JUNE 2018

ANZCA BULLETIN

ANZCA
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
FPM
FACULTY OF PAIN MEDICINE ANZCA

Slow-release opioids: **Follow-up to our statement**

Leadership changes: **Meet our new president and dean**

Reflecting on a successful SYDNEY ASM

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ANZCA Bulletin
The Australian and New Zealand College of Anaesthetists (ANZCA) is the professional medical body in Australia and New Zealand that conducts education, training and continuing professional development of anaesthetists and specialist pain medicine physicians. ANZCA comprises about 6700 fellows and 1500 trainees mainly in Australia and New Zealand. It serves the community by upholding the highest standards of patient safety.

Cover: Waiting for the 2018 College Ceremony to begin at the 2018 ANZCA Annual Scientific Meeting in Sydney.

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ANZCA
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

President's message

I come into this role with a somewhat different background to my predecessors.

I work in Adelaide, in intensive care and anaesthesia, primarily in the outer suburbs, in public and private.

I previously spent the best part of a decade in central Australia, mainly with the Royal Flying Doctor Service, in Indigenous primary health care and retrieval medicine, and later as the director of anaesthesia at the Alice Springs Hospital.

I have been lucky to have married such a wonderful woman, Sue, and to have four really great kids. Daryl Catt, the anaesthetist at Alice Springs hospital when I was a young fella, wisely told me that the grass will always be greener where I water it, and I've tried really hard to remember that. And just so you know, having had the privilege of working as a primary health physician, a retrieval doctor, an intensivist, an anaesthetist, and a councillor, the thing that's brought me the most happiness, and that I'm most proud of, is just being a dad.

So, two issues I would like to discuss are perioperative medicine, and equity.

There's been much discussion about perioperative medicine – with claims that it will significantly change our scope of practice. However, I sense some confusion about what that means in practical terms, so I would suggest the three following features will be apparent five years from now:

- Widespread recognition that patient-focused, multidisciplinary, evidence-based perioperative care improves surgical outcomes.
- We will all be perioperative practitioners, but some of us will be "perioperative specialists", who, similarly to how pain specialists lead pain medicine – will lead the education, training, professional standards and research into perioperative medicine that will benefit us all.
- Perioperative medicine will be led (but not owned) by anaesthetists, because we are best placed to provide the necessary co-ordination, logistical support, vision and energy for this collaboration.

The second issue I want to discuss is how we need to address all of the six domains of healthcare delivery – safe, timely, effective, efficient, equitable, patient-focused (STEEP).

Equity of healthcare relates to access, treatment, and outcomes.

We have achieved absolute world-class excellence in delivering safe and high quality clinical care. Our ongoing challenge is to ensure that everyone in the community benefits from that care. There are three distinct groups who don't enjoy equity of that care. Put very simply, it doesn't matter how good our care is if it's not reaching people.

The first group are our rural communities, who are subject to the ongoing mal-distribution of specialist anaesthetists, and the challenges of distance.

The second group are those marginalised members of our community, particularly our Indigenous peoples, and recent migrants.

The final group are the five billion people globally who lack ready access to anaesthesia care.

Addressing inequity does involve stepping outside our comfort zone. However, when I was in Alice Springs, doing my very best to deliver high quality anaesthesia care, I realised that if I didn't address why Aboriginal people presented so late and self-discharged so early, why there were no Aboriginal doctors in my theatre, and why I was the only FANZCA working there, that I was failing, as a perioperative practitioner, to address important issues that contribute to perioperative outcomes.

Addressing inequity is very challenging, but there are things we can do, and I'd like to outline four of them.

Number one. When I left Adelaide to return to Alice Springs I was concerned about professional isolation, and about closing doors professionally. Professor Don Moyes, the Director of Anaesthesia at the Queen Elizabeth Hospital, told me "I think it's great you're going to Alice. Let me offer you a 0.1 FTE which you can take as a one month block each year, to reconnect with your colleagues. You've got my phone number, if ever you need some advice, and whenever you do return there will be a job here for you".

So the whole process of going out bush was framed as a positive and supported experience, with no worrying concerns that I would be "forgotten". The message is that we can all be more encouraging, reassuring and supportive of young people who are prepared to go and do a stint in the bush.

Number two. Minority groups are more likely to engage with a workforce whose diversity includes representation from their community. In addition, the Māori pain medicine specialist in New Zealand, or the Aboriginal anaesthetist in northern Australia provide valuable role models. Through encouragement and support of aspiring young anaesthetists and pain specialists, we can facilitate this diversity.

Number three. Let me make a pitch for the WFSA's "Fund a Fellow" program, which is addressing the global shortage of anaesthetists. We can all work to support this, as individuals, as departments and as private groups.

And finally, we need to recognise and address unconscious biases, at both an individual and institutional level. Of course, we also need to call out blatant discrimination, which still occurs.

In closing, let me just say I am incredibly humbled to be the president of our college. I'm really looking forward to working with the ANZCA Council, the FPM Board, and with you all. I'm particularly aware that we're a very high-performing college, and that's due to the enormous talent and hard work of all our fellows, and in no small part to the enormous talent and hard work of our extraordinary staff.

Thank you.

Dr Rod Mitchell
ANZCA President

Professor David A Scott leaves strong legacy

David A Scott enjoys widely recognised expertise in research, safety and quality, pain medicine, medical leadership, and cardio-thoracic anaesthesia, and our college has been fortunate to have the opportunity to benefit from his leadership over the last two years.

David will be quick to acknowledge that the many and varied achievements of our college more accurately reflect the collective wisdom and energy of our membership, but nonetheless his leadership has clearly contributed to ANZCA's vision and successes, and to ensuring the efficient governance of our college as a bi-national, bi-specialty entity representing over 8000 fellows and trainees.

"He is a deeply thoughtful and considerate person, of true integrity and who is always prepared to listen."

The list of ANZCA's achievements over the past two years is substantial, but a number of them directly reflect David's energy and vision. Research funding to support our fellows reached $1.74 million in 2017, and we have seen the establishment of an Emerging Investigators Sub-Committee, the latter of which is to support the next generation of researchers.

The college developed a first-ever Joint Position Paper on Day Surgery in Australia with the Royal Australasian College of Surgeons and the Australian Society of Plastic Surgeons, initiated discussions about whether we want to present ourselves as anaesthesiologists or anaesthetists, progressed the evolution of perioperative medicine, strengthened international relations with our sister colleges overseas, and developed five-year strategic plans for overseas aid work and Indigenous health.

Of particular note has been David's stewardship of the development of a strategic framework to address bullying, discrimination and sexual harassment, and the Doctors' Support Program.

As a leader he has fostered, and represented a strong culture of professionalism. David has achieved a national and international reputation for clinical and academic excellence, and it is perhaps easy for these accolades to overshadow the important facts that he is a deeply thoughtful and considerate person, of true integrity and who is always prepared to listen. It is these attributes that have driven him to work so tirelessly as our president to ensure he has done all he can for his colleagues, and for our patients.

Thank you David.

Dr Rod Mitchell
ANZCA President

Above: President Dr Rod Mitchell with Immediate Past President Professor David A Scott at the ANZCA president handover and closing address at the ASM.

Anaesthesiology plebiscite

The proposed change of name to our speciality was a favourite topic of discussion for many at the 2018 ASM in Sydney. The great debate held on the final day of the meeting saw an engaged audience hear the cases for and against the proposed change, and polling with delegates both on site and on social media show that each side of the argument enjoys considerable support. Informal conversations also showed that many people feel they still need more information as to the "on the ground" implications of a name change, the reasons behind why a change is being contemplated, and whether a change of name justifies the significant costs involved. As such, the college, the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists have agreed it seems sensible to delay the proposed plebiscite, initially scheduled for later this year, to allow for the provision of further discussion and consideration.

Dr Rod Mitchell
ANZCA President

Changes to council

There are two new faces on ANZCA Council with new FPM Dean Dr Meredith Craigie replacing Dr Chris Hayes and Dr Christine Vien replacing Dr Scott Ma as new fellow councillor.

Dr Craigie focuses on adult pain medicine in the Central Adelaide LHN Pain Management Unit at the Queen Elizabeth Hospital. Her interests include pain in childhood, pain education and the wellbeing of colleagues.

Dr Vien, whose interests include regional and paediatric anaesthesia, is based at St Vincent's Hospital in Melbourne.

There have also been some changes to ANZCA committees following the changeover of presidents. Immediate Past President Professor David A Scott has been appointed chair of the ANZCA Research Committee, replacing Professor Alan Merry.

Associate Professor Leonie Watterson, Director of the Sydney Clinical Skills and Simulation Centre at Royal North Shore Hospital replaces new ANZCA President Dr Rod Mitchell as chair of the Professional Affairs Executive Committee. Dr Nigel Robertson replaces Dr Rowan Thomas as medical editor.

Dr Vanessa Beavis is the new vice-president of ANZCA and Dr Michael Vagg has been appointed vice-dean of FPM.

The FPM Board has a new member with FANZCA and FFPMANZCA Dr Susie Lord replacing Associate Professor Ray Garrick. Dr Lord, Clinical Lead at the Children's Complex Pain Service in Newcastle, is a member of several expert advisory and working groups and was lead author of the Better Pain Management Pain in Children module.

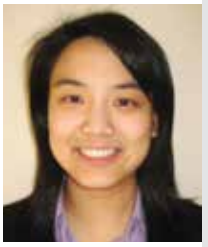
Introducing our new councillors

Dr Meredith Craigie

Dr Meredith Craigie is the dean of the Faculty of Pain Medicine. Her interest in pain medicine grew from requests to see children with burns and persistent pain while she was a paediatric anaesthetist. Dr Craigie transitioned four years ago to working solely in adult pain medicine in the Central Adelaide LHN Pain Management Unit at the Queen Elizabeth Hospital. Meredith enjoys working in the team environment at work and with FPM colleagues on faculty committees and projects. Her interests include pain in childhood, pain education and wellbeing of colleagues. Her personal pain relief strategies include exercise, gardening and travel.

See Dr Craigie's first dean's message on page 51.

Dr Christine Vien



Dr Christine Vien underwent anaesthetic training in Victoria, and now holds a full-time public position at St Vincent's Hospital Melbourne. She has particular interests in regional and paediatric anaesthesia, having completed sub-specialty fellowships in regional anaesthesia at St Vincent's Hospital and paediatric anaesthesia at the Royal Children's Hospital in Melbourne. Aside from clinical roles, her experiences extend to medical management – having been a member of, and chairing a number of committees at Monash Health and ANZCA during her specialist training, focusing on the welfare and training of junior doctors.

For the full list of ANZCA Council office bearers go to **www.anzca.edu.au/about-anzca/**. The list of FPM office bearers and a list of FPM appointments to ANZCA committees can be found at www.fpm.anzca.edu.au/about-fpm/structure-and-governance and **www.fpm.anzca.edu.au/about-fpm/committees**.

Chief executive officer's message

Doctors' health

I have reported in this column in previous issues the direction that ANZCA is taking with regard to promoting and supporting doctors' health and wellbeing. We have now published a draft framework for consultation at www.anzca.edu.au/resources/doctors-welfare. If you have something to contribute to this important work, we would love to hear from you.

We are seeking your views on for example, the three integrated action areas:

- **Promotion:** Promoting health and wellbeing by developing the positive aspects of being in the profession as well as the importance of self-care in the role of doctor. Promoting research.
- **Protection:** Protecting health and wellbeing of doctors through advocacy with employers to reduce profession-related risk factors for health and wellbeing and increasing protective strategies.
- **Support:** Providing effective and accessible services and programs to support doctors' health and wellbeing. Encouraging those who need treatment; de-stigmatising mental illness; and promoting inclusion.

The consultation document proposes that we focus on doctors' career life cycle. In other words, it intends to reflect the importance of the transition across a doctor's career stages where uncommonly high levels of stress are experienced:

- Training.
- New specialist.
- Mid-career.
- Retirement.
- Return to work (which spans all of the above transition points).

The consultation will be open until mid-July.

ANZCA launched its doctors' support program last November. It is a telephone counselling service which is available free of charge to fellows, trainees, specialist international medical graduates and their immediate families.

In the first quarter of 2018 there were 34 new referrals to the service. The top five primary work related issues during the period were:

- Work behaviours (27 per cent).
- Work practices (18 per cent).
- Work related incidents (18 per cent).
- Career adjustment (18 per cent).
- Work change (9 per cent).

The top personal related issues emerging this period were:

- Health and wellbeing (47 per cent).
- Personal relationships (42 per cent).
- Adjustment/grief and loss (5 per cent).

Of the 32 new referrals, 37 per cent were work-related and 63 per cent personal. The industry benchmark for the same period was 56 per cent work and 44 per cent personal. It should be noted that 32 referrals is a relatively small number and it may be another six months before any trends may be meaningful.

The referral service is confidential and ANZCA receives only statistical information.

Professional performance framework (revalidation)

The Medical Board of Australia is continuing its work on the professional performance framework, and intends to establish a number of groups to progress implementation. An implementation working group is being established, chaired by the chair of the medical board to provide overall direction of the implementation of the framework.

A continuing professional development (CPD) advisory group is being established to provide advice on matters related to "strengthened CPD requirements". This includes advice on changes to the registration standard for CPD and "CPD homes". Professor Kate Leslie has agreed to chair this group.

As the board progresses its work on peer review and health checks for practitioners aged 70 years and older, it will establish an older practitioners' reference group to provide feedback to the board on relevant matters.

ANZCA's role in improving Indigenous health outcomes

In Australia, Closing the Gap is a commitment made by all governments to achieve Aboriginal and Torres Strait Islander health equality by 2030. It aims to reduce disadvantage with respect to life expectancy, child mortality, educational achievement, and employment outcomes. The National Aboriginal and Torres Strait Islander Health Plan 2013-2023 supports the strategy, and aims for a health system that is free of racism and inequality, and enables Aboriginal and Torres Strait Islander people to have access to effective, high quality, appropriate and affordable health services.

The Treaty of Waitangi is New Zealand's founding document, and was signed in 1840 between representatives of the British Crown and a number of Māori chiefs. It allowed government to be established in New Zealand and migration to New Zealand to continue. The treaty is fundamental in guiding the relationship between the crown and Māori, and its intent and principles are a core consideration in government policy. Health strategies frame commitment to the treaty under three key principles: partnership, participation and protection.

These core government commitments in both Australia and New Zealand are the guiding principles underpinning ANZCA's Indigenous health strategy.

A key component of addressing inequities in Indigenous health is to improve Indigenous representation in the health workforce. Naturally this is an area where specialist medical colleges have the potential to make a meaningful impact, through initiatives such as supporting the training of Indigenous doctors.

However workforce development involves more than the recruitment and support of Indigenous doctors. It also involves ensuring that non-Indigenous practitioners are equipped to practise in a culturally responsive manner and improving the ability of mainstream health services to meet the needs of Indigenous people.

We have committed to working closely with governments and Indigenous health organisations to play our part in achieving these goals. Several organisations have developed cultural competence programs that we may wish to access to assist members accessing college education and training resources.

Pain medicine and perioperative medicine have been flagged as possible areas for collaboration between the college and indigenous health services. Essential Pain Medicine (EPM) in particular was identified as a tool for training Indigenous health workers in Indigenous communities. This presents an opportunity for the college to potentially design and establish an EPM pilot for Indigenous Australians and Māori.

We are expecting that once adopted, the Indigenous health strategy will assist us to play a meaningful part in improving the health of Indigenous New Zealanders and Australians.

John Ilott
Chief Executive Officer, ANZCA

Queen's Birthday honours

Officer (AO) in the general division of the Order of Australia

Dr David Charles Pescod, Vic
For distinguished service to medicine, and to Australia Mongolia relations, particularly through the provision of surgical and anaesthetic care, and to health education and standards.

Member (AM) in the general division of the Order of Australia

Dr David Russell Hillman, WA
For significant service to medicine as an anaesthesiologist and physician, to medical research into sleep disorders, and to professional organisations.

Associate Professor Geoffrey David Champion, NSW
For significant service to medicine in the field of paediatric rheumatology, and to medical research and treatment of musculoskeletal pain.

Dr Michael Gerrard Cooper, NSW
For significant service to medicine in the field of anaesthesia as a clinician, teacher, mentor and historian.

Associate Professor Charles Roger Goucke, WA
For significant service to medicine in the field of pain management as a clinician, academic and mentor, and to professional societies.

Medal (OAM) in the general division of the Order of Australia

Dr Mary Felicity Sutherland, SA
For service to medicine, and to the community.

Dr Stephen Bryce Kinnear, SA
For service to medicine, particularly to anaesthesiology.

ANZCA's fund-a-fellow campaign donation

The World Federation of Societies of Anaesthesiologists' (WFSA) has thanked ANZCA's Overseas Aid Committee for its $A5000 gift to the Fund a Fellow campaign.

The CEO of the federation Julian Gore-Booth said the donation would help WFSA support more fellows this year than ever before. The program, which aims to train 500 fellows and reach over one million patients by 2020, plays an essential role in meeting the shortfall in skilled anaesthesiologists in low and middle income countries by ensuring they have access to quality specialised training.

For more information on the program go to: www.wfsahq.org/get-involved/fundafellow

Letter to the editor

Assisted dying

The recent death of 104-year old Australian Professor David Goodall by self-injection of a lethal dose of barbiturate – in a Swiss clinic for legal reasons – carried an ominous message for Australian anaesthetists.

For prominent in the media report of the case was the "specialist" who aided Professor Goodall kill himself was the word "anaesthesiologist". The simple message imparted to millions of people was "anaesthesiologists help to kill people".

In my view, the ANZCA leadership should be dissociating itself and our fine college from the actions of the Swiss doctor and his clinic. That case and the new Victorian legislation on euthanasia – compounded a totally inadequate, even supine response to the Victorian Act by ANZCA and a state committee of the RACS do not bode well.

This is a serious issue that could cause a schism within the college. Silence will not suffice.

Dr Jim Wilkinson OAM MHL FANZCA
Queensland

Letters on slow-release opioids are on page 31.

Opioids, women in anaesthesia and chronic pain hot topics for media

Coverage of the Sydney annual scientific meeting (ASM) dominated our media coverage since the last *ANZCA Bulletin* (see page 42 for full report) with 670 online, print and broadcast reports in Australian and New Zealand media outlets.

In addition to the ASM reports media covered a diverse mix of issues and topics including the debate around the terminology of anaesthesiology versus anaesthesia, slow-release opioids, shortage of pain medicine physicians, management of chronic pain, and the Rare Privilege of Medicine exhibition at the Geoffrey Kaye Museum of Anaesthetic History.

ANZCA's Immediate Past President Professor David A Scott and the Chair of the Safety and Quality Committee Dr Phillipa Hore were interviewed by *The Age* medical writer Aisha Dow about the anaesthesiology versus anaesthesia debate as covered in the December issue of the *ANZCA Bulletin*. *The Age* article was syndicated to other Fairfax Media platforms *The Sydney Morning Herald*, *The Canberra Times*, the *Brisbane Times* and *WA Today* and attracted a readership of 500,000 people. Professor Scott was also interviewed by Melbourne radio drive program hosts Raf Epstein on ABC Radio Melbourne and Tom Elliott on 3AW. The issue was also followed up by *Australian Doctor* and the Wake Up Australia program on 2GB in Sydney. In New Zealand Professor Alan Merry was interviewed on the issue for *The Listener* by Ruth Nichol for a 1000-word article that reached an audience of 200,000 people.

The Tasmanian annual scientific meeting attracted media interest with delegate Dr Lizzie Elliott being interviewed about her experience working in Antarctica as part of an expert diving and hyperbaric medical team. Dr Elliott was featured in an article in the *Sunday Tasmanian* and interviewed by ABC Radio Hobart and Launceston FM.

The Rare Privilege of Medicine exhibition was profiled on ABC Radio National's breakfast program by host Fran Kelly who interviewed curator Monica Cronin and in an article on Melbourne anaesthetist Dr Lucky De Silva for the *Herald Sun* International Women's Day edition. These two items attracted a combined audience and readership of 550,000 people.

In New Zealand a 760-word opinion piece written by FPM fellow Dr Paul Vroegop calling for more pain medicine resources ran in *The Dominion Post* and stuff.co.nz with an audience of 460,000.

ANZCA and FPM's joint statement and accompanying media release on slow-release opioids attracted strong media interest in Australia. Professor Scott was interviewed by Australian Associated Press and this story was syndicated to 50 outlets across Australia with an audience of over 1 million readers. Professor Scott was also interviewed for news segments on 2GB and 3AW and these were syndicated to radio stations in Brisbane and Perth.

The joint statement was also included in a 2300 word opioids investigation story in the June edition of the *Australian Women's Weekly*. Professor Scott was interviewed by writer Ingrid Pyne for the article "One Little Pill." The magazine has a monthly circulation of 375,000 readers.

FPM's Immediate Past Dean Dr Chris Hayes, new Dean Dr Meredith Craigie and new Vice-Dean Dr Mick Vagg were featured in television news and radio segments and online and print articles. Dr Vagg was interviewed by the *Medical Republic* about the slow-release opioid statement and Dr Hayes was interviewed by Channel Nine News in Sydney about the shortage of pain medicine physicians. Dr Vagg was also interviewed by AAP about a new study on hypnosis as a treatment for chronic back pain. Dr Vagg cautioned patients against rushing out to be hypnotised saying the jury was still out on the practice for managing chronic pain. This article was syndicated to sbs.com.au, yahoo news Australia and New Zealand and the *Daily Telegraph* and *Courier Mail* and attracted a combined audience of 700,000 people.

Dr Craigie was interviewed by ABC Radio Adelaide's breakfast program for a four minute segment on chronic pain management and an article for *The Age* on pharmaceutical companies' advertisements for strong painkillers.

The debate on the effect of anaesthetic on children's brains continued with fellows Professor Paul Myles and Professor Andrew Davidson being interviewed by Fairfax Media's science editor Liam Mannix. *The Sunday Age* story was also syndicated to *The Sun Herald* and the *Canberra Times*.

Carolyn Jones
Media Manager, ANZCA

Since the March 2018 edition of the *ANZCA Bulletin*, ANZCA and FPM have featured in:

- **71 print reports.**
- **554 online reports.**
- **210 radio reports.**
- **Two TV reports.**

Media releases since the previous *Bulletin*:

Friday May 11:

Medical emergencies occur during one in 400 flights, says new study

Two new leaders for ANZCA and FPM

Thursday May 10:

Australian-led global study unlocks the secret of IV fluid treatment for millions of patients

Needle phobias a real pain for many

Surgeon league tables under the microscope at scientific meeting

ANZCA joins global patient safety foundation

Wednesday May 9:

Specialist reveals challenges of treating Australia's most obese patients

Tuesday May 8:

Does anaesthesia affect my baby's brain?

Doctor stress, burnout and hospital rosters on agenda of key medical conference in Sydney

Monday May 7:

Space exploration or catching a wave: Kids taking charge of virtual reality in hospitals

Sunday May 6:

Breakthrough blood test reveals colour of chronic pain

Saturday May 5:

Headaches affect one in 150 women after they have been given epidurals

A full list of media releases can be found at www.anzca.edu.au/communications/media

Follow us on Twitter for all the latest ANZCA news and events.

@ANZCA

My Health Record expands

Australia

Australia prepares for expansion of My Health Record

The Australian Digital Health Agency (ADHA) recently announced a significant expansion of My Health Record – the secure online summary of key health information for Australians. To date, more than one in five Australians have elected to register for a My Health Record however the ADHA recently announced that the current "opt-in" participation model will change to an opt-out arrangement. This means that by the end of 2018, a My Health Record will be created for every Australian with a Medicare or Department of Veterans' Affairs card unless they choose to opt out.

ANZCA has been engaging with the ADHA to assist in making health practitioners aware of this change and what it might mean for them. The ADHA has created a number of resources for both health professionals and patients which are available. Resources tailored specifically for specialists are available on the myhealthrecord.gov.au website. These include how to view and upload clinical information, help sheets for a range of clinical software, webinars and brochures for patients.

Further, to ensure that My Health Record fulfils its aims for healthcare professionals of improving timely access to relevant patient information and supporting clinical decision-making, ANZCA has undertaken to provide the ADHA with relevant feedback and suggestions from our fellows and trainees. The college will keep its members updated with relevant information in future communications, however should you have any feedback on My Health Record or queries about the significant expansion of the program in 2018, please contact the Policy unit at policy@anzca.edu.au.

Working to enhance rural training

On May 2-3 ANZCA hosted the first of two inter-college network meetings planned for 2018 (top right). Attended by the Department of Health and all colleges participating in the Specialist Training Program and the associated Integrated Rural Training Pipeline initiative, the purpose of the meeting was to provide program updates and exchange information between participants about the roll-out of new funding agreements and a revised operational framework that came into effect in 2018. The event also provided the department the opportunity to deliver an information and training session on a new online reporting portal that will be implemented in the latter part of 2018. Attendees also took part in guided tours of the Geoffrey Kaye Museum and its new "Rare Privilege of Medicine: Women anaesthetists in Australia and New Zealand" exhibition.

A feature of the event was a workshop on expanding regional and rural training capacity. Colleges identified a number of issues including:

- Trainee welfare and feelings of professional isolation.
- Providing suitable supervision.
- Meeting accreditation requirements.
- Ensuring trainees have access to diverse cases and adequate patient loads.
- Infrastructure deficiencies.

Several strategies to address these issues were explored by participants however it was clear that many of them will require locally developed solutions given the complexity and diversity of both regional and rural communities and specialist medical training requirements.

ANZCA's Specialist Training Program team will continue to work closely with relevant college staff and committees to enhance the college's ability to identify opportunities to expand regional training capacity in the coming years. For further information please contact the Specialist Training Program team at stp@anzca.edu.au.

