity to the picture:

1. There is a shortage of trained technicians. A recent article in the Dominion Post looked at the increasing use of locums at Wellington Hospital in response to a shortage of anaesthetic technicians. The use of locums is criticised for adding to health costs and undermining continuity of patient care.
2. Because this is a workforce issue Health Workforce New Zealand is also in on the act.
3. The technicians have been wanting a review of the AUT technician course for some time. There is debate as to whether it should remain a diploma course or become a degree course.
4. Even though both courses are taught through AUT and cover essentially the same material, the courses are run by two separate departments in parallel.
5. The Medical Sciences Council is the regulatory body that oversees the technicians so is an additional stakeholder.
6. The New Zealand Private Surgical Hospitals Association (NZPSHA) would like to develop a third course run out of the Canterbury Technical Institute. We are in discussions with NZPSHA about this course. The practical aspects of this course are as yet undefined.

The NZSA and ANZCA-NZNC have recently written to AUT, and the NZNO to say that in our opinion the RNAA course maps to PS08 and PS31. However, we have noted that to be consistent with other training pathways available in New Zealand and to enable assistants to reach a competency level that anaesthetists have come to expect, candidates need to complete at least 18 months of full-time supervised experience. Prior experience in anaesthesia assistance should be credited pro-rata, to recognise the volume of practice experience of nurses already working in the role. We have also stated that completion of a log book in conjunction with the workbooks will provide a record of completion of domains of practice, and that after the course is completed, if a candidate changes sub-specialty areas a further period of orientation will be required.

As your representatives we are focused on providing support, and being involved in ongoing dialogue with all relevant stakeholders, to help ensure the availability of a standard, competent ‘product’ for our members and for the safety of the New Zealand public.

We will continue to advocate strongly on achieving this goal.
A Chat with an Executive Member

Kathryn Hagen is a consultant anaesthetist in Auckland and a member of the NZSA Executive Committee. She is also the NZSA representative on the NZ Medical Association Specialist Council and the NZSA’s Incoming President.

What led you to study anaesthesia?
It was seeing the awesome mix of doing and thinking that anaesthetists practise every day. I was attracted to the fact anaesthetists knew heeps, but also did lots of fun, practical procedures. And they seemed like the happiest doctors you meet as a fourth year medical student!

How would you describe your training path, and where did you study?
I studied medicine at Auckland University, with a year off for travel and work between the pre-clinical and clinical years. Then I did my trainee intern year in Wellington with House Surgeon and ED Senior House Officer years completed in the capital city. We moved back to Auckland and I did my anaesthesia training across Middlemore, Auckland City and Whangarei with a fellowship year in Ireland before settling in at Level 8 Auckland City Hospital. Oh and had two children along the way; post Part 1 and post Part 2 babies!

Who was most influential during your training?
Rod Harpin in Whangarei was one of the most influential anaesthetists I spent time with. On a fifth year selective placement to Whangarei, he informed me that “you can’t spend your whole life in an operating room; you have to have something going on outside of it.” This led me to explore the opportunities provided by the ANZCA NZ Trainee Committee and Auckland Vocational Trainee Committee. I really enjoyed these roles whilst training. Being involved in the medico-political arena is quite addictive and my time at the NZTC led on to my joining the NZSA executive.

Where do you work?
Level 8 at Auckland City Hospital – my areas of interest are neurosurgical anaesthesia and spines/orthopaedics. I don’t do obstetrics (covered by Level 9 = pregnant for nine months), or cardiac (Level 4 = four chambers of the heart), but we do most other adult surgical care, including some exciting new advances in clot retrieval for acute major stroke.

What is the most satisfying aspect of your job?
Doing a good job – a well working nerve block, a nausea-free patient in recovery, watching a trainee finally ‘get it’ when explaining some obscure physiological detail.

What are important issues for New Zealand anaesthesia and why?
Task substitution – the seemingly never ending quest to find another, cheaper group of people to perform our work (prescribing, pre-assessment, sedation, etc.). Supporting the technician and registered nurse communities to maintain their awesome standards as our anaesthesia assistants.

