SEPTEMBER 2018
ANZCA BULLETIN
ANZCA
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
FPM
FACULTY OF PAIN MEDICINE ANZCA
Focus on Indigenous health
Dr Richard Harris: Insight into the Thailand cave rescue

62 Opioid forum drives debate

FPM leads a timely discussion on real-time prescription monitoring and limiting prescriptions on discharge as possible solutions to tackling the escalating use of opioids in the community.

41 Fatigue and the anaesthetist

Dr Marion Andrew and Professor David A Scott explore the cultural and systemic issue of fatigue on specialists and the importance of rostering and adapting hospital systems to maximise recovery, sleep, health and general wellbeing.

24 College endorses new Indigenous health strategy

ANZCA's strategy is underpinned by the principles of partnership, participation, equity and accountability. Significant inequities in health outcomes exist among Indigenous and Torres Strait Islander people in Australia and Māori in New Zealand but many fellows and trainees are already playing a leading role to effect change.

34 Dr Richard "Harry" Harris leads cave rescue

The Adelaide anaesthetist and cave diver reveals to the Bulletin the challenges of practising sedation deep inside an underground cave in Thailand where he led the medical response for the international team that successfully rescued a group of 12 young soccer players and their coach.

46 How to avoid drug errors

Safe medical handling and labelling requires vigilance to prevent mishaps but read how more can be done to reduce adverse events.

70 Perioperative medicine attracts trainees

A local arm of the international organisation Trainees with an Interest in Perioperative Medicine has been formed in response to growing interest in Australia and New Zealand.

Contents

4 President's message
5 Chief executive officer's message
6 Letters to the editor
8 ANZCA and FPM in the news
10 ANZCA and government: Indigenous health report
14 FPM meets Australia's Minister for Health Greg Hunt
19 ANZCA's professional documents: What would you do?
22 Get ready for ANZCA National Anaesthesia Day
24 ANZCA drives new Indigenous health strategy
34 Hero anaesthetist gives his all in Thailand rescue dive
41 Fatigue – a cultural and systemic issue
46 Safety and quality: Safe labelling
50 ANZCA Clinical Trials Network
52 ANZCA Research Foundation update
54 Library update
59 Faculty of Pain Medicine
62 Opioids and chronic pain focus of FPM forum
64 Anaesthetic history
66 CPD: How some of our private practitioners are completing practice evaluation activities
67 Would you know how to respond in an anaphylaxis emergency?
69 Medical education – why would I want to do a course about that?!
70 Perioperative medicine attracts more trainees
72 Common mistakes in audits or research
73 Diploma of Advanced Diving and Hyperbaric Medicine
76 Special interest group events
78 New Zealand news
81 Australian news
88 Obituaries
91 Future meetings

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

Cover: Lazarus, five, and mother Joanne at the Gove District Hospital in Nhulunbuy, East Arnhem Land.
Photo: Carolyn Jones

Medical editor:
Dr Nigel Robertson

Editor:
Clea Hincks

Art direction and design:
Christian Langstone

Production editor:
Liane Reynolds

Advertising manager:
Vivienne Forbes

Submitting letters and other material
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.

Advertising inquiries
To advertise in the *ANZCA Bulletin* please contact communications@anzca.edu.au.

Contacts
ANZCA
630 St Kilda Road, Melbourne
Victoria 3004, Australia
Telephone +61 3 9510 6299
Facsimile +61 3 9510 6786
communications@anzca.edu.au
www.anzca.edu.au

Faculty of Pain Medicine
Telephone +61 3 8517 5337
painmed@anzca.edu.au
www.fpm.anzca.edu.au

Copyright
ANZCA may promote articles that appear in the Bulletin in other forums such as the ANZCA website and ANZCA social media platforms.

Copyright © 2018 by the Australian and New Zealand College of Anaesthetists, all rights reserved. None of the contents of this publication may be reproduced, stored in a retrieval system or transmitted in any form, by any means without the prior written permission of the publisher.

Please note that any views or opinions expressed in this publication are solely those of the author and do not necessarily represent those of ANZCA.

ISSN:
1038-0981 (print)
2206-5423 (online)

President's message

This edition of the *Bulletin* includes an interview with Dr Richard "Harry" Harris during which he discusses the extraordinary rescue of the boys trapped in the cave complex in Thailand. His concern for the safety of his colleagues was paramount, as he found himself in the unenviable position of having to balance risks and potential adverse outcomes for both those being rescued, and those doing the rescuing. The reality was that the latter were compromising their own safety to a degree, despite all attempts to mitigate these risks. The reality also is that Harry ultimately shouldered a significant burden of this responsibility. He had little choice, and it is a responsibility that we all have to accept, and at times struggle with, within the context of the nature of our work.

The June issue of the *Bulletin* discussed the selfless efforts of Dunedin anaesthetist Dr Matthew Zacharias, working with Medecins Sans Frontieres (MSF) amidst the chaos in Iraq to provide anaesthesia to victims of violence in that nation. Previous issues have described the work of Dr Jenny Stedmon who volunteered to assist in Sierra Leone during the height of the Ebola virus outbreak, of Dr Megan Walmsley's provision of emergency care in the immediate aftermath of the avalanche that swept through the Mt Everest Base Camp in 2016, and of Dr Bryce Curran's heroic efforts during the devastation of the 2011 Christchurch earthquakes. Of course the list goes on of those colleagues who have been willing to step up and outside of their comfort zone in their preparedness to assist others, and we all acknowledge their selflessness in doing so.

I have had the privilege of recently attending the Annual Medical Symposium of Papua New Guinea along with Mr John Batten, the President of the Royal Australasian College of Surgeons (RACS). I presented some of our experiences in grappling with the challenges of delivering anaesthesia and pain medicine to far flung rural and remote communities, and shared some of the lessons we have learnt in relation to post-graduate training since we transitioned to our new curriculum in 2013.

PNG is our nearest neighbour, with a population of over eight million, which is expected to double by 2030-2035. The recent statements by the World Bank, the World Health Assembly and the Lancet Commission on Global Surgery have each underscored the importance of providing universal access to safe and affordable surgery and anaesthesia. The fact that more deaths in PNG are attributed to lack of access to surgery than to HIV (2-3 per cent of the population), tuberculosis and malaria combined will be a surprise to many of us, and highlights the importance of the contribution our college can offer.

The Overseas Aid Committee has been working towards progressing an adequately trained and supported workforce, the availability of appropriate equipment, and the establishment of appropriate standards of professional practice. With only 19 specialist anaesthetists, and 18 trainees for a population of eight million (Australia and New Zealand have well over 6000 specialists for a combined population of 29 million), I am now, somewhat bizarrely, on first-name basis with over half of PNG's specialist anaesthetists. There is obviously much work to be done, but I have developed a very real respect for the achievements of our colleagues in PNG, and I look forward to working together in partnership with them as collectively we strive for improved equity of access to safe anaesthesia. The close and effective collaboration of our college with our societies in these endeavours is also clearly evident, and another exemplar of how well we can all work together towards a common goal.

This month will see the launch of the online learning course on anaphylaxis (see page 67). This CPD Emergency Response will dramatically increase accessibility to this activity, particularly for those of us who struggle to attend face-to-face workshops. I found the module to be engaging and instructive, and I learnt a number of useful things relating to the management of anaphylaxis (exactly what those things were I will keep to myself). Those of us who are able to access a face-to-face workshop will of course still benefit from the "immersive" element of doing so.

Welcome to Spring. I hope we all manage, amidst our busy work/study schedules, to find the time to also enjoy the other important things in life, including family and friends.

Dr Rod Mitchell
ANZCA President

Above: Dr Kylie Musgrave leading a tutorial with anaesthetic service officers in PNG.

Chief executive officer's message

Medical Board of Australia

The Chair of the Medical Board of Australia, Dr Joanna Flynn AM, and a number of members finish their final terms on the board at the end of August. It is worth reflecting on the magnitude of the changes that have been implemented to health practitioner regulation since 2010.

Prior to July 2010, all states and territories in Australia had their own regulation of practitioners. In the medical profession, that required eight medical boards, all of whom did their best to not only regulate the profession according to legislation, but liaise with each other as well as the Medical Council of New Zealand to smooth cross-border regulatory issues.

In July 2010 the national law came into effect and brought with it a single national medical board (the Medical Board of Australia) which became responsible for the registration and notifications about doctors. The inaugural chair of the board was Dr Flynn, who was the previous chair of the Medical Board of Victoria.

It was only nine years ago but much has happened to improve the regulation of the medical profession in Australia. Every new scheme has its teething problems and the new national scheme was no exception. In an international sense, no other country in the world had to that time (or since, to my knowledge) attempted such an ambitious change in the structure of health practitioner regulation.

I don't wish to highlight specific examples, but I recollect that in the early years events occurred that placed extreme pressure on the board, Australian Health Practitioner Regulation Agency (AHPRA), and the national scheme.

The strong leadership from Jo Flynn and the whole medical board has been responsible for the maturing regulatory scheme that we have today. They had the vision for a truly effective model of medical practice regulation which promotes the value of the medical profession to the community while fulfilling its responsibility to protect the public. The board has demonstrated repeatedly that it is approachable and willing to listen when medical colleges and other organisations seek clarification or make suggestions for improvements.

I congratulate Jo Flynn and the retiring members of the medical board for their untiring work in establishing our national scheme.

Doctors' health

The Australian Medical Association (AMA) has announced that the Doctors Health Services Pty Ltd (DrHS) which is a subsidiary company of the AMA, is working on a proposal for a national telehealth service. DrHS has been awarded $A1 million in Commonwealth funding to develop the service.

The DrHS intention is to focus the new service on mental health and to complement existing local services, it is easily accessible and provides strong protection for the privacy of doctors and medical students who use the service.

DrHS is also developing a national package for training doctors to treat other doctors, using funds secured from the Medical Board of Australia. The training program will be underpinned by a national curriculum in doctors' health written by the Australasian Doctors' Health Network (www.adhn.org.au) which is the umbrella organisation for the doctors' health advisory services in Australia and New Zealand.

It is anticipated that this national training package will be ready by October this year.

Real-time prescription monitoring

Australia's Chief Medical Officer Professor Brendan Murphy recently provided an update on the development of real-time prescription monitoring (RTPM) in Australia.

Real-time prescription reporting and alerts will assist doctors and pharmacists to identify patients who are at risk of harm due to dependency, misuse or abuse of controlled medicines, and patients who are diverting these medicines. Once fully implemented, a national RTPM system will provide the capability for prescribers and pharmacists to check the system before writing or dispensing a prescription for a high-risk medicine.

While monitoring of controlled medicines is the responsibility of states and territories, Professor Murphy has advised that the Commonwealth is working with all jurisdictions to develop a nationally consistent system. He made the following points with regard to system development:

- Health ministers have agreed to progress national real-time prescription monitoring as a federated model, with all jurisdictions committed to achieving a national solution.
- The RTPM system will be designed with the ability to prevent cross-border drug shopping abuses.
- Regulators, doctors and pharmacists will be able to interface directly with the RTPM system, enabling the real time receipt of relevant clinical information such as patient history.
- The Commonwealth is working with jurisdictions on the development and adaptation of jurisdiction-specific regulatory systems to provide a strong technology interface and which will achieve a national RTPM solution.

ANZCA strongly supports the implementation of an RTPM system as a means of reducing the risk of harm to patients.

John Ilott
Chief Executive Officer, ANZCA

Letters to the editor

Slow-release opioids

Full support for statement

The recent position statement on slow-release opioids in acute pain has seen ANZCA continue to maintain its status at the forefront of pain management – a lead which is then followed by other nations.

What it does is to remind us of the basics, which seem to have been lost in modern practice. Namely, we are reminded:

- Opioids stand out as unique and valuable agents when they are reserved for patients who have the affective suffering, or distressing, component of pain.
- When the primary problem is of excessive nociception then there are two agents which are far more effective, these being local anaesthetic (but it must be correctly applied to a nerve, usually this is best done by a trained anaesthetist, and not just applied indiscriminately) and anti-inflammatory medications.
- Opioids therefore are best viewed as "rescue" medications. Their routine use may be necessary in some circumstances, but this is then generally viewed as a second-best option (exceptions including intrathecal morphine for lower segment caesarean section).
- Slow-release opioids are only indicated in the circumstance of unrelenting, continuous, suffering pain. They are not a shortcut remedy for non-troublesome nociceptive signals. Nor will they provide meaningful analgesia in the circumstance of intermittent activity-related pain.

Where the position statement results in a change in practice then there are at least two conceivable causes: firstly because this is what needed to happen and secondly, because there has been mis-education of clinicians on the concepts that underpin the position statement.

The introduction of the position statement has had zero impact on the practice of the Acute Pain Service at Royal North Shore Hospital. Nothing has changed for us. This is as it should be. We do use slow-release opioids for carefully selected patients with acute pain and in this circumstance I willingly provide my full support to my colleagues – as does indeed also the position statement.

Dr Gavin Pattullo FANZCA FFPMANZCA
Director Acute Pain Service
Royal North Shore Hospital, Sydney

Slow-release opioids and APMSE

I write in response to Dr Tim Skinner's letter published in the *Bulletin* in June, including the complete text accessible via the link.

Acute Pain Management: Scientific Evidence (APMSE) summarises the evidence available for different aspects of acute pain medicine. Mention of that evidence in the text does not indicate support for the use of a specific technique/drug. For example, in APMSE (2015), section 4.1.3.1 says "Intra-articular bupivacaine … more effective than morphine" in some patients. This does not support the use of intra-articular bupivacaine – see section 5.8.2 and chondrotoxicity risks.

Similarly, mention of slow-release (SR) opioid studies is not the same as supporting their use. In fact, section 5.1.1.2 notes that "CR formulations (also referred to as slow-release …) may take 3-4 hours or more to reach peak effect … analgesic effect of the immediate release opioid preparations will be seen within about 45-60 minutes. This means that rapid titration to effect is easier and safer with immediate release formulations." This wording is unchanged from the 2005 and 2010 editions for which I was lead editor.

By the early 1990s, it was clear that adding background infusions to patient controlled analgesia significantly increased the incidence of respiratory depression – a risk well known to most anaesthetists. When reports of SR opioid use in acute pain management started to appear, we (our Acute Pain Service) could see no reason why SR opioids would be less dangerous. This was based on consideration of the relevant pharmacology. We decided against using SR opioids on a routine basis and I don't believe that our patients have been any the worse for it.

Whether individuals choose to follow the statement or not, sound clinical judgement, a good understanding of the pharmacology of the different formulations and material contained in the product information sheets, as well as appropriate monitoring, should always be a part of any opioid prescription.

Professor Pam Macintyre BMedSc MBBS MHA FANZCA FFPMANZCA
Acute Pain Service, Royal Adelaide Hospital

Statement references

In response to the position statement on the use of slow-release (SR) opioid preparations in the treatment of acute pain, inadequate evidence is provided to support the recommendations in the document.

- Many direct claims made in the document do not have references provided. In particular, this seems to relate to claims of harm caused by SR opioids. For example; the first line "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" does not have a reference provided as evidence.
- None of the references provided directly support the statements they are linked to, or do not support the recommendations in the document. In particular, very few of the references are about SR opioids. For example; the statement "This recommendation is in line with other international guidelines, and statements by regulatory authorities and government agencies" is referenced to Schug et al (2015). This document actually supports the use of SR opioids with PCA as shown in this direct quote "In comparison with IV morphine patient controlled analgesia alone, controlled release oxycodone in addition to morphine patient controlled analgesia resulted in improved pain relief and patient satisfaction after lumbar discectomy and a lower incidence of nausea and vomiting, as well as earlier return of bowel function". There are other similarly inconsistent references in the position statement.

ANZCA and the FPM need to produce high quality, scientifically robust policies and guidelines. The position statement does not provide adequate scientific evidence for its recommendations. We welcome a wider debate on this important issue, but the recommendations made in this statement do not reflect the references cited.

Dr Colin Baird MRCP FRCA FFPMRCoA
For the Womens Health Pain Team
Women's Health Anaesthesia
Auckland City Hospital

Process not followed

In response to the position statement on the use of slow-release opioid preparations in the treatment of acute pain, the document did not follow the process of development proscribed in *A01 Policy for the Development and Review of Professional Documents*.

We expect our college to provide clear, reasoned and scientifically based guidelines when there is a need. The process for the development of such professional documents is clearly outlined in *A01 Policy for the Development and Review of Professional Documents*. The development of this Position Statement did not follow this process. The developers argue that the process is not required as the document simply reflects a "point-of-view", however, the title and formatting imply that the document is actually a Statement of the Position held by ANZCA and the FPM.

Of particular concern are A01 Items 2.8 and 2.11.

1.1. Item 2.8 requires a background paper be provided 1.2. Item 2.11 requires consultation with relevant groups and committees within ANZCA and the FPM

There should be a background paper detailing the process of decision-making and the evidence considered.

The New Zealand National Committees of FPM and ANZCA were unaware of the statement before its publication. Other interested parties may also have been excluded from the development process. Wider consultation would have led to significant improvements in the quality of this document and its applicability to anaesthesia and pain medicine in Australia and New Zealand.

Exclusion of one of the partnership countries means that the document cannot accurately reflect the position of ANZCA or the FPM.

We welcome a wider debate on this important issue, but Recommendations made by the college need to be developed using robust processes.

Dr Duncan Wood FFPMANZCA FANZCA
For the Womens Health Pain Team
Women's Health Anaesthesia
Auckland City Hospital

Editor's note: The SR opioid document was a position statement from the college, not a professional document. As such, it is a point-of-view on practice expectations, albeit at a high level. It involved wide-ranging discussion at FPM Board level, and by the college's Safety and Quality Committee. These groups include representation from Australia and New Zealand, the ASA and NZSA, public and private practice, and clinicians and the community. Notwithstanding this, the importance of timely communication with our fellows is acknowledged, and something that we do strive to achieve. The faculty and the college absolutely stand by the validity and evidence-base of the concerns and recommendations expressed in the position statement.

I'm an anaesthesiologist

English, like all languages, is a living growing "meme". It isn't controlled by societies, governments or advisory panels – it adapts and changes with the needs of its speakers. New words come, old words go (see: selfie, hangry, etc) under no one's direction.

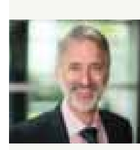
So, I'm going to start using anaesthesiologist because both we and our patients need it.

Why don't you too?

You don't need anyone's approval.

Dr Chris Jones MB BS FANZCA
New South Wales

President's message



Congratulations Rod Mitchell

Congratulations to new ANZCA President Dr Rod Mitchell on his election to office, and his first editorial in the *Bulletin*.

The editorial came across as being penned by someone who has had the edges knocked off, and is genuine. Our fellow members need our care and, at the same time, we must be spreading Reverend Flynn's concept of holding the mantle of safety for all patients throughout Australia and New Zealand in this millennium. These are great goals for us all to have. Perioperative medicine is a concept whose time has come.

Dr Andrew Bacon FANZCA
Victoria

Thai cave rescue, chronic pain and climate-smart anaesthesia key topics for media

Adelaide fellow Dr Richard "Harry" Harris who played a leading role in the rescue of the 12 members of the Wild Boars soccer team and their coach from a flooded cave complex in Northern Thailand, featured in dozens of local and international TV, radio, print and online media reports. A renowned cave diver Dr Harris was the lead medical specialist for the 100-strong Australian and international rescue team. (Dr Harris writes for the *ANZCA Bulletin* on page 34). Dr Harris sedated the children so they could be carried out of the caves by their rescuers and was reportedly the last person out of the cave.

Dr Harris and his fellow rescue diver and friend, Perth vet Dr Craig Challen, received the Star of Courage, Australia's second highest civilian bravery award for "conspicuous courage in circumstances of great peril" at a special ceremony at Government House in Canberra. They were also awarded the Medal of the Order of Australia. An ABC TV Four Corners program Out of the Dark described Dr Harris as the linchpin of the rescue effort. Bravery medals were awarded to six members of the Australian Federal Police and one navy chief petty officer for their contribution to the search and rescue mission.

