This year’s AGM was a very special occasion for our Society, for me personally and for Dr Ted Hughes who we welcomed as our President for the next 2 years. Ted is sure to bring fresh ideas, enthusiasm and energy to this role, and he will lead our Society to new heights. In my new role as Immediate Past President on the Executive Committee I am looking forward to working with Ted and to return the support Ted has always afforded to me over the past 3 years. I joined the Executive Committee in 2008 and Ted has served on the Committee since 2007. We have shared common goals throughout our respective tenures and I am truly grateful for the opportunity I have had to lead the Society in this role.

The Society issued a press release following the formal handover of the Presidency from me to Ted at our AGM which was held during the New Zealand Anaesthesia Annual Scientific Meeting from 6-9 November.

Strategic review
Our Society is a small group which achieves great things with the limited resources we have, and I think that we “punch far above our weight”. We have a real presence on the national and international stages, and we do good work.

The Executive Committee spent some time early in the year on reviewing what we do as a Society and what our vision and mission for the future of the Society should offer our members. We agreed that our vision should be “To represent and support the best interests of the community of medically registered anaesthetists in New Zealand and promote the perioperative safety of their patients” and that our mission is “To serve our membership by facilitating education, providing advocacy and support for their wellbeing.”

NZSA ACTIVITIES

Education
We have underwritten or supported AQUA, the Visiting Lectureships and BWT Ritchie Scholarships administered by NZAEC, the NZ Anaesthesia ASM, and have the 2014 Combined AACA/ASURA Meeting coming up in February. We receive our journal Anaesthesia and Intensive Care. We provide prizes for: academic presentations at the ASM; the outstanding Anaesthetic Technician graduate each year; the best paper at the Post Anaesthesia Nurses of New Zealand conference each year; and the best QA/Audit paper at the Annual Registrar’s Meeting.

NZSA is a member of the Australian and New Zealand Tripartite Anaesthesia Data Committee (ANZTADC) which collects anaesthetic morbidity data across Australasia. Our representative on this committee is Russell Rarity, along with our President and EO. The initial Chair of this Committee has been Alan Merry. This is building to be a superb, internationally recognised resource.

We jointly underwrite, with the New Zealand National Committee of ANZCA, the annual “Part 3” course aimed at senior trainees about to enter the specialist workforce. This course is the brainchild of Annick Hood and Julian Dimch. The course was held away from Auckland for the first time this year – in Dunedin after the ASM.

David Rusk and Nav Sidhu have organised an annual 2-day “Part Zero” course for three years now, aimed at those brand new to anaesthesia, or contemplating a career in anaesthesia. It covers the very basics of training, and a second day introduces the very basics of some anaesthesia techniques – this day is open to junior doctors from other disciplines as well...
as anaesthesia. We are very grateful to members of NZNC ANZCA for supporting this meeting.

Advocacy
Through the year we have written 17 submissions, and more consultations are underway:

- Pharmac (Medical devices, twice. Decision criteria review. Funding of sugammadex, gabapentin, methoxyflurane, COX-II blockers);
- NZ Nursing Council (Prescribing by Nurses, Merging of Regulatory Authorities);
- The Perioperative Nurses College of NZNO (Nurses as assistants to the Anaesthetist - twice);
- Medical Sciences Council (Scope of Practice of Anaesthetic Technicians);
- Ministry of Health (National Consensus Guidelines for PPH management, Updating the pregnancy and parenting education service);
- Medical Council of NZ (Standards and processes for recognition of vocational scopes of practice and accreditation).

I thank our Executive Committee for their considerable work on these submissions, particularly Graham Roper, Phil Eames and Kathryn Hagen.

We have met with representatives from ACC on two occasions this year, and will contribute to their review of services.

Members have expressed concern over the expansion of Southern Cross Healthcare’s Affiliated Provider Scheme. We commissioned a legal opinion, which we have made available to members. We anticipate further involvement in this delicate issue.

Our Economic Advisory Committee has been quiet over the last couple of years, and we plan to see this resurrected late this year/early next year. There is much that needs to be done.

We maintain good relationships with the New Zealand College of Midwives, and meet regularly with them and with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

We maintain close relationships with our submissions, and particularly Graham Lee and Indu Kapoor have worked Project for WFSA, and Maurice Alan Merry leads the Lifebox and I acknowledge their commitment and thank them.

and I thank them.

work is arduous and largely unseen, is on the Board of the AARS). This Education Subcommittee, and Neil MacLennan, Martin Misur, are all heavily involved in WFSA activities (Alan is Assistant Treasurer, Wayne is Chair of the Education Subcommittee, and Neil is on the Board of the AARS). This work is arduous and largely unseen, and I acknowledge their commitment and thank them.

We have been in discussion with Tourism New Zealand, who provides support for bids for international conferences, and they would be prepared to support our further bid for the 2024 World Congress. We are considering this.

Special contributions to NZSA work
As always, there are a number of members making outstanding contributions to our Society, and to our professional wellbeing, in a variety of ways. This list is by no means exhaustive and I apologise if I have missed people by mistake.

Campion Read and his team have worked extremely hard over the last several years to put together our Annual Scientific Meeting this year. The vibes were good - it was an outstanding meeting.

Kerry Gunn has led the NZ Anaesthesia Education Committee ably for the last two years. Our visiting lecturers this year were Professor Brian Anderson, Drs Matt Taylor, and Rachelle Williamson, and I thank them for their contribution to the education of our community.

Kerry, Neil MacLennan and Martin Misur once again organised a very successful AQUA meeting in Queenstown, which 130 delegates enjoyed in August.

Neil MacLennan, Martin Misur, Simon Mitchell, Chris Nixon and their teams are working frantically to prepare our next major meeting, and I know we are looking forward to the Combined AACA/ASURA meeting in February 2014.

Alan Merry, Wayne Morriss and Neil MacLennan are all heavily involved in WFSAs activities (Alan is Assistant Treasurer, Wayne is Chair of the Education Subcommittee, and Neil is on the Board of the AARS). This work is arduous and largely unseen, and I acknowledge their commitment and thank them.

Alan Merry leads the Lifebox Project for WFSAs, and Maurice Lee and Indu Kapoor have worked extremely hard on the New Zealand contribution to this, each making...
several trips to Vietnam in recent years. I acknowledge their work, and also that of the others who have just returned from Vietnam – Emma Patrick, John Hyndman, David Murchison, and Tomas Goscincki.

I would like to thank the New Zealand National Committee ANZCA for their support and help over the past 3 years in many areas, and Ted and I look forward to developing this relationship.

I must acknowledge the work of the Executive Committee. Together they cover a wide span of geography, age and experience, and I thank them for their huge support of me, and their ready help with opinion and advice. Ted Hughes in particular has been a rock-solid support for me.

Office
Renu Borst leads a lean staff of two, aided capably by Liz Stone. Deb Smart left the office late last year, and we thank her for her contribution to the work of the Society.

The staff of NZ National Committee, ANZCA and our staff meet regularly over coffee, and Heather Ann Moodie, General Manager of NZNC and Renu Borst, our EO, have regular meetings. Relationships between our offices are good.

Congratulations to:
Leona Wilson - awarded the Orton Medal, the highest honour awarded by ANZCA.
Alan Merry - awarded honorary membership of the American Society of Anaesthesiology for "International recognition as a highly respected patient safety advocate and for scholarly contributions to this topic."

In Memoriam
I note with sadness the deaths of these members of our Society:
Hugh Spencer (Hamilton). Life Member of NZSA; former Head of the Waikato Department; Life Member of the Pacific Society; Honorary Member of the Australian Society; valiant servant of ANZCA in New Zealand, receiving an ANZCA citation in 2004; ONZM 2010 for services to medicine. Hugh’s obituary was printed in the August issue of this newsletter. A further Tribute to the late Dr Hugh Spencer by Kester Brown of Melbourne, who is Past Chair of the Education Committee and Past President of the WFSA, is on the WFSA website.

Brian Johnston (Tauranga). Willing servant of the Tauranga and Whakatane Departments of Anaesthesia and communities; Family man; Missionary. Brian’s obituary was published in the May 2013 issue of this newsletter.

Sudhakar Mayadeo (Auckland). Dedicated servant of the Palmerston North, Auckland, and National Womens’ Anaesthesia Departments since emigrating to New Zealand in 1967. Sudhakar’s obituary is printed in this issue.

Finally
This is my final President’s Report for this newsletter. I am looking forward to reading Dr Ted Hughes’ editorial that will feature on these pages starting with our first issue for the 2014 year which will be published in March. Three years is a year longer than I anticipated being President, and my heart goes out to Nigel and Gail Waters over the circumstances of Nigel’s early resignation from the post of President. During my tenure I have enjoyed some amazing experiences, met some phenomenal people and been taken far from my comfort zone. I have had my eyes opened to the larger national and international world of anaesthesia. Highlights include sitting at the table with the ANZCA and the ASA Councils and attending the Common Issues Group in Banff. What makes these such highlights is the warmth and positivity of the people there – people who willingly give their own time and energy for the benefit of their colleagues and their patients.

I have loved working with Renu Borst and Liz Stone in our office. We are lucky to have them. They achieve far more than would seem possible. I have enjoyed working with the Society’s Executive Committee members over the past three years, and all have served willingly and with great good humour. I thank them for their huge support, and for keeping me on the straight and narrow. Andrew Warmington and Ted Hughes deserve special mention here and I thank them for their support and wise counsel.

I wish Ted and the NZSA well.