Choosing Wisely meeting

NPS MedicineWise hosted the second annual Choosing Wisely Australia National Meeting in Canberra on May 30. Led by Australia's medical colleges and professional societies and facilitated by NPS MedicineWise, the Choosing Wisely initiative is now in its third year and is challenging the way we think about healthcare.

There was an emphasis on the recognition and reduction of low-value healthcare, in terms of low yield tests and procedures, and also on decreasing risk and harm to the patient.

Dr Kim Hattingh, the Faculty of Pain Medicine representative on ANZCA's Safety and Quality Committee presented a poster highlighting the joint FPM/ANZCA Statement on the Use of Slow-Release Opioid Preparations in the Treatment of Acute Pain and discussed the recommendation with participants from a range of organisations.

The keynote address for the meeting was given by Mr Daniel Wolfson (above), Executive Vice President and Chief Operating Officer of the ABIM Foundation, a not-for-profit foundation focused on advancing medical professionalism and physician leadership to improve the healthcare system.

New Zealand

Meeting with the Minister of Health

ANZCA and FPM opened up channels of communication with the new New Zealand government when Dr Jennifer Woods, Professor Ted Shipton and Dr Paul Vroegop met with the Minister of Health, Dr David Clark, on March 29.

In the open and free-ranging discussion, the minister outlined his priorities of inequality, mental health and primary health – and he asked for free and frank advice.

Dr Woods, chair of the New Zealand National Committee (NZNC), spoke of inequity as a leading issue for ANZCA too and outlined the draft Indigenous health strategy working towards redressing inequitable health outcomes between Māori and non-Māori, recognising that inequity is a safety and quality issue. Professor Shipton, chair of the FPM NZNC, and Dr Vroegop talked about the burden of chronic pain in New Zealand, inequitable access to pain medicine services across the country, and the bi-directional relationship between chronic pain and mental health and addiction issues.

The minister was interested to hear that pain medicine focuses on rehabilitation and returning people to work, and that investing in pain services has potential to save costs across the social development sector. He also encouraged ANZCA and FPM to provide feedback to the government inquiry into mental health and addiction.

The minister asked about ANZCA's and FPM's views on medicinal cannabis. Professor Shipton, Dr Vroegop and Dr Woods explained that there is no evidence for the efficacy of cannabis for chronic pain, and further research is needed. Medicines in general are just a small component of the options for treating chronic pain, and better access to pain medicine services may mitigate public demand for cannabis to treat unrelieved pain. The minister understood that evidence for using cannabis-based products for chronic pain was lacking, and explained this was behind his decision not to widen access to cannabis to those with chronic pain in the Misuse of Drugs (Medicinal Cannabis and other matters) Amendment Bill before the Health Select Committee. ANZCA and FPM supported this stance, in a submission to the Health Select Committee.

Government meetings

The ANZCA NZNC invited the Medical Director of PHARMAC, Dr John Wyeth, and the Chief Medical Officer of the Ministry of Health, Dr Andrew Simpson, to its March meeting. The NZNC took the opportunity to discuss with Dr Wyeth PHARMAC's work developing national contracts for anaesthesia small equipment and consumable products, and to recommend PHARMAC set up an anaesthesia clinical advisory group to ensure appropriate products are contracted for.

The NZNC heard from Dr Simpson that the ministry is looking at developing new health targets for the minister, and that work is still progressing to develop a national electronic health record. Dr Simpson also provided updates on the mental health review and medicinal cannabis legislation.

Submissions

ANZCA prepares submissions and makes representations to government and other stakeholders on a range of policy initiatives and inquiries, many of these in response to requests for college feedback and input. ANZCA's submissions to public inquiries are available on the ANZCA website following the inquiry closing date. Note that some inquiries and requests for college input are confidential. For a listing of recent submissions visit www.anzca.edu.au/communications/advocacy/submissions.

Australia

- Therapeutic Goods Administration – Consultation on prescription strong (Schedule 8) opioid use and misuse in Australia – options for a regulatory response.
- Therapeutic Goods Administration – Consultation on management and communication of medicine shortages in Australia – a new protocol.
- Therapeutic Goods Administration – Consultation on labelling of neuromuscular blocking agents.
- Medical Board of Australia – Consultation on draft revised guidelines "sexual boundaries in the doctor-patient relationship".
- Committee on the Health Care Complaints Commission (NSW) – Handling of complaints about cosmetic health services providers in New South Wales.
- Department of Health and Human Service (Victoria) – Draft amendments to the Health Services (Private Hospitals and Day Procedures Centres) Regulations 2013.
- Royal Australasian College of Physicians – Consultation on position statement and evidence review on obesity.

New Zealand

- Justice Select Committee – End of Life Choice Bill.
- Health Select Committee – Misuse of Drugs (Medicinal Cannabis and other matters) Amendment Bill.
- Health Select Committee – Health practitioners Competence Assurance Amendment Bill.
- Health Quality and Safety Commission – Maternity vital signs chart.
- Perioperative Mortality Review Committee – 2018 draft annual report recommendations.

What would you do?

Dr Peter Roessler explains ANZCA's professional documents using practical examples.

Ageing (this) gracefully

The topic of retirement is a perennial one that appears to generate a spectrum of emotions ranging from fear to anticipation. At the centre of retirement is the issue of ageing, although discussions frequently heard in hospitals and at conferences involve fellows of all ages.

What expertise do I possess regarding ageing? In my early years as a consultant I was invited to lecture on the physiology of ageing at the short course run by the Victorian Regional Committee. Mind you, I was intrigued as to why a neonatal anaesthetist would be invited to present on ageing. I discovered the wisdom of that selection in due course as I presented on this topic for almost two decades, during which time, yes, I had aged. Also, my scope of practice at that time included the whole age range from neonatal to geriatric. It is said that with ageing comes insight and wisdom. It has also been said that my case is exceptional, although I still wonder about the interpretation of exceptional in this instance.

In this edition I propose to consider the issues associated with the ageing anaesthetist, and this is timely given the prominence of the topic of ageing during National Anaesthesia Day in October last year. Although the focus was on the ageing patient the processes of ageing does not differentiate between patient or practitioner, and no one is immune from this terminal condition.

Picture the scenario where a surgical colleague comes to you and expresses their concern about an anaesthetist, not because there have been any issues, but simply because they are concerned about the anaesthetist's advanced age.

What would you do?

While I appreciate that there may be a temptation on the part of some, to dismiss this concern purely because it was raised by a surgeon, the question remains, is their concern warranted? How would you respond?

Despite financial pressures and competition for lists, my experience has been that fellows' primary regard is patient safety and the wellbeing of colleagues rather than any opportunistic or selfish exploitation of the circumstances. This typifies collegiality, which is appropriate in this scenario as the concern was based on advancing age rather than actual clinical performance.

With regard to ageing, there is continuing emergence of research highlighting specific neurological changes accompanying ageing that affect the "fast" and "slow" neurological responses. Automated responses based on experience remain rapid, however, those that require processing and evaluation tend to slow down, resulting in a decreased ability to effectively respond to "new" clinical presentations.

In subtle ways this possibly accounts for the shifts in clinical practice observed with ageing, which include a reduced workload – initially after-hours and then also during hours; and a narrowing of case-mix – voluntary limitation in scope of practice.

Although age has been identified by the Medical Board of Australia as a risk factor for clinical performance, the vexing question that needs to be answered is at what age does this apply to any individual. Given the spectrum of performance at any specified age the application of a rigid age limit is of concern in the absence of evidence of clinical underperformance or relevant health issues. Nevertheless, participation in continuing professional development is a necessary component as inadequate activity is linked to increased risk of underperformance.

In guiding our approach to addressing the surgeon's concern, it may be helpful to refer to the ANZCA professional documents, the ANZCA *Supporting Anaesthetists' Professionalism and Performance: A guide for clinicians* booklet, and the codes of conduct of the relevant authorities in Australia and New Zealand, as well as the very well-considered ANZCA document available on the website under doctors' welfare, *Promoting good practice and managing poor performance in anaesthesia and pain medicine*.

Taking some of the concerns in turn, fatigue and ability to cope with fatigue as well as the impact on vigilance are addressed in *PS43 Statement on Fatigue and the Anaesthetist*. Health issues should be guided by the recommendations contained in *PS49 Guidelines on the Health of Specialists and Trainees*. *PS50 Guidelines on Return to Anaesthesia Practice for Anaesthetists* provides guidance in cases where there has been a significant absence from work for health or other reasons. Contracture of some of the duties contained within *PS57 Statement on Duties of Specialist Anaesthetists* may need to be considered; however, there can be no compromise on the need to undertake relevant quality assurance as stated in *PS58 Guidelines on Quality Assurance and Quality Improvement in Anaesthesia*.

Some of these aspects are emphasised with examples of good and poor behaviour reflecting clinical performance in the handbook *Supporting Anaesthetists' Professionalism and Performance: A guide for clinicians*. For example, at what point would you raise this with the anaesthetist in question, and how would you proceed? Using the ANZCA roles as a basis, the guide identifies behaviours that may be used to evaluate/support clinical performance, whether it be our own or our colleagues.

The above resources may be helpful in identifying the relevant standards as well as the value of compassion and understanding. This is encompassed very nicely in the *Promoting good practice and managing poor performance in anaesthesia and pain medicine* guideline containing sections on identifying poor performance as well as appropriate steps that a colleague may take to explore allegations of poor performance. This can be accessed at www.anzca.edu.au/resources/doctors-welfare/managing-poor-performance-in-anaesthesia-and-pain. This resource may be most helpful in differentiating concerns about age from concerns about performance.

With the often-observed voluntary narrowing of case-mix and limitations on hours worked, CPD becomes increasingly important as any reduction in CPD participation is likely to raise alarm bells with the regulatory authorities. Indeed, reductions in scopes of practice are strong reasons for adherence to the mandatory practice evaluation and emergency responses sections, as they provide the opportunity to maintain skills, as well as confirmation of performance at the expected level.

In conclusion, would you dismiss your surgical colleague's concern because there have been no reports suggesting underperformance, or would you thank them for their concern and for bringing the matter to your attention and then use the abovementioned resources to follow through? I know what I would like if I was the subject of concern (and maybe I am). I have discovered that in my case the ageing process is unkind to memory, especially with names, which is why I prefer to wear my name tag upside-down, so that I can read it should I forget my name.

The price of experience is time, which is accompanied by the accumulation of "intellectual property and corporate knowledge". When clinical performance becomes the subject of concern as a result of ageing, the opportunity should be seized to capture and utilise the resources deposited over the years by redirecting the wealth of knowledge and experience to safety and quality, and professionalism, via non-clinical conduits.

Dr Peter Roessler
Director of Professional Affairs, Policy

Professional documents – update

The professional documents of ANZCA and FPM are an important resource for promoting the quality and safety of patient care. They provide guidance to trainees and fellows on standards of clinical care, define policies, and serve other purposes that the college deems appropriate. Government and other bodies refer to ANZCA's professional documents as an indicator of expected standards, including in regards to accreditation of healthcare facilities. Professional documents are subject to regular review and are amended in accordance with changes in knowledge, practice and technology.

Recent releases

- *PS58 Guidelines on Quality Assurance and Quality Improvement in Anaesthesia* (final version).

In pilot

- *PS64 Statement on Environmental Sustainability in Anaesthesia and Pain Medicine Practice* (in pilot until February 2019).
- *PS63 Guidelines for Safe Care for Patients Sedated in Health Care Facilities for Acute Behavioural Disturbance* (approved for pilot at the April 2018 council meeting.) This document is co-badged with the Australasian College for Emergency Medicine and the College of Intensive Care Medicine of Australia and New Zealand.

All comments and queries regarding professional documents can be sent to profdocs@anzca.edu.au.

All ANZCA professional documents are available via the ANZCA website – www.anzca.edu.au/resources/professional-documents.

FPM professional documents can be accessed via the FPM website – www.fpm.anzca.edu.au/resources/professional-documents.

Can trainees' (and fellows' and other CPD participants') personal reflections be used in court?

The recent case in the UK of Dr Hadiza Bawa-Garba has raised concerns in Australia and New Zealand for young doctors and trainees.

Many medical colleges require their trainees, and some fellows and other CPD participants, to undertake consideration of their practice, reflect on their own performance and give a frank assessment of their actions and performance in particular areas. Obviously the information can be quite personal and sensitive, and may admit some error, or identify areas for improvement.

There is now concern that information might be "used against them" should medico-legal action arise or in other administrative processes.

While the outcome in the case affecting Dr Bawa-Garba is concerning, with her ultimate de-registration as a medical practitioner, there are also strong views that the same situation could not arise in Australia or New Zealand. There is also the myth that, in the Dr Bawa-Garba case, her reflective notes were used against her in the proceedings by which she was convicted criminally and ultimately de-registered. In fact it was clear that her reflective notes were not used, and were not permissible as evidence.

Dr Bawa-Garba was a registrar at the Leicester Royal Infirmary in the Paediatric Unit. The relevant case involved a six-year-old boy presenting at hospital with dehydration and other symptoms. He was initially treated for gastroenteritis and dehydration. Other tests were requested. Radiography indicated pneumonia and antibiotics were administered. Delayed blood test results were received later. There was some miscommunication between Dr Bawa-Garba, nursing staff and ultimately the consultant. A serious infection had not been identified, and the child suffered septic shock. It was suggested that the delayed response to the underlying infection was directly relevant to the child's death. Other "system" errors within the hospital contributed to this unfortunate event.

Dr Bawa-Garba and a nurse faced criminal charges for gross negligence, equivalent to manslaughter. This required more than mere negligence, and required proof beyond reasonable doubt that the circumstances were so bad and so exceptional that it amounted to a criminal act and would be a breach of criminal law. It is significant, perhaps, that the trial involved a jury, and that they were persuaded that in all of these difficult circumstances, the conduct was of a criminal nature. As a consequence Dr Bawa-Garba (and the nurse) were convicted of gross negligence, and although sentenced to two years imprisonment, it was wholly suspended for two years.

In relation to the subsequent professional action taken against Dr Bawa-Garba before the Medical Practitioners' Tribunal, the tribunal accepted that there was professional misconduct and it imposed 12 months' suspension, subject to review. It explicitly rejected de-registration as an appropriate response.

The General Medical Council, considering the decision of the tribunal, felt it was inadequate and appealed the tribunal's decision arguing that in the case of a serious criminal conviction of this nature, that de-registration should automatically apply.

The case of Dr Bawa-Garba is not over. Most recently, she has obtained the right to further appeal this decision. Her de-registration is therefore subject to further review and the outcome will be of great interest.

The case of Dr Bawa-Garba involved a relatively junior doctor in circumstances of an extraordinarily busy time in the hospital, a lack of adequate staffing, substantial overload of her work, missing clinical information and delayed test results. In the midst of all of this it was alleged that Dr Bawa-Garba also was negligent, to the extent that a court concluded that she was criminally negligent. As a consequence the General Medical Council in the UK sought and ultimately obtained her de-registration. There are a number of reasons why this is unlikely to be repeated in Australia and New Zealand:

1. The factual circumstances affecting Dr Bawa-Garba and her performance in the hospital at that time while negligent, would not ordinarily meet the Australian and New Zealand requirements for criminal negligence. Well intentioned doctors can make mistakes. These can lead to negligence claims. However a conviction for criminal negligence requires that the negligent act or omission should be of such order and magnitude that it amounts to the criminal standard equivalent to manslaughter. Australia and New Zealand cases in relation to this issue have set a higher bar than would appear to have been the case in this instance in the UK, especially given that this was a jury trial. This is especially so in New Zealand since the change in the law in the 1990s, in response to a campaign led by Professor Alan Merry.
2. The Medical Board of Australia (MBA) and the Medical Council of New Zealand (MCNZ) are unlikely to adopt the same rigid stance of the General Medical Council, in seeking automatic de-registration. In the circumstances of misconduct in both Australia and New Zealand, both the MBA and MCNZ would look at the individual circumstances of each case, and seek to understand better the nature of the charges, the details of the misconduct and the surrounding circumstances and the implications of the conviction for fitness for medical practice[1]. It is unlikely that the MBA and the MCNZ would have a position that circumstances of this nature must automatically involve de-registration.

Perhaps most reassuringly of all to trainees, fellows and other CPD participants in Australia and New Zealand is the fact that ANZCA has obtained appropriate legislative protection for the reflective notes and reflective parts of their training program (training portfolio system cases and procedures) and CPD program (practice evaluation)[2] such that the information protected cannot be revealed beyond the process for which it was intended (training and CPD). To reveal any identifying information that is documented in these sections of the TPS and CPD portfolio, including identifying the trainee or fellow, beyond that process would constitute a criminal offence.

Apart from the fact that the reflective notes of Dr Bawa-Garba were not used in the relevant court case, trainees, fellows and other CPD participants in Australia and New Zealand can be assured that the college has had, for some time, legal protection in relation to any right of access to the reflective and personal notes of trainees and fellows in relation to the training program (TPS cases and procedures) and CPD program (practice evaluation part) of the college.

Michael Gorton AM LLB. B.Comm. FRACS (Hon) FANZCA (Hon)
Principal – Russell Kennedy Lawyers

1. Health Practitioners Competence Assurance Act 2003 S 100 (1) c http://www.legislation.govt.nz/act/public/2003/0048/latest/DLM204310.html
2. See table summarising details of protections available for documented reflections.

Summary of protections available under Qualified Privilege (Australia)/Protected Quality Assurance Activity (New Zealand) legislation

Protection **IS** available for (in both countries unless otherwise stated):

1. Training portfolio system (TPS)
   a. New Zealand: "ANZCA trainee portfolio system: Cases and procedures section" (which includes the reflective notes within).
   b. Australia: "Reflective self-audit on cases and procedures within the ANZCA training program".
2. CPD Program
   a. New Zealand: "ANZCA CPD Program" (no exclusions).
   b. Australia: "ANZCA CPD Program – Practice Evaluation Section" (which includes the practice evaluation mandatory activities).
3. WebAIRS: All information submitted.

Protection is **NOT** available for:

1. TPS – rest of the documentation apart from the cases and procedures section as noted above.
2. CPD Program
   a. Australia: The rest of the program (knowledge and skills, emergency responses, CPD plan and evaluation).
   b. New Zealand: Nil (all covered).
3. WebAIRS: Any data forwarded to local systems or any pages printed out from WebAIRS submitted data.

Meeting practice evaluation activities in private practice

The recent fellowship survey included some encouraging insight into how the ANZCA and FPM CPD Program was being received with 85 per cent of respondents indicating that they felt the continuing professional development (CPD) portfolio was easy or very easy to use.

The survey also showed that the fellowship would like more information about how to complete their practice evaluation requirements, particularly from those in private practice.

The CPD Committee and CPD team will endeavour to share more information about how those in private practice can fulfil these requirements, including insights from private practitioners themselves in future editions of the *Bulletin*.

There is a misconception that participants cannot meet the practice evaluation requirements if they cannot complete a peer review of practice or a multi-source feedback (MSF) activity; this is not the case.

There are four mandatory activities in the practice evaluation category:

- Patient experience survey.
- Multi-source feedback (MSF).
- Peer review of practice.
- Clinical audit of individual or group practice.

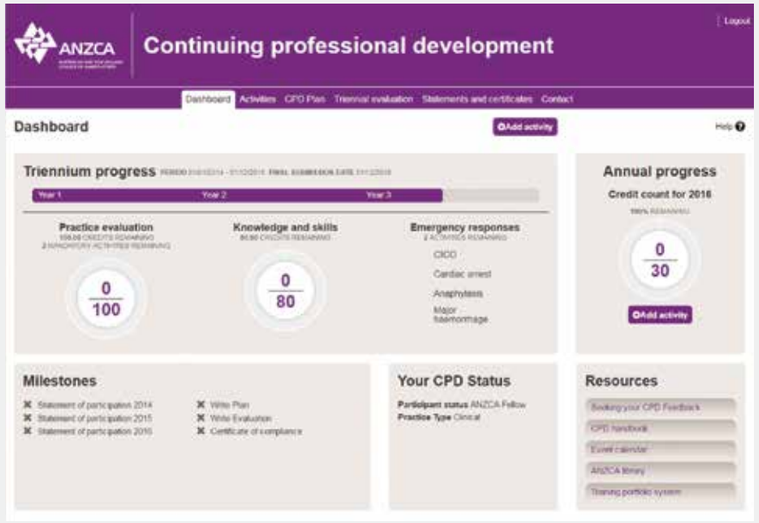
Participants may choose any two (or complete the same activity twice) per CPD triennium as a minimum requirement to achieve the CPD standard.

A patient survey and an audit are equally valuable and may be more achievable in certain circumstances.

Patient experience surveys

Patient experience surveys can be administered and the results collated by a co-worker or an assistant.

A trusted colleague or feedback provider should then have a 20-30 minute conversation with you summarising the results of each item and discuss any issues that arise form the results.



This activity is worth 20 credits. Completing this process twice within the triennium would satisfy the practice evaluation requirement of two mandatory activities per triennium.

Clinical audit of your own practice or significant input into a group audit of practice

Completing a clinical audit of your own practice is another of the four mandatory activities and can be completed by an individual without needing to rely on the assistance of other colleagues.

There are 14 sample audits on the ANZCA website, and links to the Royal College of Anaesthesia's Audit Recipe Book.

The ANZCA and FPM CPD Committee aims to develop further clinical audit samples each year to expand the available selection.

The clinical audit is worth 20 credits within the practice evaluation category. As well as claiming the actual audit, two credits per hour can also be claimed in practice evaluation for the time spent documenting the clinical audit results, including and implementing changes as a result of the audit conducted and for time devoted to presenting the audit findings locally or at a meeting/conference.

Completing this process twice within the triennium would satisfy the practice evaluation requirement of two mandatory activities per triennium.

Get in touch

If you are in private practice and feel that you are having difficulty meeting the practice evaluation requirements, we encourage you to contact the CPD team for advice, or contact the CPD Committee for guidance on how to complete practice evaluation activities within your specific practice settings.

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cpd@anzca.edu.au

Dr Nigel Robertson FANZCA
CPD Committee Chair

Medical Board of Australia's Professional Performance Framework

Released in late 2017, the Medical Board of Australia's (MBA) Professional Performance Framework provides the foundation for a new national perspective on continuing professional development (CPD) and ensures that medical practitioners in Australia practice safely and with competence throughout their professional lives.

The framework is intended to build on existing initiatives and the ANZCA and FPM CPD Program is already in good standing, as we include many of the items that will now become an MBA requirement such as practice evaluation and knowledge and skills activities, the CPD plan and triennial evaluation and the CPD portfolio.

The MBA hosted a workshop in February, hosting representatives from the Australian Health Practitioner Regulation Agency, the Australian Medical Council, the Australian Medical Association, specialist colleges, health complaints commissioners, government representatives and medical indemnity insurers to discuss any issues or concerns these stakeholders had with the structure or implementation of the framework.

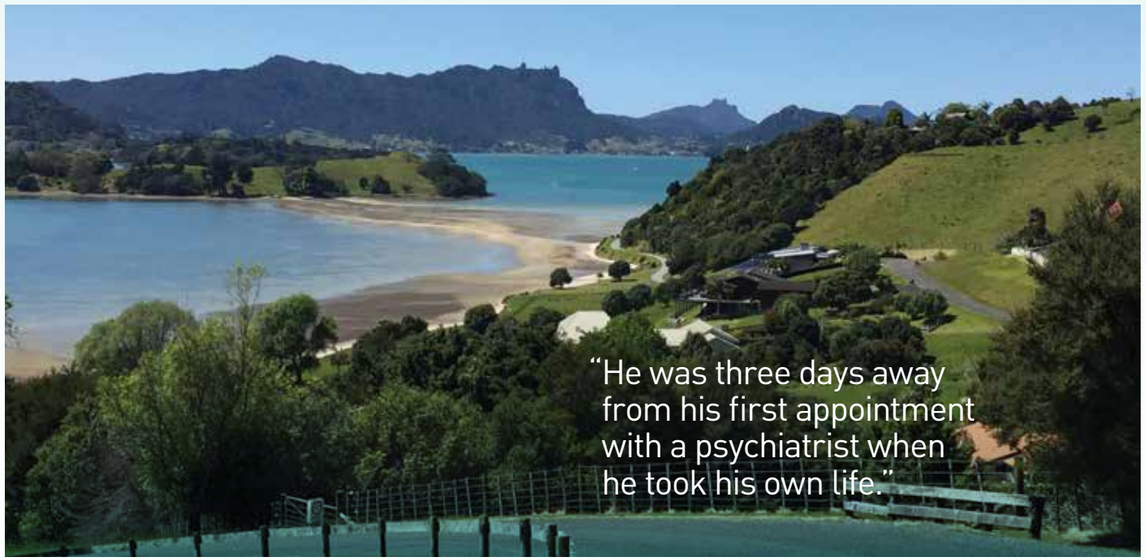
ANZCA Immediate Past President Professor David A Scott, President Dr Rod Mitchell, CEO Mr John Ilott, CPD Committee Chair Dr Nigel Robertson and Director, Education, Mr Olly Jones all attended the workshop. Finalising the framework is intended to be a collaborative exercise and further information is expected to be provided by the Medical Board at another workshop due to be held in August 2018.

ANZCA expects to begin any work required to ensure that the ANZCA and FPM CPD Program complies with all aspects of the framework in 2019, with the vision of delivering an updated CPD Standard and Program in 2020.

The CPD Committee are keen to maintain transparent communications with the ANZCA and FPM fellowships, and will provide regular updates as new information is available via the *ANZCA Bulletin*, *ANZCA E-Newsletter*, *Synapse* and other ANZCA and FPM communication platforms.