Dr Harris's role and the anaesthesia skills he used in the rescue effort sparked media interest in the specialty. ANZCA President Dr Rod Mitchell was interviewed by ABC Radio Adelaide's afternoon host Sonya Feldhoff about anaesthesia in the context of the cave rescue and Dr Harris's leadership during the mission. Dr Mitchell's 15-minute interview explained the differences between sedation and anaesthesia and how Dr Harris had worked with the Thai Navy SEALs to administer the sedation to the boys. The interview reached an audience of 20,000 listeners.

Melbourne anaesthetist Dr Peter Seal was a guest on ABC Radio Melbourne's "Known Unknowns" segment where he answered questions about anaesthesia and how Dr Harris used ketamine to prepare the boys for their journey out of the cave. The 25 minute segment also featured talkback calls from listeners and reached an audience of 90,000 people in Melbourne and regional Victoria.

In New Zealand, Professor Simon Mitchell, head of Anaesthesiology at Auckland University and a professional diver, was interviewed on Newstalk ZB.

Melbourne anaesthetist Dr Jai Darvall was interviewed by the *Herald Sun*, ABC Radio Melbourne and Radio 3AW, about the Royal Melbourne Hospital-based "Chewy trial", which is studying the benefits of chewing gum to relieve post-surgery nausea. Dr Darvall is leading the international study of 1200 patients at 30 local and international hospitals. The study received $A70,000 grant funding from the ANZCA Research Foundation. The combined media reports reached an audience of 600,000 people across print, online and radio.

The experiences of two ANZCA fellows who have spoken candidly about their own cancer diagnoses was explored on ABC Radio National's Life Matters program. NSW anaesthetists Dr Sancha Robinson and Dr Robyn Smiles were interviewed about how their experiences had influenced them in using the "care always" approach with their patients.

Dr Robinson was profiled in the March edition of the *ANZCA Bulletin*. The Radio National segment attracted an audience of 100,000 people.

One of the college's past presidents, Professor Kate Leslie, was interviewed by the ABC's Background Briefing program about the potency of fentanyl for the program's investigation into drug tampering by the Queensland Ambulance Service. Professor Leslie said it would be unusual for there to be no effect if a patient had been administered fentanyl for pain relief.

The Sydney Morning Herald interviewed ANZCA fellow Dr Rob Hackett about a campaign to standardise Australian hospital emergency numbers. The move to have a uniform number is supported by ANZCA, the Australian Resuscitation Council and the NSW Health Minister Brad Hazzard. The story attracted 90,000 readers.

The June edition of the *Medical Observer* featured a cover story on chronic pain that focused heavily on the FPM. The story included interviews with Dean Dr Meredith Craigie and Immediate Past Dean Dr Chris Hayes on how pain medicine specialists are working to find better ways to help those with chronic pain. The edition also includes a separate story on Professor Mark Hutchinson's presentation on chronic pain blood biomarkers at the faculty's 2018 Refresher Course Day in Sydney.

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

- **50 radio reports.**
- **Two print reports.**
- **10 online reports.**

Media releases since the previous *Bulletin*:

Tuesday August 28:
Combined use of opioids and benzodiazepines can be fatal, Faculty of Pain Medicine and ScriptWise warn

Friday July 27:
Climate-smart anaesthesia under the microscope

Wednesday June 13:
Australia's escalating opioid use focus of pain forum

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

Dr Craigie was interviewed by Macquarie Media national radio host Steve Price for a 10-minute segment about medicinal cannabis on his evening program which is broadcast on 50 stations across Australia including 2GB in Sydney, 3AW in Melbourne and 4BC in Brisbane. Dr Craigie told Price that scientific evidence had shown that medicinal cannabis was not beneficial for chronic pain and that the community deserves accurate information. The interview reached an audience of over 100,000 people.

The FPM opioid forum held in June at the college in Melbourne attracted media interest from ABC Radio Melbourne's afternoon program host Richelle Hunt. Dr Craigie was interviewed about the forum in a 15-minute segment that attracted an audience of 35,000 listeners.

Dr Craigie was also interviewed by ABC online for a report which ran on International Overdose Awareness Day on August 31 to raise awareness of accidental overdoses of combining prescription drugs. Dr Craigie said the risk was caused by the drugs depressing the central nervous system. The article followed a joint FPM ScriptWise media release warning of the dangers of combining prescription drugs. The 800 word article reached an audience of 232,000 people.

ABC Radio National's Breakfast program interviewed Dr Craigie about real-time prescription monitoring in response to the release of the Penington Institute's annual Australian overdose report. The interview reached an audience of 138,000 people.

FPM Board member Dr Kieran Davis was quoted in a New Zealand story "Solo mum locked in battle for funds to care for daughter battling CRPS" by stuff.co.nz about Complex Regional Pain Syndrome (CRPS). Dr Davis said more research was needed to understand the causes of CRPS, how it progresses and the role of early treatment.

Anaesthetist and pain medicine specialist Dr Jo Rotherham, chair of the FPM Queensland regional committee, was interviewed for ABC Radio Brisbane's Focus program by host Emma Griffiths for a 30 minute panel and question and answer segment on chronic pain. The segment attracted 23,000 listeners.

Professor David Story, foundation Chair of Anaesthesia at the University of Melbourne and a 2017 recipient of ANZCA's highest honour, the Robert Orton Medal, was a guest on ABC Radio Melbourne's evening program with host David Astle for a 20-minute *Explain This: Anaesthesia* segment. Professor Story discussed the history of anaesthesia and latest developments in the specialty. The segment reached an audience of 20,000 people and was broadcast to eight ABC regional Victorian stations.

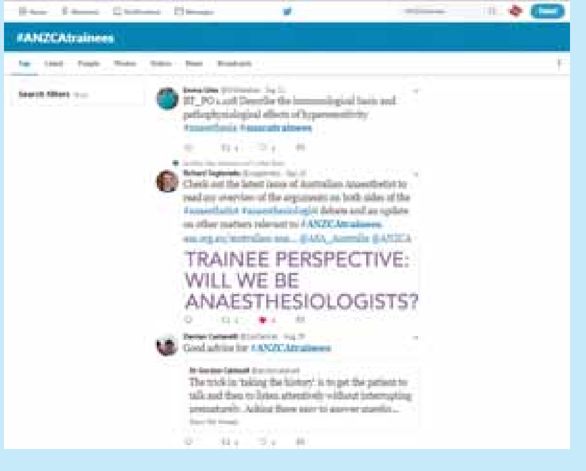
Dr Georgina Imberger, an anaesthetist at Western Health in Melbourne was interviewed for ABC Radio Melbourne about how she and other anaesthetists are practising climate-smart anaesthesia in their hospitals. Dr Imberger was interviewed ahead of the Victorian Regional Committee's joint ANZCA and ASA meeting, "Rising temperatures, the heat is on" in Melbourne on July 28. The news item reached an audience of 80,000 people and was broadcast to eight Victorian regional ABC stations.

Carolyn Jones
Media Manager

Supporting fellows and trainees through social media

Social media channels like Twitter and Facebook are great ways to connect and collaborate with your fellow doctors, as well as to keep in touch with what the college is doing and what's happening in the wider world of anaesthesia. We're always looking for new things we can do to help our fellows and trainees get the most out of social media, from running workshops to helping set up Facebook groups.

We've established a range of ANZCA-specific Twitter hashtags to flag content relating to key areas and audiences of the college. For example, we use: **#ANZCAlibrary** to let people know about new publications, apps, and library guides; **#ANZCAtrainees** for things like upcoming courses, events and resources; and **#ANZCANZ**,for (yup, you guessed it) New Zealand-related content.



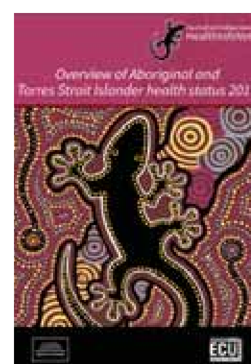
These hashtags are there for you to use too. Perhaps you want to share something you've read? Or ask a question? The Twittersphere's a busy place, so hashtags help you to target your tweets. You don't have to have a Twitter account to access hashtagged content, so you can always take a look and see if it's something that might be useful for you. But if you want to join the conversation, you'll need to create an account. And don't forget to follow us **@ANZCA** and **@ANZCA_FPM**.

If Facebook is more your thing, then make sure you follow us there – **www.facebook.com/ANZCA1992**. And if you're an ANZCA trainee, why not join one of the closed groups we've helped set up. These groups are completely private, and purely for trainees in a particular jurisdiction, so they are a safe, secure forum in which to share your experiences as an ANZCA trainee. And they're proving to be a big hit. There are currently 218 members in the Victorian group; 170 in Queensland; 109 in New South Wales; and 152 in New Zealand. Trainees are using them for everything from promoting upcoming exam practice sessions to selling second-hand textbooks. If you're based in a region that still doesn't have a group, why not contact your local trainee committee and ask if they have plans to set one up. We're happy to give them a hand getting it up and running.

Indigenous health report

Australia

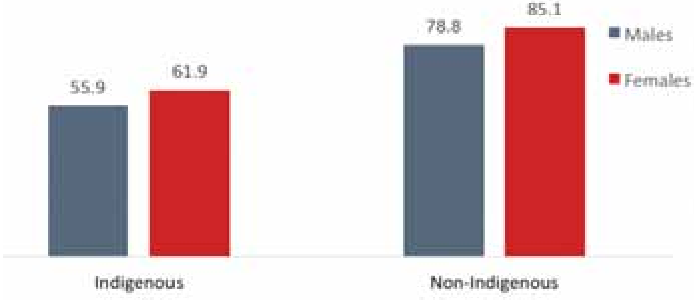
Latest report on Aboriginal and Torres Strait Islander health



The latest *Overview of Aboriginal and Torres Strait Islander health status* (2017) was recently released. Produced annually by the Australian Indigenous HealthInfoNet, the report provides a comprehensive summary of the most recent indicators of the health status of Australia's Aboriginal and Torres Strait Islander people.

The report highlights the significant differences between Aboriginal and Torres Strait Islander people and non-Indigenous people on a wide range of measures of health status and outcomes. For example:

- For 2008-2012 the ratio of direct maternal death rates was 2.2 times higher for Aboriginal and Torres Strait Islander women than for non-Indigenous women.
- In 2015-16, the age standardised hospital separation rate for Aboriginal and Torres Strait Islander people was 2.5 times that for non-Indigenous people. The vast majority of the difference in hospital separation rates between the two populations is due to markedly higher separation rates for dialysis among Aboriginal and Torres Strait Islander people.
- The median age at death for Aboriginal and Torres Strait Islander males in 2016 was 55.9 years – nearly 23 years less than that for a non-Indigenous male.



Source: Australian Indigenous HealthInfoNet 2018. Overview of Aboriginal and Torres Strait Islander health status 2017.

Progress is being made, for example over the past 10 years, the median age at death for Aboriginal and Torres Strait Islander males has increased by more than four years, and by nearly three years for females. Overall however, the latest health status report shows that there remains much work to be done to achieve health outcomes for Aboriginal and Torres Strait Islander people that are on par with those for non-Indigenous people in Australia.

The full report can be accessed at healthinfonet.ecu.edu.au.

Real time prescription monitoring coming to Victoria

The Victorian government's SafeScript real-time prescription monitoring system commences in October 2018, initially in the Western Victoria Primary Health Network catchment area. SafeScript is computer software that allows prescription records for high-risk medicines to be transmitted in real-time to a centralised database which can then be accessed by doctors and pharmacists during a consultation.

FPM has been assisting the Victorian Department of Health and Human Services on key policy and implementation aspects of SafeScript through an Expert Advisory Group.

SafeScript will monitor prescription medicines that are causing the greatest harm to the Victorian community which includes all Schedule 8 medicines, morphine, alprazolam, methylphenidate and dexamphetamine and some Schedule 4 medicines including all benzodiazepines, zolpidem, quetiapine and codeine.

The data required for SafeScript will be collected automatically from Prescription Exchange Services (PES) which support the electronic transfer of prescriptions from medical clinics to pharmacies. When a prescription is issued at a medical clinic or dispensed at a pharmacy, the PES will send a record of the prescription in real-time to SafeScript. No additional data entry will be necessary to record a prescription in SafeScript.

After an 18 month introductory period to allow health practitioners to familiarise themselves with the system, from April 2020 it will be mandatory to check SafeScript prior to writing or dispensing a prescription for a high risk medicine. There will be exceptions in some circumstances, including when treating patients in hospitals, prisons, police gaols, aged care and palliative care.

The Department of Health and Human Services has a range of resources about the introduction of SafeScript available for health professionals.

Victoria's SafeScript joins Tasmania's Drugs and Poisons Information System Online Remote Access (DORA) which began rolling out to Tasmanian pharmacies and general practices in 2012. Since DORA commenced in Tasmania, deaths from Schedule opioid eight analgesics drug overdoses have fallen significantly.

Important regulatory changes effective from July 2, 2018: What doctors need to know

The following regulatory changes, effective from July 2, 2018 are necessary to ensure complete and accurate patient data in SafeScript and will require:

- Prescribers to include the patient's date of birth on all prescriptions for medicines monitored through the system. Prescribing software should prompt clinicians to include this information for computer-generated scripts. The Department of Health and Human Services is engaging with software vendors to support this change.
- Online registration for access to SafeScript will open later this year. The Department of Health and Human Services is working with Australian Health Practitioner Regulation Agency (AHPRA) to fast-track and automate the registration process for access to SafeScript for clinicians.
- To benefit from this automated on-line registration process, it is important that Victorian clinicians ensure their registration details with AHPRA, especially their principal place of practice and email address are up-to-date.

Anthony Wall
Senior Policy Advisor, ANZCA

Australian submissions:

- Department of Health – rural procedural training programs review and reform options.
- Medical Board of Australia – draft revised "Good medical practice: a code of conduct for doctors in Australia".
- Medical Board of Australia – supervised practice framework.
- National Health and Medical Research Council – "Guidelines for guidelines" draft modules.
- Queensland Health – regulation of general, spinal or epidural anaesthetic; or sedation, other than simple sedation.

New Zealand

Changing New Zealand's health system

New Zealand's health system is being put under the microscope with a high-powered review announced by the Minister of Health at the end of May. Some commentators say this could mean a much-needed revolution in health services while the opposition pan it as an example of this government's "review-it is".

There is no doubting the grunt behind the broad health and disability review with Helen Clark's top advisor in the last Labour government, Heather Simpson in the chair. The draft terms of reference are wide but the scattered nature of the health system is singled out for scrutiny. The draft talks about the complicated mix of governance, ownership, business and accountability models. "This complexity can get in the way of ensuring public money is spent to invest in, and provide, healthcare to the public in a coherent and smart way".

ANZCA's New Zealand National Committee (NZNC) has submitted on the draft terms of reference also highlighting the fragmented nature of health services. The NZNC has urged that the review team include members with expertise in Māori health, Pacific health, epidemiology, health economics, and those directly involved in acutely delivered medical services. The review will not give a final report until the beginning of 2020 and changes will take time to implement so for now, work continues on areas where ANZCA can have influence.

In May, Dr Jennifer Woods (NZNC Chair) and Dr Kerry Gunn (NZNC member) met with the Medical Director of Pharmac, Dr John Wyeth, to discuss Pharmac's work negotiating national contracts for anaesthesia devices, and to find out more about how anaesthetists can best provide advice to Pharmac. The NZNC will look at establishing a reference group of anaesthetists with expertise in equipment, to help respond to Pharmac consultations. Dr Woods also attended a Health Workforce New Zealand workshop to discuss the sustainability of the future health workforce.

The Faculty of Pain Medicine has also been busy, submitting on a significant inquiry into mental health and addiction in New Zealand. In its submission, the faculty's NZNC explained that chronic pain and mental health have a bidirectional relationship, and it must be recognised that the high prevalence of chronic pain in New Zealand will be contributing to poor mental health in segments of the population.

New Zealand submissions:

- Civil Aviation Authority – definition of a crew member.
- Mental Health and Addiction Inquiry – government inquiry into mental health and addiction.
- Standards New Zealand – Draft New Zealand Standard: Ambulance and Paramedicine Services.
- Medical Council of New Zealand – statement on safe practice in an environment of resource limitation.
- Via the Council of Medical Colleges – draft terms of reference for the Government Review of the Health and Disability Sector.
- Council of Medical Colleges – Professional Behaviours Taskforce.
- Medsafe – Codeine – draft alert communication.
- Medical Council of New Zealand – Consultation on fees payable to the Medical Council.
- Pharmac – Proposal to list a range of Medical Devices supplied by Device Technologies and Medipak.
- Ministry of Health – Proposed changes to the National Health Index (NHI) system.

FPM meets Australia's Minister for Health Greg Hunt

The Dean of FPM Dr Meredith Craigie, Vice-Dean Dr Michael Vagg and General Manager Helen Morris met the Australian Minister for Health Greg Hunt in Melbourne on July 16 to discuss a range of issues including the National Pain Strategy, opioid prescribing and the need for a consistent national rollout of real time prescription monitoring.

Mr Hunt acknowledged FPM's role as a valued advisor with Mr Hunt supporting FPM's central role in the development of the National Action Plan on Chronic Pain Management. The FPM leadership advised Mr Hunt that the faculty would continue to work closely with Painaustralia to develop the plan and ensure that endometriosis, arthritis and osteoarthritis are included to avoid fragmentation of strategies.

Other topics focused on extending the number of allied health visits for chronic pain patients, specialist pain medicine physician access to item number 132 and FPM educational initiatives to support rural and remote health practitioners.

FPM advised Mr Hunt that increasing the number of allied health visits allowed under the GP Management Plan for chronic pain patients would make a difference to the lives of those affected by chronic pain and reduce the burden of pain on society.

Mr Hunt said he saw merit in FPM's move to seek an extension of access to item number 132 – which is available to consultant physicians – to all specialist pain medicine physicians. This would remove the anomaly whereby specialist pain medicine physicians who have FRACP or FAFRM as their initial specialty can access the item number which covers consultations of at least 45 minutes but those with FRACGP, FANZCA, FRANZCP or FRACS as their primary specialty cannot access it.

The extension of access would enhance the financial viability of consultations in pain medicine and reward appropriate provision of consultative practice rather than the existing arrangements which FPM argues incentivise the practice of interventions in pain management.

Dr Craigie has written to the Chair of the Medicare Benefits Schedule Review Taskforce, Professor Bruce Robinson, outlining the faculty's argument for extending access for item number 132. Immediate past FPM Dean, Dr Chris Hayes, chairs the taskforce's Pain Management Clinical Committee and several FPM fellows are also involved as members of the clinical committee and other taskforce committees.

Mr Hunt said he also believed the proposal to fund licencing for rural and remote health practitioners to complete the FPM Better Pain Management Program had merit and was very interested in the faculty's development of a six month workplace-based Certificate in Clinical Pain Medicine for GPs or other interested doctors to complete.

Concerns about opioid prescribing were also discussed at the meeting following the Chief Medical Officer Professor Brendan Murphy's decision to write to 5000 GPs warning them of the risk of over prescribing opioids. The letter warned 70 per cent of fatal opioid doses came from prescription drugs.

FPM has agreed to work with the federal Chief Medical Officer to develop an online forum on opioid prescribing for GPs.

Private health insurance

The impact of proposed private health insurance reforms on Australian chronic pain patients was discussed at a meeting between FPM, Painaustralia and the Australian Pain Society, and key government officials in late August.

There is a strong view that the reforms, due to come into effect in April 2019, will disproportionally impact chronic pain patients and have far-reaching implications for millions of privately insured consumers who rely on existing coverage to access chronic pain management.

The group has recommended that the proposed reforms be amended to ensure that current private health insurance coverage is retained and be expanded to include pain management as a basic inclusion across all proposed categories (basic, bronze, silver and gold). More expensive and lesser-used chronic pain treatment options could be restricted to silver and/or gold coverage, and these deliberations need to be made in close consultation with pain specialists and consumers.

Pain MedsCheck

FPM has written to Mr Hunt regarding the new $20-million Pharmaceutical Society of Australia/Pharmacy Guild trial program to help pharmacists prevent incorrect use and overuse of pain medication.

Under the Pain MedsCheck trial, pharmacists will be resourced to provide face-to-face evaluation of a patient's medicines and their pain management strategies.