Rob Carpenter
November 2013

THE NEW PRESIDENT OF NZSA – DR TED HUGHES

The President of the New Zealand Society of Anaesthetists, Dr Ted Hughes, is a fulltime specialist anaesthetist at North Shore and Auckland Hospitals. On his way to an MChB in 1986 he did two masters degrees, one in physiology and the other in pharmacology. The logical progression was into anesthesia training mainly in Auckland, with a final year in Sydney at St Vincents (1993). He was at Greenlane and National Womens’ from 1993 to 2000. At these two adjacent hospitals he did cardiothoracic, transplant, vascular, ENT, O&G anaesthesia, acute and chronic pain. In 2000 he shifted to North Shore Hospital (NSH), where he did anaesthetics and ICU work. He was Supervisor of Training for NSH ICU for 6 years. He joined the NZSA Executive Committee after being appointed to the PMMRC (NZ Perinatal Maternity Mortality Review Committee) in 2007. He was education officer, currently chairs ACECC, does obstetric liaison, and is involved in anaesthesia technician training. As the first President of Pacific Islands descent Ted has been heavily involved in NZSA aid work in the Cook Islands and was deployed to Samoa after the tsunami. At work Ted enjoys helping out as part of a team. When Ted’s not at work he is usually to be found in the great outdoors riding a bicycle or paddling a kayak, usually with his family.

NZSA REPRESENTING, SUPPORTING AND PROMOTING NZ ANAESTHETISTS SINCE 1948

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

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

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

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

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

Keynote Speakers

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

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

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

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

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

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

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

Ban Tsui MD, PhD
Professor, Department of Anesthesiology and Pain Medicine, University of Alberta Hospital Edmonton, Canada
At the New Zealand Anaesthesia Annual Scientific Meeting (NZA ASM) which is co-sponsored by the New Zealand Society of Anaesthetists and the Australia New Zealand College of Anaesthetists, anaesthetists from around New Zealand and abroad gather to develop their professional and medical educational expertise.

This year’s NZA ASM at the magnificent Dunedin Town Hall was a wonderful educational event with a fabulous social programme and an exceptional turnout.

The Mayor of Invercargill, Hon Tim Shadbolt, was the first guest speaker and his entertaining address was warm, funny and set the scene for the guest speakers to follow.

At this year’s conference the keynote speakers were: Professor Mark Warner, the Annenberg Professor of Anesthesiology at the Mayo Clinic and a past President of the American Society of Anesthesiologists; Professor Eric Jacobsohn, Professor and Head of the Department of Anesthesia University of Manitoba, and Professor Jamie Sleigh, specialist anaesthetist at Waikato.

Professor Mark Warner’s fascinating speech to delegates on the ground-breaking marvels of nanotechnology entitled “The Future of Anaesthesiology” is covered in a press release published on the ANZCA website entitled “Tiny technology, huge benefits – medical use of nanocrystals”.

In addition, the keynote speakers and a number of other invited speakers provided workshop and PBLD presentations.
NZSA ASM Continued...

Left and right: Drs Emma Patrick and Phil Eames, both current NZSA Executive Committee members, and former Trainee Representative on the committee Dr Nathan Kershaw

Dr Neil MacLennan (seated) at one of the workshops. Dr MacLennan is the co-convenor of the 2014 Combined AACA/ASURA Meeting which will take place in Auckland from 21-25 February

Immediate Past President of NZSA Dr Rob Carpenter and his wife Claire Carpenter at the ASM Dinner

Professor Mark Warner and his wife, Dr Mary Ellen Warner

NZSA President Dr Ted Hughes and his wife Dr Margaret Blakeley at the ASM Dinner

ASM Convenor Dr Campion Read and Dr Ulla Reymann, organising committee member and convenor of Workshops and PBLDs

President of the Australian Society of Anaesthetists Dr Richard Grutzner and his wife Jane Grutzner

At left and right: Nicola Smith-Guerin NZATS Examination Co-ordinator and Chair of NZATS Kylie Parry. Middle: Renu Borst Executive Officer NZSA

Lucky winner of the book A Practice of Anaesthesia for Infants and Children co-authored by Dr Brian Anderson was Dr Rob Carpenter. NZSA President Dr Ted Hughes awarded the prize and Pat Johnston, Manager, Destination Conference Management Services made the draw
Messsage of thanks from ASM Convenor, Dr Campion Read

“It was my privilege and pleasure to convene the recent NZA ASM Dunedin 2013 on behalf of the New Zealand Society of Anaesthetists and the ANZCA New Zealand National Committee. The dedication and unstinting hard work of everyone on the organising committee made my job a pleasant one. We all relied on the inspiration and leadership of Kerry Gunn at the NZAEC, as well as everyone working so hard on our behalf in the Society and National Committee. To meet and work with excellence, and have it rewarded by an appreciative reception from the many registrants, is humbling.”

Dr Campion Read, Convenor Dr Hansjoerg Waibel Scientific Convenor, NZA ASM Dunedin 2013

The Organising Committee of the NZA ASM Dunedin 2013

We acknowledge the dedicated and hardworking team effort that made the conference such a success and thank the Convenor Dr Campion Read, the scientific convenor Dr Hansjoerg Waibel and Drs Andrew Smith; Angela Dewhirst; Carol Padgett; David Hunt; Duncan Watts; Geoff Laney; Helen Weir; Jason Henwood; Joe Sherriff; Justin Holborow; Kerry Gunn; Lisa Horrell; Marcus Renner; Mathew Zacharias; Patricia Telavich; Paul Templer; Robyn Chirnside; Tim Wright and Ulla Reymann for this. The meeting was a great success for Pat Johnston, Director of the professional conference organising company Destination Conference Management Services, and her team.

Continuing Professional Development at the ASM

Details about the category and level of CPD credits allocated for this event are provided on the ANZCA website www.anzca.edu.au/fellows/continuing-professional-development. For assistance with credit allocation please contact the CPD Unit at cpd@anzca.edu.au.

Lifebox Donations at the ASM

We appealed for Lifebox donations again this year at the ASM. At the ASM Dinner which was held at Larnach Castle, a total of $7,600 was pledged in donations and this included a combined bid of $1,500 by Professor Eric Jacobsohn and Professor Mark Warner for a packet of Vietnamese Coffee donated by Dr Maurice Lee. Thank you everyone for your donations - it’s your generosity that makes this appeal successful.

NZSA Prizes

The following prizes were awarded by incoming NZSA President Dr Ted Hughes at this year’s Annual Scientific Meeting.

2013 John Ritchie Prize Winner
1. Dr Colin Marsland of Wellington won the Ritchie Prize for his abstract “Emergency percutaneous transtracheal ventilation in an obstructed airway model in sheep: oxygenation, airway pressure and carbon dioxide clearance using the Ventrain® and Manujet®”. Dr Marsland received a cheque for NZ$5,000 with his certificate.

NZSA Trainee Prize Winner
2. Dr Yiyi Zhang of Hamilton won the Trainee Prize for “Standardization of Propofol-Remifentanil Co-induction for Electroconvulsive Therapy”. Dr Zhang received a cheque for NZ$2,500 with her certificate.

NZSA Poster Prize Winner
3. Dr Philip Quinn of Wellington won the Poster Prize for “Hyperoxia During Cardiopulmonary Bypass: A Systematic Review”. Dr Quinn received a cheque for NZ$500 with his certificate.

Entries for the Ritchie Prize and Trainee Prize were presented during an excellent session during the ASM, while posters were presented during lunchtimes over the course of the meeting. The standard of research and presentation was excellent, and we congratulate all presenters.”

New Zealand Anaesthetic Technicians’ Society Best Anaesthetic Technician Speaker Prizes – sponsored by NZSA

At its September Executive Committee Meeting the NZSA Executive Committee approved sponsorship to the value of $800 for the NZATS Best Anaesthetic Technician Speaker. Dr Mark Featherston, NZSA Treasurer, congratulated the following prize winners who received first, second and third places in the competition which attracted eleven speakers. The NZSA Prize for the NZATS Best Anaesthetic Technician Speaker was awarded as follows:

1. First Prize awarded to Matt Savage for the “Malignant Hyperthermia Workshop”.
2. Second Prize awarded to Hazel Harrison for “Human Factors in Relation to Communication in the OR”.
3. Third Prize was awarded to Paul Butler for “Jehovah’s Witnesses; transfusion considerations”.

Book Competition at the ASM

Professor Brian Anderson, Adjunct Professor of Anaesthesiology University of Auckland and Paediatric Anaesthetist/Intensivist at Starship Childrens’ Hospital edited and co-authored, with Charles Cote and Jerrold Lerman, the major paediatric anaesthesia textbook released in February this year titled: A Practice of Anesthesia for Infants and Children.

We thank Prof. Anderson for donating two copies of the book to the NZSA. Dr Rob Carpenter won the Lifebox donation draw at the Larnarch Castle ASM dinner and Dr Colin Marsland received the other copy on the night for volunteering to review the book.

ASM Competition

There was a Health Care Industry Competition at the ASM that caused a lot of excitement amongst the delegates with the first prize being the new iPad Air. Six people scored 100% on the quiz and names were drawn out of a hat. NZSA member Dr Lars Molvig was the lucky winner and the recipient of the iPad. His partner, Dr Felicity Pugh, who is also an NZSA member, won the Smith Medical Prize.

Immediate Past President of NZSA, Dr Rob Carpenter, accepting the book prize from President Dr Ted Hughes
Dr VB (Bruce) Cook was nominated for Life Membership of the NZSA by Dr Graham Sharpe. Dr Sharpe’s citation was presented at the AGM and is printed below.

**LIFE MEMBERSHIP CITATION FOR DR (VERNON) BRUCE COOK**

Bruce Cook is an icon of New Zealand Anaesthesia.

He is 90 years old this year, living in retirement in Marlborough. His family were originally from the East Coast of Scotland, and he always claimed lineage from Captain James Cook, who was actually a Yorkshireman from Whitby but sailed up and down the north-eastern coast of the UK in his collier many years before becoming a Royal Navy explorer. The veracity of this claim remains open to debate.

He graduated MBChB from Otago in 1948. After house surgeon years in Wellington, he went overseas for anaesthetic training in the US (at Cleveland) and then the UK. Whilst in Britain he managed to fall between the old DA and the (then) new FFARCS. This allowed him to return to New Zealand with both qualifications. He gained the FFARCS in 1958 by, he claims, paying a fee and having a chat with some Australians.

In 1961, Bruce formed the Mayfair Anaesthesia Group (known by local surgeons as the Mafia) with Alf Slater and Dave Wright. The group was named after the Mayfair Chambers on the Terrace where Alf Slater had rooms, but was also a nod to Sir Robert Macintosh, who had started the Mayfair Gas Company in England before the War. The group established the practice of anaesthetists charging their own fees, and when Bowen Hospital opened in Ngaio in 1971 they had a base from which they could run a comprehensive private anaesthesia practice.