Why did you volunteer to work with the Society?
I enjoy being aware of the bigger picture and being involved in the Society is one way to make sure you are alerted to the issues affecting the medical and health environments. Also, I am a firm believer that you have no platform to complain if you are not prepared to be involved and help change happen. After time in Ireland where they seemed to have no effective Society (the I on the end of the AABGI must be in microscript), it felt more important than ever to be involved with the NZSA and help keep its >70-year charitable work going.

What would you like to achieve for the Society?
I would love to see the profile of the NZSA improve among the anaesthesia community. It would be great if the new anaesthesia trainees got the chance to appreciate the role of the society; both historically prior to the bi-national college formation, but also currently in the way it supports educational events, prizes, the anaesthesia technicians, the Special Interest Groups etc.

What do you like to do outside of work?
My boys are four and seven, so life outside of work and the NZSA is centred on school, sports and the chaos of family life.

What’s an ideal holiday for you and your family?
A summer at Matheson’s Bay, a fabulous small beach about 80km north of Auckland; just round the corner from John Key’s Omaha. My family has been visiting there since 1950 and you could never tire of it!
WEBAIRS NEWS

By Dr Martin Culwick

In May 2016 Professor Michael Cousins AO retired from full-time practice. Professor Cousins has initiated many valuable and important contributions to anaesthesia, pain medicine and patient safety. In the latter context, he instigated the formation of the ANZCA Safety and Quality Committee and the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC). In 2004 Professor Cousins set up a number of working groups, including the Quality and Safety Taskforce and the Data Taskforce. The findings of these taskforces led to the formation of the ANZCA Quality and Safety Committee and ANZTADC in 2006. These two committees are now regularly creating resources to improve patient safety, with ANZTADC’s webAIRS initiative providing an enduring repository of patient safety information.

WebAIRS has now collected over 4000 incident reports. 127 sites report data and there are also many individuals who are independently registered. For the local administrators of sites there are some new analysis features in webAIRS. Accessed via the Administration tab on the homepage, “Incident Charts” gives the opportunity to view local statistics in specified date ranges. The chart below gives a snapshot of bi-national figures as at 27 June 2016.

There is ongoing analysis of webAIRS data with articles detailing findings and themes featuring in publications of the parent organisations and peer reviewed journals. Scientific meetings also provide opportunities for shared learning. The upcoming ASA National Scientific Congress (Melbourne, 17-20 September) features the following webAIRS presentations:

Tuesday 20 September
11am – 1pm
Chair: Dr Gregory Deacon
Session: Error Reduction Strategies – how you can improve your practice
- The Bowtie Diagram – a concept that incorporates causal analysis and event management. Dr Daniel Clarke
- Are all human errors also system errors? Prof Neville Gibbs
- What do you do when the unexpected happens? A/Prof Kersi Taraporewalla
- Show us the evidence! An analysis of webAIRS data. Dr Martin Culwick

For those who are not yet registered for webAIRS, the process has never been simpler. Streamlined registration involves a tick box approval of site terms and conditions. Anaesthetists can choose to link with an already registered site, set up a new site or enter incidents as an individual. Reports can be submitted completely anonymously and CPD points are earned with every incident that is logged into the database. Ultimately, contributing to this important safety and quality initiative leads to unique learning opportunities and practice improvement.

For more information:
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

ANAESTHESIA VALUE CURVE

Following on from our President’s column, here is a detailed explanation of the anaesthesia value curve.

The quality of anaesthesia care is dependent on the resources invested. The black curve represents the actual value of anaesthesia care. Increased resource investment improves anaesthesia quality; however, point “pav” resides beyond the point of diminishing marginal returns, and continued resource investment only slightly increases quality. The grey curve represents the capacity of current healthcare metrics to quantify the quality of anaesthesia care: these metrics appear to underestimate the growth and total value of anaesthesia care. If a healthcare system expended “$” resources resulting in “pav” quality, it would be receiving a high actual value of anaesthesia care at a point where continued resource investment would add little to anaesthesia quality.

If this healthcare system pursues a cost-savings strategy based on the current quantitative anaesthesia quality measures, it may identify “pqv” as an efficient value because the quantifiable value curve has a point of diminishing returns that occurs at a lower level of resource investment than the actual value of anaesthesia care. So resource expenditure would be reduced to “*$.” Such a choice in resource expenditure will marginally affect the quantifiable quality (ΔQqv) but may significantly reduce the actual quality of anaesthesia care delivered to patients (ΔQav).