Further information about the professional performance framework can be found on the Medical Board of Australia's website: **www.medicalboard.gov.au/Registration/Professional-Performance-Framework.aspx**

Learning from Richard's death



I have recently been catapulted back to the UK from New Zealand in the wake of my intensive care consultant husband's death. My children and I are still reeling from Richard's suicide, which took place six months ago, at home, while my daughter and I were walking the dog.

Richard and I met as junior doctors in Brisbane, and have also worked in Perth, Dunedin and, latterly, Whangarei, after 10 years back in Herefordshire, England. We shared a deep love of both Australia and New Zealand, and chose to return to the latter in 2016. It had been increasingly difficult for British doctors to find intensive care consultant posts in either country in recent years, and when a job came up in Northland, New Zealand, and we became aware of the area's incredible natural attributes, including the world-renowned Tutukaka coast, Richard felt compelled to apply.

Just as we prepared to make the journey across the globe, including packing up our possessions into a shipping container, making arrangements for our two dogs to fly out to join us and selling our house, Richard received the letter all doctors dread – notification that a complaint had been made against him to the General Medical Council (GMC).

This effectively put our plans on hold indefinitely and caused us months of stress. Camped out in a holiday cottage, living out of suitcases, we sent our children back to the school they thought they had left for good, and returned to the jobs we had resigned from. Finally, the complaint resolved in Richard's favour, we left the UK, assuming that our emigration would be permanent, and we were determined to put the GMC investigation and all the associated anxiety and uncertainty behind us.

Unfortunately, the effects of a complaint – even one statistically highly likely to be found in the doctor's favour, as in Richard's case – last far longer than the period of investigation. Richard did a lot of soul-searching during those months. He had always been known for his sound clinical judgment and for his decisiveness at work, for his steadiness under pressure, for his relaxed and calm manner and his sense of fun – he loved to banter with the nurses and doctors he worked with and had an open and forthright manner with everyone he met.

This sense of having been born to do the work that he did was something he exuded effortlessly, and I envied him this, having always questioned my own place within medicine and my choice of general practice as a career.

In the aftermath of the complaint, however, he talked to me much more about the ethical dilemmas he faced at work, all of which cropped up in intensive care, rather than during the course of his anaesthetic work, which continued to come easily and naturally to him. He began to question his decision making. He began worrying about cases that previously would have caused him no concern. He brought his work home in a way that I hadn't seen him do before.

By this time, he had settled into his new role at Whangarei Hospital and was enjoying getting to grips with a new system, despite the challenges of adapting to a new country and different ways of working. He was popular with his colleagues, and his direct communication style went down well with his patients, who appreciated his warmth and his honesty. He enjoyed learning about the Māori culture, and would give me and the children impromptu tutorials on Māori word pronunciation, having been inspired to make headway in this area by some powerful and thought-provoking cultural awareness teaching at the hospital.

Opposite page from left: Headland Farm Park, Tamaterau, Whangarei; Dr Richard Harding and Dr Kate Harding in NZ; their last photo together taken in Melbourne in October 2017.

"He began worrying about cases that previously would have caused him no concern."

At home, however, it was clear to us both that his mood was slipping downwards, and it seemed that the long months of anxiety and powerlessness in the face of the GMC complaints procedure, coupled with a move across the globe, were catching up with him.

Richard did well on antidepressants and weaned himself off them after six months, with his doctor's blessing. He threw himself into our new coastal lifestyle: running, cycling, diving and fishing. He frequently had his morning coffee in the sun while gazing at our astonishing view, which took in the gleaming blue of the harbour waters, Mount Manaia in the distance and the shimmering greens for which New Zealand is famous. He deeply loved his new environment, and we often walked on the beach together, marvelling at our good fortune in having landed in a place so heart-stoppingly beautiful.

The illness then recurred some six months later, slowly taking hold, fuelled by his on-call rota and the associated sleep disturbance that, constitutionally, he had always found difficult, but which this time took a disproportionate toll on his mental health. He went back on to his medication, but this time, agitation was an increasingly prominent feature of his illness, and it became clear to us both that he was on the wrong drug; that, this time, he needed something different. He was three days away from his first appointment with a psychiatrist when he took his own life.

I have written elsewhere (www.theguardian.com/lifeandstyle/2018/feb/24/went-walk-returned-husband-suicide-depression) about finding Richard dead, trying to resuscitate him while knowing it was entirely futile to do so, helping the children to say goodbye to him, watching the paramedics drive him away, knowing that I would never see him again. Fielding the policemen's questions, thanking the neighbours for their help, shutting the door on them and at the same time on our old life, unable to imagine how our new life could possibly take shape without him. Suffice to say that we did – somehow – survive those early days, and that our new life is unfolding without him, though it still seems incredible sometimes that such a thing should be possible, or even allowed.

We have returned to the UK, to the security that comes from living near family and old, dear friends, though I have made friends for life in New Zealand and will never forget their kindness in the aftermath of Rich's death. We are adapting to life as a unit of three, rather than four. I have returned to work, compelled to do so as soon as possible by my new status as sole breadwinner, and by the absence of any life insurance pay-out. I am taken out of myself and my troubles by my hospice work, and am well supported by my work colleagues, many of whom are close friends.

Richard's mental health troubles were, in comparison with those of other doctors who have taken their own life, short-lived and intense. He had had one previous episode of depression in his early 20s; there was no recurrence for 23 years, until the period following his GMC complaint and our emigration. He was open about being investigated (probably in part because he was confident that he would not be found guilty of poor clinical judgement, on which count he was correct) and found his colleagues to be uniformly supportive and reassuring. He still died.

(continued next page)

Learning from Richard's death (continued)

It is hard to predict who will succumb to suicidal thoughts both during and after an investigation. He would not have been on anyone's "one to watch" list. It is debatable how much of a factor the GMC investigation was in causing his death, since his suicide occurred 22 months after first receiving the "letter of doom", as we called it. I personally feel that its effects were insidious, that a complaint, however minor, has deep and long-lasting ramifications for doctors, who tend to be sensitive to any suggestion that they are not looking after their patients properly. Of course we make mistakes. Some of us even commit crimes. The vast majority of us are just trying to do our best, however. We genuinely want to help our patients, do some good in this troubled world, go home to our families feeling that we made a difference – however small, however temporary.

Here in the UK, I am working with the Association of Anaesthetists of Great Britain and Ireland, which is looking into the suicide rate among anaesthetists. This is well known to be higher than average, due in large part to their easy access to lethal injectable drugs. Of course, many suicides have nothing to do with complaints. Some are substance misuse-related, others associated with long-term chronic health conditions, physical as well as mental (although the distinction between the two is artificial and not always helpful).

One of the goals of this work is to put in place ways of trying to reduce the risk of suicide for individual doctors, while equipping hospital departments to offer better support to those affected by such tragedies when they do occur. Colleagues are hit hard by the loss of a doctor in their midst to suicide, and the remorse and guilt that I feel as Richard's wife are felt by his friends and workmates too.

I am no expert in the field of doctor wellbeing, and am learning as I go along. I am grateful to those who are teaching me, and allowing me to play my own tiny part in the work that is being undertaken in this area. Richard's death was simply unimaginable to me, knowing as I did – do! – how much he loved his family. I have to live with the consequences of this failure of imagination every day, as do my children and everyone else who has been affected by his death.

I miss him desperately. I miss our life in New Zealand, our enchanting peninsula, the greens and the blues. I long to go back, but, for now, I belong here in Britain, lashed by rain, Brexit a constant background rumble of discontent. Richie is with me wherever I am, as is the grief – a deep, dark central weight within. Not for one moment do I doubt how much we were loved by him, not for one moment do I think that he knew what he was doing to us by leaving us. Sometimes that helps; more often, it doesn't.

If this article has raised concerns for you, please contact the ANZCA Doctor's Support Program.

Dr Kate Harding

Dr Kate Harding is a hospice doctor and part-time GP now working in Herefordshire, UK, following the death of her husband Richard. She lives with her two children and her cavalier King Charles spaniel, Mo. She can be found on Twitter at @KateJH1970.

This article was originally published in MJA InSight www.doctorportal.com.au/mjainsight/2018/18/doctors-wellbeing-learning-from-richards-death/

Have your say...Doctors' Health and Wellbeing Draft Interim Framework

ANZCA is committed to developing a health and wellbeing framework that supports our members, at every stage of their career, and provides guiding principles for future initiatives in this area. Part of this process is seeking your thoughts, on what matters most to you. An online response form is available for all fellows, trainees and specialist international medical graduates to provide comment on the framework until July 15.

In February 2018, a group of trainees, fellows, councillors, staff, and representatives from our sister colleges and societies met with the college to support the development of our proposed new approach to doctors' health and wellbeing.

The proposed framework intends to guide the college's prioritised efforts on doctors' health and wellbeing strategically over the coming years. This will govern the planning and delivery of both actions deemed to be directly within the college's control and those that are best achieved in collaboration with other stakeholders.

The following framework has been adapted to the college's needs from beyondblue's "First responders" good practice model for mental health and wellbeing" because of the similarities in its principles, action-orientated approach and the people it aims to support.

The overarching intent

The overarching intent of this framework – better health and wellbeing – encompasses the holistic health and wellbeing of our doctors.

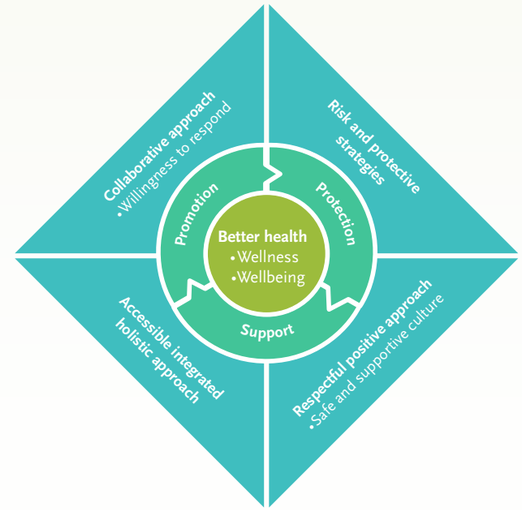
Three integrated action areas

1. **Promotion:** Promoting the positive aspects of being in the profession as well as the importance of self-care in the role of doctor. Promoting research.
2. **Protection:** Advocating to reduce profession-related risk factors for health and wellbeing and increasing protective strategies.
3. **Support:** Providing effective and accessible services and programs to support doctors' health and wellbeing. Encouraging those who need treatment; de-stigmatising mental illness; and promoting inclusion.

Four key principles

There are four key principles that will guide the implementation of all health and wellbeing actions in alignment with this framework.

1. **A collaborative approach and a willingness to respond:** Reflecting the collective effort considered essential to achieve the overarching intent. We are all part of shifting the professional paradigm to one that considers the health and wellbeing of our doctors a priority.
2. **Risk and protective strategies:** Reflecting our ability to promote strategies to modify the risks to our doctors through education, policies and other areas of influence in employer organisations.
3. **A respectful, positive approach to creating a safe and supportive culture:** Reflecting our ability to provide leadership and advocacy in the profession, supporting a culture which positively embraces the importance of doctors' health and wellbeing.
4. **An accessible, integrated, holistic approach:** Reflecting our ability to provide integrated strategies that consider work environment, personality factors, home and personal life, and the potential stigma associated with seeking help.



Career life cycle

This reflects the importance of the transition across the following stages to a doctor's career: training; new specialist; mid-career; retirement; and return to work. And that this should be considered in relation to the framework intent, actions areas and principles.

What happens next?

Responses from this consultation will be used to further develop the draft framework. Updates will be provided via the ANZCA website and through other college communications. Further consultation is anticipated to occur to map current ANZCA doctors' health and wellbeing initiatives against the framework over the coming months.

Have your say

For further information and to provide feedback go to www.anzca.edu.au/resources/doctors-welfare.

Wing commander flies high with Defence medical teams

Anaesthetist Dr Alex Douglas, the recipient of an Australian Medal for Gallantry, writes about how her experiences growing up in South Africa and her Australian Defence Force deployments in Rwanda, East Timor and the Middle East have shaped her approach to the specialty.

Born in 1967 in Johannesburg as Carol Louise Vaughan-Evans my early years were spent with extended family in Zimbabwe where safety and security were paramount.
At the age of 11 or 12 I was at a gathering with family and friends without my parents when there was a terrorist attack. This became a solidifying moment in my life – the army came and rescued those being held hostage. I vowed then that I would do the same thing one day as a doctor.

My parents, concerned for their three daughters, sought a new life that was far less dangerous. We emigrated to Australia in 1982, first to the Hunter Valley in New South Wales and then Tasmania. My sporting passions included karate and hockey and a strong sense of fitness as I was determined to serve in the military.

I gained my Bachelor of Medicine and Bachelor of Medical Science in 1992 from the University of Tasmania and soon after I began my studies I joined the Australian Defence Force. During my holidays and spare time I began my military training and worked for Tasmania's 10th Field Ambulance. On graduation I went straight into a full time medical role as an Officer of the Royal Australian Army.

I enjoyed my military training and responsibilities and revelled in the work. In 1995 as an Army Captain with nearly three years' experience I was deployed to Rwanda. My unit was based at Kibeho (a refugee camp) where more than 5000 people were massacred. The Royal Australian Army Medical Corps saved many lives in Kibeho and I was awarded the Medal for Gallantry in 1996.

I then went on to be the first female doctor to work at the Special Air Service Regiment (SASR). I have since served on many overseas deployments.

After my posting to the SASR I decided to resign from full-time service and start training as a specialist in both anaesthesia and intensive care. To help alleviate the pressure I experienced with post-traumatic stress that went untreated I changed my name to Alexandra Evan Douglas.

Having completed my training and gaining a position as a consultant specialist I moved into a full time role with the Royal Australian Air Force and I'm now a Wing Commander based with the Headquarters Health Services Wing in Amberley, Queensland. I've been deployed many times overseas including five months in the Middle East. To maintain my medical skills I work at the Gold Coast University Hospital with the intensive care unit.

I've handled the transition from resource-poor field work to modern clinical environments in Australian hospitals relatively easily.

Extract from the Medal for Gallantry citation awarded to Major Vaughan-Evans (now Douglas) in 1996:

"Her gallant performance of duty, distinguished leadership and tireless and selfless efforts, often under fire and always under appalling conditions, Major Vaughan-Evans was directly responsible for saving the lives of many Rwandan people. Her calmness in this life threatening situation and her ability to make clear and accurate medical assessments under pressure were of the highest order. In addition, her compassion and dedication to those she was treating, ability to improvise when supplies ran low, and outstanding medical expertise were the finest traditions of the Royal Australian Army Medical Corps. Her acts of gallantry and leadership whilst under fire were an inspiration to all members of the Australian Medical Support Force Team at Kibeho."

"It is an adjustment. I can be at the Gold Coast University Hospital and then a week later I'm in full uniform armed to the teeth."

It is an adjustment. I can be at the Gold Coast University Hospital and then a week later I'm in full uniform armed to the teeth. I don't feel like I am going to do anything differently but it is a bizarre thing to be walking along and being mindful of improvised explosive devices and the like while a week before I was worried about whether I would be hit by a car crossing the road.

It makes you incredibly grateful when you ask for something and it's available and you don't suddenly have to change or adjust your thinking to adjust or make a contingency plan on the back foot. If you are suddenly presented with a child in the civilian sector and you weren't expecting it you just go and get a paediatric pack whereas in the military if you weren't expecting a child there's some serious adapting that's required.

Specialists who have worked in Defence are flexible but very determined. You do develop a bit of a spine.

A lot of the technical developments we now use in trauma medicine comes from the military domain such as the reintroduction of tourniquets. The combat experience is really about trauma care and anaesthesia has been a step for me to get to ICU. I am very passionate about trauma. It really is a disease for me and I believe there is much more we can do.

In addition to the Medal for Gallantry Wing Commander Douglas has received:

- Australian Active Service Medal with clasps for International Coalition Against Terrorism, East Timor and Rwanda.
- International Force East Timor Medal.
- Australian Campaign Medal for Afghanistan.
- Australian Service Medal with clasps for Counter Terrorism/ Special Recovery, Timor Leste, Special Operations and Iraq.
- Operational Service Medal.
- Australian Defence Force Medal.
- UN Rwanda Medal.
- NATO medal with International Security Assistance Force clasp.

As Dr Douglas was preparing her story for the Bulletin *she was just days away from participating in her first "half Ironman" event – the Tweed Coast Euro – which included a 1.9 kilometre swim, a 90 kilometre cycle and a half marathon. Her results were impressive – of the 21 men and women who were competing for the first time in the competition she came sixth with a time of 6:09:16.*

Opposite page: Wing Commander Alex Douglas with the Australian Specialist Health Group in Kandahar Airfield's Role 3 medical facility, checks equipment. Source: Australian Defence Force.

This page: Aeromedical Evacuation Liaison Officer Wing Commander Alex Douglas prepares a wounded soldier for his journey home from Afghanistan. Source: Australian Defence Force.

News

webAIRS

Respiratory aspiration incidents reported to webAIRS

webAIRS reporting provides a unique opportunity to analyse various themes of anaesthesia incidents for the purpose of quality improvement. It was respiratory aspiration data that was given recent focus at ANZCA's 2018 ASM.

Since Mendelson's publication in 1946, there have been numerous journal articles relating to acid aspiration of gastric contents[1]. The presentation of webAIRS data at the ASM reconfirmed that aspiration remains an important complication of anaesthesia despite high awareness of risk and management techniques. While prevention is often cited as the mainstay in avoiding incidents of aspiration, the analysis of the webAIRS incident data revealed that approximately 40 per cent of affected patients were considered to be of no risk, and approximately 50 per cent were elective. There did not appear to be a reliable predictor of aspiration with a history of reflux reported in only one in seven of cases. It is also interesting to note that aspiration occurred during a rapid sequence induction in 15 per cent of the webAIRS reports.

In terms of outcome, almost 60 per cent of patients experienced a prolonged length of stay or unplanned admission to intensive care. Death occurred in 6.6 per cent of the incidents of aspiration reported to webAIRS.

The full analysis of the aspiration data will be published in a scientific journal. What the current findings highlight is the need for vigilance around aspiration even in the absence of perceived high risk.

The second half of 2018 will see further themed analysis and conference presentation of webAIRS data. The Publications Group led research will examine causal and management factors as well as outcomes. The ASA NSC in October will feature a session on the importance of incident reporting with presentation of airway specific data analysis.

Dr Martin Culwick, Dr Michal Kluger, Sarah Walker and Dr Pieter Peach

Reference:
1. Medelson CL. The aspiration of stomach contents into the lungs during obstetric anaesthesia. AM J Obstet Gynecol. 1946; 52: 191-205.

Safety alerts

Safety alerts are distributed in the "Safety and quality" section of the monthly *ANZCA E-Newsletter*. A full list can be found on the ANZCA website: www.anzca.edu.au/fellows/safety-and-quality/safety-alerts.

Slow release opioids: Message from the president and dean

The release of our "Position statement on the use of slow-release opioid preparations in the treatment of acute pain" has created welcome and energetic discussion among ANZCA and FPM fellows.

Many have applauded it and cite changes to practice already implemented as a result, both by individuals and by hospitals across Australia and New Zealand. Others have expressed concern with the content of the statement, and/or the implications that such a college publication has for independency of practice (see page 31).

It is clearly evident that inappropriate slow release (SR) opioid use is causing serious harm within our community. The United States is in an even more difficult situation. It is beholden upon ANZCA, including the Faculty of Pain Medicine (FPM), to give due consideration to our role in addressing this dilemma.

As such, the faculty and the ANZCA Safety and Quality Committee have worked together to develop and publish an evidence-based position statement, with the intention of conveying the key message that SR opioids are not recommended for use in the management of patients with acute pain. Importantly, this message is being promoted to reach *all* opioid prescribers.

It should be noted that the discussion relating to SR opioids was clearly stated to be regarding their use in opioid-naive patients. It is acknowledged that many experienced practitioners and pain management teams have long been prescribing SR opioids for closely monitored acute pain management, with no apparent morbidity. It is also recognised however that the management practice of "experts" often drive management protocols more broadly, and are seen as role-models for evidence-based best-practice. Our concern is that unlicensed and unconsidered practices are creeping into everyday "normal" acute pain management regimes.

The realities are that many experienced acute pain management practitioners achieve adequate results without using SR opioids, that SR opioids have been associated with significant morbidity (and mortality) when used for management of acute pain, and that many patients commenced on SR opioids for post-operative acute pain management remain on them, inappropriately, for months afterwards. The consequences of this can be tragic, and we all need to consider our role in addressing this.

The SR opioid document is a position statement from the college. As such, it is a point of view on practice expectations, albeit at a high level. The statement is neither a mandate nor intended to dictate the practice of experienced specialist anaesthetists and pain medicine specialists.

However, the position statement does unashamedly encourage us all to re-evaluate the role of SR opioids in our acute pain management practice. Of note, we need to at least be aware that these agents are not licensed for such use, and to give due consideration that many experienced colleagues achieve safe and effective acute pain control using readily titratable, multi-modal analgesia regimes.

We acknowledge that any comment the college makes in the public arena will be interpreted as an expression of expectation relating to professional practice, As such, any contribution made by the college to public discussion is always carefully considered.

In this case, the proposal for a statement and the statement itself was discussed at several FPM Board meetings, and ANZCA Safety and Quality Committee meetings over a six-month period. The latter 18-member committee has broad representation including anaesthesia and pain fellows, from public and private practices and metropolitan and semi-rural areas, as well as community and policy representation. There is wide geographic distribution from WA to NZ.

We thank the faculty board members and the Safety and Quality Committee for their important contribution to this significant community health issue.

Dr Rod Mitchell
ANZCA President

Dr Meredith Craigie
FPM Dean

"Position statement on the use of slow-release opioid preparations in the treatment of acute pain" can be found via www.anzca.edu.au/front-page-news/position-statement-on-slow-release-opioids.

Fellows respond to the statement

Anaesthetists have a long and excellent record in patient safety, making Australia and New Zealand two of the safest countries to have an anaesthetic in.

As we continue to work in acute pain management and move further into perioperative medicine we bring the attributes and skills around patient safety to areas beyond the operating theatre.

The ANZCA/FPM position statement and supporting comment from Dr Kim Hattingh, Professor Pamela Macintyre, Professor Stephan Schug, Dr Meredith Craigie and Dr Phillipa Hore (March 2018 *ANZCA Bulletin*) is a document that represents an important resource to assist in reducing opioid-related harm and deaths on the wards and after discharge. I congratulate Dr Hattingh and her colleagues on the production of this (long desired) local statement.

I understand some of my medical and nursing colleagues find the statement a challenge and are concerned that it would require an unmanageable change in their practice, resulting in patients being in uncontrolled pain. Yet as-needed dosing of immediate release opioids is certainly compatible with staffing levels on general wards in our public hospitals. Additionally good patient safety practice means being willing to change our practice to safer alternatives, even if we do not have first hand experience of the complications.

As someone who has been gravely concerned about the escalating use of non-titratable formulations of these drugs with highly variable (both within individuals over time and across the population) therapeutic indices, I am pleased to now have documented support from my college and faculty to assist in continuing to raise this issue one-on-one with colleagues, and more broadly within the organisation that I work in. It has already helped prompt change in approaches to pain management practices on our rehabilitation ward.

Dr Suzanne Cartwright FANZCA FFPMANZCA
Tamworth, NSW

I am writing to condemn the college and FPM's endorsement of this "position statement".

This is independent of any debate about the advisability of the use of SR opioids in perioperative pain management. It is also independent of any discussion about solutions to the problem of abuse of prescription opioids in our communities.

We wrote as a department, to the college and FPM, expressing our concerns about the document on two counts: There was no consultation process with the wider membership of either professional body; there is no evidence provided to support the recommendations in the statement.

In response to our letter, the college and FPM replied that a lesser standard is required for an endorsed position statement than for other professional documents. Any other professional body, and any lawyer, might be forgiven for misunderstanding the subtle distinction. Ask any lawyer what they understand by the term "college-endorsed position statement".

My straw poll in recent Australasian scientific meetings suggests that the prescription of SR opioids for perioperative pain is widespread. There is much concern that the college has made this practice medico-legally difficult. This might be appropriate if there was overwhelming or even convincing evidence to support the college's position. There is not.

We have read through the references provided in the statement. They do not contain scientific evidence to support the statements or recommendations.

Promoting, publishing and endorsing an unsubstantiated opinion piece as a position statement is an embarrassing and unscientific way of "generating discussion".

The college has declined to publish our full letter in the *Bulletin*, requiring 300 words only. Our full letter and the college's response are available at this download:
https://app.box.com/s/98va7sxcvj1x2g10beqk8ishzcre707h

We continue to demand that the college and FPM withdraw this document, until such time as a full, evidence-based debate can be had within our community. Until then, we should not tolerate this paternalistic attempt to control our practice.

Dr Tim Skinner, MB BCh, FANZCA, FRCA, Dip IMC RCSE
Consultant Anaesthetist
For the Women's Health Pain Team
Women's Health Anaesthesia
Auckland City Hospital

Not all opioids are the same

The ANZCA/FPM "Position statement on the use of slow-release opioid preparations in the treatment of acute pain" has engendered much healthy conversation, but frequently the question has been asked; "Which opioids are the less sedating ones referred to in the statement (with "less sedating" inferring less risk of respiratory depression)?"

In our modern armamentarium of analgesics, we have a large number of "opioids". The term opioid in this context covers a wide range of analgesic compounds, which can be very different in their effects and adverse effects. It has been stated that "*the categorisation of all analgesics that have any component of opioid mechanism of action into the same class is anachronistic*"[1] and that the importance of multi-mechanisms of action of some modern opioid analgesics should be emphasised with separation of tramadol, tapentadol and buprenorphine from "conventional" opioids, which are relying nearly exclusively on agonism at the μ-receptor.

The common term used to describe these medications is "atypical opioids", although there are other proposals including "atypical centrally acting analgesics"[2]. The discussion on the need of a new terminology to separate these atypical opioids from conventional opioids has been ignited in particular by the "opioid epidemic" in the US and a number of other countries[3], as the former show different side effect profiles and a lower abuse potential than conventional opioids.

These "atypical" opioids also show properties which qualify them as "opioids with the least sedative (and therefore respiratory depressant) effects" mentioned in the statement. While neither slow-release tramadol and tapentadol, nor transdermal buprenorphine preparations are Therapeutic Goods Administration (TGA)-approved for the treatment of acute pain, they are worth considering if slow-release preparations are deemed necessary.

The mechanism of action of tramadol combines a relatively weak μ-opioid receptor agonist (primarily mediated via an active metabolite M1) with a monoaminergic reuptake inhibition, namely of serotonin (5-HT) and noradrenaline reuptake[4]. It is thereby the prototype of an atypical opioid with a low risk of respiratory depression compared to conventional opioids[5,6]. However, rare cases of respiratory depression have been described in CYP2D6 ultrarapid metabolisers, either in children[7] or in adults with renal impairment leading to retention of the active metabolite M18.

In a direct comparison of opioids with regard to mortality and serious adverse effects, captured by the Researched Abuse, Diversion and Addiction-Related Surveillance (RADARS®) System Poison Center Program in the US, tramadol showed lower mortality, lower serious adverse effects and lower rates of hospitalisation than all other opioids except tapentadol[9]. Furthermore, the risk of abuse10 is low and diversion rates are similar to tapentadol and lower than all conventional opioids[11].

The analgesic effect of tapentadol is based on a synergistic combination of low μ-opioid receptor agonist activity with neuronal norepinephrine-reuptake inhibition without a relevant effect on serotonin. This explains the extremely low risk of respiratory depression; in the above-mentioned US Poison Center Program there was no recorded mortality from tapentadol and all other serious adverse effects occurred at the lowest rates of all opioid analgesics investigated9; in network meta-analysis of opioids in the chronic pain setting, tapentadol was ranked the most tolerable one [Meng, 2017 #23332]. Similar findings are reported for rates of abuse and diversion[11].

Buprenorphine binds with very high affinity at μ-opioid receptors, but with lower affinity and intrinsic activity at the K- and δ-receptors, the nociceptin receptor (NOP/ORL-1 mediated effects) and possibly a further not yet defined receptor system[1,12,13]. There appears to be no ceiling effect for analgesia, and a lower risk of respiratory depression although case reports of respiratory depression for the sublingual preparation do exist[14]. The long time to analgesic effect (12-24 hours) and steady-state plasma concentration (72 hours) limits the usefulness of transdermal buprenorphine in the acute setting[12].

Overall, a differentiation between conventional and atypical opioids is a clinically useful approach in view of the different mechanisms of actions, side effect profiles, and abuse potentials of the latter compounds. Atypical opioids may therefore play an increasing role for patients in the acute pain setting as they fulfil the criteria for less sedative/respiratory depressant opioids. In addition, the less sedating effects and their lower potential for abuse and diversion might make them preferable as discharge medications in view of the concerns about conventional opioids in this setting[15].

It should again be noted that monitoring for opioid-induced respiratory depression, using an appropriate sedation scoring system, and adjustment of the dose as required, remains essential for the safe prescription of opioids. Acute Pain Services, anaesthetists and pain medicine physicians should lead the way in the education and promotion of safety concepts relating to safe use of opioids as part of our role in opioid stewardship.

Professor Stephan Schug, Professor Pamela Macintyre, Dr Kim Hattingh

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The reality of humanitarian work in Iraq

I consider myself to be brave, probably because I am 73 (not out) in my life's innings. But this morning at work I got a nasty bouncer – I witnessed a child crying in utter anguish clinging on to the feet of her dying father who was brought in collapsed and unable to be resuscitated. Yet another young child was left fatherless in an already troubled country.

I am on my ninth overseas humanitarian mission, currently in northern Iraq with Médecins Sans Frontières/Doctors Without Borders (MSF). A number of anaesthetists from Australia, and a few from New Zealand, are doing similar kind of work as I do. This is working in countries with ongoing conflicts or its consequences, in makeshift hospitals with very limited facilities and taking care of the sick and vulnerable people, who wouldn't otherwise receive any medical care.

Many of my anaesthetist colleagues might be shocked to learn that the only readily available investigations to manage major surgical and obstetric emergencies are bedside haemoglobin and blood sugar monitors, and urine dipstick. One depends on basic clinical skills and an understanding of the functioning of the human body to do the rest. It is really remarkable what a surgeon, an anaesthetist and a couple of enthusiastic nurses can achieve with limited resources, bringing comfort and solace to the people.

Only the other morning, while walking the short distance from our residence to the hospital, the sun just peeping through some of the totally destroyed houses on to almost empty and well-littered streets, I was recalling the busy last few weeks.

The work starts the usual way every day as we all assemble in the emergency room for the morning ward rounds, almost always led by the expatriate surgeon. Last week we welcomed our new surgeon from Portugal, who thought that Ronaldo was definitely a better player than Messi in every aspect of the beautiful game (by the way, no one agreed with him).

During typical ward rounds the group consisting of the surgical team, local doctors, nurses and translators. We all march through the emergency room, ICU, male and female wards, often accompanied by a posse of flies which increase in numbers as the rounds progress. We finish the round in a ward where men with chronic ulcers and malnourishment with scabies are housed.

Daily anaesthesia work consists mostly of dealing with effects of burns and blast injuries. These need regular dressing, debridement or skin grafting. There is no doubt ketamine is a great drug for majority of these patients. There is a scatter of other cases including gunshot wounds, road traffic accidents, blast injuries and severe burns. We offer occasional elective surgeries, particularly for the internally displaced people from nearby camps.

Mass casualties do occur at varying frequency. The team deals with them as efficiently as possible with some amount of insouciance to the ongoing chaos and following our mass casualty plan. The largest number during my time was eight adults following a road traffic accident, though this could increase considerably during times of conflicts.

We transfer some of them away to other larger hospitals for CT scans, neurosurgical input or major orthopaedic work. Serious burns over 40 per cent are also transferred to specialist hospitals after overnight stabilisation. For practical reasons, patients are transferred mostly during daytime. These are just clinical realities and are taken in their stride.

Our hospital has an unusually large input of children of all ages and everyone is very proud of their ability to save majority of them from both medical and surgical ailments.

Attempts to save little children, many with severe infections, burns or major accidents, fail in spite all our best efforts and this is the most upsetting time for people. Watching the anxiety, concern, disappointment, tears and heartbreak on the faces of waiting parents, particularly young mothers, can be a daunting task: one often has to hold back the tears and pretend to be brave. I can vividly recall a young mother of a one-year-old child, carrying her dead daughter in her arms, only to be told that the accident had already killed her. The mother's anguish, intense grief, helplessness and loud sobbing, remains with me as one of my saddest memories.

However it is our fair share of successful management of the critically ill that really justifies our time spent in places like this. One quietly wonders how a reasonably well-to-do country like Iraq, with a relatively strong health service infrastructure, ended up like this within a few short years, having to depend on aid organisations for basic health needs.

I discovered that it is one of the hardest, but most rewarding experience, to simply comfort the male members of the family of the deceased. That is the time even the bravest looking man needs support, even from a stranger. There is nothing like a compassionate hug from someone, particularly a doctor, to let them express their grief in full and a few minutes spent is worth a lifetime to that individual. Cultural rules of Iraq prevent men from being too close to women outside their own families.

Apart from basic human emotions like compassion and concern, we also see evidence of cruelty of humans against each other. Conflicts in most countries are generated and supported by rich and powerful countries for spurious reasons, but the civilian population is left with death, destruction and total anarchy with often unresolved and ongoing conflicts.

"There is nothing like a compassionate hug from someone, particularly a doctor, to let them express their grief in full."

Even though we had one of the finest field anaesthesia machines in Glostavent helix in the OT, plenty of spinal needles, access to an ultrasound machine to do nerve blocks, and a Monnal T50 ventilator in the ICU and ample supply of oxygen concentrators all around the place, there are limitations to the variety of drugs and equipment.

We often long for an extra bit of something for our patient: an investigation, a piece of equipment, a drug but you know what, we get through with none of those extras. In fact, we are overjoyed that the patient is doing well in spite of lack of items you might consider a necessity to our routine practice in Australia and New Zealand.

There is a vast and unfamiliar world out there for those anaesthetists who seek a new challenge. It is a worthy adventure.

Dr Mathew Zacharias,
Dunedin anaesthetist

Dr Zacharias who has been working on a field assignment with Médecins Sans Frontières in Iraq.

For more information about joining Médecins Sans Frontières, visit www.msf.org.au or www.msf.org.nz.

From left: Buildings destroyed and unoccupied litter the landscape near the hospital; Dr Mathew Zacharias at work; Though short of equipment, the hospital does have one of the finest field anaesthesia machines, the Glostavent helix.

Reflecting on a successful SYDNEY ASM

Reflecting on the ASM

This was the first ANZCA Annual Scientific Meeting (ASM) held in the beautiful new Sydney International Convention Centre (ICC). Perhaps it was the lure of this impressive venue, perhaps it was sparkling Sydney itself, perhaps it was the outstanding workshop and scientific program, or perhaps it was the prospect of another collaborative meeting with the Royal Australasian College of Surgeons? Whatever the reasons, this ASM attracted a record number of registrations and it is our hope every single delegate, and every invited speaker, found the conference a valuable and enjoyable experience.

As always, the ASM week was extremely busy and included several events outside the meeting itself. Prior to the ASM, a highly successful Emerging Leaders Conference was held in the Blue Mountains, inland from Sydney, which brought together future leaders in both anaesthesia and surgery. Over the same weekend, two extremely well subscribed meetings were held in the ICC – the Obstetric Anaesthesia Special Interest Group satellite meeting and the FPM Refresher Course Day. The ASM then launched on the Monday with a massive day of workshops which saw delegates scattered across multiple rooms and then multiple locations across the city. It was truly a wonder to behold the complexity of the workshop day rolling on without a hitch! The College Ceremony was held that evening with an inspiring oration by Raelene Castle, the first female CEO of a national football league, who brought a fascinating perspective as a powerful woman in what was once a man's world. A record number of new fellows presented at the ceremony, which was streamed live and, amazingly, viewed nearly four thousand times from locations all over the world.

Given the theme of the meeting, "Reflecting on what really matters", we made efforts to reflect not just on what matters clinically and scientifically but also to reflect on broader issues such as health equity, the global environment, and physician well-being.

Several combined sessions with RACS were dedicated to issues of global and Indigenous health and, following the footsteps of last year's Brisbane ASM, we were able to support safe surgery in developing countries by making a donation to Lifebox. This donation was on behalf of all those who generously gave their expertise and time to present or chair workshops, lectures and other sessions at the ASM. Also, one of our workshop convenors, Dr Andrew Lansdown, put much effort into organising the first ASM Charity Fun Run. More than 60 delegates gathered before sunrise to jog around the harbour foreshore, under the Harbour Bridge, and around the Sydney Opera House. The chosen charity for this event was the Indigenous Marathon Foundation, which promotes a healthy, active lifestyle in Aboriginal and Torres Strait Islander youth.

Because the environment also really matters, we attempted to limit the ASM footprint. Each year ANZCA explores more ways to reduce printed material for the ASM, and increase the usability of the electronic program. We sourced recyclable take-away coffee cups and the ANZCA Geoffrey Kaye Museum provided keep-cups to anyone who could pass a quick historical quiz. It is well-recognised that reducing excessive meat consumption will be essential for global sustainability, therefore we served exclusively vegetarian food for one whole day of the ASM. Fortunately, the meals were so good that few omnivores even noticed!

Another feature of the ASM that really matters is the opportunity to catch up with colleagues from around the region and around the world. Our ASM is world-renowned for its friendly atmosphere and great social program. To stimulate conversation and to acknowledge that we are more than just our jobs, we decided to provide free badges displaying our extra-curricular interests.

Snapshot

Delegates 2404
Speakers and facilitators 500
Plenary sessions 6
Concurrent sessions 42
Workshops and SGDs 150
Focus sessions 10
e-posters 170
Combined sessions with RACS 25

Unfortunately, we underestimated their popularity and the badges ran out – "Coffee Addict" and "Wine Lover" went first. On a more serious note, we also used the ASM as a platform for promotion of improved access to help for the concerning proportion of our colleagues with serious mental health issues.

The ASM social program was, as usual, a raging success. We opened the week with a welcome reception in the Powerhouse Museum with its eclectic collection of fascinating artefacts. If you weren't there, you should find someone who was to ask them about the amazing dessert! The grand finale of the social program was the Gala Dinner held jointly with the surgeons. More than 1200 guests enjoyed a beautiful meal and great dancing. Those who preferred to move away from the music were treated to cocktails and harbour views.

The ASM is a flagship event for ANZCA and an increasingly complex undertaking, requiring more than two years of planning. Our organising committee took on the challenge and responsibility with some trepidation but, with the support of the college events team and the wider anaesthesia community, we found the experience enormously rewarding. We wish future organising committees all the best and very much look forward to enjoying the fruits of their efforts.

Dr Tim McCulloch
ASM Convenor

Dr Veronica Payne
ASM Deputy Convenor

Scientific program

The scientific program was designed around the theme to “reflect on what really matters” to our specialty. This included both refreshers and the latest scientific and research outcomes and how they mattered for all anaesthetists on a daily basis.

The opening plenary discussed the difficult ethical and moral arguments involved in surgery in the elderly and sick patient. It involved excellent talks by Dr Linda Sheahan, a palliative care physician and ethicist and Dr Ken Hilman, an intensivist with an interest in end-of-life interventions. A great panel discussion then followed based around common clinical scenarios. Our invited international visitors Dr Richard Dutton, Professor Karen Domino, Dr Fiona Keirnan and Professor Jenny Weller spoke about pay-for-performance measures in anaesthesia, communication with our patients and among operating theatre "teams" and behavioural economics in healthcare. They also delivered a number of high quality talks throughout the scientific program.

The other plenary sessions across the week were delivered by a number of international experts on topics as broad as communication, standardised outcome measurements, the importance of worldwide access to safe anaesthetic services and why perioperative mortality was not linked to your anaesthetist, but maybe related to your surgeon. Dr Bronwyn King gave a very inspiring and popular talk on her journey to set up "tobacco-free portfolios" after realising her super was invested in tobacco companies.

We also had the great advantage of combining with RACS for the Sydney conference, which gave us a wealth of cross-specialty knowledge and allowed candidates to visit either "combined", “surgical” or “anaesthetic” sessions. Some of the more popular combined sessions looked at data of the safety of general anaesthesia in children as well as what mattered to families of children undergoing operations, the shared airway in head and neck surgery and the management of the bleeding trauma patient and of the mass casualty event.

The final combined plenary session explored the issues of physician burnout and doctors’ welfare and told us to both look after ourselves, and to look after each other. Professor Dan Sessler delivered a fantastic closing session, imploring us as a specialty to really reflect and challenge the information that we use to inform our practice. There were too many highlights in the concurrent sessions to mention, but included sessions on patient safety, obesity anaesthesia, and practice in a rural setting, perioperative medicine and obstetrics. All of the sessions are available for fellows to view on the virtual ASM in their own time.

The task of bringing together the scientific program was made easier by the fantastic help of all the presenters and facilitators. It is humbling to be involved in a specialty where people are happy to give up their time to prepare and give fantastic talks and workshops and I thank everyone involved in the program for their help. I hope all the attendees had a great time at the conference and found the scientific content educational, confronting and enjoyable.

Dr Ben Olesnicky
ASM Scientific Convenor

Workshops and small group discussions

With more than 130 workshop and small group discussion sessions, this year’s program aimed to provide a mix of emergency response activities, technical and non-technical skills as well as tips and tricks for anaesthesia practice and for life. Drawing from the expertise and generosity of our facilitators and teachers, the program provided a comprehensive and exciting range of sessions, with something for everyone.

A major aim of the program was to provide as many emergency response workshops as possible to ensure better access for delegates. To this end, in addition to the comprehensive program of emergency response activities held on the Monday workshop day, our facilitators and teachers provided CICO and ALS workshops daily throughout the rest of the week. Most of these extra sessions were scheduled during the lunch break, meaning that delegates did not have to miss any of the excellent scientific program sessions on offer.

New workshops were offered, and others were given an innovative spin – a reflection of the ingenuity of the facilitators. The program saw delegates engaging in simulation activities (obstetric emergencies, echocardiography, neuroanaesthesia, intraoperative neuromonitoring, one-lung anaesthesia, ECMO, pre-hospital trauma management); employing old and new technology (ventilators, ultrasound and echocardiography, endoscopy, THRIVE, ROTEM/TEG, apps and virtual reality); trying a cadaveric or animal carcass session (anatomy for anaesthetists, ophthalmic anaesthesia, various regional anaesthesia catheter workshops, and trauma skills sessions); as well as reflecting on their communication and mindfulness skills. Our anaesthetist teachers even had delegates trying their hand at yoga and photography.

The lunchtime small group discussion sessions were extremely popular, and covered a broad range of topics from managing issues that arise in clinical anaesthesia practice, through to maintaining volume and currency in rural anaesthesia, and also how to prepare for retirement. They allowed for open and lively discussion between delegates and facilitators, encouraging the sharing of ideas and experience.

Coordinating all these sessions were the wonderful ANZCA events team, and chiefly Fran Lalor, Senior Events Officer. Fran’s professionalism, organisational skills, and friendship made orchestrating this huge workshop and small group discussion program a breeze for us. We can’t thank Fran and the rest of the events team enough for the mammoth effort undertaken to bring the workshop and small group discussion program to life.

A program of this scope and breadth was only possible due to the incredible talent, generosity, and passion of all our facilitators and teachers. Local national and international demonstrators including anaesthetists and other doctors, allied health staff, medical students, and representatives from the healthcare industry all came together to provide their time and expertise to contribute to the workshops and small group discussions. All of the facilitators and teachers invested a significant amount of time and effort into producing some truly fabulous workshops, often forgoing their own chance to attend the ASM sessions to teach. We would like to wholeheartedly thank everyone who worked on the workshop and small group discussion sessions for the role they each played in helping us all to reflect upon what really matters.

Dr Shanel Cameron
Dr Andrew Lansdown
ASM Workshop Co-convenors

From everyone at Lifebox to everyone at ANZCA – thank you!

Your generous donation will make a life-changing difference to colleagues and their patients, helping Lifebox make anaesthesia and surgery safer on a global scale.

During the ASM, ANZCA presented a $A10,000 cheque to Lifebox on behalf of all ASM speakers, presenters, facilitators and contributors in lieu of the usual gifts.

FPM wrap up

This, the last pain Refresher Course Day (RCD) under the current name, drew the largest ever number of registrations. In recognition of how the content of the day has outgrown the fairly restrictive title, it will be called the Annual Pain Medicine Symposium from the 2019 Kuala Lumpur meeting onwards.

As part of the RCD Professor Mark Hutchinson managed to be a media and audience darling with his research on colour mapping of pain. Our wonderfully warm and friendly FPM NSW Visitor was Professor Tor Wager, who explained his research on the neuro-circuitry of fear avoidance and the central role it plays in the establishment of chronic pain.

The presentations on currently available and tested online pain programs and how to adapt pain programs to patients from different cultural backgrounds were immensely practical. They have already prompted me to write my first prescriptions for an online program for patients waiting for chronic pain clinic appointments.

The risky prescribing session saw the forensic and addiction communities encouraging pain clinicians to utilise naloxone prescribing and opioid substitution therapy more frequently in pain practice. They also spoke for a dissolution of the porous and fairly artificial distinction between prescription and illicit harmful drug use. These ideas should help inform the FPM opioid forum in June.

The highlight of the FPM dinner at the lovely Ivy Ballroom was the perfectly pitched after-dinner address by Catherine Keenan from the Sydney Story Factory. Both funny and moving Catherine reminded us how much of a human need it is to tell our story and know that it has been heard and that it is worth telling.

The cadaveric workshops were oversubscribed and very well received however they will not be offered in Kuala Lumpur in 2019 for logistical reasons. Their possible role, context and content for future ASM inclusion is likely to be addressed by the new Procedures Working Group within FPM.

The ASM program was well supported and featured many of our own fellows, including Dr Stephen Gibson on his experience with percutaneous cordotomies, Professor Paul Glare on pain in survivors of cancer, Dr Marc Russo on CRPS, and our perennial favourites Professor Pamela Macintyre and Professor Stephan Schug with the latest in acute and transitional pain. Our FPM ASM Visitor, Professor Oscar de Leon-Casasola proved to be a font of wisdom on almost every clinical pain topic, a truly delightful individual, and a modern-day Fred Astaire on the dance floor…a high bar for future international visitors.

I would like to thank Dr James Yu, Dr Martine O'Neill and Dr Andrew Patterson for their able assistance in putting the program together, and the amazing staff at ANZCA and FPM who were encouraging guides through the process. An extra mention goes to the ANZCA design team who made me want to frame the RCD abstract book and the Communications unit who were still working when we were onto the champagne at conference end. The ANZCA Regional Organising Committee were a pleasure to work, put together a fantastic program, and in quiet moments taught me how to use Twitter.

Having been given a preview of the excellent program for next year's FPM meeting I am already looking forward to seeing you all in Kuala Lumpur in 2019.

Dr Jennifer Stevens
FPM Scientific Convenor

Name change for FPM's Refresher Course Day

The FPM Refresher Course Day has been renamed as the FPM Annual Pain Medicine Symposium in time for the 2019 Annual Scientific Meeting in Kuala Lumpur.

The new name, which was approved by the faculty's Professional Affairs Executive Committee, better reflects the high quality content and structure of the event, which attracts leading local and international pain medicine speakers and researchers.

The 2018 FPM Refresher Course Day attracted 400 delegates, several international speakers and featured a broad range of presentations on issues such as opioids, medicinal cannabis, blood tests for chronic pain, pain management in the elderly and the Kings Cross safe injecting room.

Prizes

Gilbert Brown Prize
Dr Rani Chahal for "STEP: Surgical Thrombo-Embolism Prevention Protocol: Post-Implementation Re-audit – Impact of a newly developed risk stratification model and a smartphone APP on venous thromboembolism".

Trainee Academic Prize
Dr Rebekah Potter for "Rationalising group and screen testing in adult elective surgical patients" and Dr Nathalie Gomes for "Simulation to assess latent safety threats and operational preparedness within anaesthetic locations in a new children's hospital".

Open ePoster Prize
Dr Julie Lee for "Rotational thromboelastometry (ROTEM®) in obstetrics: baseline parameters in uncomplicated and complicated pregnancies. A prospective observational study on parturients".

Trainee ePoster Prize
Dr David Shan for "The effect of a pulmonary bundle of care on postoperative pulmonary complications: A quality improvement project".

FPM Dean's Prize
Dr Luke Arthur for "Erythromelalgia in children: Presentation, genotype, and treatment response".

FPM Best Free Paper Award
Dr Daniel Chiang for "The prevalence and risk factors associated with persistent pain after breast cancer treatment".

Keynote presentations

ANZCA ASM Visitor Ellis Gillespie Lecture
Professor Karen B Domino, "Communicating with patients – what matters".

FPM ASM Visitor Michael Cousins Lecture
Professor Oscar de Leon-Casasola, "The neurobiology of acute postoperative pain and the translation to post-surgical pain management guidelines".

ANZCA Australasian Visitor Mary Burnell Lecture
Professor Jennifer Weller, "Tribes, teams and trust."

ANZCA NSW Visitor's Lecture
Dr Richard P Dutton, "Pay-for-performance: How do we make the measures relevant?"

FPM NSW Visitor's Lecture
Professor Tor Wager, "Why do some of my patients have so much more pain than I think they should?"

Organising Committee Visitor's Lecture
Dr Fiona Kiernan, "Organising Committee Visitor: Behavioural economics in healthcare".

Raising our profile

Newspapers, radio, TV

The Sydney ASM received widespread coverage across Australia and New Zealand with 670 online, print and broadcast reports. According to media monitoring service iSentia the ASM coverage reached a combined audience of 7.8 million people and would have cost $A1.5 million if bought as paid advertising.

Highlights included a Channel Nine Sydney news report on FPM Refresher Course Day speaker Professor Mark Hutchinson and his Adelaide team's revolutionary blood test to detect chronic pain, and Sydney anaesthetist Dr Andrew Weatherall's interview with Radio National Breakfast host Fran Kelly on how virtual reality can be used to calm children before their operation. These two segments had a combined audience of nearly 600,000 people.

Other highlights included page one articles in New Zealand's Dominion Post newspaper (surgeon league tables as explored by Dr Andrew Klein in his plenary address) and the Brisbane Courier Mail (mental health and burnout.) These two topics attracted a combined 150 reports across Australia and New Zealand.

Some of the more popular topics for media were Toowoomba anaesthetist Dr Jamie Beit's presentation on obesity and Professor Paul Myles' RELIEF study results. Both Dr Beit and Professor Myles were interviewed on radio about their presentations and research. Other popular topics were burnout among anaesthetists and other specialists (*The Herald Sun* page 2, syndicated to the *Geelong Advertiser*, the *Courier Mail* and the *Adelaide Advertiser*) opioid prescribing (*The Age* page 3, syndicated to the *Canberra Times*, the *Sydney Morning Herald* and brisbanetimes.com.au) and futile medical treatment.