FPM is concerned that the scheme has been developed without appropriate input from medical specialists and does not adequately recognise that the successful treatment of chronic pain requires a multidisciplinary approach.

Pharmacies will receive $100 for an initial consultation and another $33 for a 15-minute follow-up three months later to assess whether the intervention has made a difference. Neither of these interactions is required to involve a patient's primary pain physician.

It follows an Australian government decision to ban pharmacists from selling codeine over the counter, which came into effect in February.

Clea Hincks
Director, Safety and Advocacy

What would you do?

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

Golden egg or goose?

"Hi Sandy, it has been a pleasure working with you over the past month. Shortly I will be opening a private facility and would like to invite you to provide your services to our patients. Joining me will be a cosmetic surgeon who is looking for an anaesthetist. My endoscopy lists will initially involve one day per week with sedation only, and the cosmetic surgeon will operate on a fortnightly basis, also with sedation only. They will be good lucrative lists without involving general anaesthesia."

You have just been offered a "golden egg". This is the sort of stuff that we dream of. Or is it? Could it turn into a nightmare? Instead of being a golden egg could you end up being a goose?

Faced with this invitation what would you do?

While there exists a maldistribution in the provision of anaesthesia services between city and regional/rural locations the demand for work centrally creates competition for positions in public, and for private work. New fellows not infrequently subscribe to on-call rosters in private facilities as their initial main source of income, resulting in little opportunity to develop relationships with surgeons, which is considered important in enhancing team outcomes. Some might argue that short term exposure to surgeons may not be a bad thing! Irrespective of which side you're on, participation solely in on-call services places significant stress on income and time, with irregular hours and the element of unpredictability and consequent lack of stability.

Like us, our procedural colleagues are seeking opportunities to develop and grow their practices, and with the growth in the number of smaller facilities they have more choices. The spectrum of private facilities is very broad ranging from tertiary level hospitals with ICUs and catering for all the major subspecialties, to small hospitals with no ICU/HDU and one or two operating theatres, through to clinics with suites instead of fully equipped operating theatres in which endoscopies and dental procedures may be performed.

This brings me back to the invitation above, where proceduralists seek our services to assist them.

After the initial excitement of the invitation an uneasy feeling ensues in the pit of the stomach arising from working in a new and unknown environment. Questions arise including the reference to the administration of general anaesthesia, but these are rationalised by reassuring oneself that all will be well.

Indeed, the first three lists go well with nice simple introductory cases, but during a subsequent cosmetic surgical list the surgeon requests deeper sedation. After some discussion sedation is deepened … "After all, it's only sedation!", after which a supraglottic device is required to be inserted to maintain the airway. All goes well so "no harm, no foul". Nevertheless, you report it to the facility owner who makes it quite clear that these are lucrative lists and they are keen to retain the cosmetic surgeon so if you wish to continue there it is imperative to keep the surgeon happy and comply with their needs for levels of sedation as long as it is not general anaesthesia. Has this dream become a nightmare? Is the emphasis on avoidance of general anaesthesia ringing alarm bells?

There are many subtle, and some not so subtle, ways that we may be pressured into becoming involved in practices with which we feel uneasy. At times we may choose to rationalise our decisions but on other occasions we may simply not be aware of the regulatory issues and consequent risks.

It is sobering to contemplate the findings of the South Australian Coroner in regard to the deaths of two obese patients with obstructive sleep apnoea and other co-morbidities treated in a small private facility, neither of whom had a pre-anaesthesia assessment. The coroner was critical of the fact that despite predictable anaesthetic challenges they were managed in facilities that did not have the ability to care for such patients. The recommendations included excluding patients at risk requiring close postoperative monitoring from private hospitals that do not have the facilities for monitoring and managing such patients.

Recently I had the situation where a surgeon with whom I have had a professional association for several decades working in their fully accredited private hospital was "keen" to operate on a patient whose risk profile clearly exceeded the capabilities of their hospital. Compounding this was that the surrounding hospitals were unwilling to accept the patient for only postoperative care, and also that the surgeon was not credentialled at any other hospitals as all surgery was performed at their hospital. Eventually, temporary accreditation was granted, and surgery performed at the nearby larger hospital. All proceeded uneventfully, apart from a minor surgical complication, but the surgeon conceded that the decision to operate in the other facility was appropriate.

While this has digressed from the original proposition above it is included because not only may we be pressured into acceding to demands but also into accepting patients that would be better cared for in a different facility.

With changes being instituted by regulatory authorities in several states (and variations between the states) there is an increasing need to be aware of those changes and our responsibilities to avoid running foul of them. I was almost a victim to such circumstances many years ago when anaesthetising for a colleague in one of our northern states in a private facility that unbeknownst to me was not licensed for general anaesthesia despite being fully equipped and staffed. The reason for failure to be registered was that the lift was too small to accommodate a trolley/stretcher. Having raised the question with the surgeon I discovered that providing anaesthesia in that facility was a breach of the regulations. My withdrawal of services was met by a willingness to apply for credentialling, and a transfer of the surgeon's practice to a registered private hospital. I think that this exercise elicited the best of my graded assertiveness.

I hear you ask, "So how does one determine whether a facility meets the standards?" If you didn't ask, then congratulations for being so familiar with our college's professional documents and the local regulations. For those that did ask I would draw your attention to the following:

What would you do? (Continued)

- Regulatory requirements – ensure that the facility is registered/licensed.
- Governance – even small facilities are required to comply.
  - Credentialing and Scope of Clinical Practice – appointments require the involvement of such committees even in single operator facilities. The process should also comply with *PS02 Statement on Credentialling and Defining the Scope of Clinical Practice in Anaesthesia*.
  - Consent – *PS26 Guidelines on Consent for Anaesthesia or Sedation* offers clear advice.
- Staffing – This is sometimes where resistance may be met due to financial considerations.
  - The pivotal criteria are defined in the appendix of *PS09 Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures*.
  - Assistance to the anaesthetist is addressed in *PS08 Statement on the Assistant for the Anaesthetist*.
  - The postoperative requirements are outlined in *PS04 Statement on the Post-Anaesthesia Care Unit* (currently under revision and due for pilot release in November 2018).
- Equipment
  - *PS18 Guidelines on Monitoring During Anaesthesia*.
  - *PS54 Statement on the Minimum Safety Requirements for Anaesthetic Machines and Workstations for Clinical Practice*.
- Standards of clinical care
  - Documentation of anaesthesia care should be guided by *PS06 The Anaesthesia Record. Recommendations on the Recording of an Episode of Anaesthesia Care*.
  - Facilities should be available to facilitate pre-anaesthesia consultation in accordance with *PS07 Guidelines on Pre-Anaesthesia Consultation and Patient Preparation*.
  - Above all is the matter of patient selection to ensure that the facility is suited to the patient's risk profile as outlined in *PS15 Guidelines for the Perioperative Care of Patients Selected for Day Care Surgery*.

At various stages during our careers we will face situations that may require an appreciation of the regulatory environment in which we operate. In addition, there may be times when we are subjected to pressures, either subtle or overt, that engender feelings of consternation. Succumbing to such pressures may pose risks, and ultimately the decision that needs to be made is whether we can manage those risks in the best interests of our patients.

Dr Peter Roessler
Director of Professional Affairs, Policy

Professional documents – update

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

Recent release

- *PS15 Guidelines for the Perioperative Care of Patients Selected for Day Care Surgery* (July 2018).

Currently in pilot

- *A01 Policy for the Development and Review of Professional Documents* (in pilot until July 2019).
- *PS63 Guidelines for Safe Care for Patients Sedated in Health Care Facilities for Acute Behavioural Disturbance* (in pilot until April 2019).
- *PS64 Statement on Environmental Sustainability in Anaesthesia and Pain Medicine Practice* (in pilot until February 2019).

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.

Contribute to the development and review of ANZCA professional documents

We are seeking expressions of interest from fellows to participate in upcoming professional document reviews.

The review of each ANZCA professional document is undertaken by a document development group (DDG) made up of fellows with expertise and knowledge aligned to the particular document under review.

DDG members collaborate to review and update professional documents via email and teleconference at times that fit their schedules. Serving as a DDG member provides a valuable opportunity to contribute to safety and quality of care for patients.

The following professional documents are scheduled for review prior to the end of 2018:

- *PS55 Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations* (previously T01) (www.anzca.edu.au/documents/ps55-2012-recommendations-on-minimum-facilities-fo.pdf)
- *PS56 Guidelines on Equipment to Manage a Difficult Airway During Anaesthesia* (previously T04) (www.anzca.edu.au/documents/ps56-2012-guidelines-on-equipment-to-manage-a-diff.pdf)

If you are interested in being nominated for one of the above DDGs, or for more information, please contact profdocs@anzca.edu.au.

ANZCA DRIVES NEW INDIGENOUS HEALTH STRATEGY

As specialist anaesthetists and pain medicine physicians, we direct much energy towards maximising safety and quality in the clinical care that we deliver. Through education and training, the maintenance of professional standards of practice, and research, we strive to ensure that our patients receive the absolute best in outcomes. We can rightly be proud of the fact that Australia and New Zealand remain among the safest countries in the world to receive anaesthesia.

There are a number of areas though where we have clearly identified room for improvement. For example, patient mortality is exceedingly rare in the immediate peri-operative period, but there is seemingly much that needs to be done to address longer term outcomes. Hence our initiatives to further the development of "peri-operative medicine".

And then there are those sectors within our community who do not enjoy the same health outcomes as the rest of society. Most obviously among these sectors are our rural communities, the Indigenous peoples in Australia, and the Māori in New Zealand.

The reasons behind poor health outcomes for Indigenous populations are complex, and at times the role of anaesthesia and pain medicine in addressing them might seem obscure. We tend to be an outcomes-focussed profession (a good thing), and there are a number of clearly defined steps we can take in relation to improving Indigenous health outcomes, all of which are in keeping with our role as specialist healthcare providers.

The Indigenous population of Australia is 2.5-3 per cent of the total population, but our Indigenous representation is less than 0.1 per cent of the specialist anaesthesia/pain medicine workforce. In New Zealand the figures are 15 per cent and 6 per cent respectively. We can be more proactive in encouraging and supporting young Indigenous doctors into and through training in our specialty. We would do well to ensure the attributes that we consider when selecting trainees mirror those of the community which we serve. Workforce diversity enriches us all.

Most of us don't consider ourselves to be prejudiced. Unconscious (and conscious) bias remains a great challenge that we all need to address. When such bias manifests as racism it can be particularly destructive.

We need to minimise the inappropriate prescribing of long-acting opioids, the long-term management sequelae of which are too often borne by rural community-controlled health care organisations.

The potential exists to do more to facilitate the provision of high care anaesthesia and pain medicine services to rural communities, which is where the burden of Indigenous morbidity and mortality is felt.

We can undertake research to help identify why Indigenous patients don't access our healthcare institutions to the same degree as the non-Indigenous community, and to better understand to what extent, and why, poor Indigenous perioperative outcomes occur.

The new Indigenous health strategy presented in this *Bulletin* has been developed after extensive and considered consultation with involved stakeholders, and provides a broad framework on which I hope we can continue to address this health inequity.

Dr Rod Mitchell
ANZCA President

Above from left: Royal Darwin Hospital specialist anaesthetist Dr Edith Waugh reassures young patient Justine and her mother Alisha as they prepare for Justine's dental procedure at the Gove District Hospital in Nhulunbuy, East Arnhem Land; Justine and her mother Alisha, who have travelled from Groote Eylandt, are shown an anaesthetic mask similar to the one that is used in the hospital's theatre.

ANZCA DRIVES NEW INDIGENOUS HEALTH STRATEGY (CONTINUED)

Indigenous doctors embrace vision

Six years ago while still a medical student Dr Dash Newington attended her first ANZCA Annual Scientific Meeting (ASM). There were no student registrations so she had to bring a letter from the University of Sydney's medical school confirming her interest in pursuing anaesthesia so she could register.

She found it daunting. But having started medical school aged 24 after leaving school and working as a manager at McDonald's and studying business management at TAFE she was determined to learn as much about the specialty as she could. She figured the ASM was a good place to start.

This year Dr Newington returned to the ASM and her experience was vastly different. Since her first visit the college has not only introduced discounted student registrations but now funds Indigenous students and junior doctors' scholarships so Australian and New Zealand Aboriginal and Torres Strait Islander and Māori students and junior doctors can attend.

ANZCA has sponsored 12 Indigenous students and junior doctors to the ASM since 2014 and Dr Newington is now an Indigenous mentor. An Aboriginal trainee who is on a paediatric rotation at the Lady Cilento Children's Hospital in Brisbane, Dr Newington will start her provisional fellowship in 2019.

Dr Newington and Dr Paul Mills (above), Australia's first Torres Strait Islander anaesthetist, are working with ANZCA as members of the Indigenous Health Committee to help drive the college's Indigenous Health Strategy which was recently endorsed by council. Dr Mills was admitted to fellowship this year and is now a consultant anaesthetist at the Sunshine Coast University Hospital in Queensland.

Dr Newington and Dr Mills hope the development of an Indigenous strategy as part of the college's 2018-2022 Strategic Plan will pave the way for other initiatives to attract and train more Indigenous anaesthetists and specialist pain medicine physicians. ANZCA has four Aboriginal and Torres Strait Islander fellows and four trainees but no FPM fellows or trainees. In New Zealand there are 15 Māori trainees, 21 fellows, three FPM trainees and two FPM fellows.

Above: Dr Paul Mills and Dr Dash Newington.

ANZCA's Indigenous Health Committee already supports several other initiatives to promote the recruitment and retention of Aboriginal and Torres Strait Islander trainees. These include engaging with the Australian Indigenous Doctors' Association (AIDA) and Te ORA, which represents Māori medical students and doctors, and establishing support networks and mentoring programs for trainees.

The new Indigenous Health Strategy is underpinned by the principles of partnership, participation, equity and accountability. It acknowledges that health inequity is a safety and quality issue and is supported by four key pillars of governance, partnership, workforce and advocacy. Significant inequities in health outcomes exist among Indigenous and Torres Strait Islander people in Australia and Māori in New Zealand and these are evident across a wide range of measures including surgical outcomes.

ANZCA's strategy supports Australia's bipartisan federal Closing the Gap campaign, a formal commitment made by all Australian governments to achieve Aboriginal and Torres Strait Islander health equality by 2030.

The Council of Australian Governments (COAG) has set measurable targets to monitor progress that are reported on to parliament annually, including closing the gap in life expectancy within a generation, and halving the gap in mortality rates for Indigenous children under five within a decade, as well as education targets.

The college acknowledges the role it can play in improving Indigenous health outcomes by increasing the number of Indigenous health practitioners in the health workforce. The 2018-2022 ANZCA Strategic Plan includes the aim of doubling the number of successful Indigenous trainees in anaesthesia.

ANZCA INDIGENOUS HEALTH STRATEGY FRAMEWORK

Governance
ANZCA will ensure Aboriginal, Torres Strait Islander and Māori voices are represented at high levels across its governance structure.

Partnerships
ANZCA will develop relationships and work together with Indigenous community groups, consumers, academic groups, service providers, and health organisations.

Workforce
ANZCA will develop initiatives to support recruitment and retention of Indigenous doctors, undertake education through its training, curriculum and CPD program, and strengthen cultural safety training for all trainees, fellows and ANZCA staff.

Advocacy
ANZCA will advocate for health equity issues to be addressed across a wide range of spheres, including research, education, policy, and service provision.

Dr Newington and Dr Mills hope more initiatives to expand training opportunities for Indigenous junior doctors can be developed as part of the strategy.

"The key is helping junior doctors to get into training as I suspect there are a lot of people out there who are suitably qualified and experienced who want to do anaesthetic training but don't have an opportunity to get onto the program," Dr Newington explained.

"One option would be to introduce some form of solid process into the accreditation standards of those hospitals that are accredited as training facilities. This would also encourage employment among Indigenous staff – not just doctors but allied health staff as well."

ANZCA's Indigenous Health Committee was established in 2011 with Dr Rodney Mitchell as the inaugural chair. Now, as college president, Dr Mitchell has publicly committed to facilitating diversity in the specialty's workforce. Dr Mitchell said ANZCA had already undertaken a series of initiatives to improve cultural and clinical safety, advocate for Indigenous health and attract and support Indigenous people to train and specialise in anaesthesia and pain medicine.

ANZCA is working in co-operation with other colleges through the Council of Presidents of Medical Colleges to support Indigenous health initiatives and the new Indigenous Health Strategy will complement this.

"Eight years ago ANZCA had no Indigenous Health Committee, we weren't involved with mentoring, we weren't collecting data on Aboriginal, Torres Strait or Māori fellows or trainees and we had one Indigenous anaesthetist in Australia so we have actually come a long way," Dr Mitchell explained.

"The committee now has majority Indigenous representation, we have introduced ASM scholarships, support mentoring programs and have developed podcasts. We're now training rural GPs (in anaesthesia) and we're going to try and be more proactive in encouraging and supporting Indigenous trainees to pursue anaesthesia and encourage people to be aware of unconscious bias.

"We also need to continue to engage with AIDA and Te ORA and advocate with the other colleges for appropriate funding of Indigenous health."

Dr Mitchell, who has extensive experience working in remote communities, says the focus of the strategy on workforce, governance, advocacy and partnerships is crucial for diversity.

"Supporting the delivery of service to rural communities as specialist anaesthetists and GP anaesthetists is important," Dr Mitchell said.

"Even though the majority of Indigenous people live in the city, the majority of Indigenous morbidity is in rural or remote areas. We do have a role to train rural specialists and rural GPs in delivering high quality care in a rural and remote environment."

ANZCA's partnerships are also increasingly playing an important role in forging networks and alliances with Indigenous health organisations and practitioners. For the first time the college was represented at the biennial Pacific Region Indigenous Doctors' Congress in Hawaii in July with Dr Mitchell attending to discuss health workforce issues.

In a presentation at this year's ASM in Sydney Dr Newington gave a passionate and insightful analysis of "equity versus equality" in Australian and New Zealand's medical history. In 1893 the first Australian women graduated as doctors from the University of Sydney and the first Māori male doctor graduated in 1904.

In 1983, 90 years after the first Australian women graduated with medical degrees, the first Aboriginal doctor, Dr Helen Milroy (now Professor Milroy), graduated from the University of Western Australia.

Indigenous medical practitioners are under-represented in Australia and New Zealand but the number of Indigenous medical students in both countries is increasing. In 2016, the University of Otago made history with its 45 Māori medical graduates. For the first time the number of Māori medical graduates matched the proportion of Māori in the general population. (About 15 per cent of New Zealand's population identify as Māori). In Australia 2.5 per cent of the population identify as Aboriginal or Torres Strait Islander. Dr Newington says if those figures were replicated for anaesthesia the college would have 116 Indigenous fellows, 32 trainees, eight FPM fellows and two FPM trainees.

What ANZCA is doing

ANZCA is undertaking a number of initiatives to:

- Improve cultural and clinical safety.
- Advocate for Indigenous health.
- Attract and support Indigenous people to train and specialise in anaesthesia and pain medicine.

Activities include:

- Mentoring.
- ASM scholarships.
- Indigenous health podcasts.
- Cultural competency modules.
- Inviting Indigenous new fellows to the Emerging Leaders Conference.

Doctors who are Aboriginal or Torres Strait Islander often face extra challenges in the workplace, such as discrimination.

A recent AIDA member survey found that of the Aboriginal and Torres Strait Islander respondents:

- More than 48 per cent had experienced either a few incidents per month, or daily incidents of bullying, racism and lateral violence in their workplaces.
- Only 43 per cent of those who experienced these incidents reported them.
- Half reported that colleagues had a negative reaction to their cultural identity, with misconceptions about perceived privileges and easier pathways into and through medicine for Indigenous Australians being the most commonly cited reaction, indicating a large gap in cultural education and understanding.

Source: Australian Indigenous Doctors Association 2017, Report on the findings of the 2016 AIDA member survey on bullying, racism and lateral violence in the workplace. https://www.aida.org.au/wp-content/uploads/2017/07/Report-on-AIDA-Member-Survey_Final.pdf

ANZCA DRIVES NEW INDIGENOUS HEALTH STRATEGY (CONTINUED)

"Dr Penny Stewart, Alice Springs Hospital's Director of Intensive Care, has introduced a 12-month hospital position for an Aboriginal and Torres Strait Islander doctor with a six-month anaesthesia placement and six months in the intensive care unit."