The New Zealand Private Surgical Hospitals Association (NZPSHA) – an overview

NZPSHA President Dr Ian England provides an overview of the NZPSHA’s role and work, and explains why private hospitals need to be considered more strategically as a vital key to achieving the Government’s health policy.

The NZPSHA was established in 2005 to represent the interests of private surgical hospitals within New Zealand and promotes excellence in healthcare. Our mission is to promote, position and connect the private surgical hospital sector in New Zealand.

Our primary roles are:
• To represent and advance the position of private surgical hospital providers in New Zealand through influencing the health opinion of both policy makers and the public.
• To strengthen the sector through facilitating a networking framework that will support individual members in their delivery of clinical and business excellence.

The NZPSHA Represents:
• 25 member organisations
• 38 surgical facilities
• 1,860 surgical beds (including ICU, recovery, day-stay chairs and resourced beds)
• 3,325 FTE (combined payroll exceeding $120 million).

NZPSHA members provide procedures for approximately 164,000 patients every year, representing approximately 50% of all elective surgery performed in New Zealand. Principal funders include private insurers, ACC, District Health Boards and paying patients. The large majority of member hospitals provide overnight care. ACC and DHB contracts account for over 40% of work for some of our members.

NZPSHA represents an important part of the country’s health sector. Our membership coverage extends the entire country and member hospitals perform a full range of elective surgery from complex neurosurgery and cardiothoracic surgery through to minor procedures. Currently, private hospitals in New Zealand do not provide rehabilitation, mental health care services and only one NZPSHA member hospital provides maternity care.

Public private partnerships with private hospitals are a cost effective way of delivering health outcomes and NZPSHA believes they should be encouraged. Contracting of elective surgery is carried out on a regional basis and the nature of contracts varies considerably. NZPSHA member hospitals have theatre capacity available; a survey on private theatre capacity undertaken by NZPSHA in 2015 showed that NZPSHA member hospitals are in a position to complete 156,000 additional surgical procedures per annum without changing existing theatre capacity allocation. Therefore, our member hospitals are well placed to assist the Ministry of Health to increase national elective surgery volumes in a timely and reliable manner. NZPSHA continues to push this message.

NZPSHA believes private hospitals are a vital key to the success of the Government’s health policy and need to be considered more strategically. As healthcare costs are projected to increase by almost 60% from 6.8% of GDP in 2010 to 11.1% of GDP in 2060, it’s time to start the conversation on long term health funding in New Zealand.

The “unmet” demand for elective surgery remains at over 170,000 New Zealanders and this demand has a negative impact on the quality of life for many. NZPSHA believes the Government should look at options that increase the desirability of health insurance and encourage New Zealanders to take responsibility for their healthcare needs. Due to rising premiums, the proportion of lives covered by private health insurance begins to decline precisely when the likelihood of requiring elective surgery begins to accelerate.

NZPSHA has a strong focus on quality, and as such runs its own internal quality indicator programme and reports aggregated data to the Health, Quality and Safety Commission. NZPSHA holds two-yearly “Leaders in Quality Awards” to showcase our members’ quality initiatives and to facilitate sector-wide learning and growth, leading to improved service and business delivery and safer patient care.

The Association welcomes close links with NZSA to share knowledge on sector matters and its workforce.

The Association is run by a seven-member Executive, supported by an Executive Director.

For further information on NZPSHA, visit www.nzpsha.org.nz

Dr Ian England
President – NZPSHA
Chief Executive - Acurity Health Group Ltd
LIFEBOX VIETNAM

Dr Peter A. Schenk says he was privileged to be part of a NZSA Lifebox (NZ) trip to Vietnam to distribute pulse oximeters. He writes about his ‘gratifying’ experience and how Lifebox supports the delivery of quality care for Vietnamese patients.

I accompanied Dr Indu Kapoor (NZSA Lifebox Chair) in June to distribute pulse oximeters to anaesthesia medical practitioners, aiming to achieve 100 per cent coverage of operating locations in Binh Dinh.