ANZCA distributed 11 media releases on a range of topics and issues including obesity, mental health, in-flight medical emergencies, surgeons' league tables, hypnosis and virtual reality, anaesthesia and children and ANZCA's new partnership with the Patient Safety Movement.

Four journalists attended this year's ASM as guests of ANZCA: Rachel Thomas, health reporter for New Zealand's *The Dominion Post*, Grant McArthur, the medical editor of the *Herald Sun*, *The Age* health reporter Aisha Dow and Sarah Wiedersehn of Australian Associated Press.

Social media

With more than 9500 tweets, 1600 participants, and 22.8 million impressions #ASM18SYD was the best-performing ASM hashtag to date. It also dramatically out-performed #RACS18.

So thank you to everyone who "joined the conversation", and, in particular, to our top-10 tweeters. Between them, Dr Katie Ben, Dr Scott Ma, Dr Tracey Tay, Dr Eric Levi, Dr Tanya Selak, Dr Rhys Thomas, Dr Minh Le Cong, and Dr Anthony Herbert clocked up more than 1700 tweets. Two of them weren't physically at the ASM. And one of them was a surgeon. Which really demonstrates the power of Twitter as a tool for collaboration and crowd-sourced education.

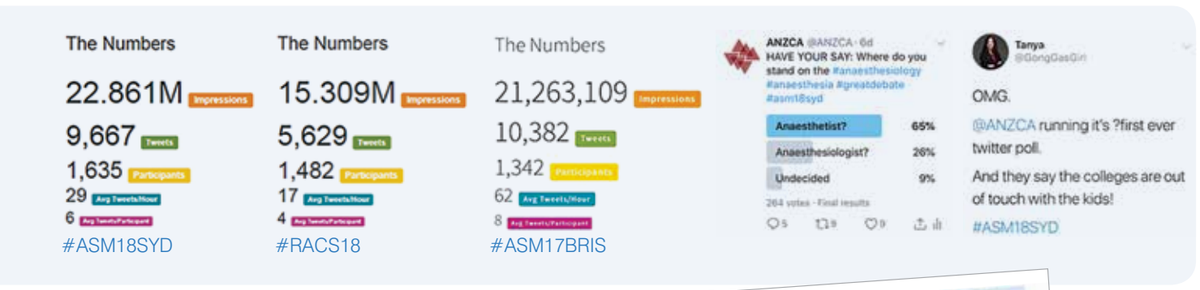
Our Twitter poll (a first for us) to support the Great Debate on the final day of the ASM attracted 264 votes which was encouraging.

On Facebook, our posts were engaged with (liked, shared or commented on) 25,250 times and our broadcast of the College Ceremony via Facebook Live was seen by nearly 4000 people from as far afield as Canada, India, Ireland and the UK.

This year, we streamed 13 sessions on Periscope (with permission from the presenters), almost double the number last year. The total audience was more than 1800 people, with the most popular session Dr Fiona Kiernan's on behavioural economics.

Our videos of interviews with keynote speakers and college leaders on YouTube have already been watched nearly 7000 times.

Clea Hincks, General Manager, Communications



To see all the photos, interviews, e-newsletters and media coverage go to asm.anzca.edu.au/asm-photos-interviews-e-newsletters-media.

Steuart Henderson Award

Professor Jennifer Mary Weller

Professor Jennifer Weller has been awarded the ANZCA Steuart Henderson Award for fellows who have demonstrated excellence and provided outstanding contribution, scholarship, and mentorship to medical education in the field of anaesthesia and/or pain medicine.

Professor Weller obtained her medical degree from the University of Adelaide. She became a member of the Royal College of Anaesthetists in 1981 and a fellow of ANZCA in 1995. She worked in Wellington, New Zealand, for 10 years before moving to Auckland in 2004, from which time she became increasingly involved in medical education in a growing number of areas.

She obtained a Masters in Clinical Education in 2002 and an MD in 2006. She first became involved with educational matters in the college in 1999. Her current roles include the chair of the Education Special Interest Group, a member of the Education Development Training Committee, the Curriculum Evolution Working Group, and the Research Committee. She has recently finished her 12 years as a final examiner and chaired a number of other education-related committees.

Professor Weller extensively meets every criteria for this award. Her contributions to teaching and learning are overwhelming. She established a new post-graduate education centre in clinical education at the University of Auckland over 10 years ago, in which she has employed staff, mentored more than 200 students, and produced an impressive research output. She has been an enormous influence on the development of simulation-based training throughout Australia and New Zealand. She was the main driving force behind the establishment of ANZCA's Effective Management of Anaesthetic Crises course.

The recent award of a multi-million dollar grant for a national patient safety program for every operating theatre in New Zealand is one example of her ongoing interest, commitment, leadership, and success in simulation and multidisciplinary teamwork training. Her influence in the research behind and implementation of workplace-based assessments within the college cannot be over-stated. The list of research publications, conference presentations, book chapters, and media reports is extensive.

Professor Weller has received 30 grants mainly for educational projects over the past 25 years. She was recently appointed as the ANZCA representative on the International Collaboration of Colleges of Anaesthesia working on competency-based medical education in anaesthesia globally. Her list of awards is impressive, with the most recent being the Douglas Joseph Professorship awarded by ANZCA in 2016, and a lectureship awarded by the Royal College of Anaesthetists in 2017.

Professor Weller's contribution to these numerous and diverse fields of medical education is nothing short of extraordinary.

From the citation by Dr Natalie Smith at the College Ceremony during the 2018 ANZCA Annual Scientific Meeting in Sydney.

Robert Orton Medal

The Robert Orton Medal is ANZCA's most prestigious award and is made at the discretion of ANZCA Council, the sole criterion being distinguished service to anaesthesia, preoperative medicine and/or pain medicine. The award was established by the Faculty of Anaesthetists, Royal Australasian College of Surgeons, in 1967.

Associate Professor Richard George Walsh

Richard Walsh graduated with MBBS from the University of Sydney in 1974. He completed his internship, residency and anaesthetic training at Royal Prince Alfred Hospital (RPAH) and gained his FFARACS in 1980. He was then appointed a Visiting Medical Officer at RPAH with a major interest in cardiothoracic anaesthesia and perfusion. He has continued this appointment, along with appointments at Strathfield Private Hospital and Macquarie University Hospital. He has been an Adjunct Associate Professor at the University of Sydney since 2001 and in 2011 was appointed Clinical Associate Professor at Macquarie University.

Professor Walsh's contribution to our profession has been outstanding with significant involvement with the Faculty of Anaesthesia, ANZCA, the Australian Society of Anaesthetists (ASA), the World Federation of Societies of Anaesthesiologists (WFSA) and the NSW Medical Council. He served on the NSW Regional Committee and Panel of Examiners (1986-1992) and in 1988 was elected to the board of the faculty. He had numerous roles on the board including overseeing the transition from the faculty to the college and was on the first ANZCA Council until 2000. He was elected ANZCA President in 1998.

He has also served on ASA's federal executive committee (1982-1987) and was honorary federal secretary during that time. Following on from these roles Professor Walsh became chair of the World Congress of Anaesthesiologists' organising committee and president of the World Congress of Anaesthesiologists meeting in Sydney in 1996. He then continued his global interests serving on the WFSA executive committee from 1998 to 2008 including eight years as treasurer.

Professor Walsh has also contributed to the regulation of the profession through the Medical Council of NSW since 2002 and he is currently the deputy president. He has been awarded many honours including honorary fellowships of the College of Anaesthetists, Royal College of Surgeons in Ireland and the Academy of Medicine, Singapore. Other awards include the ASA's Gilbert Brown Award in 1996, the Pask Certificate of Honour from the Association of Anaesthetists of Great Britain and Ireland in 1997 and the Centenary Medal of Australia in 2002.

He has been and remains an enormous contributor to the profession and a very deserving recipient of the Robert Orton Medal.

From the citation by Dr Patrick Farrell at the College Ceremony during the 2018 ANZCA Annual Scientific Meeting in Sydney.

Michael Cousins portrait unveiled

A portrait of Professor Michael Cousins, AO, AM, a world expert in pain medicine, was unveiled at the annual scientific meeting's 2018 ANZCA Research Foundation cocktail party.

Professor Cousins, a former ANZCA president and FPM dean was the first chair of the foundation and a special guest at the cocktail party with his wife Michele. The portrait was painted by award-winning artist and former GP Peter Smeeth who became a full-time artist in 2008 after 34 years practising medicine.

Smeeth was the winner of the Packing Room Prize at the 2017 Archibald Portrait Prize at the Art Gallery of New South Wales and has been a finalist in several major art prizes including the Doug Moran National Portrait Prize and the Blake Prize.

Professor Cousins had several sittings with Smeeth including photographic shoots. The portrait was commissioned in 2017 but completed this year.

Right: Professor Michael Cousins with his wife Michele after the unveiling of his portrait.

Emerging leaders working together

The 2018 Emerging Leaders Conference (formerly the New Fellows Conference) was held from May 4-6 at the Hydro Majestic Hotel in the Blue Mountains, NSW. It was the first time the meeting (#ELC18) had been combined with RACS's Younger Fellows Forum.

The "Working together" meeting welcomed 20 delegates who had been selected by their respective regional committees in New Zealand, Malaysia, Papua New Guinea and Hong Kong. A similar number of delegates from the nine subspecialties within RACS also attended.

The meeting opened with a combined plenary lecture on gender diversity and inclusion presented by Australian business leader and mentor Diana Ryall. This thought-provoking and engaging session examined an important and contemporary issue in both colleges and in the wider community.

This was followed by another combined and interactive session "What makes a good operating theatre medical team?" presented by Dr Stuart Marshall (FANZCA). The opposing view, highlighting the medical and legal implications of what happens when teams do not work well together, was presented by Dr Joseph Lizzio (FRACS).

A team building "Licence to spy" exercise was held on site at the hotel. This was well received by delegates and a great way for anaesthetists and surgeons to interact before dinner and a fiercely-contested trivia quiz.

The second day of the conference began with an ANZCA-only session hosted by New Fellow Councillor Dr Scott Ma and the college's Digital Communications Manager Al Dicks who introduced delegates to the pros and cons of social media platforms. Delegates were encouraged to join Twitter after being shown the basics of the communication tool and help build the Twitter army ahead of the Annual Scientific Meeting in Sydney.

The meeting then reconvened with RACS when a session on doctors' mental health was tabled. Dr Marion Andrew (FANZCA), chair of the Welfare Special Interest Group, combined with Dr Sally Langley (FRACS) to address "Self-care for a successful team". This was followed by Professor Michael Baigent (FRANZCP) who presented "A healthy team requires a healthy team member".

Dr Tracey Tay (FANZCA) and health research economist Penny Reeves presented a detailed and informative introduction into health economics, "Making choices in healthcare", in an ANZCA-only session. The day ended with a combined session "Pathways to leadership" featuring Dr Scott Ma, Dr Harry Eeman (New Fellow Board Member, FPM) and Dr Andrew MacCormick (Younger Fellows Chair, RACS). The highlight of the dinner at Parklands Country Garden and Lodges were the speeches made by both ANZCA President Professor David A Scott and RACS President Mr John Batten.

On the final morning, the day began with a combined session introducing delegates to the science and art of mindfulness from Mr Anthony Dunin (FRACS). This was followed by an ANZCA-only panel discussion where delegates were invited to ask questions from the leadership team including President Professor David A Scott, Dr Scott Ma, Dr Harry Eeman and Councillor-in-residence Dr Michael Jones. After morning tea a challenging session on the ethics and legal implications of futile treatment was hosted by Dr Margot Heaney (FANZCA).

A final session that explored the past, present and future of leadership and mentoring was hosted by Dr Robert Buckland (FANZCA). The meeting was then closed and delegates bussed to the Sydney International Convention Centre for the ASM.

Dr Craig Coghlan
Emerging Leaders Conference Convenor

Clockwise from left: The emerging leaders at the Three Sisters lookout; Saturday night dinner at Parklands; team building activity – Licence to Spy.

Here is what some of the delegates at this year's Emerging Leaders Conference had to say about the meeting.

Dr Candice Peters FANZCA

"If somebody offers you an amazing opportunity and you're not sure you can do it, say yes and learn how to do it later".

That's a quote from Sir Richard Branson that a colleague shared with me a few years ago in an effort to inspire me to do things I thought I had no business doing. It turns out she attended what was then the New Fellows Conference and serendipitously this quote came up at the ELC. I have never really considered myself an emerging leader, but when I was nudged by one of our SOTs to apply, I figured there was no harm in trying (and in the era of Trump, absolutely anything is possible: insert smirking emoji here!).

The theme "Working Together" encompassed the unique nature of this year's conference as participants working in anaesthesia and pain medicine from across Australia, New Zealand, Hong Kong and Malaysia joined forces with younger fellows from the Royal Australasian College of Surgeons for the first time with a joint agenda. This was certainly one of the highlights for me: meeting new fellows from these disciplines, sharing the highs and lows, discussing common gripes (let's call them challenges) and actually learning from one another's perspectives, which doesn't happen easily during our day-to-day work, particularly with the increasing performance pressure facing us all in a stretched healthcare system.

The opening session on gender diversity by the inspirational and aspirational Diana Ryall AM, a former high school teacher and managing director of Apple Australia from 1997-2001, opened my eyes to unconscious bias and privilege (including my own) and what inclusion truly means ("Diversity is being invited to the ball, inclusion is being asked to dance"). She was so on point for what is as relevant to the corporate world as it is to modern medicine by asking some very thought-provoking questions: "If you were told the most important person was about to walk into the room, how many of you would imagine a man?" and inspired my very first tweet: "Only when we have as many incompetent women in positions of power as incompetent men will we truly have achieved equality". Think about it.

Dr Harry Eeman, FPM Board Member and Rehabilitation Physician gave a riveting, yet sobering account of his journey to fellowship and pathway to leadership, a significant proportion of which was spent as a patient after being struck-down with severe GBS during an overseas holiday. He taught me that we all are disabled in one way or another, only some of us have insight into it!

Dr Nirooshan Rooban FANZCA

It was my pleasure to attend the 2018 Emerging Leaders Conference (ELC) "Working Together" in the Blue Mountains. Gaining insight into the values of the many leaders on show, difficult choices in healthcare and where some of the new challenges to our specialty lie were among the benefits of this combined meeting with the younger fellows of RACS.

Things I took away are:

1. Social media is something to be embraced as an educational tool.
2. The earlier we educate people about burnout, resilience and mental health, the more chance of preventing issues before they occur.
3. The importance of hearing the vision of leaders – the chair panel discussion with ANZCA councillors was particularly illuminating.

For people thinking about attending, I would say go for it. It definitely allows you to see the varying leadership styles, you make some great connections and you learn a bit more about yourself. Thank you to the ANZCA crew and co-convenors for putting on a very worthwhile meeting.

Dr Rochelle Barron FANZCA

I attended the recent Emerging Leaders Conference (ELC) in the Blue Mountains and would really encourage anyone who is interested to apply for next year – especially any women who are looking for opportunities. Don't put it in the "too hard" basket!! And don't feel you need to have a lot of experience or fit the typical profile of an outspoken confident leader; it was an awesome inclusive weekend that played to many different strengths.

There was a lot of excellent discussion about team work, communication, and preventing burnout. We had interactive sessions on the use of social media (I'm still not convinced on Twitter, sorry guys), mindfulness and mentoring. I especially enjoyed the "Pathways to leadership" talks from our own new fellow board members – an excellent demonstration of different types of people getting involved in their own way and in their own style. Inspirational.

Dr Paul Vroegop FFPMANZCA, FRANZCP

I was really inspired by Diana Ryall, executive, previous CEO for Apple Australia and founder of "Xplore for Success" which offers services to organisations to support professionals to achieve personal success. She spoke passionately about gender, privilege, bias and inclusion/exclusion, and equality and equity, and challenged us to recognise our own biases and how to change the behavior of ourselves and the organisations we are involved with.

The discussion on leadership by Dr Rob Buckland, who focused on leadership styles, leadership competencies and leading change, with an emphasis on knowing yourself to optimise health outcomes by promoting effective leadership, clinical governance and sustainability. This was followed by Dr Scott Ma's entertaining lessons to lead by; "Pathways to leadership – lessons from a goose", which I took to heart.

Lastly, but not least, Dr Tracey Tay and Penny Reeves' crash course in health economics introduced me to a number of frameworks for looking at improving population health outcomes that I have already been utilising in my clinical roles, and opened my eyes to learning a new language…

The ELC was most importantly an opportunity for networking, discussions and connecting the dots with an inspiring and entertaining group of like minded colleagues, incredibly encouraging when we can often feel as though we are working in isolation.

Save the date!

2019 Emerging Leaders Conference
April 26-28

"Leaders without borders"
The Saujana Hotel, Kuala Lumpur

For further information, please contact Kate Galloway at events@anzca.edu.au

Applications open soon.

Restrictive versus liberal fluid therapy in major abdominal surgery RELIEF trial success

Results of the RELIEF (restrictive versus liberal fluid therapy in major abdominal surgery) trial were presented to a packed audience at this year's scientific meeting in Sydney, and results published in the prestigious *New England Journal of Medicine*. The RELIEF trial was the first large randomised trial evaluating perioperative IV fluid volumes, and was funded by the ANZCA Research Foundation and NHMRC.

Each year at least 310 million people undergo major surgery worldwide. All receive intravenous (IV) fluids. Clinicians have traditionally administered generous amounts of IV fluids perioperatively, to correct for preoperative fasting, blood loss and other fluid deficits. But the optimal IV fluid regimen for patients undergoing major abdominal surgery was unclear. If fluid administration is restricted it is likely that hypotension needs to be treated with vasopressors. Vasopressors may impair organ perfusion, threaten local tissues at the site of IV administration, cause arrhythmias, and be mistakenly used when hypovolaemia is the underlying cause. On the other hand, excess IV fluid administration causes tissue oedema, with increased pulmonary morbidity, impaired coagulation, and poor wound healing. Most recent guidelines, particularly those focussing on enhanced recovery after surgery, have recommended limiting IV fluid administration, aiming for a zero-balance.

The RELIEF trial was a pragmatic, multicentre, randomised, trial conducted in 47 hospitals across seven countries. A total of 3000 patients were enrolled and randomly assigned to a restrictive or liberal IV fluid regimen. The study population consisted of at-risk patients undergoing planned major abdominal or pelvic surgery with an expected operative duration of at least two hours. The primary endpoint was disability-free survival, a novel patient-centred outcome measure. Secondary outcomes included 30-day acute kidney injury, a composite of septic complications, surgical site infection or death, and 90-day renal replacement therapy.

The findings of the study surprised many: although the two groups of patients had similar disability-free survival at one year, those in the restrictive group had a higher risk of acute kidney injury, surgical site infection, and need for renal replacement therapy after surgery. Accordingly, the authors recommended that a moderately liberal approach to perioperative IV fluid therapy for patients undergoing major abdominal surgery.

Foundation update

Research update

Applications for the 2019 grant round closed on April 3, with a record 61 applications received compared to 55 in the previous year. The number of first time foundation grant applicants increased from 14 in 2017 to 25 in 2018.

Applications from female principal investigators increased from 17 in 2017 to 26 in 2018.

New research committee chair

Professor Alan Merry has stepped down as chair of the ANZCA Research Committee after 10 years in the role. The foundation acknowledges and thanks Professor Merry for the important work he has done in guiding the college's research grant program to its strength and transparency. While Professor Merry has stepped down as chair, we are pleased that he has decided to remain a member of the committee. At the May 11 new council meeting, Immediate Past President Professor David A Scott was appointed as the new chair. The foundation looks forward to working closely with Professor Scott in implementing research strategies within the college's 2018-2022 strategic plan.

Second term for foundation chair

Past ANZCA president Dr Genevieve Goulding was appointed to continue for another two-year term as chair of the foundation, which is looking forward to continuing to work with Dr Goulding to further build the foundation.

Successful foundation reception at the ASM

The Sydney ASM included the foundation's reception, the most successful to date with approximately 130 attending. The new Andrew Couch Prize for the Trainee Academic Session was announced by Dr David Elliot, chair of the NSW Anaesthesia Continuing Education Committee. Dr Couch, a NSW trainee, passed away last year. The foundation is honoured to have been involved in announcing this ongoing tribute to Dr Couch.

It was also an honour to host a moving tribute by Professor Scott to Professor Michael Cousins, acknowledging his extensive and formative contributions to the college, foundation, FPM, and the fields of pain medicine and related research.

Professor Merry inspired guests with achievements of foundation-supported research including the Australian Clinical Trials Alliance's Trial of the Year 2017 award to ATACAS. Professor Merry thanked CSL Behring for its award to Dr Julie Lee's ROTEM platelet study, Dr Peter Lowe for his generous grants especially the inaugural ANZCA Melbourne Emerging Anaesthesia Scholarship (AMERS; awarded to Dr Jai Darvall of Royal Melbourne Hospital), and all other donors and patrons. Finally, he encouraged people to support similar scholarships, for the Australian and New Zealand researchers of the future.

Joan Sheales Staff Education Award

This award, designed to support ANZCA staff to contribute to ANZCA's mission was made possible by a generous donation in 2014 from Professor Barry Baker in honour of ANZCA's first CEO, Joan Sheales. The 2018 winner, Hannah Sinclair, Membership Manager, in the Fellowship Affairs unit, will use the prize to visit the Royal College of Physicians and Surgeons of Canada and study their approach to continuous improvement in member services. The foundation congratulates Hannah and thanks Professor Baker, for his wonderful support for the development of ANZCA staff.

Leadership Circle lunch

The second lunch was hosted at the college in April, with chair Mr Ken Harrison, then ANZCA President Professor David A Scott, and ANZCA CEO Mr John Ilott. Keynote speaker Professor Kate Leslie AO, past ANZCA president and eminent anaesthesia researcher, explored research in anaesthesia and pain medicine including the important areas of anaesthetic depth and postoperative cognitive deficit.

Guests expressed amazement at the complexity of anaesthesia. Representatives from the Cancer Council of Victoria, Medibank Better Health Foundation, Idapt consulting, Development Impacts, Normanby Capital, Minter Ellison, CSL Behring, and the Bennet Group attended, as well as individual foundation donors. The foundation is following up with those interested in potential future support.

Member Advantage

The Member Advantage program has been launched to provide a range of purchasing benefits for fellows, trainees, SIMGs, ANZCA CPD participants and staff. The program provides a new sustainable, source of funding for the foundation's research grants program. The level of funding will depend heavily on members' usage. Funding comes from commissionable products, such as financial services, cards, insurances and motor vehicles.

It is a great way to save money while supporting the foundation. All members should have received a welcome email and instructions, and can log in via the ANZCA website. For queries contact Anna Smeele at asmeele@anzca.edu.au.

Thank you foundation donors

The foundation again warmly thanks all its generous donors for their ongoing support.

Rob Packer
General Manager,
ANZCA Research Foundation

"Saving lives, improving life"

To donate, or for more information on supporting the foundation, please contact Rob Packer, General Manager, ANZCA Research Foundation on **+61 3 8517 5306** or email **rpacker@anzca.edu.au**. Gifts can be made via **www.anzca.edu.au/fellows/foundation**.

Faculty of Pain Medicine

Dean's message

Conversations connect us and help us to make sense of the world.

The recent ANZCA Annual Scientific Meeting theme of "Reflecting on what really matters" prompted some deep thinking. It seems to me that listening and being heard are what really matters. Therefore, the highlight of the ASM for me was the many varied conversations I noticed happening throughout our week together. The FPM Refresher Course Day program set the tone.

More than 220 participants heard multiple outstanding presentations that led to animated conversations at the breaks. Some were sharing the latest scientific research or lessons from the clinical world.

Others were personal stories often tragic and painful about the experiences of refugees, the challenges of inadvertent opioid dependence or the struggles of the elderly. The joint programs with our ANZCA and Royal Australasian College of Surgeons colleagues were of a similar high standard; facilitating discussions across the artificial boundaries of specialist practice that often inhibit conversation.

The discourse on Indigenous health was one standout for me. I left the session inspired by some of the innovative strategies connecting clinicians with Indigenous patients yet dismayed at the paucity of Indigenous specialist pain medicine physicians. On a personal level, I enjoyed being involved in many conversations connecting with colleagues around shared interests. Dialogue with our partners from the Hong Kong College of Anaesthesiologists and Board of Pain Medicine and separately with the RACS Pain Section will facilitate stronger working relationships of mutual benefit, especially around pain education and training.

As we look to the future, the 2018-22 strategic plan will guide the many conversations needed to fulfil the faculty's vision "to reduce the burden of pain on society through education, advocacy, training and research". Priority areas include discussions around opioids in chronic non-cancer pain and procedures in pain medicine; working with our partners, Painaustralia and the Australian Pain Society on advocacy for pain services; and last but by no means least, conversations around the health and wellbeing of fellows and trainees. The faculty's world-class educational offerings will be enhanced by a six-month training option currently under discussion, addressing strategic goal four.

Pursing strategic goal two of positioning the faculty as the trusted source of expertise in pain medicine led to a meeting with Australian health minister, Mr Greg Hunt, in September last year and will be followed up with a second conversation in July. Promotion of an overarching, government endorsed National Pain Strategy and consideration of chronic pain within the National Strategic Framework for Chronic Conditions will be high on the agenda. Review of funding models for pain medicine so that patients can access the multidisciplinary care they need is another key discussion point focussing on strategic goal one. Continuing dialogue with Australian Department of Health officials around funding for pain medicine training positions and research will also be pursued.

The faculty's engagement with the Therapeutic Goods Administration (TGA) has been another avenue of fruitful discourse with discussions last year around medicinal cannabis and the rescheduling of codeine. The next conversation was at the TGA's Opioid Forum on June 1 considering the regulator's role in addressing the challenges around opioid use. I spoke about the faculty's position statements.