Bruce continued as part time consultant at Wellington Hospital until 1988, and gave his last private anaesthetic at the Home of Compassion in 1993.

In retirement Bruce settled in Renwick. He had an interest in the wine industry, and was an initial owner of Le Brun, who pioneered methode champenois in New Zealand. This association led to a wine tour of France in 1990, followed by an ESA conference in Warsaw. The conference included a day trip to Auschwitz, this visit having a profound affect on Bruce as he faced the ultimate inhumanity by the Nazis.

Bruce was a member of the NZSA Executive in the late 1960s and early 1970s, taking various roles culminating in being President in 1972-73.

Bruce was a favourite with his registrars. In fact he was often the “go to” consultant because his advice was always helpful and practical. But more importantly, Bruce had a collection of anaesthetic aphorisms that stayed with his trainees long after they had forgotten the pulmonary gas equation. Some of his “Cookisms” include:

“Surgery is like sex – it’s a non-spectator sport”

“Signs of a surgeon in trouble: adjust lights; adjust table; ask for more relaxation; remove alternative organ and close.”

“Moving an operating light always results in the surgeon placing the back of his head in the focus point.”

“Hate all surgeons, but hate slow surgeons the most.”

“Surgery begets surgery.”

“Three essentials for a safe anaesthetic: a tube in the trachea; a needle in the vein; a roll of one inch sticky tape.”

Recognition also came in The Press from Raybon Kan, no less, when he was doing a story for the Evening Post on cardiac surgery at Wakfield. He referred to Bruce as “…the Jack Pallance of anaesthesia...” with “…the voice of a Shakespearean thespian combined with the face of a professional pugilist!”

Dr Bruce Cook has dedicated a professional lifetime to the practice of anaesthesia in New Zealand, and has served the Society in its highest office. We feel that his recognition is late in coming, but surely it is time for him to be made a Life Member of the New Zealand Society of Anaesthetists.

**Dr Graham Sharpe**

**NZSA Life Member**

**Dr Phil Thomas**

**NZSA Member**

**NEW LIFE MEMBER OF THE NZSA**

**Dr Phil Thomas**

**NZSA Member**

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**INTRODUCING NEW NZAEC CHAIR**

- **Dr Graham Roper**

Dr Graham Roper is a Specialist Anaesthetist based at Christchurch Hospital and took over as Chair of the New Zealand Anaesthesia Education Committee (NZAEC) in November 2013. Dr Roper has been a member of the New Zealand Society of Anaesthetists (NZSA) Executive Committee for three years.

Dr Roper attended Otago Medical School and undertook his Anaesthetic training in Hawkes Bay, Wellington, and New South Wales gaining his Fellowship in 1997. After postgraduate work in Oxford UK, Dr Roper returned to Christchurch in 1999 as a full-time Specialist Anaesthetist at Canterbury District Health Board (CDHB) with interests in cardiothoracic anaesthesia and teaching.

In 2005, Dr Roper became the Clinical Director of Anaesthesia Christchurch Hospital CDHB, and held this post for six years. Twelve months ago Dr Roper took up an appointment as Head of Anaesthesia Services at Greymouth, West Coast District Health Board.

Dr Roper has been an ANZCA Primary Examiner for about 8 years, regularly participates in the annual Christchurch anaesthesia primary examination course and is a resuscitation trainer.
OBITUARY: Dr Sudhakar Vishnu Mayadeo

By Vasu Hatangdi
FANZCA, Auckland New Zealand

Sudhakar Mayadeo, formerly of Auckland, New Zealand, was born on 3 November 1935 and passed away peacefully in his sleep on the morning of 18 February 2013.

Sudhakar received his formal education in India having gained his MBBS in 1959 from the University of Pune (Pune) in the state of Maharashtra, India. He gained his Diploma in Anaesthetics (DA) from the University of Bombay 1961 and later continued his further studies to complete his MD (Anaesth) in 1965 from the prestigious All India Institute of Medical Sciences (AIIMS) in New Delhi. New Zealand has had a close association with AIIMS over many years, having partly funded the initial cost of setting up of AIIMS in 1955 under the Colombo Plan.

Not surprisingly, the winds of fate brought Sudhakar to New Zealand in 1967 when he joined the Anaesthesia Department at Palmerston North Hospital under Dr Dick Rawstron. Sudhakar was a very competent anaesthetist and was very popular and well-liked by his colleagues in the department. He moved to Auckland in 1971 and joined the Department of Anaesthesia at Auckland Hospital under the Directorship of Dr Jack Watt, and later gained his FFARACS in 1972.

After his fellowship, Sudhakar was transferred to work as a full-time specialist at the National Women’s Hospital where he worked for many years and was actively involved with anaesthesia for O&G and epidural service for obstetrics. He joined the Anaesthesia Auckland Group in 1980 as a part-time practicing anaesthetist, specialising mainly in anaesthesia for O&G and plastic and cosmetic surgical procedures. Sudhakar developed a flourishing and successful private practice until he retired in 2005.

In his leisure time, he enjoyed reading and was keen on music and cricket and played an active role in promoting the language and culture of his state of Maharashtra. Being a dedicated oenophile he often visited vineyards for wine tasting and was always excited when he saw or read about any new high quality wines and made sure his wine cellar was well stocked. He even had a personalised car registration plate - Vintage 35.

Although he had a few health issues over the last few years after he retired, he was certainly blessed to have passed away peacefully without much suffering.

He leaves behind to cherish his memories, his wife Anuradha, a daughter, a son, three grandchildren and many friends and colleagues. I am deeply touched by his tragic loss as I have known Sudhakar from the time we were training together at Bombay and over the years watched with interest our mutual progress in professional development and seen our families grow. May his soul rest in peace.

This year we welcomed trainee representatives Drs Kate Romeril and Kerry Holmes and co-opted Drs Yvonne Wagner, Kaye Ottaway and Paul Templer to our Executive Committee. At its final meeting for the year during the ASM in Dunedin, the Executive Committee bade farewell to Dr Kathryn Hagen who first served on the Committee as the Trainee representative in December 2012 and later as a consultant. Dr Hagen has been a very active and supportive member of the committee throughout her tenure and is moving to Ireland to take up a Fellowship in 2014. We wish Kathryn all the very best and look forward to catching up with her when she returns to New Zealand in 2015.

Meeting dates in 2014
The Executive Committee will meet on the following dates in 2014:

- 14 March
- 27-28 June (joint meeting between NZNC ANZCA and NZSA)
- 23-24 August and AGM at the Annual Queenstown Update in Anaesthesia meeting (dates TBC)
- 21 November

The end of the year is rapidly approaching and hopefully holiday plans are coming along nicely for everyone. It’s a good time to really push the ‘life’ component of work-life balance as lists slow down and everyone gets at least a little break for a brief period. Make sure you use your leave, plan something nice and try to leave theatre/pain rounds/surgical registrars behind.

**Workforce**

A recent meeting of the Doctors-in-Training Committee produced some interesting statements from Health Workforce NZ. There were difficulties placing all new Medical Graduates into Intern jobs at the start of this year. Apparently this was not unexpected, but was a situation that had developed sooner than expected. Medical Student numbers will increase to a total of 550, an increase of 200 from the initial baseline. This number is based on what HWNZ believes can be safely trained, not what is demanded by the market. They are hoping to reach a position of zero doctor vacancies in the next decade, this essentially means an oversupply of doctors. Trainees were told they would have to come to terms with the labour market, so it appears that a job at the end of your training is no longer a reasonable expectation unless one is prepared to undertake training in areas of need such as Palliative Care.

These markets clearly move in cycles, but it seems that the medical job market is being actively oversupplied so will not ease up for new graduates anytime soon. Talks of clearing the pipeline for training seem to be in progress, it remains to be seen how this will affect Anaesthesia.

**Exams**

Congratulations to everyone that made it over one of these immense hurdles in the second sitting. Hopefully the world is looking a brighter place and you are finding things to do with all your free time. For those that missed it this time, commiserations. Read your feedback, try to take it on board and please make sure you take some time off to relax your brain and enjoy the sunshine before getting back into it.

Dr Kerry Holmes
Trainee Representative
NZSA Executive Committee

Dr Kerry Holmes
Trainee Representative
NZSA Executive Committee

Dr Kate Romeril
Deputy Trainee Representative
Profile of Dr Rachelle Williamson who has recently joined the Society

I am your good friend, Rachelle Williamson. You may not have met me yet, but it is a distinct possibility, should you wish it to be.

I recently learned that the Queen of England signs off on all of her letters to fellow Heads of State, as above. I have no delusions of grandeur, and will never be queen of anything, including my own household. But I thought I would address my Fellows of the College in a similar manner and see how it takes off. I am sure you will all be tracking the viral progress, via social media sites with great anticipation!

Well so far I have told you very little except my name and antiquated ways, including my complete derision and distaste for all forms of electronic social media. I would possibly consider “twittering” if a member of royalty told me they were “my good friend.” I have been a proud wife and Mum of two wonderful stepdaughters for nearly 10 years. Despite our fantastic relationship they will not twitter or friend me on Facebook. Devastating.

I am an Anaesthetic Specialist at Christchurch Hospital, and will be entering my third year as a Fellow of ANZCA upon publication of this article. I thoroughly enjoy being a general anaesthetist. I find the variety of work, the multidisciplinary interaction, and the practical aspects of my job, both challenging and rewarding.

Currently a significant amount of my enjoyment is derived from teaching, and participation in continuing clinical education. This year I attended the Foundation Teacher Course run by ANZCA in my pursuit of becoming a better teacher. I would recommend this to any consultant who teaches registrars or trainees in theatre. But most of all, the thing that makes me happy at work is having fun, and feeling valued. As such, I take the time to be approachable and diplomatic, working hard to ensure all members of my theatre team feel appreciated.

Merry Christmas
Happy New Year

Contributions to New Zealand Anaesthesia
Welcome!
To contribute your profile for this column or submit an article for the newsletter please contact us.