We were invited guests of the Vietnam Society of Anaesthesiologists (VSA), which coincided with the Society’s national conference. I gave a short presentation during the Quality and Safety session of the VSA meeting. The Lifebox workshop was made possible by working closely with the Department of Health Binh Dinh province, the New Zealand Vietnam Trust and the VSA.

I had been keen to get involved in work of this nature and when the opportunity presented itself, after talking with Dr Kapoor about her experiences with Lifebox in Vietnam and the ability to participate, I jumped at it. I had been to Vietnam before as a tourist and am captivated by this South East Asian country; its beautiful verdant valleys, pristine beaches, divine cuisine and most of all, its gentle, friendly, engaging people. Our activities took place in Quy Nhon, the coastal provincial capital city of Binh Dinh province. We settled in and met with our Vietnamese counterparts, in particular Mr Phuoc Nguyen – translator and organiser extraordinaire who helped us prepare for our workshop, run by Dr Kapoor and myself.

Prior to the workshop, the NZSA purchased 37 Lifeboxes and 10 neonatal probes from the Lifebox donations given to NZSA, most distributed at the workshop held at the Quy Nhon District Hospital. Invitations to attend the workshop were based on a needs assessment undertaken prior to our arrival and representatives from 14 out of 15 hospitals in the province attended.

Dr Kapoor opened the session with a historical narrative on how the project, Global Safe Surgery Initiative, was conceived and its goals. We then launched into an interactive tutorial on Hypoxaemia, emphasising early diagnosis, the very important role of pulse oximetry and introducing an algorithm on management. The World Health Organisation’s (WHO) pre, peri and postoperative checklists were also discussed. The Hypoxia algorithm and WHO checklists had been translated and were provided to participants as an aide de memoir and to take back to their hospitals or clinics. There was an exercise to demonstrate the safe and appropriate use of the equipment. Ten oximeters came with neonatal probes and were distributed to hospitals providing neonatal anaesthesia care, and to the Department of Health via Dr Johan Morreau (Paediatrician/Neonatologist and Chairman of the New Zealand Vietnam Trust) who was also in Quy Nhon on a teaching mission. He sent us a photo later in the day of four neonates under phototherapy that were being monitored with the new pulse oximeters.

The workshop ended with an immensely gratifying experience – the official handing over of the pulse oximeters to participants. This equipment, which we take for granted in the western world, will make a real difference to the delivery of quality care for Vietnamese patients.

There are still 24 Lifeboxes remaining with the VSA that will be distributed (alongside Lifebox education) to the smaller centers via trainees visiting university hospitals for training.

I came away from the experience wanting to be more involved, either to run more of these workshops or to come back as a teacher/trainer in various aspects of quality care provision.

I am very aware that work of this nature needs to be commissioned from within; to that end I hope to hear of an invitation in the not too distant future!
Alan Goody, Chair of the NZSA Overseas Aid Committee, reflects on his rewarding experiences supporting anaesthesia and healthcare in the Pacific. He also writes about how anaesthetists can be part of the NZSA’s aid work, and provides an overview of the latest developments.

I was recently invited to speak to the Waikato Anaesthetic Technicians Continuing Education Group about my experiences working in the Pacific. It was a great chance to reflect on my own journey into this rewarding area and how it began.

It was 2009 and a plastic surgical colleague, Ben Norris, asked me if I would like to join an Interplast trip to Samoa. I had done my elective in Samoa, so it was a great opportunity to go back. Also, the surgeon’s wife Norma and my wife Sharron were best friends and they were hatching plans to meet up while we worked (I didn’t realise that this kind of thing is actively discouraged by Interplast).

The trip to Samoa was a steep learning curve; not in terms of giving anaesthetics or the equipment, but how to be a productive and guest doctor in another country’s health system. How to consider both the short and long term goals (such as developing capacity) of the surgical trip, plus being welcome to return in future to make a difference. Interplast set a very good standard in how they approached these issues and gave me a great start.

Less than two months later, Samoa was hit by a large tsunami. My wife had developed a great affection for Samoa after her stay and strongly encouraged me to head to Samoa. I had serious doubts about my usefulness and assumed that New Zealand would have a plan to send a suitable medical unit to assist. As a member of the NZSA executive at the time I made a number of enquiries but there was limited information.