There are now 348 Aboriginal and Torres Strait Islander doctors in Australia and 465 registered Māori doctors in New Zealand.

In 2016, 35 Indigenous doctors graduated in Australia and another 77 Māori students completed their medical degrees in New Zealand. Seventy-eight Indigenous students started their medical degrees in 2017 in Australia – 2.4 per cent of all Australian commencing medical students. In New Zealand, 101 students started their medical degrees in 2017 – 17.6 per cent of all New Zealand medical degree commencements.

"Most of the Indigenous medical workforce are pre-vocational doctors, waiting for the opportunity to commence specialty training," Dr Newington said.

Both Dr Newington and Dr Mitchell cited college fellows who are mentoring and supporting the next generation of Indigenous doctors. Dr Penny Stewart, Alice Springs Hospital's Director of Intensive Care, has introduced a 12-month hospital position for an Aboriginal and Torres Strait Islander doctor with a six-month anaesthesia placement and six months in the intensive care unit. Dr Mich Poppinghaus, a member of the college's Indigenous Health Committee founded the Pital Tarkin mentoring program to support Indigenous medical students in Newcastle while the Flinders Adelaide Indigenous Medical Mentoring Program also plays an important role.

The path to specialty for Indigenous junior doctors varies among Australia's medical colleges. Dr Newington and Dr Mills favour a model that provides additional specialist training positions for Indigenous doctors.

Most Australian medical schools offer Indigenous entry pathways into medicine either by allocating a percentage of places to suitable Indigenous applicants, a dean's Indigenous list or an alternative pathway that places less emphasis on the traditional admissions tests.

But according to a 2017 Australian Indigenous Doctors Association survey 60 per cent of all Aboriginal and Torres Strait Islander medical students and doctors had experienced racism or discrimination on a weekly basis. The survey findings were highlighted in a 2018 NAIDOC Week keynote lecture at the University of Newcastle by Professor Gail Garvey, a leader in Indigenous cancer research at the Menzies School of Health Research. Dr Garvey noted that "some Aboriginal students and graduates have said that careers advisers told them not to try for medicine because it was 'a bit beyond' them," she said.

"They need to be realistic, of course, but also supportive, and look at how they can support the student to achieve their dreams rather than cut them down."

Dr Mitchell hopes college fellows and trainees will not only support the Indigenous health strategy but consider how they can contribute to improving excellence in rural healthcare and workforce diversity.

"It would be great to have more people actively encouraging, supporting and mentoring young people who are interested in anaesthesia to help them get on to training programs."

Carolyn Jones
Media Manager

Above left: Dr Paul Mills, Dr Dash Newington and NZ medical student Grace Williams, one of the ANZCA 2018 ASM Māori scholarship recipients.

Opposite page clockwise from top left: ANZCA President Dr Rod Mitchell out in the field with Indigenous communities during his early years of practice; Dr Leona Wilson blessing the pounamu gift; Dr Mitchell and NZ fellows after the presentation of the pounamu.

Recognising Dr Rod Mitchell

At a dinner at ANZCA House on July 20, 2018, a number of New Zealand fellows presented ANZCA President Dr Rod Mitchell with a pounamu in recognition of his work with Indigenous people. The gift was blessed by former ANZCA president Dr Leona Wilson in Wellington Harbour. This is ANZCA Vice-President Dr Vanessa Beavis' speech.

E ngā rau rangatira mā, e huihui mai nei, tēnā koutou, tēnā koutou, tēnā tātou katoa

Esteemed leaders gathered here today, three times greetings to you all.

I want to take a moment tonight to note an aspect of Rod's life experience that he brings to the presidency of ANZCA – his time in central Australia, with Australia's Indigenous people.

The understanding and empathy that he gained there adds to ANZCA's inclusiveness. It underscores that the college exists for the wellbeing of all Australians and all New Zealanders.

In this spirit, I bring to Rod the good wishes and support of the fellows of ANZCA in Aotearoa/New Zealand, delivered in the style of New Zealand's Indigenous people – the tangata whenua of Aotearoa.

Rod, on behalf of all the New Zealand fellows I give you this gift of pounamu.

Pounamu is the most precious stone of New Zealand's Indigenous people. It is found only in the tribal territory of Ngāi Tahu, in the South Island. For its appearance, it was made into personal adornments. For its hardness and toughness, it was made into weapons and tools for woodcarving.

Ngāi Tahu traded pounamu in ocean and river canoe voyages spanning thousands of kilometres. Culturally and economically, it was so important that Ngāi Tahu negotiated the control of pounamu as an express term of their treaty settlement with the crown.

By tradition, you are gifted pounamu, rather than buying a piece for your own adornment. By custom, it is first blessed or cleansed in a simple ceremony, by immersing it in a natural body of water. In this case, a group from the New Zealand office took to a nearby beach and put it into the waters of Wellington Harbour – Te Whanganui a Tara.

The timing was special, because last week was Matariki, the Māori New Year, an astronomical event that sets the timing for the planting of crops, and all the seasonal activities for the year. As it happened, it was also the week in which a rare southern right whale made Wellington Harbour its home for the week. So the omens are good for this pounamu.

This gift is to encourage you, as you build on the work of the rangatira, the presidents who have gone before you, in the journey towards equity for Indigenous peoples of both our countries.

I end with a proverbial saying, a fitting one for an organisation whose purpose is the wellbeing of all people:

Nāu te rourou, nāku te rourou, ka ora te iwi.
Nāu te rākau, nāku te rākau, ka mate te hoariri.

With your food basket and my food basket, the people will be healthy.
With your weapons and my weapons, our enemies will be overcome.

Kia ora tātou katoa.

[Waiata]
Te aroha,
Te whakapono,
Me te rangimārie,
Tātou tātou

ANZCA DRIVES NEW INDIGENOUS HEALTH STRATEGY (CONTINUED)

Darwin team leads Top End response

Specialist anaesthetist Dr Edith Waugh is a familiar face to many of the young patients in the Royal Darwin Hospital's children's ward.

The *Bulletin* accompanied her on a recent ward visit so she could check on two-year-old Jill who had been admitted a few days earlier for management of chronic suppurative lung disease. Jill's condition required a HRCT and bronchoscopy under general anaesthesia assessing the severity of condition followed by two week intensive intravenous treatment of antibiotics and Dr Waugh wanted to see how her young patient was faring.

Days earlier Dr Waugh anaesthetised Jill and established vascular access into Jill's left arm which she then securely bandaged. Jill was pleased to see Dr Waugh on her morning round but seemed unperturbed by the interest in her arm. She was more concerned with finding her plastic building blocks and eating the apple on her bedside table.

Jill's grandmother Barbara Moore had flown to the hospital with Jill from their home in the remote Aboriginal community of Amata near Alice Springs and was staying with her in the ward during her intravenous antibiotic treatment. Jill was just one of many Aboriginal patients under the care of Dr Waugh and her colleagues at the hospital who provide essential healthcare to Australia's Indigenous communities in Australia's top end.

Between 50-60 per cent of the hospital's inpatients are Aboriginal and the hospital has a dedicated team of Aboriginal liaison officers and health practitioners to ensure Indigenous patients are getting the medical and health services they need. Seventy per cent of the hospital's Aboriginal patients do not have English as their first language and the Top End Health Service provides a centralised interpreter service for Aboriginal languages.

Dr Waugh is part of the hospital's anaesthesia "flying squad" led by the hospital's Director of Anaesthesia Dr Brian Spain. She is one of several anaesthetists who travel the 2000 kilometre round trip a few times each year to Nhulunbuy in East Arnhem Land for the Gove District Hospital patient lists. Gove Hospital's catchment area of 40,000 square kilometres, which is about the same size as Switzerland, covers 18,000 people who live in dozens of remote Aboriginal communities.

On her most recent trip in August Dr Waugh spent two days working with the hospital's GP anaesthetists Dr Greer Weaver and Dr Josh Mark giving three-, four- and five-year-old patients general anaesthesia facilitating their dental procedures.

Three-year-old Justine had travelled to Gove from her Groote Eylandt home with her mother Alisha McDonald for dental treatment so she could have four teeth extracted and be given some fillings. Dr Waugh talked to Justine and her mother before she was taken to theatre and explained how the strawberry-scented anaesthetic gas would give her magic breath and make her laugh.

Having moved to Darwin from Melbourne in 2012 after first working there (and completing a Masters of Public Health & Tropical Medicine) as a resident in 2002 Dr Waugh understands the challenges of providing healthcare for Indigenous Australians and the Close the Gap initiative to improve health outcomes.

"Rheumatic heart disease, chronic suppuratives disease and chronic ear infections are among the biggest health issues affecting young Indigenous Australians so culturally appropriate decision making (in healthcare) is crucial," she explained.

"We do complex medicine here in Darwin extremely well but we mustn't forget that health and equity are so important. If we can facilitate preventative care by treating our young Aboriginal patients early on we can hopefully prevent a life time of lung disease."

Dr Waugh said cultural storytelling in Aboriginal communities was helping to demystify the hospital and medical system for Aboriginal patients.

"Maintaining a positive, non-traumatic environment for patients, especially children, is crucial as it means they will have a willingness to engage in healthcare in the future."

Dr Waugh's experience with Indigenous patients has given her an understanding of the healthcare challenges faced by Aboriginal communities compared with the rest of the population. Dr Waugh says Indigenous mothers are four times more likely to have had insufficient antenatal care and also more likely to suffer from medical complications of pregnancy.

"Our decreasing but still highest maternal and perinatal mortality rates compared to other states are a result of the persistent gap in Indigenous health outcomes," Dr Waugh said.

"However, the health literacy about regional anaesthesia and anaesthesia is improving since positive experiences have spread with cultural storytelling and our improved efforts to communicate and provide appropriate care. Improving health care services to Indigenous mothers in the top end is only one of many determinants of mothers' and babies' health and wellbeing.

"The challenge is to influence the socio-economic, cultural and environmental conditions that will improve future outcomes," Dr Waugh said.

Carolyn Jones
Media Manager

Above from left: Lazarus, five, and mother Joanne at the Gove District Hospital after his dental procedure; Gove District Hospital theatre team anaesthetic nurse James Deneefe, GP anaesthetist Dr Greer Weaver, anaesthetist Dr Edith Waugh and scrub nurse Kerry Brusnahan; Dr Waugh with her patient Jill, two, and grandmother Barbara Moore in Royal Darwin Hospital. Photographs: Carolyn Jones

ANZCA DRIVES NEW INDIGENOUS HEALTH STRATEGY (CONTINUED)

Young NZ leaders in anaesthesia

Dr Amanda Gimblett

Photo: Chrissie Irvine

Ko Taupiri te Māunga
Ko Waikato te awa
Ko Tainui te waka
Ko Ngāti Maniapoto tōku iwi
Ko Neville rāua ko Deborah ōku mātua
Ko Amanda Gimblett tōku ingoa

Mount Taupiri is the Mountain I affiliate to
The river I affiliate to is Waikato
The waka I affiliate to is Tainui
My tribe is Ngāti Maniapoto
My parents are Neville and Deborah
My name is Amanda Gimblett

Growing up on a farm in north Canterbury on New Zealand's South Island, Dr Amanda Gimblett initially describes her childhood as "traditional" but then admits maybe it wasn't so run of the mill. Her father's decision to change careers from farmer to pharmacist meant a change in lifestyle.

"My dad ended up living in Dunedin for four years studying while we were in north Canterbury... It was a very big move."

It showed a determination that inspired her when she started to do medicine. If things had gone to plan, the young, idealistic sports enthusiast would have been the All Blacks' physio. However a "fabulous" physics teacher spurred her on to think bigger and doing the first year of health science was a decider when she found biomechanics wasn't enough.

Dr Gimblett says support for Māori students at the University of Otago made a huge difference: "We had 18 [Māori] students in the class which is about 10 per cent – quite an achievement. We had a big strong cohort, people who were natural leaders, and fantastic support services through the university."

She knows from talking to others in medicine that being Māori and female would have meant a very different experience a few decades ago.

Apart from choosing anaesthesia on her elective in Alice Springs, Dr Gimblett didn't get to see the potential of the specialty until a senior house officer position came up in Christchurch – spurring her home. It was then she was redirected from what she thought was a career in surgery.

"It was an illustrative time as I got to see anaesthetists as balanced, considered and holistic people in the way they cared for patients, put them at ease and also interacted with other staff."

> "I got to see anaesthetists as balanced, considered and holistic people in the way they cared for patients."

As a member of ANZCA's Indigenous Health Committee, Dr Gimblett is a strong believer in working for equity in the health system.

"I know many struggle with the term and may see it as preferential treatment but that is not the case. It is about achieving the same outcome for everyone down the road and if we have to do that in multiple ways then that is what we do."

Working for equity in anaesthesia will create more diversity in the workforce. But Dr Gimblett says learning to better engage with Māori patients can be explored now.

She recommends connecting with the Hui Process, a learning tool that Otago medical students are taught in New Zealand. The four elements are *Mihi* (greeting and engagement) *Whakawhānaungatanga* (making a connection), *Kaupapa* (attending to the main purpose) and *Poroporoaki* (concluding).

"It is a great cross cultural tool with or without Te Reo (Māori language). It is about engagement."

Dr Courtney Thomas

Ko Tapuae o Uenuku te māunga
Ko Waitoa te awa
Ko Tākitimu te waka
Ko Ngāi Tahu tōku iwi
Ko Ngāti Kuri te hapā
Ko Takahanga te marae
Ko Courtney Thomas ahau

The mountain I affiliate to is Tapuae o Uenuku.
The river I affiliate to is Waitoa
The waka I affiliate to is Tākitimu
My tribe is Ngāi Tahu.
My subtribe is Ngāti Kuri.
My marae is Takahanga.
My name is Courtney Thomas

Delivering culturally responsive care and a focus on equitable outcomes is also on Dr Courtney Thomas' radar. Following two years behind Dr Gimblett at the University of Otago meant the Central Otago farm girl had a great role model as both frequented the university's Māori Centre.

Engaging with the Māori Centre and Te ORA, the Māori Medical Practitioners Association, were important steps in helping Dr Thomas reconnect with her culture.

"The centre was fantastic not only as a place to go but they were really inclusive with tutorials and a mentoring program."

It made a difference in the way Dr Thomas saw the world and her place in it. This journey continued during her early years at university and throughout her medical degree. She recalls her family's experiences with stories of her grandfather "being spanked for speaking Te Reo Māori at school". Her family's motivation to find out where they are from and celebrating that identity is important to her and she hopes her own daughter will grow up appreciating their shared mission.

Dr Thomas' father likes to say he knew his inquisitive daughter was going to be a doctor when he found her examining the gastrointestinal system (poking the innards) of a dead sheep on their farm while her brother ran away screaming.

However, she says it was her mother's experience with breast cancer that put medicine in her sights.

"The breast cancer gene runs in my family unfortunately and my mother was first diagnosed with it when she was 30. She got it again when she was 42 and it was terminal."

As a young child Dr Thomas watched the workings of the hospital and staff, and then again as she entered her second year at Otago. They were life changing experiences.

Dr Thomas says while she was the first person in her family to go to university, she had enormous support: "Although my family didn't have an academic background, they were very hard-working and that was instilled in me very early on."

This shows as she takes on her next challenge as chief investigator on a pilot research project assessing Māori patients' experience of anaesthesia in the perioperative setting. She hopes the findings from this research will enable resource development to assist anaesthetists in delivering culturally competent care to Māori patients.

"In part this is about understanding their experiences, what their needs are and how we can meet them". She says while New Zealand may have a world class health system, health statistics reveal discrepancies in how people access and benefit from healthcare.

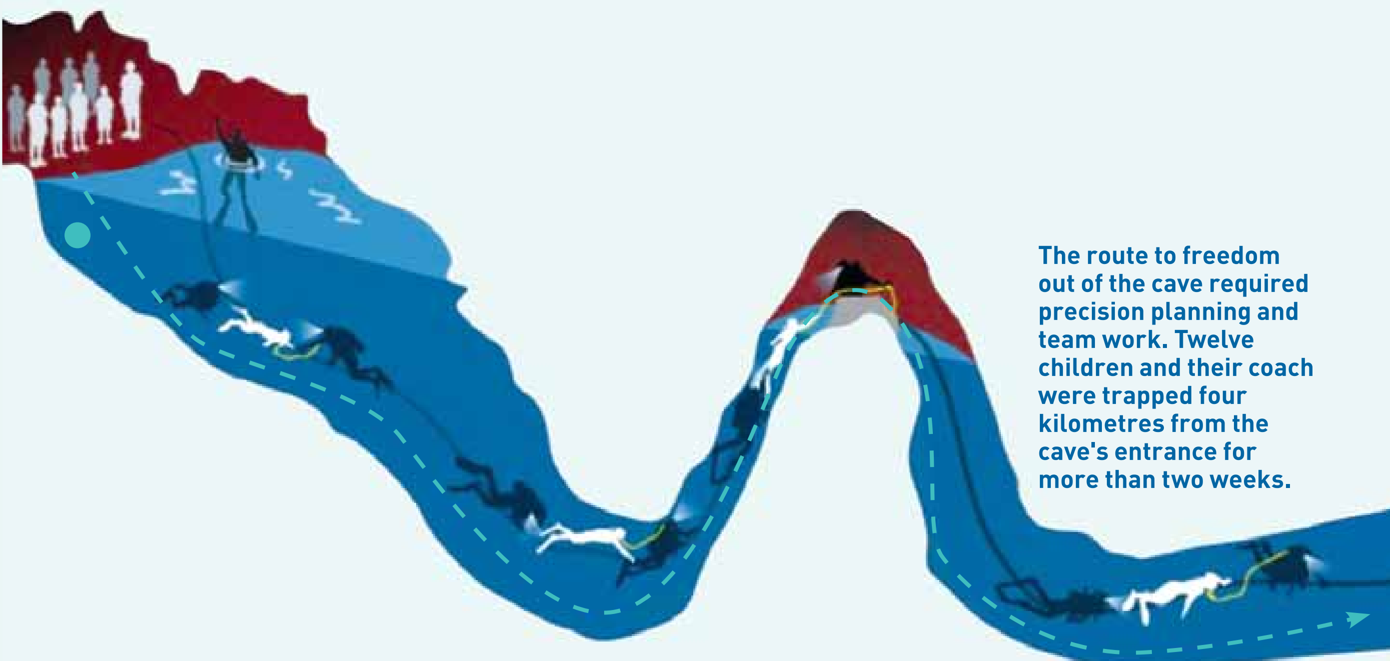
Dr Thomas joined the New Zealand National Committee as the new fellow representative in June and is ANZCA's representative on Te ORA, the Māori Medical Practitioners Association.

Adele Broadbent
Communications Manager, NZ

HERO ANAESTHETIST GIVES HIS ALL IN THAILAND RESCUE DIVE

Adelaide anaesthetist and internationally renowned cave diver Dr Richard "Harry" Harris has been hailed as a hero for his role in the rescue mission to free 12 children and their soccer coach from a flooded Thai cave where they had been trapped for more than two weeks. All were successfully brought to safety on July 10.

Here he describes for the *ANZCA Bulletin* how his love of diving began, his role in the rescue operation that required specialised diving and medical expertise, the importance of teamwork and the challenges of practising anaesthesia while four kilometres inside a cave.



The route to freedom out of the cave required precision planning and team work. Twelve children and their coach were trapped four kilometres from the cave's entrance for more than two weeks.

THE LEAD-UP

"I've been diving since I was about 13. I did my diving course when I was 15 and then at uni I got involved with the university diving club and did a bit of teaching, cave and commercial diving. It's always been a big part of my life.

I didn't really pursue cave diving though until about 2000 when I was fishing at Port MacDonnell, south of Mount Gambier. On the way home I popped into a property with one of the most beautiful sinkholes and that reminded me how amazing the freshwater caves were. So I went back and retrained and from then on I was completely obsessed with it. The water in the sinkholes is crystal clear. The clearest tropical water you have ever swum in, is nothing compared to the clarity of these freshwater caves. It's like floating in air. It's quite disconcerting at first but when the sunlight shines down into them they're quite beautiful.