The conversation around opioids will remain high on the faculty's agenda as the pendulum swings away from long-term opioid use recognising the less than optimal outcomes and harms experienced by patients. The faculty held its own forum on opioids and pain on June 16. Again, this forum will be informed with talks from experts sharing their knowledge from multiple perspectives followed by small group discussions ending with innovative solutions to take us forward.

Finally, we need conversations looking inward, recognising our shared humanity. We allocate time every day to speak with patients and hear their stories of conversations gone wrong or never had or lost opportunities. These are difficult conversations. Added to other life events, they can impact on the health and wellbeing of fellows and trainees. We need to take a little time out in our busy days to check in with our colleagues and ourselves. There are resources to assist whether issues are professional or personal. All assistance is confidential. I encourage you all to make this a priority in your working week.

As I look to the next two years as your dean, I feel excited about the future. I plan to visit all Australian states and New Zealand over this time. In last year's fellowship surveys, many fellows indicated their enthusiasm for engaging more with faculty activities. I look forward to meeting and chatting with as many of you as possible.

Dr Meredith Craigie
Dean, Faculty of Pain Medicine

Dr Chris Hayes – a dean who built strong relationships

It is my pleasure on behalf of the fellowship, the board, the general manager and faculty staff to thank Dr Chris Hayes for his dedication, hard work and leadership of the Faculty of Pain Medicine at the completion in May of his busy two years as the dean.

Chris's inclusive, reflective style has been the hallmark of his leadership of the faculty. His search for synergies with others underpins his ability to nurture important relationships. Behind his gentle, personable approach, though, is a quiet determination and persistence that gets results. Chris is courteous and fair in his discussions with everyone be they fellows, trainees or those from outside the faculty. The faculty staff have appreciated his calm, thoughtful approach and especially the alacrity with which he responded to their requests.

The faculty has flourished under Chris's leadership. Stronger engagement with government through representations at state and federal level, including a meeting with Federal Health Minister Greg Hunt, has raised the profile of the faculty as a valued advisor, a key strategic goal. Chris has also led faculty interactions with government agencies, especially with the Therapeutic Goods Administration on key issues around medicinal cannabis and the re-scheduling of codeine.

He has strengthened the faculty's already close relationships with key strategic partners, the Australian Pain Society and Painaustralia. Chris has been a very strong advocate of the need to longitudinally assess patient outcomes from pain management programs to inform the evolution of clinical practice. He will continue to provide leadership on the Electronic Persistent Pain Outcomes Collaboration management and scientific committee and has renewed the conversation around outcome monitoring of devices in procedural pain management.

Chris has skilfully steered the faculty board through a complete committee restructure, the development of an ambitious strategic plan for 2018-22 and a range of challenging discussions. Every board member has appreciated the way Chris enables everyone to express their views while quietly remaining in control of the discussion, drawing it to a close in a timely manner with an insightful summary and action plan. He has been a strong voice for the faculty as its representative on the ANZCA Council as well.

Chris has led closer engagement with the fellowship through the topical forums held late last year as a way of encouraging wide-ranging conversations on some of the more controversial issues in contemporary pain medicine, namely medicinal cannabis and procedures in pain medicine. These robust discussions have informed the revision of the faculty's position statement on medicinal cannabis, and the faculty's new working group on procedures in pain medicine.

Chris's wise counsel is sought after far outside the faculty. The recent invitation from Professor Bruce Robinson, Chair of the Medicare Benefits Schedule Review Taskforce, to chair the committee tasked with reviewing item numbers related to pain medicine exemplifies the high regard in which Chris is held.

I am delighted that Chris will serve on the faculty board for another year and will provide leadership for the faculty in other capacities into the future.

Dr Meredith Craigie
Dean, Faculty of Pain Medicine

News

New fellows

We congratulate the following doctors on their admission to Faculty of Pain Medicine fellowship.

By completion of the training program:

Dr Jason Siauw Wei Chow, FRANZCOG, FFPMANZCA (NSW).

Dr Alireza Feizerfan, FRCA, FANZCA, FFPMANZCA (WA).

Dr Gunjeet Singh Minhas, FAFRM (RACP), FFPMANZCA (Queensland).

Dr Alan Nazha, FANZCA, FFPMANZCA (NSW).

Dr Michelle Ann O'Brien, FANZCA, FFPMANZCA (Queensland).

Dr John Alexander Prickett, FANZCA, FFPMANZCA (NSW).

Dr Jane Catherine Standen, FANZCA, FFPMANZCA (NSW).

By invitation (honorary Fellow):
Professor Fiona Mary Blyth, AM (NSW).

This takes the number of fellows admitted to 470.

Training unit accreditation

The following hospitals have been accredited for pain medicine training:

- Fiona Stanley Fremantle Hospitals Group, WA.
- Pain Matrix Geelong, Victoria.
- Pain Science Joondalup, WA.
- Precision Health, Victoria.
- Royal Adelaide, SA.

New board member

Dr Susan (Susie) Lord is from New South Wales and obtained FANZCA and FFPMANZCA in 2004. She has been Clinical Lead, Children's Complex Pain Service, Newcastle since 2013 and was Staff Specialist, Department of Anaesthesia, Intensive Care & Pain Management, John Hunter & John Hunter Children's Hospitals, Newcastle from 2004-2013. From 2004 she is also Conjoint Senior Lecturer, School of Medicine and Public Health (Newcastle). Her interests include procedural interventions (now non-procedural so no conflict of interest), pain in childhood and adolescence, remotely supported care for people in regional, rural, and remote locations and closing the gap in access and outcomes for Indigenous people with pain.

FPM office bearers as elected at the new board meeting on May 9

Dean	Dr Meredith Craigie
Vice-Dean	Dr Michael Vagg
Assessor	Dr Dilip Kapur
Assistant Assessor	Associate Professor Paul Gray
Chair, Examinations Committee	Dr Eric Visser
Chair, Learning and Development Committee	Dr Aston Wan
Chair, Professional Affairs Executive Committee	Dr Michael Vagg
Chair, Professional Standards Committee	Dr Melissa Viney
Chair, Research and Innovation	Dr Chris Hayes
Chair, Scientific Meetings Committee	Dr Jennifer Stevens
Chair, Training and Assessment Executive Committee	Dr Kieran Davis
Chair, Training Unit Accreditation Committee	Dr Kieran Davis
Senior Editor Pain Medicine Journal	Professor Milton Cohen
Co-opted Council Member (appointed by council)	Dr Vanessa Beavis

The FPM Executive Committee comprises:
Dr Meredith Craigie (Dean)
Dr Michael Vagg (Vice-Dean, Chair Professional Affairs Executive Committee)
Dr Kieran Davis (Chair Training and Assessment Executive Committee)
Ms Helen Morris (GM FPM)

Endometriosis – time for action

"To spend years living in chronic pain with no diagnosis, being labelled drug seekers, losing jobs, enduring repeated surgeries and not being believed, suddenly here we are in Parliament House. Our voices are finally being heard."

– Sylvia Freedman of EndoActive

December 5 last year was a big day for people living with endometriosis. Federal politicians Ms Nicolle Flint MP and Ms Gai Brodtmann MP launched the nonpartisan Parliamentary Friends of Endometriosis Awareness with a formal event at Parliament House[1]. For those who may not be aware, parliamentary friendship groups are groups formally recognised by the presiding officers of the parliament which last for the term of the parliament[2]. They provide a non-partisan forum for politicians to meet and interact with stakeholder groups on issues relating to a specific area of concern.

The launch was an opportunity for women to share their stories of life with endometriosis, heart-wrenching litanies of pain and loss. Courageous partners also spoke of the shared devastation experienced by families as the women they love struggle on a daily basis with this frequently hidden condition. They were supported by speakers from the newly formed Australian Coalition for Endometriosis (ACE), a collaboration of awareness groups, patients, clinicians and researchers including the Pelvic Pain Foundation of Australia, Endometriosis Australia, EndoActive, QENDO and the University of Queensland.

Federal Minister for Health, Mr Greg Hunt and Labor Shadow Minister for Health, Ms Catherine King, attended the launch along with other members of parliament. The women's harrowing descriptions of their experiences and that of Ms Nola Merino MP who shared her daughter's story of life-threatening endometriosis surgery visibly moved them both.

Minister Hunt offered an apology, saying "The time is long overdue to bring this condition out of the dark… On behalf of all of those in parliament and all of those who have been responsible for our medical system, I apologise." He promised that the Turnbull Government would create the first National Action Plan for Endometriosis to provide women and their families with the support they deserve[3].

Why all the fuss?

Endometriosis is a chronic progressive disease estimated to affect around 700,000 women and girls in Australia, 120,000 in New Zealand and 176 million world-wide[4] and the costs are high[5]. Endometriosis can be well managed, but it becomes a problem for many because of the often debilitating pain experienced by many sufferers. Over time, pain episodes can extend to the intermenstrual period so that many women are experiencing pain on most days of the month that is the progression to chronic pelvic pain. Also, it is not uncommon for women to struggle with other visceral pain conditions like irritable bowel syndrome[6] and pelvic muscle spasm and bladder symptoms. It has serious deleterious effects on their sleep, mental health and social wellbeing.

Historically an under-recognised condition both by the community and the medical profession, endometriosis has been under-diagnosed and poorly treated. To this day, many women experience confronting and unhelpful interactions with the healthcare system. They are often perceived to be exaggerating their pain severity, attention seeking or drug dependent[1]. Key drivers of these attitudes are the social taboos around menstruation, beliefs about "the right amount of pain" for the condition, the lack of objective measures of pain, and the poor correlation between the extent of the pathology seen on laparoscopy and reported pain experiences. The pathophysiology of endometriosis encompasses a range of nervous system changes including new nerve growth in endometriosis lesions, stimulation of inflammatory processes, peripheral and central sensitisation and inadvertent nerve injury from surgical excision of lesions.

How can we help?

It is time to change outmoded attitudes and beliefs in the community and the health sector. Minister Hunt has followed up on his promise. A roundtable to develop the National Action Plan for Endometriosis was held in February. The tight three-month timeline has produced an action plan aligned with the goals of the National Strategic Framework for Chronic Conditions (AHMAC 2017) as the first step[7]. In addition, the May federal budget allocated one million dollars to educate healthcare practitioners about endometriosis[8]. In New Zealand, Endometriosis NZ has been influential in the NZ Ministry of Health establishing their Task Force to improve diagnosis and management of endometriosis and pelvic pain9. The Endometriosis NZ "me™" program has been teaching menstrual health in New Zealand schools for more than 25 years[10]. A pilot project of this program in Adelaide last year was rated very highly by the participants with requests to continue the program this year and beyond.

Unfortunately, although the New Zealand Pain Society has representation on the New Zealand Task Force, both the Australian National Action Plan and the New Zealand Task Force have not included ANZCA and the Faculty of Pain Medicine as partners which seems to be a lost opportunity. Specialist pain medicine physicians (SPMPs) and anaesthetists can play a significant role at a critical time by improving perioperative care for these women. They can be patient advocates, asking the hard questions about whether surgery is necessary and will it treat the pain. The evidence suggests that repeated surgery may not be beneficial and, in fact, may contribute to worsening pain. Anaesthetists have a prime opportunity to influence the pain experience in the perioperative setting. This can be a very frightening time for these girls and women; a lot is at stake. They deserve to be treated with dignity and compassion. Anaesthetists and SPMPs also act as role models for the junior medical staff and play a pivotal role in teaching modern pain management strategies.

(continued next page)

Fast facts about endometriosis

- Affects one in 10 women of reproductive age regardless of age, background or lifestyle.
- Cause remains unclear.
- Seven to 10 times more likely if a close relative has endometriosis.
- Delay in diagnosis on average seven to 12 years.
- One in three will experience fertility problems.
- Absenteeism and presenteeism common in the workplace.
- Costs of healthcare, lost jobs, impact on productivity and social costs in the billions of dollars.

Opposite page: Sylvia Freedman and her mother Lesley.

This page from left: Federal Minister for Health, Mr Greg Hunt; Ms Nicolle Flint MP with Ms Nola Merino MP.

An increasing number of women are being referred to pain management clinics as chronic pelvic pain is recognised more frequently. SPMPs are trained to manage these patients in the context of a multidisciplinary approach, best teamed with a specialist pelvic physiotherapist and pain psychologist as a start. The FPM Board is working towards a closer partnership with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists aiming to identify synergies for sharing knowledge and skills.

Whether they are consciously aware of it or not, most anaesthetists and SPMPs will know at least one woman with endometriosis and chronic pelvic pain. They are our sisters, mothers, friends and work colleagues. Recent events are giving women living with endometriosis some hope now.

Dr Meredith Craigie
FPM Dean

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9. https://nzendo.org.nz/endo-news/enz-working-with-the-nz-government/ accessed May 21, 2018.
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Objectives of the Parliamentary Friends Group include:

1. To raise awareness of endometriosis as a reproductive and chronic pain condition affecting many women throughout Australia.
2. To inform members and senators of the plight of sufferers of endometriosis with a view to securing funding for further medical research and awareness raising.
3. To facilitate a forum whereby organisations already working on endometriosis research and awareness raising can come together to coordinate their activities.

Refresher Course Day





The faculty's Refresher Course Day and annual scientific meeting (ASM) programs were a tremendous success and a tribute to the hard work of the faculty's Refresher Course Day and FPM ASM Scientific Convenor, Dr Jennifer Stevens.

The Refresher Course Day attracted 224 delegates and received strong support from the healthcare industry with our major sponsor Seqirus and three exhibitors present. The program, "Pain: The dark side of the mind", explored the darkness that can be experienced living with pain, brain damage, emotional and physical aspects of pain and anxiety beyond the confines of the hospital. Also covered was implications of prescribing pain medication and challenges of pain in the elderly population.

The keynote speakers Professor Oscar de Leon-Casasola and Professor Tor Wager provided excellent, thought-provoking presentations that created much discussion. The academic sessions were followed by a dinner at The Establishment Ballroom, which included an inspirational after-dinner talk by Catherine Keenan, founder and executive director of The Sydney Story Factory.

Name change for Refresher Course Day

The FPM Refresher Course Day has been renamed as the FPM Annual Pain Medicine Symposium in time for the 2019 Annual Scientific Meeting in Kuala Lumpur. The new name, which was approved by the faculty's Professional Affairs Executive Committee, better reflects the high quality content and structure of the event.

Clockwise from above left: FPM Dean Dr Chris Hayes with FPM ASM Visitor Professor Oscar de Leon-Casasola; Dr Kieran Davis, Dr Vanessa Beavis and Dr Kushlin Higgie after the morning session; Ms Bernadette Brady presenting on multicultural pain management programs; FPM NSW Visitor Professor Tor Wager with Dr Hayes.

Prize winners

ANZCA trainee Dr Luke Arthur from South Australia, is this year's winner of the Dean's Prize, awarded at the Faculty of Pain Medicine's annual general meeting in May. Dr Arthur won the award for his paper titled "Erythromelalgia in children: Presentation, genotype, and treatment response".

Dr Daniel Chang, from New Zealand, won the Best Free Paper Award at the 2018 FPM free paper session at the annual scientific meeting. His paper was titled "The prevalance and risk factors associated with persistent pain after breast cancer treatment".

The Rare Privilege of Medicine: Women Anaesthetists in Australia and New Zealand

The Rare Privilege of Medicine

Each year the Geoffrey Kaye Museum of Anaesthetic History develops a temporary exhibition to expand the awareness and research on the history of anaesthesia and pain medicine in Australia and New Zealand. On International Women's Day, March 8, 2018, the museum launched its new online exhibition "The Rare Privilege of Medicine: Women anaesthetists in Australia and New Zealand". The physical exhibition was launched on April 18, to coincide with the Australian Heritage Festival.

The exhibition investigates the professional lives of 10 women anaesthetists, ranging in date from 1896 to the present. These women came to medicine through very different paths, and the trajectories of their careers were also markedly different. With these women's stories, the museum hopes to inspire other women but also to challenge other researchers to find women's stories in medical history, and bring them into the public domain.

The exhibition was also promoted at the ANZCA annual scientific meeting with an exhibition booklet and keepcup. To get a keepcup, fellows needed to be able to provide the name of at least one woman anaesthetist
from before 1950. Fortunately, it was an open book question, all the answers were inside the exhibition booklet, and there was a 100 per cent success rate.

To view the online version of the exhibition, go to https://geoffreykayemuseum.org.au/rareprivilege/.

Above: Dr Winnie Hong, one of the first women to sit for fellowship with ANZCA's Faculty of Pain Medicine with her keepcup at the Sydney ASM.

FPM history project

This year we also launched an online history project for the Faculty of Pain Medicine, looking at the development of the faculty from the earliest days of the college. We were privileged to work with Professor Michael Cousins in the lead up to the launch. The online history project is now available for viewing, along with three new versions of the Lives of the Fellows project.

To view the FPM history project go to www.geoffreykayemuseum.org.au/faculty-of-pain-medicine-history/.

To view the Lives of the Fellows project go to http://anzca.online-exhibition.net/fellows/.

Medical History Masterclass

This year, we will once again be running the Medical History Masterclass, facilitated by Monash University's Associate Professor Paula Michaels. The masterclass will be on August 4, 2018, and registrations are now open. Participants in the ANZCA Continuing Professional Development program can claim attendance under the knowledge and skills category "short courses, workshops" for two credit points per hour.

For more information, or to register, go to the museum page on the college website: www.anzca.edu.au/about-anzca/geoffrey-kaye-museum.

What's new in the library

Calling all ANZCA and FPM researchers – promote your research and publications!

AIRR | ANZCA Institutional Research Repository

ANZCA Library – in association with the ANZCA Research Foundation – are excited to announce the launch of the ANZCA Institutional Research Repository (AIRR).

Launched at the ANZCA ASM in Sydney in May, AIRR is an institutional repository that identifies, captures, stores and facilitates retrieval of the research and publication output of ANZCA and FPM fellows, trainees and staff for the collaborative benefit of local and global clinicians, researchers and health educators.

Do you publish or present papers?

We are seeking researchers and authors who would like to register and start contributing their publications via self-submission; set-up an author profile; or provide comment/feedback.

Content you can contribute:

- ANZCA and FPM fellow research grants (publications and outcomes).
- ANZCA and FPM fellow publications (not related to research grants, for example: journal articles, theses, book chapters).
- ANZCA and FPM trainee research (published and unpublished).

Key points:

- Now live (beta-testing): http://airr.anzca.edu.au.
- All ANZCA and FPM-related research and publication output is being brought together in the one spot.
- Content is now discoverable via Google and Trove thereby increasing visibility of ANZCA and FPM-related research and publications.
- Researchers can register to self-submit content, as well as create an author profile.

Access the new AIRR Library Guide: http://libguides.anzca.edu.au/research/airr.

New journals

New England Journal of Medicine (NEJM)

The *New England Journal of Medicine* (NEJM) is a weekly general medical journal that publishes new medical research and review articles, and editorial opinion on a wide variety of topics of importance to biomedical science and clinical practice. Access NEJM through the following link: www.nejm.org.ezproxy.anzca.edu.au/.

Other recent new journals include:

- Aerospace Medicine and Human Performance (AMHP).
- Pain.
- The Clinical Journal of Pain.
- Journal of Graduate Medical Education (JGME).

Fellows and trainees can find these and many other recent anaesthesia and pain medicine titles on the ANZCA Library's latest titles list: http://libguides.anzca.edu.au/news/titles.

The above titles are also available via the library journals page (www.anzca.edu.au/resources/library/journals) and via BrowZine (http://browzine.com/libraries/1231).

ANZCA Library at the ASM

The ANZCA Library ran two workshops – "Beyond Google: An introduction to the ANZCA Library" and "The Undiscovered Country: Advanced searching using MEDLINE" during the 2018 ANZCA Annual Scientific Meeting in Sydney.

The two sessions provided attendees with an opportunity to meet directly with library staff and to learn more about the library and how to utilise its services. By the end of the second workshop, attendees who wanted to undertake their own literature searches learnt how to build better searches in Ovid Medline and PubMed. Both sessions were enthusiastically received and will be offered to delegates again at the 2018 ASM in Kuala Lumpur.

Library staff were also on hand to meet with fellows and trainees at the ANZCA Lounge.

Above from top: Kieran Matharu and Megan DeGuerre from Elsevier with ANZCA Manager, Knowledge Resources, Laura Foley; an@tomedia developer Norm Eizenberg with RACS Library Manager, Graham Spooner and ANZCA Library Manager, John Prentice.

Referencing and citation help

Library Guides

The library has developed a new library guide to highlight the various reference/citation manager tools available. The guide has information and links to the various support resources and output styles available for many of the more popular tools including EndNote, RefWorks, Zotero and Mendeley.

Access the new referencing library guide here: http://libguides.anzca.edu.au/referencing.

The ANZCA Library maintains a number of library guides that are designed to bring together key resources to support particular aspects of pain medicine.

There are guides are based around:

- Particular specialist/subject areas – for example: Airway management, paediatric pain, and many more.
- Guidance on searching specific databases – for example: Ovid MEDLINE and PubMed.
- Supporting the growing number of ANZCA-subscribed apps including Read by QxMD, ClinicalKey, BrowZine and Audio-Digest.

The ANZCA library guides can be accessed at: http://libguides.anzca.edu.au/.

Follow the #ANZCALibrary on Twitter

Want to stay up to date with the latest news and resources from the ANZCA Library? Follow @ANZCA on Twitter and you will see weekly updates from the library using the #ANZCALibrary tag.

The library spotlights online resources, new books and articles of particular interest as soon as they hit the collection.

Books for loan

New books for loan

Books can be borrowed via the ANZCA Library catalogue: www.anzca.edu.au/resources/library/book-catalogue.html

Talley & O'Connor's clinical examination. Volume 1: a systematic guide to physical diagnosis
Talley, Nicholas J and O'Connor, Simon. – 8th ed – Chatswood, NSW: Elsevier Australia, 2018.

Talley & O'Connor's clinical examination. Volume 2: a guide to specialty examinations
Talley, Nicholas J and O'Connor, Simon. – 8th ed – Chatswood, NSW: Elsevier Australia, 2018.

Hyperbaric medicine practice
Kindwall, Eric P [ed]; Whelan, Harry T [ed]. – 4th ed. – Flagstaff, AZ: Best Publishing Company, 2017.

A Circuitous history of anaesthesia and analgesia in Cairns to 2017
Grace, R. [self-published] – c 2017.
Kindly donated by the author Dr Robert Grace.

9th International Symposium on the History of Anesthesia [program]: Boston ISHA-9 2017
Desai, M. and Desai, S. [Program directors] – Boston, Mass.: ISHA, 2017.
Kindly donated by Dr John Crowhurst.

Experience anesthesia history in New England
[Place of publication not identified]: [publisher not identified], c 2017.
Kindly donated by Dr John Crowhurst.

Explain pain
Butler, David S.; Moseley, Lorimer. – 2nd ed. – Adelaide, SA: Noigroup Publications, 2013.

Turn the ship around: a true story of turning followers into leaders
Marquet, L. David. – New York: Portfolio, 2015.

Contact the ANZCA Library
www.anzca.edu.au/resources/library
Phone: +61 3 9093 4967
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New eBooks

eBooks can be accessed via the ANZCA Library website: www.anzca.edu.au/resources/library/ebooks

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Vander's renal physiology
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Conversations to enhance learning

Anaesthesia is primarily taught as an apprenticeship model. As supervisors when we arrive at work we have multiple agendas including providing safe, high-quality patient care, perhaps reviewing patients from a previous list, completing non-clinical work-and providing an environment which facilitates learning.

ANZCA places the responsibility for learning with the trainee[1], and the role of the supervisor is to support lifelong learning. It is important the supervisor encourages this philosophy with the trainee. Questions often arise as to how to do this in a structured way. There are several factors that evidence demonstrates are necessary for learning, and this article will focus on three: Setting goals, providing feedback and promoting reflection.

Elements of a learning and teaching experience

Six elements to consider when facilitating a learning and teaching experience. This is a continuous cycle of learning. Establishing psychological safety is imperative. Planning involves the use of "Set, body and closure" (see figure 1).

Figure 1.

Why have a conversation about learning?

Teaching has been referred to as "A mysterious process by means of which the contents of the notebook of the professor are transferred to the notebook of the student without passing through the mind of either." *-att. Edwin Emery Slosson.*

How can we prevent this?

Inherently we know if we set goals we are more likely to achieve them, so engaging with the trainee to identify their learning goals is a good place to start.

Take home points:

- A learning conversation is a dialogue, not a one-way transfer of information from the supervisor to the trainee.
- Start with goal setting – focus on specifically identifying what the trainee wants to learn.
- End with guidance for further learning.

Structure for learning and teaching

Table 1.

Set the scene

- Learning needs assessment conversation.
- Agree learning objectives with the trainee.
- Outline the approach the learning and teaching will take.
- Discuss relevance of what will be covered with the trainee.

Body

- Consider content or skills you will include specific to the agreed learning objectives.
- Consider how learning will be facilitated. Possibilities include:
  - Use of questions.
  - Tools: SNAPPS, One minute preceptor.
- Review of learning.

Closure

- Summarise the key points.
- Feedback conversation.
- Evaluate.

Where do I start?

Early in medical school we hear the maxim that "more is missed by not looking than not knowing". This is true of teaching and learning as well – if we "teach" something the learner has no interest in, how much learning occurs? As supervisors, if we can identify the trainees perceived learning needs and align our teaching to make this both relevant and practical[2] we may facilitate knowledge retention and learning more effectively. It's important to remember that even at similar stages of training, trainees may have diverse interests and learning needs.

The clinical environment is a rich learning space enabling application of theory into practice, development and refinement of skills and opportunity to problem solve in real time. To capitalise on these opportunities, a conversation to plan the list and potential learning is beneficial.

Taking a few minutes to determine the trainee's learning needs enables you to tailor the teaching and learning episode and when relevant include your "pet topics". Be mindful with pet topics as trainees may find this frustrating if these topics are not aligned with their individual needs or a repeat of a previous interaction. Next you can establish a short plan to effectively deliver the teaching itself or "body" then evaluate the teaching during the "closure" (see Table 1).

Phrases that may be useful to begin this conversation may include:

- "What would you like to learn today (get out of this list)?"
- "Is there anything you are working on (from previous feedback) that you would like to try and build on during this list?"
- "What is one thing you would like to take away from today?"
- "What would you like feedback on today?"

This conversation may assist the supervisor to gain insight into the trainee's current knowledge and skills as well as assist the trainee to identify specific learning needs not previously considered. As with other new skills or approaches this conversation may feel awkward at the start.

(continued next page)

Conversations to enhance learning (continued)

Barriers to the conversation

Supervisors often have several reactions to the suggestions they should start the list by asking the trainee what they want to learn:

"We won't have time, there's too much work pressure."
Planning at the start of the list (or before) allows time to assemble equipment or call for patients early to allow extra time to focus on teaching. Additionally, it creates an environment expecting learning to take place. This approach capitalises on opportunity, and even in high turnover situations trainees can identify learning opportunities.

"What if they don't come up with anything?"
It might be the first time a trainee has been asked what they want to learn! To start the discussion, try presenting two or three learning opportunities related to the list and ask them to choose one to start a conversation. Once the trainee knows you're serious about meeting their needs, they are often quite happy to discuss where the gaps are, or ask questions.

"I don't want to teach what they want to learn."
This can be a challenge particularly with trainees who may wish to learn something outside the scope of the list. The onus is therefore on the supervisor and trainee to work together to find relevant learning opportunities! The exam-focused trainee may prioritise viva practice over presence in a list and this may be appropriate for a period. However, utilising the time in theatre to underline the principles of the exam (for example, pharmacology in action) is an opportunity to reinforce knowledge and evidence suggests application of knowledge results in long-term behaviour change. A useful approach is to make explicit your thinking and make explicit why you do what you do.

"It's exhausting to be teaching all the time."
This is a common statement from participants in the ANZCA educators program! Yes, it is exhausting – which is why few of us explicitly teach throughout an entire list. In any list there will be teaching moments – some planned (aim for at least one at the start of the list), others opportunistic as well, and learning moments where the trainee can benefit from guided self-directed learning[3]. Role modelling is a valuable tool to promote learning and can be supported by a reflective learning conversation.

In my (Kara's) experience, trainees usually have highly practical, achievable aims for learning on a list. These include performing a WBA, practicing a technique, discussing why I do things the way that I do, talking about a difficult case, or career planning. Allowing the trainee to take the lead in establishing the agenda has opened conversations that are fascinating and rewarding for both the trainee and for me. Don't underestimate a trainee's ability to recognise your strengths and play to them!

What about afterwards?

The feedback conversation is an opportunity for purposeful dialogue between the trainee and the supervisor to share perspectives related to performance and assist the learner to identify goals and actions for ongoing development. Feedback conversations after working with multiple supervisors over time provide an opportunity for the trainee to gain information through a variety of lenses enabling strengths and gaps in knowledge, skills and professional behaviours to be identified and discussion regarding ongoing improvement.

The feedback conversation focuses on reflection (self-assessment), and involves an exploration of things that worked well and areas for ongoing development. An important final step is for the trainee to take responsibility for creating an action plan towards improvement.

A typical feedback conversation may include phrases such as:

"Tell me what you think worked well today."

"Is there anything you would do differently or will continue to consider after today?"

"Was there anything you would do differently next time?"

"What feedback do you have for me as a supervisor?"

The Fundamentals of Feedback modules in Networks is a valuable resource to advance your skills in feedback: https://networks.anzca.edu.au/d2l/home/7108.

Conclusion

The clinical environment provides many opportunities for learning. Maximising these with conversations designed to plan, implement and benefit from these opportunities is highly satisfying for both supervisors and trainees.

For more information: ANZCA educators program www.anzca.edu.au/resources/learning/anzca-educators-program

Dr Kara Allen
Supervisor of Training, Royal Melbourne Hospital,
Mecical Lead, Monash Simulation,
ANZCA Education Program Facilitator

Mr Maurice Hennessy
Learning and development facilitator, ANZCA

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Successful candidates

Court of Examiners for 2018.1 Primary Exam.

Primary fellowship examination February/April 2018

Ninety-four candidates successfully completed the primary fellowship examination:

AUSTRALIA

Australian Capital Territory
Nicole Elizabeth Somi

New South Wales
Benjamin James Bartlett
Kathryn Marie Brooker
Mark Elie Chemali
Tejas Chikkerur
Kate Howson
Gregory Kalogeropoulos
Adam Michael Kelly
Melissa Xiao-Ming Kuo
Jaroslaw Jerzy Latanik
Andrew William Maccioni
Benjamin Ross McAlpin
Briana Loloma Miller
William Cobley Moor
Erin Mary Nelson
Nikhil Subhaschandra Patel
Lauren Deborah Paton
Daphne Subarna Premnath
Anthony Anis Almendra Qureshi
Richard Pieter Ruberti
Michael John Scerri
Patrick Vincent Sheehan
Samuel Weka Stewart
Brendon Jonathan So
Michael Tyrrell Taylor
Simon Tiew Fong Ting
Rheily Paige Ward
Samuel Charles Wotherspoon

Queensland
Catherine Jane Bella
Matthew Jacob Black
Matthew Jonathan Bolland
James Edward Lloyd Booth
David John Burgess
Michael John Busser
Joshua Cher Jin Chew
Larissa Maree Cowley
Rian James Crandon
Emmanuel Dhoss
Nicholas John Egerton
Karl Alexander Eisner
Nicole Elise Galletly
Courtney Lee Hawthorne
Jane Caroline Leadbeater
Andrew Gregory Little
Jun How Low
Antimony Ashley Mar
Rajesh Pachchigar
Emma Elaine Paver
Romitha Vidushan Ranasinghe
Thomas Benjamin Roberts
Danielle Rebecca Scott
Jacqueline Anne Seebold
Jai Sharma
Yi Ching Siah
Carling Ann Tills Simmons
Catherine Stephanie Stirzaker
Zach Daniel Tappenden
Leigh David White

South Australia
Shaun Peter Campbell
Paul Timothy MacLure
Alicia May Paterson
Charlotte Naomi Wade
Timothy James Wonders

Tasmania
David John Hargreaves

Victoria
Brian Nee Hou Chee
Asha Simon d'Arville
Alexandra Lee Hill
Luxmana Sean Jeganathan
Vivian Liang
Ainsley Christina Lorych
Li Yong Ng

Western Australia
Louisa Ann Corr
Alicia Louise Cullingford
Shilpa Desai
Owen Patrick Gray
Xiao Liang
Sneha Neppalli
Ray Paramalingam
Darren Paul Sherwin

NEW ZEALAND
James Edward Bickley
Karen Mu-Hsuan Chiu
Carole Ann Gillespie
Matthew Hart
Amiria Isabelle Taylor Howie
Renee Clair Hope
Matthew Jeremy Lowe
Anna Jan Mearns
Bridget Irene McKenzie
Keryn Dale McLeay
Anna Julia Pozaroszczyk
Christopher Peter Burnett Shaw
John Edward Shepherd
Peter Yang Xiang
Nicholas Casimir Zichy Woinarski

Renton Prize
The Court of Examiners recommended that the Renton Prize at this sitting of the primary examination be awarded to:

Brian Nee Hou Chee, Victoria

Merit certificate
The Court of Examiners recommended that merit certificates were awarded to:

Michael John Busser, Queensland

Court of Examiners for 2018.1 Final Exam.

Final fellowship examination March/May 2018

One hundred and fifty seven candidates successfully completed the final fellowship examination at this presentation and are listed below:

AUSTRALIA

Australian Capital Territory
Martin Michael Dempsey

New South Wales
Caroline Ban
Christopher John Bell
Mitchell David Blake
Kate Elizabeth Blatchford
Samuel John Boyers
Oliver Mark Carson
Supriya Chowdhury
Phillip Wayne Collins
Timothy David Cooper
Tara Kristen Dalby
Zoe Daskalopoulos
David Richard Denman
Thomas Egan
Andrew Herbert Emanuel
Daniel Fletcher
Damitha Viraj Anton Fonseka
Michael Adam Ginsburg
Daniel David Gorman
John Paul Harper
Nathan Andrew Hewitt
Dinushka Iroshima Devi Kariyawasam (Pakiarajah)
Swaetha Koneru
Bianca Gkin-Hui Lan
Andrew Peter Lindberg
Mateusz Piotr Lisik
Leela Manik
Jessie Kowhai Maulder
Luke John McConnell
Joel Brian Menzies
Jonathan David Moore
Jessica Nghiem
Graham Collin O'Connor
Gabrielle Papeix
Dana Michael Perrignon Roth
Kate Smith
Jason Chiong-Hui Tiong
Nilru Priyanka Vitharana
Aleksandar Vukomanovic

Queensland
Rafal Bacajewski
Tamsin Catherine Barratt
Cameron Morton Bell
Rachel Claire Bourke
Andrew Charles Bower
Hanna Denise Burton
Rebecca Kathleen Caragata
Gillian Hilda Cook
Corey James Dore
Jonathon Paul Fanning
Nevin Mark Fernandez
Nathan Bruce Flint
Nicholas James Gerbanas
Alice Hazel Gynther
Jessica Anne Hegedus
Yena Hwang
Lee Nicholas Imeson
Behruz Mohammad Jamshidi
Ashton Jeffery
Juan Sebastian Lopera Alvarez
Thar Nyan Lwin
Claire Jane Maxwell
Tony James Miller-Greenman
Martin Misevski
Stephen James Naughtin
Luke Bradley Nottingham
Adrian Pregelj
Patrick James Rubie
Lilyana Putri Satiowijaya
Thomas John Shepherd
Christopher John Slattery
Iain Cameron Walker-Brown

South Australia
Nicole Diakomichalis
Anisha Kulkarni
Kylie Musgrave
Marthinus Vermeulen
Elena Clare Vowels
Samuel Jeremy Whitehouse

Tasmania
Nathaniel Guy Jackson
Harry Arthur Laughlin
Peter Michael Mulcahy

Victoria
Sarah Jane Ashcroft
Jonathan Li Wern Au
Nicholas John Cameron
Isabelle Laura Cooper
Henry James Davidson
Tabara Dione
Kathryn Anne Donaghy
Julia Alexandra Dubowitz
Cameron Gibson Galbraith
Andrew John Goldberg
Jina Hanna
Jackson Thomas Hawkes-Sutton
Timothy Boh Chu Ho
Zacchary James Ivey
Patricia Ky
Sophie Ann Lee
Yasmin Safia Lennie
Bianca Antoinette Macula
Nirnitha Manivasagan

Successful candidates (continued)

Matthew David Mathieson
Alexander John McCann
Therese Rose Nigro
Georgia Catherine Preece
Ramanan Rajendram
Dashiell Trinity Reed
Andrew Leslie Simons
Yuet-Ching Sing
Harridharshan Janahan Sivakumar
Liam George Twycross
Alice Elizabeth White
Peter Daniel Williams
Luke William Willshire
Elliot Lachlan Wilson
Zi Yang

Western Australia

Natalie Akl
Lisa Mariana Parisouk Alarcon
Vincent Bryan Anderson
Simon Peter Bradbeer
Suze Dominique Bruins
Maya Calvert
Peter Benjamin James Garnett
Jodie Lisa Jamieson
Ryan Maslen
Michael Tak Kwan Miu
Simon Don Papaelias
James Franklin Preuss
Craig Melville Rainbird
Scott Cameron Sargant
Archana Chandrashekar Shrivathsa
Bojana Stepanovic
Syed Muhammad Syed Abdul Hamid

NEW ZEALAND

Charlotte Emily Adamson
Siva Sundari Arumugam
Michael Johan Barlev
Lisa Marion Barneto
Jane Christy Carter
Thida Evennett
David Choi
Yanyi Chuah
Nicola Anne Delany
Nicholas Charles William Eaddy
Mehreen Maqsood Farrow
Nicholas Stephen Harrison
Victoria Anne Lyon
Aaron James Macdonald
Fynn Maguire
Leesa Jane Morton
Hye-Won Karen Park
Matthew Byron Rowe
Charlotte Louise Smith
Matthew James Sumner
Nicole Kyla Vogts
Arihia Elizabeth Te Mare Waaka
Maya Williams

HONG KONG

Ka Chung Shek
Shuk Wah Tse

MALAYSIA

Seleen Cheah

SIMG examination

Six candidates successfully completed the Specialist International Medical Graduate Exam at this presentation and are listed below:

Akhilesh Kumar Tiwari, Queensland
Josko Zaja, Queensland
Leandro Cardoso, Western Australia
Esha Sethi Chaudhary, Western Australia
Patricia Eveline Nientiedt, Western Australia
Evelina Shepherd, Western Australia

Cecil Gray Prize

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended 30 June 2018, be awarded to:

Alice Hazel Gynther, Queensland

Merit certificates

Merit certificates were awarded to:

Jessica Anne Hegedus, Queensland
Harry Arthur Laughlin, Tasmania
Zacchary James Ivey, Victoria
Craig Melville Rainbird, Western Australia

Diploma of Advanced Diving and Hyperbaric Medicine

ANZCA congratulates the following doctors on their award of the Diploma of Advanced Diving and Hyperbaric Medicine:

Professor Michael Bennett, FANZCA FRCSI (NSW)

Dr Glen Campbell Hawkins, FANZCA (NSW)

Dr Jan Peters Lehm, FAZNCA (NSW)

Dr Barbara Elise Trytko, FANZCA, FCICM (NSW)

Dr Robert Turner, FANZCA (NSW)

Dr Kenneth Robert Thistlethwaite, FRACGP (Qld)

Dr Susannah Sherlock, FANZCA, FCICM (Qld)

Dr Paul David Cooper, FANZCA, FCICM (Tas)

Dr Elizabeth Jane Elliot, FRACGP (Tas)

Dr Rod Franks, FACEM (Tas)

Clinical Professor David Smart, FACEM (Tas)

Dr Andrew William Harold Fock, FANZCA (Vic)

Dr Ian Christopher Gawthhrope, FACEM (WA)

Correction

In the March 2018 edition of the *ANZCA Bulletin*, an article by Dr Richard Seglenieks had an incorrect sign off.

It should have read:
Dr Richard Seglenieks
Chair, ASA Trainee Members Committee

We apologise to Dr Seglenieks.

A VAST improvement for resource-limited settings

VITAL ANAESTHESIA SIMULATION TRAINING

As of July 2017, I have been undertaking a global health and anaesthesia fellowship at Dalhousie University, Halifax, Nova Scotia, Canada. Armed with the luxury of time, flexibility in expected output and a strong collaborative partnership between Dalhousie University and the University of Rwanda, I have focussed my fellowship on developing and piloting the Vital Anaesthesia Simulation Training (VAST) Course. The VAST Course is a novel, three-day simulation based program centred on core clinical and non-technical skills, promoting safe anaesthesia and perioperative care in resource-limited settings.

In low- and middle-income countries (LMICs) resource limitations, severe workforce shortages and scarce professional development opportunities pose significant challenges to the provision of safe anaesthesia[1,2]. The content of the VAST Course was specifically designed to reflect the case mix encountered in district hospitals, a level in the health system of LMICs recognised as a pivotal target for quality improvement initiatives[3,4]. The course focuses on anaesthesia and resuscitation for obstetric, paediatric and trauma care as well as safe general surgery and pain management. Beyond the clinical material, VAST utilises simulation and reflective learning (debriefing) to highlight the role of anaesthestists' non-technical skills. VAST creates an immersive simulation environment without reliance on advanced or expensive simulation technology. This is achieved through the combination of basic task trainers, iPads using SimMon software, simple props (for example, airway equipment, syringes, drapes), representative documentation, photographs of pathology and briefing cards to prepare participants for their role during scenarios.

VAST is grounded upon a longstanding association among the anaesthesia departments at Dalhousie University, University of Rwanda and the Canadian Anesthesiologists' Society International Education Foundation (CASIEF). Extensive foundational work has already been conducted in Rwanda in both medical education and simulation[6-8]. I have had the pleasure of VAST co-authorship with Dr Livingston (Dalhousie University, Halifax, Canada) and Dr Mukwesi (Rwanda Military Hospital, Kigali, Rwanda), who were both central to this foundational work. Collaboration with the Scottish Centre for Simulation and Clinical Human Factors provided a robust framework for simulation design and debriefing, which we have adapted for suitability in resource-limited settings. VAST has been developed in consultation with the World Federation of Societies of Anaesthesiologists (WFSA), who have endorsed the pilot courses. Additionally, I am grateful to CASIEF and Dalhousie University for their financial support.

The VAST Course was conducted three times during January 2018, in Kigali, Rwanda. In total, 40 participants completed the training. More than 50 per cent were non-physician anaesthesia providers. We also delivered two VAST Facilitator Courses, mentoring 12 trainee-facilitators. The goal of the facilitator course is to develop a network of local VAST facilitators who will promulgate the course and promote sustainable delivery.

Course evaluations were universally positive. The pilot courses provided great insight into the feasibility of conducting a three-day simulation-based course in a resource-limited setting on a modest budget. From the perspective of course design, the lessons learnt will be used to refine the course prior to future delivery.

With hindsight and time, I cannot help but reflect on the pilot courses as a great success. However, in the moment, there were multiple obstacles to overcome. The most notable challenge was trying to meaningfully conduct and debrief simulation scenarios with a diverse group of participants, who often switched between three languages. While English has replaced French as the official language, French and the ubiquitous Kinyarwanda are often deferred to. Additionally, the stakes were raised when the Minister of State in charge of Public Health and the Commandant of the Rwanda Military Hospital joined us for a demonstration scenario and certificate presentations at the end of the second course. Their evaluation and ongoing endorsement of VAST are central to a locally-driven and meaningful future rollout of VAST in Rwanda.

Stemming from the pilots, we have secured the endorsement of Ministry of Health to promote dissemination of the VAST Course in Rwanda. Additionally, we are working with the University of Rwanda to extrapolate VAST into a longitudinal simulation curriculum for anaesthesia trainees in Rwanda. We also are planning to conduct a formal assessment of the program, in terms of ability for knowledge translation of non-technical skills and for efficacy of facilitator training. Following delivery of the pilot courses, the overwhelming impression amongst the project leads and reflected from participants, is that VAST has potential value across a wide range of resource-limited settings. I look forward to ongoing partnership with the WFSA and am hopeful that with the support of ANZCA and ASA we will be able to explore avenues for trial of the VAST course closer to home.

I sincerely thank the ANZCA Overseas Aid Committee for awarding me the Overseas Aid Trainee Scholarship.
Overseas work in a resource-limited setting has provided me not only a rewarding personal experience, but an avenue to harness fortune and privilege in an attempt to give back to the global community. I have been able to hone my teaching abilities and meaningfully apply the skills and knowledge developed during ANZCA training. Further, the process of designing and delivering the VAST Course has driven me to explore what underpins effective medical education.

Dr Adam Mossenson
ANZCA Provisional Fellow, MPH
Assistant Professor and Global Health Fellow, Dalhousie University,
Halifax, Nova Scotia, Canada

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Opposite page from left: Certificate presentation and the end of the inaugural VAST Course; Debriefing; Without needing to rely on expensive technology and complex equipment, psychological fidelity and "buy in" can be achieved; Demonstration scenario for the Commandant, Minister of State and entourage.

Special interest group events

Obstetric anaesthesia – delivering what matters

The 2018 Obstetric Anaesthesia SIG meeting "Obstetric anaesthesia – delivering what matters" was held at the International Convention Centre in Sydney as a satellite meeting to the ASM. It was wonderful to see the ongoing interest in obstetric anaesthesia with more than 400 delegates attending.

The aim of the meeting was a broad ranging update in obstetric anaesthesia best practice. We welcomed three international invited speakers, Professor Richard Smiley, Professor Marc Van de Velde and Professor Warwick Ngan Kee, two of whom had not spoken in Australia before, and provided interesting perspectives on what's new and the future of obstetric anaesthesia. We were left in no doubt as to the Belgian view of remifentanil with the declaration that Professor Van de Velde hates this drug on birth unit.

Particularly well received were the talks from non-anaesthetists in the program, in keeping with obstetric anaesthesia as a team sport. These included the role of interventional radiology in managing placental abnormalities from Dr Tim Harrington, the concerning trend towards earlier delivery from Professor Jonathan Morris and a very interesting discussion of the incidence of post-partum post-traumatic stress disorder from psychiatrist Professor Philip Boyce. A particular mention also to Dr Edith Waugh, a Darwin anaesthetist, who presented an insightful and moving talk on the issues around caring for Indigenous parturients.

In addition to the four emergency response workshops held on the Saturday afternoon we were able to offer for the first time emergency response sessions covering the four topics in obstetric scenarios at the Westmead and Royal North Shore Simulation Centres. These proved very popular and engaging.

We were thrilled with the response to the inaugural Micheal Paech Prize for Research in Obstetric Anaesthesia. Following three excellent presentations the prize was awarded to Dr Patrick Tan for "High flow humidified nasal pre-oxygenation in pregnant women – The HINOP1 Study".

We would like to especially thank Sarah Chezan, Hannah Sinclair and the team from the college for all their fantastic help in making both the meeting and social program a success. The Saturday evening harbour boat ride to dinner was a special highlight. Finally a huge thank you to all the fantastic presenters and workshop instructors who gave their time and efforts and made it all possible.

Dr Jane Brown and **Dr Surbhi Malhotra**
Obstetric Anaesthesia SIG Convenors

Clockwise from top left: Professor Warwick Ngan Kee, Professor Marc Van de Velde, Dr Surbhi Malhotra, Associate Professor Victoria Eley, Dr Jane Brown and Professor Richard Smiley; Professor Michael Paech presenting the winner of the inaugural Michael Paech Prize for Research in Obstetric Anaesthesia, Dr Patrick Tan; Delegates during a break viewing the e-posters on display; Professor Marc Van de Velde and Associate Professor Alicia Dennis during question and answer time.

Research workshop – opening avenues

Whether you want to do a small research project or get on board with a huge trial, the ANZCA research workshop provided a taste of all that's available for trainees and fellows when it ran on March 23 in Auckland.

Topics from both national and international speakers ranged from how to do a pilot study to the ins and outs of airways research.

The "Young and the Restless" section was three presentations looking at the good, the bad and the ugly in diploma, masters and PhD study. Dr Daniel Chiang, who is a recipient of an ANZCA Foundation grant for his gene research into post-surgery pain in breast cancer patients, says being knocked back on ten previous grant applications made him successfully hone back his proposal. On the benefits of research, he says, "I feel I'm a better doctor with a wider clinical and academic understanding of our profession".

Dr Carolyn Deng and Dr Nicola Broadbent both had a public health lens on their post graduate research emphasising how understanding the complex environment patients come from affects outcomes.

Once you have finished your research, do you start thinking of publishing? Another speaker, editor of the *Canadian Journal of Anesthesia* Dr Hilary Grocott says no. He emphasises you need to be thinking about publishing right from the design phase. He said editors look for whether the research is new, important and well done.

Above from top: The Young and the Restless from left: Dr Nicola Broadbent, Dr Carolyn Deng and Dr Daniel Chiang; Dr Hilary Grocott and ANZCA Research Workshop organiser, Dr Tom Fernandez.

Laws on medicinal cannabis and end of life

New Zealand is facing debates at the highest level about issues that have been exercising our friends across the Tasman for some time – what we do about medically-assisted dying and what is our stance on the growing demand for medicinal cannabis that is driving changes in the law?

The ANZCA New Zealand National Committee has submitted on both using the experience from what has happened in the Australian jurisdiction, the environment in New Zealand and the specific aspects of the legislation proposed.

So what are the issues?

The debate about the use of medicinal cannabis reached the New Zealand parliament late last year.

There were two bills vying for oxygen, with a more liberal private member's cannabis bill failing at first reading. This one, proposed by a Green MP, would have allowed the terminally ill and debilitated to legally grow cannabis if prescribed by their doctor.

The government's Misuse of Drugs (Medicinal Cannabis and other matters) Amendment Bill was introduced to the House in December and passed its first reading late January. It is now being considered by the Health Select Committee.

The bill introduces an exception and statutory defence for terminally ill people to possess and use illicit cannabis and to possess a cannabis utensil. It also enables the setting of standards that products manufactured, imported and supplied under licence must meet, and amends Schedule 2 of the Act so that cannabidiol products are no longer classed as controlled drugs.

Key points from ANZCA's and FPM's position on medicinal cannabis, with particular reference to its use in the management of patients with chronic non-cancer pain, are as follows:

- ANZCA and FPM do not take a stance on the issue of decriminalisation of personal use of cannabis preparations.
- There is little evidence for the efficacy of cannabinoids in chronic non-cancer pain situations.
- ANZCA and FPM do not recognise a need for greater availability of medicines in general and in particular do not endorse the use of cannabinoids in chronic non-cancer pain until such time as a clear evidence-based therapeutic role for them is identified in the scientific literature.
- Substances intended for therapeutic purposes should be fully characterised chemically, pharmacologically and toxicologically.
- ANZCA and FPM are concerned about the adverse effect profile in cannabis users, including impaired respiratory function, psychotic symptoms and disorders, and cognitive impairment, particularly in the developing (including adolescent and young adult) brain.

The End of Life Choice Bill passed its first reading in December and is now being considered by the Justice Select Committee. The bill gives people with a terminal illness or grievous and irremediable medical condition the option of requesting assisting dying.

Some of the main points in the New Zealand National Committee submission included questioning the clarity of the definition of assisted dying, that medical practitioner or health service participation in assisted dying should be voluntary with no need for an objection to be qualified, and that there should be guidelines on what information a medical practitioner must provide. The submission also emphasised that quality palliative care services must be accessible across New Zealand, and research and investment into palliative care must be prioritised. Assisted dying legislation must not become a substitute for good palliative care.

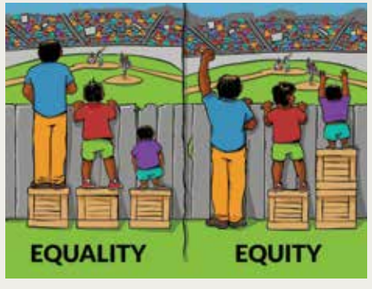
Submissions on both these bills can be found on the ANZCA website.

Tēnā koutou katoa – let's talk about equity

Quality assurance coordinators (QAC) from hospitals all over New Zealand were challenged to think about what equity looked like in their workplace when they attended their meeting in Wellington in April.

QAC was addressed by the group manager Kiri Rikihana whose job, among other things, is supporting the implementation of Te Whai Oranga, the Health Safety and Quality Commission's Māori advancement framework.

Her first task was to show how equity differs from equality using the illustration (right) and discussion after.



Kiri Rikihana explained that equity means "everyone has the same outcomes – whatever it takes".

She says for too long Indigenous groups have been blamed for their health problems. Yet the weighted statistics illustrate Māori have been the canary in the health system indicating where the major issues are going to appear in the population.

Kiri Rikihana spoke about how we can design health systems differently to attain equity but it takes leadership, strategy, capacity, good measurement, accountability and vision.

The Health Quality and Safety Commission has developed an Equity Explorer which provides information on how health and health care varies between groups of people, and between district health board (DHB) areas of Aotearoa New Zealand. Two types of group are compared: ethnic groups and groups based on socioeconomic status (deprivation).

www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/equity-explorer/.

Kiri Rikihana challenged anaesthetists to ask what are some of the biggest barriers to addressing equity in their workplace, what would help overcome them and what is their sphere of influence?

Above from top: Health Quality and Safety Commission Group Manager, Kiri Rikihana; Illustration of Interaction Institute for Social Change by artist Angus Maguire.

Australian news

Australian Capital Territory

Scan and Ski Workshop

After the immense success of our inaugural Scan and Ski Workshop in July 2016 we are delighted to announce that we will be running the event again in 2018. The workshop will be held from Friday July 13 to Saturday July 14 at the Thredbo Alpine Hotel in the Kosciuszko National Park. Dr Ross Peake will again convene the workshop, together with world-renowned ultrasound specialists Dr Alwin Chuan, Dr Peter Hebbard, Dr Andrew Lansdown, Dr Brad Lawther, Dr Harmeet Aneja and Dr Sam Sha.

The workshop will run over two days, using the morning and evening sessions for hands-on ultrasound scanning and instruction, and leaving the middle of each day free for skiing or sightseeing in the beautiful NSW Snowy Mountains. The workshop will cover upper limb blocks, lower limb blocks, trunk and spinal blocks, among other topics.

Online registration is now open via the ANZCA ACT website or if you would like to find out more please email Kym Buckley in the ACT office kbuckley@anzca.edu.au or phone +61 2 6221 6003. Places will be limited to 35 participants so don't delay.

ACT Regional Committee update

We welcome three new members to the ACT Regional Committee for 2018-2020 – Dr Manasi Rai, Dr Monika Tecsy and Dr Bibhuti Thakur. Our new members are joined by existing members Professor Thomas Bruessel, Dr Natalie Marshall, Dr Girish Palnitkar and Dr David Reiner to round out our full complement of seven elected members. We would like to sincerely thank Dr Andrew Hehir who has sadly stepped down from the committee for his tireless efforts as ACT Regional Chair over the period 2014-2017.

Art of anaesthesia – A game of risk?

On behalf of the ACT Regional Committees of ANZCA and the ASA, we invite you to attend the Combined Art of Anaesthesia meeting to be held in Canberra over the weekend of September 15 and 16, 2018.

This year the meeting will be held at the National Museum of Australia, overlooking the picturesque Lake Burley Griffin and only a short distance to the Floriade festival, Australia's premier flower show, which is held annually at Commonwealth Park.

This year our theme is "A game of risk?" Risk is increasingly something we all have to deal with on various levels. This year's program not only hopes to explore risk from a clinical context (namely assessment and minimisation) but also through exploring risk from different perspectives, namely the patient, the trainee, the workforce, and historical perspectives to see whether we have actually learned from past mistakes.

Our lecture series will run on Saturday September 15. Leading the exploration of this theme will be Professor Francesco (Franco) Carli from McGill University, Canada, as our invited international speaker. Professor Carli will focus on prehabilitation as a means to risk attenuation along with providing guidance on how to formulate ERAS packages for smaller hospitals. He will be complemented by our interstate speakers – Dr Jai Darvall, Dr Lachlan Miles, Dr Stephen Bolsin, Dr Martin Culwick, and Ms Kate Cole-Adams who, along with our local speakers, will demystify the risks that we face on a day-to-day basis and provide strategies on how to deal with such challenges.

On Sunday September 16, we will run the mandatory CPD workshops Can't Intubate, Can't Oxygenate (CICO) and Anaphylaxis. In addition, Professor Carli will run a Prehabilitation Workshop which will complement his talk given a day earlier.

September is a wonderful time to visit Canberra – particularly with the opening weekend of Canberra's Floriade flower festival. Bring the family, stay for the weekend and enjoy a unique and thought provoking scientific meeting along with experiencing the best of spring in the nation's capital.

Victoria

Quality assurance meetings

Convened by Dr Dean Dimovski, the first of a series of two quality assurance meetings was held on Saturday May 26 at the college. The presentations included “Obstetric haemorrhage” delivered by Dr Andrew Buettner, and “Management of the suboptimal obstetric spinal/epidural block” presented by Dr Maggie Wong. As with all our quality assurance meetings, following the presentations the groups split to have small group discussions on cases and then they come together again to give summaries from their groups. The meeting was well attended with 49 registered and very positive feedback was received. The second quality assurance meeting is scheduled to be held on Saturday October 13 – save the date!

FPM VRC CME Evening Meeting

The Faculty of Pain Medicine VRC held their first CME evening meeting for the year on Wednesday May 23. Dr Martyn Lloyd-Jones (Addiction Medicine Specialist, St Vincent’s Hospital) and Ms Maureen Chesler (Pharmacotherapy Development Officer, Department of Health and Human Services) presented on "High dose Buprenorphine/Naloxone for the treatment of opioid dependent pain patients". It was a successful event with 35 registrations and was sponsored by Indivior.

Annual combined CME meeting and emergency response workshops

The annual combined ANZCA/ASA CME meeting will be held on Saturday July 28, and emergency response workshops on Sunday July 29 at the Sofitel on Collins in Melbourne. This year’s meeting theme is “Rising temperatures, the heat is on” and along with the additional workshops being held the next day, there is also an optional audit component which can attract an additional 20 CPD points. To date these have all been very well received and we are expecting to have a good turnout on the day.

Queensland

A CME evening with a difference

Following on from the art and mindfulness workshop held at the Queensland Art Gallery (QAGOMA) in Brisbane as part of the 2017 ANZCA ASM, several workshops have been held for registrars in Brisbane to help alleviate stress during peak exam time. It has not taken long for consultants to ask “what about us?” so for our first CME lecture evening of the year we arranged for it to be held at QAGOMA. On March 27, 33 delegates arrived for a cocktail reception in the gallery itself, of which we had sole use, followed by the workshop. At first there was a brief introduction by Dr Anna Hallett, who has been facilitating these workshops and Susan Rothnie, one of Queensland Art Gallery’s educators. The topic of mindfulness was introduced together with how the appreciation of art can be used as a mindfulness exercise.

We were then taken into the gallery as four groups by volunteer guides from QAGOMA. Each group spent the best part of an hour looking in detail at and discussing two works of art, both modern and traditional. After our exclusive use of the gallery we returned to the lecture theatre where we were able to discuss the role of mindfulness in our lives, together with general welfare topics. As with the registrar workshops, several learning points came out of the workshop. Most notable was the fact that since the workshop was a CME event worthy of CPD points, it gave delegates permission to take time out for themselves and it was observed how important that simple fact was. Also, delegates found it very interesting hearing how differently their colleagues saw and interpreted a work of art, illustrating the fact that often circumstances at work and at home are open to individual interpretation without there necessarily being a correct or incorrect approach.

Finally the workshop concluded with five minutes of mindfulness and the delegates left the gallery feeling relaxed after their evening of art appreciation. The feedback from the delegates was very positive with comments that the content of the workshops was excellent and that the evening was an enjoyable unique experience. We will continue to hold registrar art and mindfulness workshops at exam time and there was one held at the Museum of Contemporary Art in Sydney at this year’s ASM.

Dr Anna Hallett, Convenor

Faculty of Pain Medicine CME evening

The first Queensland FPM CME evening of 2018, “Opiate stewardship: Let’s make it happen” was held on March 6. Guest speakers Benita Suckling, Acute Pain Pharmacist at Redcliffe Hospital, and Dr Joann Rotherham, Director of the Acute Pain Service at the Princess Alexandra Hospital, gave an informative presentation on the opiate stewardship program. Delegates were provided an overview of analgesic stewardship measures here and abroad, the evidence for positive change and a practical guide to help healthcare providers implement these changes. The evening was well received and attended.

Courses

The focus in Queensland over the past few months has been the primary and final practice vivas. On Tuesday March 20 and Wednesday April 4, Dr Ed Pilling convened the primary practice viva evenings, and Dr Jesse Gilson convened final practice viva evenings on Thursday April 26 and Wednesday May 2. These courses will be repeated again on Wednesday September 5 and Thursday September 13, and final practice on Thursday September 27 and Wednesday October 3, 2018. Trainees should register for the vivas by emailing qldcourses@anzca.edu.au. If you are interested in being an examiner for these evening courses please e-mail kshah@anzca.edu.au.

Above clockwise from left: Attendees enjoying the workshop at the Queensland Art Gallery; Ms Benita Suckling and Dr Joann Rotherham; Primary practice viva evening on April 4.

Tasmania

Tasmanian midwinter meeting

You are invited to book now for the Tasmanian Midwinter Meeting which will occur on Saturday August 25, 2018. The organising committee look forward to you joining us to discuss "Traps and hazards", both in anaesthesia practice and on the fairways, at Barnbougle – one of Australia's top five rated golf courses. Three highly knowledgable and experienced interstate speakers will present on airway mangement, hepatobilary surgery and regional anaesthesia, in addition to a range of high quality local speakers. You can also gain important emergency response CPD points by attending a breakfast anaphylaxis workshop while not missing out on the presentations.

At the end of the day, enjoy pre-dinner drinks as you watch the sun set over beautiful Bass Strait, followed by a three-course sit-down dinner, all included in your conference package. Relax further on the Sunday morning by joining an organised golf round with your colleagues.

Experience a part of Tasmania that many Tasmanians have not, the stunning and barely touched north-eastern coastline. You may also want to visit one of Launceston's Tamar Valley wineries before you head home.

This is the second time the meeting has been held at Barnbougle and has proved to be a very popular destination, so book now!

Visit ww.tas.anzca.edu.au.

Dr Karl Gadd
Convenor, August Mid Winter Meeting

Encouraging students

Dr Nina Loughman and Dr Harry Laughlin provided an educative and entertaining presentation at the recent careers expo organised by the Tasmania University Medical Students' Society at the Medical Science Precinct in Hobart on Thursday May 2, 2018.

More than 130 medical students attended ranging from eager first year to fifth year students. ANZCA also provided a stand manned during the break by Dr Mike Challis, Dr Nina Loughman and Dr Harry Laughlin to answer any questions that the students may have regarding anaesthesia or pain as a career. A lot of interest was shown by the students, who had a lot of questions for the doctors.

This page clockwise from above: Dr Harry Laughlin, Dr Nina Loughman and Dr Mike Challis; Dr Sharon Keripin and Dr Penny Briscoe; Dr Julia Cox.

South Australia and Northern Territory

FPM meeting

The first SA FPM CME meeting was held at the college on February 26. Dr Penny Briscoe gave an update on the recent move of the Central Adelaide Local Health Network (CALHN) Pain Medicine Unit from the Royal Adelaide Hospital to the Queen Elizabeth Hospital. Dr Sharon Keripin provided members with the progression of regulations on medicinal cannabis and codeine prescribing. The June CME will be a joint meeting with the addiction medicine specialists.

CV and interview skills evening

Dr Julia Cox and Dr Munib Kiani recently represented ANZCA at the AMA(SA)'s CV and interview skills evening. The education event was held for medical students and young doctors to assist with getting into a training program.

Emergency response and airway ultrasound workshops

The SA/NT CME Committee held a series of emergency response and airway ultrasound workshops in Adelaide in March 2018. Delegates were able to complete their emergency response workshop requirements in one afternoon by attending both Can't Intubate Can't Oxygenate (CICO) and Anaphylaxis workshops. Two hands on Airway Ultrasound workshops were also offered to delegates.

The CME Committee acknowledges the hard work and commitment of facilitators Dr Paul McAleer, Dr Richard Walsh, Dr Nagesh Nanjappa, Dr Alison Brereton, Dr Christie Lang, Dr Faith Crichton, Dr Zoe Lagana, Dr Nikki Dyson, Dr Kate France, Dr Donna Willmot and Dr Joey Ng who dedicated their valuable time to ensure the workshops were a success.

Part one course

It was great to see so many new faces at the first part one session for 2018. The weekly tutorial is held over the entire year and is open to introductory and basic trainees in independent and rotational accredited training positions and RMOs with an interest in anaesthetic training. All participants are required to present up to three primary topics per year. Staff and trainees are extremely grateful to Dr Agnieszka Szremska, the course facilitator, as well as the numerous consultants who assist the trainees in their presentations.

President visit to SA

ANZCA Immediate Past President Professor David A Scott visited the South Australian regional office in April for the SA/NT Regional Committee Meeting which was also attended by ANZCA President Dr Rod Mitchell from South Australia. Members discussed regional as well as topical issues including the specialist training program, international rural training program and the welfare and trainee survey.

Left from top: Emergency response and airway ultrasound workshops.
Above from top: Part one course participants; Dr Thien LeCong, Professor David A Scott, Dr Scott Ma, Dr Gurunath Murthy and Dr Rod Mitchell.

Australian news (continued)

Western Australia

Autumn Scientific meeting a great success

The Autumn Scientific Meeting was held at Joondalup Resort on April 7 and the theme was "We are all in this together – Volunteerism, self-care and responsible anaesthesia". The delegates consisted of 117 anaesthetists and 30 anaesthetic technicians who enjoyed the sunny surroundings of the beautiful lecture theatre. The autumn meeting was held for the first time at the new venue which was received well by the delegates. The presentations included lectures on sustainability, practical aspects of volunteering with the Red Cross; the Bunny Wilson Lecture was presented by Dr David Perlman and was a highlight for the delegates.

The fully subscribed workshops included "Can't intubate, can't oxygenate", facilitated by Dr Scott Douglas, "How to write, run and mark a mock viva" by Dr Prani Shrivastava and team, and a "SafeTALK: suicide prevention training workshop" by Ms Lorna Hirsh. The feedback has been positive and we thank the presenters, lecturers and sponsors who contributed to the success of the conference.

In 2018 the WA CME Committee will hold the Country Conference from October 26-28, 2018 at the Pullman Resort in Bunker Bay. It is convened by Dr Nirooshan Rooban and Dr Trevelyan Edwards, and a program and registration will be available shortly.

All committee meeting dates for 2018 and committee members are on the ANZCA WA website for future reference.

New South Wales

NSW trainees' Facebook group

The NSW trainee committee has set up the NSW Anaesthetic Registrars' Facebook group as a way of improving interaction between ANZCA registrars across the state, and as part of our efforts to improve trainee welfare. We will also use this group to promote trainee-related educational and social events. Please note that this is a closed group, so you need to be added or approved following a request to be added.

For further information about NSW courses, and the NSW trainee social networks and social events please email nswcourses@anzca.edu.au.

New South Wales

Primary refresher course in anaesthesia

This is a full-time revision course, run on a lecture/ interactive tutorial basis and is most suitable for candidates presenting for their primary examination in the first part of 2019.

Date: Monday December 3 – Friday December 7, 2018
Venue: ANZCA New South Wales Regional Office, 117 Alexander Street, Crows Nest

Fee: $A330 (including GST)

Applications close on Monday November 19, 2018 (if not already filled).

Part Two refresher course in anaesthesia

The course is a full-time revision course, run on a lecture/interactive tutorial basis and is open to candidates presenting for their final fellowship examination in 2019.

Date: Monday December 10 – Friday December 14, 2018
Venue: ANZCA New South Wales Regional Office, 117 Alexander Street, Crows Nest

Fee: $A363 (including GST)

Applications close on Monday November 26, 2018 (if not already filled).

The number of participants for the courses will be limited. Preference will be given to those candidates who will be sitting the primary or final examination. Late applications will be considered only if vacancies exist.

For information contact Tina Lyroid via nswcourses@anzca.edu.au or +61 2 9966 9085.

New South Wales

Part Zero Course

"About to start training in anaesthesia?"

ANZCA welcomes you to the Part Zero Course on Saturday November 3, 2018 from 10am to 4pm at the ANZCA NSW Office, 117 Alexander Street, Crows Nest.

Who is it for?

- New anaesthetic trainees and partners (Partners are also welcome to attend the final session at 2.20pm).
- Supervisors of training.
- Head of departments.

Program highlights

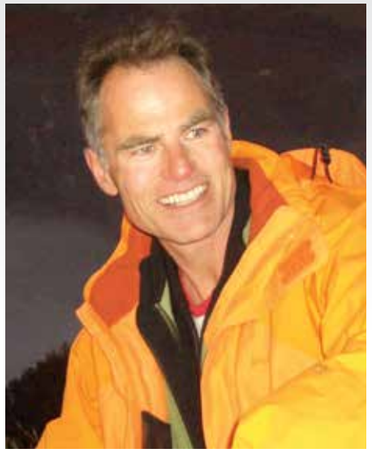
CV, interview, selection – how to get on training?; anaesthesia training – what is ahead for you and your family?; top training tips – curriculum/TPS/WBAs made easy; how to study and PASS the primary exam; FANZCA career options; trainee welfare and mentorship; meet and greet fellow trainees, SOTs and HODs.

RSVP

Tina Lyroid via nswcourses@anzca.edu.au by Friday October 26, 2018.

Obituary

Dr Bruce Marks, FANZCA 1962-2018



It is with great sadness that we acknowledge our friend and colleague, Bruce Marks, 56, of Perth, WA, who passed away on March 4, 2018, at his home in Cottesloe.

Bruce Marks was born in Melbourne, to Ann and Brian Marks on March 3, 1962. He was the youngest of six children. He went to Melbourne Grammar, where he excelled academically. His headmaster wrote that Bruce will have a brilliant career. He was right. He graduated in medicine at Melbourne University in 1985, completing his anaesthetic training in 1995 when he moved to Perth.

I first met him in the mid-1990s when we were senior registrars at Royal Perth Hospital. Our friendship developed around windsurfing and then kiteboarding on the beautiful blue waters of Cottesloe and Gnaraloo.

Bruce conducted a successful practice as an anaesthetist. I worked together with Bruce every Friday afternoon at Bethesda Hospital for many years. He entertained all of us in theatre, while giving anaesthetic sedations for my patients having pain interventions. He was extremely comfortable with both patients and theatre staff. His innate abilities and skills, including his commonsense approach, made working with him a pleasure.

Bruce left medicine in 2007 to follow his passion for sport and travel. He did this over the next decade, accumulating enviable experiences and wonderful friends. Bruce was a person who enjoyed life and lived it to the full. By the age of 56 he had already experienced several lifetimes of adventure.

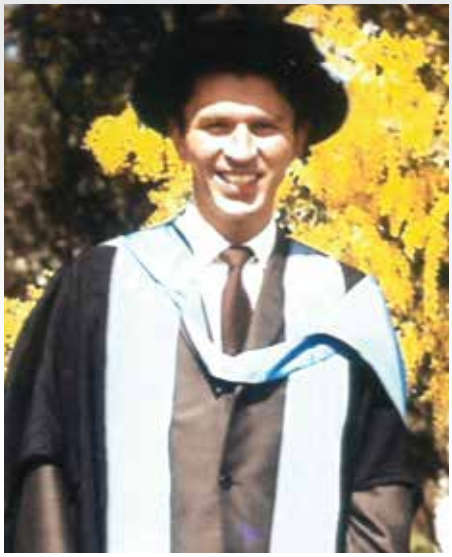
His memory will be remembered on the Western Australian coast, the world's oceans, and on the mountain ranges where he rode the thermals. His large circle of paragliding friends, who responded to his charisma and thoughtfulness, will no doubt miss him.

Bruce's intelligent, sensitive side made him extremely likeable. His friends will remember him as a kind and gentle soul with a love for nature. He was also pragmatic, quirky, absolutely unique, a total riot, and always ready with a huge smile.

He will be profoundly missed by his wife, Carla, and his five siblings, Andrew, John, Jenny, David, and Michael.

Dr Stephanie Davies MBBS FANZCA FFPMANZCA
Painless Clinic
Perth, Western Australia

Dr Donald Stenhouse, FANZCA 1936-2018



Donald Stenhouse was born in Stonehaven, Scotland and grew up in Dars-Es-Salaam, Tanganyika (now Tanzania) where his father was a district officer. Donald said that he was "imprinted" as a child with life in Tanganyika, and "home" was always a plain that was hot and dry with head-high grass.

Donald was sent to school in Stonehaven. He found Scotland bitterly cold, grey and perpetually raining. Nevertheless, he stayed on to study medicine and graduated MB ChB (Aberdeen) in 1961.

Douglas Taylor, a former lecturer in Aberdeen, suggested to Donald that he come and spend a year at Otago University in the Physiology Department, in 1964, as a junior lecturer. Basil Hutchinson was in Dunedin that year demonstrating in physiology. He and his wife Diana got to know Donald well, and this important friendship continued the following year when Donald won a fellowship to do a PhD at the Australian National University (ANU) in Canberra, in neurophysiology and the Hutchinsons moved to Melbourne for Basil to complete his fellowship.

Donald's PhD (ANU, 1968) in neurophysiology was supervised by John Eccles. Ted Hughes recounts asking Donald a clinical question that he answered using the Nernst Equation completely "off-the-cuff". Despite his obvious talent for this field, it seems that the attraction of the increasingly mathematical research of his ANU group began to pale, and Donald decided to return to clinical work. Basil suggested he come to Auckland (where Basil was now based) to do anaesthesia. Interestingly, Donald seemed to show no interest in pursuing further research. Perhaps the standard of the science he had been pursuing was so high (Eccles shared the 1963 Nobel Prize for Medicine and Physiology) that anything less seemed trivial.

On the other hand, he was a hugely valued mentor to me in my own early clinical research. Notably, he put many painstaking hours into extracting data from medical records, and then helping me write the manuscript of Merry... ... Stenhouse... et al (1992). First-time coronary artery bypass grafting: The anaesthetist as a risk factor. *British Journal of Anaesthesia*, 68, 6-12. Donald's encouragement and guidance was pivotal to this work and to the direction of my own career.

Donald trained in anaesthesia in Auckland, won the Cecil Gray Prize for the 1974 final examination, becoming FFARACS and then FANZCA in 1992. He was appointed to a consultant position at Green Lane Hospital, where he practised cardiac anaesthesia with considerable distinction. At that time, cardiac anaesthetists' responsibilities extended into postoperative intensive care, often for days or even weeks after surgery. Donald had a deep understanding of physiology, and was also technically gifted, and very compassionate. Donald's surgical colleagues trusted him completely and he had a wonderfully calming influence when situations became tense. At the request of the vascular surgeons, Donald set up a clinic for patients with ischaemic leg pain, and established his own chemical sympathectomy list (under image intensification). He subsequently taught this skill to several colleagues, including me. For some years he worked closely with Sir Brian Barrett Boyes, and also Alan Kerr, on complex paediatric cardiac cases.

The culture of the department at Green Lane Hospital, led by Eve Seelye at that time, was strongly oriented to full time public practice. In 1987 Donald, John McDougall, and I simultaneously dropped three tenths each to become part-time and enter private practice. I would certainly not have felt able to undertake this radical move without the support of Donald and John. Donald worked in private for many years, primarily at the Mercy Hospital with Clive Robinson and then with Ken Graham, while continuing at Green Lane for most of his career. He was closely involved with the early heart transplants and with many other cutting-edge advances to patient care at Green Lane.

Donald was a Quaker for much of his life, but in his latter years gave up all religion. Understandably, Donald found the social norms of the society in which he spent the first two thirds of his life very difficult. He combined scrupulous intellectual honesty with great kindness and humanity. I have heard from many of his friends about his supportiveness during challenging times.

Diana and Basil visited Donald's mother in Stonehaven in 1985 and were able to tell her of her elder son's success and their friendship with him. Donald also had a sister, who died in a car accident some years ago. He was very close to Bill Pearson (1922-2002) and subsequently to Jim Courtney. He was always a supportive and true friend to me and many others.

Professor Alan Merry ONZM, FANZCA, FFPMANZCA, FRCA, FRSNZ
Auckland, New Zealand