There was political will to send a medical team from New Zealand but no previous plan to follow so our Ministry of Health sent out an email requesting volunteers to send a team. Waikato put together a list of names as a team of doctors and nurses and this approach, rather than simply sending lots of names, meant that the majority of our team came from Waikato. I volunteered to be medical team leader, naively assuming this would mostly be about building our relationship with the Samoans.

Again, this was a very steep learning curve for me as New Zealand had not really done anything like this before. With no planning, there was a lot of fluidity in how things got done and a bit of a vacuum. This led to tension as we worked our way through issues between clinicians and the New Zealand government representatives. Fortunately, despite the tension we were able to provide excellent outcomes for the tsunami victims. I was very grateful for my experience working as a duty anaesthetist, and theatre had provided me with useful skills to negotiate my way through. As before, I found anaesthesia was the easy bit.

In 2011 at the Christchurch ASM, the NZSA committed to form the Overseas Aid Committee (OAC). As I was on the NZSA Executive Committee I became a member. Wayne Morris was the inaugural chair. I quickly came to learn how many amazingly dedicated colleagues were involved in this area, each bringing their own unique strengths. Wayne was an excellent choice to lead our group and I admired his commitment, and organisational and negotiation skills. Eventually Wayne needed to step down as he became Chair of the World Federation of Societies of Anaesthesiologist’s (WFSA) Education Committee. I remember the large pregnant pause on a teleconference as he requested a volunteer to take over. I guess with the same reckless attitude that had got me to Samoa I heard my voice volunteering over the phone.

I’m not sure if I’m a great Chair: I hate meetings, especially teleconferences. I dislike email as it always seems to escalate my commitments and I’m a hopeless procrastinator when it comes to writing reports. But I do see amazing things happening thanks to the efforts of NZSA members. It’s a privilege to be associated with them. I like to think that the NZSA’s overseas aid work is really valued by our members and hopefully we can develop more pathways for members to become involved that do not solely rely on the chance opportunities that came my way.

“Personally it has been hugely rewarding and has helped me overcome a sense of burnout and disillusionment in medicine”

Personally it has been hugely rewarding and has helped me overcome a sense of burnout and disillusionment in medicine. Part of my talk to the Anaesthetic Technicians was about how we have renamed the developing world the “Real World.” The way we practise medicine in New Zealand is an unaffordable luxury for the majority of people globally and extraordinary in the history of humankind.

Huge strides have been made in anaesthesia quality and safety in the last 50 years. Australasian anaesthetists have been at the forefront of many advances and continue to invest huge effort and money in making the very good excellent. And yet many of our nearest neighbours have been left behind and struggle to achieve even okay in anaesthesia quality and safety. This means there are opportunities to make meaningful improvements to healthcare in our region.

Perhaps the greatest lesson from my journey to the Pacific has been that when you strip away all the fantastic technology and systems that support our work in New Zealand, when all you have is the most basic equipment and your training and experience to fall back on, when you cannot rely on the quality of postoperative care, then what really matters, are the simplest of things we do. I have become far more of a perfectionist about the time and care I put into placing intravenous lines. Whereas I used to measure my worth as an anaesthetist with the speed at which I could turn over cases I’m now more interested in the quality of my extubations and encouraging trainees to take as much care at emergence as they do at induction. Even today in New Zealand I believe some patients are at risk of harm due to poor intravenous line placements and poorly executed extubations, mostly due to our failure to take these core tasks seriously enough.

What have OAC members been up to lately?

Cyclone Winston

Wayne Morriss, Tony Diprose and I were members of the largest ever NZMAT deployment this year to Fiji after Cyclone Winston. Wayne had lived in Fiji previously and was ideally placed to lead
the initial assessment team. He reported back that the Fijian health service (with considerable input from our Fijian anaesthetic colleagues) was responding extremely well to the disaster. There was no need for an immediate response as they had the initial problems in hand. Eventually a decision was made to send two light primary/public healthcare teams to the Lau group and Koro Island, which had been hit hard by the cyclone. A surgical team was also sent to provide local doctors and nurses who had responded to the emergency a chance to rest. We spent two weeks working in the main hospital in Suva as fully integrated members of the theatre team. For Tony and I it was a great chance to build on our previous relationships with many of the Fijian medical staff and we found it easy to be of use.