The deepest sinkhole in the Mount Gambier area is about 120 metres. Most are up to 40 metres in depth. Some are just big holes in the ground and some fan out in a big sock shape. In contrast, the Thai (Tham Luang Nang Non) cave complex is usually a dry cave with a bit of a stream running through it. In the monsoon season the cave floods and it is hazardous. It's totally unpredictable. It's a really dangerous environment.

I hold a number of positions as a search and rescue (SAR) officer for different caving organisations Australia wide, and in my SAR role for the Cave Divers Association of Australia I run some training programs. These are really aimed at accident prevention. The idea is to frighten people enough to make them really think carefully about avoiding the point where they are going to need a body recovery or a rescue! Also it teaches people the basics of how to how to respond to those sort of emergencies.

> "When I was asked to consider sedating the Thai kids my initial response was absolutely not. It's just not possible."

I have been teaching this program for the past six years. I had been doing quite a bit of training based on how to manage a situation where someone was injured or disabled and required transport through an underwater section of a cave. I had reached the conclusion that if someone was completely incapacitated with a head injury or a medical problem it was probably impossible to save them. So when I was asked to consider sedating the Thai kids my initial response was absolutely not. It's just not possible.

Rick Stanton the British cave diver (who was involved with the Thai rescue mission) is the only guy I know personally who has actually rescued someone from such a cave – a group of six British soldiers who got themselves stuck in a flooded cave in Mexico in 2004. That was a 170-metre section of cave – not a two and a half kilometre section – and they were able bodied soldiers so he could teach them to dive and swim out with them. The Thai mission was a quantum leap; much more difficult and complex.

THE CALL

I have been friends with (Perth vet) Craig Challen since 2005. We had both been cave diving explorers and we met up on an expedition to the Kimberley in Western Australia. We recognised kindred spirits in each other through our interest in exploration so we have been cave diving together for quite a few years.

I was in an operating theatre in Adelaide on the Thursday morning (July 5). I had been chatting with Rick Stanton on Facebook messenger in Thailand that week and also another Belgian cave diver; talking about logistics and offering support. I had not heard anything so I assumed everything was under control. And then I got a phone call from Rick that morning and he said "We think you need to come over. We're still looking at the sedation issue but regardless we could do with another pair of hands."

I asked him to speak to the Department of Foreign Affairs and Trade (DFAT) people on the ground over there. Because I was already a member of AUSMAT (Australian Medical Assistance Team) they could fast track everything so that made it very easy. I said I would come but I said I needed Craig with me because you need someone to watch your back and to dive with.

Left: Dr Richard Harris, who has been diving since he was 13, on one of his expeditions. Source: Dr Richard Harris.

HERO ANAESTHETIST GIVES HIS ALL IN THAILAND RESCUE DIVE (CONTINUED)

Clockwise from left: Mission team members, including Dr Harris and Dr Challen, at Government House in Canberra after receiving their bravery awards; Dr Harris prepares for another dive; Dr Harris and Dr Challen returning home from Thailand on board a RAAF C17; Dr Harris with members of the rescue team. Source: DFAT

You don't need to be a diving pair underwater but it's good to have a trusted friend in those kinds of situations. It's important to have someone you can talk to and thrash things out with. Craig and I had planned to leave at 5am the next day (Friday) for a trip to the Nullarbor but we were on a flight to Thailand a few hours later on the Thursday. It all happened very quickly.

THE PLAN

The Thais had control and command of the overall operation. Any decisions had to go through them for approval and in fact the Thai Prime Minister was on the phone during one of the meetings that approved the final plan on the Saturday night.

I was with the Australian Federal Police and the DFAT team, but at the end of the day when you are diving you are responsible for your own safety. I was happy to present a plan to the Thai government and to the AFP of what I was prepared to do and what I thought had a chance of success. The divers – the seven British, four "Eurodivers" and the two Australians were pretty autonomous, we had long discussions about the best way to handle the diving operation. We were the only ones beyond chamber three of the nine chambers in the cave so it was pretty much up to us beyond that point anyway.

In terms of the medical side of things I had several meetings with the Thai military medical people. They had a couple of anaesthetists there and they got me on the phone with a paediatric psychiatrist and a critical care doctor. I had to talk through my plan with them and get their input and they raised some valid questions and issues. We negotiated what was a reasonable thing to do. It was a fairly robust discussion about the pros and cons. I was completely clear with them that it was an extraordinarily high-risk operation, and to be frank I felt I was trying to sell something to them that I really didn't believe was going to work. But I said "if you're happy I'm prepared to give it a try."

THE BREATHING CIRCUIT

As part of the preparation we immersed a local child with a full face mask in a swimming pool so we could make sure that the mask didn't leak.

We tried lots of different types of mask to get the right one. We were looking for something that would give us the best chance of sealing the airway for each child without leaking. Getting a seal to fit on these tiny kids' faces was a big ask because most commercial diving equipment is made for large men. Eventually a suitable mask was sourced.

I had a couple of colleagues in Adelaide who I was also in contact with about the procedure – through them a paediatric anaesthetist, a paediatric psychiatrist and intensivist were also consulted on my behalf.

I was pretty sure the kids were going to need (sedation) top ups on their way out of the cave. All up, there were a group of 13 international cave divers stationed throughout the cave complex. I had to teach them how to judge what level of anaesthesia the kids were at and explain that they might need a top up during the 3-4 hour journey out of the cave.

> "The thought of one of the kids waking up, thrashing around and causing the death of one of the rescuers was a very worrying issue for me."

I encouraged them to err on the side of being heavy handed because my primary concern was the risk to the rescuers. The thought of one of the kids waking up, thrashing around and causing the death of one of the rescuers was a very worrying issue for me. So I had to talk them through giving intramuscular injections. None of the divers had a medical background. One was a fireman and that was about the closest thing to a paramedic. But these guys were amazing, real "can do" guys, very practical, very capable and very tough. They didn't baulk at all. They all practised injecting an empty water bottle and I said as long as you don't inject the wetsuit and you get it into the meat of the leg it will be fine. In the end all the boys required top ups on the way out.

THE ANAESTHETIC

I was very grateful that I had spent two years in Vanuatu doing a lot of ketamine anaesthesia, however my experience of giving intramuscular ketamine was small. I wasn't that familiar with how fast the intramuscular ketamine was going to work or its duration so I was pretty nervous.

THE RESULT

This mission worked because of the respect and co-operation between all the people involved, particularly the divers. If I didn't know any of the British divers, if they didn't know us, if we had a lot of egos and chest beaters there I think the whole thing could have gone really badly. But it all just came together, an amazing experience for me.

The Thai government were very quick to recognise that they needed external expertise and that their military divers didn't have the specific skill set to do this job. In a different place with a different bunch of people it might not have worked at all.

My AUSMAT training was excellent but my experience in Vanuatu and my pre-hospital and retrieval experience were crucial. I enjoy challenges and working in weird places. I just felt this job was purpose made for me and I feel very privileged to have been part of it.

I do sympathise with, and respect our surgical colleagues. They're faced with doing something like a Whipple's and they know the high risks of the operation. But there's obvious risk for the patient if they don't do the surgery. So they have to back their judgement.

There's always doubt in your mind that maybe you're doing something that is so extremely dangerous you shouldn't proceed. And there's a tiny chance they might survive if you do nothing. That was one of the hardest things for me to get my head around. I had to make a decision and then not dwell on it, knowing that we were just doing our best. I would have been paralysed by indecision otherwise."

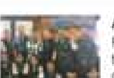
**Dr Harris's first person account is an edited extract from his Bulletin interview with ANZCA President Dr Rod Mitchell and media manager Carolyn Jones on August 23, 2018.*

***Dr Harris and Dr Challen were awarded the Star of Courage, Australia's second-highest bravery award, and medals of the Order of Australia (OAM) for their roles in the rescue. Six Australian Federal Police members and one navy officer were awarded bravery medals and OAMs for "acts of bravery in hazardous circumstances."*

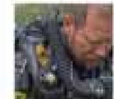
A SELECTION OF SOCIAL MEDIA POSTS

Jennifer Woods @jenbwoods · Jul 12
I'm in awe of your contribution to this courageous and dangerous effort @drharry64 For me, you have exemplified all the best qualities of an @ANZCA anaesthetist #patientsfirst #expertdoctor #DHM #retrievalmedicine

Rodney Mitchell @DrRodMitchell
Hearfelt acknowledgement to Harry from all your colleagues @ANZCA for contributing so selflessly to the rescue of the boys from the Thai caves ...



ANZCA @ANZCA
First photo of the Thai-led #ThaiCaveRescue team including @drharry64 and Perth vet Dr Craig Challen released by @JulieBishopMP after their heroic effort last night.
pic.twitter.com/wv55lcB2Z4

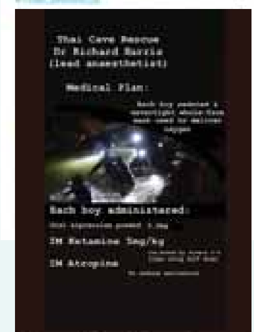


ANZCA @ANZCA
READ: Over the weekend, Adelaide #anaesthetist and #FANZCA Dr Richard Harris @drharry64 was one of the first medics to reach the 12 boys and their coach trapped in #thumluangcave, clearing the way for the rescue attempt. http://ow.ly/8qDI30kR8vC #ThaiCaveRescue #LivesOfOurFellows
pic.twitter.com/jer7jMTmrV

David Scott @scottdav44 · 24h
Totally agree - a fantastic and vital contribution from Dr Richard Harris @drharry and the global rescue team in incredibly challenging circumstances... Inspiring!

Rodney Mitchell @DrRodMitchell · Jul 12
Hearfelt acknowledgement to Harry from all your colleagues @ANZCA for contributing so selflessly to the rescue of the boys from the Thai caves @drharry64.
Similarly, heartfelt condolences.
Thanks Harry. You made the world a better place.

Made a quick insta-style pic to summarise presentation from @drharry64 at #ANZCA



SPECIALISTS READY FOR ACTION IN DISASTER RESPONSE

Below from left: AUSMAT medical staff including anaesthetists Dr Brian Spain (second from left) and NZ fellow Dr Tony Diprose (far right); anaesthetists training on an AUSMAT ventilator; training in the field hospital. Source: NCCTRC

Since the Bali bombings in 2002 Australia and New Zealand's medical community has played a key role as emergency responders to many of our region's natural disasters and medical incidents.

The National Critical Care and Trauma Response Centre (NCCTRC) in Darwin runs the Australian Medical Assistance Team (AUSMAT) course which now has more than 700 health professionals, including anaesthetists, nurses and other health practitioners, on a national medical disaster team data base.

AUSMAT's role in emergency and disaster medicine was highlighted recently by the deployment to Thailand of Adelaide anaesthetist Dr Richard "Harry" Harris as the lead medic for the rescue mission to free 12 children and their soccer coach from a flooded Thai cave where they had been trapped for more than two weeks. Dr Harris completed an AUSMAT course in 2013.

Once participants have successfully completed the course they are placed on the database which is constantly updated with contact, passport and vaccination details to ensure that should there be a medical emergency a response team can be quickly deployed.

The centre, which is based at Royal Darwin Hospital, was established by the federal government after the Bali bombings. The AUSMAT Emergency Medical Team is accredited by the World Health Organization.

The *ANZCA Bulletin* was given exclusive access to a recent AUSMAT five-day training course in Darwin. The course includes scenarios such as brain trauma, obstetrics, burns, draw-over anaesthesia, ethics, blood transfusions and team management and leadership.

Tent shelters that serve as deployable field hospitals complete with emergency wards, operating theatres and high dependency units were erected on an oval in one of Darwin's outer suburbs to give participants an understanding of what they would expect once deployed. On the day the *Bulletin* visited an obstetric scenario was under way with participants watching as two midwives began to "deliver" a baby from a medical mannequin.

Four anaesthetists from Royal Darwin Hospital attended the course while New Zealand fellow Dr Tony Diprose was part of the AUSMAT faculty team. The Hawke's Bay anaesthetist is a member of the NZ Medical Assistance Team (NZMAT) and he was deployed to Vanuatu after Cyclone Pam in 2015 and Fiji in 2016 after Cyclone Winston. The course also included visiting international specialists from Israel, Vanuatu, Fiji and Tonga.

According to AUSMAT team leader Dr Brian Spain, Director of Anaesthesia and Medical Co-Director of Surgery and Critical Care at Royal Darwin Hospital, "to be able to provide sophisticated emergency care is very rewarding and the Australian disaster response teams have an excellent reputation."

Thirty years ago Dr Spain was a medical student in Mendi in Papua New Guinea's Southern Highlands Province. He returned there earlier this year to provide medical assistance but it was under very different circumstances – he was there in his AUSMAT role as part of the response team after the 7.5 earthquake hit the country. Landslides had buried homes and dozens of people died.

Dr Spain said he was privileged to have been able to return to Mendi to help the community recover: "The infrastructure was largely intact but essential medical care was needed and the AUSMAT team were able to respond and mobilise quickly to provide that."

When deployed in the field the AUSMAT teams are easily identified by their pale blue shirts with "Australian doctor" or "Australian nurse" emblazoned on their backs.

Dr Spain said the rigorous conditions of AUSMAT deployments meant anyone who wasn't prepared to eat ration packs, didn't like getting their feet dirty or could not accept command and control protocols would not be suitable for the team.

"There is a staged selection and assessment process so anyone who isn't suited to these roles would not be selected," he said.

"You need to be flexible and be a lateral thinker in addition to be being a talented clinician but not have a fixed mindset. Having prehospital skills is also important as we need team members who are multi-skilled."

Dr Spain said anaesthesia was the only clinical speciality in AUSMAT that had been part of every AUSMAT deployment since the National Critical Care and Trauma Response Centre was established.

"Many anaesthetists have also worked as retrieval doctors and they are very skilled at providing clinical logistics," Dr Spain explained.

"Because of the broad skills that anaesthesia brings to the medical profession anaesthetists are essential for all the AUSMAT team deployments."

The structure of each team varies according to the needs of the disaster or emergency. Some disasters may require more assistance in general surgery and paediatric and obstetric medicine while others may require general medical help or medical evacuations.

AUSMAT teams can be deployed with just a few hours' notice. A warehouse full of medical and surgical equipment, medicines and ration packs is well stocked so AUSMAT advance teams can start setting up field hospitals within hours of arriving on a mission.

Carolyn Jones
Media Manager

Fatigue – a cultural and systemic issue

A 2017 UK national survey to assess the incidence and effects of fatigue among 3772 trainee anaesthetists, found that despite the known risks of fatigue to physical health, psychological wellbeing and personal relationships, it is still prevalent. Fifty-seven per cent of trainees stated that they had experienced either an accident or a near miss on travelling home after nights. Trainees reported that night shifts had the most significant effects, commenting on, the lack of breaks and inadequate rest facilities[1]. This survey demonstrates how high a toll fatigue exacts on anaesthetists, professionally and personally.

There is a paucity of evidence on fellows' experiences of fatigue, but it is clearly not restricted to junior doctors and trainees. It affects both public and private practitioners. Anaesthetic consultants commonly work more than 10 hour-long daytime shifts, often followed immediately by remote call for a further 14 hours. This results in interrupted sleep several times a night, and driving back and forth to the hospital with no facilities readily available to sleep. The option for a second on-call consultant anaesthetist or the availability of a non-clinical session the next day, is not an option in private practice and not always available in public hospitals, especially in smaller units and country areas.

Doctors' hours have reduced compared to the 1980s, however, unlike the airline industry's protocols for pilot flying hours, there exists no official guidance regarding the appropriate provision of a minimum standard of rest between clinical duties or facilities to be made available for doctors. Simply reducing duty hours has not translated into improved patient care or doctor wellbeing – rest and fatigue is more complex than just rostering and workload, important though this is. Attention must be given to the duration of the working day, proper rest and meal breaks, rest facilities, number of days on-call, days off, education regarding the optimisation of "recovery" time, and for trainees, protected teaching and education time[2].

The Australian Medical Association's Safe Hours Audit (2016) showed that 53 per cent of doctors in Australia are still working rosters that put them at risk of performance impairment due to fatigue. This is higher in registrars (59 per cent) compared to consultants (47 per cent) but is of concern in both groups, especially as this has not changed since the previous survey in 2011.

Fatigue – a cultural and systemic issue (continued)

"As a trainee I had a special name for fatigue – 'Trout Pate Syndrome'. This came from a scary experience of a very busy string of 12-hour night shifts while studying for primary exams. I was exhausted, but rather than heading home, found myself in David Jones Food Hall pondering which totally unnecessary pot of trout pate to buy. Aware of a sudden wave of nausea and the absurdity of the situation, I left the pate on the shelf, and drove home, narrowly missing a woman and child on a pedestrian crossing. Most anaesthetists have their own catalogue of such near-misses or worse. Apart from the fishy detail, I also suspect that we have personal examples of the 'poorly judged logic' of adding another activity to the mix – maybe in an attempt to wind down."

Dr Marion Andrew

"Long shifts were a traditional rite of passage of a junior doctor. The longest I recall as a resident was 78 hours – Friday morning to Monday noon. There was little opportunity for 'power naps' and mostly I was kept alert by the variety of demands, chatting in the residents' lounge, and some degree of oversight by registrars and nurses. I was lucky I lived close enough to walk home. Forty-eight hour shifts were common on weekends as a registrar, and I know of tragic accidents with junior doctors driving home from country rotations after long shifts. Fortunately this shouldn't happen now, but it is well recognised that after 'only' 24 hours awake, some aspects of cognitive function are more impaired than being over .05."

Professor David A Scott

How does fatigue impact on safety and performance?

It is no surprise that fatigue is a hidden risk factor that can potentially have disastrous consequences. Michael Farquhar's 2017 editorial in *Anaesthesia*[3] makes the point that, the keen but fatigued team "go factor" mindset of NASA decision-making likely contributed to the disastrous launch of the US Space Shuttle Challenger. He compares this decision, to the relentless pressure on fatigued staff in health systems to achieve cost-driven targets and avoid patient cancellations at the expense of their wellbeing and safety of patients.

Fatigue can contribute to adverse events and critical incidents[4]. Data from other industries has shown fatigue to be commonest in a bimodal distribution between 3am and 7am and between 1pm and 4pm, when circadian drowsiness is greatest. Sleep medicine experts have found that the decrement in cognitive psychomotor performance after 17 hours of sustained wakefulness is equivalent to the performance impairment observed with a blood alcohol level of 0.05 per cent, and after 24 hours to a blood alcohol level of 0.1 per cent[5]. A meta-analysis of laboratory studies of sleep loss in fit young adults who were short-term and chronically sleep deprived demonstrated mean cognitive performance to be 1.37 standard deviations below the mean of the control group. This must impact on clinical decision-making[6].

Anaesthetists are trained to a high level with the expectation that we will remain alert, maintain sustained periods of vigilance, respond rapidly to acute situations and make judgements that prioritise patient safety. Fatigue has been shown to impair vigilance, response accuracy, and performance of motor and cognitive functions[6]. It is important to recognise that when fatigued, we show a lack of insight into our impaired decision making processes[7]. The dedication and goodwill of anaesthetists in being flexible, working through breaks, doing extra hours and covering sick leave can be open to exploitation by health services. In private practice, there are a range of factors driving the decision to "carry on" with the next morning's list – these include a sense of obligation to the patients and surgeon, difficulty in finding someone else who is free and willing to cover, and a sense that it will be "ok". Some of these factors are improving, especially within group practices. We are, however often unconsciously complicit, by adopting the "hero role" and buying into the false belief that our skills, judgement and empathy are impervious to fatigue.

Fatigue is contributed to by numerous factors including acute and chronic sleep debt, physical demands, physiological states including hydration and nutrition cognitive load, environment, motivation, personal stress, and significantly our circadian rhythms.

