President's Blog

July-August 2018

I was one of a very fortunate cohort of New Zealanders to attend this year's European Society of Anaesthesiologist's (ESA) conference in Copenhagen. Like all European cities, history is all around you and as a small-town Kiwi boy you can only look at your surroundings in wonder and awe. I had not realised that the blue tooth symbol is the runes for Harold the Bluetooth. The Danish "empire" was extensive in the past and there is a plethora of palaces, castles etc. which are easy to access and well worth visiting.

Oh yes, the conference was good too. I enjoyed the sessions and the European opinions and approaches.

Prior to the ESA, I attended the CIG (Common Issues Group) annual meeting, hosted by the Association of Anaesthetists of Great Britain and Ireland (AAGBI). The CIG comprises of six-English speaking anaesthesia societies. I admit that I feel somewhat anxious prior to these meetings as I sit at the same table with the Americans who have about 60,000 members and the Brits who have 11,000! The NZSA by comparison has 600 plus members (although to put this in perspective our per capita membership rates are similar) and New Zealand's economy is smaller than most of their major cities. Nevertheless, we have a seat at the table and the opportunity to present and offer our views and perspectives. Topics discussed reflect the remarkable commonality between us, despite the differences in size, demographics, ethnicities etc. At this year's CIG the issues which we focused on especially were:

- *Drugs*: Somewhat surprising to me, the North Americans struggle with drug supply more than we do. Even basics like vec, roc and hyperbaric bupiviicaine. This is partly due to company consolidations and manufacturing/factory failures. I suspect the FDA regulations may contribute also. In New Zealand we are partially protected by PHARMAC's contractual obligations in which pharmaceutical suppliers accept responsibility to maintain ongoing supply and to notify PHARMAC if they become aware of a possible shortage. Additionally, they are usually liable for any extra costs involved in sourcing another product – this requirement means suppliers will often prioritise New Zealand above other markets when there are international stock shortages.

  Drug safety was also discussed at the CIG and at the ESA. All societies have experts in this area; it would be ideal to bring these experts together and agree on priorities for the future, including where the best bang for our buck is. Interestingly, all CIG members have agreed to work together to reduce drug supply problems. Depending on the progress we make, we may look at collectively resolving other issues. This is very exciting as together we represent the majority of English-speaking anaesthesiologists worldwide.

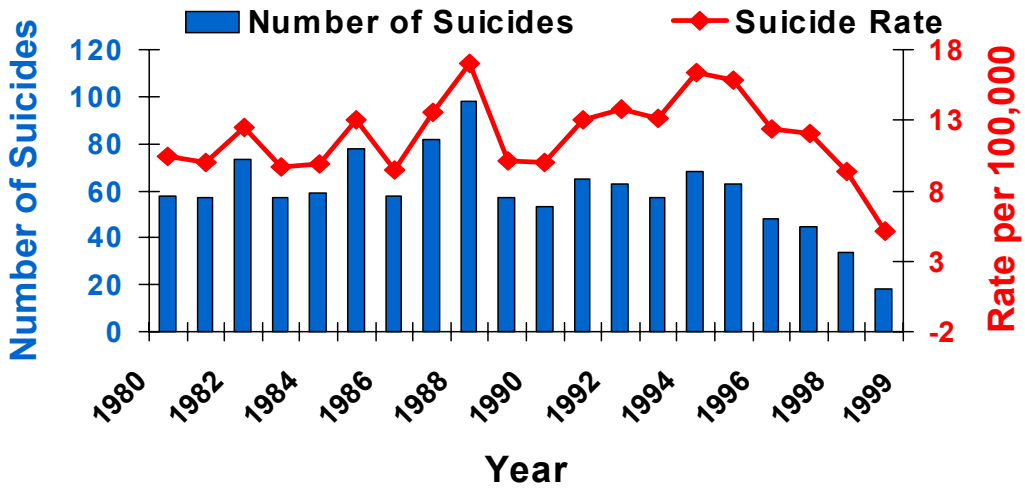
- *Welfare*: Welfare is a big focus for the NZSA and one of the key themes of the NZSA's "Behind the Scenes" forum this year (4 August 2018 in Christchurch). I encourage members to look at the programme and register. https://www.anaesthesiasociety.org.nz/education/nzsa-forum-2018/
  We have an excellent line up of presenters including keynote speaker Health and Disability Commissioner Anthony Hill. I have had the privilege of speaking with him on a number of occassions and he provides a useful

perspective on the complaints process. I found him to be honest and direct, and although we don't agree 100% on all issues I am delighted that he has agreed to come and speak to us. Having heard him present at our recent annual joint ANZCA NZNC-NZSA meeting I can attest that his talk is highly relevant, informative and will stimulate discussion. Please note that this year's NZSA Forum is the day after the Christchurch Department's "Shakes" meeting which you can find out more about here.