**Life box**

Indu Kapoor and Peter Schenk visited Vietnam where they ran workshops and distributed Lifeboxes in the Binh Dinh province. (You can read Peter’s great article about the trip on p.14) There are still 24 Lifeboxes with the Vietnam Society of Anaesthetists and they have been given the mandate to distribute these to the smaller centres via trainees visiting university hospitals for training.

**Disaster Response workshop at the ANZCA ASM**

Maurice Lee facilitated this well received workshop in Auckland. Participants included other members of the NZSA OAC, representatives from AUSMAT and NZMAT and the New Zealand military.

**World Congress Hong Kong**

The NZSA is sponsoring three anaesthetists from the Pacific to attend the World Congress in September. We will also be co-sponsoring, with the Australian Society of Anaesthetists (ASA) for the President of the Pacific Anaesthesia Society to attend. The WFSA has an excellent sponsorship programme, which we are taking part in. The recipients are young anaesthetists from the Cook Islands, Fiji and Tonga.

**Trainee Grant to attend the Pacific Society Meeting**

We are looking for an advanced anaesthetic trainee to attend the Pacific Society of Anaesthetist’s annual refresher course in Fiji. The dates will immediately precede the World Congress to facilitate the delegates going to Hong Kong via Nadir. The expectation is that the trainee would do a presentation as directed by the organising committee and be involved in the full meeting. It will provide the opportunity to develop ongoing relationships in our future anaesthetic workshop. A grant of NZ$1000 is available to cover the costs of travel and accommodation. Additional costs above this amount would be self-funded.

**Interested in overseas aid work?**

As my article has indicated, chance played a big part in how I became involved in Pacific aid work and personal satisfaction of my involvement has been immense.

If you are interested in volunteering, a good place to make yourself available is through the ASA database of volunteers. You can register through the ASA website. Opportunities are circulated to you via email and may include being a member of a short term surgical trip or a longer term locum position.

The ASA also sponsors the Pacific Fellowship. This is aimed at new Fellows but older Fellows can also apply. It is largely a teaching position in Suva with some clinical work over a three-month period. If you have a connection with Vietnam, you may be interested in continuing the NZSA’s efforts with Lifebox Vietnam as part of the NZSA Lifebox initiative.

Perhaps you have an idea for a project to assist the development of anaesthesia. Feel free to approach members of the OAC and perhaps together we can advance it beyond an idea.

Are you interested in becoming involved in the committee? I am certainly keen to attract new members to ensure we have long term continuity.

Thank you for your ongoing support.

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Wayne Morriss in Fiji
A recent report by The Lancet Commission on Global Surgery found that more than five billion people, of the world’s seven billion lack access to safe and affordable anaesthesia and surgical care. The number one priority to address this crisis is meeting the shortfall in skilled anaesthesiologists in lower income countries.

The World Federation of Societies of Anaesthesiologists (WFSA) began offering fellowships in 1996 to young anaesthesiologists from low and middle income countries to improve patient care, and access to safe anaesthesia. Twenty years later the programme has trained more than 250 fellows from across Africa, Asia, Europe and Latin America.

The WFSA is now campaigning to expand the programme and train record numbers of talented, young anaesthesiologists.

**Fund a Fellow: Building on 20 Years of Success**

The WFSA’s Global Fellowship Programme offers over 50 placements each year. To sustain this WFSA is asking individuals, especially anaesthetist colleagues, to “Fund a Fellow” to help train 500 Fellows and reach over one million patients by 2020.

Julian Gore-Booth, Chief Executive Officer of WFSA (UK), explains: “Supported by leading hospitals and dedicated WFSA volunteers, we have been able to offer fellowships to anaesthesiologists from lower income countries at no cost to themselves. But successful applicants can only access these opportunities if their travel and living costs are supported.”

“It is essential that we make these opportunities available to anaesthesiologists who are already working in the countries that need their expertise and leadership the most.”

Dr Wayne Morriss, Consultant Anaesthetist at Christchurch Hospital and Chair of the WFSA Education Committee, says that 30 per cent of the global burden of disease can be treated with greater access to surgical treatment, yet the surgical patient continues to be neglected.