Sleep and circadian rhythm

Sleep is a physiological need essential for healthy functioning. Individuals vary in how much sleep they need with the average being seven hours a night. The circadian clock is biochemical oscillator with a stable phase synchronised with the Earth's solar day and thus the external light and dark cycles. The circadian rhythm is not only generated from the supra-chiasmic nuclei of the anterior hypothalamus, but also from multiple peripheral circadian clocks located in many tissues of the body (even to a cellular level)[8], indicating that circadian rhythms, metabolism and nutrition are closely interlinked.

Having evolved as daytime creatures, our human circadian rhythms are very powerful and we experience a physiological low when working at night akin to jetlag. Shift working disrupts the normal entrained circadian rhythm. After a night shift, sleep is typically one to four hours shorter than that after day shifts and is of poorer quality. After four to six hours of sleeping, the subject typically awakens but is then unable to return to sleep thus, restricting sleep duration. Even short-term sleep restriction results in abnormal physiological changes, including reduced glucose tolerance, increased blood pressure, activation of the sympathetic nervous system reduced leptin levels, and increased inflammatory markers. Fatigue has a cumulative effect and causes lapses in attention, reduced cognitive throughput, slowed working memory, depressed mood and perseveration of thought. The theory that chronic sleep restriction can potentially affect general health is supported by epidemiological studies of self-reported short sleep duration being associated with obesity, heart disease and mortality[9].

Doctors cope and continue to provide a high level of care despite these mental and physiological challenges – but at a cost. The normalisation of fatigue, early in a medical career, is likely to contribute to producing a workforce, who are vulnerable to the higher burnout detected by beyondblue in doctors under the age of 30 years as well as reduced physical wellbeing[10]. Mitigating strategies such as use of alcohol or self-prescribed drugs, can reduce sleep latency time, but result in poorer sleep quality and can lead to substance abuse and further health issues – including suicidal thoughts[11]. Disruption of circadian rhythms and sleep cycles is aggravated by ageing, and in addition to short-term cognitive impairment may contribute to neuroinflammation and, if persistent, to neurodegeneration[8].

Fatigue: Whose responsibility?

With unpredictable 24-hour healthcare demands, fatigue is an inevitable human factor. However when fatigue and emotional exhaustion become the norm in our working culture, we risk losing the ability to detect it and do what's required to protect patients, our colleagues and ourselves. The responsibilities of anaesthetists in managing fatigue are set out by ANZCA in their professional statement *PS43 Statement on Fatigue and the Anaesthetist* (2007) on the website – this document is currently being revised and updated[12]. The AMA also provides a national code of practice in addition to a useful fatigue risk assessment tool (ama.com.au/article/2016-ama-safe-hours-audit).

We have a responsibility to guard against fatigue by managing our time and balancing work with rest, sleep and other energy-recharging social activities. Throughout shifts, particularly night shifts, we should monitor our mental and physical energy levels and consider not proceeding with clinical duties (at least alone) if we detect excessive fatigue. A number of fatigue assessment tools are available including the Epworth Sleepiness scale, Occupational Fatigue Exhaustion Recovery (OFER) Scale, Swedish Occupational Fatigue Inventory (SOFI) and the AMA Fatigue Risk Assessment Tool, to assess degrees of sleepiness and fatigue. We can protect against fatigue as part of self-care by optimising sleep, avoiding taking on too many commitments, both in and out of work, and ensure we take breaks and regular annual leave. Being alert for the negative consequences of fatigue is also important with its potential to lead to exhaustion, cynicism, and reduced effectiveness at work, "burnout" and mental ill-health.

Health organisations that are concerned about patient safety and quality of care will have a vested interest in the wellbeing of their doctors, since fatigue is costly in terms of efficiency, risk management, long term sick leave and retention. The relentless push to achieve cost-driven targets by organisations may be unknowingly contributing to impaired mental and physical health and eroding motivation. A recent paper promotes nine strategies organisations can take to combat fatigue, burnout and improve engagement in the workplace[13].

Dr Kate Harding podcast

In the last edition of the *ANZCA Bulletin*, we featured "Learning from Richard's death", an article by Dr Kate Harding about the suicide in New Zealand of her husband, Dr Richard Harding, who was an anaesthetist and intensivist.

Dr Harding, who has since returned to the UK with her family, was interviewed for "Life in the Fastlane", an emergency medicine and critical care education blog.

In the podcast, Dr Harding talks about fatigue as a contributing factor to her husband's death. Access the podcast via: **https://lifeinthefastlane.com/mastering-intensive-care-032/**

For more information about health and wellbeing issues, including where to get help if you are experiencing your own difficulties, please visit the ANZCA website's "Doctors' health and wellbeing" page – www.anzca.edu.au/resources/doctors-welfare.

The Anaesthesia Association of Great Britain and Ireland (AABGI) has recently taken a lead, embracing social media and seeking to raise awareness of the importance of good sleep habits and strategies to help doctors manage working night shifts in their #FightFatigue campaign.

What action is required?

A comprehensive bi-national toolbox approach to minimise fatigue and fatigue-related risks is needed for anaesthetists in Australia and New Zealand, that includes establishing fatigue education, fatigue management plans, fatigue management resources, and mitigating interventions. The differing situations of junior doctors, and consultants in public and private practice need to be considered. ANZCA is looking to collaborate with the work done by the Royal College of Physicians and Surgeons of Canada in addition to that of the AAGBI and UK and Irish colleges in developing a locally relevant toolkit.

We need to start the conversation amongst ourselves, our colleagues, department managers and health service organisations, to encourage education about the costly effects of fatigue, to recognise the imperative for protected breaks and better access to facilities for rest and monitoring, and to provide enforcement mechanisms at a local level.

A cultural change is needed as well, to encourage and support good clinical practice and alter the perception that "carrying on" when there are reasonable options is not "heroic" and is not in the best interests of ourselves or our patients.

Fatigue – a cultural and systemic issue (continued)

Are there fatigue management interventions that you can introduce in your department or practice?

We can begin by looking at our own departments and see how we can work with hospital management to make facilities available where doctors can rest or sleep.

Addressing rostering and adapting systems to maximise recovery, sleep health and general wellbeing is also important. Private practitioners can consider how their groups can provide cover after overnight call – and this is happening in many groups already. Understanding of how best to get "recovery" sleep is also needed.

The Anaesthesia Association of Great Britain and Ireland (AABGI) website has useful resources with standards and downloadable assessment tools.

Dr Marion Andrew FANZCA
Chair, Welfare of Anaesthetists
Special Interest Group

Professor David A Scott FANZCA FFPMANZCA
Immediate Past President, ANZCA

References:

1. McClelland l, Holland J, Lomas JP, Redfern N, Plunkett E. A national survey of the effects of fatigue on trainees in anaesthesia in the UK . Anaesthesia 2017;72:1069-77
2. Bolster, L., & Rourke, L. (2015). The Effect of Restricting Residents' Duty Hours on Patient Safety, Resident Well-Being, and Resident Education: An Updated Systematic Review. Journal of Graduate Medical Education.
3. Farquhar M. For nature cannot be fooled. Why we need to talk about fatigue. Anaesthesia 72(9) July 2017.
4. Merry AF, Warman GR. Fatigue and Anaesthesia Anaesthesia and Intensive Care 2006; 577-578.
5. Dawson D, Reid K. Fatigue, alcohol and performance impairment. Nature 1997; 688: 235.
6. Banks S. Dinges D Behavioural and physiological consequences of sleep restriction. Journal of Clinical Sleep Medicine 2007 Aug 15; 3(5): 519-528.
7. Capanna M, Hou R, Garner M, Yuen HM, Hill CM, Risk taking in junior doctors working nights shifts in Intensive care. Intensive care medicine 2017;43:709-10.
8. Musiek, E. S. and D. M. Holtzman (2016). "Mechanisms linking circadian clocks, sleep, and neurodegeneration." Science 354(6315): 1004-1008.
9. Johnston J. Physiological links between circadian rhythms, metabolism and nutrition. Experimental Physiology 2014 99.9(2014) pp1133-1137.
10. Beyond blue 2013 National Mental Health Survey of Doctors and Medical Students. www.beyondblue.org
11. Wong MM Brower KJ The prospective relationship between sleep problems and suicidal behaviour in the National Longitudinal Study of Adolescent Health Journal of Psychiatric Res 2012.
12. PS43-2007 Statement on fatigue and the anaesthetist. www. anzca. edu.au.
13. Tait D, Shanafelt MD Noseworthy MD Executive leadership and physician wellbeing: Nine organisational strategies to promote engagement and reduce burnout Mayo proceedings 2017.

Tips for managing fatigue

- Educate yourself, your department and your organisation about fatigue.
- Take responsibility for managing fatigue.
- Practice and promote good recovery and sleep habits.
- Take your breaks and cover others for breaks.
- Encourage positive attitudes to rest and sleep – be a role model.
- Take regular annual leave to recharge.
- Find somewhere in your facilities to allocate for rest/sleep for staff working nights and on call.
- If you are not sleeping well consult your GP.
- For shift work, roster forward-rotating shifts – mornings-evenings-nights – which are associated with the least disturbance to normal sleep patterns.
- Consider individual variation in sleep requirements and personal circumstances when rostering.
- Avoid a prolonged period of night shifts as this can result in serious sleep deficit.
- If you are involved in runs of overnight shift work, have a low threshold for calling for assistance.
- Management plan for non- clinical duties post call covered by another anaesthetist or postponed.

Resources

The Anaesthesia Association of Great Britain and Ireland (AABGI)
www.aagbi.org/professionals/welfare/fightfatigue

Sleep Health Foundation
www.sleephealthfoundation.org.au/

Australasian Sleep Association
www.sleep.org.au

Sleep Council UK
https://sleepcouncil.org.uk

AMA Fatigue Risk Checklist
https://ama.com.au/article/managing-risks-fatigue-general-practice-gps-and-gp-registrars

FatigueRiskManagementSystemResourcePack
http://enhancingresponsibility.com/wp-content/uploads/2014/01/Queensland-Health-Fatigue-Risk-Management-System-resource-pack-2009.pdf

The Royal College of Physicians and Surgeons Canada
www.researchgate.net/profile/Jason_Frank/publication/262185472_Fatigue_Risk_Excellence_Towards_a_PanCanadian_Consensus_on_Resident_Duty_Hours/links/0a85e536efd8742f43000000.pdf

Safe labelling

Human factors of medication handling

I know we *think* we read the label, but what do we *really* do when we select and check medications prior to administration?

There's plenty of evidence that drug errors happen more frequently than we'd like to admit in anaesthesia. Indeed, some estimates put the rate of adverse medication errors as high as one in every 20 anaesthetics depending on the definition[1].

In some ways it's not surprising. Anaesthetists give a median of seven drugs per anaesthetic encounter. We give agents often with narrow therapeutic indices that can look surprisingly similar, usually storing them all together in a single draw. One suggestion is to force anaesthetists to read the label more carefully by redesigning the presentation and workflow.

If we were to force anaesthetists to read the drug ampoule labels correctly then logically we would remove all other cues that might be misleading. As a result, all our medications would be packaged the same. Just like plain packaging on cigarettes, no advertising symbols or colours that could distract or mislead would be allowed, merely the name, dose and expiry dates.

Of course, the position of where the ampoules would be kept in the draw could also give some clue to what the medication was. So, imagine storing all of our medications in theatre in a large bucket. Every time we needed a drug we would need to rifle through the bucket to find the correct ampoule. It may take a while, but at least we'd read the label properly, right?

We all know that creating a "bucket of drugs" identical to each other is not only impractical but would create additional risks. We can imagine some of them – an inability to find the right ampoule under time pressure, to adequately restock, or to improve the efficiency of the theatre list. In a practical sense producing identical presentations is impossible as many medications require brown glass to protect from UV light, some need to be stored in the refrigerator, some need reconstituting and some, like propofol or patent blue dye are highly distinctive in their appearance. Surely there's a better way – a solution to help us manage anaesthetic medications to prevent mix-ups and mistakes?

To find out, we need to take a trip away from anaesthesia and into the realm of human factors, and cognition. Human factors in its broader sense relates to how the working environment is designed to minimise the risks of human error, and to maximise the strengths (such as pattern patching, experience and predictions) of the clinician that perform better than a purely automated system. Indeed, communication and emergency management that many people consider to be human factors is a small, albeit important part of safety science.

The truth is that we don't select our ampoules based on reading the label, but all of the mostly subconscious cues in the environment. Size, position and colour all play a role in determining what we pick up. In addition, other cues that might be less obvious play a role such as temperature, which might prevent us from inadvertently mistaking an ampoule of midazolam, from say, cisatracurium.

We can make these cues more obvious and use them to our advantage if we are strategic. ANZCA's professional document *PS51 (Guidelines for the Safe Management and Use of Medications in Anaesthesia)* describes the principles and best practice for the purchase and handling of anaesthetic drugs[2].

Ensuring that there are as few medications that look similar to each other as possible is important, as is the communication of any change in presentation from the purchasers to the clinicians. Emergency medications such as adrenaline/epinephrine must be easily accessible but should be away from commonly used drugs to prevent inadvertent administration. Muscle relaxants are of course the most feared

> "Our eyes and brain often trick us into believing what we expect to see is what we actually see."

SEDATIVE	INDUCTION AGENT	OPIATE/ ANALGESIC	RELAXANT OR REVERSAL		ANTIBIOTIC	ANTIEMETIC
2ML	20ML	2ML OR 10ML	5ML RED	5ML PLAIN	10ML	2ML

A

BACK OF TRAY – ALREADY GIVEN		EMERGENCY DRUGS	
FRONT OF TRAY – TO BE GIVEN	RED CAP OR AMPOULE ATTACHED 2ML OR 20ML		

B

Medication strip for use in operating theatre.

Order derived from an unpublished survey of New Zealand anaesthetists practice, discussions with many practitioners over many years and common sense.
Based on an original idea by Dr Bruce Rudge.

Instructions

Print this sheet in colour.
Cut around border of both tables and oppose edges A and B to make a long strip
Laminate within an A3 laminating pouch
To save money several strips can be laminated in the one pouch (leave at least 1cm margin around each strip)
Cut out each laminated strip and place on anaesthetic drug trolley
Laminated strip can be wiped with surface disinfectant between cases

Anaesthetic medication strip with standard order and syringe size v02 (2014)
Copyright free, please distribute and use for patient safety

Queries and comments to:
stuart.marshall@monash.edu

of accidental ampoule switches and the solution of keeping these medications in a separate box may help prevent their accidental use.

Reading the label of the packaging is of course an important check but we should be aware that our eyes and brain often trick us into believing what we expect to see is what we actually see. Mechanisms to prevent this include having a well-lit area with no distractions and drawing up one medication at a time. The colour-coded label for the medication should be applied to the syringe immediately and before the syringe leaves the hand. A second check of the labelled syringe against the ampoule is recommended, as is a third check just prior to administration. Sophisticated barcode readers and pre-filled syringes can provide a more robust system but are expensive.

The use of standard size and position can also be helpful when arranging medications on the work surface to prevent picking up the wrong item. This principle of size and shape "coding" was one of the first human factors redesign processes. The father of human factors, Alphonse Chapanis, re-engineered the shape of the aircraft flaps and gear knobs to prevent gear retraction while the aircraft were on the ground – a common problem prior to this[3].

A round shape for the landing gear control and a flat shape for the flap controls were immediately obvious when felt and represented the items they affected. We have a similar system with coarse fluting on the oxygen knob of many anaesthetic machines that uses the same principle.

For medications it is helpful to have size coding of syringes for certain medications. As well as a red-barrelled syringe, the use of a 5 ml syringe size for only muscle relaxants or reversal helps prevent a switch with an anxiolytic such as midazolam prior to induction. This also aids the creation of standard dilution of agents on the work surface.

Ordering of the position of the syringes on a clean surface provides yet another cue and helps prevent "syringe swaps". A cognitive aid in the form of a pre-designed compartmentalised tray such as that recently described by Almghairbi ensures that if more than one anaesthetist is involved in the case there is a common understanding of the syringe layout[4]. A more economical solution is a laminated strip that can be produced cheaply and easily wiped with disinfectant between cases (available from https://www.dropbox.com/s/8wyhdmb9mx1990a/Medication%20trolley%20strip.docx?dl=0).

Like many aspects of care in anaesthesia, safe practice requires vigilance and a constant effort to prevent mishaps. However, there are systemic changes and routines we can all adopt to prevent as many errors as possible.

Dr Stuart Marshall
Senior Research Fellow,
Anaesthesia Teaching and Research,
Monash University

References:

1. Nanji KC, Patel A, Shaikh S, Seger DL, Bates DW. Evaluation of perioperative medication errors and adverse drug events. Anesthesiology. 2016;124(1): 25-34.
2. ANZCA. PS51 (2018): Guidelines for the Safe Management and Use of Medications in Anaesthesia Accessed 29/7/18.
3. Chapanis, A., Garner, W. R., and Morgan, C. T. Controls for Human Use in Applied experimental psychology. New York: John Wiley and Sons, Inc., 1949, p308-15.
4. Almghairbi DS, Sharp L, Griffiths R, Evley R, Gupta S, Moppett IK. An observational feasibility study of a new anaesthesia drug storage tray. Anaesthesia 2018; 73: 356-64.

Above from left: Worksurface layout with separate container for neuromuscular blocking drugs and laminated, colour-coded strip prompting a standard syringe layout.

Safe labelling (continued)

Different shades of blue

The ANZCA professional document *PS51 Guidelines for the Safe Management and Use of Medications in Anaesthesia* highlights the importance of the five Cs of medication administration: correct medication, patient, dose, route and time. Occasionally situations can arise in clinical practice where satisfying these five Cs prior to drug administration can be challenging.

One such situation occurred in our hospital and it was related to the incorrect administration of a blue dye to a patient during surgery.

At the conclusion of an elective gynaecological procedure a 65-year-old female was having a cystoscopy to visualise both ureteric jets in order to exclude injury. Visualisation proved to be difficult and the surgeon requested "blue dye" be given to the patient as an aid for the procedure. The anaesthetist was then presented with a single vial of blue dye retrieved from the pharmacy storeroom. This was subsequently diluted in 10mls of normal saline and administered intravenously. Over the next 10 minutes the patient's peripheral oxygen saturations dropped to 85 per cent and skin became blue/grey in appearance. The urinary tract remained difficult to visualise. Over the next 60 minutes the saturations recovered and after 48 hours the patient's skin colour normalised. What had occurred was a medication error where Patent Blue V had been administered intravenously instead of Indigo Carmine for ureteral visualisation.

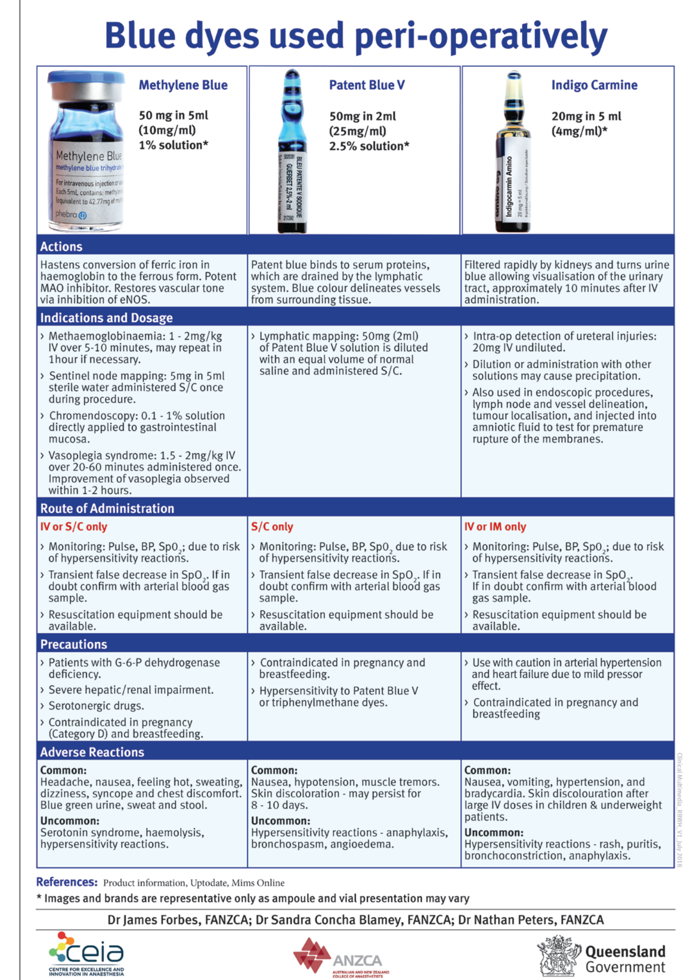
Blue dyes commonly used perioperatively including Methylene Blue, Patent Blue V and Indigo Carmine. These have different indications, preferred routes of administration, and side effect profiles which can be unfamiliar to anaesthetists required to administer them infrequently. Compounding their often-infrequent use is their similar blue appearance and their often limited (or non-English written) product information which can be difficult to access is a timely manner.