- *Suicide*: Tragically suicide rates are high and both the Society and College view this as a priority to address. What intrigues me after much discussion and reading, is that we have very poor knowledge of what will work to reduce suicide rates. It is also controversial as one view is that there is very little we can do. However, as anaesthesiologists we are at risk; an American survey of physician deaths found male anaesthesiologists as the biggest single group, while per head female physicians are at a much greater risk. (1) I have found this paper most useful. It also points out that underlying depression and alcohol use are major issues. I take my hat off to our colleague who addressed this issue very openly in a recent ANZCA Bulletin. (2)

  The American Airforce have taken this seriously and probably reduced the suicide rate by two thirds. However, they humbly point out that due to the lack of a control group such a claim is not possible. I have included a graph from their report below and you can make your own judgement. The interventions began in 1994. (3) Perhaps more importantly and what we as a group need to think about is the following quote:

  "Many individuals have risk factors, and while only a very small number will attempt or complete suicide, all exhibit decreased functioning contributing to lost workdays and reduced productivity. We must get our people help when they first show signs of distress."



- *Fatigue*: The AAGBI is running a campaign to raise awareness of the consequences of fatigue. We know that we are not at our best in the small hours but equally this is often when we are also most challenged. Akin to the airforce programme above, a multipronged

approach is required. The NZSA Executive have approved the NZSA to support AAGBI's campaign and we will keep members updated through our communication channels.

- *Environment*: The other Societies have made great progress in promoting environmental sustainability and reducing their health sector's carbon footprint. They have agreed to share resources and research with us. NZSA CEO Renu Borst and NZSA Communications Manager Daphne Atkinson recently attended a hui on the Zero Carbon Bill consultation organised by Ora Taiao (the NZ Climate and Health Council). Climate Change Minister James Shaw spoke at this event and encouraged the health sector to submit on the Bill. We are in the process of writing a submission. We have also formed an environmental advisory group, chaired by Matt Jenks, to assist us and provide advice on environmental matters. I personally find this issue difficult as everything we do seems to have an environmental consequence. However, as in suicide prevention doing nothing is not an option either.

- *POCD*: The Americans have a major project in this area, the Brain Health Initiative. Another complex and interesting topic. Many of you may already be aware of e.g. that those with pre-existing deficits and undergoing major surgery are at highest risk. As in many areas, attention to multiple small details is where the money is. This involves increasing awareness through to less use of benzo's and volatiles; use of more regional anaesthesia and reducing myocardial ischemia. (4) Interestingly, there is a recent article (5) looking at the benefit of α 2 agonists. This is a very comprehensive study. However, the dose of dexmetatoidine of 25 mcg/kg – not something I will be trying in my next fractured NOF or acute abdomen!

- *Bawa-Garba*: I assume you have all heard and reflected on this UK case. In case you are not familiar with the details, I encourage you to read this article https://www.independent.co.uk/news/health/hadiza-bawagarba-junior-doctor-death-boy-jack-adcock-manslaughter-gross-negligence-gmc-high-court-a8281386.html
  New Zealand's Medical Protection Society ran a webinar recently which our Incoming President Kathryn Hagen attended. Of some concern, expert opinion does not discount a similar scenario occurring here. I am hoping Anthony Hill will be able to give us his views at our forum in Christchurch.

Last week I had my formal, annual meeting with the Minister of Health. I had met David Clark as the Opposition Health Spokesperson but not as Minister. I was interested to see if his change in status had altered him but am pleased to report that he has retained his pleasant, interested nature although I got the impression that he was a bit more gun shy. We raised a number of issues, including:

- The tension we all have balancing elective versus acute surgery. This led to a discussion about health targets, which I found useful and I was able to reiterate concern about acute surgery.
- Anaesthetic assistants; we highlighted the shortage and tried to summarise in 10 minutes the complexities of the topic. Again, I thought this was a useful and fruitful discussion.

Unfortunately, due to time pressure we were unable to get our teeth into the National Maternity Record or as some of you may affectionately know it, Badgernet. You are

welcome to request a copy of the briefing paper we provided to the Minister if you wish by emailing comms@anaesthesia.nz

As always may the force be with you.
David

References:

1. Jennifer J. Robertson, MD, MSED and Brit Long, MD, The Journal of Emergency Medicine, Vol. 54, No. 4, pp. 402–409, 2018
2. The Bulletin, March 2018, p22
3. The Airforce Suicide Prevention Program; A Description of Program Initiatives and Outcomes, 2001
4. Khalil S, Postoperative Cognitive Dysfunction: An Updated Review
5. Dian-Shi Wang, Dexmedetomidine Prevents Excessive γ-Aminobutyric Acid Type A Receptor Function after Anesthesia**. Anesthesiology 2018.**