2013 Part 3 Course Review

This year’s Part 3 Course was held on Saturday 9 November, at the end of the ASM in Dunedin. The course provides an opportunity for advanced trainees to explore issues they face in making the transition from an RMO to an SMO. It is known as the “Part 3 Course” because the path to qualifying as a consultant and Fellow of the Australian and New Zealand College of Anaesthetists is achieved on completion of three stages in the examination process.

The course was initiated by ANZCA’s NZ Trainee Committee and is hosted jointly by ANZCA and NZSA. Drs Julian Dimech and Annick Depuydt were invited to convene the first course in 2011 because of experience they had providing a similar course at Middlemore Hospital and they have run the course every year since then. This year, Dr Jason Henwood of Dunedin assisted them.

Next year the course will return to the Ko Awatea Centre at Middlemore where the first two courses were held. However, the intention has always been to have the course move around the country and in 2015 it is likely to be held in Wellington.

The programme for this year’s course was ‘Leaving the Nest…and Soaring into the Future’ - aptly put considering that the course is about the coming of age as an SMO and that the Otago Peninsula is home to some of the rarest wildlife in the world including the breeding colony of the one of the world’s rarest birds, the Royal Albatross.

A total of 67 registrars have attended this course since it began. Of the 18 registrars who attended this year’s course, more travelled from Wellington to attend than from any other location in New Zealand and the number of North Island attendees was more than double the South Island contingent.

For the morning session, participants split into smaller groups of 3 or 4 to discuss CVs and interview techniques. Each group was led by a facilitator (Drs N Chadderton, A Depuydt, J Dimech, J Henwood and N O’Brien). Cornwall Strategic’s Steve McCrone, who has a background in Human Resources, provided useful information to participants about how to present themselves at interviews and create/maintain a positive reputation throughout their career. Denys Court from the Medical Protection Society worked with Dr Julian Dimech to present and discuss a medico-legal case. Various aspects of the case introduced specific themes to keep in mind or address when dealing with difficult cases that have the potential to lead to legal action.

The first of the afternoon sessions was entitled ‘Where will FANZCA take you?’ comprising six presentations on a ‘day in the life’ from a variety of anaesthetists. Dr Geoff Long covered ‘College life’ and gave an overview of ANZCA and the various ways that consultants can interact or become involved with the College, such as becoming an examiner, sitting on the New Zealand National Committee or being a Supervisor of Training, etc; Dr Rob Carpenter spoke about the pros and cons of private practice and was followed by Dr Jason Henwood who spoke about ‘making changes’ and becoming an influential member of your department; Professor Jamie Sleigh enlightened participants about research and academia; and the art of work/life balance was addressed by Dr Robyn Chirnside in her ‘working smart’ session. Interestingly, the most popular topic in this session was presented by Dr Cambell Bennett who promoted the benefits of rural practice.

All presenters were ranked highly and the course evaluations have provided useful feedback for the course organisers to take on board. The common theme was that the participants gained most from pragmatic sessions that gave a well rounded overview within a timeframe appropriate to the attention span of the group. A conversational approach to presentation rather than via Powerpoints was preferred and getting a job was cited as being a greater motivator than money, which perhaps accounts for the popularity of the topic on rural practice.

Dr Annick Depuydt chaired the final session of the day, ‘Things I wish I had known …’, which included a panel discussion using many of the session two presenters.

After the course the participants and Faculty reconvened at Ironic Café, a short walk from the Town Hall, the venue of the ASM. Overall, feedback on the course was positive with additional comments given such as ‘Fantastic course – will recommend to registrars who haven’t been’, and ‘Really worthwhile. Thank you!’.
During my Provisional Fellowship at Middlemore Hospital I realised that to be more complete as a consultant I would need to experience how Anaesthesia was practiced away from the Australasian (and ANZCA based) system. After an elective in the United States in my final year of medical school I was always keen to return to North America to experience their healthcare system as a practising doctor to compare and contrast how this system works compared with what I have grown up with and am used to back home.

In February of 2012 I started to look for positions in Canada. I had contact with a Consultant who worked in Halifax, Nova Scotia who provided me with a list of fellowship positions available in various Anaesthetic Departments around Canada. After some emails I finally placed an application to the Toronto General Hospital for a Fellowship in Anaesthesia for Liver Transplantation; Hepato-Biliary Surgery and Surgical Oncology. After completing the application process I heard I had attained a position in April 2012. At this point I commenced the long and onerous task of obtaining a work permit and registration with the College of Physicians and Surgeons of Ontario. Despite filing all the paperwork in plenty of time this was only finally completed two days before I was scheduled to start work.

Toronto General Hospital is a quaternary 500-bed hospital situated in the ‘Discovery District’ of downtown Toronto and is affiliated with the University of Toronto. Nearby there are numerous other hospitals and research institutes. The Hospital for Sick Children is across the road; as are Mount Sinai Hospital and the Princess Margaret Cancer Centre. There is a strong history of research and innovation with the initial clinical use of both insulin and heparin occurring here. More recently the Hospital has become a centre of excellence in Canada for Organ Transplantation; Hepato-Biliary Surgery and Urological Surgery including Robotics and Gynaecological Oncology. In addition to the Monday to Friday workload there are also on call requirements. One week in four I am on call for 7 days for Liver and Pancreatic transplantation which can mean call backs at unusual hours to perform anaesthesia for a transplant. Four times per month I take a 24-hour call (at times from home) for general emergencies – this can be very busy and at times very unwell patients come through for laparotomies or relook procedures.

Transplantation is a fascinating part of my job and is something that I had not experienced in New Zealand. The breadth of my clinical experience has been amazing in Toronto. This centre performs around 150 Liver Transplants per year – this is amongst the most of any centre in North America and is a particular leader in Live Donor Liver Transplantation. The number of Whipple Resections is also large with some surgeons doing upwards of 50 per annum. I am given considerable autonomy in the Operating Room meaning I have learnt how to manage some extremely complex situations, but with the ability to call for help should it be needed. To date I am very happy with the scenarios I have been exposed to and the skill mix I have been able to attain.

Outside of the Operating Room I have developed some research interests including conducting small studies assessing the use of new equipment in Liver Transplant patients and am involved with the planning and conduct of a meta-analysis with some of the Cardiac Anaesthetists. I hope to cultivate and continue with some research on my return to New Zealand with the connections I have made in Toronto.

Dr Nick Lightfoot – Seeking broader horizons in Toronto’s ‘Discovery District’

Toronto is a large and multi-cultural city which is ideally located to explore both Canada and the United States. The Canadian people are by and large very helpful and generous. To date I have been on a camping trip on the shores of Lake Ontario with some locals and have explored both Ontario and Quebec with trips to the Niagara Region, Ottawa, Montreal, and Quebec City. Quebec offers some contrast to the largely anglophone Ontario – you can drive down the street and see road signs flashing in French and have no idea what they mean. I have also had the chance to go further afield with weekends away to Chicago and shortly to Washington DC. Next year, the Canadian Anaesthetists Society is having their annual conference in St John, Newfoundland. This will give me a chance to network with other Canadian Anaesthetists and to see another part of the country which is bound to offer some contrast to that which I have already seen.

Overall I am enjoying my experiences in Canada. As with any move to a new country there will always be struggles and I do miss my family, friends, and colleagues back home. However, balanced with this are the new skills I have attained, the ability to make new friends, and the convenience of living in a large city. I am looking forward to returning to Middlemore Hospital in July of 2014 to continue working as a consultant and to try and build on my time away by integrating what I have already learnt from my training in New Zealand with new skills I am picking up from my time away.

Should any trainee or member have any questions about arranging time in Canada please do not hesitate to be in contact with me through the New Zealand Society of Anaesthetists’ office. Nicholas Lightfoot

NZSA Member
This year’s fifth Annual Queenstown Update in Anaesthesia held in August was a great success. The convenors, Neil MacLennan and Martin Misur put together a scientific programme covering a wide range of topics relevant to anaesthesia practice. Professor David Story from Melbourne, spoke on perioperative mortality and on the management of patients with diabetes. The latter presentation was particularly insightful given his own experience as a diabetic. There were presentations from local speakers on difficult patients in the PACU (post-op pricklies), aortic stenosis, orthopaedics, and what to do at a road crash. We also heard about trends in vascular surgery and an entertaining view of evidence-based medicine from Tony Smith (a cynic’s guide to evidence-based medicine). The programme and full abstracts are featured on the AQUA website www.aqua.ac.nz.

As usual, the scientific programme was well balanced with learning and recreation. The event was set in a family friendly environment that allowed the doctors to attend meetings in the morning and catch up with colleagues, friends and family on the ski slopes in the afternoon.

**Dr Anna Petrocelli**

- **the “AQUA Experience”**

As usual AQUA 2013 not only met my expectations but exceeded them. The meeting kicked off with a lively and thoroughly enjoyable cocktail party where old friends, colleagues and reps of the sponsoring companies met. The academic program covered a broad range of relevant topics ranging from periop medicine to post op problems, blood issues and medico legal issues to mention a few. The lectures and the speakers while of a high standard were also fun and entertaining. Despite the grumblings of lack of snow most of us managed to find some snow and do some skiing!

The meeting ended with an amazing evening on Coronet Peak on the Saturday night with much fun, laughter, the AB’s winning the rugby and, of course, me winning the prize!!

Thank you to Martin Misur, Kerry Gunn, Neil MacLennan, and Karen Patching for their hard work. Also thanks to the companies who sponsored the meeting, and, last but not least to the NZSA for supporting this meeting and sponsoring the prize.

**Dr Anna Petrocelli**

NZSA member

**Winning Entries in the AQUA Scarf Competition**

This year the NZSA prize was offered for “the most innovative way to wear the AQUA scarf”. There were a number of enthusiastic entries and due to the high number of entries the prize money was split into two categories, one for kids and one for adults. Dr Petrocelli received the loudest applause for her entry and won first prize. Dr Petrocelli donated her prize of $100 to the Starship Foundation.

It was harder to decide on an overall winner in the childrens’ section so the three winners in this section were awarded $30 each.