This error prompted the development of a poster highlighting the important aspects of the blue dyes which are used peri-operatively. The poster is now located in all theatres in our institution were blue dyes are likely to be administered around the time of surgery. A recent visiting anaesthetist made comment about the value that this poster may have in their institution. This prompted our local perioperative pharmacy group to share this resource with the ANZCA Safety and Quality Committee, who have recently endorsed the poster. It is accessible online for reproduction via the ANZCA safety and quality resources webpage: www.anzca.edu.au/fellows/safety-and-quality/publications-and-resources.

We hope that making this resource available to others prevents any future potential errors related to the administration of blue dyes to patients perioperatively.

Dr Christine Pirrone
Advanced Trainee

Dr Nathan Peters FANZCA
Department of Anaesthesia and Perioperative Medicine, Royal Brisbane and Women's Hospital, Queensland



Blue dyes used peri-operatively

	Methylene Blue 50 mg in 5ml (10mg/ml) 1% solution*	Patent Blue V 50mg in 2ml (25mg/ml) 2.5% solution*	Indigo Carmine 20mg in 5 ml (4mg/ml)*
Actions	Hastens conversion of ferric iron in haemoglobin to the ferrous form. Potent MAO inhibitor. Restores vascular tone via inhibition of eNOS.	Patent blue binds to serum proteins, which are drained by the lymphatic system. Blue colour delineates vessels from surrounding tissue.	Filtered rapidly by kidneys and turns urine blue allowing visualisation of the urinary tract, approximately 10 minutes after IV administration.
Indications and Dosage	› Methaemoglobinaemia: 1 - 2mg/kg IV over 5-10 minutes, may repeat in 1hour if necessary. › Sentinel node mapping: 5mg in 5ml sterile water administered S/C once during procedure. › Chromendoscopy: 0.1 - 1% solution directly applied to gastrointestinal mucosa. › Vasoplegia syndrome: 1.5 - 2mg/kg IV over 20-60 minutes administered once. Improvement of vasoplegia observed within 1-2 hours.	› Lymphatic mapping: 50mg (2ml) of Patent Blue V solution is diluted with an equal volume of normal saline and administered S/C.	› Intra-op detection of ureteral injuries: 20mg IV undiluted. › Dilution or administration with other solutions may cause precipitation. › Also used in endoscopic procedures, lymph node and vessel delineation, tumour localisation, and injected into amniotic fluid to test for premature rupture of the membranes.
Route of Administration	IV or S/C only › Monitoring: Pulse, BP, SpO_2; due to risk of hypersensitivity reactions. › Transient false decrease in SpO_2. If in doubt confirm with arterial blood gas sample. › Resuscitation equipment should be available.	S/C only › Monitoring: Pulse, BP, SpO_2 due to risk of hypersensitivity reactions. › Transient false decrease in SpO_2. If in doubt confirm with arterial blood gas sample. › Resuscitation equipment should be available.	IV or IM only › Monitoring: Pulse, BP, SpO_2; due to risk of hypersensitivity reactions. › Transient false decrease in SpO_2. If in doubt confirm with arterial blood gas sample. › Resuscitation equipment should be available.
Precautions	› Patients with G-6-P dehydrogenase deficiency. › Severe hepatic/renal impairment. › Serotonergic drugs. › Contraindicated in pregnancy (Category D) and breastfeeding.	› Contraindicated in pregnancy and breastfeeding. › Hypersensitivity to Patent Blue V or triphenylmethane dyes.	› Use with caution in arterial hypertension and heart failure due to mild pressor effect. › Contraindicated in pregnancy and breastfeeding
Adverse Reactions	**Common:** Headache, nausea, feeling hot, sweating, dizziness, syncope and chest discomfort. Blue green urine, sweat and stool. **Uncommon:** Serotonin syndrome, haemolysis, hypersensitivity reactions.	**Common:** Nausea, hypotension, muscle tremors. Skin discoloration - may persist for 8 - 10 days. **Uncommon:** Hypersensitivity reactions - anaphylaxis, bronchospasm, angioedema.	**Common:** Nausea, vomiting, hypertension, and bradycardia. Skin discolouration after large IV doses in children & underweight patients. **Uncommon:** Hypersensitivity reactions - rash, puritis, bronchoconstriction, anaphylaxis.

References: Product information, Uptodate, Mims Online

* Images and brands are representative only as ampoule and vial presentation may vary

Dr James Forbes, FANZCA; Dr Sandra Concha Blamey, FANZCA; Dr Nathan Peters, FANZCA

Clinical Multimedia_RBWH_V1_July 2018

Safety alerts

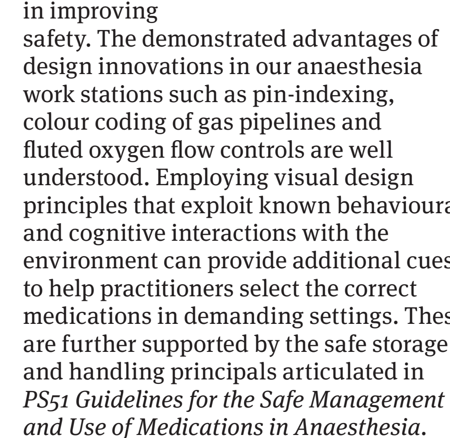
Safety alerts are distributed in the "Safety and quality" section of the monthly *ANZCA E-Newsletter*. A full list can be found on the ANZCA website: www.anzca.edu.au/fellows/safety-and-quality/safety-alerts.

New warnings on labels of medicines containing neuromuscular blocking agents

Anaesthetists are familiar with the problem of drug errors that relate to visually indistinct or look-alike medication labels and packaging. Recent legislative changes in Australia have taken us one small step toward safer medication handling by introducing a requirement for standardised mandatory warnings on the labels and packaging of neuromuscular blocking agents. The change, facilitated by the Therapeutic Goods Administration, is the result of an extended period of advocacy and collaboration between pharmacy advisory groups, the pharmaceutical industry and ANZCA.

The new requirements are described in Therapeutic Goods Order No. 91 – *Standards for labels of prescription and related medicines* (TGO 91), under section 6 and subsection 10(8A). They specify that if a medicine contains a neuromuscular blocking agent then the primary packaging and the label on the container must include the statement: "Warning: Paralysing agent" or "Warning: Paralyser".

The text is to be of a minimum prescribed height and will be in black text on a fluorescent red or warm red background consistent with user-applied label colours for syringes containing medicines used during anaesthesia (adapted from ISO 26825:2008). Some exceptions are made for very small and plastic ampoules (including the only preparation of suxamethonium currently available in Australia). The changes were enacted in July 2018 but manufacturers will have until September 2020 to incorporate the new warnings.



The new labelling and packaging requirements are no panacea for medication errors within our speciality, but are an acknowledgement of the role careful design may have in improving safety. The demonstrated advantages of design innovations in our anaesthesia work stations such as pin-indexing, colour coding of gas pipelines and fluted oxygen flow controls are well understood. Employing visual design principles that exploit known behavioural and cognitive interactions with the environment can provide additional cues to help practitioners select the correct medications in demanding settings. These are further supported by the safe storage and handling principals articulated in *PS51 Guidelines for the Safe Management and Use of Medications in Anaesthesia*.

Some may regard the new labelling changes as inconsequential, but the lessons learned and the significance of the collaborative effort are worth celebrating in their own right. This story began several years ago with an actual medication error and a promise to a patient that we would work to prevent these types of error in the future. The strong local relationship of anaesthetists and hospital pharmacists enabled the production of a report that was presented to the TGA by the Victorian Therapeutic Advisory Group on the Quality Use of Medicines with ANZCA's endorsement. Subsequent meetings with members of the pharmaceutical industry, facilitated by the TGA and supported by data from WebAIRS, have led to the legislative change described above. The collaboration is a model of how ANZCA can serve the community by fostering safety in anaesthesia care and is hopefully a platform that can be built upon for further gains.

Dr David Bramley FANZCA
Western Health, Victoria

webAIRS: Nasal oxygen and diathermy in close proximity: another warning about fire risk

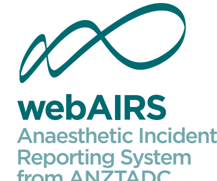
Further to the March *Bulletin* report on "High flow nasal oxygen and fire risk" by Keith Greenland, there have been three recent reports to webAIRS[1]. In each of these incidents, supplemental oxygen appears to have contributed to the ignition of either the patient hair, the eyebrows or the theatre drapes.

All three webAIRS reports involved oxygen delivered by the nasal route in sedated patients – one via nasal prongs, the other two via high flow nasal oxygen. Fortunately, in each case the fire was rapidly extinguished. The three procedures involved surgery to the head, suggesting that supplemental oxygen collecting beneath the head drape may have been a contributing factor. On each occasion, the source of ignition was diathermy when being used in the close proximity to the open delivery of supplemental oxygen. From the timing and information provided, it appears that alcohol skin preparation was not a factor in these cases of operating theatre fire.

These incidents provide a timely, further reminder of the risks of the use of diathermy in close proximity to open delivery of supplemental oxygen. It is likely that the risk is greatest when high flow oxygen is used. When diathermy is necessary, supplemental oxygen should be temporarily ceased and wet gauzes or sponges should be used to protect flammable areas.

Reference:

1. Web Based Incident Reporting System (webAIRS) from the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC). www.anztadc.net/. Accessed 3/7/18.



Strategic Research Workshop

Top row from left: Views of Coogee Beach, NSW; Professor Kate Leslie and Professor David Story; Dr David Bramley, Ms Samantha Bates, Ms Anna Tippett and Ms Gayle Claxton.

Middle row from left: Emerging research leaders workshop participants; Anaesthesia Research Coordinators Network panel Ms Courtney Player, Dr Minal Menezes, Ms Samantha Bates, Ms Gillian Ormond, Ms Margie McKellow; Ms Courtney Player.

Bottom row from left: Dr Julia Dubowitz, Dr Rochelle Ryan, Dr Natalie Smith, Associate Professor Victoria Eley, Dr Maryann Turner; Breakout area with poster display.

The road to success

The 10th annual meeting opened with CTN Executive Chair, Professor Philip Peyton, reflecting on how this meeting has grown from 30 delegates at ANZCA House to more than 150 delegates in the past few years at Coogee Crowne Plaza, NSW. These meetings have been essential to bring together investigators, fellows, trainees and research coordinators to develop multicentre research proposals. The Restrictive versus Liberal Fluid Therapy for Major Abdominal Surgery (RELIEF) trial, recently published in the *New England Journal of Medicine*, was presented as a new proposal at the workshop in 2010. The RELIEF trial was ranked number one project grant in the NHMRC project grant round in 2012. This underpins the collaborative approach to develop research proposals through to trial delivery and the CTN's road to success.

Keynotes

Our keynote statistician for the meeting was Ms Sabine Braat from the University of Melbourne. Ms Braat challenged the minds of the audience with multiple endpoint testing in trials, otherwise known as multiplicity, and later discussed subgroup analyses in clinical trials, including stratification analysis and testing for subgroup-treatment interactions. Her advice is that investigators should seek expert clinical input to define clinically important questions, and interpret findings with caution (with an eye to biological plausibility and statistical strength of the information). Professor Helena Teede, executive director Monash Partners and director, Advanced Health Research and Translation Centres, discussed strategies for strengthening collaborative approach in healthcare which formed the basis for establishing the core platform Australian Health Research Alliance, which is the umbrella organisation of seven advanced health research translation centres and two centres for innovation in regional health. The aim of this alliance is to ensure that there is a collaborative approach to improving the healthcare system which is health service-led, priority driven, and a collaborative approach to research design.

In-depth proposals

Delegates enjoyed in-depth proposals discussions on CTN-endorsed trials, such as the Cryopreserved vs liquid platelets trial (CLIP-II) led by Professor Michael Reade. This trial will definitively determine if frozen platelets are safe and effective to use and will justify widespread change in clinical practice in military and remote medicine. Professor David Story presented the research proposal for "Beyond REASON". Ten years on from the Research into Elderly Patient Anaesthesia and Surgery Outcome Numbers (REASON Study), a new multicentre, prospective, observational study is being planned to determine the strength of association between pre-defined factors and 90-day mortality in non-cardiac surgery patients 70 years and older with expected hospital stay of at least one night. It is hypothesised that frailty and socioeconomic factors will be associated with adverse outcomes. Also in this session, Dr Robert Gotmaker, discussed Bayesian adaptive trial design for regional anaesthesia trials, and Dr David McIlroy described the proposed TRIGS trial, a trial of tranexamic acid to influence surgical site infection for patients undergoing gastrointestinal surgery.

ANZCA Research Foundation Novice Investigators Prize session

For the second year running, we held the ANZCA Research Foundation Novice Investigators Prize session. Five talented emerging research leaders presented their research proposals and were judged for presentation style and scientific quality. Max Evers, Toastmaster, judged the presentation delivery and clarity. At the meeting close, Mr Evers provided invaluable tips on what makes a good presentation. Tips included practicing speech to keep to time, making eye contact that includes the whole audience, preparing for possible questions, have vocal variety, being mindful of pace and using pauses rather than ums and errs, and most importantly speaking with passion and belief. We congratulate all fellows and trainees for participating in this session and for their high quality presentations and to Dr Katrina Pirie for winning this prestigious award.

Anaesthesia Research Coordinators Network

The Anaesthesia Research Coordinators Network (ARCN) enjoyed a full program this year with plenty of opportunities for networking ahead of the formal program. This year, we held an inaugural networking dinner to give research coordinators an opportunity to link in with their regional mentors and peers ahead of the formal program. More than 20 posters were on display from hospitals across Australia and New Zealand as part of the inaugural poster session. Research coordinators showcased their talent, research, and challenges, strengths and opportunities within their department.

Emerging research leaders workshop

We received feedback from our emerging research leaders workshop in 2016 that participants wanted more time for networking and problem solving. Group work activity based around an imaginary NHMRC grant proposal was developed to allow participants to improve their skills in branding of their project; to improve their score on significance and innovation; to enhance their own track record in the areas of community engagement and participation, professional involvement and international standing; and to establish a world-class research team. The participants had a lot of fun creating catchy acronyms for the study and then moved on to the serious business of creating a successful grant application. Facilitators at each table provided sage advice, including keynote speaker Professor Helena Teede, CTN Executive Chair Professor Philip Peyton and chief investigators of ANZCA CTN-endorsed studies. Emerging researchers were given insights on how to get research departments started by Dr Matthew Doane, from Royal North Shore Hospital. This included budgeting, research tools, stakeholder buy in and embedding a culture of research.

The ANZCA CTN intends to hold this workshop regularly in order to ensure a pipeline of research leaders for anaesthesia and perioperative medicine research.

Wrap up

Delegates once again enjoyed the sunshine and spectacular views of Coogee Beach, NSW, with a varied and interactive program of research updates, new trial proposals, keynotes and the POISE-3 trial start up meeting. The meeting closed with a panel discussion with panellists Professor David A Scott, Associate Professor Rachael Parke, Associate Professor Susan Donath, Ms Sabine Braat and Dr Tom Painter raising key topics such as lack of research coordinator funding across the network and the risks. We thank all the delegates, speakers and organisers of this year's meeting and we look forward to seeing everyone next year August 9-11, 2019.

Karen Goulding
CTN Manager

Foundation update

New ANZCA Melbourne Emerging Researcher Scholarship

At the ANZCA/ASA combined ACE meeting in Melbourne on July 28, Professor David A Scott presented the foundation's inaugural ANZCA Melbourne Emerging Researcher Scholarship (AMERS) to Dr Jai Darvall (right), from the Royal Melbourne Hospital, for his PhD-related study "Frailty assessment, impact and effect of protective factors in older surgical and critically ill patients". Foundation donor Dr Peter Lowe is providing this $A20,000 scholarship annually for five years to support an emerging anaesthetist researcher enrolled in a PhD at Melbourne Medical School.

Professor Scott also presented the fourth annual ANZCA Melbourne Emerging Researcher Award of $A10,000, to Dr Rachel Chapman (far right), Royal Melbourne Hospital, for her project "A pilot study of current anaesthetic practice and outcomes for children undergoing adenotonsillectomy at the Royal Children's Hospital".

Provisional/New Fellow Research Award 2019

This award, conferred in alternate years by the ANZCA Research Committee, was designed to support ANZCA emerging researchers, and is made possible by generous donations in 2014 and 2017 from Professor Barry Baker. The ANZCA research committee has allocated the second award to Dr Courtney Thomas from Auckland City Hospital, for the study "Māori engagement with anaesthesia in the perioperative setting: A qualitative assessment". Income generated by Professor Baker's generous endowment will again be matched from ANZCA's annual research funding contribution for novice investigators resulting in a $A20,000 grant for the award.

Encouraging new scholarship donors

The foundation has a special program to allow donors to provide scholarships for talented emerging researchers studying for higher research degrees in anaesthesia and pain medicine, at specific individual universities across Australia and New Zealand. If you would like to provide such a scholarship please contact the foundation for a confidential discussion.

Medibank Better Health Foundation (MBHF)

Representatives of the MBHF attended our Leadership Circle functions in late 2017 and April 2018, hearing presentations from Professor Dave Story on research and reducing complications in high-risk patients, and Professor Kate Leslie on depth of anaesthesia. MBHF subsequently expressed interest in providing a grant for an investigator-led study on risk assessment and postoperative outcomes through the foundation, to be co-ordinated by the APPMU at the University of Melbourne.

The foundation has also negotiated that MBHF support an additional study in regional anaesthesia for major joint replacement surgery and patient outcomes. MBHF has agreed to also provide $50,000 for this investigator-led study, and applications for this second grant will be open for all ANZCA fellows and announced once funding is confirmed.

Member Advantage

The ANZCA Member Advantage member benefits program for college fellows, trainees, SIMGs and staff was launched in July, with the primary purpose of providing purchasing benefits for ANZCA members. Over 2800 members have now joined the program, which is also expected to deliver a slowly growing new stream of income for funding ANZCA research grants.

The program is a great way to save money while supporting the foundation. For members who did not join in the initial launch period but would like to do so, please contact Anna Smeele at foundation@anzca.edu.au to opt in. Anna will add your name to our monthly upload of new members to the service provider, Member Advantage.

Supporting professional development for research coordinators

Skilled, capable research coordinators are critical for ANZCA fellow-led research studies. Yet often their education and professional development is unfunded. To meet this urgent need Dr Tom Painter, Royal Adelaide Hospital, has compiled a two-year professional development program that could be provided for just over $4500 per coordinator.

The foundation is seeking benefactors to donate to help one or more research coordinators to complete the South Australia program, or to initiate similar programs in other regions.

Perioperative Medicine Research Workshop

Research Committee chair Professor David A Scott and foundation general manager Rob Packer were invited by Professor Steve Webb (intensivist and director of clinical research, St John of God Hospital, Subiaco, Western Australia, and deputy chair, Australian Clinical Trials Alliance) to attend a multi-specialty workshop in Perth on August 21 on advancing research in perioperative medicine, focusing on collaboration, effectiveness, and sustainability.

Professor Scott spoke on postoperative delirium, and associate professor John Rigg FANZCA (retired), gave an overview of the growth, impact and global recognition of ANZCA CTN-led research. Professor Webb also introduced the foundation to SJOG Foundation's acting CEO, Ms Bianca Pietralla, to discuss potentials for collaborative fundraising.

Thank you foundation donors

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

Rob Packer
General Manager,
ANZCA Research Foundation

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**.