Dr Ninadini Shrestha from Nepal was awarded the WFSA Pain Management Fellowship in Hyderabad, India last year. She recalls one patient in particular, a 70-year-old man who was brought in suffering from a fracture to the right humerus.

“He was given a supraclavicular brachial plexus block with catheterisation for continuous plexus anaesthesia. The relief was immediate and he called his wife ‘Jaau’ literally meaning ‘my life’ as soon as he saw her. And she just smiled.”

“That was the moment I became passionate about pain management. That moment taught me that we cannot control or cure disease, but we can decrease suffering and improve the quality of life by doing pain management.”

Since returning to her hospital in Nepal, Dr Shrestha has used her fellowship training to make changes in pain management.

“There is a tremendous need for me to introduce an organised approach to acute and chronic pain management protocols and assessment tools in our pain management clinic. Designing a database tool that makes our pain cases entry useful for future research and record keeping is my top priority, as it will guide us in our practice,” she explains.

“The WFSA Fellowships are an ideal way to learn from the experts and they also cover our financial requirements, a major barrier for people in developing countries.”

In 2015 the World Health Assembly in Geneva unanimously approved a resolution: “Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage,” in what was a landmark decision to address this global health crisis. The WFSA made a statement to the Assembly: “We can address the combined elements of workforce, drugs, equipment and infrastructure that not only ensure a safe provision of anaesthesia, but contribute to strengthening health systems and improving health outcomes in a manner that is affordable, life-saving and an outstanding return on investment.”

Globally there is a shortage of more than one million specialist surgeons, anaesthesiologists and obstetricians. This number is set to rise to 2.2 million by 2030 if there is not substantial scale up in surgical care and strengthening workforce. The Fund a Fellow campaign will ensure that many more anaesthesiologists receive first class training in the coming years.

Please give what you can and help your colleagues around the world to access these opportunities.

**TO DONATE** to the Fund a Fellow campaign visit www.wfsahq.org/get-involved/fundafellow or https://wfsahq.charitycheckout.co.uk/

From the Archives ~ Forty Years Ago!

The second Newsletter for 1976 appeared in August and was 32 pages long. The Editorial dealt with acid aspiration syndrome and then a series called “Forum” commenced, the first topic being New Zealand Anaesthetic Training. Professor Barry Baker led off this discussion, followed by comments from Dr Jim Clayton and Dr Michael Roberts. There was a letter from Dr Anthea Hatfield on acid aspiration and the use of pre-operative antacids.

Society News began with an article by Professor John Gibbs, Reflections on Taking over the NZSA Secretariat. Regional News followed with Wellington’s contribution delivered by Anthea Hatfield. This reported a visit by Dr Bob Boas from Auckland who spoke on Acupuncture, and noted the appointment of Dr Bill Cochrane as full-time Director of Anaesthetics in Wellington.

In Christchurch Dr Christopher Male from the UK was welcomed. There were some role changes, and Drs Chris Evans and John Gibbs were involved with registrar training. A detailed obituary for Associate Professor John Ritchie of Dunedin followed. Many New Zealand anaesthetists had their early training with him.

The historical item in this Newsletter was on Local Anaesthesia in General Surgery by Stephen Barclay, which was published in the New Zealand Medical Journal in 1949. Mr Barclay was surgeon superintendent at Grey Hospital in Greytown at a time when trained anaesthetists were few and far between. He later moved to Whangarei Hospital.

Basil Hutchinson,
Life Member

Humour

Observed recently by NZSA Life Member Basil Hutchinson was the following entry in the dessert section of a hotel dinner menu: “Tiramisu dusted with Chocolate and served with Brandy Analgise and Fresh Cream.”

That should take the pain away!
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PROCEDURES
- ENT Surgery
- Open abdominal surgery
- Laparoscopy
- Procedures ending sooner than expected or short procedures

In New Zealand BRIDION is listed for the following scenarios:

Where surgery duration is unexpectedly short

Unexpectedly difficult airway that cannot be intubated and requires rapid reversal of anaesthesia and neuromuscular block

Reversal of profound neuromuscular block from rapid sequence induction using rocuronium

Severe neuromuscular degenerative disease where neuromuscular block is required

References: