MARCH 2018

ANZCA BULLETIN

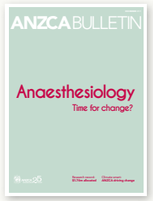
Your feedback:
Fellow and trainee surveys

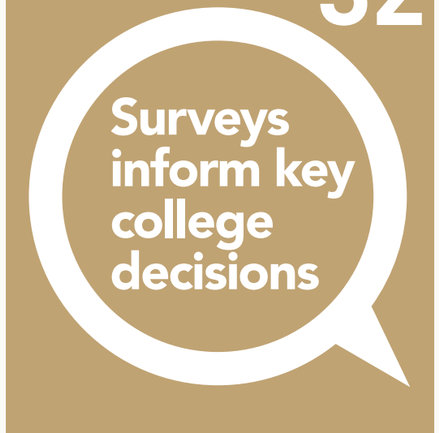
Anaesthesiology:
Your views on change

Warning to doctors: Slow-release opioid risks

ANZCA
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

FPM
FACULTY OF PAIN MEDICINE
ANZCA





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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 across Australia and New Zealand and serves the community by upholding the highest standards of patient safety.

Cover: ANZCA and FPM have commenced an education campaign, warning doctors of the potentially fatal risks of prescribing slow release opioids when treating acute pain in opioid-naive patients.

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We encourage the submission of letters, news and feature stories. Please contact *ANZCA Bulletin* Editor, Clea Hincks at chincks@anzca.edu.au if you would like to contribute. Letters should be no more that 300 words and must contain your full name, address and a daytime telephone number. They may be edited for clarity and length.

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ANZCA
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

President's message

What's going on?

The year ahead promises to be interesting, progressive and challenging, so I thought it might be useful to highlight some of the many areas that our college is working on to advance our specialty and profession, us as individuals, and our ability to provide the best of care for our patients. Much of this work is underpinned by our strategic plan 2018-2022, which is available for scrutiny on the website www.anzca.edu.au/about-anzca.

Education and training. A pillar of college activity is the training of our future specialists and the ongoing continuing medical education (CME) support for our fellows.

This is a huge year for the Education unit, with many significant projects being undertaken to deliver more resources and opportunities.

Perioperative medicine. Following the successful special interest group meeting in November, Dr Sean McManus (ANZCA councillor, Queensland) is working with a core group of fellows, the ANZCA units, and relevant colleges to progress this qualification for those interested, while preserving the opportunity for every FANZCA to continue to be skilled in perioperative care, and for trainees to be fully prepared. While not underestimating the enormity of the undertaking we are leading, real collaboration is being achieved in developing this expanding area of anaesthesia (and other specialty) practice. One project exemplifying perioperative collaboration for better patient outcomes is the Australian and New Zealand Emergency Laparotomy Audit – Quality Improvement (ANZELA-QI) Pilot Project being managed in conjunction with the Royal Australasian College of Surgeons.

GP anaesthesia. In Australia there are roughly 410 non-specialists in rural and regional areas who practise as anaesthetists, providing important services to their communities. ANZCA supports this role of suitably skilled and trained medical practitioners, and has done so for many years in collaboration with the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine in delivering the Joint Consultative Committee on Anaesthesia qualification in particular. This program needs enhancing and updating and so a more formal qualification, a diploma in rural anaesthesia is being established. Governed by ANZCA, it will be collaborative with the above colleges and provide a well-trained and supported workforce of anaesthetists for rural and remote areas where specialists are unable to meet the community needs. Dr Rod Mitchell (ANZCA president-elect, SA) is leading this project.

Rural and regional workforce. In addition to strengthening rural GP anaesthesia, the college is working hard to improve training opportunities which are based in regional centres so that retention and growth of specialist anaesthetists is encouraged. Collaborators in this in Australia include the University Rural Training Hubs and the federal government through the specialist training program. Support for existing practitioners is also important through access to continuing medical education, networks and advice. Appropriate relief for practitioners in remote or rural areas is also vital and we are working with the Australian Society of Anaesthetists on this.

Anaesthesiology. ANZCA Council supports progressing a full analysis of the possibility and implications of a name change of our specialty from "specialist anaesthetist" to "anaesthesiologist". The latter clearly differentiates us from any other providers of anaesthesia care in our community. A name-change is neither a trivial nor easy undertaking for a major credentialing and standards-setting body such as ANZCA. We will work with the societies to ensure that, once an informed discussion has occurred, and should a majority of our members be supportive, then a name change will ensue.

Safe sedation and day procedures. ANZCA considers that the three pillars requiring procedures to be done in licenced facilities are intravenous sedation, large local anaesthetic doses, and large or complex listed procedures. Advocacy to state governments and the New Zealand government has been ongoing. Dr Phillipa Hore (Chair, Safety and Quality Committee, Victoria), Dr Rod Mitchell, Dr Nigel Robertson (councillor, NZ) and I have worked with our national and regional committee chairs on this representation. This advocacy for safer patient care requires collaboration from our surgical and other clinical colleagues, which we are achieving through the help and support of ANZCA's Policy, Safety and Quality unit.

Opioid analgesics. There is much ongoing activity to ensure that opioid analgesics are used safely and effectively for both acute and chronic pain. The Faculty of Pain Medicine, led by the Dean Dr Chris Hayes (NSW), was instrumental in seeking and supporting the regulation of codeine. Jointly with the college, advocacy for more considered use of slow-release opioids is under way, especially in acute pain.

Advocacy and consultation. The heavy load of providing advice and consultative feedback to governments, regulators and other health bodies in Australia and New Zealand is spearheaded by the experienced and professional ANZCA staff. In collaboration with fellows, dozens of often complex documents are prepared and submitted every year, often at short notice, to ensure that the voice of our specialty is heard. One clear example is the Medical Board of Australia's new Professional Performance Framework. Many of these submissions are able to be viewed on our website.

This is my last message in the *ANZCA Bulletin* as president because after two years in this privileged role, I will be handing over to Dr Rod Mitchell at the final session of the ANZCA Annual Scientific Meeting in Sydney. There will be more on Rod in the June *Bulletin* but I would like to say that the college will not be guided by better hands. Thank you for your support and engagement!

Professor David A Scott
ANZCA President

Chief executive officer's message

Review of ANZCA's past five years

In my December column I commented on the achievements of 2017. Now that we have completed the past five-year strategic planning period and adopted an updated plan for 2018-2022, we have also reviewed our performance over the 2013-2017 period.

The revised continuing professional development (CPD) program and new online CPD portfolio system was introduced to fellows as far back as 2014 and two cohorts have now completed the triennial program with very high levels of compliance. The ANZCA CPD structure has proved to be sound in the ongoing development of recertification of the medical profession by the regulators in Australia and New Zealand. We are confident that ANZCA's fellows who comply with ANZCA's CPD system will also be compliant with the regulators' requirements.

I'm pleased to report that in the recent fellowship survey the importance of the provision of CPD by the college was rated as high or very high by respondents. It was also encouraging to read that 87 per cent of fellows correspondingly rated the online CPD program as good or very good.

In 2015 the Faculty of Pain Medicine developed and launched the free opioid calculator, smartphone app and website to promote consistency in converting opioid combinations. This has been widely accepted and adopted around the world since its launch.

ANZCA's highly successful National Anaesthesia Day (NAD), that attracts widespread media coverage, was re-launched in 2013. Since then, NAD has gone from strength to strength in both countries and is a most effective medium for promoting better understanding of anaesthesia and anaesthetists to the general community thanks to strong fellow engagement.

Advocacy with government is a key role for ANZCA on behalf of anaesthetists and specialist pain medicine physicians. It is a very busy part of our lives but the efforts are often unseen by fellows. In 2015 for example, we made more than 100 submissions to governments in both countries. The number of submissions has risen considerably since that time. During 2017 significant resources were devoted to promoting the college's and faculty's position on the introduction of medicinal cannabis, licensing of day surgeries for intravenous sedation and high doses of local anaesthetic, and real-time prescription monitoring.

There have been many more significant achievements over the past five years and I urge you to read the new strategic plan (via www.anzca.edu.au/about-anzca) including the summary of the college's achievements.

Electronic voting

ANZCA is implementing an electronic voting system this year for its elections. Elections will be held for council and the faculty board in the first part of the year and other elections will be conducted in this manner as required through the year.

The electronic voting system will save the college an estimated $A15,000 on the council election alone as there will be no need to print ballot forms and custom-sized envelopes as well as the saving on postage throughout Australia and New Zealand and many overseas destinations.

The new system will be more secure as every fellow will have a unique identifier that will record each fellow's vote as soon as it is lodged. It will also reduce the number of informal votes as it will not permit voting for more than the specified number of candidates.

We also expect that the new voting system will increase the proportion of fellowship voting. ANZCA's traditional participation rate in council elections is around 16 per cent. Other colleges who have introduced electronic voting have seen their participation rates climb to as high as 25 per cent.

Of course an electronic voting system requires that every member needs electronic access and that begins with a valid email address. At this stage we still have a small number of members without email addresses. For the 2018 elections we will allocate unique voting codes for those members and mail them to those fellows without email addresses. This will require them to access the website to vote but it will still be much easier than mailing responses.

I encourage you to log into the ANZCA website (www.anzca.edu.au/membership/login) to update your email address and to make it easier for you to participate in this year's elections.

Visitors from Hong Kong

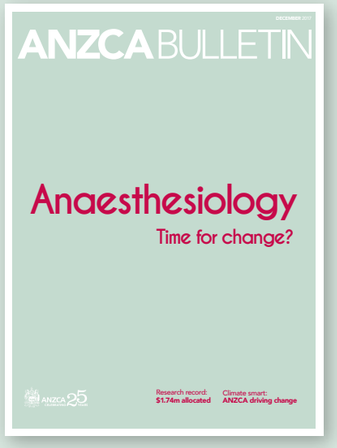
ANZCA will formally conclude its fellowship training program in Hong Kong, Singapore and Malaysia in the first half of 2019. Both ANZCA and the Hong Kong college are enthusiastic about strengthening our ongoing relationship with co-operation in several areas of fellowship training. We were therefore pleased to host ANZCA fellow Dr Tony Ng in February. Dr Ng also sits on the Board of Pain Medicine, Hong Kong College of Anaesthesiologists (HKCA) and was pleased to meet Helen Morris our General Manager, FPM and talk with Dr Michael Vagg about collaboration in education and training for pain medicine.

Our Education unit's Olly Jones and Maurice Hennessy were able to provide information on education initiatives with a view to more a long-term partnership. Dr Ng was in Australia for three weeks, visiting the Royal Prince Alfred Hospital in Sydney and observing at the Royal Children's Hospital in Melbourne.

President of the Hong Kong College, Associate Professor Chi Wai Cheung, HKCA board member and ANZCA examiner, Dr Simon Chan and HKCA CEO, Ms Kristy Cheung will be attending the ANZCA Annual Scientific Meeting in Sydney in May.

John Ilott
Chief Executive Officer, ANZCA

Anaesthesia verses anaesthesiology – your views



Anaesthesiology – an alternative view

In response to the article in *ANZCA Bulletin* December 2017, entitled "Anaesthesiology – Time for change?" I make the following points.

1. The statement that anaesthesia is "the second most important medical intervention – ever" has nothing to do with the case, and could be disputed. It is a chauvinistic beginning to a weak series of arguments.

2. Anaesthesia must be the only branch of medicine whose members feel the need to promote their specialty and to enhance its identity with the community through marketing and communication.

3. I find it hard to believe there are some who complain that patients don't know that an anaesthetist is a doctor. In some 50 years of practice in anaesthetics I cannot recall any such cause for concern. If the number of such people is one in 10, bear in mind that more than twice that number has an IQ below 90.

4. The fact that the term anaesthesiologist is used in 150 countries does not mean much without knowing which countries they are, and how they relate to each other, and to the rest of the world. It is likely that the majority are non-English speaking countries. It is also likely that some have been under the behemothic influence of the United States.

The term anaesthetist has been traditional in an important section of the world, namely the United Kingdom, Ireland, Australia, New Zealand and until recently, South Africa and Canada. It should be remembered that the UK was for many generations the place for aspiring Australian trainees and specialists to learn their theory and hone their skills. The latter were the pioneers of Australian anaesthetics. They lived their lives as anaesthetists.

South Africa still has its College of Anaesthetists, and its *Journal of Anaesthesia and Analgesia*. Canada still has its *Journal of Anaesthesia*. It is sad that both countries have changed to anaesthesiologists in their respective societies.

Perhaps they thought that the name change would better fit with the name of the World Federation, but that is really a non sequitur. Even the Americans have not followed the lead of the world body, as they do not apply the ae digraph.

Britain's closest neighbour, France, a country that protects its language more than any other, and is a member of the World Federation, has its Société d'Anesthésie et de Réanimation, unchanged.

The Americans changed the name from anesthetist to anesthesiologist in 1945. The reason for this has not been made clear. In one important respect the US does not compare with our part of the world. There the word anesthetist, pronounced with a short first e, is reserved for nurse specialists.

What is clear is that the American lead has not been followed by Australia or New Zealand during the intervening 73 years. Our different course is historically and culturally based, and well understood. It gets us into no trouble internationally. It provides us with an honoured distinction – a source of pride, not a cause for shame.

It has to be said that the word anaesthesiologist in our context has a distinct air of pretentious self-aggrandisement. Surely, our stature depends on who we are, not what we are called.

The fact that the World Federation of Societies of Anaesthesiologists has chosen the latter term is a clear case of the weight of American influence that should not be underestimated for its effects on other cultures throughout the world.

5. The idea that the word anaesthesiologist better reflects the role of anaesthetists beyond the operating theatre is hard to understand. Surely where such other activity is a major part of a person's work it is better to express that more specifically, such as anaesthetist and pain specialist.

6. How does the term anaesthesiology encompass the scope of the specialty more broadly? What is it about the suffix "ology"? Does it improve our image to join the ranks of astrologists, iridologists and scientologists? Is the academic and scientific base of paediatrics and obstetrics not sufficiently reflected in their names? Do physicists feel this insecurity?

7. The word anaesthetist has never required qualification by a preceding word such as specialist. Those who use the combination are demonstrating a lack of self-confidence. An anaesthetist is a specialist. The onus is on those who are not specialists to insert a qualification, such as GP anaesthetist, or trainee anaesthetist.

8. The costs involved, and the sheer time and energy that would need to be devoted to this dubious project is not worth any likely good that will come from it. And there will be harm.

9. The word anaesthetist has been in use since 1861. It was a well-chosen term. It has a long history and tradition. I would caution that a symbolic break with our great pioneers in the field could be regretted.

Dr Peter Beahan MBBS FANZCA
Stirling, WA

What's in a name?

We support a name change from anaesthetist to anaesthesiologist.

The article in the December 2017 issue of the *Bulletin* outlines many of the key issues. As board members of the World Federation of Societies of Anaesthesiologists (WFSA), we are frequently struck by the confusion caused by the use of the term "anaesthetist". At a global level, anaesthetist is usually used to describe a non-physician anaesthesia provider or, sometimes, a non-specialist physician anaesthesia provider. Our use of the name to describe a specialist physician provider and the overall lack of consistent terminology matters when talking to governments or the public and contributes to a widespread misunderstanding of our role.

We can understand some resistance to changing to "anaesthesiologist", a term that many people associate with the United States. However, anaesthesiologist (or anesthesiologist) is actually a global name, not an American one. The number of countries using anaesthetist to describe a specialist physician provider is small and dwindling – mostly countries with past strong links to the United Kingdom.

It is worth stopping and thinking about the number of other medical specialties that use the suffix "-ology". Cardiology, pathology, gastroenterology, dermatology, otolaryngology, rheumatology etcetera. At a time when we are increasingly defining our role in terms of perioperative medicine, there is an opportunity to adopt a name that is consistent with the specialist nature of our work.

A final small, but important, point: For some reason, anaesthesiologist is easier to say than anaesthetist. As a specialty, we struggle enough with brand recognition. A change of name to anaesthesiologist will help to define our role and, as a bonus, will be easier to say.

Dr Wayne Morriss FANZCA
Professor Alan Merry ONZM FANZCA FFPMANZCA FRCA
New Zealand

Time for change?

I really think the term anaesthesiology (with "ae") should be used. Every time I go overseas and explain that I am an anaesthetist, I quickly add that in your country it's the same as an anaesthesiologist (if the person is American or European) because an anaesthetist over there is a nurse while an anaesthesiologist is a MD. Heavens above many people in Australia today still do not fully understand that we are trained doctors. To them if you're not a GP then you're not a doctor.

As for Dr David Brooks' letter re marriage equality, I couldn't agree more with his sentiments, especially his statement "...the council does not give the vaguest hint that it has insights into a more complex nuanced conversation".

Bravo Dr Brooks.

Dr Michael Allam FANZCA (retired)
ACT

Awards

Fellows honoured on Australia Day

Congratulations to the following FANZCAs who were appointed as a member of the Order of Australia:

Dr Colin Ross Chilvers, AM, for significant service to medicine in the field of anaesthesia as a clinician, to medical education in Tasmania, and to professional societies.

Clinical Associate Professor Marcus Welby Skinner, AM, for significant service to medicine in the field of anaesthesiology and perioperative medicine as a clinician, and to professional societies.

Associate Professor Peter Laurence McNicol, AM, for significant service to medicine, particularly in the fields of anaesthesiology, liver transplantation, and transfusion medicine.

2018 ANZCA National Anaesthesia Day

- **Mark Tuesday October 16 in your diaries.**
- **Book your hospital foyer space.**

The theme for 2018 is "Anaesthesia is not sleep. It is so much deeper."

ANZCA National Anaesthesia Day is held each year to raise awareness of the crucial role anaesthetists play in healthcare. The aim of the 2018 theme is to help the community understand the extensive skills of anaesthetists that ensure the safety of patients.

An ANZCA initiative, National Anaesthesia Day is held each year on October 16 to mark the anniversary of the day in 1846 that ether anaesthesia was first demonstrated publicly.

ANZCA will send posters and other material to hospitals in late September.

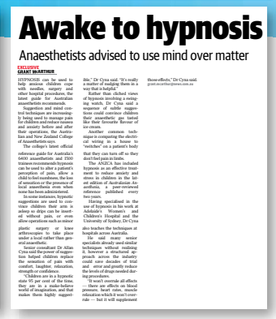
Please contact communications@anzca.edu.au for more information.

ANZCA National Anaesthesia Day

Codeine, hypnosis and fentanyl hot topics in the media


RACE MEDICS UNSUNG HEROES

'I had no warning, it just came on and the lights went out'


Awake to hypnosis

Anaesthetists advised to use mind over matter


Health waste: spinal fusion added to list

Spinal fusion added to waste list

The February 1 codeine up-scheduling changes led to several FPM media interviews and an opinion piece by Dean Dr Chris Hayes in *The Sydney Morning Herald*, *The Age*, *The Canberra Times*, *The Newcastle Herald*, *WA Today*, and another 125 regional and rural Fairfax Media mastheads. A total of 169 news items in 30 days reached 1.2 million readers and had an advertising equivalent value of $480,000.

Dr Hayes was also interviewed by ABC Radio Sydney Drive host Richard Glover on February 1. Dr Hayes and FPM's Director of Professional Affairs Professor Milton Cohen were guests on the nationally syndicated *Talking Lifestyle* Healthy Living radio program on the Macquarie network in the lead-up to the restrictions discussing the codeine ban and alternative pain treatments.

Dr Hayes also appeared on ABC Radio Hobart's breakfast program and ABC Radio Illawarra's morning program. *The Conversation* published an article on opioids by FPM Vice-Dean Dr Meredith Craigie on February 2 which was also published on ABC online. Dr Craigie also appeared on ABC Radio Adelaide's late afternoon program on January 29. FPM's Chair of the Professional Affairs Executive Committee Dr Mick Vagg was a featured guest on ABC Radio Melbourne's 774 morning program where he discussed pain management and alternatives to codeine. Dr Vagg was also interviewed and quoted in an article "Bracing for the Codeine Consults" for medicalrepublic.com.au.

An FPM media release "Clock ticking for over-the-counter codeine sales" on January 8 was followed up by news.com.au, *The Daily Mail* and news radio stations 3AW and 2GB. The radio "grabs" were then syndicated across Australia to nearly 30 radio stations.

The Age on January 24 published a letter from Dr Hayes, "Codeine must be prescribed", in response to an opinion piece by Professor Peter Carroll, the President of the NSW branch of the Pharmaceutical Society of Australia published in *The Age* and *Sydney Morning Herald* on Monday January 22 opposing the up-scheduling decision. This reached 90,000 readers.

Dr Vagg also featured in several media articles on FPM and Choosing Wisely's latest information campaign. A joint FPM and Choosing Wisely media release "New healthcare advice: Benzodiazepines will not help low back pain" led to a page one article in *The Australian* on February 14 which focused on the recommendation to not refer axial lower lumbar back pain for spinal fusion surgery and an Australian Associated Press article that was syndicated to *The Guardian*, sbs.com.au, 9news.com.au and yahoo.com in Australia and New Zealand. The recommendations were also reported by healthtimes.com.au and 6minutes.com.au. This coverage reached more than 2 million readers.

Australasian Anaesthesia (the Blue Book) featured in a *Herald Sun* page 3 exclusive story on January 16 with a report on the hypnosis in children chapter co-authored by FANZCAs Dr Allan Cyna and Dr Rob Laing. The story reached an estimated audience of 1.2 million people and was syndicated to *The West Australian*, the *Gold Coast Bulletin*, the *Daily Telegraph*, the *Hobart Mercury*, the *Cairns Post*, the *Adelaide Advertiser* and the *Courier-Mail*. The issue was also covered by 3AW's morning breakfast program, ABC Radio Melbourne and 6PR in Perth.

In Tasmania, local media covered the awarding of Australia Day honours to fellows Dr Colin Chilvers and Dr Marcus Skinner for their significant service to medicine, anaesthesiology and medical education. Articles on Dr Chilvers and Dr Skinner as Members of the Order of Australia (AM) were featured in *The Mercury* and *The Examiner*. Associate Professor Dr Laurence (Larry) McNicol from Melbourne was also awarded an AM.

Tasmanian print and broadcast media also followed the North West Regional Hospital (NWRH) accreditation issue with interest. ANZCA President Professor David A Scott was interviewed in Melbourne for WIN-TV news in Launceston and *The Mercury* on November 23 and *The Advocate* and ABC Radio Tasmania also followed the story.

The role of anaesthetists as part of the volunteer medical team for the world's largest ocean water swim, the annual Lorne Pier to Pub event, featured in a *Herald Sun* article on Friday January 12 by health editor Grant McArthur. The article profiled former competitor Howard Fuller who collapsed with a heart attack during the event's Mountain to Surf race in 2013. The quick thinking actions of the medical team, including FANZCA Dr Kevin Moriarty, helped save his life. The "Race medics saved my life" story reached a newspaper print readership audience of 350,000 people. Dr Peter Roessler and Dr Mark MacLennan helped facilitate the story with Dr Moriarty and Mr Fuller.

Professor Scott was interviewed by the *Sydney Morning Herald* for a story about fellow Dr Rob Hackett's initiative to have anaesthetists and other medical staff identified by name on their theatre caps (#TheatreCapChallenge) to improve patient safety and teamwork. For more on this story see page 28.

Professor Scott was also interviewed by news.com.au for a feature article on fentanyl in the wake of media reports that an illegal market for the drug is flourishing in Australia.

Professor Cohen was interviewed by Sydney talk back host Steve Price on the top rating 2GB breakfast program on Monday January 8 about the federal government's decision to allow the export of local medicinal cannabis products. The interview reached an audience of 172,000 people.

An ANZCA media release on an ANZCA Research Foundation funded chronic pain study led by FANZCA Professor Paul Rolan was reported by the *Adelaide Advertiser* and Australian Associated Press and nearly 30 other media outlets including the *Courier-Mail*, the *Daily Telegraph* and *The West Australian*.

Carolyn Jones
Media Manager, ANZCA

Since the December 2017 edition of the *ANZCA Bulletin*, ANZCA and FPM have featured in:

- 19 print reports.
- 50 radio reports.
- 180 online reports.
- 1 TV report.

Media releases since the previous *Bulletin*:

Tuesday January 16:
Hypnosis can help reduce anxiety in children before their operation

Monday January 8:
Clock ticking for over-the-counter codeine sales

Monday December 11:
North West Regional Hospital accreditation statement

Thursday December 7:
New chronic pain spinal fluid study may hold key to better treatment

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

Anaesthesia and pain medicine stories joint winners of ANZCA Media Award


Australian writer Kate Cole-Adams (above left) and New Zealand journalist Donna Chisholm (above right) are the joint winners of the ANZCA Media Award for 2017.

Ms Cole-Adams' entry *Vanishing Act* which explores what happens to patients under anaesthesia was published in Fairfax Media's *Good Weekend* magazine.

"The feature article examined the significance of the ongoing – but often overlooked – debate over memory and awareness under general anaesthesia," Ms Cole-Adams said.

Ms Chisholm's report "You Don't Look Sick" was published in *North and South* magazine.

"The editor knew pain management was a significant health issue for readers. I interviewed a number of experts in the field, before finding a new treatment – virtual reality – that is producing promising results in the treatment of chronic pain," Ms Chisholm explained.

The award, for the best news story or feature about anaesthesia or pain medicine, was judged by former ABC journalist, lecturer and media training expert Doug Weller; anaesthetist and *ANZCA Bulletin* Medical Editor Dr Rowan Thomas; and former *Age* health editor and Ambulance Victoria media director Tom Noble.

The award is designed to encourage high-quality reporting on anaesthesia and pain medicine, and to raise the profile of the profession in the community.

The judges described Ms Chisholm's feature as "an engaging, well written, and extensively researched piece that presents highly technical and complex concepts in a way that is accessible to the reader. Donna's report describes non pharmacological treatments for chronic pain."

The judges said Ms Cole-Adams' entry was "a clever and challenging article that both demystifies and celebrates the world of anaesthesia. By putting herself at the centre of the story Kate takes us on a journey that keeps the reader engaged and fascinated by the continuing evolution of our understanding of anaesthesia and leaves the question open about how much more there is to discover."

The articles can be found at:

- www.noted.co.nz/health/health/how-new-technology-helps-patients-combat-pain/
- www.smh.com.au/lifestyle/anaesthesia-what-we-still-dont-know-about-the-gift-of-oblivion-20170511-gw2uhh.html

Carolyn Jones
Media Manager, ANZCA

Safe sedation and new New Zealand government gets busy in first 100 days

Australia

ANZCA hosts roundtables on patient safety and sedation

ANZCA is continuing to engage with other colleges and key stakeholders about safe sedation, particularly in private day facilities. ANZCA hosted the first safe sedation roundtable in Australia on February 14 and another in New Zealand on March 8. The aim of the roundtables were:

- To understand the current safe sedation practices in Australia and New Zealand.
- To identify common principles and standards of safe sedation training across professional groups in Australia and New Zealand and identify areas of difference.
- To articulate the ideal safe sedation experience for patients.
- To identify the next steps in making safe sedation safer.

The feedback and information collected from attendees will inform ongoing work of the college in development of professional standards, learning objectives and training and strengthening patient information.

Following consultation with ANZCA in 2017, the Victorian Department of Health and Human Services (DHHS) released a discussion paper on an update to Victoria's Health Services (Private Hospitals and Day Procedure Centres) regulations. Members of ANZCA's Safety and Quality Committee provided feedback to this discussion paper which can be found in the advocacy section of the ANZCA website.

In South Australia, licensing for stand-alone private day procedures centres is being introduced on May 1, 2018 under the *Health Care Act 2008*. All newly licensed facilities will be required to meet standards of construction, facilities and equipment with reference to the *Australasian Health Facility Guidelines* and maintain accreditation against the *National Safety Quality Health Service Standards*.

Following a meeting with the Minister for Health, Peter Malinauskas in October last year, ANZCA's president and vice-president propose to follow up with the South Australian health department to discuss ANZCA's position on safe sedation in stand-alone private day procedures after the March state election.

Australian submissions:

- Department of Health and Human Services (Victoria) – Statutory duty of candour discussion paper response.
- Department of Health and Human Services (Victoria) – Update to Health Services Regulations (Private Hospitals and Day Procedure Centres) 2013 consultation paper response.
- RANZCP – Administration of Electroconvulsive Therapy Professional Practice Guideline.
- Australian Commission on Safety and Quality in Health Care – Colonoscopy Clinical Care Standard consultation response.

Colonoscopy clinical care standards

ANZCA's representative on the national colonoscopy clinical care standard working group, Dr Phillipa Hore, Chair of the ANZCA Safety and Quality Committee, helped to influence a positive outcome confirming ANZCA's leadership in setting standards for sedation. *PS09 Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures* will continue to be followed. Delivery of IV propofol will only be by medical practitioners and any further ANZCA developed documents on sedation will be regarded as the standard.

Above from left: ANZCA hosted the first safe sedation roundtable in Australia on February 14; Another roundtable was held in New Zealand on March 8; Dr Phillipa Hore, Chair of the Safety and Quality Committee hosted a meeting between the Victorian DHHS officers and representatives from RANZCOG and the ADA to discuss proposed amendments to the regulation of anaesthesia in day procedure centres. From left: Dr Peter Roessler, ANZCA DPA Policy; Jennifer O'Connor and Matthew Hopcraft, ADA Victorian Branch; Adam Fitzgerald, ANZCA Senior Policy Advisor; Dr Phillipa Hore, Chair, ANZCA Safety and Quality Committee; Victor Di Paola, Deb Sudano, Bronwyn Wolfgang and Jinty Wilson, DHHS.

New Zealand

Government policy reviews

With the new government in full swing, it has been a busy start to the year in New Zealand. In December, David Seymour's End of Life Choice Bill passed its first reading and was referred to the Justice Select Committee, which is seeking public comment by February 20. ANZCA's New Zealand National Committee will provide feedback on the draft bill, consistent with the approach ANZCA has already taken in several Australian jurisdictions. ANZCA will refrain from commenting on the need for laws in New Zealand allowing assisted dying, as this is an issue for the New Zealand government and public to determine. However, ANZCA will provide feedback on the proposed legislative framework, to ensure that any legislation does not negatively impact on fellows and patients.

Medicinal cannabis

Medicinal cannabis continues to be an issue to watch. In January, the government's *Misuse of Drugs (Medicinal Cannabis) Amendment Bill* passed its first reading, and was referred to the Health Select Committee. The bill is open for public comment until March 21. The bill would introduce an exception and a statutory defence for terminally ill people to possess and use illicit cannabis, amend the classification of cannabidiol so that it is no longer classed as a controlled drug and enable regulatory standards to be set for the manufacture, import and supply of products. The bill is part of the Labour Party's 100-day plan, which included introducing legislation to make medicinal cannabis available for people with terminal illnesses or in chronic pain. Further information is available here: www.parliament.nz/en/pb/bills-and-laws/bills-proposed-laws/document/BILL_75877/misuse-of-drugs-medicinal-cannabis-amendment-bill.

New Zealand submissions:

- Medical Sciences Council of New Zealand – Revised scope of practice for anaesthetic technicians.
- Pharmac – Proposal to fund pregabalin, and change the funded brand of gabapentin and listing restrictions.
- Pharmac – Proposed bulk fluids listing for DHB hospitals.
- Pharmac – Proposal to list methylnaltrexone bromide.
- Pharmac – Proposal to list anaesthesia small equipment and consumable devices.

Green MP Chloe Swarbrick's member's bill *Misuse of Drugs (Medicinal Cannabis and Other Matters) Amendment Bill* is no longer on the agenda, after it failed to pass its first reading. The bill went further than the government bill, and would have made a specific exemption for any person with a qualifying medical condition to cultivate, possess or use the cannabis plant and/or cannabis products for therapeutic purposes, with the support of a registered medical practitioner.

Mental health and addiction

The government has also announced a ministerial inquiry into mental health and addiction, which will be chaired by former Health and Disability Commissioner, Professor Ron Patterson, and is due for completion in October. ANZCA will monitor the inquiry and if there are opportunities to input we will consult with fellows across ANZCA and FPM.

Pharmac

Pharmac continues to expand its management of medical devices, and has begun negotiating national contracts for anaesthesia small equipment and consumable devices. At this stage, the contracts are not sole supply and district health boards (DHBs) can still purchase alternative products. However, in time, Pharmac will move to market share procurement. The New Zealand National Committee has urged Pharmac to establish an advisory group to provide expert clinical advice about the appropriateness of the products being listed. Dr John Wyeth, Medical Director of Pharmac, has also been invited to the NZNC's March meeting to discuss this issue.

Skills shortage list

The Ministry of Business, Innovation and Employment has advised it is removing the profession "anaesthetist" from the long-term skills shortage list, to take effect from February 19. Employers can still recruit anaesthetists from overseas, but will have to satisfy a labour-market test first, demonstrating they have tried to recruit in New Zealand, but have been unsuccessful in doing so. There is an exception to this, in that employers accredited by the immigration department are still able to recruit from overseas without satisfying the labour market test. A number of DHBs are accredited employers with the immigration department. Although anaesthesia has been removed from the long-term skills shortage list, Resident Medical Officer is still listed on the immediate skills shortage list (aimed at filling temporary skill gaps). This means Resident Medical Officers (excluding those in first and second year) can still be recruited from overseas without having to satisfy the labour market test.

Jo-anne Chapman
General Manager,
Policy, Safety and Quality, ANZCA

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.

- *PS64: Statement on Environmental Sustainability in Anaesthesia and Pain Medicine Practice (pilot)* and its accompanying background paper was approved at the February council meeting.
- *PS51: Guidelines for the Safe Management and Use of Medications in Anaesthesia is currently in pilot.*

Feedback is encouraged during the pilot phase for all professional documents. 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.

Doctors' health and wellbeing – new strategies

ANZCA is in the process of developing new strategies under the theme of "sustainability of the profession". This includes strategic objectives around the health and wellbeing of fellows, trainees and Specialist International Medical Graduates.

Over the past couple of months an understanding has been growing around the wide range of activities already in development and/or in place to support this important strategic priority. We are very grateful for the continued efforts of various ANZCA and ANZCA-affiliated groups, including the Welfare of Anaesthetists Special Interest Group (SIG), in providing support and resources for the health and wellbeing of fellows, trainee and SIMGs.

From an organisational perspective, doctors' health and wellbeing potentially presents an almost limitless scope of work. In order to best harness our individual and collective efforts, the ANZCA Executive Committee is seeking a governing, overarching framework on health and wellbeing. This is intended to guide planning and delivery of actions deemed to be within ANZCA's control, of actions that are best achieved in collaboration with other stakeholders, and, to prioritise the college's efforts strategically over the coming years.

A half-day workshop was held at ANZCA House on February 19 to discuss considerations with regards to developing a draft ANZCA framework on health and wellbeing. Attendees included representatives from: ANZCA trainees, fellows, councillors, FPM and staff, the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists, the Welfare of Anaesthetists SIG and other medical colleges (Royal Australasian College of Surgeons, Royal Australasian College of Physicians and Royal Australian and New Zealand College of Psychiatrists) were present to share their learning/experiences.

Further to the workshop discussion, broader consultation will occur regarding the draft ANZCA framework throughout 2018 in order to ensure it is representative and meaningful for ANZCA and those it aims to support. It is intended that an interim ANZCA framework for doctors' health and wellbeing be completed and in place in 2019/2020.

The ongoing progress of this very important initiative will be reported to Dr Rodney Mitchell, ANZCA president-elect and project sponsor, and the ANZCA Executive Committee.

Information regarding this strategic initiative can be found via www.anzca.edu.au/resources/doctors-welfare.

Carolyn Handley
Deputy CEO, ANZCA

Above from left: Participants at the half-day workshop; panellists sitting from left: Dr Kym Jenkins, President, The Royal Australian and New Zealand College of Psychiatrists, Ms Linda Smith, CEO, The Royal Australasian College of Physicians and Mr John Biviano, Deputy CEO, Royal Australasian College of Surgeons.

What would you do?

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

You really did that?

In this edition I would like to explore the matter of acceptable practice and the impact of changes that occur over time. Research, technology, and outcome data are all drivers of change in clinical practice. However, for many reasons that are beyond the scope of this article, some practices tend to linger.

Going back to when I was a young registrar, sometime last millennium (although not quite yet regarded as an "oxygen thief"), I participated in practices that were at the time contemporary, but that these days could be regarded by most as unacceptable. For example, I recall the challenges we faced with long acting anaesthetic agents and muscle relaxants. In an attempt to speed up changeovers patients were not infrequently transferred to PACU while still intubated. Of course there were many reasons why patient outcomes in those days were poorer than today, however, airway complications were a significant contributor. This was despite anaesthesia colleagues in my training hospital, being rostered to PACU, and the presence of experienced nursing staff.

When I related this story to a young colleague their response was "You really did that?"

So my question is "What would you do if you discovered that I was still engaged in this sort of practice?"

Being a collegial group, we aim to support and work with each other in our endeavours to continually improve our performance. When we notice a behaviour or practice in a colleague that is of concern it behoves us to ensure that this is brought to their attention so that they may be made aware of the concern. However, if the practice is deemed to present a significant risk to patients (or others), under national law there is a requirement to notify the regulatory authorities.

When it comes to deciding whether such a practice presents unacceptable risks to patients and therefore, must be reported, it can be a difficult and vexing discussion in our minds.

In pondering over whether my practice is still appropriate or whether it constitutes significant risks the following questions are triggered in my mind:

- What are the risks associated with caring for an intubated patient and subsequent extubation?
- What is the state of recovery of laryngeal reflexes in these patients?
- What is the state of reversal of muscle relaxation – (neuromuscular monitoring)?
- In the post-surgery setting are intubated patients still considered to be anaesthetised or emerging from anaesthesia?
  - Should I remain with my patients until they are successfully extubated?
  - Should I remain in the facility until successful extubation is achieved?
- Am I immediately available or have I committed to my next patient?
- Have I handed over to another anaesthetist that is immediately available if I am not going to be immediately available?
- Is the PACU nurse specifically trained and adequately experienced?
- Are the majority of fellows engaging in this practice?
- What are my motives for engaging in this practice?

The two main reasons for delaying extubation are either inadequate recovery from muscle relaxants, or inadequate recovery from anaesthesia. We are all aware that dislodgement of an endotracheal tube that is left in situ due to inadequate reversal poses a major risk, and consequently close monitoring by skilled medical practitioners is essential. On the other hand, if the tube is left in situ due to prolonged narcotisation or inadequate recovery from anaesthesia then is the patient deemed to still be anaesthetised? (Refer to definitions in *PS09 Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures*). If so, then handover to a PACU nurse means that airway management and management of anaesthesia is transferred to a non-medical practitioner.

Such action disregards the intentions inherent in *PS59 Statement on Roles in Anaesthesia and Perioperative Care* in which it is clearly stated that "The provision of anaesthesia is a medical role". Transfer of responsibilities to non-medical practitioners sets a dangerous precedent by blurring the roles.

The recently updated *PS15 Guidelines on Monitoring During Anaesthesia* contains recommendations on the use of quantifiable neuromuscular monitoring, which may assist in managing patients in whom neuromuscular blocking agents have been used.

The salient professional document in this instance is *PS53 Statement on the Handover Responsibilities of the Anaesthetist*. It is noteworthy that although responsibility may be shared, the anaesthetist still retains responsibility for care of patients in PACU. Item 4.4 specifically states that "The anaesthetist must be readily available to deal with any unexpected problems, or alternatively ensure that another nominated anaesthetist or other suitably qualified medical practitioner is available and has access to the necessary information about the patient".

While it is appreciated that item 4.2.2 makes reference to instructions relating to specific issues such as airways etc, and it could be interpreted that this includes instructions about extubation, the issue is still whether it constitutes safe practice, and if so, in what setting.

During my early years, hypoxia and upper airway obstruction post-extubation were not an uncommon event in PACUs, and their severity was sufficient to trigger MET calls. The incidence of this has fallen dramatically with the advent of shorter duration anaesthetic drugs including hypnotics/sedatives, opioids, muscle relaxants, along with the development of monitors for depth of anaesthesia and muscle relaxation. These have paved the way for a more controlled environment for extubation and emergence prior to transfer to PACU.

So, if I had retained my practice of having my patients extubated in PACU by the nursing staff, and that on occasions I (or my nominated anaesthesia colleague) was not immediately available while I had an intubated patient in PACU, what would you do? Would you speak to me about it, or to my head of department, if there was one, or would you feel obliged to report me to the regulatory authority? I am grateful that the option of being hung, drawn, and quartered is no longer available as I fear that might have been my fate by popular demand.

All said and done, we are constantly being observed by our nursing colleagues, and irrespective of our actions, it is more than likely that practices perceived to be unusual will be questioned by them and potentially escalated. This underscores the need to ensure that our practices are safe and beyond reproach.

Dr Peter Roessler
Director of Professional Affairs, Policy

Slow release opioids – the need for a statement

The harm that can result from opioids initiated in hospital is evident from increasing reports of adverse events.

The use of slow-release (SR) opioids in the management of acute pain has become commonplace despite overseas guidelines warning against the practice. However, an Australian/NZ opinion has been lacking, with many prescribers unaware that they are often prescribing contrary to product licencing and warnings.

Examples of tragic adverse outcomes can be found in coroners' reports. These cases highlight the fact that using regularly administered SR opioids added to a PCA or PRN opioid regimen can carry the same risk as adding an intravenous background infusion to a PCA, that is increased risk of respiratory depression, better described as opioid-induced ventilatory impairment (OIVI). In these cases, sedation was often not recognised as an early sign of OIVI, especially when respiratory rate was within the "normal" range.

The death in 2014 and subsequent coroner's report of an opioid-naive young man who was admitted with acute-onset debilitating headache also highlighted educational needs. These include failure to realise that pain not responding to immediate-release (IR) opioids does not make SR opioids more likely to work, as not all acute pain is opioid responsive.

The importance of regularly checking on a patient's level of sedation was again a relevant feature.

The management of acute pain should allow rapid titration (up or down) of analgesia, as interpatient opioid requirements vary enormously, even for the same type of surgery or injury. Furthermore, acute pain associated with trauma or surgery can fluctuate significantly within short time periods and often decreases rapidly after the initial onset. The slow-onset and sustained effects of SR opioids make rapid titration impossible and side effects (if encountered) unpredictable and possibly very long-lasting.

In 2016, guidelines published by the Centre of Disease Control and Prevention (CDC) specifically warned against using SR opioids in the management of acute pain. More recently, a guide to opioid prescribing published by the Royal Australian College of General Practitioners (RACGP) similarly notes that only IR opioids should be used in the treatment of acute pain in the general practice setting.

The Faculty of Pain Medicine and ANZCA Safety and Quality Committee recognised that a joint statement was needed to start to effect change in the hospital setting. A working group was formed to draft the statement. This statement was then revised and endorsed by FPM and subsequently the ANZCA Safety and Quality Committee. This document does not constitute a guideline, but a statement of opinion designed to inform and recommend.

It is recognised that change cannot happen without stakeholder engagement, and plans are under way to involve other medical colleges and professional bodies as well as the media. It is time that we start to take greater responsibility for our role as often the initiating prescribers, and for both the acute and chronic sequalae. Anaesthetists are ideally placed to lead stewardship over the use of opioids in the management of acute pain.

Future areas of document development include guidance on discharge opioid prescribing and ongoing use of these medications after discharge. A formal request was made by the RACGP to collaborate with FPM on this matter.

Dr Kim Hattingh, Professor Pamela Macintyre, Professor Stephan Schug, Dr Meredith Craigie and **Dr Phillipa Hore**

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Royal Australian College of General Practitioners (2017) Prescribing drugs of dependence in general practice. Part C: Opioid prescribing, https://www.racgp.org.au/your-practice/guidelines/drugs-of-dependence-c/

Statement on the Use of Slow-Release Opioid Preparations in the Treatment of Acute Pain

RECOMMENDATION

Slow-release opioids are not recommended for use in the management of patients with acute pain.

The inappropriate use of slow-release opioids for the treatment of acute pain has been associated with a significant risk of respiratory depression, resulting in severe adverse events and deaths.

This recommendation is in line with other international guidelines, and statements by regulatory authorities and government agencies[1-5]. The recommendations are also in line with the approved indications for slow-release opioids listed by regulatory authorities including the TGA in Australia, Medsafe in New Zealand, and the Food and Drug Administration (FDA) in the US.

BACKGROUND

1. The Therapeutics Goods Administration (TGA) in Australia and the New Zealand Medicines and Medical Devices Safety Authority (Medsafe) in New Zealand are responsible for the regulation of medicines.
2. TGA and Medsafe approved indications for the use of different slow-release opioids and patches are listed in the product information sheets for each. Indications include *"the management of moderate to severe chronic pain unresponsive to non-narcotic analgesia", "the relief of chronic pain unresponsive to non-narcotic analgesia", "treatment of opioid-responsive, chronic severe pain", the "treatment of moderate to severe chronic pain"* or *"prolonged relief of opioid responsive severe and intractable pain in adults"*. Use in the management of acute pain is not an approved indication. Recommendation is also usually made that SR opioids not be used preoperatively or for the first 24 hours postoperatively.
3. The listed indication for a transdermal fentanyl patch is for *"the management of chronic pain requiring opioid analgesia"*, but note is made that these patches are specifically contraindicated in opioid-naive patients and in the *"management of acute or post-operative pain"* because serious or life-threatening hypoventilation may occur which can be fatal.

CONCERNS ABOUT THE USE OF SLOW-RELEASE OPIOIDS IN THE MANAGEMENT OF ACUTE PAIN

1. Addition of a background infusion to opioid administration by IV PCA is known to markedly increase the risk of respiratory depression[1,6,7]. Administration of a new slow-release opioid in addition to IV PCA or PRN oral opioids is essentially the same as adding such a background infusion.
2. If sedation/respiratory depression occurs as a result of a combination of "background" slow-release opioids in addition to PCA bolus doses, then excessive sedation/respiratory depression is likely to be more sustained than if an opioid PCA background was ceased when excessive sedation was first noted.
3. Interpersonal variation in pharmacokinetics and response to opioids make predicting a dose of sustained-release opioid in an opioid-naive person impossible[1], and if side effects are encountered, they may be of sustained duration.
4. In most patients, pain intensity will decrease reasonably rapidly over a few days. In order to minimise the risk of opioid-related adverse effects, the patient's opioid doses must also decrease over this time.
5. Long-term opioid use often begins with treatment of acute pain[2]. It is known that a proportion of patients prescribed an opioid for management of their acute pain will still be taking an opioid one or two years after discharge[8]. Prescription of slow-release opioids in the initial treatment of pain is associated with an increased risk of long-term opioid use[9]. When opioids are used for acute pain, especially for discharge or in the community, the quantity prescribed should be based on the expected duration of pain which is severe enough to require an opioid[2].

PRACTICE POINTS

1. The most appropriate initial treatment of acute pain using oral opioids is by titration of immediate-release opioids on a PRN basis. Most immediate-release opioids will reach peak effect within one hour[1]. The peak effect of slow-release opioids will not be seen for some hours.
2. For opioid-naive individuals, the initial PRN dose of the immediate-release opioid should be age-based; for patients transitioning from PCA, PRN dosing can be guided by their previous PCA opioid requirements[6]. Such PRN dosing permits treating acute pain in a targeted way, which is variable, often changes with activity, and is likely to improve with time. There is no safe maximum dose of opioid, therefore the importance of titration of the dose according to effect and adverse effects (especially using sedation scores) should be stressed[1,6,10].

Statement on the Use of Slow-Release Opioid Preparations in the Treatment of Acute Pain (continued)

3. In postoperative or post-traumatic patients with prolonged pain states, it may sometimes be useful to introduce a slow-release opioid in a previously opioid-naive individual on a temporary basis after careful reassessment. Consideration should then be given to opioids with the least sedative (and therefore respiratory depressant) effect. In establishing an appropriate dose, time to steady state should also be considered. As daily opioid requirements may vary considerably in the acute pain setting, the dose should be frequently assessed and reduced appropriately. Communication with the primary service (including rehabilitation services) or general practitioner about the temporary basis of this prescription is essential.
4. Patients, who are already taking a slow-release opioid prior to admission, including those in opioid-substitution programs, are tolerant to and physically dependant on that opioid. After independent confirmation of the drug and dose, their slow-release opioid should be continued[1]. The patient's acute pain should be treated using multimodal analgesia including titration with PRN immediate-release opioids.
5. Not all pain is opioid responsive. If excessive sedation develops (as a warning sign of impending respiratory depression), but pain is still present, then reassessment should occur, and consideration be given to non-opioid analgesia. Slow-release opioids in this scenario add further complexity and risk.
6. Accidental deaths from pharmaceutical opioids in Australia exceeds those from heroin[11] and the rate appears to be increasing[12]. Therefore prescription of opioid analgesia for patients discharged from hospital needs to be undertaken with caution due to the risks of abuse, misuse and diversion, adverse effects, and interactions with other medication (in particular benzodiazepines and alcohol), impairment of driving and increased risk of falls[8] .
7. The planning of weaning and ceasing the opioid remains the responsibility of the person who initiated it. The need for discharge opioids should be assessed. Appropriate instructions should be conveyed to the patient about opioid weaning as well as timely formal communication to junior medical staff and/or the patient's general practitioner about discontinuation of these medications in a planned timeframe.
8. Psychological and social aspects of a patient in pain need to be addressed in parallel to medical approaches such as analgesics, even in an acute pain setting. Preoperative anxiety, catastrophising and depression or other mental health issues can amplify a patient's expression of pain, and are associated with increased risk of developing persistent pain. Addressing these may be an important factor in treating acute pain adequately[1].

Note: The term "slow-release" is used by the Australian Commission on Safety and Quality in Health Care in its National Inpatient Medication Chart10 and covers all medications that may be referred to as slow-release, sustained-release, extended-release, modified-release and long-acting. For the purposes of this statement, "slow-release" will also refer to transdermal opioid patches and methadone.

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This statement can be found at www.anzca.edu.au/resources/endorsed-guidelines

Endorsing gender equity

ANZCA and FPM strongly endorse gender equity because of its ethical, social, and economic benefits to fellowship and the broader community. In 2017, a Gender Equity Working Group (GEWG) was established to achieve equal opportunities for all genders.

With four of the past five ANZCA presidents women and strong female representation of trainees (51 per cent between the ages of 31 and 35), some may wonder if the college has a gender equity problem. We do have much to celebrate but there is more that we can do to ensure equal representation of women and men across our fellowship and in leadership and management positions.

As one of their first initiatives, the working group and ANZCA team sought to understand how gender equity affects FANZCAs and FFPMANZCAs using information sourced from ANZCA and FPM databases and responses to the 2017 ANZCA and FPM fellowship surveys. The latter included data from the 1992/5838 (35 per cent) FANZCAs and 124/396 (31 per cent) FFPMANZCAs who responded. All datasets include fellows residing in Australia, New Zealand and overseas.

Cause to celebrate

The historical gender imbalance within anaesthesia and pain management is rapidly diminishing as women enter and complete training. Forty-five per cent of ANZCA trainees are female, indicating more women than previously are being admitted to training. Similarly, recent and imminent female representation in the roles of ANZCA president and FPM dean are closing the gender gap within executive leadership. There appears to be balanced gender representation in clinical anaesthesia and pain medicine practice and opportunities to engage in research success with ANZCA research grants.

Many other issues addressed in the fellowship survey, not reported here, demonstrated small or no gender differences.

Traditionally, women's visibility in research and scholarship has been low due in part to poor representation as invited speakers, panellists, convenors of conferences and delegates[1-3].

But ANZCA has been pro-active on this issue by promoting, mentoring and actively advocating for gender balance in conferences and leadership opportunities. This has been achieved through the Emerging Leaders' Conference, placing the issue on the agenda at the 2017 ANZCA Annual Scientific Meeting (ASM) with a conscious effort to identify and attract female speakers and introducing an onsite crèche for fellows with children attending the ASM. Of the speakers and facilitators at the 2018 Sydney ASM, 33 per cent are women.

Areas for action

In line with other sectors, female FANZCAs are underrepresented in departmental leadership and, compared with men, female FANZCAs and FFPMANZCAs want more opportunities in leadership, education and research.

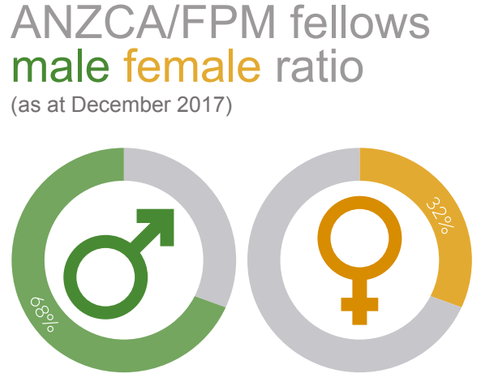
Across society, low female representation in high income professions is a well-recognised hallmark of gender inequality. Women currently comprise 32 per cent of FANZCAs and 25 per cent of FFPMANZCAs and no fellows are registered as transgender or non-binary gender. These figures demonstrate that across all ages, anaesthesia and pain medicine are now male dominated professions. In any discussion of gender equality, it is important to set quotas for representation that are realistic in comparison to the population. Based on representation in fellowship, we accepted 32 per cent and 25 per cent as parity when evaluating current gender representation within anaesthesia and pain medicine, respectively.

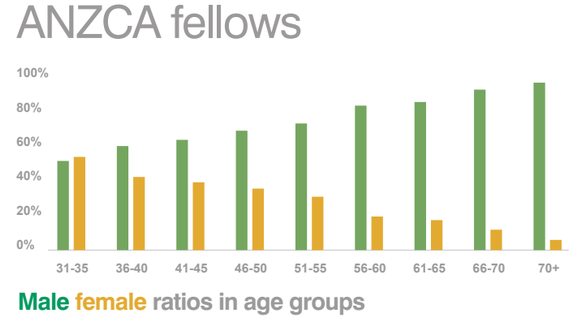
The fellowship survey data confirms that both men and women have family responsibilities and that about one quarter of men and women struggle to achieve a satisfactory work life balance. Meanwhile, male trainees are underrepresented in parental leave. Here, their 4 per cent representation is much lower than other sectors. This however may reflect how the primary and secondary parental leave data has been captured. The data on bullying, discrimination and sexual harassment is worrying overall and reflects similar results from other medical colleges. ANZCA takes an active role in eliminating the incidence and impact of these behaviours for the benefit of all fellows and trainees by developing a working party and position statement on Bullying, Discrimination and Sexual Harassment (BDSH) and more recently through the establishment of the Trainee Wellbeing Working Group. However, the survey results oblige us to address these behaviours as an ongoing strategy.

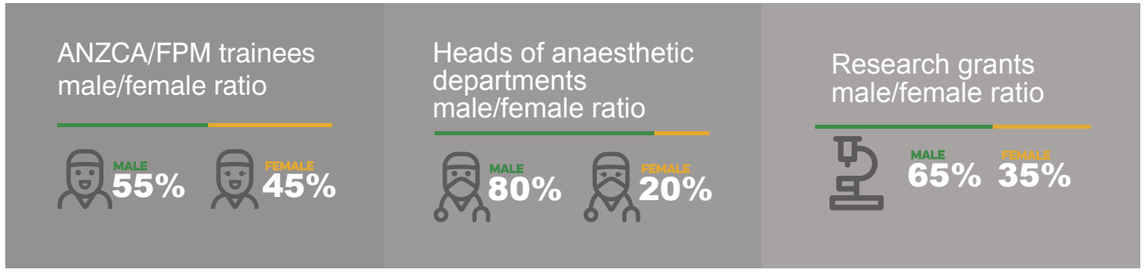
Survey scorecard

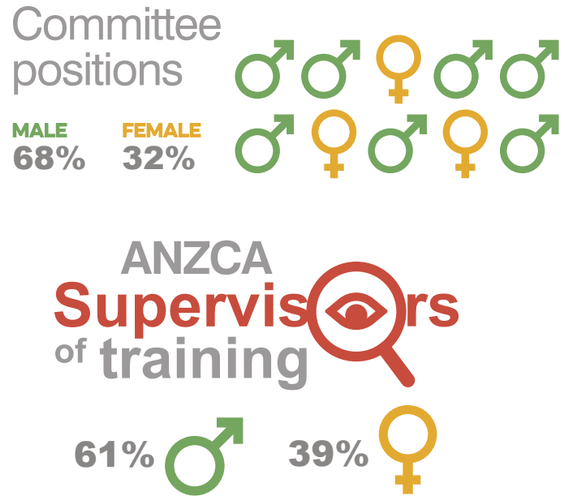
Anaesthesia and pain medicine practice and satisfaction with practice

Access to meaningful and well-remunerated work is another key marker of gender equality[4]. Overall, male FANZCAs currently report more hours of work per week (M 43% v F 37%) with similar data reported for FFPMANZCAs. There were no gender differences in proportions of FANZCAs practicing clinical anaesthesia, acute or chronic pain, intensive care or rural practice, nor were gender-based differences observed in the provision of sub-speciality pain services, among FFPMANZCAs. While the distribution of public versus private practice is not known for FANZCAs, more female than male pain medicine specialists report working in the public sector, in some capacity (M 76% v F 97%) and more females than males report working exclusively in the public sector (M 32% v F 61%). More male than female FANZCAs report feeling "very or quite satisfied" with their practice profile (M 71% v F 64%), with similar findings reported by FFPMANZCAs. Approximately 10 per cent of FANZCAs and FFPMANZCAs desire more clinical work with no gender differences however, more FANZCA men report wanting to work less overall (M 32% v F 24%). Approximately 10 per cent of FANZCAs desire less administration duties however this is higher for FFPMANZCAs (M 19% v F 26%). No income data is available.









Endorsing gender equity (continued)

Leadership and management

Unbalanced gender representation in senior leadership has received considerable attention within the business and academic sectors. This is not simply because of its association with income, but because it is recognised that the perspective and values of leaders influence working conditions, promotion opportunities and culture within the organisations they lead[5-8].

Within ANZCA accredited hospitals, the head of department roles favour males (M 80% v F 20%) and slightly more men than women report having leadership or management roles (M 25% v F 19%). In contrast, while men outnumber women as ANZCA Supervisors of Training (M 61% v F 39%), the percentage of female SOTs is slightly greater than the percentage of female FANZCAs overall. Overall, 41 per cent and 42 per cent of male and female FFPMANZCAs report having leadership and management roles, demonstrating women are relatively overrepresented compared to their population within the FPM. Meanwhile, among FANZCAs who are dissatisfied with their practice profile, more women than men want opportunities to advance in leadership (M 13% v F 22%). This is similar for FFPMANZCAs.

Research and education scholarship

Among FFPMANZCAs, 36 per cent of men and women report having a research component to their practice. This is less for FANZCAs (M 16% v F 12%). Based on three-year data, gender balance has been achieved within recipients of the ANZCA Foundation research grants (M 65% v F35%), including lead investigators (M 64% v F 36%). Slightly more female than male FFPMANZCAs reported desiring an opportunity to conduct more research (M 37% v F 45%) whereas, no gender differences were reported among FANZCAs.

Approximately 50 per cent of FANZCAs and FFPMANZCAs of both genders report having educational roles within their practice and approximately 30 per cent of FANZCAs and 40 per cent of FFPMANZCAs report volunteering to ANZCA committees and or educational initiatives, in some capacity. Here, gender imbalances tend to even out across all roles, which include organiser, lecturer, mentor and facilitator. However, more female FANZCAs report teaching trainees in the workplace (M 81% v F 88%) and seeking more opportunities to advance in educational roles (M 17% v F 27%). This data is similar for FFPMANZCAs.

Wellbeing: Bullying, discrimination and sexual harassment

The fellowship survey included questions on quality of life and options to complete the Kessler (K10) questionnaire and a questionnaire on bullying, discrimination and sexual harassment.

Quality of life is reported as "very good" to "excellent" for the majority of FANZCAs (M 88% v F 88%) and FFPMANZCAs (M 86% v F 79%). However, many FANZCAs and FFPMANZCAs struggle with work-life balance. For example, approximately one-quarter of FANZCAs (M 25% v F 27%) disagreed or strongly disagreed with the statement "my work situation leaves me enough time for my family and/or personal life". The percentage was higher for FFPMANZCAs (M 34% v F 54%). In another expression of work-life balance, a high percentage of FANZCAs "agreed" or "strongly agreed" that "there were occasions when I think I should have taken time off for illness but did not do so" (M 60% v F 61%). This was similar for FFPMANZCAs.

The K10 measures 10 markers of psychological wellbeing and generates a composite severity score in the low, moderate, high and very high range. A small number of FANZCAs (M 10.5% v F 12.4%) and FFPMANZCAs (M 16% v F 4%) scored in the two highest grades. Fortunately, very few respondents rated any of the 10 individual measures as occurring "most" or "all of the time". Overall, however, the responses to the quality of life and K10 questions suggest that work-life balance and mental health are important issues for all genders.

The BDSH questionnaire measured fellows' exposure over a three-year period to a range of unacceptable behaviours. The results, which are more detailed than can be reported here, are concerning overall and in terms of gender imbalance. Here, they reveal that more FANZCA women than men reported being personally subjected to bullying (M 33% v F 42%), discrimination (M 14% v F 28%) and sexual harassment (M 3% v F 8%). In all categories, more women than men witnessed these behaviours, and felt less adequately prepared and supported to deal with them. The results for FFPMANZCAs are not dissimilar.

Obstacles to gender equity

Gender equity initiatives must address factors that hinder participation in the workforce and or promotion. Key factors include gender imbalance in recruitment and training or continuing professional development and or disruptions caused by parenting leave or inflexible working conditions. Where do we stand on these issues?

Data on ANZCA trainee leave patterns indicate that gender influences reasons for interruptions to training with female ANZCA trainees more likely to take leave for parenting roles (M 4% v F 96%) and illness (M 37% v F 63%) while more male trainees interrupt training due to no position being available (M 64% v F 36%). However, time to complete training is slightly longer for males versus female, at 5.9 versus 5.2 years, respectively. As training in pain medicine is often completed after FANZCA training, equivalent data are not currently available.

A number of gender-based preferences for continuing professional development (CPD) are apparent. For instance, interrogation of the ANZCA CPD platform over the last four successive years demonstrates that the percentage of female FANZCAs completing CPD is consistently between 1 per cent and 10 per cent higher than men in eight categories (morbidity and mortality review; team-based scenarios; formal courses; learning sessions, problem-based learning discussions; trainee work-based assessment and cardiac arrest sessions) whereas CPD activities were weighted toward men by between 1 per cent and 10 per cent in two categories (journal reading and patient satisfaction surveys). Delegate registration databases indicate that, relative to their population, women are over represented at ANZCA Special Interest Group meetings (M 53% v F 47%). Analysis of the 2017 Fellowship survey revealed few gender-based differences regarding satisfaction among FANZCAs and FFPMANZCAs
with a range of CPD activities provided by ANZCA and FPM.

When considering obstacles to achieving their desired changes in their practice, more female than male FANZCAs reported feeling that they are "too busy with family commitments" (M 17% v F 26%) however this was somewhat reversed for FFPMANZCAs (M 22% v F 16%). In contrast, female FANZCAs reported feeling that they "lack the necessary skills" to make desired changes to practice (M 5% v F 11%) and this was slightly more pronounced for female FFPMANZCAs (M 5% v F 16%).

Blind spots

Our research has provided a snapshot on data related to gender equity however it does not give the complete picture. Within its remit, ANZCA will continue to gather data with the aim of monitoring progress in achieving gender equality.

Benchmarking

In this article we accepted a benchmark of 32 per cent and 25 per cent for FANZCAs and FFPMANZCAs, respectively. As the gender distribution of younger anaesthetists and pain specialists is changing rapidly, the benchmarks will need to follow suit in coming years. However, we should also ask ourselves "is this the right approach?" Rather than adopting benchmarks that reflect imbalance, several key opinion leaders advocate that we should set benchmarks to model gender equality (as well as racial and other expressions of diversity), rather than just reflect it[1,2]. We endorse this approach.

ANZCA's Communications team is also developing a social media strategy to support the college's gender equity commitment.

Associate Professor Leonie Watterson
Chair, Gender Equity Working Group

The Gender Equity Working Group comprises:

Associate Professor Leonie Watterson, NSW Chair
Dr Vanessa Beavis, NZ member
Dr Bridget Effeney, Queensland member
Dr John Leyden, NSW member
Dr Nicole Phillips, NSW member
Dr Mark Priestley, NSW member
Dr Lindy Roberts, WA member
Professor Kate Leslie, Victoria member
Dr Mike Todd, trainee, member, NZ
Dr Suzanne Cartwright, FPM member
Ms Jan Sharrock, member, GM, Fellowship Affairs
Ms Hannah Sinclair, member, Membership Manager
Ms Kate Galloway, Committee Support Officer
Ms Gabby White, Membership Services

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Learning to live without the lure of alcohol

An anaesthetist, writing anonymously, gives a candid account of how he discovered he had a drinking problem.

It is 3am. I am the medical house officer in a district general hospital in the UK in the last century. A patient is deteriorating, and I am unsure how to proceed. With increasing nervousness I consider my options. I know my senior house officer is busy with another sick patient, and her unclerked admissions are stacking up on the ward. I consider calling the registrar who is on a one-in-two on-call, but hesitate to disturb that doctor's desperately needed sleep. At no point do I consider calling the on-call consultant – that is never done.

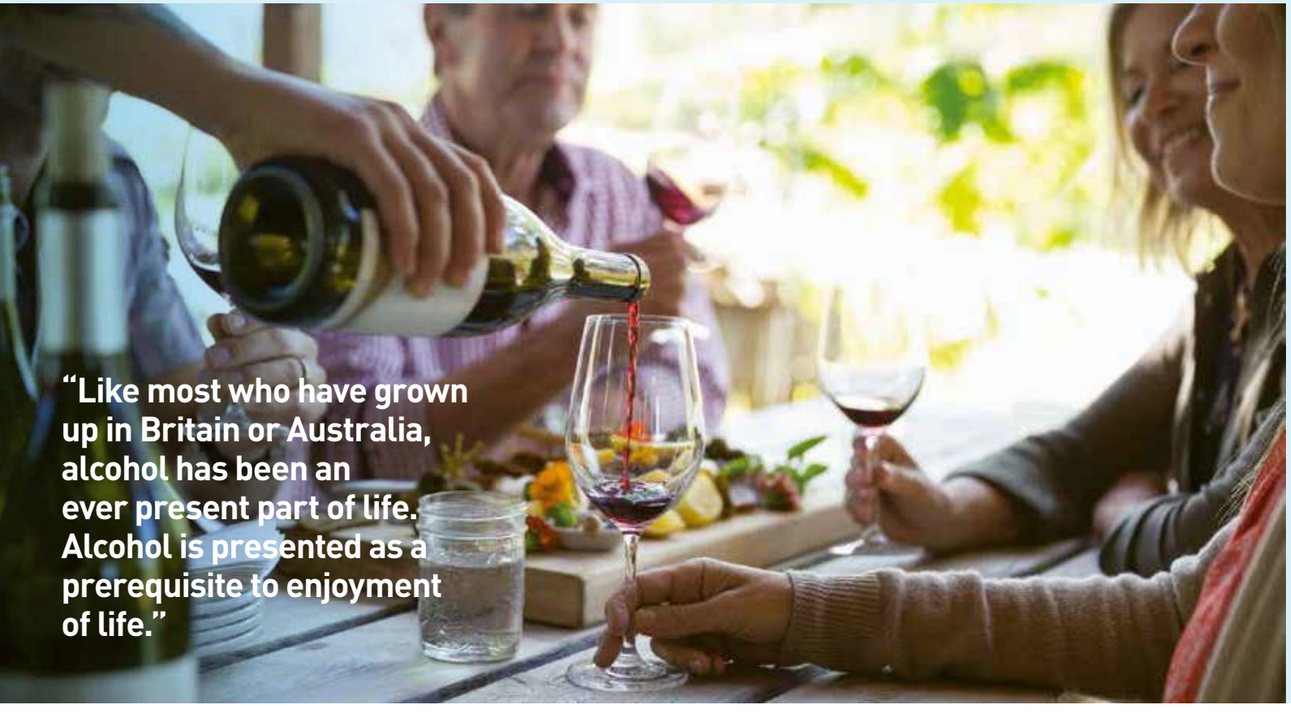
As I desperately flick through the *Oxford Handbook*, the nurse shouts from the patient's bedside to put out a cardiac arrest call. Despite the patient's chance of survival now having diminished considerably, the sense of panic leaves me. Not only is there now a well-rehearsed script to follow, the Advanced Life Support (ALS) algorithm, but help will shortly arrive in the form of the cardiac arrest team.

Twenty years later, as a FANZCA, I attended a session on doctors with addiction at the 2016 ANZCA Annual Scientific Meeting in Auckland. As was usually the case outside work, I was somewhat hungover. I can't remember the exact reasons for choosing the session, but I wonder if subconsciously I was hoping for information or help for my own, as yet unacknowledged, addiction.

Like most who have grown up in Britain or Australia, alcohol has been an ever-present part of life. As children we saw it served at every celebration. We observed admired adults enjoying it, apparently responsibly. At university there was a culture of heavy drinking.

Alcohol is presented as a prerequisite to enjoyment of life. Articles on "the most liveable cities" show photographs of attractive sophisticates enjoying wine. Medical magazines have sections on wine tasting. It is inescapable. As pharmacological tolerance to alcohol develops, it is predictable that most people, on average, tend to drink a steadily increasing amount as time goes on.

My alcohol consumption gradually increased over the years since I had my first drinks as a young teenager and my first binges with my school rugby team. Being drunk became a regular part of my life. Inadvertently I insulted and upset people I love. I remember little of my extravagant and expensive 40th birthday party. I frequently neglected my children as I nursed a hangover.



"Like most who have grown up in Britain or Australia, alcohol has been an ever present part of life. Alcohol is presented as a prerequisite to enjoyment of life."

To protect the personal and psychological wellbeing of its fellows and trainees, ANZCA offers a range of resources.

Visit **www.anzca.edu.au/resources/doctors-welfare** for these resources and to access the free ANZCA Doctors' Support Program.

However, I never went to work drunk, nor did I drive drunk. I never drank alcohol while on-call. In studying for my primary and final exams I stopped drinking for weeks. I fell back on these facts to deny my problem.

Society's attitude to alcohol and our language around alcoholism also fuelled my denial. I couldn't be an alcoholic – alcoholics didn't hold down jobs like me. An alcoholic couldn't be a supervisor of training for years, act periodically as head of department, and become a college examiner. An alcoholic would drink every day, would drink when on call, and would turn up to work drunk – I did none of these. Yet almost every time I drank I became drunk, and most nights when not on-call, I drank.

In the neo-Baroque Great Hall of the Auckland Town Hall I listened to the inspirational Dr Ruth Mayall, a British anaesthetist, describe her descent into alcoholism and drug abuse, and her subsequent recovery. It was clear she was an alcoholic, yet she also never went to work drunk, nor drove drunk. A major pillar of my denial collapsed. Some rickety pillars remained, and it took another year for these to be destroyed before a sustained effort at recovery was undertaken.

I have alluded to some factors that promote denial. In common parlance the term "alcoholic" carries a stigma, and an assumption that one's drinking has already seriously harmed relationships, dignity, employment and other areas of life.

The phrases "alcohol problem" and "problem drinking" are bandied about with no clear definition for most lay people. The language and stigma around alcohol addiction is more than unhelpful, it actively contributes to delays in recognition and seeking help.

Many of us have already lost control over our drinking, and are drinking more and more frequently than we want. Society discourages us from addressing this or seeking help until it has already caused serious harm. Like the cardiac arrest last century, help arrives only after the odds of survival have diminished significantly.

Society classifies alcoholics as "different". As Annie Grace argues in her book *This Naked Mind*, anyone who drinks is potentially at risk of harm from addiction. The division into us ("responsible drinkers") and them ("alcoholics") is comforting for both parties. The "responsible drinkers" are not challenged to address their behaviour – they see no risk of deterioration – and the "alcoholics" are supported in their abstinence.

"Being drunk became a regular part of my life. Inadvertently I insulted and upset people I love…However, I never went to work drunk."

I believe that most drinkers are at risk of descent into addiction, whether that ultimately manifests itself as what we call "alcoholism", or whether that manifests itself as unhappiness or health problems. This is an unpopular view and I wouldn't expect to convince readers in a few paragraphs. I encourage anyone who feels they may have lost control over alcohol, or simply wishes to cut down, to read *This Naked Mind*.

I now do not drink, and I am happier, as are my wife and children. In reaching this point I have called upon many resources. After the support of my wife, the most valuable have been online support communities, including doctors.net.uk and hellosundaymorning.org (with its associated app "Daybreak"). The logic presented in *This Naked Mind* will appeal to doctors who value evidence and critical appraisal. While I disagree with some of the arguments and conclusions presented, there is a wealth of convincing material, appreciation of which has changed my life.

When I moved to Australia in the early part of this century, the Medical Emergency Team or "MET Team" was well established, responding to clinical deterioration and markers of deterioration before cardiac arrest. I have put out a "MET call" for my drinking, and am hopeful the result will be better than if I had waited for the cardiac arrest.

Anonymous, FANZCA

News

High Flow Nasal Oxygen and Fire Risk – cautionary note on device usage

Fire in the operating room is a rare but potentially devastating event. Three factors are required to create fires in the operating theatre: an oxidiser (such as oxygen or nitrous oxide), ignition source (usually diathermy or laser) and a fuel source (e.g. airway devices such as nasal cannula and tracheal tubes)[1,2]. There are number of reports of airway fires occurring during airway surgery including tracheostomy and laser resection during microlaryngoscopy when an airway device (e.g. tracheal tube) is the fuel[2,3]. Broadly speaking High Flow Nasal Oxygen (HFNO) may be associated with fires in 1) airway passage and 2) in the head and neck region (excluding airway).

Airway fires

These cases may occur during "tubeless" techniques when there is no airway device present, the patient is anaesthetised and breathing spontaneously with HFNO and the surgeon are using an ignition source such as diathermy or laser[4]. A recent case[5] of airway fire occurred during hard palate biopsy when Transnasal Humidified Rapid-Insufflation Ventilatory Exchange (THRIVE) and monopolar diathermy were used. An arc occurred between the diathermy tip to a titanium implant, causing a brief ignition on the diathermy grip. This case highlights the fire risk when using diathermy in an oxygen-enriched environment as a result of HFNO during airway surgery.

Other fuel sources, which may ignite in the presence of high FiO2, include burn eschar. Many of these fires go unreported and rarely cause patient morbidity. A flame or spark is often observed at the diathermy or laser tip where eschar acts in a similar manner to a BBQ heat bead. Surgical staff may falsely infer that the ignition source has malfunctioned but there has been accelerated burning of burn eschar leading to a flash fire[6]. Although there may be damage to the diathermy insulation, this may be secondary to the flash fire of the eschar due to the oxygen-enriched atmosphere.

The cause of the fire starts with the accumulation of tissue on the diathermy tip, especially when an arcing technique such as "spray" coagulation is used, and high heat is generated. The tissue debris becomes charred eschar, which then becomes an ember and poses a fire hazard as an ignition source and as fuel6. The fire risk is increased substantially in the presence of HFNO due to the high FiO2. Reducing the FiO2 and expired circuit oxygen concentration below 0.3 is important to mitigate this risk[7-9]. Adequate time (e.g. 2-3 minutes) should be allowed for the FiO2 to drop in the surgical field prior to use of the diathermy or laser.

Surgical prevention of flash fires related to burning eschar include frequent use of abrasive pads to clean diathermy tips or damp sponge for cleaning "non-stick" Teflon and silicone electrodes, using short electrosurgical unit (ESU) activations at the minimum power settings, allowing sufficient time for heat in the diathermy tip to dissipate, avoiding ESU modes intended for arcing coagulation (e.g. Coagulation, Spray, Fulgurate) and do not modify or add to the insulation of active electrodes. Wet drapes and swabs should be placed over any fuel areas in the surgical field. Close communication between anaesthetist and surgeon is essential.

Fires outside the airway and in the head and neck region

The latter cases include the use of HFNO during local anaesthesia and sedation techniques for head and neck surgery[10]. In these cases alcoholic preparations and surgical drapes often provide fuel sources. The increased FiO2 through an open source such as HFNO increases the fire risk. In such cases, the use of HFNO instead of standard oxygen nasal cannula should be carefully considered. The goal should be to deliver the minimum amount of supplementary oxygen to maintain the patient's haemoglobin oxygen saturation at a suitable level[11]. It is suggested that reducing the FiO2 below 0.3 will substantially reduce the risk of fire but it is not eliminated.

The surgeon should consider if non-alcoholic surgical preparations are suitable. If alcoholic solutions are used, sufficient time to allow the alcohol to evaporate completely is important[12]. Anaesthetists should consider the use of non-alcoholic preparations especially in the head and neck region when inserting central lines in the head and neck region prior to surgery[12]. Finally, as oxygen is denser than air, surgical drapes should be positioned around the patient to avoiding pooling of oxygen near the operative site[13].

News (continued)

It is the anaesthestists' role is to ensure the lowest oxygen concentration for patient safety by lowering FiO2 and scavenging oxygen by suctioning. Increasing FiO2 directly increases the risk of ignition and speed of fire propagation while total burn time decreases[14]. This equates to a higher risk of high intensity flash fires. Decreasing FiO2 substantially decreases this risk[15]. The Anesthesia Patient Safety Foundation recommends reducing the FiO2 to less than 0.3 during laser surgery[16]. If possible, standard nasal cannula at flows < 6l/min-1 may be used instead of HFNO [17]. Cannula should be properly placed during the entire surgical procedure. Displaced cannula may lead to high FiO2 in the surgical field and increase the risk of fire[18].

It should be noted that the HFNO cannula themselves are not laser or diathermy-resistant and may act as a fuel source when an ignition source is close by. Catastrophic fire may occur should the cannula be accidently burnt when it is being used to administer high FiO2 levels. Adequate fire safety training and prevention are essential for patient safety when surgical diathermy or laser is intended to be used in close proximity to these cannula.

In summary, HFNO's role in difficult airway management remains a significant advancement in anaesthesia, intensive care and emergency medicine[19-22]. However, extreme caution should be taken with the use of HFNO outside difficult airway management, especially in the presence of an ignition source during airway and head and neck surgery. The risk of fire should be balanced by the benefits of HFNO to the patient. It is recommended that an air-oxygen blender be used with HFNO when performing airway and head and neck surgery. This will allow the operator to reduce the FiO2 to the lowest possible value while supporting the patient's oxygen saturation at a safe level. The prevention of procedural fires when using HFNO requires close communication between health care providers throughout the procedure. Surgical drapes should be configured to avoid oxygen pooling under the drapes and from flowing into the surgical site. Flammable skin-prepping solutions should be allowed to dry before draping. Wet gauzes and sponges should be used around any ignition source.

Dr Keith B Greenland, FANZCA
Chair, Airway Management Special Interest Group

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ALERT: Severe Euglycaemic Ketoacidosis with SGLT2 Inhibitor Use in the Perioperative Period

Background

Sodium-glucose co-transporter-2 (SGLT2) inhibitors ("gliflozins") are oral medications that act by promoting glucose excretion in urine and are used in the treatment of Type 2 Diabetes Mellitus[1,5,6].

There have been recent reports of patients with type 2 diabetes who are taking these medications developing euglycaemic diabetic ketoacidosis (euDKA) leading to severe acidemia requiring ICU/HDU admission during the peri-operative period[2,6].

The clinical chemistry features of euDKA include:

- Acidemia: Plasma pH <7.3.
  - Metabolic Acidosis – Standard Base excess <-5 mmol/L.
  - plasma bicarbonate <15 mmol/L.
- Wide anion gap: anion gap >12mmol/L (albumin corrected).
- Normal or mildly increased plasma glucose: glucose <14 mmol/L.
- Increased plasma ketones.
- Urinary ketones may be normal or increased.

Possible triggers for euDKA include:

- Restricted dietary intake (for example, fasted).

Surgery.

- Dehydration.
- Active infection.

Cases of ketoacidosis with SGLT2i use in type 1 diabetes have also been reported in clinical trials[3].

One possible mechanism for the atypical situation of diabetic ketoacidosis in patients with type 2 diabetes is that SGLT2 inhibitors blunt insulin production in the face of stress hormones leading to increased ketotic metabolism.

Features

DKA should be considered in patients taking SGLT2i who:

Develop drowsiness, abdominal pain, nausea, vomiting, fatigue or unexplained deterioration or acidosis.

Have fingerprick ketone (or blood beta-hydroxybutyrate) levels >0.6 in the perioperative period, or >1.5 at any other times.

Have metabolic acidosis on VBG or ABG.

Note:

1. Normal plasma glucose levels do not exclude the diagnosis.
2. Normal urine ketones do not exclude the diagnosis.
3. Lactic acidosis is an important differential diagnosis but may also precipitate euDKA.

SLGT2 inhibitor agents include dapagliflozin (Forxiga), empagliflozin (Jardiance), canagliflozin (Invokana, available in New Zealand but not in Australia), or a combination with metformin (Xigduo, Jardiamet).

Recommendations for practice

- SGLT2i be ceased up to three days pre-operatively or in other physically stressful situations (the two days prior to surgery and the day of surgery). This may require an increase in other glucose lowering agents during this time.
- Strongly consider postponing non-urgent surgery if SGLT2 inhibitors have not been ceased three days prior to surgery, and blood ketones are >0.6, or where HbA1c is >9.0%, as these are indicators of insulin insufficiency, and a high risk of DKA.
- Routinely check both blood glucose and blood ketone levels in the perioperative period if the patient is unwell or is fasting or has limited oral intake and has been on an SGLT2i prior to surgery.
- If the blood ketone level is >0.6mmol/L in an unwell pre or peri-operative patient, or >1.5 mmol/L in all other unwell inpatients who have been on an SGLT2i, the treating medical officer and the anaesthetist, should be contacted to perform an URGENT ABG or VBG to measure the Base Excess.
- Contact the treating medical officer or endocrinologist or physician on-call for assistance for blood ketone level >1.5 in any patients on these medications.
- euDKA should be treated as a medical emergency.
- All patients with euDKA should also receive a review by the endocrinologist or physician on-call. If required contact your referral tertiary hospital for advice.
- Patients who have day surgery/ procedures should only recommence SGLT2i if on full oral intake. It may be prudent to consider delaying recommencement of SGLT2i for a further 24 hours though consideration should also be given to the effects of withholding SGLT2 inhibitors (and metformin if on combined medication) on glycaemic control.
- For more major procedures, SGLT2i should only be restarted post-operatively when the patient is eating and drinking and close to discharge (usually 3-5 days post-surgery).

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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 at www.anzca.edu.au/fellows/safety-and-quality/safety-alerts

Patient safety: #TheatreCapChallenge goes viral

Sydney anaesthetist Dr Rob Hackett, a champion of patient safety, is thinking big with simple initiatives that he believes will help save lives.

Patient safety campaigner Dr Rob Hackett knew he was onto something when a British student midwife saw his "As mad as a hatter?" tweet and blog post in November last year and created the twitter hashtag #TheatreCapChallenge.

The senior consultant anaesthetist's idea of having hospital theatre staff wear surgical caps with their names to improve patient safety struck a chord with Alison Brindle and within hours #TheatreCapChallenge was being shared with cap-wearing selfies from surgical staff in Australia, the UK, the US, Europe and South America. *The Times* of London soon picked up the story followed by *The Sydney Morning Herald*.

The wearing of cotton hats to identify medical staff in theatre as a way of preventing medical error is just one of several projects Dr Hackett advocates as part of his PatientSafe Network campaign. The projects are listed on the website and he encourages feedback and ideas from hospital staff and specialists through the website and his twitter handle @patientsafe3.

Dr Hackett really does live and breathe his patient safety campaign which emphasises that medical error is the third leading cause of death in hospitals globally, topped only by heart disease and cancer.

His aim is to reduce adverse events in hospitals through the introduction of systems that minimise medical error with the support of frontline medical and theatre staff and their hospital leadership to help drive change.

"There is no getting away from the fact that we all make mistakes but we can change the conditions humans work within – we can change things so there is less likelihood of errors occurring and leading to adverse events."

Saving lives

In 2016 the *British Medical Journal* reported medical error as the third greatest killer in hospitals. If patient safety is to improve we need to accept that:

- An error is something we will all make.
- Learn how to stop errors causing adverse events.
- Have frameworks to put this learning in place.

Source: Dr Rob Hackett, FANZCA, *PatientSafe Network* www.psnetwork.org/fixing-healthcare-safety/.

"Australia is the safest place in the world to have an anaesthetic and could be the Toyota of healthcare if more hospitals embraced change."

"Change can be simple yet it does require a lot of courage," Dr Hackett says.

Among the projects already under way is a campaign to ban the use of the lightly tinted topical antiseptic solution chlorhexidine in hospitals and replace it with a vividly coloured alternative. Dr Hackett believes this simple change in practice will lead to better patient safety and save lives. In a high profile case in Australia in 2010 Sydney woman Grace Wang was in labour with her first child when she was given an epidural of the antiseptic instead of anaesthetic. Mrs Wang almost died and was left paralysed by the procedure.

Dr Hackett believes Australia is already a world leader in patient safety but could still be doing more to reduce the number of unnecessary medical errors.

"Australia is the safest place in the world to have an anaesthetic and could be the Toyota of healthcare if more hospitals embraced change," he told the *Bulletin*.

"The frameworks we exist in don't work to deliver safety solutions. The best we deliver is an alert or a reminder that gets lost in a sea of other alerts and policies and we keep making the same errors again and again."

Dr Hackett believes that for patient safety to improve all healthcare stakeholders should develop a better understanding of the "human factors" approach to patient safety.

"I'm still to meet anyone in healthcare who still doesn't want the absolute best for their patients but we all need to understand the human factors approach to patient safety.

"There is no getting away from the fact that we all make mistakes but we can change the conditions humans work within – we can change things so there is less likelihood of errors occurring and leading to adverse events."

Admitting that his patient safety campaign "was a bit of a lonely ride at first" Dr Hackett sought the advice and expertise of his brother-in-law, a creative director at an advertising company, on how best to get his message across.

The PatientSafe Network website and a "Remove Central Lines Supine" animation video initiative soon followed and then the labelled surgical caps idea took on a life of its own through social media.

Dr Hackett was struck by the virtual default ticking of the boxes in the pre-surgery "time out" form which asks if all medical staff present have introduced themselves and their roles.

"The form was always ticked with this question but it is often never done. And it's quite sad that it isn't and even if it is done we forget each other's names very quickly particularly if we are focusing on something else like keeping someone alive.

"I had tried writing names on whiteboards and has also thought about name labels but these get covered up. And then I thought about the caps and how stupid that would look. But then I thought who cares, we look stupid already walking around in pyjamas."

Dr Hackett says while he can't take credit for the labelled caps as an original idea, the campaign has highlighted the power of social media and commitment from other frontline medical staff around the world to drive change at the hospital coalface to prevent misidentification of staff.

"I love the hats for a number of reasons – it's an obvious patient safety intervention and it's a win-win situation for healthcare. When you now have patients asking 'where's your name on your cap?' you know that this kind of change is possible.

"I work in seven or eight different hospitals in Sydney but interactions are better when we know each other's names. When you're trying to save someone's life as they're having a cardiac arrest and there's 20 people in the room it can be a struggle to even ask for a pair of gloves if you don't know who everyone is. I've now noticed that when I wear my hat other medical staff pay more respect to the time out form.

"While the #TheatreCapChallenge has now gone all over the world change will still take time," Dr Hackett says.

"There are hundreds and possibly thousands of other little things we can do and each will save a lot of lives."

Carolyn Jones
Media Manager, ANZCA

Clockwise from top left: British student midwife Alison Brindle; Labelled theatre caps; Dr Rob Hackett's "mad as a hatter" twitter post; Support for the #TheatreCapChallenge; Anaesthetists show their support.

How a cancer diagnosis taught me the importance of "care always"

Their experiences as cancer patients have led to fellows Dr Sancha Robinson and Dr Robyn Smiles sharing the "care always" principle with anaesthetists and other specialists. Here, Dr Robinson tells her story.

Late last year Dr Robyn Smiles and I were asked to speak about our experiences as cancer patients at a perioperative medicine meeting in Manly. Our message was "care always".

Originally from the UK, I started training as an anaesthetic registrar in Townsville before moving to Newcastle. In 2010, aged 31, I was diagnosed with metastatic bowel cancer. At the time I was in my first year of advanced training, working full time and getting up several times a night to my eight-month-old daughter. There were few symptoms – I found a lump in my belly while I was having a shower. In retrospect I was a bit short of breath when I went for a run (I thought I was just a bit unfit), I was tired all the time (that would be the baby!) and I'd lost a bit of weight.

The lump didn't go away, so after a week I went to my GP who couldn't feel anything, but sent me for an ultrasound scan "just to be sure". I duly attended the same afternoon and after identifying some abnormal looking golf ball sized black blobs I was run through the CT scanner.

The clinic was closing up and only a few nurses and the radiologist were left. Just after 5pm on Thursday October 7 I was called into the radiologist's office. The first thing I noticed was a scan on the light box behind him – I thought to myself "that patient has got something huge in their liver". As the radiologist started talking I realised that it was my scan on the light box. He told me I had right-sided bowel cancer with a liver met and lymph node involvement.

The nurses were crying (they were in the "care always" camp, as was the radiologist who some months later sent me a card to say he was glad I was doing OK).

I did the only sensible thing and phoned my friend who was a surgical registrar in Darwin before driving home to see my daughter and eat cookies and cream ice cream. The next day I went to see my supervisors of training and told them that I really wanted to be an anaesthetist.

Things moved really, really slowly over the weekend. The waiting was hard because it felt like sitting on a ticking time bomb. It was difficult to manage emotionally and I hoped that the radiologist was wrong and that I had secondary TB with its slightly better stats.

I sat alone in my daughter's room in the middle of the night wondering if I would see her walk and talk, let alone go to school and grow up. Why did this happen to me? I'm a doctor, not a patient. Bowel cancer is a theoretical disease that happens to other people. Early the next week my worst fears were confirmed by a colonoscopy and PET scan. The liver surgeon told me I had a 15 per cent chance of surviving five years.

Then things moved really, really quickly. I had a synchronous hemicolectomy and liver resection exactly two weeks after the diagnosis – and I made scones on the morning of the operation and sent them along with jam and cream for the theatre team. I was not too daunted by the prospect of surgery as there was really no option. Ever practical, I updated my will with the help of my father in the days leading up to the surgery.

As I was wheeled in the anaesthesia nurse confided that he had suffered from testicular cancer some years earlier and that he was doing well. It was very comforting to have someone with me who had done this journey too. Post op I spent a few days in ICU, uncomfortably stuck to the bed with drips, catheters, drains and an epidural. I really wanted my mum to look after me but she was in the UK. So the ICU nurse offered to be my mum for the day. She gave me a bed bath, resulting in a wonderful feeling of cleanliness after being covered in sticky Betadine. Years later it's still these acts of kindness that I remember the most.

The pain was excruciating. I forced myself up and out of bed using a walking frame to lap the unit, bent double because my wound was so tight. The drain made me feel like I was impaled on a tree trunk and having a shower took effort equivalent to climbing Kilimanjaro. Rudely I insisted on a blood transfusion which solved my dizziness, and dictated that my urinary catheter should be removed. I was bloody well determined to get out of there as soon as possible and a week after surgery I was home.

"The first thing I noticed was a scan on the light box behind him - I thought to myself 'that patient has got something huge in their liver'."

Following surgery I had five months of chemotherapy. I had a deep vein thrombosis in my shoulder due to my portacath and had chronic pain in my abdomen and shoulder. Throughout the chemo I experienced debilitating nausea and diarrhoea and spent some days in hospital after the first chemo dose due to dehydration and abdominal pain.

The neuropathy in my hands caused me to drop hot cups of tea because I couldn't feel them slip through my fingers. I couldn't feel my daughter's soft baby hair with my fingers and had to use my lips or cheek. I had shooting pain in my cheeks as the saliva came when I ate and shooting pain in my forehead when I cried, which was often.

Neuropathic pain in my feet and lower legs burned, particularly at night. It was like having the worst hangover for months on end, sometimes just a few beers kind of hangover (immediately before the next cycle of chemo) and sometimes a whole bottle of tequila kind of hangover (a few days after chemo). I lived on lemonade icy poles.

My parents, sister and brother-in-law who came over from the UK to help me were very supportive. Despite being a medical professional it was difficult to navigate the system and sometimes difficult to get people to listen to me and I ended up taking someone to every appointment. Working a couple of days a fortnight was like a holiday from cancer because for a few hours I could forget about my problems and help someone else.

There was no local support network for young adults with bowel cancer and the Cancer Council told me that it would be "too distressing when I died" for them to be able to connect me with one of their volunteers one-on-one. I felt very alone.

The hospital psychologist phoned me six weeks after surgery having made no prior contact and, when I explained the massive upheaval my life had undergone, she replied "I challenge you that nothing will ever be the same again".

Eventually I found a local charity which ran a patient support group and I went to speak to Annie Lawrie, a swearing, drinking nun who listened to my story and finally said "it's really shit this has happened to you". It was such a relief that finally someone got it.

I mourned the loss of my future with my daughter, the loss of my independence, the loss of my health, the loss of financial security, and the loss of my marriage (which was not entirely due to the cancer, but certainly partly related to it). Well-meaning people kept telling me to "be positive" otherwise I wouldn't "beat cancer" (Because what else can you say? Just in case you were wondering, this is not the right thing to say!) Initially I found this very difficult. I couldn't pretend to "be positive" if I didn't genuinely feel it. I felt I was failing at this "battle with cancer" and people would think I died because I hadn't "fought" hard enough.

In the end I decided it was absolute rubbish, and the best thing to do was accept how I felt and wallow on the couch in self-pity if I needed to, then pick myself up and get on with it. I learnt to appreciate the small things I could enjoy, like going to music lessons with my daughter or watching the waves at the beach. I had to plan for the worst and hope for the best. I accepted that I might die soon. Walking through a department store one day the assistant tried to sell me anti-wrinkle cream – I laughed and told her if I got wrinkles I'd be doing well.

I changed oncologists and, since our first conversation was about handbags, I knew that she understood me. In May 2011 I had another PET scan which showed no signs of cancer.

Seven years on I remain cancer free. By the time this goes to print my daughter will be eight years old, thriving at school and torturing me with her terrible violin practice. Pilates has fixed my chronic pain.

I have a loving partner and we go sailing and camping together which I find very restorative. I am now a fully qualified anaesthetist and working as a staff specialist and supervisor of training at John Hunter Hospital in Newcastle. I am fortunate to be surrounded by so many incredibly supportive anaesthesia and surgical colleagues who "care always".

For doctors "care always" is a scary thing to do because the traditional teaching is to dissociate from our patients to protect ourselves. Now I strive to "care always" because I feel better when I do. I can drive home knowing I've done the right thing by the patient.

To "care always" does not mean that we have to fix things, just that we have to be prepared to stand unflinchingly with our patient.

"...it is those small acts of kindness that they will remember: the warm blanket, the extra moment to sit and listen, the box of tissues produced at exactly the right time."

As anaesthetists we are in a unique position to "care always" for patients when they are at their most vulnerable. Yes, we must shepherd them through surgery safely and comfortably with all our skill and modern anaesthetic wizardry. But years later it is those small acts of kindness that they will remember: the warm blanket, the extra moment to sit and listen, the box of tissues produced at exactly the right time.

I consider myself lucky to have these experiences. Being a patient has taught me a lot about being a doctor. That the smallest things you can do to show you "care always", even if only for a minute, are incredibly therapeutic for patients.

Dr Sancha Robinson, FANZCA
John Hunter Hospital
Newcastle

Above from left: Dr Sancha Robinson today with her daughter; Dr Robinson at John Hunter Hospital.

Surveys inform key college decisions

"The action plans (one each for ANZCA and FPM) are being prepared through consultation with college units, committees, working groups and individual fellows and trainees."

More than a third of all fellows responded to the recent fellowship survey that seeks feedback from fellows on their attitudes and perceptions and on how the college meets their needs and expectations. Running every three to four years, the survey also assists with the delivery of services to fellows and supports strategic and business planning.

A total of 5934 surveys were distributed to ANZCA and FPM fellows commencing Friday October 27, 2017 and closing December 4, 2017. The overall response rate was 36 per cent for ANZCA and 31 per cent for FPM (dual fellows encouraged to complete the FPM survey) establishing a benchmark for comparison in future surveys. The response rate puts the college in the top 90 per cent when comparing responses with similar organisations.

The FPM survey, a first, was closely aligned with ANZCA's survey. Both surveys asked questions on bullying, discrimination and sexual harassment (BDSH) and health and wellbeing, another first. The completion of these sections was voluntary and ethics approval was applied for and received. Of the total participants, 85 per cent of ANZCA respondents and 83 per cent of FPM respondents went on to complete the BDSH and health and wellbeing sections. Response rates were highest among New Zealand fellows (91 per cent) and lowest for overseas-based fellows (69 per cent).

While the majority of fellows who responded to the surveys have commented favourably on the college, its work and its staff, there are areas where improvements can and should be made. As with previous surveys, the college will develop a college-wide action plan to address areas of concern or where improvements have been identified. The action plans (one each for ANZCA and FPM) are being prepared through consultation with college units, committees, working groups and individual fellows and trainees. ANZCA's Professional Affairs Executive Committees will oversee progress and both the plans and progress reports will be available on the college website.

Feedback and responses to the BDSH and health and wellbeing sections will be used to further support the work being done by the college on the recommendations from the Bullying Discrimination and Sexual Harassment Working Group (www.anzca.edu.au/documents/comms_bdsh-wg-report_20170219.pdf) and to assist in assessing if the recommendations should be reviewed and/or expanded.

Our survey – what we covered

- Current perceptions of the importance of ANZCA's roles and services to the profession – and how well ANZCA is seen to be performing in the provision of these roles and services.
- Overall attitudes towards ANZCA, including perceptions of its image, and satisfaction with its annual subscription fee, CPD events and other services.
- An optional section on BDSH as well as "you and your wellbeing" including mental health, general health, quality of life and desire to practice medicine.

Where possible, the college will also work with other professional organisations to ensure the interpretation of the feedback and initiatives and resources developed for fellows and trainees are done using expert guidance and practice. Consultation with and the role of the Welfare of Anaesthetists Special Interest Group in both BDSH and health and wellbeing will be integral in ensuring the relevance and integrity of all initiatives and resources.

Dissemination of the de-identified findings of the fellowship surveys to college committees will also ensure that there is a broad awareness and understanding of the findings and that where needed work can be undertaken in a consistent and co-ordinated way across committees and college units. Where gender, diversity of location has been identified this too will help support tailoring of initiatives and services.

Thank you to all the fellows who took the time to complete the 2017 fellowship surveys and for your honesty and willingness to provide valuable feedback.

Jan Sharrock
General Manager, Fellowship Affairs, ANZCA

Key findings – ANZCA

In this section are the top findings from the 2017 fellowship survey.

Commentary is supported by graphs where available to better highlight responses and in some instances shows the breakdown of either age, region or gender.

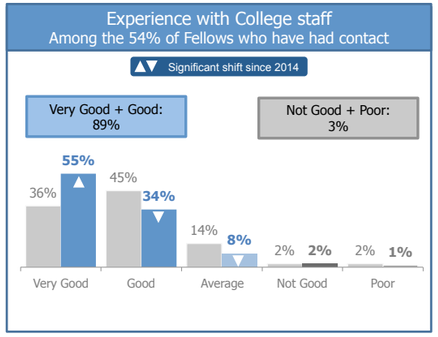
When percentages are quoted they relate to the number of fellows who responded to the surveys.

Feedback that suggests either a deficit or work could be done to improve the college and its delivery of services to fellows has also been included and will form the basis of the action plan.

General

Overall perceptions of ANZCA are positive with 86 per cent of participating fellows rating the college as good or very good. While not directly comparable with 2014, results suggest an increase in fellows rating of ANZCA's performance as very good.

Experience with college staff

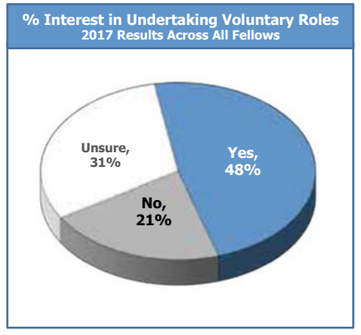


Fellows' experience with college staff has been increasingly positive (89 per cent, up from 81 per cent), with significantly more reporting that their experience was very good (55 per cent, up from 36 per cent).

Eight per cent of fellows suggest that ANZCA could better represent all members, rather than a select few. This pertains to a perceived locational bias (urban, Melbourne, and Australia in particular) as well as those who were better socially connected within the profession.

A total of 83 per cent of fellows are aware of the work and focus of the ANZCA Research Foundation with some work needed on promoting the support of overseas aid and Indigenous health activities.

Future intentions: With regards to voluntary roles

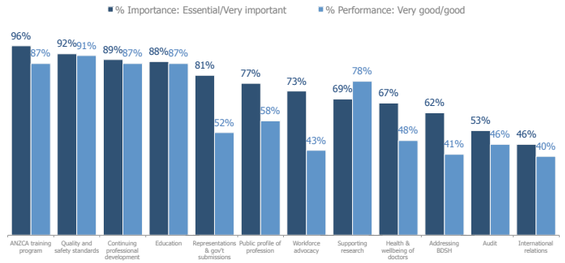


Sixty per cent of respondents are currently undertaking a voluntary role with the college and 48 per cent of all respondents indicated a preference to undertake a voluntary role in the future, with the most desirable roles being examiner, accreditation visitor, lecturer and supervisor of training. Interest was highest among new fellows (72 per cent) and those aged under 40 (74 per cent).

The performance of Networks, the learning management system used by the college was not rated highly by fellows with 40 per cent of respondents indicated they had not used Networks, or that its performance was average or below. The college committed to undertaking work to enhance and improve the system and the fellow experience.

The services seen to be the most important/valuable for ANZCA to provide are the training program and quality and safety standards followed closely by continuing professional development (CPD) and education.

ANZCA roles: Importance versus performance



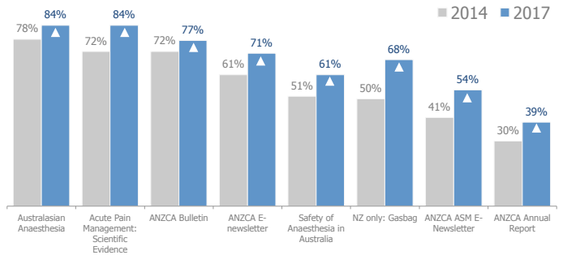
Fellows also believe that ANZCA should play an important role in advocating for the speciality, raising the profile of the profession and supporting initiatives that deal with doctors' wellbeing and BDSH.

When assessing ANZCA's performance against all roles, 2017 results show significant increases from 2014. In areas where fellows indicate ANZCA's performance could better meet the level of importance of a role (for example workforce advocacy, public profile of profession, health and wellbeing and addressing BDSH), the college will better communicate the work done in these areas as well as the outcomes.

Communications

There has been a significant increase (on 2014) in fellows' good and very good rating of ANZCA's various publications and communications with *Australasian Anaesthesia*, *Acute Pain Management: Scientific Evidence* and the *ANZCA Bulletin* the top three performers.

ANZCA publications and communications: Trend results



Surveys inform key college decisions (continued)

When asked what topics they would like to see have greater coverage, fellows indicated that CPD, safety and quality, health policy and government submissions and college events and conferences.

As was the case in 2014, a strong majority of fellows (steady at 83 per cent) say the current amount of ANZCA email communications is about right.

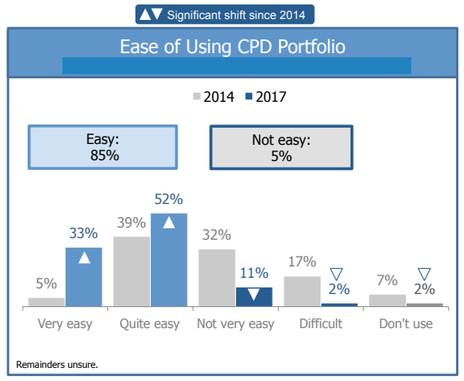
It is evident that while social media (Twitter and Facebook) is used well at events and conferences there is more work to be done to engage with fellows using this communication channel.

CPD

The CPD Program (portfolio and events) has seen improvement since 2014. In 2017, CPD portfolio ease of use is significantly higher when compared to 2014 results, with far fewer fellows finding the portfolio not easy to use.

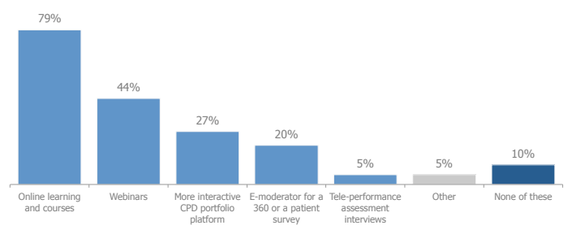
Fellows' perceived usefulness of CPD events has significantly increased since 2014, particularly those who find events very useful (32 per cent up from 17 per cent) with a majority (72 per cent) of fellows overall finding the CPD events useful.

CPD Portfolio: Ease of use



Overseas-based fellows are less satisfied with the usefulness of these events with the college looking at more online access and flexibility around the ANZCA annual scientific meeting (ASM) in particular.

New approaches to learning and assessment



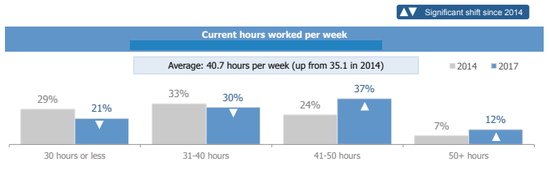
The majority (79 per cent) of fellows support the inclusion of online learning and courses in CPD activities and value highly peer review, multisource feedback, access to the ANZCA Library, workshops and the CPD dashboard when completing their CPD requirements.

Nearly one in two fellows (47 per cent) reported that their clinical workload presented a barrier limiting their participation in CPD activities, while around one in three noted that their family commitments (37 per cent) and/or availability of relevant activities (30 per cent) hindered their participation. Nonetheless, one in four fellows (25 per cent) reported experiencing no barriers to CPD participation.

Workforce

Fellows have indicated that there has been an increase in the number of hours worked (up 5.6 hours since 2014, from 35.1 to 40.7). A majority of fellows rated their quality of life, general health and psychological levels positively; one in four disagree their work situations leaves them enough time for family/personal life and six in 10 indicate they have worked through illness.

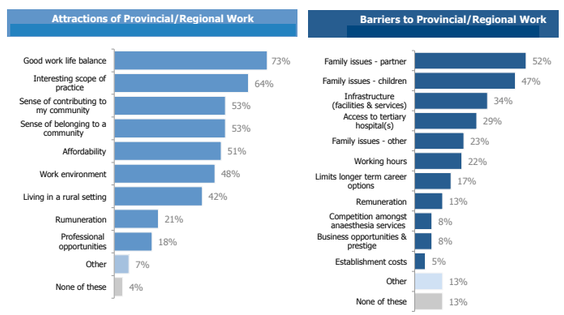
State of practice



Those fellows working in a provincial/rural/regional area find having a good work life balance (73 per cent) and interesting scope of practice (64 per cent) to be key attractions. Nonetheless, fellows overall see family issues – particularly those related to their partner (52 per cent) and/or children (47 per cent) – as barriers to working in such a location.

Nine in 10 fellows (91 per cent) are satisfied with their practice profile, with two in three being very and quite satisfied (68 per cent). The most common change to the practice profile desired by fellows is to work less overall (29 per cent) with the one in four fellows (25 per cent) who feel that their clinical workload is a barrier to changing their practice profile.

Provincial and regional work



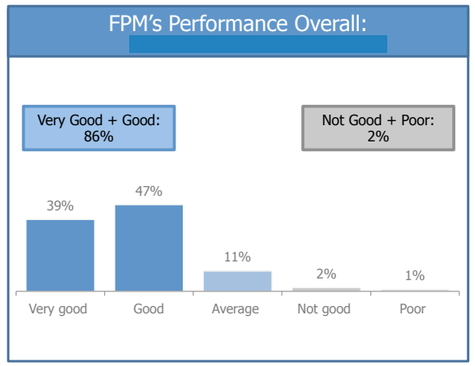
Key findings – FPM

In 2017 for the first time, FPM conducted a fellowship survey and for the most part aligned their questions with ANZCA. The feedback from fellows will allow the faculty to set benchmarks for future surveys and to develop its action plan on how to better provide and enhance services to fellows. Information will also assist ANZCA. Dual fellows of both ANZCA and FPM were encouraged to complete this survey.

General

Overall perceptions of FPM are positive (86 per cent rate it as good or very good). Nonetheless results are lower for overseas-based fellows and those aged under 40.

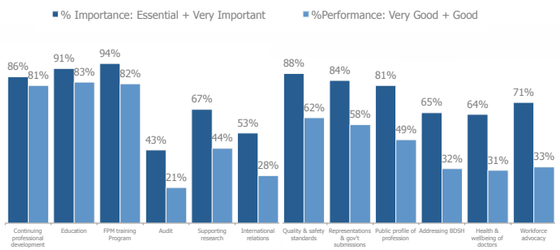
Perceptions of FPM overall



A clear majority (86 per cent) of fellows rate the performance of the faculty as very good or good overall – with more than one in three (39 per cent) rating performance as very good.

The services seen to be the most important by fellows for FPM to provide are the training program, education, quality and safety standards and continuing professional development (CPD).

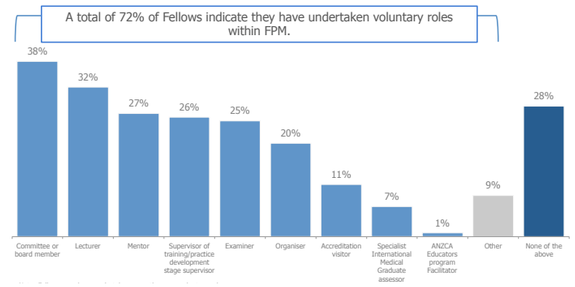
FPM roles: Importance versus performance



While four in five fellows rated FPM's performance as good or very good in the provision of education (83 per cent), FPM Training Program (82 per cent), and CPD (81 per cent) there is room for improvement in regard to quality and safety standards, profile of the profession and advocacy. Work is being done in these areas however it seems that greater communication of what is being done and the outcomes is needed.

Around three in four (72 per cent) fellows have undertaken voluntary roles within the faculty with the most frequently reported roles, a committee or council member (38 per cent), followed by lecturer (32 per cent), mentor (27 per cent), supervisor of training/practice development stage (26 per cent), and examiner (25 per cent). Fifty-one per cent of fellows indicated they would be interested volunteer roles in the future.

Voluntary roles undertaken within FPM



Communication

The majority of fellows expressed a desire for greater coverage of topics related to FPM in the *ANZCA Bulletin* and e-newsletters; particularly CPD events, news and opportunities, health policy and submissions to the government, and FPM and ANZCA events and conference. Stories on research and researchers was also identified as a priority.

The publications most highly rated by fellows were *Acute Pain Management* (90 per cent good or very good), *Synapse* (81 per cent), and the *ANZCA Bulletin* (76 per cent). The vast majority of fellows were unsure of how to rate Twitter (81 per cent), Facebook (85 per cent), and YouTube Channel (89 per cent).

Explaining the benefits and multiple uses for social media will help fellows better engage with these communication channels.

Advocacy

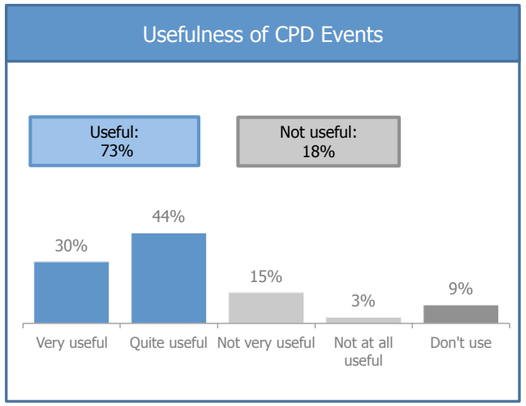
More than one in 10 fellows suggests that the faculty could advocate for the profession to a greater extent (15 per cent) and better represent all members, rather than a select few (11 per cent) for example, advocating the importance and uses of pain medicine to government so that the role and value of the profession is better-understood.

Surveys inform key college decisions (continued)

CPD

Results for the FPM CPD program (portfolio and events) are mixed, but an opportunity exists for deeper engagement with fellows. Nearly a third of fellows do not use the CPD portfolio at all – an area for focus. Nonetheless, three in four fellows find locally organised CPD events useful; a majority of fellows are satisfied with the types of CPD activities they do undertake; and one in four fellows experience no limitations to their participation in CPD activities.

Locally organised CPD events



The CPD activities that fellows cited as most beneficial to their practice and CPD were meetings and workshops (27 per cent), lectures and conferences (19 per cent), and ASM/scientific meetings (15 per cent).

Workforce

FPM fellows are working an average of 40.5 hours per week, with more than one in two (55 per cent) working more than 40 hours per week. Nearly half (46 per cent) of all fellows expect to retire within the next 10 years and the majority of fellows (86 per cent) practice in a metropolitan area.

Half of all fellows' practice hours (51 per cent) are spent working in chronic non-malignant pain services, with only 8 per cent of hours spent working in acute pain services, and 4 per cent in cancer pain services.

Practice profile: Distribution of hours

Breakdown of Practice Hours	
Practice Areas	
Chronic non-malignant pain services	51%
Acute pain services	8%
Education	8%
Other sub-speciality	7%
Leadership & Management	7%
Administration of Services	4%
Research	4%
Cancer pain services	4%
Other	7%

When asked about what change fellows most desire to make to their practice profile the feedback was more opportunities to conduct research (40 per cent). The next most desired change to practice profiles is to work less overall (30 per cent). Fellows cited their heavy clinical workload as the primary barrier to making their practice profile more desirable.

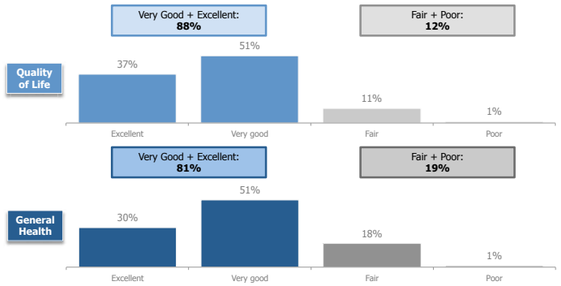
Health and wellbeing and bullying, discrimination and sexual harassment

The following commentary provides an overview only of responses to the health and wellbeing and BDSH sections of both the ANZCA and FPM surveys. As previously stated the college is seeking support of experts in these areas to interpret the results, and then to support actions that can be undertaken by the college to better support fellows.

ANZCA health and wellbeing

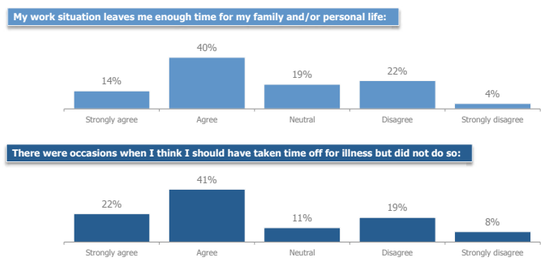
A series of questions were asked based on the internationally recognised Kessler Psychological Distress Scale (K10). More information is available at: www.beyondblue.org.au/the-facts/anxiety-and-depression-checklist-k10.

Quality of life and general health



The majority of fellows rated their quality of life positively, with nearly nine in 10 saying that their quality of life was very good or excellent. Similarly, general health was rated positively by the majority of fellows.

Work-life balance



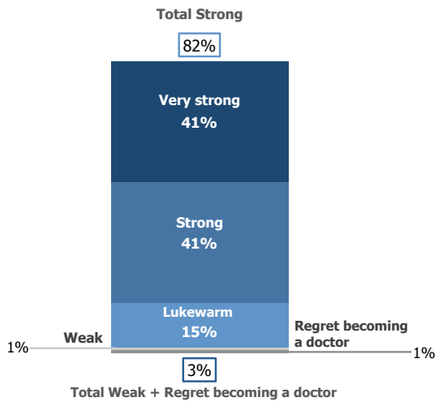
One in two fellows strongly agree or agree their work situation leaves them enough time for family/personal life (54 per cent); although one in four (26 per cent) disagree or strongly disagree. Six in 10 fellows (63 per cent) say they worked through illness when they should have taken time off.

Although the clear majority of fellows fall into the low or moderate category of psychological distress (89 per cent), one in 10 fellows is experiencing some higher levels of distress.

There is a sentiment among fellows that there is stigma attached to divulging mental health issues (89 per cent agree or strongly agree). Two in three Fellows (65 per cent) would not want people to know if they were suffering from mental health issues.

Overall, the desire to practice medicine among fellows is still quite strong, with 85 per cent stating their desire to practice is strong or very strong.

Desire to practice medicine



ANZCA – BDSH

The results of the bullying, discrimination and sexual harassment (BDSH) sections of the fellowship survey have been passed to Carolyn Handley, ANZCA's Deputy Chief Executive Officer who is responsible for the development and implementation of a fellows' health and wellbeing program and for the ongoing review and actioning of the recommendations of the BDSH Working Group.

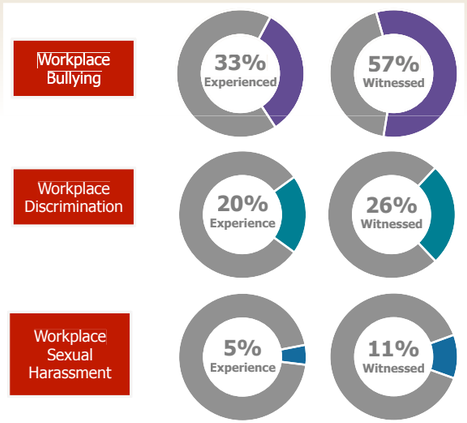
Other college committees and units have also been provided with the feedback to further assist in developing action plans around BDSH.

Overall results from the BDSH questions show that 33 per cent of respondents experienced bullying with 57 per cent witnessing it; 20 per cent experienced workplace discrimination and it was witnessed by 26 per cent while 5 per cent experienced sexual harassment with it being witnessed by 11 per cent.

About two in three fellows who responded to the survey felt that they were adequately prepared and supported to deal with BDSH and had received formal education and training on identifying, managing and preventing it.

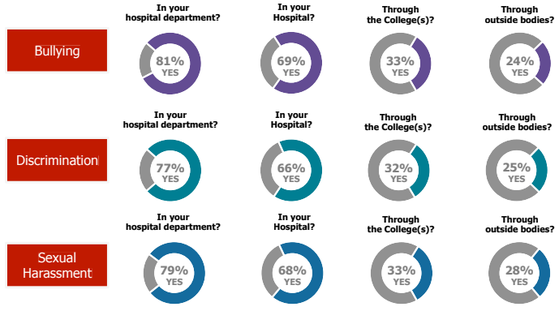
Surveys inform key college decisions (continued)

Summary of key results: Reported BDSH occurrence



While the majority of fellows report knowing how to seek help regarding BDSH through their hospital, only a minority know how to seek help through their college(s) (approximately one in three) or through outside bodies (approximately one in four) leaving room for improvement and feedback that will inform the college's action plan.

Know how to report or seek help regarding



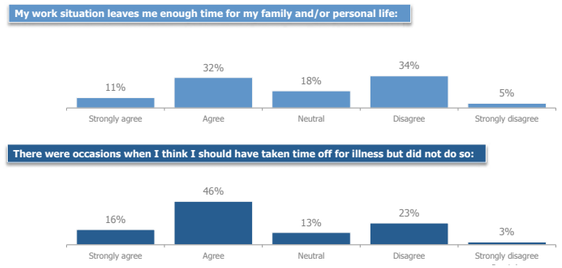
When looking at gender specific results there is a significantly greater incidence of bullying being personally experienced and witnessed by fellows who are female and they feel significantly less prepared to deal with bullying behaviours in the workplace. Female fellows experience a significantly greater incidence of discrimination, two times more likely than males and are also more highly represented when it comes to sexual harassment in the workplace.

Feedback shows that the college would better support fellows by providing ongoing education and training especially related to reporting of and seeking assistance for when BDSH occurs.

FPM health and wellbeing

The majority of fellows rated their quality of life (84 per cent) and general health (72 per cent) as excellent or very good.

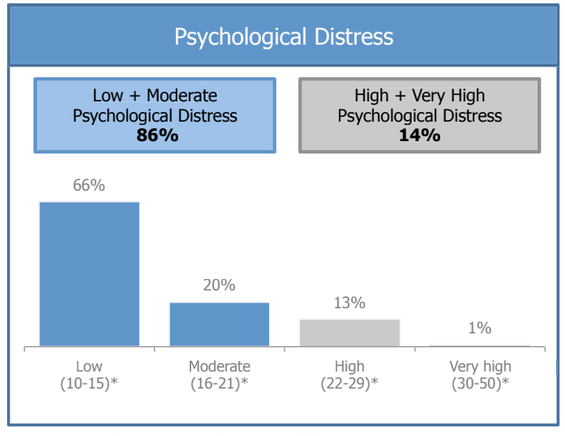
Work-life balance



Despite the majority of fellows rating their quality of life, general health and psychological levels positively, one in four disagree their work situations leaves them enough time for family/personal life and six in 10 indicate they have worked through illness.

Four in five fellows (81 per cent) maintain a strong or very strong desire to practice medicine.

Mental health and the Kessler Scale



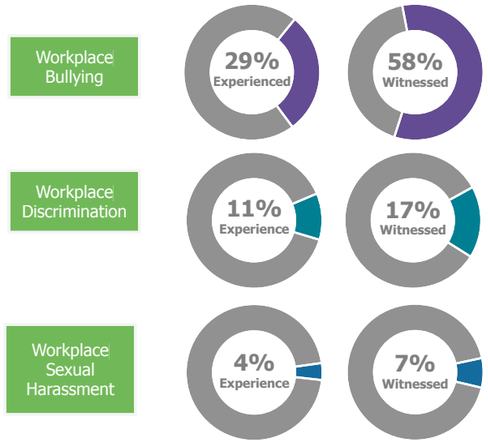
*Note: Scoring of Kessler Scale follows ABS score groupings and categories.

Two in three fellows (66 per cent) have low levels of psychological distress, a further 20 per cent have moderate levels of psychological distress. To note, 13 per cent of fellows experience high levels of psychological distress. This is significantly higher than the ANZCA respondents.

FPM – BDSH

The feedback from the inaugural FPM fellowship survey, including the section on BDSH will be valuable in guiding the faculty's priorities and support delivery of the FPM: Strategic Plan 2018-2022. These actions and initiatives will also contribute to the overarching college action plan.

Summary of key results: Reported BDSH occurrence



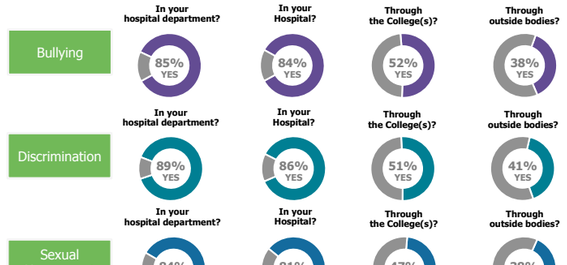
Overall results show that 29 per cent of fellows responding to the survey personally experienced workplace bullying with 58 per cent personally witnessing it; 11 per cent personally experienced workplace discrimination and it was witnessed by 17 per cent and 4 per cent personally experienced workplace sexual harassment with 7 per cent personally witnessing it.

Around three in four fellows feel adequately prepared and supported to deal with bullying (77 per cent), discrimination (75 per cent), and sexual harassment (75 per cent).

As with the ANZCA results, female fellows report a higher incidence of personally experiencing bullying, discrimination and sexual harassment. Fellows who are female are significantly less likely to feel prepared and supported to deal with BDSH behaviours in the workplace.

Fellows' knowledge of how to report and seek help for these issues, especially though the college/faculty is an area where further work is required and will be reflected in the action plan prepared by the college and faculty.

Know how to report or seek help regarding



Faculty of Pain Medicine

Dean's message

Drawing towards the end of my two-year term as dean I find myself in a reflective mood, pondering our faculty's achievements and challenges.

Differentiating nociception and pain

In reading a recent peer-reviewed pain journal I was drawn to an editorial discussing procedural approaches to the problem of sacroiliac joint pain. The author reviewed the utility of diagnostic blocks to target the presumed peripheral generator, the sacroiliac "source of pain". In response I considered the body of accumulated neuroscience research that differentiates nociception and pain. I recalled the wise words of Patrick Wall, stating that "the labelling of nociceptors as pain fibres was not an admirable simplification, but an unfortunate trivialisation under the guise of simplification". Such a trivialisation, as Wall implies, has the potential to undermine successful diagnosis and treatment.

Recognition of the sacroiliac joint as simply one possible source of nociception among others allows space to consider the contributory roles of the nervous and immune systems along with brain interpretation in the experience of pain. Such a view explains the observation that two people may share similar sacroiliac joint pathology and yet one experiences pain while the other does not. There is room to acknowledge that non-biomedical treatment strategies may modulate the experience of pain. In this broader context there is a need to carefully weigh any procedural benefits against potential negative effects related to reinforcement of passive beliefs and behaviours.

Procedural implications

We have begun a process, as a faculty, of increasing our commitment to training in procedural practice. As we embark on this journey we need to continue to evaluate procedural outcomes in the light of contemporary pain neuroscience and the sociopsychobiomedical approach.

At face value procedures have simple utility in select cases of acute pain and palliative care, given the short duration of requisite therapeutic benefit. In the context of chronic pain a procedure may create a window of opportunity for the person to increase function while pain intensity is lower. However there is also the risk of diminishing the person's commitment to active self-management. We need to boldly ask the question of whether or not the procedure facilitates net gain in terms of biological, psychological and sociological plasticity.

Outcome measurement

The electronic Persistent Pain Outcomes Collaboration (ePPOC) has matured significantly in recent years. There is a high rate of data capture at the time of patient referral. The mid-year 2017 report recorded data from 21,433 active patients across 60 services in Australia and New Zealand; of these there were 3,588 pathway outcomes reported (16.7 per cent of cases) with additional follow up data returned at end of episode and post episode. Overall the average questionnaire return rate was 83 per cent. This means that the major contributor to the relatively low amount of follow up data recorded is patient attrition from treatment pathways rather than any deficiency in the ePPOC system.

The greater part of follow up data from ePPOC comes from group pain management programs. There is minimal follow up data relating to procedures. Overall outcomes are positive with approximately 80 per cent of patients deriving clinically significant benefit in at least one key area. Of patients who returned data at both referral and episode end, 26 per cent reported clinically significant reduction in pain intensity (defined as ≥30 per cent reduction) and many made clinically significant gains in other areas: pain interference (58 per cent), self-efficacy (48 per cent), depression/anxiety/stress (approximately 50 per cent) and catastrophising (52 per cent).

As the faculty moves to accredit specific sites for procedural training the incorporation of ePPOC will facilitate comprehensive outcome analysis.

A pain device implant registry has been under active discussion for some time. ePPOC is one possible provider of such a service. If this were adopted it would allow the measurement of clinical outcomes in addition to traditional registry data. Such a system could provide information beyond numbers of devices implanted, complication rates and lists required for product recall. The impact of the implant could be evaluated across multiple domains and compared to less invasive treatment modalities.

The challenge ahead

The faculty has great foundational strength in our revised curriculum with its sociopsychobiomedical underpinning and the ePPOC system of outcome measurement and benchmarking. We need to keep these foundations in the forefront of our minds as we negotiate the complexities of an increasing commitment to procedural training and as we tackle the challenges of opioid and cannabinoid policy. We need the courage to defend inter- and multidisciplinary care and determination to avoid the conflation of nociception and pain.

Dr Chris Hayes
Dean, Faculty of Pain Medicine

New Fellows

We congratulate the following doctors on their admission to Faculty of Pain Medicine fellowship by completion of the training program:

Dr Alette Bader, FRACGP, FFPMANZCA (Queensland)

Dr Anthony Carrie, FANZCA, FFPMANZCA (New Zealand)

Dr Megan Eddy, FRACGP, FFPMANZCA (Victoria)

Dr Roopa Gawarikar, FRANZCR, FFPMANZCA (ACT)

Dr Christopher Jones, FANZCA, FFPMANZCA (New Zealand)

Dr Joseph Kluver, FRACGP, FFPMANZCA (Queensland)

Dr Yuen Chuan Leow, FRACP, FFPMANZCA (NSW)

Dr Sonya Ting, FANZCA, FFPMANZCA (WA)

Dr Jamie Young, FAFRM (RACP), FFPMANZCA (Victoria)

This takes the number of fellows admitted to 461.

FPM consultative forum
Considering opioids and chronic pain

FPM to host opioid forum

A rapid rise in unexpected deaths resulting from the misuse of prescription opioids now surpasses Australia's road toll and poorly managed pain – a critical public health issue – now has the attention of government.

Most recently, the Therapeutic Goods Administration has issued a paper for public consultation entitled "Prescription strong (Schedule 8) opioid use and misuse in Australia – options for a regulatory response?"

The faculty has been very engaged in contributing to and taking a leadership role in these and other discussion in relation to opioids.

The faculty was a strong advocate for the up-scheduling of codeine and has had significant success in raising the profile of the profession and this issue through media engagement.

In this edition of the *Bulletin* we also launch the *Statement on the Use of Slow-Release Opioid Preparations in the Treatment of Acute Pain* (see page 14),

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Considering opioids and chronic pain consultative forum 2018

When: Saturday June 16, 2018

Where: ANZCA House, 630 St Kilda Road, Melbourne

Provisional program:

Session 1: How did we get in this mess?

Session 2: Highlights from new research

Session 3: Defining reasonable clinical practice

Session 4: Leading the new conversation about opioids and chronic pain

FPM
FACULTY OF PAIN MEDICINE
ANZCA

Steppe out – dealing with chronic pain in Mongolia

A passing conversation with a colleague from Western Australia a few years ago has led to an ongoing relationship with counterparts in Mongolia for a New Zealand pain medicine specialist.

Dr Roger Goucke, former dean of FPM and one of the developers of the Essential Pain Management (EPM) program, suggested Dr Tipu Aamir might like to join him working with Mongolian anaesthetists in pain medicine. Dr Aamir is now planning his third trip to this landlocked country between Russia and China.

Dr Aamir, deputy chair of FPM New Zealand National Committee, says after running three EPM workshops he suggested patient questionnaires, used in Australia and New Zealand, be translated into Mongolian so some evidence can be captured about the sort of pain issues that are being faced.

He's presently analysing the data that has been gathered already from the first few batches of questionnaires with Mongolian patients. "This is really the first survey done in Mongolia looking at the presentation of chronic pain patients. Depending on the outcome, it will give more information about what is needed and where," Dr Aamir says.

The Auckland-based psychiatrist says the initial results have already encouraged more discussion about chronic pain. "The patients are not too dissimilar to New Zealand patients so together we need to think about similar chronic pain treatment programme as we have here."

There is a rudimentary pain clinic running in the sprawling capital city of Ulaanbaatar. The capital city of more than 1.3 million people has growing urban poverty and groaning infrastructure. A new university hospital will open there next year and it's planned to have a dedicated chronic pain clinic.

Since the fall of the Soviet Union in the 90s, which ended seven decades of communist rule, more and more private hospitals have opened up in Ulaanbaatar. But it is the public hospitals who deal with some of the most complex cases being brought into the capital from the far-flung reaches of the country where there are no services.

Dr Aamir says the FPM-driven EPM workshops have been well received and he's now up to his fifth, with Mongolians from various parts of the health system attending.

Other ANZCA fellows are involved in training anaesthetists and also produce a publication translated into Mongolian for the Annual Meeting of Mongolian Society of Anesthesiologists.

Dr Aamir says he's been most impressed with the anaesthetists he's been working with in Mongolia. "They're really interested in developing their practice. They're open to new ideas and they run with projects, making changes and following through even though they face limited resources."

He says working in Mongolia is an extremely satisfying experience. "I'm really pleased that I can share knowledge gathered over the years and train others." He urges fellows who get the chance to do similar stints in the developing world, to grab the chance. "Take some time off and just do it," he says.

Adele Broadbent
Communications Manager, NZ

Above from left: The vast rural landscape of Mongolia where communities are often hours away from health services; Dr Tipu Aamir, centre in front of whiteboard, with his Mongolian colleagues.

Lifebox a vital tool for saving lives across the globe

Opposite page from left: Presenting Lifeboxes to JDW National Referral Hospital, Papua New Guinea in November 2016; Anaesthetic Scientific Officers in the recovery room of Mt Hagen General Hospital, Papua New Guinea; Anaesthesia nurse Lifebox pulse oximetry workshop in Ulaanbaatar, Mongolia; Dr Kaeni Agiomea with a Lifebox pulse oximeter; Lifebox presentation to JDW National Referral Hospital; Monitoring a patient in Mongolia. Credit: Lifebox Foundation, Lauren Anders Brown.






Every year millions of lives are put at risk because of unsafe surgery and anaesthesia. A pulse oximeter is the most important monitoring tool in modern anaesthesia yet around the world tens of thousands of operating rooms do not have access to these devices.

Lifebox was established in 2011 as a joint initiative of the World Federation of Societies of Anaesthesiologists, the Association of Anaesthetists of Great Britain and Ireland and the Harvard School of Public Health to provide life-saving pulse oximeters to operating theatres around the globe. More than 15,000 Lifebox pulse oximeters have now been distributed to more than 3000 hospitals in 14 countries and more than 5000 health workers have been trained in how to use them.

Lifebox is evolving to deliver other programs and education initiatives to make every operating room a safer place for patients and healthcare providers. In addition to donating pulse oximeters and educating staff in their use, Lifebox is working to improve surgical safety in other ways, such as helping hospitals to introduce the World Health Organization's Surgical Safety Checklist. The Clean Cut program now being piloted in Ethiopia takes this a step further to improve peri- and post-operative practice by tackling the high rates of surgical site infections in low resource operating rooms.

Lifebox Australia and New Zealand (ANZ) was established in 2015 as a partnership between ANZCA, Interplast Australia and New Zealand, the Australian Society of Anaesthetists (ASA), the New Zealand Society of Anaesthetists (NZSA) and Lifebox Foundation to work with hospitals in the Asia Pacific to introduce pulse oximeters into clinical practice.

Anthony Wall
Senior Policy Adviser, ANZCA

www.lifebox.org

Recent Lifebox ANZ highlights

Myanmar

In 2017, the Myanmar Society of Anaesthesiologists coordinated the donation of 50 oximeters to 15 hospitals throughout Myanmar. For the first time in Myanmar, education was conducted by local instructors. An ongoing project will place a further 700 oximeters in hospitals in Myanmar to join the 150 oximeters donated to date.

Papua New Guinea

Lifebox ANZ has been very active in Papua New Guinea (PNG) and at the PNG Medical Symposium in September 2017. Thirty new oximeters were distributed to hospitals by PNG co-ordinator Dr Arvin Karu.

Pacific

In November 2016, the ASA hosted Pacific Lifebox Champions Dr Luke Nasedra (Fiji) and Dr Bata Anigafutu (Solomon Islands) at the ASA National Scientific Congress. The presence of Luke and Bata at the meeting helped raise the profile of Lifebox in the anaesthesia community and assisted the ASA in raising more than $A20,000 for Lifebox. The value of Lifebox oximeters in the Pacific is best expressed by Pacific Lifebox champion, Dr Kaeni Agiomea from the Solomon Islands, who has recently been quoted as saying: "Life ain't safe without a Lifebox oximeter."

Bhutan

Dr Steve Kinnear, an anaesthetist and Lifebox volunteer from Adelaide introduced Lifebox to Bhutan in 2015 while assisting with anaesthesia teaching. He has returned to Bhutan each year, and has continued to teach oximeter use and support the local anaesthetists.

"Lifebox is evolving to deliver other programs and education initiatives to make every operating room a safer place for patients and healthcare providers."

PNG's 'Text Book doctor'

Dr Hogande Kiafuli works at the Gaubin Rural Hospital on Karkar Island, Papua New Guinea where he deals with some of the challenges of providing medical care in rural and remote areas of PNG.

For two years Dr Kiafuli was the only medical officer at the hospital on Karkar – an island of 80,000 people. The hospital has only recently received a Lifebox pulse oximeter and there are no staff trained in anaesthesia apart from Dr Kiafuli and the anaesthetic training he received during his residency. Referral to the nearest hospital with an anaesthetist is only possible during daylight hours (an outboard motor for boat transfer is only available between 7am and 5pm), and is also dependent on the ability to arrange land transport on the mainland.

Without the three agents lignocaine, bupivacaine and ketamine 500 annual operations at Gaubin Hospital would not be possible. A watch, a manual sphygmomanometer and a portable finger pulse oximeter – these are all that are used to observe anesthetised patients.

One extraordinary story in particular highlights the challenges Dr Kiafuli faces. A woman in labour was brought by her family to the hospital where Dr Kiafuli quickly assessed complications. The patient had gone into shock from blood loss due to a ruptured uterus and the baby was lying outside the uterus and was within the abdominal area causing pain and bleeding. As it was after 6pm, transfer to a larger hospital was not possible.

Dr Kiafuli decided to perform a hysterectomy to save the patient's life, despite never having undertaken this operation before. Having performed a blood transfusion with blood donated from the patient's family and clinic staff, Dr Kiafuli then removed the blood that had clotted in the abdomen – itself a challenge in the absence of electric suction or foot pumps. Next, the source of the bleeding was located and clamped and the ruptured uterus removed. As Dr Kiafuli explained: "I didn't know how to do the hysterectomy so I told my MO to hold the open medical text book while I read what was in the book and applied it. I had no time to feel undecided or worry because two lives were at stake. I read how to do the operation and physically did it at the same time." Since word of the story spread, Dr Kiafuli has become known as the "Text Book doctor".

How you can help

One Lifebox oximeter complete with training materials and warranty costs about $US250. There are lots of ways the ANZCA community can help by individual donations, bequests or requesting guests consider a donation in lieu of gifts at an upcoming special occasion such as a wedding or birthday.

At the ANZCA Annual Scientific Meeting in May last year, speakers generously donated to Lifebox ANZ in lieu of receiving speakers' gifts – a simple act which led to a $A10,000 donation for Lifebox.

Donations to Lifebox ANZ are now tax deductible and can be made online at: www.interplast.org.au/learn-more/our-work/lifebox-australia-newzealand/.

lifebox
Australia & New Zealand

ANZCA Trainee Survey

For the third year in a row, the ANZCA Trainee Survey confirms a high level of trainee satisfaction with the anaesthesia training program, while identifying areas for improvement.

The 2017 online survey, launched on August 30, invited 1479 trainees to participate. The survey ran for three weeks attracting 566 responses (38 per cent).

In 2016 and 2017, the trainee survey asked about respondents' experience of the specialist training program, supervision and the hospitals learning environment across Australia and New Zealand. In 2017 we extended the survey to explore Indigenous identification, how trainees use social media, and think about rural, remote and private practice.

Hospital training environment

Like 2016, trainee respondents were positive about their hospital placement experience. Trainees were invited to identify up to three recent hospital placements resulting in information on 1121 hospital placements in 2017. Over 90 per cent of respondents agreed with the following:

- There were allowances made to attend part 1-2 courses (94 per cent agree/strongly agree).
- They had appropriate access to leave (93 per cent).
- They felt well supported at their workplace (92 per cent).
- Their supervisor of training was helpful and actively engaged in their training (90 per cent).

However a notable number of respondents either disagreed or strong disagreed that they:

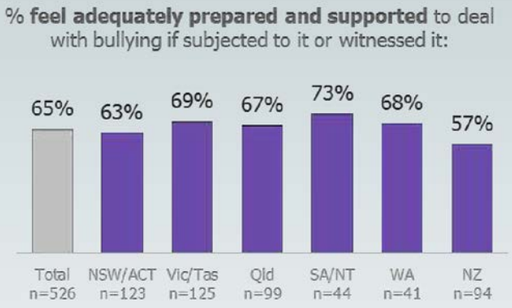
- Had a balanced roster (for example, hours, overtime, weekends etcetera) (19 per cent).
- Had adequate formal teaching (tutorials etc) (18 per cent).
- Had opportunities to complete specialised study units (16 per cent).

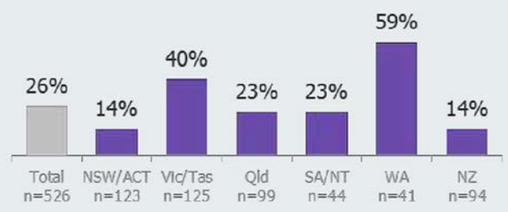
Around half of respondents (55 per cent) reported that they worked between 41-50 hours a week, with 4 per cent working more than 61 hours a week on average.

Supervision and feedback

Trainees were positive about supervision and feedback with high rates of agreement (82-95 per cent) with the following:

- The supervision I receive is appropriate to my level of training (94 per cent agree/strongly agree).
- I am able to use the feedback I receive in the workplace to improve my performance (92 per cent).





Training program

Trainees were overall positive about the training program with satisfaction levels at 70-75 per cent; however the response rate suggests there is room for improvement in relation to:

- Satisfaction with the overall usability of the training portfolio system (70 per cent).
- Completing the workplace-based assessments provides feedback I can use to improve (73 per cent).
- The volume of practice targets describe appropriate minimum experience to prepare me for consultant practice (75 per cent).
- The learning resources on ANZCA Networks are helpful for my learning (72 per cent).

There was a significant increase in agreement (agree/strongly agree) in the past 12 months that the volume of practice targets describe appropriate minimum experience to prepare for consultant practice (75 per cent). This is up from 63 per cent in 2016, driven by NSW/ACT (72 per cent up from 61 per cent in 2016), Victoria/Tasmania (76 per cent, up from 61 per cent), Queensland (82 per cent, up from 71 per cent) and South Australia/Northern Territory (80 per cent, up from 64 per cent).

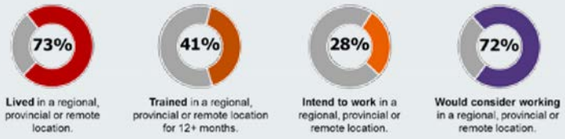
% Yes	Total N=566	NSW/ACT N=134	Vic/Tas N=131	Qld N=108	SA/NT N=45	WA N=48	NZ N=100
Lived in a rural, provincial, regional or remote area.	73%	75%	71%	**87%**	**49%**	63%	73%
Trained in a rural, provincial, regional or remote area for 12+ months.	41%	41%	36%	**62%**	**20%**	**17%**	43%
Intend to work in a rural or provincial area at the conclusion of training.	28%	34%	28%	24%	**13%**	23%	35%
Would you consider working in a rural or provincial area post.	72%	69%	69%	**64%**	82%	67%	**84%**

Use of social media

Facebook is the only form of social media that trainees are using regularly, with one in two (47 per cent) reporting that they use it often and an additional one in five (22 per cent) using the site occasionally.

Rural, provincial and remote work

Nearly three in four trainees have, at some point, lived in a regional, provincial or remote location (73 per cent). While many trainees would consider working in such a location (72 per cent), far fewer trainees intending to work in rural area (28 per cent).

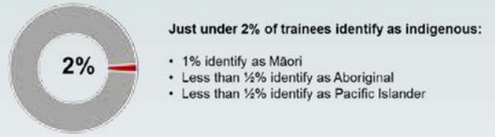


Intention to work in private practice

Upon achieving fellowship, more than five in six (85 per cent) trainees are considering working in private practice. NZ trainees are significantly less likely to be considering work in private practice (72 per cent versus overall 85 per cent).

Indigenous identification

Fewer than 2 per cent of respondents identified as Indigenous. New Zealand had the greatest proportion of trainees with an Indigenous identification rate of 6 per cent.



What happens now?

While many aspects of the survey indicate positive results that confirm 2016 findings, it is recognised that there is always room for improvement.

The Trainee Committee appreciates the time taken by trainees to complete the survey and is keen to use the information acquired to make recommendations to various ANZCA committees. Pertinent points will also be fed back, completely de-identified, to individual hospitals for their consideration.

Various ANZCA units are developing action plans in response to the 2017 survey results. Some of the practical changes currently in process include:

- Improvements to the TPS, with the first release of new functionality available in late March 2018 and further enhancements by the end of the year.
- New Workplace-Based Assessment support resources available on Networks, including practical tips, checklists and a comprehensive list of frequently asked questions. There are resources for trainees, WBA assessors and supervisors of training to help everyone understand the philosophy of WBAs and how these enhance learning. A rollout of local training is also being planned.

Thank you to all of the trainees who participated in the survey. We encourage those of you who didn't get a change to respond in 2017 to engage with the 2018 survey so that your voice can be heard by the college and your feedback used to continue to improve our world class training program.

ANZCA Trainee Survey (continued)

BDSH

The optional bullying, work place discrimination and sexual harassment (BDSH) section of the survey was completed by 526 trainees; 93 per cent of those who completed the trainee survey.

Trainees were asked whether they had directly experienced or witnessed BDSH in the past 12 months. Information was sought about the perpetrators, what action was taken and how effectively the issue was resolved. Respondents had the option of indicating whether they wanted further contact with the college regarding any concerns.

Workplace bullying

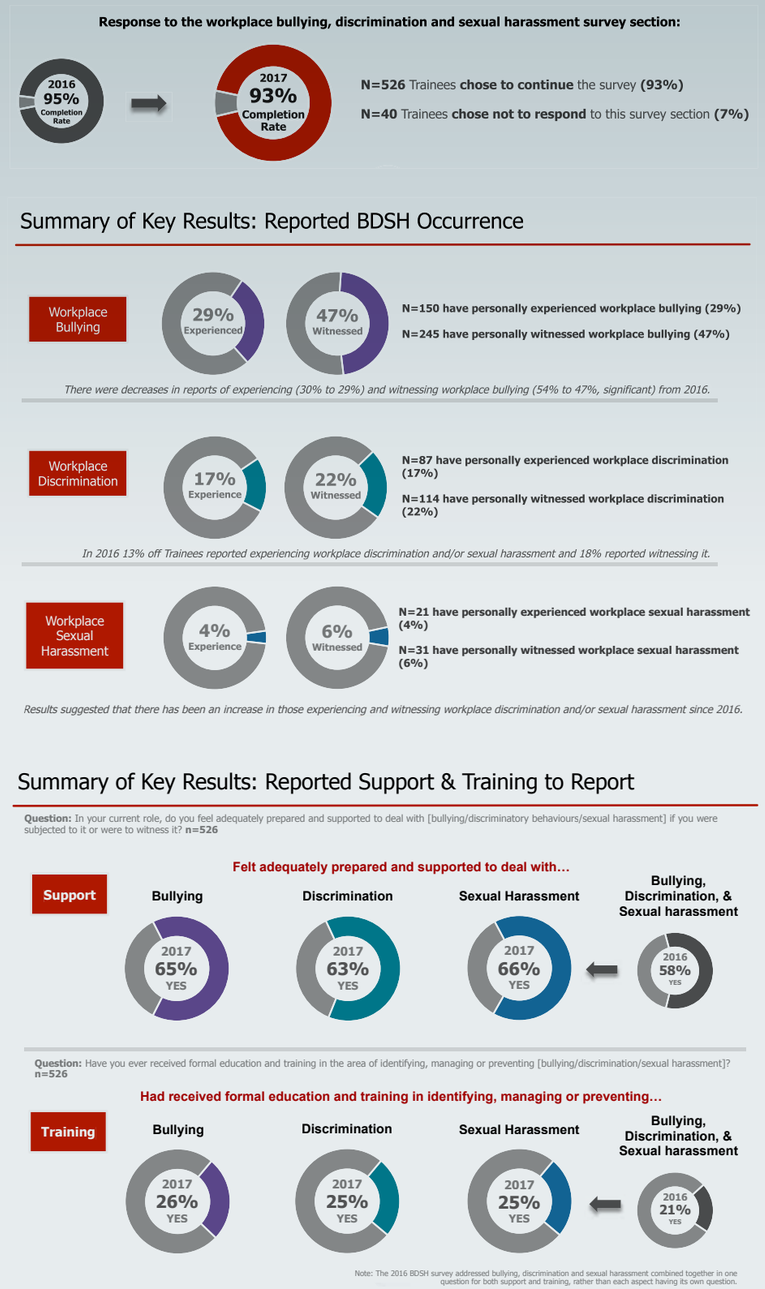
One hundred and fifty (29 per cent) respondents indicated they had personally experienced workplace bullying in the past 12 months and 47 per cent have personally witnessed workplace bullying. This is a decrease in reports of experiencing (30 per cent to 29 per cent) and witnessing workplace bullying (54 per cent to 47 per cent) from 2016.

With regard to managing bullying, 26 per cent of trainees had received formal education and training to identify bullying behaviour and 65 per cent felt adequately prepared and supported to deal with bullying behaviours. Eighty-eight per cent knew how to report or seek help in their hospital department, 65 per cent in their hospital, 48 per cent through ANZCA and 34 per cent through other bodies.

Workplace discrimination

Eighty-seven trainees indicated they had personally experienced workplace discrimination (17 per cent) and 22 per cent of respondents had witnessed workplace discrimination.

Twenty-five per cent of trainees have received formal education and training in identifying, managing and preventing workplace discrimination and 63 per cent felt adequately prepared and supported to deal with it.



Workplace sexual harassment

Twenty-one trainee respondents indicated they had personally experience workplace sexual harassment (4 per cent) in the past 12 months. Six per cent have personally witnessed sexual harassment.

Twenty-five per cent of trainees have received formal education and training in identifying, managing and preventing sexual harassment and 66 per cent of trainees felt adequately prepared and supported to deal with sexual harassment.

The trainee survey in 2016 combined workplace discrimination and sexual harassment. In that year 13 per cent of respondents reported personal experience of workplace discrimination and/or sexual harassment and 18 per cent had personally witnessed such behaviour.

What happens now

ANZCA is committed to working towards building respect in the medical workplace and eliminating bullying, discrimination and sexual harassment. We encourage all trainees and members:

- To check out the *Operating with Respect* eLearning module available from ANZCA Networks. The module, developed by RACS, promotes appropriate behaviours in medical practice and workplace.
- To access the ANZCA Doctors' Support Program, a professional counselling service that offers confidential, short term support for a variety of work related and personal problems that may affect you at work or home. It is a free service for all ANZCA fellows, trainees, SIMGs and immediate family members.

The ANZCA Bullying, Discrimination and Sexual Harassment Working Group report released in 2017 identified a range of ways that the college can strengthen its focus on BDSH by improving and systematising our complaints approach, professionalism framework and regulations, identifying and developing useful resources, working collaboratively with like-minded organisations and ensuring regular monitoring through audit and feedback.

The results of the 2017 survey and the recommendations from the working group are being considered across the college and will inform further developments of the college health and wellbeing work program.

The college has followed up with those trainees who requested contact, providing details of resources and supports that are available.

All trainees are reminded that they can seek confidential support regarding these or other matters causing them stress and encouraged to visit the Doctors welfare page on the ANZCA website.

Dr Maryann Turner and **Dr Shanthi Pathirana**
Co-Chairs, ANZCA Trainee Committee (2017)

Missing candidates

The successful Tasmanian primary exam candidates were not included with the successful candidates listing in the December *ANZCA Bulletin*. The *Bulletin* apologises for this oversight.

Tasmania
Elizabeth Anne Judson
Alice Elizabeth Mulcahy
Jana Ludmila Vitesnikova

Pressures on trainee workforce

Supply and demand issues are ongoing concerns for younger anaesthetists, writes Dr Richard Seglenieks.

Junior doctors are facing an increasingly competitive working landscape. The number of medical schools in Australia has increased nearly fourfold in just 10 years, from six in 2008 to 23 today[1]. The number of commencing medical students has risen from 1837 in 2002 to 3853 in 2017, with graduate numbers more than doubling in the 10 years to 2016[2].

Among graduating students, anaesthesia is disproportionately popular. It was the first preference for future field of practice for 9.9 per cent of 2016 graduates[2], making it the fourth most popular specialty, despite anaesthetists only constituting 4.4 per cent of all registered medical practitioners[3]. Even this large discrepancy in percentages belies the true surplus of graduates interested in anaesthesia after taking into account the growth in graduate numbers.

The increasingly competitive nature of early post-graduate years also flows on to trainees in anaesthesia. Workforce has been a major concern in anaesthesia for a number of years, though Australian government modelling from 2016 is somewhat reassuring, indicating that the anaesthetic workforce in Australia is "in balance, with the potential to shift into oversupply if trainee numbers are increased or if there is not a decrease in international medical graduates."[4]

The April 2014 issue of *Australian Anaesthetist* focused on workforce issues, with articles highlighting the importance of avoiding both oversupply and undersupply of anaesthetists[5] and outlining the role of increasing trainee numbers contributing to greater competition for limited positions after training[6]. Concerningly, declining access to public hospital work for new fellows was linked with less stable work arrangements and a rising trend of "honorary" (unpaid) work[7].

This ultimately creates a demanding environment for trainees and pre-vocational graduates looking to set themselves apart from the pack.

Competition has long been a part of the medical career path, however, simply by numbers alone this is far greater now than it has tended to be in the past.

Anecdotally, I have noticed significant anxiety around securing both training positions and consultant work. Many junior doctors are undertaking time-consuming and expensive further education, such as the various Master of Medicine degrees on offer, where previously they may have opted to focus their additional efforts on clinical work, study or the often-neglected necessities for self-care (spending time with family and friends, exercising, sleeping, etc).

These extra courses may be beneficial in some ways, for example by increasing the qualifications and skills of junior staff and encouraging involvement in important non-clinical activities such as teaching and research. However, it's not uncommon for these to be pursued purely for résumé building and they may be more of a reflection of the privilege some individuals have to invest more time and money in work-related activities outside of work, rather than demonstrating greater keenness or ability.

Sometimes, the growing extra-curricular commitments of junior staff are confronted by a system that traditionally lacks flexibility. Every junior doctor I have discussed this with recalls an experience of work interfering unexpectedly or unfairly with their life. From the intern refused a Saturday off for a close friend's wedding to the registrar denied leave for an overseas course they had already booked, there is an expectation to function as a reliable automaton that can be rostered whenever and wherever one is needed. We make significant sacrifices in order to pursue a career that while interesting and rewarding, is also busy and challenging. Anaesthesia is one of the more thankless medical specialties, particularly when compared with the surgeons we work with daily.

London anaesthetist Dr Donald Bateman captured this sentiment well, observing that "the best anaesthetists are unobtrusive both as to their persons and their techniques; they are missed more in their absence than they are noticed in their presence."[8]

> "I have noticed significant anxiety around securing both training positions and consultant work."

Unfortunately, this problem is still likely to get worse before it gets better. More and more graduates are being supplied to a bottlenecked system, without a commensurate supply of training positions (which must be closely matched to the availability of specialist work). This article isn't about finding a solution – many smarter people than I have been working on this for years. My hope is simply to highlight the issue and encourage you all to please keep an eye out for your juniors – their lives may be more stressful than they seem.

Dr Richard Seglenieks, FANZCA
Anaesthetic Registrar, St Vincent's Hospital, Melbourne

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Website redesign

Technology is changing at such as rapid rate that one "website year" is now estimated to be the equivalent of up to 18 human ones. Which makes the ANZCA website a truly geriatric 120!

Despite being rated "very good" or "excellent" by more than 70 per cent of trainees and "good" or "very good" by nearly 80 per cent of fellows in recent surveys, our current website can no longer meet the needs of our key stakeholders. And with more and more core college services – including subscriptions and elections – going online, it will come as no surprise that a complete overhaul is a core priority for us in 2018.

Redeveloping a website of this size is no mean feat. For starters, there are more than 2000 pages and 3000 PDFs. But it's also incredibly exciting.

What's new?

The new site will allow us to deliver an increasingly personalised experience for every user. This means that a final year anaesthesia trainee in New Zealand will effectively see a completely different website to, say, a pain medicine fellow in Tasmania. You'll be able to bookmark your favourite pages and choose what you see in your newsfeed. And if we think you'd be interested in an event; a safety alert; a news story; or something in the ANZCA Library, we'll tag it so you see it next time you log in.

Content will be far more streamlined. And you'll be able to share anything you like on your social networks at the click of a button. Looking for a "prof doc" or research grant? Searching the site will be a whole lot easier too. And over time, we plan to introduce "single sign on"; making it easier for you to access your continuing professional development (CPD) or training portfolio system (TPS); Networks; and ANZCA Library without having to re-enter your credentials.

The website in numbers

- Age in website years: Seven
- Age in human years: c120
- Number of unique visits in 2017: 285,000
- Number of page views in 2017: 3,500,000
- 2141 pages
- 3406 PDFs

The redevelopment is also a great opportunity to cement ANZCA's position as the pre-eminent authority on anaesthesia and pain medicine in Australia and New Zealand. We're developing a range of new patient information resources, including animated videos and factsheets. And we'll be doing a lot more to showcase the achievements of our fellows in fields such as research, education, and community development.

Where are we at?

We've already completed the first round of consultation, and would like to thank all the fellows, trainees, specialist international medical graduates, and staff who have provided input into the "feel" and functionality of the site. Over the next few months, we'll be inviting feedback on the prototype, and working closely with our various business units to tighten up the content and streamline the user experience.

Alan Dicks
Digital Communications Manager, ANZCA

Leading change for good on the world stage

Dr David Wilkinson, the immediate past president of the World Federation of Societies of Anaesthesiologists, called on his medical and anaesthesia contacts to secure essential equipment for Papua New Guinea.

It took him nearly half a century but more than 40 years after an Australian colleague suggested he make the long trip from London to Papua New Guinea (PNG), Dr David Wilkinson finally achieved his goal last year.

Although he was only in the country for 12 hours the immediate past president of the World Federation of Societies of Anaesthesiologists (WFSA) made a lasting legacy that has helped transform the 200-bed Alotau General Hospital in Milne Bay Province in Papua New Guinea's south-east.

Using his own money and donations secured through the WFSA, its treasurer Professor Alan Merry and a British-based charity, Save Anaesthesia Worldwide, Dr Wilkinson funded a Diamedica Helix Ventilator for the hospital which the chair of ANZCA's Overseas Aid Committee, Dr Michael Cooper, presented to the hospital in September.

"Now that the World Bank has determined that for every dollar you invest in this sort of healthcare for surgery and anaesthesia you get a $10 return, this may lead to change."

When Dr Cooper heard that Dr Wilkinson and his wife Norma would be making a fleeting port stop to Alotau in May 2017 during a two-week Pacific cruise he contacted the hospital's director of anaesthesia Dr Lucas Samof to see if he would be interested in showing the Wilkinsons around the hospital.

"We couldn't believe it when we docked at Alotau," Dr Wilkinson told the *Bulletin* from his home in Bishop's Stortford in Hertfordshire, 50 kilometres north-east of London.

"Dr Samof had organised a welcome party for us with a special cake and took us on a tour of the hospital. There are real difficulties there in PNG. We wandered into one of the wards and saw a patient with a tracheostomy scar and his arm in plaster. It turns out they had to ventilate him but then the ventilator broke and they couldn't fix it. He was ventilated by hand for the next six to 10 days by nurses and relatives.

Above from left: The Wilkinsons are welcomed to Alotau; Dr Michael Cooper presents the donated Diamedica ventilator to the hospital.

"My first thought was this is ridiculous. This hospital needs a ventilator. I talked to some people at Diamedica, a British company that makes anaesthesia equipment for developing countries. The charity Safe Anaesthesia Worldwide threw in a thousand pounds and I talked to the WFSA and the treasurer Professor Alan Merry. I leant on Alan a bit and they donated another thousand, which was almost half the cost, and I put in the rest.

"Michael delivered the ventilator to the hospital in September and it's been used many times since then."

Dr Cooper, senior anaesthetist at The Children's Hospital at Westmead and St George Hospital in Sydney chairs the WFSA's Paediatric Anaesthesia Committee. He says Dr Wilkinson "has probably done more for world anaesthesia than anyone" during his four years as president of the organisation.

"David, while he was president, probably visited more countries than any other anaesthetist and this has helped to consolidate the WFSA as the lead organisation for anaesthesia globally. It is now the 'go-to' organisation for the World Health Organization for anaesthesia/anaesthesiology," Dr Cooper explained.

Dr Wilkinson says he ended his tenure as WFSA president on an optimistic note knowing that many anaesthetists have a growing awareness of the challenges ahead for five billion of the world's seven billion people who live in developing countries.

"They need three things very badly – they need people who are trained, they need equipment and they need drugs for safe anaesthesia. Governments have been reluctant to do anything about it but now that the World Bank has determined that for every dollar you invest in this sort of healthcare for surgery and anaesthesia you get a $10 return, this may lead to change.

"This investment means you can transform someone from being a drain on the economy to someone who is productive and now ministers of finance in many countries are beginning to see the benefits of that."

Dr Wilkinson, who is now retired from clinical practice, helped drive the concept of day surgery in the UK in the 1980s. He helped develop one of the UK's first day surgery units at St Bartholomew's (Barts) Hospital in London.

The history of anaesthesia is his other big passion. His interest in anaesthetic equipment and the history of the speciality led to him proposing to Barts' leadership that he start collecting equipment for the hospital's first anaesthesia museum.

In their spare time he and Norma made regular driving trips and scoured the UK for anaesthetic equipment that would help tell the story of the specialty's history and ensure their preservation.

In recognition of his contributions to the history of anaesthesia Dr Wilkinson has been appointed Laureate of the History of Anaesthesia of the Wood Library-Museum of Anaesthesiology in Chicago.

"My first thought was this is ridiculous. This hospital needs a ventilator."

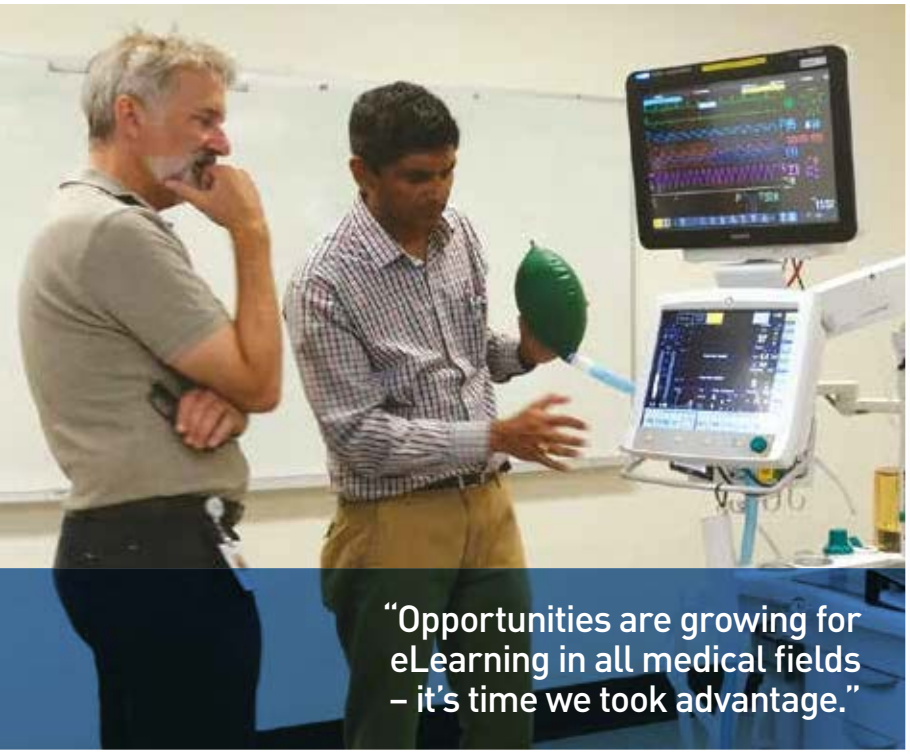
Having spent 20 years with the WFSA Dr Wilkinson has now taken a step back from officialdom only to find himself in demand as a tour leader for specialist medical travel. In between his history commitments – which includes compiling the 150-year history of the anaesthesia department at Barts – he will head to China and Japan this year where he will lead two anaesthesia tours.

He has a strong connection to Australia including a lifelong friendship with Melbourne ANZCA fellow Dr Laurie Doolan who first planted the seed of a PNG visit with Dr Wilkinson all those years ago in London when they were completing their anaesthesia fellowship.

He spent several months in Perth in the late 1970s at Princess Margaret Hospital in the paediatric department and his daughter Fiona, a physiotherapist, lives in Canberra with her family.

Carolyn Jones
Media Manager, ANZCA

Opportunities in eLearning



The Anaphylaxis eLearning Project Steering Group is developing four experiential case studies to demonstrate the management of anaphylaxis crises in perioperative care.

Asynchronous eLearning offers easily accessible materials and enables fully flexible skill-sharing unmatched by other types of instruction.

With new technology opportunities on the horizon, the ANZCA Education unit has been working with fellows to devise ways to drastically improve the elearning and collaboration opportunities for fellows, trainees, SIMGs and staff. The Networks platform is evolving, with significant improvements planned mid-year. Opportunities are growing for elearning, and Networks can offer learners and instructors the possibility of widespread sharing through rapid development.

The creation of elearning materials requires competencies that go beyond traditional teaching. In response to this need, new models are being developed to support our experts in translating their knowledge to an online environment more easily. Storyboarding processes and other instructional design tools will enable the faster development of anaesthesia and pain medicine training resources. Elements such as robust processes for training needs analysis, repurposing and customising existing content, and guidelines for minimum standards to ensure consistency are all under development. Evaluation data using system tracking and other tools can monitor its quality and efficacy, and support a cycle of continuous improvement.

As part of the ANZCA Educators Program a module has been created, "Technology in teaching and learning", to provide an introduction to tools that offer opportunity for shared learning through the use of technology. This interactive workshop enables participants to use a range of practical tools. In addition, the module enables participants to explore the evidence for use of technology in the learning space and focuses on ways to determine the value of web-based materials and apps.

Perioperative Anaphylaxis Emergency Response is one specialist area that is making use of the Networks learning and collaboration management system. The Anaphylaxis eLearning Project Steering Group has developed four experiential case studies to demonstrate anaphylaxis crises in perioperative care. The project has evolved through various production stages in order to refine content and deliver the best possible model for meeting ANZCA's CPD requirements for the emergency response category of management of anaphylaxis.

Group members have worked holistically as not only subject matter experts, but also as instructional designers (storyboarding content, recording narration, and directing video and photography) and actors in order to produce the most authentic, effective and high-quality product.

The Education unit acknowledges the hard work and creativity of group members, past and present: Dr Helen Kolawole, Dr Richard Waldron, Dr Sarah Green, Dr Karen Pedersen, Dr Nagesh Nanjappa, and Dr Shanthi Pathirana.

Lee Cheers
Learning and Development Lead, ANZCA

Above from left: Dr Rod Mitchell and Dr Nagesh Nanjappa prepare a monitor simulation for an eLearning module, Queen Elizabeth Hospital, SA; Excerpts from the latest eLearning module prototype for Perioperative Anaphylaxis Response: Case A – Total Knee Replacement.

The rare privilege of medicine: Women anaesthetists in Australia and New Zealand

Throughout the 19th century, women slowly emerged from their private and domestic lives. Many began to look to professions such as medicine to enable them to perform public roles.

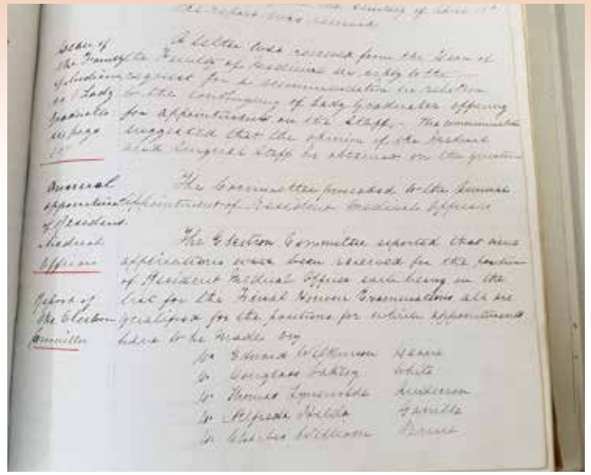
Georgina Dagmar Berne was the first woman to study medicine in Australia in 1885. Difficulties at the University of Sydney forced her to complete her qualifications abroad.

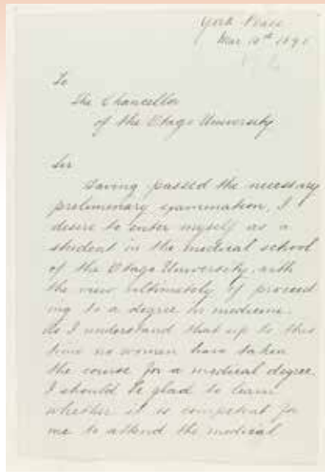
When the University of Otago admitted its first woman medical student there was little resistance and her studies, graduation and residency appear to have been without controversy. A young Emily Siedeberg wrote directly to the University Chancellor, seeking admission to medicine. The university sought advice from the Dunedin Hospital, who gave assurances they would enable her to complete her qualifications with hospital based training. Years later, Dr Emily Siedeberg revealed the male students had thrown body parts at her during anatomy classes. Siedeberg was appointed anaesthetist at the Dunedin Dental School from 1921-1931.

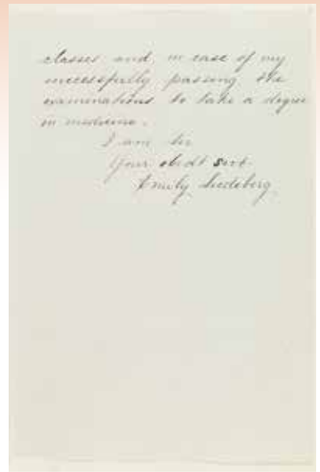
Small numbers of women followed Siedeberg's example. Three graduated from medicine in 1904, and only one in each of 1902, 1903, 1906, 1910 and 1911. The decline in women studying medicine in New Zealand, led newspapers of the day to incorrectly announce that "...the craze for women studying medicine had gone". Instead, many New Zealand women travelled to the UK to study medicine at the London School of Medicine for Women.

The School of Medicine at the University of Melbourne opened in 1862 and it took 25 years to admit women. These women displayed great academic ability but were then publicly condemned for trying to complete their qualifications with hospital residencies. Dr Janet Greig graduated in the top six of her year at the University of Melbourne in 1896.

Traditionally, the top six graduates automatically qualified for a residency at Melbourne General Hospital. The idea of women residents met with much opposition, playing out in the newspapers of the day. Eventually, hospital management voted 13 to six in favour of taking on the "lady graduates".







In 1900, Greig was appointed to the position of honorary anaesthetist at the newly formed Queen Victoria Hospital. She was the first woman in Australia appointed to such a position. And, with perhaps a touch of poetic justice, she was also appointed honorary assistant anaesthetist at the Melbourne General Hospital in 1903.

Professor Tess Cramond (Brophy), often referred to the practice of medicine as a rare privilege. No other profession was afforded so much insight into the human condition, or could offer such crucial help at critical times. She was also a specialist anaesthetist and, in 1972, was elected dean of the Faculty of Anaesthetists. Yet, even she probably couldn't have imagined that some 45 years later 32 per cent of fellows and 45 per cent of trainees would be women.

The rare privilege of medicine: Women anaesthetists in Australia and New Zealand looks at the professional lives of some early women anaesthetists in Australia and New Zealand. It explores the difficulties they faced as they tried to make their mark in a male dominated field. It also reveals their many triumphs.

Material for this exhibition will be rolled out across the year, with the launch of the online exhibition coinciding with International Women's Day, March 8. Keep an eye on the museum's blog (www.geoffreykayemuseum.org.au/) and Twitter feed (@GKMuseum) for more information.

Monica Cronin
Curator, Geoffrey Kaye Museum of Anaesthetic History, ANZCA

This page from left: Minutes Book from Melbourne General Hospital. Courtesy of Royal Melbourne Hospital Archives; Letter from Emily Siedeberg to University of Otago Chancellor requesting permission to study medicine. Courtesy of NgÐ Uare Taoka o HÐkena – The Hocken Collections, University of Otago.

What's new in the library

Better searching for anaesthesia- and pain-related articles

Every year the National Library of Medicine (NLM) update the Medical Subject Headings (MeSH) to include new topics that can be searched in the Medline/PubMed database.

In 2018, a number of new terms have been added that are relevant to anaesthesia and pain medicine, including the following:

Addiction medicine
A medical specialty focused on the diagnosis and treatment of addictive behaviour disorders, including substance related disorders and impulse control disorders; and the management of co-occurring medical and psychiatric conditions.

Anaesthesia, cardiac procedures
A range of methods used to induce unconsciousness; analgesia; and muscle relaxation during cardiac procedures.

Clinical deterioration
A critical disease progression, often measured by a set of clinical parameters, which activates hospital rapid response team.

Contraindications
A condition or factor associated with a recipient that makes the use of a drug, procedure, or physical agent improper or inadvisable. Contraindications may be absolute (life threatening) or relative (higher risk of complications in which benefits may outweigh risks). Contraindications, drug and contraindications, procedure are also available.

Drug misuse
Use of a drug for a purpose not consistent with legal or medical guidelines.

Early goal-directed therapy
Critical care treatment using intensive monitoring and aggressive management of perioperative hemodynamics in high-risk patients.

Hemodynamic monitoring
Continuous measurement of the movement and forces of blood in the cardiovascular system.

Multimorbidity
The complex interactions of several co-existing diseases.

Pain, procedural
Pain associated with examination, treatment or procedures.

Prescription drug monitoring programs
Programs – usually run by state governments – that require pharmacists to collect and distribute data on the prescription and dispensation of controlled substances. They are intended to prevent the abuse of such substances by the patient, or their transfer to recreational users and drug dealers.

Risk evaluation and mitigation
Strategies required by the US Food and Drug Administration (FDA) Amendments Act of 2007 when a question exists as to whether the benefits of a drug outweigh its risks. These constitute a safety plan with several potential components, including a medication guide, a communication plan, elements to ensure safe use and an implementation system to help guide the prescribers, pharmacists and patients.

Substance abuse, oral
Abuse, overuse, or misuse of a substance by ingestion.

Therapeutic index, drug
The ratio of the dose that produces toxicity to the dose that produces a clinically desired or effective response.

Read more about the changes here: www.nlm.nih.gov/pubs/techbull/nd17/nd17_mesh.html

Search for these terms in the ANZCA Ovid Medline or PubMed databases here: www.anzca.edu.au/resources/library/databases.

BJA and BJA Education have moved

The *British Journal of Anesthesia* (BJA) and *BJA Education* have moved to a new publisher (Elsevier).

The move in publisher has also resulted in both titles moving from the Oxford Journals platform to the ScienceDirect (Journals Consult) platform.

Both *BJA* and *BJA Education* can be accessed from the ANZCA Library journals page: www.anzca.edu.au/resources/library/journals.

Be sure to update any saved links!

Please note: This also means that the current Oxford BJA app can no longer be used to access either of the above journals.

Make the most of your ANZCA Library!

As with previous years, the ANZCA Library will be conducting two workshops during the 2018 ANZCA ASM in Sydney.

Beyond Google: an introduction to the ANZCA Library
An introduction to the wide range of library resources available to fellows and trainees, with a focus on the primary and most useful tools, products, and services. After attending the workshop, participants will have a greater awareness and understanding of the resources and services and tips and tricks for using them.

The undiscovered country: advanced searching using MEDLINE
This workshop will focus on literature searching in the MEDLINE databases, using Ovid and PubMed. After attending the workshop, participants will have a greater understanding of the use of MeSH headings, focusing, exploding and filtering searches, and a clearer idea of the key differences between Ovid MEDLINE and PubMed. Please note: Participants should have some experience with searching and using library resources.

Library staff will once again be available at the ANZCA booth during the 2018 ASM, ready to show you all the resources and answer your information questions. A number of publishers will be participating at the booth, providing promotional material, free pens and giveaways, and information about the ANZCA Library subscribed resources, plus your chance to provide feedback.

AudioDigest: LDI Clinical Compendia Anaesthesiology (NEW)

The ANZCA Library now provides audio resources so you can keep up-to-date on the latest anaesthesia and pain medicine research and practice in your car, office, home, gym or while travelling.

AudioDigest provides instant online and mobile access to 371 accredited audio lectures and board reviews presented by experts from leading institutions, bringing clinicians a convenient continuing medical education (CME/CE) experience.

The LDI Clinical Compendia is comprised of an extensive collection of hand-selected lectures in the field of anaesthesia and pain management:

- Each lecture includes a written summary.
- Automatically synchronises your progress across your computer and your smartphone.
- A mobile app is available for Apple iOS and Android.

Further details and access information can be found on the ANZCA Library news page: http://libguides.anzca.edu.au/news.

Therapeutic Guidelines (NEW Trial)

ANZCA Library is trialling *Therapeutic Guidelines (eTG Complete)* throughout 2018.

Therapeutic Guidelines (eTG complete) is a leading source of accurate, independent and practical treatment advice for a wide range of clinical conditions. It includes explicit instructions for therapy, assisting practitioners in making decisions to ensure their patients receive optimum treatment.

The ANZCA Library would love to receive your feedback during this trial: http://anzca.libsurveys.com/feedback or email: library@anzca.edu.au.

Further details and access information can be found on the ANZCA Library trials page: http://libguides.anzca.edu.au/news/trials.

What's new in the library (continued)

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.

Patient information and consumer health resources

A new library guide has been developed to highlight authoritative and accessible patient information databases, tools, and websites. ANZCA fellows and trainees can use these resources to find current and relevant patient handouts and consumer health information, produced especially for the patient.

Access the new patient information library guide here: http://libguides.anzca.edu.au/drpatientinfo/home.

New and updated Library Guides

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, pain medicine, and many more.
- Guidance on searching specific databases – for example: Ovid MEDLINE.
- Supporting the growing number of ANZCA-subscribed apps including Read by QxMD, ClinicalKey and BrowZine.

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

Finding it difficult to keep up-to-date with your readings?

Read by QxMD aims to provide a single place to keep up-to-date with new medical and scientific research. It allows you to set up an alert service, with information about the latest article publications being sent to you via email or as an alert direct to your smart device! The personalised settings allow you to target new content on the basis of journal, topic or keywords and is an essential tool for those fellows and trainees who would like to keep up-to-date with their readings but are finding themselves time-challenged.

For additional information, including full access details, see the Read by QxMD library guide: http://libguides.anzca.edu.au/apps/read.

Making the most of ANZCA journals

Ever wondered how to access the complete ANZCA journal collection or would like to browse the latest issue of a favourite journal?

BrowZine

Following a successful trial in 2017, the Library will be continuing with BrowZine throughout 2018. BrowZine allows users to browse, read and follow the complete ANZCA journal collection* in a beautiful visual display, providing issue/article level access for each journal. BrowZine can be accessed via your web browser or via an app installed on your smart device.

**Note: Some back-files are excluded.*

For additional information, including full access details, see the BrowZine library guide: http://libguides.anzca.edu.au/apps/browzine.

Contact the ANZCA Library
www.anzca.edu.au/resources/library
Phone: +61 3 9093 4967
Fax: +61 3 8517 5381
Email: library@anzca.edu.au

New books

New books for loan

Abundance: the future is better than you think
Diamandis, Peter H.; Kotler, Steven. – New York: Free Pre ss, 2014.

Australasian anaesthesia 2017: invited papers and selected continuing education lectures
Riley, Richard [ed]. – Melbourne, Vic.: Australian and New Zealand College of Anaesthetists, 2017.

Diagnostic and statistical manual of mental disorders: DSM-5
American Psychiatric Association – Washington; London: American Psychiatric Publishing, 2014.

The fundamentals of surgical instruments: a practical guide to their recognition, use and care
Moutrey, Steve – Shrewsbury, UK: tfm Publishing Limited, 2017.

Hooked: how to build habit-forming products
Eyal, Nir; Hoover, Ryan. – London: Portfolio Penguin, 2014.

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

New eBooks

Assisted ventilation of the neonate
Goldsmith, Jay P. [ed]; Karotkin, Edward H. [ed]; Siede, Barbara L. [ill]. – 5th ed. – St Louis, Missouri: Elsevier Saunders, 2011.

Atlas of image-guided spinal procedures
Furman, Michael B. – 2nd ed. – Philadelphia, PA: Elsevier, 2018 [2017].

Australasian anaesthesia 2017: invited papers and selected continuing education lectures
Riley, Richard [ed]. – Melbourne, Vic.: Australian and New Zealand College of Anaesthetists, 2017.

Basic sciences in anesthesia
Farag, Ehab [ed]; Argalious, Maged [ed]; Tetzlaff, John E. [ed]; Sharma, Deepak [ed]. – New York: Springer, Cham, 2018.

Brenner and Stevens' pharmacology
Brenner, George M.; Stevens, Craig W. – 5th ed. – Philadelphia, PA: Elsevier, 2018.

Conn's current therapy 2018
Kellerman Rick D.; Bope Edward T. – Philadelphia, PA: Elsevier, 2018.

Cottrell and Patel's neuroanesthesia
Cottrell, James E [ed]; Patel, Piyush [ed]. – 6th ed – United States of America: Elsevier Inc., 2017.

Hagberg and Benumof's airway management
Hagberg, C. A. [ed]; Artime, Carlos A. [ed]; Aziz, Michael F. [ed]. – 4th ed. – Philadelphia, PA: Elsevier/Saunders, 2018 [2017].

Irwin & Rippe's intensive care medicine
Irwin, Richard S. [ed]; Lilly, Craig M. [ed] ; Mayo, Paul H. [ed]; Rippe, James M. [ed]. – 8th ed. – Philadelphia, PA: Lippincott Williams & Wilkins, 2018.

Kaplan's essentials of cardiac anesthesia for cardiac surgery
Kaplan, Joel A. [ed]; Cronin, Brett [ed]; Maus, Timothy [ed]. – 2nd ed. – Philadelphia, PA: Elsevier, 2018 [2017].

Manual of simulation in healthcare
Riley, Richard H [ed]. – 2nd ed. – Oxford: Oxford University Press, 2016.

Pain management secrets
Argoff, Charles E [ed]; Dubin, Andrew [ed]; Pilitsis, Julie G [ed]. – 4th ed. – Philadelphia, PA: Elsevier Inc., 2018.

Retrieval medicine
Evans, Charlotte [ed]; Creaton, Anne [ed]; Kennedy, Marcus [ed]; Martin, Terry [ed]. – [London]: Oxford University Press, 2016.

Oxford textbook of anaesthesia
Hardman, Jonathan G [ed], Hopkins, Philip M [ed], Struys, Michel MRF [ed] - Oxford: Oxford University Press, 2017.

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

Good start for emerging researchers in 2018

First ANZCA Melbourne Emerging Researcher Scholarship awarded

Dr Jai Darvall of Royal Melbourne Hospital has been awarded the ANZCA Research Foundation's first ANZCA Melbourne Emerging Researcher Scholarship. Funded through a generous gift from foundation governor patron, Dr Peter Lowe, as part of his long-term commitment to assisting the development of emerging researchers, the new scholarship will help Dr Darvall pursue his PhD and complete his related research study "Frailty assessment, impact and effect of protective factors in older surgical and critically ill patients".

2018 ANZCA Melbourne Emerging Anaesthesia Researcher Award

Dr Lowe also again provided $A10,000 for this award in 2018 which was awarded to Dr Rachel Chapman for her project "A pilot study of current anaesthetic practice and outcomes for children undergoing adenotonsillectomy at the Royal Children's Hospital". Dr Chapman is the fourth recipient of this award.

Leadership circle

The new ANZCA Research Foundation Leadership Circle is a special program for people and organisations who want to make strategic contributions to improving health outcomes for people having anaesthesia and surgery and pain patients, by supporting more research in perioperative and pain medicine led by ANZCA fellows.

Leadership circle members commit to donate $A10,000, $A25,000 or $A50,000 annually over three or more years, reflecting the timeframe and minimum funding required for many medical research projects from design to completion and publication.

The program is also intended to generate leadership gifts that help motivate others to also provide significant donations for research in anaesthesia, pain and perioperative medicine to improve scientific knowledge for better patient outcomes.

Mr Ken Harrison, chair of the new program, worked with the foundation to host the inaugural leadership circle lunch at ANZCA House on November 14, 2017, to officially launch the new program. Mr Harrison and ANZCA CEO Mr John Ilott spoke about the purpose of the program, and Professor David Story, head of the University of Melbourne's Anaesthesia, Perioperative and Pain Medicine Unit, presented an inspiring overview of the great need for high-quality anaesthetist-led research in perioperative and pain medicine.

CSL Behring becomes first corporate leadership circle gold member

After attending the launch of the leadership circle, CSL Behring Head of Scientific Liaison Mr Jason Russell has announced that CSL Behring, the Australian Government's contracted national blood fractionator, will increase its support to just over $A25,000 per annum over three years to qualify for membership as an ANZCA Research Foundation Leadership Circle Gold Member.

CSL Behring has already provided $A70,000 in 2017 for a new research grant over two years, and the ANZCA Research Foundation thanks CSL Behring for this exciting new level of commitment.

Dr Julie Lee receives inaugural CSL Behring ANZCA Research Award

In late 2017, Dr Julie Lee of Royal Brisbane & Women's Hospital was awarded the inaugural CSL Behring ANZCA Research Award, for her project "ROTEM® and platelet function in pre-eclamptic obstetric patients: A prospective observational study on labour ward inpatients".

Research support and grants for 2019

The 2019 research grant funding round opened for applications in December and will close at 5pm on Monday April 2, 2018.

Emerging Investigators Sub-Committee

The Emerging Investigators Sub-Committee of the Research Committee was established in 2017 to develop strategies to increase college-wide support for emerging researchers and is chaired by college President Professor David A Scott.

Joan Sheales Staff Education Award

Professor Barry Baker made a generous donation in 2014 in honour of past ANZCA chief executive officer, Ms Joan Sheales. The gift funds the Joan Sheales Staff Education Award, which makes a grant available every second year to help an ANZCA staff member develop their professional capacity to support the college's delivery of high-quality training and education in the specialties. The first award was won in 2016 by Ms Monica Cronin, Curator of the Geoffrey Kaye Museum of Anaesthetic History, and the next will be awarded in April.

Foundation subscriptions appeal

Each year many fellows generously donate with their subscription payments to help the foundation provide more support to more projects. A total of $A55,490 has been received. Last year, fellows donated a record amount of $A64,000 with their subscriptions.

The ANZCA Research Foundation warmly thanks all donors for their generous contributions towards the growth of research supporting quality and safety in anaesthesia, perioperative and pain medicine.

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**.

Hosting at the ASM and updates on trials

ANZCA CLINICAL TRIALS NETWORK

ASM sessions

The ANZCA Clinical Trials Network (CTN) Executive will host two sessions at the upcoming ANZCA Annual Scientific Meeting held in Sydney (May 7-11). We look forward to hearing the results of the Restrictive versus Liberal Fluid Therapy in Major Abdominal Surgery (RELIEF) trial, which will be presented by Professor Paul Myles in our "late breaking trials" session. In addition Dr Mark Shulman will be presenting the results of the Measurement of Exercise Tolerance before Surgery (METS) study. Professor Myles and Dr Shulman will be joined by Dr Karen Domino, Dr Fiona Kiernan and Dr Daniel Sessler for a panel discussion.

The second CTN session will feature presentations from Dr Fiona Kiernan who is a health economist and anaesthetist from Ireland, Professor Monty Mythen who will present an update on large UK led perioperative trials, and Professor Stephen Nicholls, who will present on what outcomes matter in cardiology trials.

There will be a meet and greet with the CTN Executive and trials teams on Wednesday May 9 from 1-1.45pm at the ANZCA lounge to give delegates the opportunity to discuss our latest trials and how they can get involved. There will also be a small group discussion on getting started in multicentre research on Monday May 7. The IV iron for Treatment of Anaemia before Cardiac Surgery (ITACS) trial study team is hosting an Information session on Tuesday May 8 from 3.30-4.30pm. All fellows and trainees are welcome to attend.

For up-to-date information on the CTN sessions at the ANZCA ASM, visit anzca.edu.au/ctn.

Pilot grant scheme

ANZCA Pilot Grant Scheme assists fellows who wish to conduct pilot studies for high-quality multi-centre trials that will potentially attract large-scale peer-reviewed funding. ANZCA allocates $A30,000 each year to the ANZCA Clinical Trials Network to administer a fast-track pilot grant scheme open to fellows of ANZCA and the Faculty of Pain Medicine (FPM). Grants of $A10,000 are available each year. Applicants are encouraged to present their research proposal at the annual ANZCA Clinical Trials Network strategic research workshop held in August, where they will receive peer-review feedback from the Clinical Trials Network Executive. Deadlines for 2018 applications are May 25 and October 5. For further information about the Pilot Grant Scheme and to download the guidelines visit: www.anzca.edu.au/research/anzca-clinical-trials-network/pilot-grant-scheme.

ROCKet trial blasts off

The first ROCKet trial participant was recruited at Austin Health in December. There has been a keen interest from sites to participate in the trial and we look forward to getting these sites on board throughout the year. New sites are welcome to express their interest to participate.

New paediatric sites needed for the T-REX trial

The T-REX trial has commenced recruitment at paediatric hospitals in Australia (Royal Children's Hospital in Melbourne, Sydney Children's Hospital, The Children's Hospital at Westmead and Princess Margaret Hospital for Children in Perth) and in the United States (Children's Medical Centre, Dallas). We invite fellows or trainees with an interest in supporting multi-centre research at paediatric sites to express their interest to participate in the T-REX trial.

Karen Goulding
ANZCA Clinical Trials Network Manager

ROCKet: Reduction Of Chronic Post-surgical Pain with Ketamine

A multicentre double-blind placebo controlled randomised trial of the effect of perioperative ketamine on the risk of development of chronic post-surgical pain.

Study hypotheses: That intravenous ketamine given prior to and following surgical incision for up to three days reduces the incidence of chronic post-surgical pain at 12 months.

Summary

Study size: 4884 patients.

Study design: Large, multicentre, randomised, double blind trial.

Primary outcome: Chronic post-surgical pain at 12 months.

Study population: Elective abdominal surgery involving a skin incision at least 8 cm in length, including open inguinal herniorraphy, non-cardiac thoracic surgery, including mastectomy, breast reconstruction surgery and VATS, and major (non-spinal) orthopaedic surgery.

Per patient payment: estimate $A650

Contact: Sofia Sidiropoulos (ROCKet Trial Manager) sofia.sidiropoulos@unimelb.edu.au

The T-REX trial: Neurodevelopmental outcome after standard dose sevoflurane versus low-dose sevoflurane/dexmedetomidine/remifentanil anaesthesia in young children

The aim of this trial is to determine if low-dose sevoflurane/dexmedetomidine/remifentanil anaesthesia is associated with superior neurodevelopmental outcome compared to standard dose sevoflurane anaesthesia in children less than two years of age having surgery expected to last 2.5 hours or longer.

Summary

Study size: 450 participants.

Study design: Phase III randomised active controlled, parallel group, assessor blinded, multicentre, superiority trial.

Primary outcome: Global cognitive function as assessed by the full scale IQ score of the Wechsler Preschool and Primary School Intelligence Scale assessed at three years of age.

Study population: infants aged less than 2 years of age scheduled for surgery expected to last 2.5 hours or longer.

Per patient payment: $A1000

Contact: Suzette Sheppard (TREX Trial Manager) suzette.sheppard@mcri.edu.au

Anaesthesia in Zambia

Fellow Dr Monique McLeod spent six months in Lusaka working with local anaesthetists with support from ANZCA's Overseas Aid Committee.

Until recently, there had not been a single anaesthetist trained in Zambia since 1964.

It is easy to envisage the significant impact this had, and still has, in addressing the ongoing burden of surgical illness in Zambia. This lack of trained doctors spurred the development of a project called the Zambia Anaesthesia Development Program (ZADP) in which I have been privileged to be involved.

The program was set up in 2012 to address the major deficit of anaesthetists. This aligns with the UN Sustainable Development Goals promoting universal access to health care, as a third of all disease needs some form of surgery and anaesthesia. The aim of this project is to train local Zambian anaesthetists and set up a self-sufficient anaesthesia department and training program at the University Teaching Hospital in Lusaka.

Now 18 doctors enrolled in the four-year specialty training program in anaesthetics. Several have completed the training now, however there are still only 30 anaesthetists in the whole country – a country of 16 million, of whom three quarters live in poverty and have a life expectancy of only 57 years.

I worked in Zambia for six months as part of the program with support from the ANZCA Overseas Aid Committee. There are typically between four and six anaesthetic doctors from around the world that volunteer to help train Zambian anaesthetists under the program. Our role is to provide clinical teaching and supervision as well as initiating quality improvement programs, research and system development and working with trainees who are potential future healthcare leaders in Zambia. The focus of my role was paediatric anaesthesia, neonatal resuscitation and intensive care. Other participants had slightly different roles and focused on developing and delivering the anaesthesia curriculum and examinations, ophthalmic anaesthesia, or airway management in ICU.

As with most things, there were positive aspects within my role though there were also challenges.

Successes included initiating multidisciplinary neonatal resuscitation training and creating and coordinating a Neonatal Resuscitation Committee. This committee continues to convene and is currently addressing staff communication issues, documentation, equipment provision, a triage system for caesarean sections and a call system for neonatal resuscitation. The aim of the committee, through these different avenues, is ultimately to reduce neonatal mortality.

Learning about a different culture, where people are inherently friendly, hearing their stories and making new friends were highlights of the placement.

I also appreciated the opportunity to develop skills for anaesthesia in a resource poor setting. In addition, I found developing and facilitating a seminar on ethics and professionalism with local anaesthesia trainees very rewarding. There had not been much education or support in these areas, and yet it is a system where this remains a significant issue, particularly with maintaining a patient-centred model of care.

Working in a system with a lack of patient centred care, in a strong hierarchical system with limited patient autonomy, was significantly different to my previous experiences. Although six months seemed sufficient when accepting the position, it takes a long time to learn the system, understand cultural implications and gain the trust and cooperation of local staff and trainees.

Handing over quality improvement projects slowed their progress as new teams addressed the same challenges. Similarly, the Zambian anaesthesia trainees warm to and trust people only to have them rotate through again every three to six months.

The cultural perception of the hospital also made it difficult at times to build trust with the local community. People would present to traditional healers when they became unwell or symptomatic which would significantly delay their presentation to the hospital. This meant pathologies were often more complex or end stage when patients arrived and further perpetuated the cycle of late presentations with many believing the hospital is a place where patients die.

In addition, there is the challenge of having patients who are unable to receive necessary care due to a lack of resources or trained personnel. There are patients that manage well through surgery only to die from a lack of staffing or adequately trained staff in ICU overnight. Patients aren't fed and wounds aren't cleaned if family cannot do it. Ventilators fail when the cylinder oxygen runs out and shock or illness can't be treated due to a lack of medication.

Above from left: University Teaching Hospital, Lusaka; Dr Samuel Sibanda, Dr Katie Foy, Dr Monique McLeod; In the neurosurgical theatre a yellow bucket collects rain from a hole in the roof.

"The aim of this project is to train local Zambian anaesthetists and set up a self-sufficient anaesthesia department and training program in Lusaka."

Implementing potential future improvements is fraught. Funding and resource allocation would clearly benefit the system and improve patient care, though finding, maintaining and directing these resources can be challenging.

Family, professional and financial reasons limit how long people are able to stay, and so where it may be beneficial to have longer placements it may just not be feasible. A longer in-country cross-over period may aid handover, however, this also presents a challenge with different start times for different levels of training. Ongoing online communication, however, and in depth involvement of local trainees, and hence consistency, would support transitions and is currently being encouraged.

Another future direction that is evolving is people who have previously undertaken the placement often remain involved but in different capacities.

Participants return as consultants, offering exam practice, subspecialty teaching or continue to contribute remotely by helping with recruitment and funding opportunities.

This will improve consistency with teaching and project development. I am still involved in the neonatal resuscitation project and hope to return to Zambia in the future. As this resource pool of previous participants increases, more importantly, so too does the number of Zambian graduates and the generation of self-sufficiency, which is the definitive goal.

It is a worthwhile project and a truly beneficial and rewarding position to undertake.

Placements like these, which are longer term and aim to integrate with local establishments, have the benefit of addressing systemic issues and establishing change with the fundamental goal of generating a self-sufficient system and providing locally trained anaesthetists for Zambia.

Dr Monique McLeod, FANZCA
Senior Clinical Fellow, Paediatric Anaesthesia
Royal Hospital for Children, Glasgow

Special interest group events

Quality assurance in obstetric anaesthesia

The Obstetric Anaesthesia Special Interest Group (SIG) is facilitating standardised data collection in obstetric anaesthesia, with the release last month of their quality assurance datasets (available via www.anzca.edu.au/fellows/special-interest-groups/obstetric-anaesthesia).

These documents provide two data sets with definitions, specific to obstetric anaesthesia and labour analgesia. The ultimate aim of the SIG is to establish a binational database from which specific Australian and New Zealand benchmarks can be established. Collecting standardised information is the first step in achieving this aim.

Why do we need binational data on obstetric anaesthesia outcomes?

More than 300,000 women in Australia and 55,000 women in New Zealand give birth each year. A significant proportion of these women will require anaesthetic care for analgesia or anaesthesia. Currently, obstetric anaesthetists in Australia and New Zealand compare their practice to targets proposed by the Royal College of Anaesthetists[1]. While these targets are readily available, they do not necessarily reflect the unique features of healthcare in Australian and New Zealand.

In Australia and New Zealand, obstetric anaesthesia may be provided by specialist, trainee and GP anaesthetists. These healthcare professionals practice in different contexts, ranging from small regional hospitals performing caesarean sections and labour epidurals, to large tertiary centres with sub-specialty obstetric anaesthetists caring for women with complex co-morbidities. Existing data collections relating to maternity care collect coarse endpoints such as rates of general anaesthesia use, which are not useful for assessing and improving the quality of our important service.

An exciting time in obstetric anaesthesia

In a major achievement, Dr Guy Godsall, a specialist anaesthetist at the Sunshine Coast University Hospital in Queensland is this year launching the Statewide Obstetric Anaesthesia Benchmarking System. Thirty-six hospitals have signed on to contribute to this database, which is supported by the Statewide Anaesthesia and Perioperative Care Clinical Network and funded by the Queensland Health Clinical Excellence Division Health Improvement Unit.

We know other obstetric anaesthetists across Australian and New Zealand are already collecting quality assurance data at the local level and there is significant interest in sharing that data. Through the ANZCA website, the Obstetric Anaesthesia SIG is not just providing datasets and definitions, but also connecting individual sites who wish to collaborate, compare and share their data. Together with the Queensland benchmarking system, we believe this is a strong start toward our endpoint of a bi-national database.

Associate Professor Victoria Eley
Chair, Obstetric Anaesthesia Special Interest Group
v.eley@uq.edu.au

Dr Guy Godsall
Sunshine Coast University Hospital
guy.godsall@health.qld.gov.au

Reference:
1. Colvin J, Peden C, (Eds). Raising the standard: A compendium of audit receipes. 3rd ed. United Kingdom: Royal College of Anaesthetists; 2012.

New Zealand news

NZ National Obstetric Anaesthesia Leads (NOAL) turns two

ANZCA and the NZSA have supported the establishment of a national clinical network of obstetric anaesthetists over the last two years, which has grown to include a representative from nearly every DHB in New Zealand. The group was set up by Aidan O'Donnell (Waikato), Douglas Mein (Wellington) and Matthew Drake (Auckland).

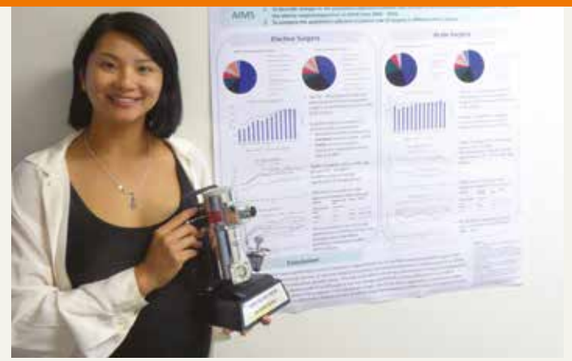
Before NOAL was established there was no forum in New Zealand for national issues affecting obstetric anaesthesia to be discussed, and no means for ideas and good practice to be shared. Meeting face-to-face three times a year has fostered an excellent sense of collegiality and networking between small units and large tertiary centres.

Between meetings the group email list allows a rapid straw poll of contentious issues or advice on management of clinical problems. An example of this is after FDA and subsequently Medsafe issued a warning that Tramadol was contraindicated in breastfeeding. The ability to quickly discuss the evidence and formulate a national group consensus view was very useful to influence Medsafe to moderate its advice. Consequently members of the group were reassured that they were supported in continuing to use tramadol judiciously for acute pain following caesarean section.

NOAL has a cloud drive to share guidelines, charts and other related documents. Previously each DHB developed these in isolation leading to a large amount of duplicated effort and unnecessary variation in practice. This has proved particularly useful for anaesthetic input into national guidelines, such as the forthcoming revision of the Ministry of Health's National Consensus Guideline for treatment of Postpartum Haemorrhage.

One meeting each year includes a joint session with obstetric and midwifery clinical leaders. This allows exchange of perspectives and joint solutions to shared problems, such as how best to provide women with adequate unbiased information on labour analgesia, issues with the forthcoming electronic National Maternity Record, and coordinating a national approach to managing the growing obesity epidemic among parturients.

Sharing ideas and experience of novel techniques has been very useful for disseminating innovative practice across the country. Using anaesthesia to improve success rates of external cephalic version, making labour less potent to allow mobility in labour, tranexamic acid for postpartum haemorrhage, experience of ROTEM-guided point of care testing from the Welsh Obs Cymru patient safety initiative, and enhanced recovery programmes in obstetrics have all been discussed and are spreading New Zealand-wide as a result.



The art of fellowship and presentation at the ARM

Dr Carolyn Deng from Auckland City Hospital won the ANZCA NZ National Committee prize for the best scientific presentation at the 2016 Annual Registrar Meeting (ARM), held in December. Her research looked at a 13-year trend in acute and elective surgery for patients aged 60 and above at the Auckland District Health Board.

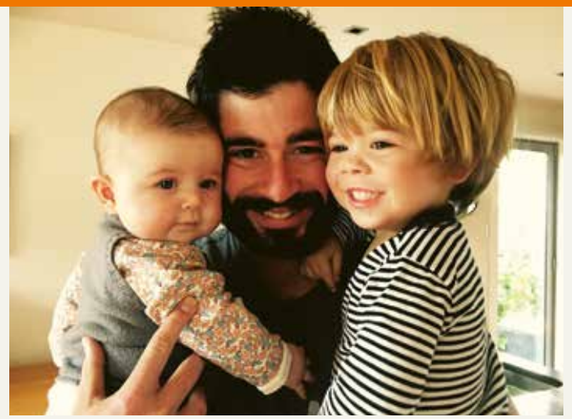
Dr Deng also took the Caduceus Prize for Excellence in Anesthesiology Research for her single-centre, randomised controlled pilot trial comparing performance of direct laryngoscopy for endotracheal intubation in surgical patients.

A morning session for the trainees focused on professional development. Dr Jonathan Panckhurst, chair of the ANZCA Trainee Committee, updated the trainees on the role of the Committee and issues of relevance for the trainees. Dr Rob Burrell from Counties Manukau DHB gave a thought-provoking talk on Sustainability and Anaesthesia which covered topics including recycling of operating room waste, the environmental effect of anaesthetic agents and how his DHB has reduced its carbon footprint.

This year the Fellowship Forum featured Dr Era Soukhin of Dublin, Ireland, Dr Grace Chang from Singapore and Dr Michael Tan from Toronto, Canada. They were sharing their fellowship experiences. This generated discussion about organising a fellowship, the benefits gained from fellowship experiences and the uncertainty of leaving the security of a training position and acquiring an SMO job.

The afternoon session covered topics ranging from airway management, patient satisfaction, fasting in labour, diabetic management and surgical epidemiology. As part of the process, all presenting trainees prepare a scientific poster as well as an oral presentation. This is designed to help them develop the skills required to prepare for submission of research or audit at an external meeting.

Dr Lora Pencheva was awarded the NZSA Prize for Best Quality Assurance Presentation for her work on restricting oral intake and antacid use in labour: adherence to a new guideline.



Scholarship paves the way

Relocating a family for a year on an overseas fellowship can prove prohibitive for young anaesthetists so being awarded the BWT Ritchie Scholarship has made the move financially viable for new ANZCA fellow Dr Oliver Brett of Christchurch.

"The fellowship at Vancouver General Hospital for a year consists of a relatively small salary which would just cover rent so moving there with my wife and two young kids in July was going be a big financial burden," says Dr Brett.

The fellowship is a general clinical fellowship, and Dr Brett also plans to learn transthoracic echocardiography while in Canada. The scholarship will also help with the online learning and sitting of exams on this specialty. "I can then build on the online learning by getting clinical experience in Vancouver that I can use back in New Zealand. Transthoracic echocardiography is another useful skill that can enhance anaesthetic care in the perioperative period," he says.

Dr BWT Ritchie undertook his anaesthetic training in the UK at a time when there was very little financial support for registrars, and they were required to travel overseas to complete their training. He set up the BWT Ritchie Scholarship to assist registrars in financial hardship to extend their international training.

Applications for the 2019 fellowship close on October 31. Please visit www.anaesthesiaeducation.org.nz for more information.

TIVA, IT & opioids – lectures to the regions

The New Zealand Anaesthesia Education Committee's (NZAEC) visiting lectureship program is making some stimulating presentations available to the regions this year.

Dr Ian Williams practice-changing presentation – a personal journey, my experience with TIVA –outlines why total intravenous anaesthesia (TIVA) remains a minority anaesthetic in many practices. The presentation includes observations and examples of best practice, including his experiences during the past three years of administering over 1500 TIVA's. Dr Williams hopes that with better understanding of the techniques and monitoring equipment available, this excellent form of anaesthesia will be utilised more often.

The opioid epidemic in the US, lessons learned is the topic of Dr David Sidebotham's presentation looking at the perils and consequences of opioid analgesia.

Dr Lara Hopley delivers the third of the lectures looking at the state of health IT in New Zealand through a post-election lens.

Please visit www.anaesthesiaeducation.org.nz/lectureship for more details.

Above from left: NOAL group from left: Dr Matt Drake, Dr Han Truong, Dr Douglas Mein and Dr Tim Parris Piper. Dr Truong is explaining the Patient Controlled Oral Analgesia (PCOA) blister pack initiative for women following caesarean delivery; Dr Carolyn Deng with her winning presentation and ANZCA best scientific presentation award; Dr Oliver Brett with his children Lucy (left) and Thomas; Dr Ian Williams, Dr Lara Hopely and Dr David Sidebotham.

Australian news

Queensland

Art and mindfulness

The first Queensland continuing medical education evening of 2018 will be held at Queensland Art Gallery (QAGOMA) on March 27. An initiative of Dr Anna Hallett with an interest in the wellbeing of doctors, and Dr David McCormack, Chair CME Committee.

Art appreciation as a form of mindfulness can assist in coping with stress and long hours working in anaesthesia. The first art and mindfulness workshop took place as part of the ANZCA ASM in May 2017. Following on from its success, anaesthetic registrars from the Princess Alexandra and Logan hospitals have undertaken similar workshops at QAGOMA with the support of Dr Hallett.

Building on these workshops, art appreciation and mindfulness is now open to Queensland Fellows. The program includes exclusive access to The Queensland Art Gallery, and an opportunity to network and enjoy a cocktail reception. Topics that will be discussed as part of the program include: highlighting aspects of our personalities that make us prone to burnout; using art as a form of relaxation in itself, or as a form of mindfulness; using art as a way to reconnect with people, family, friends, patients and work colleagues; the realisation of the world that is present outside medicine. Fellows may claim CPD activity under the knowledge and skill category: workshops for two credits per hour.

Registration is now open via the ANZCA website.

Save the date – ACE conference

The Queensland ACE Conference will be held on Saturday June 30 at the Brisbane Convention and Exhibition Centre. The organising committee is currently developing the program and further details will be available shortly. Please refer keep an eye on the ANZCA website for the latest updates. We look forward to seeing you there.

Courses

Preparation at the Queensland Regional Office has been focussed on the February 17 Part Zero Course, to welcome new trainees into the ANZCA training program, and the first final exam preparation course, convened by Dr Stuart Blain, will be held from Monday February 19 to Friday February 23, 2018. Also the primary lecture program will run across five Saturdays from February through to June.

Other news

The Queensland Regional Office recently received a copy of the portrait of Dr Genevieve Goulding, immediate past President of the College. The digital photographic portrait, the first of its kind for a past president, was the entry for the Martin Kantor prize, by award-winning photographer Chris Budgeon. As well as being displayed at ANZCA House, Melbourne, the portrait will hang proudly in the regional office, as a reminder of the outstanding contribution Dr Genevieve Goulding continues to give to the college and to anaesthesia.

New South Wales

Anatomy course

The “Anatomy for anaesthetists” course was held on November 24, 2017 at the University of Sydney was well received with 29 delegates attending. Many thanks again to Dr Elizabeth O’Hare, Dr John McCarty, Dr Joe McGuiness, Dr Kevin Russell, Dr Jennifer Stevens, Dr Gurdial Singh, Dr Luke Bromilow, Dr Andrew Armstrong and Dr Graham Bruce who dedicated their valuable time to create such an excellent and educational workshop.

Australian Capital Territory

Scan and Ski Workshop

After the great 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 30 participants so don’t delay.

Art of Anaesthesia – save the date

In 2018, the annual Art of Anaesthesia scientific meeting will be held over the September 15-16 weekend. This coincides with the renowned Floriade festival on the shores of Lake Burley Griffin and is a beautiful time to visit the nation’s capital. This year the meeting will be held at the modern National Museum of Australia and the convenors Dr Girish Palnitkar and Dr Carmel McInerney already have many wonderful ideas to make this year’s meeting bigger and better than ever. Of particular note is confirmation of our international keynote speaker Dr Franco Carli, Professor of Anesthesia at McGill University and a world expert in prehabilitation and ERAS. We can’t wait to welcome Dr Carli to our meeting. Save the date now!

ACT Trainee Committee

In 2018 we welcome a new Trainee Committee and look forward to working closely with them over the next year. Newly elected members are: Dr Julia Hoy (Chair), Dr Sifi Vattakunnel (Deputy Chair), Dr Martin Dempsey, Dr Stuart McKnown, Dr Nicole Somi, and Dr Holly Manley (co-opted). We look forward to working closely with the committee during 2018.

Australian news (continued)

Victoria

Part Zero Course

The Part Zero Course for introductory and basic trainees was held on Friday March 2 at the college. The course was well attended with a total registration of 50 trainees. There was an interactive team building session and airways workshop for the trainees. A panel of supervisors of training also attended as part of the program to take questions from the registrars with regard to concerns, issues and expectations of the first year in training.

Ray Hader Award presented

Last year ANZCA Fellow Dr Antoinette Brennan, a visiting medical officer anaesthetist at Monash Medical Centre received the Dr Ray Hader Award for Pastoral Care from ANZCA President and Professor David A Scott (left) and Dr Brandon Carp, Ray Hader's friend who established the award in Ray's memory. Dr Brennan received a certificate and $A2000 to be used for training or educational purposes.

Final fulltime course

This five-day course was held at the Parkview Hotel from February 12-16. This particular course broke the record number registered with 107 trainees attending the course. As in the past it was encouraging to have among our attendees trainees from New Zealand and interstate. To the convenor, Dr Glenn Downey, and all of the valued presenters of the course, we would like to offer our sincere thanks for their time and commitment to our academic activities.

Western Australia

Autumn Scientific Meeting and more

The Autumn Scientific Meeting has opened for registration and will be held at Joondalup Resort on April 7, 2018. The theme "We are all in this together – volunteerism, self-care and responsible anaesthesia" includes presentations on sustainability, practical aspects of volunteering and the Bunny Wilson Lecture by Dr David Perlman. Workshop options include "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. There are places available in the workshops, contact the WA office for registration or register via the ANZCA online calendar.

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, a program and registration will be available later in the year.

For a more casual and private meeting environment, Western Australia's EO/SOT Committee held their annual dinner meeting in-house on Wednesday, January 31 at the WA ANZCA office in Wembley. A Thai cuisine theme was savoured in a beautifully decorated meeting room, with a small gift waiting for each member to thank them for their time and commitment to the committee.

ANZCA WA held the Part Zero Course on February 9 for 11 new trainees commencing during 2018. Dr Jay Bruce and Dr Kevin Hartley welcomed the new group, providing information on managing schedules, with some valuable insight into effective ways of achieving work-life balance as an anaesthetic registrar. They also led a fun group exercise to encourage team building, cooperation and thinking outside the box.

Guest speakers were a combination of trainees, supervisors of training, consultants and executive officers to discuss professionalism and performance, ANZCA resources, the Training Portfolio System, welfare, mentoring and training, to mention a few. The extensive mix of experience gave the new trainees a greater understanding of what is expected of them and what their positions will involve. We thank Kevin and Jay for their valuable time in coordinating another successful program.

The Part Two Course is also well under way. If you are a trainee studying for your exam and would like some further tutoring please visit the ANZCA calendar for the Part Two Tutorial registration page.

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

Finally, we would like to congratulate the 2017 recipient of the ANZCA/ASA Gilbert Troup Prize in Anaesthetics, Dr Shannon Marantelli.

Above from top: EO SOT Committee enjoying the dinner; Dr Kevin Hartley presenting to the Part Zero trainees; Dr Kevin Hartley with Dr Siaavash Maghami and Dr Keat Chan; Dr Jay Bruce, Dr Ange Palumbo and Dr Kevin Hartley.

Tasmania

Tasmanian ASM Trainee Day

Thirty-one delegates attended the Trainee Day at the historic Hadley's Orient Hotel in Hobart. While most of those registered were from the three regions of Tasmania, trainees from Melbourne, Geelong, Sydney and even Perth valued the dynamic presentations by local and interstate speakers.

Interstate speakers included Dr Rani Chahal from the Peter MacCallum Cancer Centre, Victoria who spoke on the nuances of anaesthesia for head and neck cancer surgery: anatomy, pathology and the shared airway; Dr Lachlan Miles from Austin Health, Victoria presented on the perioperative management for non-cardiac surgery in the adult cardia or pulmonary transplant recipient; Dr Ginette Falcone on "Discomfort in the comfort zone – a tsunami of maternal haemorrhage in placenta percreta"; and Clinical Associate Professor Philip Ragg from the Royal Children's Hospital, Victoria on "Do we really need to fast children".

Two current examiners presented a session on "surviving and thriving the primary and final exam". The trainees greatly appreciated some invaluable pointers from Tasmanian speakers Dr Mark Reeves and Dr Tom Mohler.

A highly successful and popular panel discussion mediated by Dr Darren Meehan finished the day. The five-member panel included both presidents of ANZCA and ASA and senior Tasmanian anaesthesia and pain consultants candidly sharing their experiences on their chosen career paths and work/life balance.

Positive feedback commended the diversity of the panel and topics with one mentioning the "good variety of topics, all very relevant, excellent speakers" and another pointing out the "great mix of exam focus, career focus and engaging content".

The co-convenors were pleased with the outcome of the day and greatly appreciated the contribution of everyone involved in implementing the successful day.

Dr Yang Yew and **Dr Liz Judson**
Co-Convenors Tasmanian Trainee Day 2018

Foundation Day and Part Zero courses

The annual Foundation Day and Part Zero courses were held in Launceston on February 16 and 17. The Foundation Day concentrates on practical skills and knowledge for registrars and SRMOs just starting off in anaesthesia. Nineteen people from around Tasmania attended. There were ALS, CICO, and epidural workshops as well as introductory sessions on pre-operative assessment and pain management. Feedback was very good with the hands-on nature of the sessions always being popular.

Dr Luke Murtagh was the convenor of the ANZCA Part Zero course. Twelve new ANZCA trainees and future trainees attended. It's a collegial day with time for trainees from around Tasmania to meet up socially, including a Chinese New Year Dinner the night before. Topics covered include the ANZCA Curriculum, TPS, and examination preparation.

Welfare and Professional Behavior are increasingly important areas. The support structure for trainees in Tasmania of peers, mentors, departmental welfare officers and ANZCA trainee and fellow committee representatives was outlined. Ways of identifying, responding to, and reporting unacceptable behaviors were discussed.

The group were reminded that they are the first cohort of trainees where rural background was taken into account for their selection. They will all spend two years of their training in Tasmanian rural or regional hospitals. Career advice was given that prospects for consultant jobs when they finish training are likely to be in rural/regional Australia rather than the capital cities.

Colin Chilvers, Foundation Day Convenor
Chair, Tasmanian Regional Committee
ANZCA

Tasmanian Annual Scientific Meeting

Sixteen keen ALS and 47 major haemorrhage workshop participants started the day early with a barista style coffee and light breakfast before their 7am and 7.15am workshops. The remaining 70 delegates gradually arrived for a day of talks and presentations based on the theme "Anaesthesia – Out of the Comfort Zone".

A diverse range of topics took delegates beyond their comfort zones, challenged thinking and provided new knowledge, new approaches and reassurance for difficult clinical situations. The engaging topics included:

- Associate Professor Philip Ragg on "Adult congenital heart disease – you can run but you can't hide".
- Dr Lachlan Miles on "Perioperative management for non-cardiac surgery in the adult cardiac or pulmonary transplant recipient".
- Dr Catherine Olweny on "Help, my patient has a myopoathy! Understanding muscle disorders".
- Dr James Griffiths "Zen and the Art of Communication for the Anaesthetist".
- Dr Jeff Ayton from the Antarctic Division; Dr Lizzie Elliott and Clinical Professor David Smart shared their knowledge and experience in Antarctica with their talk on "Antarctic Gases".
- A panel discussed and debated "Challenges and practices of paediatric anaesthesia in regional areas, especially the associate credentialing issues. "You can't do that! Credentialing challenging clinical need" saw five panelists including Professor David A Smart; Associate Professor David M Smart, Dr Bruce Newman, Dr Jeremy Sutton, Dr Sarah Boardman and Dr Catherine Olweny.

The meeting finished with the president's address for both ANZCA and ASA and the annual general meetings for the Tasmanian regional committees of ANZCA and ASA.

At the end of an interesting and challenging day, 60 people relaxed to the soft sounds of the harp, flute and keyboard in the comfort of the Henry Jones Art Hotel while sipping on Tasmanian wine and beers and soft drink and enjoying canapes made up of locally sourced ingredients.

Feedback on the day was largely very positive with delegates enjoying the variety of quality speakers as well as the opportunity to get their CPD points ticked off at the breakfast workshops and not missing any of the presentations.

The Tasmania ASM 2018 was a successful meeting and reflects the quality of CME activities in the state. The quality of speakers, the ongoing support of ANZCA and the ASA with the presence of both presidents, and the efforts of the organizing committee all contributed to a successful meeting.

Dr Lia Freestone
Convenor, Tasmanian ASM 2018

Above clockwise from left: 2018 Tasmanian combined ASM – Panel discussion on "You can't do that! Credentialing challenging clinical need". Sitting down from left: Dr Jeremy Sutton, Dr Simone Boardman, Dr Catherine Olweny, Associate Professor David M Smart and Professor David A Scott. Standing up from left: Dr Karl Gadd and Dr Bruce Newman; Antarctic display at the Tasmanian ASM. From left: Dr Lizzie Elliot; Dr Jeff Ayton (Antarctic Division) and Clinical Professor David Smart; Social gathering at the IXL Atrium, Henry Jones Art Hotel for the Tasmanian ASM meeting; Panel discussion on careers and work/life balance at the Trainee Day.

South Australia and Northern Territory

Part Zero Course

The SA and NT regional office held the Part Zero Course for introductory trainees commencing the training program on Saturday January 20, 2018. The orientation course included information about the training portfolio system, workplace based assessments, exams, mentorship and work/life balance. It was a relaxed, yet informative day which included a light-hearted look at when life doesn't quite go to plan.

Above from left: Dr Munib Kiani (course facilitator), Dr Emma Panigas, Dr Rachel Jesudason, Dr Andrew Burch, Dr Aimee Som, Dr Matthew Higgins, Dr Joanne Tan and Dr Christopher Stanton.

Annual SA and NT trainee dinner

The annual SA and NT trainee dinner was held at The Store, North Adelaide on Saturday, November 4, 2017. Guest speaker Dr Peter Carlin gave an engaging presentation and perspective on anaesthetics, training and general life advice. It was a good night, with good food and good company.

Dr Martin Elvis Lum, FANZCA 1959-2017

Martin was born and raised in Napier, New Zealand. He was a student at Napier Boys High School where he was noted to be gifted, outgoing and popular.

His interests included music and photography and he played several musical instruments including piano and viola. He enjoyed arranging recitals where he would perform using an instrument he chose for the day.

Later, in his spare time in Sydney, he regularly formed chamber music groups.

Martin's photography interests continued when he lived in Sydney and Melbourne. He exhibited at the Ballarat Internationale Foto Biennale and his photographs from the Sydney 2000 Olympics are now held by the National Library of Australia.

Martin studied medicine at Otago University. He was based in Wellington for his clinical terms and was admitted to fellowship there. In addition to his medical studies he also volunteered with St John Ambulance.

He had an early interest in trauma and resuscitation and joined resuscitation committees when able. Memorable experiences included working at a trauma hospital in Washington DC and working with St John Ambulance caring for injured anti-apartheid protesters during the 1981 Springbok Rugby tour of New Zealand.

In 1991 Martin moved to Sydney where he started working at Liverpool Hospital. Between 1991 and 1995 he also worked at CareFlight as a specialist in retrieval medicine where he was acting medical director for two years. Martin played a key role in helping to embed critical care retrieval as an essential and accepted component of ambulance, trauma and critical care services in NSW.

Early road retrievals involved the doctor travelling by taxi to the referring hospital with equipment, stabilising the patient and booking a road ambulance. Martin was instrumental in establishing the role of the doctor as part of the pre-hospital and inter-hospital critical care teams.

Frustrations in the field required enthusiasm, persistence and a sense of humour – Martin had these in abundance. Martin was also involved in the development of CareFlight's international retrieval service by jet ambulance, or, more commonly in the early days, aboard regular passenger flights. He performed some of the first missions of this type.

In 1995 Martin left CareFlight to devote more time to his role as Director of Anaesthesia and Recovery at Liverpool Hospital. With his lifelong passion for postgraduate continuing education he embarked on an MBA.

Martin was part of the new wave of clinical leaders who accepted that to lead a department well it was not enough to just have excellent clinical skills (neuroanaesthesia in Martin's case). Being equally qualified in leadership and management Martin brought his insights from his MBA to Liverpool Hospital's anaesthetic department. In his consultative style, he established a multidisciplinary leadership team and shared decision-making involving nursing staff as partners in this process. Martin introduced a quality improvement structure and process that ensured the young and growing department maintained high quality services, equal to the larger, more established hospitals.

Martin also led the department through the expansion and modernisation of Liverpool Hospital's theatres. Always generous with his time and advice those fortunate enough to have been part of the department then remember Martin fondly. Innovation was encouraged and failure was an opportunity to learn.

Martin was also instrumental in establishing the Anaesthetists in Management special interest group at ANZCA, creating a forum for others to learn and discuss the knowledge, skills and behaviours that anaesthetic leaders and managers needed to develop alongside their clinical careers.

In 2006 Martin relocated to Melbourne, joining the Department of Health and Human Services where he held executive roles in health service performance, quality safety and patient experience, as well as contributing to the redesigning hospital care program, and the executive connect program.

He was also the Minister of Health's appointee to the Board of the Victorian Institute of Forensic Medicine for several years.

This left increasingly little time to continue practising clinical anaesthesia, and his association with ANZCA where he had been an enthusiastic attendee at the management SIG. With his MBA and extensive work experience, Martin was always in high demand as a speaker and workshop facilitator. He gave his time and knowledge generously and was a wonderful mentor for new heads of departments of anaesthesia.

Sadly, a series of psychological stresses resulted in a decline in his mental and physical health and wellbeing. He passed away peacefully at his home in September 2017.

He is survived by his parents Mary and Charlie, and siblings Janet, Virginia and David.

Dr David Lum, FANZCA, Westmead Hospital, and family

Dr Andrew Hill, FANZCA, Liverpool Hospital and CareFlight

Dr Tracey Tay, FANZCA, John Hunter Hospital

Dr Vanessa Beavis, FANZCA, Auckland District Health Board

Dr Blair Munford, FANZCA.

Ms Anna Burgess, DHHS Victoria

Richard Harding, FRCA FANZCA 1970-2017

Richard was a consultant in anaesthesia and intensive care medicine, working for the Northland District Health Board at Whangarei Hospital in New Zealand.

Richard qualified from Nottingham Medical School in 1993 and, after completing house jobs, decided to work in Brisbane, Australia, where he stayed for just over a year before returning to the UK to embark on specialty training in anaesthesia and intensive care. During his specialty training Richard spent time in Edinburgh and in Yorkshire. On gaining his certificate of completion of training (CCT), the pull of the southern hemisphere saw Richard journey back to Australia, where he spent a year working in Perth before crossing the Tasman Sea to take up a consultant position in Dunedin, where a love affair with New Zealand began.

Richard then returned to the UK in 2007 to take up a consultant post at the Hereford County Hospital where he became the clinical lead for critical care the following year. Richard was instrumental in setting up the vascular access service in Hereford, and in 2009 became the clinical lead there for organ donation.

In 2013 he also took on a part-time role at the Queen Elizabeth Hospital, Birmingham, working in ICU, which he greatly enjoyed. In due course, the lure of the New Zealand lifestyle became too strong to resist, and in 2016 Richard moved to Northland with his wife Kate, a GP and hospice doctor, and their teenage children Amy and Jake.

Richard began working at Whangarei Hospital in late 2016. He soon established himself as a valuable addition to both the departments of anaesthesia and intensive care medicine. Again he found himself involved in organ donation, and began to initiate the process of accrediting the hospital for donation after cardiac death. He became a fellow of the Australian and New Zealand College of Anaesthetists shortly before his death.

He threw himself into the Kiwi way of life, buying a boat, and taking up fishing and open water swimming. He was never happier than when he was walking his dogs with his family around the beautiful coastline of Northland. He loved travel, and took his family to Fiji, Japan and Australia while living in New Zealand.

Richard was regarded by all who knew him as a highly competent, confident and amiable colleague. His approach to work was to get on with what needed doing with the least fuss possible, and then get on with the rest of living. His stand-out phrase when asked for advice was "crack on"! He was very much a "go-to" person for assistance, with excellent technical skills and a "can-do" manner which made asking for help easy.

The other abiding memory of Richard was that of a cacophonous and infectious laugh, which resonated round the theatre suite and intensive care units with pleasing frequency whenever he found something amusing. This is sorely missed at his workplace.

Richard suffered from two episodes of depression in the last 18 months of his life. He died as a result of the second on October 23, 2017. He is survived by Kate and his children, his father, his brother and sister and wider family, and his many friends and colleagues.

Dr Dan Owens, FRCA FFICM (UK), Specialist in Anaesthesia and Intensive Care Medicine, Northland DHB, New Zealand

Dr Jo Coates, FRCA FANZCA, Specialist in Anaesthesia, Northland DHB, New Zealand

For help or information, visit beyondblue.org.au or spinz.org.nz or call Lifeline (Australia) on 13 11 14 or Lifeline (New Zealand) on 0800 543 354.

More information, including access to Welfare of Anaesthetists Special Interest Group resources, can be found at www.anzca.edu.au/resources/doctors-welfare

Dr (Vernon) Bruce Cook, FANZCA , FFARACS 1923-2018

Bruce Cook died on January 13 in Marlborough, New Zealand at the age of 94.

He was born on June 23, 1923 in Yorkshire. His father was a New Zealand pilot with the RFC where he met and married a volunteer nurse. They all soon moved back to Palmerston North where the family owned a timber mill.

After attending Terrace End Primary and Wanganui Collegiate, Bruce graduated MB ChB from Otago in 1948. House surgeon years in Wellington were followed by anaesthetic training in the US (at Cleveland) and then the UK. While in Britain he managed to fall between the DA and the FFARCS allowing him to return to New Zealand with both qualifications. He gained the FFARACS in 1958 by, he claimed, "paying a fee to chat with some Australians over tea and biscuits".

Bruce was appointed senior registrar in Wellington in 1955. After five years he was promoted to junior specialist, and in 1961 he went part-time forming the Mayfair Anaesthetic Group (known colloquially as the Mafia) with Dr Slater and Dr Wright. The practice was named after their rooms, but also giving a nod to Sir Robert Macintosh and his Mayfair Gas Company in the UK.

In those early days, anaesthetists were paid by the surgeon. Bruce's first private fee was one guinea (one pound one shilling), then the standard fee no matter what the surgical case. In the 2000s, after repeated requests from Bruce, an anaesthetic colleague tendered a fee for one guinea. After some research Bruce discovered that a guinea coin, last minted in 1813, was now valued at £4000 ($NZ7600). Bruce thought this fee extortionate, and settled the account with a bottle of single malt.

Bruce continued as a part-time consultant at Wellington Hospital until 1988 and gave his last private anaesthetic at the Home of Compassion in 1993. He was an early enthusiast for spinal anaesthesia and cardiac anaesthesia, administering the first anaesthetic for a private CAVG in Wellington in 1984, at the then Calvary Hospital. His association with these Catholic hospitals led to his meeting Pope John Paul II in 1986.

Bruce was a member of the NZSA Executive in the late 1960s and early 1970s, and was president in 1972-73. He was made a life member in 2012.

In retirement, Bruce settled in Renwick. He had an interest in the wine industry, and was an initial part-owner of Le Brun, who pioneered Methode Champenoise in New Zealand. This association led to a wine tour of France in the 1990s, and a lasting friendship with Daniel Le Brun.

Bruce had a wide and eclectic range of interests. Aside from wine, his great love was cars. He raced early Jaguars and Porsches, and imported one of Wellington's first BMWs in 1971. He remained a member of the local Jaguar Drivers' Club until his death. He was also a shooting enthusiast, helping to found the Wellington Pistol Club and build its first range. Also a keen boatie, he spent many hours fishing on the waters of Wellington Harbour or the Marlborough Sounds.

Bruce Cook loved language and literature, and lived his life following the advice of Polonius to Leartes in Hamlet: "This above all: to thine own self be true."

This love of language was reflected in his pithy anaesthetic aphorisms, known as "Cookisms" and long remembered with affection by his former registrars. These included pearls of wisdom such as:

"Surgery is like sex – it's a non-spectator sport."

"Signs of a surgeon in trouble: adjust lights; adjust table; ask for more relaxation."

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

"Surgery begets surgery."

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

Comedian and commentator Raybon Kan, in an article on cardiac surgery at Wakefield, referred to Bruce as "...the Jack Pallance of anaesthesia..." with" ... the voice of a Shakespearean thespian combined with the face of a professional pugilist!"

Bruce's beloved wife Beverly pre-deceased him. He died of renal failure, following a fractured hip on December 22. He was "Pater Familias" to his four children and two grandchildren, all of whom he loved dearly.

Kua hinga te totara i te wao nui a Tane. *The totara has fallen in the forest of Tane.*

Vale Bruce Cook: physician; raconteur; scholar; gentleman.

Rosie Cook
Dr Graham Sharpe, ONZM FANZCA
Dr Phil Thomas, FANZCA