**What’s on the programme for AQUA 2014?**

Details and dates of next year’s meeting will be posted on the AQUA website early next year.

**NZSA AGM 2014**

In 2014 both the NZSA and the New Zealand National Committee of the Australian and New Zealand College of Anaesthetists (NZNC ANZCA) will hold their AGMs at AQUA. Early in 2014 we will be calling for nominations for the position of President-Elect, Treasurer, and Secretary on the NZSA Executive Committee. More details will be published in our weekly newsletter to members, the Ezine.
WEBAIRS News

There are currently 61 sites registered with webAIRS and 1957 incidents have been reported as of September 2013. Data from these incidents were used in a presentation entitled ‘Incident Reporting and webAIRS’ and in the workshop ‘Critical Incident Monitoring using webAIRS’ at the New Zealand Annual Scientific Meeting in November 2013.

Mobile app
The Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) and the web-based Anaesthetic Incident Reporting System (webAIRS) has released a mobile version of webAIRS. The original development of the incident reporting page was performed by Dr Pieter Peach, the local webAIRS administrator at Cabrini Hospital, Malvern, Victoria and forwarded to webAIRS for consideration. The web app was then further customised for the webAIRS website to include a mobile login and to save the data in the database. A screenshot of the application is shown opposite. The mobile version can be reached at www.anztadc.net/mobile/mobile.aspx and a demo version can be viewed at www.anztadc.net/demo/mobile.aspx. There are also enhanced registration assistance links, frequently asked questions and further development of the morbidity and mortality reporting tool.

Recent Alerts
Recent alerts include these reports.
1. WebAIRS has received an alert that two patients within the space of a week have bitten through the wall and into the lumen of a Pro-Breathe Armourflex LMA (Praecox Medical). Both cases occurred during the emergence phase after eye surgery. At this webAIRS site, one of the anaesthetists performed a comparison bite test with this model LMA and a standard reinforced endotracheal tube. He easily bit through the wall of the Pro-Breathe LMA but was unable to bite through the standard reinforced ETT. The manufacturer has been contacted and a response will be published when available. The company literature recommends the use of a bite block with the device (which they also manufacture).
2. An alert has been notified to webAIRS regarding a single lumen peripherally inserted central line (PICC). The catheter has a guidewire to stiffen the catheter during insertion. In the case reported the guidewire was not removed prior to commencing the infusion. The catheter subsequently fractured and the guidewire migrated requiring surgical removal, which was fortunately possible percutaneously. This incident reinforces the need to carefully read the manufacturer’s instructions if the user is not familiar with the device. Although it is possible to infuse liquid through the catheter with the guidewire in place, the guidewire should be removed prior to commencing the infusion. The company has been contacted and a response will be published in the next issue of this Newsletter.

WebAIRS thanks the reporters for these interesting alerts. We plan to release more de-identified alerts in coming webAIRS reports. ANZTADC will be grateful if future, unusual reports are flagged as alerts when reported. Also remember to report problems with LMAs or other devices as suggested above via webAIRS or directly to ANZTADC@anzca.edu.au if not registered with webAIRS.

Adjunct Professor Martin Culwick
FANZCA, MIT Medical Director,
ANZTADC
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Email: anztadc@anzca.edu.au

There was a wealth of material in the November 1973 Newsletter. Editor Pen Brown commented on the role of this publication, anaesthetic technician training, continuing education of anaesthetists, and the beneficent role of Dr Humphrey Rainey and the Tasman Vaccine Laboratory in sponsoring our Newsletter.

Tom Magner of Rotorua wrote on the Need for Anaesthetic Technicians, their training and then-poor remuneration; Cressy Free (Wellington) described a Simple Anti-Pollution Device, and wrote about Dopamine; Pen Brown (Wellington) wrote on Clinical Experience with Oral Pentazocine (Fortral), and AG Buist (Hawera) wrote on Clinical Experiences with Ketamine in Dental Surgery.

The Annual North Island Meeting which had been held at the Wairakei Hotel, 29 June-1 July, 1973, marked the 25th Anniversary of our Society. A well attended conference drew nearly fifty anaesthetists, and the guest speaker was Dr Cedric Phys-Roberts of Oxford. Summaries of papers included Patricia McDonald’s (Auckland) Premedication with rectal thiopentone in children; AI De Silva (Hamilton) presented a case of magnesium intoxication (with prolonged curarisation); Ron Trubuhovich (Auckland) spoke on organophosphorous poisoning; VS Pavan (Hamilton) on use of the Air-Shields Ventimeter in neonatal and paediatric anaesthesia; Paul Kemphome (Hamilton) on ketamine for status asthmaticus; Russell Comber (Auckland) on death associated with anaesthesia; Preston Calvert (Whangarei) on gross cardiac irregularities, and Stewart Robinson’s (Auckland) ‘Down at the seaside’ was about cardiovascular defence against wet asphyxia, and the diving reflex.

Correspondence included Colin Chivers’ (Wairarapa) letter on bronchoasperm and anaesthesia on induction; HK Winkle of Glaso (Palmerston North) on the unwanted effects of adrenalin; Malcolm Fisher’s (Wellington) letter was titled ‘Should ambulance drivers do lumbar punctures?’ in which he asked was it realistic for ambulance officers to do intubations - a suggestion from a pathologist. Things have changed a lot since then!

Holdings of audio-digest tapes by the Anson Foundation were detailed by Jack Watt, while EG McQueen (Prof. Pharmacology, Dunedin) wrote about the Australian Society of Clinical and Experimental Pharmacologists and invited anaesthetists to join. There were notices for the 4th Asian and Australasian Congress of Anaesthesiologists to be held in Singapore in September 1974, and the 4th European Congress of Anaesthesiology in Madrid in the same month.

Society News introduced eleven new members, there was the President’s Report for 1972 from Bruce (Spotty) Cook, and minutes of the AGM of the Society held in Wairakei on 30 June 1973. A report from the Auckland Chairman (Bill Peskett) followed and there were reports from Otago, Wellington and Westland. There was also a report on the South Island Meeting held in Timaru on 24 June. Dr Phys-Roberts presented two papers - Problems in the management of the hypertensive patient, and How much oxygen during one lung anaesthesia? Other papers were by Jim Clayton (Dunedin) Complacency or thromboembolism; John Ritchie (Dunedin) Safety in anaesthesia; David Bush (Christchurch) Anaesthetic problems associated with the injector technique for bronchoscopy; Betty Main (Dunedin) Anaesthesia for children’s tonsillectomy; Bill Poynt (Christchurch) Anaesthetic problems associated with laparoscopy, and Gwenda Lewis (Christchurch) Ketamine - an anaesthetic or a trip?

David Wright (Wellington) reported on the 46th GSM of the RACS in the Shangri-La Hotel, Singapore, May 6-10, and at that meeting Tony Newson (Auckland) shared the Gilbert Brown Prize with David Pilditch (Brisbane, and later Dunedin). Tony’s paper was ‘The clinical significance of elevated creatine phosphokinase levels’. Also a report on the South Island Meeting held in Timaru on 24 June. Dr Phys-Roberts presented two papers - Problems in the management of the hypertensive patient, and How much oxygen during one lung anaesthesia? Other papers were by Jim Clayton (Dunedin) Complacency or thromboembolism; John Ritchie (Dunedin) Safety in anaesthesia; David Bush (Christchurch) Anaesthetic problems associated with the injector technique for bronchoscopy; Betty Main (Dunedin) Anaesthesia for children’s tonsillectomy; Bill Poynt (Christchurch) Anaesthetic problems associated with laparoscopy, and Gwenda Lewis (Christchurch) Ketamine - an anaesthetic or a trip?

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This bummer issue of the Newsletter (64 pages) closed with a list of all members with their addresses, and the usual advertisements.

Dr Basil Hutchinson
Life member

FROM THE ARCHIVES ~ Forty Years Ago!

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NZSA Representing, Supporting and Promoting NZ Anaesthetists since 1948
After a nightmare journey from England to New Zealand (and that's another story) I was met by Al and Carol Grant, both New Zealanders whom I worked with in Southampton. At that time they were living in Glenfield. He was an orthopaedic surgeon and Carol was a theatre nurse, both at Auckland Hospital.

When I learned on 8 January that I was to work at Middlemore Hospital, I was given a single hospital room across the railway line. I couldn’t abide that room so moved in with Al and Carol on the North Shore. In 1973 it took only 20 minutes to drive from there to Middlemore. After 2 weeks I found a respectable 2 bedroom flat in Gillies Avenue.

Auckland Hospital was very different then; the main hospital was what is now the support building, surrounded by various other old buildings, all of which have been demolished and replaced. The Anaesthetic Department was a prefab building by Park Road consisting of, I think, three rooms – one for the secretary, another for the HoD and the third for the rest of us. There weren’t many of the rest of us and the consultants had lists in all three hospitals. North Shore Hospital was only a twinkle in someone’s eye at that time. After a few years, the department graduated to the ground floor of what is now the mail room in the support building. That was great – we had our own separate offices and a large seminar room. For some reason we were later moved to the first floor (now Level 6 Outpatients) then to Level 14 and finally where we are now.

There was Costley Block, a beautiful old wooden building which housed elderly and infirm patients, as well as cockroaches. My mother-in-law died there. Wallace Block also stood proud on the site which is now a car park. Eyes and ENT were done there. We had our own separate offices and a large seminar room. For some reason we were later moved to the first floor (now Level 6 Outpatients) then to Level 14 and finally where we are now.

There were two operating rooms but no recovery area; patients were recovered in the corridor, until there was a death. Then a small alcove, housing two beds, but with oxygen, suction and better lighting was provided. Believe it or not, neurosurgery was also performed in one of these theatres. After induction, posterior fossa craniotomy patients were placed sitting almost at 90 degrees, with their arms strapped to a metal head-screen by gauze bandages and the head strapped to them. The art of anaesthesia really came into its own – what techniques should one use – spontaneous breathing against a semi-closed expiratory valve, to keep the venous pressure up, or ventilate the patient and rely on the surgeon’s expertise to prevent an air embolus? Remember, there was no monitoring as we knew it today, only eyes, ears and fingers, and eternal vigilance.

In 1975 I was appointed Tutor Specialist. Although I was FFARCS I had not done the required 8 years of practice. In 1978 I was elected a FFAARCS and obtained specialist recognition.

From 1984-1992 I was on the Executive Committee of the NZSA being the Newsletter Editor. I was also the representative for the small group of independent private anaesthetists around that time.

The politics, which have changed so much during this time, are not really clear to me. When I first arrived, the hospital was managed by a charming Medical Superintendent, Dr Warren. One could visit him at any time, and he was always ready to listen. The Auckland Health Board offices were in Wellesley Street, where the new Art Gallery now stands. Sometime later, another government decreed that public hospitals should be profit-making concerns, so they were called CHEs, (Crown Health Enterprises) and business managers were appointed to run the hospitals, together with more lower-tiered managers. Now we are back to elected hospital boards, and I congratulate Chris Chambers on being re-elected to the Board. In the early 2000s the government of the time decided that stand-alone clinics would be the way to go. So with much upheaval, but planning by David Sage and others, and organised by Nigel Robertson (who, in November this year, became Chair of the New Zealand National Committee ANZCA) with his cohorts, Greenlane Cardiothoracic Hospital and National Women’s Hospital were transferred across to the new Auckland City Hospital. All of this was accomplished within a very short time.

When David Sage went on his sabbatical in 2000 to investigate the planning of the new hospital, I was asked to take over the Anaesthetic Allergy Testing Clinic. Having only one clinic with him it was a steep learning curve! Dr Peter Cooke has most

ably taken over this clinic.

On the whole, I enjoyed my time providing anaesthesia in Auckland. There have been some ups and downs which, I suppose, is to be expected. This great department has strength, collegiality, and friendliness which will continue to make it move forward. We would not be where we are today without the support and efficiency of all our secretarial staff. In the early months I missed going to work: getting involved with patient care; doing sub-tenon blocks, and the camaraderie of being with a great group of people. I had wonderful send-offs from the Short Stay Surgical Unit and the Level 8 Anaesthetic Department.

There was a bit of misunderstanding with the Medical Council. I had already paid my Annual Practising Certificate to the previous November, and notified them of my intention to retire in the New Year. I also ticked the box to remain on the register. Therefore I assumed I could continue writing scripts. I learned a year later from my local pharmacist that I was no longer registered. Whereupon I contacted the NZMC and was informed that, although I am still on their register, as my APC had expired I could no longer practice in any form, including writing scripts. I could pay for another APC (at full price) in order to prescribe, but would require oversight. Interesting!

It took me quite a long time adjusting to retirement, after 43 years in anaesthetic practice. I found it difficult to adjust to the “all or nothing” attitude of administrators especially as I had been employed in the same hospital for 38 years. However, my department was thoughtful and appointed me as an honorary consultant, and for the first couple of years I was occasionally contacted for my opinion of certain allergy matters. I have also attended a couple of the Australian and New Zealand Anaesthetic Allergy Group (ANZAAG) meetings both in New Zealand and Australia, being an inaugural member.

Following my retirement I took a course of tai-chi for the older person. This was sponsored by ACC, but has now been abolished. I relearned bridge and continue to play weekly. Of course all the puzzles in the New Zealand Herald are done over breakfast! I joined a garden club, and in the past months I have been looking after my two grandchildren for two afternoons a week - two boys 2 and 4 years old. There’s always something to do in the garden and greenhouse. Looking back I wonder how I managed to fit so much into my life, with the horse and dogs, and parents while I was working.
Pointe-Noire, Republic of Congo. “If it looks like a ship and it sails like a ship and makes sounds like a ship… it’s probably a floating hospital. At least if it’s the one that belongs to Mercy Ships,” commented Sarah Kessler of the Lifebox Foundation who spent a week onboard the MV Africa Mercy assisting with the training and distribution of donated pulse oximeters to West African anaesthesia providers. The Africa Mercy is the world’s largest civilian hospital ship. The 16,000 tonne vessel provides a transportable platform for an international volunteer crew of 450 to provide world-class health care services to those suffering at the lowest end of the United Nation’s Human Development Index. The crew tends to 82 patients at a time in the general and intensive care wards, as well as the ship’s five operating theatres. The theatres are also supported by a pathology lab, x-ray and cat-scan, and pharmacy - everything medically required to make the floating hospital self-sufficient. The delivery of world class health care services is brought to the reach of some of Africa’s poorest people at their point of need. Approximately 67,000 free surgeries have been performed over 35 years in orthopaedic, maxilla-facial, ophthalnic, obstetric specialities as well as general surgery, such as goitre and hernia removal. The commitment by Mercy Ships to each nation it serves on the yearly rotation includes a partnership with the nation’s Ministry of Health with a view to sustainability and mentoring. In addition to the anaesthesia services provided onboard, Mercy Ships conducts anaesthesia conferences and courses each year in the port of call in order to build sustainability in the nations the charity serves. Currently docked in Pointe Noire, Congo-Brazzaville (also known as the Republic of Congo) the Africa Mercy Anaesthesia Education programme hosted 180 local participants over a three-day period in May, training a variety of healthcare professionals. Lectures, small groups and practical sessions were provided for doctors, nurses, and medical students. A three-day course was also offered for 25 attending midwives.

The intended outcome of these events is increased knowledge and awareness among anaesthetists of what is currently considered to be ‘best practise’ in the developed world regarding anaesthesia techniques, equipment, monitoring and anaesthetic drugs. The local Ministry of Health partnership with Mercy Ships during the 10-month field service also provides a venue for the anaesthetic community in Congo-Brazzaville to meet together to share difficulties, challenges and problems they all face trying to deliver some sort of service in such a resource limited setting.

Dr Michelle White MBChB DCH FRCA is the resident Anaesthesia Consultant onboard the Africa Mercy. She volunteered for five, two-week assignments over six years before signing on as a long-term volunteer.” I felt I wanted to take on the professional challenge of being the first long-term anaesthetist on board, and also felt a Christian sense of calling to serve. I resigned my consultant job and headed for the ship in January 2012.” Dr White is responsible for anaesthesia, intensive care and pain services on board, and the medical oversight of all their healthcare education projects.

“We aim to train the whole ‘surgical ecosystem’ - including anaesthesia, ward and theatre nurses, sterile processing, hygiene and infection control, radiology and medical leadership, as well as the surgeon. I once saw a surgeon in Africa fix an elderly lady’s broken leg in exemplary fashion, only for her to die weeks later from infection caused by bed sores because of lack of adequate nursing care. I am passionate about being a part of helping low income countries improve their healthcare services. I have a dream that we can improve the ‘surgical ecosystem’, especially with regard to care for children.”

“Here in Congo-Brazzaville I have met with officials from the World Health Organisation (WHO) and the Ministry of Health, conducted surveys of the hospital facilities, collated requests for training and presented a Healthcare Education Plan to the government for the next 10 months.”

The Healthcare Education projects run by Mercy Ships cover the World Health Organisation (WHO) Safe Surgery Checklist which is part of the Safer Surgery Saves Lives Strategy. The strategy targets four areas of surgical care: teamwork, anaesthesia, infection control, and measurement and surveillance. The WHO Safe Surgery Checklist addresses various aspects of these and has become a worldwide standard in most operating rooms in developed countries. The Checklist helps reduce mortality and complications and infection rates by up to 50%. This is a low cost initiative which is ideal for countries in Africa. All Mercy Ships theatres use the checklist and all education participants witness and take part in the process.

The implementation of the Safer Surgery Saves Lives Strategy has the potential to profoundly impact on improving safety in surgery on a global scale. It forms the foundation of healthcare education and training for the ‘surgical ecosystem’ provided by Mercy Ships. The only item of expense is the pulse oximeter, hence the partnership with Lifebox.

Lifebox is a global health charity that provides equipment and training to improve the safety of surgical care in low-resource settings. To date, they have distributed more than 6000 pulse oximeters to hospitals in 99 countries worldwide, and trained several thousand health care workers in pulse oximetry and the WHO Surgical Safety Checklist. With a shared goal for safer surgery in mind, Mercy Ships works with Lifebox to distribute pulse oximeters and provide free seminars on the device’s use to anaesthesia providers who may not have had previous exposure. After receiving Lifebox training, delegates are given their specifically designed pulse oximeters - portable, durable, capable of working in hot dusty climates, and labelled in French – to meet the needs in local hospital or health care facilities.

Dr White concludes, “If we can help individuals both by providing care for the patient in front of us, and training others, then lives truly are transformed in more ways than one. Transformed people, transform nations.”

Middlemore Hospital Specialist Anaesthetist, Dr Grant Waters MBChB, FANZCA volunteered for a second two-week period onboard the Africa Mercy in November. “I am returning to Mercy Ships for another period of volunteer service because I found working on the ship extremely rewarding in many ways. People in West Africa have the odds stacked against them on many levels, and helping them overcome some of those odds through medical intervention or training medical providers is hugely rewarding. Interacting with volunteers from a wide range of life experience and backgrounds, and meeting the challenge of a complex case that one may not have previously encountered.
is rewarding, particularly in the supportive environment provided by the collective experience of the volunteers."

Dr Iain Gilmore is a regular volunteer with Mercy Ships, and will be representing the hospital ship charity at the 2014 Combined AACA/ASURA meeting in Auckland in February 2014. "Mercy Ships allow anaesthetists to provide first world anaesthetics to those living in third world countries in a safe, modern hospital environment. The five operating theatres on board the Africa Mercy are well equipped with brand new anaesthetic machines, piped gases and fibre optic bronchoscopes. Every anaesthetic on Mercy Ships allows a life changing, and in many instances, a life-saving procedure. I hope to volunteer regularly throughout my anaesthetic career and will not hesitate to recommend Mercy Ships to any colleague who is interested."

For more information see www.mercyships.org.nz or www.Lifebox.org

Since 1978, Mercy Ships has performed services valued at more than NZ$1 billion, directly impacting more than 2.35 million of the world’s poorest people. Volunteers and staff with Mercy Ships have:

- Performed more than 67,000 life-changing operations such as cleft lip and palate, cataract removal, straightening of crossed eyes, orthopaedic and facial reconstruction. The operations are free to patients.
- Treated over 520,000 patients in village medical and dental clinics. Educated about 5,770 local health care workers, who have in turn trained multiple thousands in primary health care.
- Trained over 29,400 local professionals in their areas of expertise (anaesthesiology, midwifery, instrument sterilisation, orthopaedic and reconstructive surgery, leadership).
- Completed over 1,100 community development projects focusing on water and sanitation, education, infrastructure development and agriculture.
- Around 40 New Zealanders volunteer their services with Mercy Ships every year.

Sharon Walls
Communications Manager
Mercy Ships NZ
Email: sharon.walls@mercyships.org

Dr Iain Gilmore.
In October this year I was privileged to be involved in a trip to Vietnam on behalf of the NZSA and Lifebox. Lifebox is a global initiative with the aim of reducing the number of areas of anaesthesia working without oximetry to zero. There are an estimated 70,000 operating rooms worldwide without oximetry, and what started as a WHO initiative the “Global Oximetry Project” (GOP) in 2007 has developed into a multinational program called Lifebox.

The team included consultant anaesthetists from around the country: myself from New Plymouth, Maurice Lee who coordinated the trip (North Shore), Indu Kapoor (Wellington), John Hyndman and David Murchison (both Christchurch) and Tomas Goscinski (Gisborne).

We were hosted in Vietnam by the President of the Vietnamese Society of Anesthesiologists (VSA), Professor QC Thang who along with the VSA secretary Miss Van, did a wonderful job of welcoming us as well as arranging the logistics for our groups who divided up to visit as many hospitals as possible, in sometimes challenging areas of the country.

The aim of the trip was to provide a half-day teaching session for a small group of Vietnamese anaesthetists in Hanoi, including an introduction to the concept of Lifebox and approaches to adult education. The second aim of the trip was to audit two regions of the country where Lifeboxes had been distributed in the past year and to distribute the remaining Lifeboxes Maurice had brought with him. These were to be distributed by Maurice, Tomas and Prof Thang in the Buon Me Thuot province in the Central Highlands region. They provided teaching sessions on anaesthetic mortality, the WHO Safety checklist, pulse oximetry theory and practical workshop sessions with case discussions.

After the first morning session Indu and myself travelled to the Nghe An province south of Hanoi. David and John took the overnight train to Sapa in the Lao Cai province up in the northern highlands. We were each accompanied by interpreters to aid our ability to converse with the anaesthetists we hoped to meet in the provincial hospitals. I was paired with a rather wonderful young anaesthetic registrar, Dr Ha Nguyen from Hanoi who had impeccable English and far better French than I could manage after 10 years of French lessons! She was able to glean far more feedback from the anaesthetists I met due to her engaging manner.

Nghe An is one of the largest provinces in Vietnam with a population of approximately 2.9 million people. The province contains 437 communes, the highest in any province in Vietnam. It is also one of the poorest provinces. The area is vulnerable to typhoons and significant flooding which affects both the agriculture and infrastructure of the region.

In April 2013, 30 Lifeboxes were distributed in the province by the NZSA team and myself and Indu were able to visit nine district hospitals that were recipients of those. The hospitals I visited were of varying sizes ranging from 25 beds to 215 beds and between 1 and 5 operating rooms. The largest of the hospitals had two...
anaesthetists and three anaesthetic nurses, whilst the smallest had a solo anaesthetist and 1 anaesthetic nurse. Each hospital had one multifunction monitor as part of a government initiative to provide monitoring. However, in all hospitals there was a theatre without oximetry which was now being provided by the Lifebox donated to them.

Without exception, in all the hospitals that were audited we found that the Lifeboxes were functioning well, were well cared for and were rarely idle. They were being used in A&E for sedation MUAs, on labour wards for high-risk obstetrics, neonatal resuscitation, postoperative care, inter-hospital transfers and pre-operative assessments. I met obstetricians and surgeons who were also delighted with the Lifebox and it was obvious that the anaesthetists and surgeons were working together to provide the best care they could for their local population.

The welcome myself, and Dr Ha Nguyen received at each hospital was exceptional. The hospitality and warmth of the doctors and nurses we encountered was humbling. Often I was met not only by the anaesthetists, but also the surgeons, nurses and the hospital directors. I know that my colleagues were also met with similar receptions. There are undoubtedly challenges when trying to organise and participate in projects such as Lifebox. I suspect we do not realise the efforts that the VSA committee would have gone to, in order to make our trip as smooth as possible. Information can be hard to come by, considering what the roads are like, how many provincial hospitals and anaesthetists there are in the country, what equipment they have and what funding there is available to them, as each province differs. A typhoon had struck the Nghe An province the week before we arrived and they could not get information as to the state of the roads in the area or whether indeed we would be able to get to any of the smaller hospitals. However, intrepid lasses that we are, Indu and I reassured them that we could brave backcountry unsealed kiwi roads and so we should be just fine (and we were!). There are no detailed road maps for many areas, and without local drivers we surely would have never found our way out of the city.

On a different note, I am sure that many of our members and readers have donated toward this excellent project. I would like to reassure them that their donations are providing an excellent robust and lifesaving piece of monitoring equipment.

This project has also allowed us as NZSA members to form a lasting connection with the VSA through Prof Thang. Their engagement is key to the success of this project, and with over 1000 district hospitals in Vietnam that is no small feat.

I would also like to thank Maurice for organising so much of this trip and teaching me how to cross the road in Hanoi (no laughing matter I’ll have you know) “cross like a boss” will ring in my ears for years to come. And to my great colleagues who made up the trip, and the lovely Dr Ha Nguyen, thank you. I hope to have made some friends for life.

So next time you are thinking of joining in a “fun” run (is there such a thing?), a cake bake or other fund raising opportunity, please consider Lifebox as a truly worthy recipient. It may save a life.

Dr Emma Patrick
NZSA Executive Committee Member

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Dr Emma Patrick
NZSA Executive Committee Member
A Few Days in the Life of an Anaesthetist at Rarotonga Hospital

I have been helping out on occasions at Rarotonga Hospital for a number of years now. The main purpose of the trip I made in August this year was to allow the sole anaesthetist, Dr Mary Teokotai (or Dr Mary, as the locals call her) to attend a MOET (Managing Obstetric Anaesthesia and Emergencies) course in Wellington. The course organisers kindly offered to pay all her expenses. But she needed someone to cover for her. The other aims of my trip were to teach junior staff and to provide help and advise on equipment and any other matters that arose.

The strange thing about going to Rarotonga is that by crossing the date line, you get there before you have left New Zealand. Dr Mary was leaving on the same plane that I arrived on so we did the handover of the cell phone at the airport.

After a short sleep it was time to cycle to the hospital for medical grand round. I spoke about New Zealand practice in several situations e.g. reducing late still birth rates in Pacific Islanders by early intervention. I noted that Rarotonga was following the latest recommendations of the Perinatal and Maternal Mortality Review Committee by doing this. I also pointed out that studies on Northern Territory aboriginal children have shown that impetigo may be a major risk factor for children developing acute rheumatic fever, which is a significant problem throughout the Pacific. The rest of the day was taken up with meetings with the hospital manager, clinical director of medical staff and other senior staff members and inspecting the anaesthesia and theatre areas.

The following morning I reviewed plans for the refit of the outpatient department (OPD). The OPD will have four bed spaces with high-pressure air as part of a planned refit, now completed.

To cope with a difficult intubation scenario. We had available a video laryngoscope, donated by the NZSA, and an LMA, in addition to our normal equipment. Dr Teokotai was unable to intubate the patient conventionally due to a Grade 3 view – almost certainly due to a very stiff neck from his long-term diabetes – and so I used the video laryngoscope to rescue the situation prior to any significant desaturation. This was a very useful learning experience for Dr Teokotai, highlighting the need for several intubation and ventilation strategies. I then showed him how to perform a wrist block and the patient awoke pain free 80 minutes later.

On arrival at the hospital the following day I found out that a 29/40 premature baby with an estimated foetal weight of 1.3 kg was due to deliver in the next 36 hours. The obstetrician, Dr May, had delayed labour with a tocolytic (nifedipine) and was giving steroids for foetal lung maturation using dexamethasone, as betamethazone was unavailable. The two babies that had delivered at 29 weeks this year had both died because they could not be resuscitated. I made sure that a T-bag was available because I doubted the efficacy of the old laerdal bag equipment in the paediatric unit. A valveless T-bag is a very reliable piece of equipment. It is standard practice for babies of this size and age to get CPAP after delivery in New Zealand. Rarotonga Hospital lacks a proper baby CPAP unit but has two adult high-flow nasal canulæ F&P units, which I donated three years ago. I was able to reconfigure one to deliver naso-pharyngeal CPAP for the baby. It also allowed additional oxygen to be added and was completely humidified. The actual delivery into the naso-pharynx can be given, as it was in the 1980s, using a shortened nasal endotracheal tube placed with the tip just behind the uvula under direct vision.

In the ICU the anaesthesia technician and I reconfigured an old anaesthesia machine to work as a paediatric ventilator. The ventilator can deliver pressure-cycled ventilation at pressures from 7 up to 30 cm H₂O at a rate of up to 60 breaths per minute using a humidification system from an adult ventilator. We ended up with a reliable three-tiered resuscitation system set up beginning with a T-bag, moving on to naso-pharyngeal CPAP, finishing with the ability to provide...
short term ventilation if needed. This was done over a couple of hours.
Meanwhile in the Emergency Department was a Balclutha woman, who had stood on a stone fish. I demonstrated the use of ankle blocks for treating this pain problem rather than the traditional bucket of hot water. Using a mixture of bupivacaine and lignicaine she was rendered pain-free in under 10 minutes. Although the pain from a stone fish envenomation can continue for several days, the ankle block would give cover for the worst of it. It is worth noting that over 50,000 New Zealand tourists visit Rarotonga each year.

In the afternoon we had two acute cases which I used as teaching sessions for Dr Teokotai:
1. A miscarriage in a 29-year old woman at 10 weeks with retained products for a D&C.
2. A 25-year old Fiji-Indian woman with a right labial abscess from a very infected Bartholins cyst requiring incision and drainage with packing (too large for marsupialisation). We used a GA with LMA and 20 mg of morphine but as she was still sore when she awoke in the recovery room, I showed Dr Teokotai how to do an illo-inguinal/genito-fermoral block in the recovery room which rendered her pain free.

The premature baby was born the following day. The mother got to 7 cm very quickly without any distress and an epidural was not needed. The baby came out in reasonable condition but did not initially breathe. The paediatrician, Dr Dawn, started to resuscitate the baby but it was very clear to me that the bag was not working, in particular it was unable to provide more than 10 to 15 cm of water pressure. I used the T-bag to assist the baby with the first couple of breaths successfully inflating the lungs then allowing the baby to breathe spontaneously. We then placed a naso-pharyngeal CPAP tube, taped it in and had the child on CPAP. Within a few minutes we were able to wean the oxygen off and had the child breathing air with saturations in the mid-90s.

The baby was left under the care of Dr Dawn who over night switched the baby to head box oxygen and removed the CPAP. I reviewed the baby several times over the weekend and it required low dose amnionphyllyne for apnoeas and bradycardias but was otherwise well. A few days later the baby was transferred to Starship on a regular Air New Zealand flight. Last I heard she was doing well.

At 0455 I was called to the OR for a post partem haemorrhage (PPH) in a 29-year old P1G2 weighing 110 kg with severe pre-eclampsia on a magnesium infusion with a blood pressure of 180/110. She had lost 1.5 litres of blood and had at least a quarter of a placenta still inside the uterus. Crossmatched blood was available and ready but no coagulation studies were available. In view of the situation I decided on a rapid sequence induction rather than a spinal as I was worried about further bleeding.

Dr Teokotai had been working in the hospital and was keen to help. We discussed the reasons for using a GA. He did the intubation well. I showed him how to control blood pressure in a severely pre-eclamptic patient using a bolus of magnesium (10 mmol) between the propofol and suxamethonium. This is important as Rarotonga does not have access to alfentanil, remifentanil, or sufentanil nor is an arterial line available. We used intermittent propofol boluses and nitrous oxide/oxygen avoiding sevoflurane in order to avoid uterine relaxation. Midazolam and fentanyl were also used with syntocinon. We gave also gave her two units of blood.

The rest of the day was taken up with lots of meetings and handing over to Dr Mary, who returned from Wellington. I then rode 33 km around the island, stopping for cheesecake and Atiu Coffee (from my mother’s island) before buying six shirts in the very large sizes which are easy to find in Rarotonga. While cycling in Rarotonga I always wear a helmet. Few motorcyclists wear helmets and only expatriates and visitors wear them while cycling. The fatality rate from motorcycle accidents is high. Hopefully this will change.

Ted Hughes
**Book Reviews**

*A Practice of Anaesthesia for Infants and Children.*

By Charles Cote, Jerrold Lerman, Brian Anderson.


The fifth and latest edition of this highly regarded textbook of paediatric anaesthesia is authoritative, comprehensive and up to date. It is well organised, well written, and well presented. Expert international authorship, breadth of content, consistent clarity of writing, extensive use of graphics and concise chapter length, make this thousand page textbook remarkably approachable.

There is a satisfying combination of expert review of basic physiology, fundamental principles and practical anaesthesia techniques alongside more in-depth coverage of topical issues such as anaesthesia and the developing brain, anaesthesia in the developing world, extreme prematurity, paediatric pharmacokinetics, ultrasound and more.

Chapters are extensively referenced and the reader can refer to the searchable online version to access the hyperlinked papers directly. A small number of key references are included at the end of some chapters. This strategy keeps the size of the book manageable but may frustrate readers who lack on-line access. The on-line version also allows access to a comprehensive video library with content including aspects of airway management, regional anaesthesia, cardiology, ultrasound guided vascular access, positioning and portable anaesthesia machines in developing countries.

The elevation of Professor Brian Anderson to lead author status in this edition is a superb personal accomplishment and with chapter author Dr Niall Wilton, enhances the international profile of New Zealand paediatric anaesthesia.

Their contributing chapters related to pharmacokinetics and orthopaedics and spinal surgery are excellent.

This is a very well-conceived general textbook of paediatric anaesthesia. It strikes an excellent balance between breadth and depth of material. It is approachable and current. It is a valuable resource for anyone involved in the anaesthetic care of children and as such warrants inclusion in the library of every Department of Anaesthesia. As a teaching resource, the 5th edition is enough to make this luddite take an iPad into theatre!

**Dr Colin Marsland Wellington**


All you need to know…

This handbook comes to us from Princess Margaret Hospital in Perth, Western Australia. It is an attractive soft-back publication of modest size, ideally suited to throwing in a small backpack or bike pannier.

The entire spectrum of a paediatric anaesthetist’s workload is covered in 31 short chapters. It starts logically with a comprehensive overview of paediatric anaesthesia. Chapters then deal with the basics of pharmacology, fluid management, pain management, congenital syndromes and, importantly, behavioural management before moving onto anaesthesia for surgical and medical subspecialties. There is an emphasis on common important conditions – for example Chapter 16 deals specifically with bronchoscopy and removal of foreign bodies from the trachea.

Key points, tips and notes are clearly highlighted in green – allowing for easy, rapid revision of a chapter.

The text is enhanced by clear, high quality illustrations and diagrams – with perhaps the exception of some of the circulation diagrams in the chapter on congenital heart disease.

The handbook’s real strength lies in its informal yet informative style. It is packed full of practical commonsense advice. Everything from how to position the uncooperative toddler for i.v. insertion to how to administer Salbutamol into a breathing circuit.

Referencing between chapters of the book is also a strength – avoiding the unnecessary repetition (and at times contradictions!) common in some large multi-author textbooks of old.

If I were to predict areas of criticism it would perhaps include the following. Each point of fact in the text is not specifically referenced, this produces text uncluttered by footnotes or references yet the sceptic may have trouble making the leap of faith required to accept the author’s word for it. The bibliography at the conclusion of each chapter contains key references and is broken into sub-headings according to topic, allowing the keen reader to pursue a topic further.

I sense there may be criticism levelled at the brevity of this handbook. For example, the 15-page chapter on regional anaesthesia is without a single ultrasound image. This is readily acknowledged in the text, and reference given to a comprehensive recent review article on the topic.

This is perfect for trainees to read during their paediatric anaesthesia “run” and preparing for their fellowship examination. It will also serve as a useful refresher for the occasional paediatric anaesthetist.

*Your Guide to Paediatric Anaesthesia* is a credit to its authors and editors – as a trainee commented to me “It tells you all you need to know… and importantly, no more”.

**Chris Smit**

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Tax Residence – Inland Revenue’s Draft Guidelines Reviewed

Recently The Press reported that Richard Branson had made a decision to leave the United Kingdom and move permanently to Necker Island, his paradise home in the Caribbean. Forbes Magazine ranks Branson as the United Kingdom’s sixth wealthiest man with an estimated wealth of £2.9 billion. He has owned the island since the 1970s, and his home has recently been extensively renovated following a devastating fire in 2011. The move means that Branson will be a non-resident of the United Kingdom. As a result, he will only be taxed in the United Kingdom on income that is generated there.

New Zealand has a similar approach when it comes to who pays tax here – although we don’t have too many individuals with the level of wealth that Branson has. Generally, New Zealand tax residents are taxed on their worldwide income. This includes exposure to a number of comprehensive regimes that pull in income earned from associated offshore entities. Those provisions include the controlled foreign company and foreign investment fund rules, accruals rules, and foreign trust rules. Non-residents are generally only taxed on income that has a New Zealand source.

The meaning of New Zealand tax residency therefore becomes very important. Reference must be made to both New Zealand’s domestic tax rules as well as any applicable double tax agreements. The latter provide tie-breaker tests in the event that a person is tax resident in more than one country at the same time under the local rules of each.

The New Zealand rules have two main tests. The first is a relatively objective “day count test”. Once you have been physically present in New Zealand for 183 days in a 12-month period, you’re a tax resident. To escape that status, you need to be physically outside New Zealand for 325 days in a 12-month period.

The second, more subjective, test is the “permanent place of abode” test. Regardless of the outcome of the day count test, you will be a New Zealand tax resident if you have a permanent place of abode here. There is no definition of that term in the Income Tax Act, so reliance has to be placed on court decisions and Inland Revenue guidelines.

Very broadly, the concept of a permanent place of abode can be thought of as like “a place to call home”. It’s the centre of a person’s domestic life, so things like the availability of a home, the location of family, and social and economic connections all come into play. Inland Revenue uses the phrase “an enduring relationship with New Zealand” to describe the concept.

Late last year, Inland Revenue released a draft Interpretation Statement indicating their updated views on residency. It’s the first update they’ve done since 1989. A significant change is Inland Revenue’s view on the permanent place of abode test, where much greater emphasis has been placed on the “availability” of a dwelling.

New Zealanders often get opportunities to work overseas for extended periods. Extended OEs in the United Kingdom are a common example but so is the number of expat Kiwis living in the Middle East – often in low or no-tax places like Dubai. Unless New Zealand tax residency is lost, the foreign income will still be taxable in New Zealand.

To prepare for that, and because it often makes financial sense anyway, it’s common practice to rent out the family home while the family are living overseas. Provided sufficient other changes to cut ties to New Zealand are also made, to date that’s generally been enough to sever the ties to New Zealand.

An example given in the Inland Revenue guideline describes a situation where a taxpayer leaves New Zealand with her family for a three-year secondment to Canada, during which time the family home in New Zealand is rented out. Inland Revenue’s view is that the taxpayer retains a permanent place of abode in New Zealand, and therefore New Zealand tax residency, as there is still an “available dwelling” notwithstanding the fact that it has been rented out.

Inland Revenue’s revised view remains at “draft” status. If adopted, it will have far-reaching consequences, and may mean that New Zealanders face the tax equivalent of the Hotel California: you can check out any time you like but you can never leave.

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

Merry Christmas and a Happy New Year

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