Sharing knowledge and resources

When her mother's recovery from an operation didn't go according to plan, Lauren Whittle, a Charles Sturt University student, realised the value of medical libraries.

Throughout most of June this year, my mother was in and out of hospital for severe appendicitis. Even after the successful operation to remove the offending organ, things continued to go wrong. Her infection count refused to go down, the pain wouldn't leave her, and various complications wreaked havoc with her body.

In spite of the chaos and worry, my confidence in the doctors and health professionals responsible for her care never wavered – confidence that is cemented by both the existence of medical libraries such as the ANZCA Library.

Multiple research studies have shown that medical libraries have a significant impact on both patient care and clinical decision making1, and this was certainly the case with my mother. At one point, her attending doctor admitted that he had no idea as to why her symptoms were still presenting in spite of the treatment being given, and that he would need to consult the hospital's library and research team to find further answers.

The common perception is that doctors and health professionals know everything, that they are infallible, that they hold the keys to life and death, that they deduce what is wrong with their patients and that they know exactly what the cure is, every time, as if by magic. The truth is that it is entirely unreasonable and unfair to expect doctors and health professionals to know, let alone try and remember, absolutely everything about medicine – this is where the value of medical libraries cannot be underestimated.

When I first contacted the ANZCA Library about undertaking a placement, my main reason for doing so was that I thought medical libraries would be interesting, and would present a challenge

that I wouldn't find in a school or public library. Because of the experience with my mother, by the time I actually arrived, my reasons had shifted from mere interest to finding out exactly what medical libraries can do for their users.

My naivety and inexperience had me picturing the library as a service for doctors to find books about medicine – how wrong I was. I was drawn into a service that does so much more than that. During my three weeks at ANZCA, I undertook multiple literature searches (covering topics as broad as the use and withdrawal of filter needles, awareness during ECT and uvula trauma as a result of videolaryngoscopy), helped to source full text articles for patient care, arranged to send out copies of books to anaesthetists throughout Australia, uploaded fellow publications into the new research repository, contributed to the creation of a new library guide, evaluated donation lists and assisted with the inventory of the print serials archive.

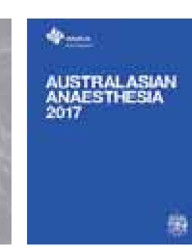
At the end of three weeks, I'm glad I made this decision. I was challenged, I grew as a professional, and I was able to help people. I can't ask for much more than that.

Reference:

Marshall JG, Sollenberger J, Easterby-Gannett S, Morgan LK, Klem ML, Cavanaugh SK, Oliver KB, Thompson CA, Romanosky N, Hunter S. The value of library and information services in patient care: results of a multisite study. Journal of the Medical Library Association 2013;101(1):38-46.

Lauren Whittle recently completed a work placement in the ANZCA Library.

ANZCA and FPM publications discoverable on Google Scholar



In the past 18 months, users of the Informit database/collection (all the universities in Australia, along with TAFEs, government departments, organisations, libraries and hospitals) have produced:

- 835 hits on *Acute Pain Management: Scientific Evidence* (fourth edition).
- 400 hits on editions of *Australasian Anaesthesia.*

Both *APM:SE and Australasian Anaesthesia* (the "Blue Book") are not only searchable in the database/collection itself, but also discoverable through Google Scholar.

Informit can be accessed via the Library databases page: www.anzca.edu.au/resources/library/databases

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.

Discover the world with a new library system

ANZCA Library users will soon be able to access the entire collection of ANZCA Library's resources through a new discovery portal.

The new system will include the following features:

- The ability to search across the entirety of ANZCA's journals, articles, books and e-books through a single "Google-like" search.
- The ability to save lists, send links and export citations for all library content.
- Online reservations and self-renewals for print books.
- Revamped e-book, e-journal and databases access lists.
- Library orientation/introductory and help pages.

Work has already begun, and the new discovery interface is expected to be unveiled in early October.

Users may notice some print book irregularities in the old catalogue during the transition – please contact the library (library@anzca.edu.au) if you are unable to locate an item on the old catalogue.

Referencing and citation help

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

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

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

Want to expose your articles and research to a wider audience?

Add your publications to ANZCA's new institutional repository (AIRR), and it will also be discoverable on both Google and Trove.

http://airr.anzca.edu.au

Recent contributions to AIRR:

- Leslie K, Story DA, Diouf E. Out of Africa: three generalisable lessons about clinical research. *British Journal of Anaesthesia* 2018. [Epub ahead of print]
- Russo M, Georgius P, Santarelli DM, et al. A new hypothesis for the pathophysiology of complex regional pain syndrome. *Medical Hypotheses* 2018. 119: 41-53.
- Woodgate CJ, Vagg MF. Managing neuropathic pain after surgery. *Pain management today* 2018. 5(2): 72-75.
- Shipton EE, Bate F, Garrick R, et al. Systematic review of pain medicine content, teaching, and assessment in medical school curricula internationally. *Pain and therapy* 2018. [Epub ahead of print]

To learn more about the ANZCA and FPM institutional repository and how you can contribute, check out the dedicated AIRR Library guid: http://libguides.anzca.edu.au/research/airr.

Multimedia resources

Looking for images for a written presentation or a procedural video to demonstrate a particular technique?

The library has developed a new library guide to highlight the various multimedia resources available via the ANZCA Library's databases and collections.

Examples include: AccessAnesthesiology (patent safety modules and procedural videos), ClinicalKey (400+ Procedures Consult videos) and Ovid (56,000+ anesthesiology videos and images).

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

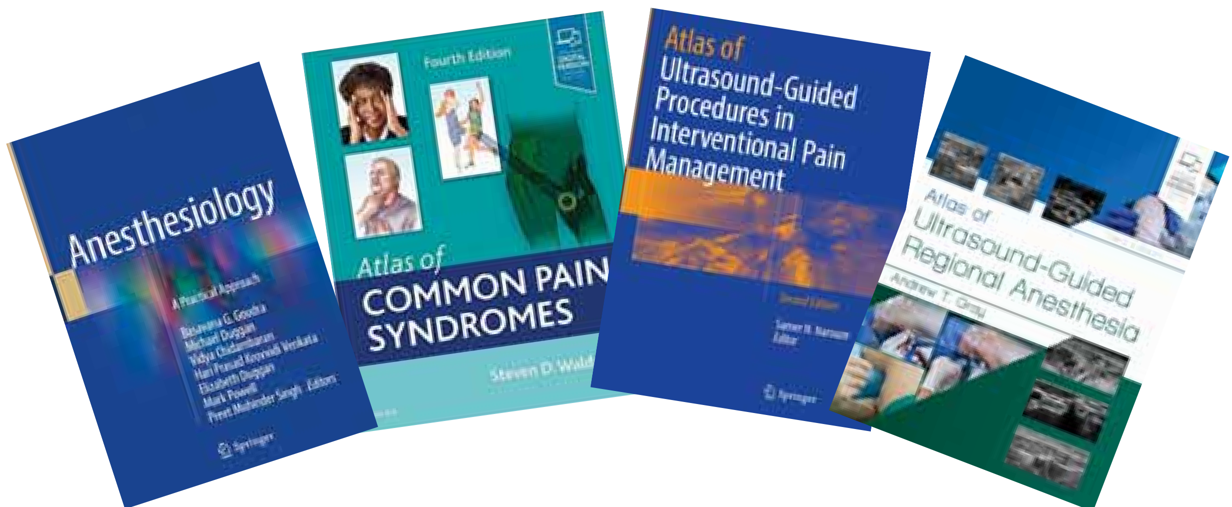
Books for loan

New books for loan

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

Basic and clinical pharmacology
Katzung, Bertram G. – 14th ed. – New York: McGraw-Hill, 2018.

Pain killer: an empire of deceit and the origin of America's opioid epidemic
Meier, Barry. – 2nd ed. – New York: Random House, 2018.



New eBooks

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

Anesthesiology: a practical approach
Goudra, BG [ed]; Duggan, M [ed]; Chidambaran, V [ed]; Venkata, HPK [ed]; Duggan, E [ed]; Powell, M [ed]; Singh, PM [ed]. – Cham, Switzerland: Springer International Publishing, 2018.

Atlas of common pain syndromes
Waldman, Steven D. – 4th ed. – Philadelphia, Pennsylvania: Elsevier Saunders, 2019.

Atlas of ultrasound-guided procedures in interventional pain management
Narouze, Samer N [ed]. – 2nd ed. – New York, NY: Springer, 2018.

Atlas of ultrasound-guided regional anesthesia
Gray, Andrew T. – 3rd ed. – Philadelphia, PA: Elsevier Saunders, 2019.

Essentials of equipment in anaesthesia, critical care, and peri-operative medicine
Al-Shaikh, B; Stacey, S. – 5th ed. – Edinburgh: Elsevier, 2019.

Essentials of pain medicine
Benzon, Honorio T [ed]; Raja, Srinivasa N. [ed]; Fishman, Scott M. [ed]; Liu, Spencer [ed]; Cohen, Steven P. [ed]; Fishman, Scott M. [ed]. – 4th ed. – New York: Elsevier, 2018.

Modern anesthetics
Schüttler, Jurgen [ed]; Schwilden, Helmut [ed]. – Berlin: Springer, 2008.

Oxford textbook of anaesthesia for oral and maxillofacial surgery
Shaw, Ian [ed]; Kumar, Chandra [ed]; Dodds, Chris [ed]. – Oxford University Press, 2011.

The anaesthesia science viva book
Bricker, Simon. -- 3rd ed. -- Cambridge: Cambridge University Press, 2017.

Short answer questions in anaesthesia
Bricker, Simon. – 2nd ed. – Cambridge: Cambridge University Press, 2014[2002].

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

Faculty of Pain Medicine

Dean's message

Over the past three months the faculty has been engaged in a range of issues of national importance over and above the regular work of the FPM staff and committees.

Engagement around the problem of opioids in chronic pain has been extensive. Several FPM fellows attended the Therapeutic Goods Administration opioid forum on June 1 at which I presented the faculty's current position. It was an opportunity for the faculty to have a say in the potential regulatory changes aimed at reducing opioid-related harms. I also represented FPM at the Society of Hospital Pharmacists of Australia (SHPA) Medicines Leadership workshop on July 31 where the focus again was on opioids, this time looking at the hospital setting and the interface with the community.

The faculty's own forum "Opioids and chronic pain – continuing the conversation" on June 16 was an opportunity for fellows and trainees to engage with an excellent panel of invited speakers and guests from diverse backgrounds. Fellows had input in progressing the faculty's strategy on this issue during the workshop on the day and in the follow up survey. These outcomes will inform the board's discussions about revising professional document *PM01 Recommendations regarding the use of opioid analgesics in patients with chronic non-cancer pain* – 2015 and direct engagement with other professional organisations and the community.

FPM is being asked more frequently to have a say in the media on critical health matters concerning pain, particularly around opioids and cannabis. The faculty has partnered with ScriptWise, a not-for-profit organisation dedicated to preventing the harms associated with prescription medication use. A joint media release was launched leading into International Overdose Awareness Day on August 31. FPM's immediate past president Dr Chris Hayes features in several videos on the ScriptWise website at www.scriptwise.org.au talking about opioids and benzodiazepines. I can recommend sharing them and the other resources as you engage in those difficult conversations with colleagues and patients.

On July 16, Dr Mick Vagg, Vice-Dean, Ms Helen Morris, General Manager, and I met again with the federal Health Minister Greg Hunt. Discussions included the MBS review around allied health visits allowable under the GP Management Plan for chronic pain patients and anomalies in access to MBS item number 132, the Pain Device Implant Registry, the national rollout of Real Time prescription Monitoring and concerns about the Chief Medical Officer's letter to the top two per cent of opioid prescribers.

FPM's close working relationship with Painaustralia in developing the National Action Pain on Pain was highlighted. The faculty's proposal to fund licencing for rural and remote health practitioners to complete the Better Pain Management program led to an invitation to submit a more detailed proposal.

> "FPM's close working relationship with Painaustralia in developing the National Action Pain on Pain was highlighted."

Formal submissions were made to the MBS Review Taskforce and the Medical Research Future Fund review as well as opportunities to review the SHPA *Standard of practice for pain management for pharmacy services* and submissions by other medical colleges to AHPRA reviews. The latest issue is the Private Health Insurance bill that is before the senate. Concerns about unintended consequences for chronic pain sufferers led to a joint meeting with Painaustralia, the Australian Pain Society and the Neuromodulation Society of ANZ and staff from Minister Greg Hunt's office and the Department of Health on August 30 with a formal submission to follow.

Finally, it was a great pleasure to represent the faculty in early August at the fifth Scientific Meeting of the Laboratory and Clinical Research Institute for Pain, Department of Anesthesiology, University of Hong Kong. Collegial discussions towards a closer working relationship with the Hong Kong Board of Pain Medicine and a visit to Queen Mary's Hospital were highlights.

FPM will host our Hong Kong colleagues in return at the Spring Meeting in Cairns in October. I look forward to seeing you all there.

Dr Meredith Craigie
Dean, Faculty of Pain Medicine

News

New fellows

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

- **Duane Elijah Anderson**, FANZCA, FFPMANZCA (Western Australia)
- **Suran Dhanapala**, FANZCA, FFPMANZCA (Victoria).
- **Babak Farr**, FAFRM(RACP), FFPMANZCA (Victoria)
- **Benjamin James Manion**, FAFRM(RACP), FFPMANZCA (Queensland)
- **Ilonka Meyer**, FANZCA, FFPMANZCA (Victoria).
- **Vincenzo Mondello**, FRANZCP, FFPMANZCA (Western Australia).
- **Yvonne Murray**, FRCPC, FFPMANZCA (New Zealand).
- **Olivia Ong**, FAFRM(RACP), FFPMANZCA (Victoria)
- **Hima Shailaja Venugopal**, FAFRM(RACP), FFPMANZCA (South Australia)
- **Sze Ming Wong**, FANZCA, FFPMANZCA (Hong Kong).

This takes the number of fellows admitted to 477.

Consultation – procedures in pain medicine

A key goal of the 2018-2022 Strategic Plan is to enhance the suite of FPM educational offerings in Australia, New Zealand and internationally, particularly with respect to procedures. In March the board convened a Procedures Working Group (PWG) to strive toward successful achievement of this goal. Success in this context means that the fellowship is engaged in program development and delivery, and ultimately that the majority of procedural interventions done in a multidisciplinary context are by recipients of our training.

The first task of the PWG was to develop a position statement on procedures in pain medicine. Valuable feedback from internal and regional FPM committees was provided throughout the development process, and indicated a broad support for the faculty undertaking this strategic initiative. A pilot position statement has now been endorsed by board for consultation with the fellowship and relevant external organisations.

In essence the position statement makes three important statements of intention. The first statement is a commitment to develop a clinical standard for procedures in pain medicine, the second is a commitment to provide and endorse training for the purposes of credentialing by health services and the third is a commitment to collaborate with other organisations in order to further the aims of promoting safety and quality in the use of these procedures.

The next step for the PWG is to commence development of clinical care standards that will reflect optimum standards of practice for procedures, utilising a format developed by the Australian Commission on Safety and Quality in Health Care. These standards will inform development of a training pathway and continuing professional development framework in conjunction with the relevant faculty committees. Your feedback on the position statement will be critical in informing these next steps.

This position statement is being piloted for a period of six months and will be reviewed again in January 2019.

Dr Mick Vagg
Chair, Procedures Working Group

Medicinal cannabis

Subsequent to the FPM consultative forum “Considering medical cannabis for chronic pain” held in October 2017, the faculty has promulgated a revised position statement on medicinal cannabis *PM10 Statement on “medicinal cannabis” with particular reference to its use in the management of patients with chronic non-cancer pain*. The fundamental stance taken by the faculty in this respect has not changed since the statement was first published in 2015: The scientific evidence for the efficacy of cannabinoids in the management of people with chronic non-cancer pain is insufficient to justify endorsement of their clinical use in this setting.

This stance has been reinforced by the landmark systematic review and meta-analysis of the literature on cannabinoids in chronic non-cancer pain[1], this study forming the basis of the TGA document, “Guidance for the use of medicinal cannabis in the treatment of chronic non-cancer pain in Australia[2]”.

The background paper to PM10 has been modified to discuss not only the Stockings et al paper and the TGA guidance but also a synopsis of the major preceding publications on which much opinion, especially from advocates and the industry, has been based.

This revised professional document is being piloted and will be reviewed again in December 2018.

References:

1. Stockings E, Campbell G, Hall WD, Nielsen S, Zagic D, Rahman R, Murnion B, Farrell M, Weier M, Degenhardt L. Cannabis and cannabinoids for the treatment of people with chronic non-cancer pain conditions: A systematic review and meta-analysis of controlled and observational studies. Pain 2018, in press.
2. www.tga.gov.au/node/732373

Policy on professional documents

FPM professional documents describe the stance of the faculty on matters concerning or related to the practice of pain medicine. The documents on policy must be clear, precise and accurately reflect the position of the faculty. The documents on standards must be accurate, up to-date, reflect best practice, and be evidence-based when possible. Driven by these requirements, the board endorsed *AP01 Policy for the Development and Review of Professional Documents* which describes the process for development and review of the documents. The document is being piloted and will be reviewed again in January 2019.

We welcome your feedback on these documents which can be found on the faculty website fpm.anzca.edu.au/resources/professional-documents. For further information or to provide feedback, please email fpm@anzca.edu.au.

Correction

A caption on page 55 of the June 2018 *ANZCA Bulletin* contained an error. A photo of Ms Gai Brodtmann, MP, was incorrectly captioned as Ms Nola Merino, MP. We apologise for the error.

Opioids and chronic pain focus of FPM forum

"Opioids and chronic pain" was the theme of the third forum held by the Faculty of Pain Medicine on June 16. Australia is facing a major public health issue with opioid harms escalating and the annual death toll from prescription opioids now double the national road toll. New Zealand does not seem to have the same problem – at least not yet, hopefully never.

Professor Euan Wallace, CEO of Safer Care Victoria, opened the forum and set the scene for a great day attended by 53 delegates in the newly refurbished ANZCA auditorium with another ten participants joining remotely.

Guest speaker Ms Rustie Lassam soon answered the question of why we are still talking about opioids with her account of "the full Monty". Her 30-year battle with prescription opioids started innocently enough in adolescence by a well-meaning doctor as she struggled to manage persistent back pain.

How we got to this point was eloquently outlined by Dr Marc Russo as he took the audience through a sobering history lesson of pharmaceutical industry advancement and clever marketing converging with a time of potent moral argument that people suffering with chronic pain had a basic human right to pain relief the same as those in palliative care.

Professor Anne Duggan, Clinical Director at the Australian Commission on Safety and Quality in Health Care (ACSQHC) presented the current situation derived from the 2015 Atlas of Health Care Variation data. She described a 10-fold range in opioid prescribing across Australia, highlighting the association between the postcode areas of highest and lowest rates and socio-economic status and service availability. By the end of session one, the delegates were engaged and were armed with questions after half an hour of discussion.

A change in the conversation to recent research around safe and appropriate opioid use in chronic pain management was the focus of the second session. Associate Professor Mark Daglish, Director of Addiction Psychiatry, Royal Brisbane and Women's Hospital, highlighted the challenges of problematic analgesic use compared with opioid addiction and the association of opioid use and depression.

Simple education of trainee GPs about appropriate opioid prescribing proved to be an unsuccessful strategy in changing prescribing according to immediate past FPM Dean Dr Chris Hayes who presented details of his joint project with GP Dr Simon Holliday in the Hunter-New England area. However, a league table of opioid prescribing by junior hospital doctors from pharmacy discharge medication data along with targeted one-to-one education proved to be beneficial in changing behaviour in Dr Jenny Stevens' hospital. Patient-led opioid de-prescribing was described by Dr Diarmuid McCoy using case studies highlighting some of the difficult situations faced by patients.

How regulation, prescription tracking programs and data from the private sector can help get us out of this dilemma were also considered. Adjunct Professor John Skerritt, Deputy Secretary Health Products Regulation, outlined the possible federal regulatory changes that were considered at the Therapeutic Goods Administration's opioid forum on June 1. Real-time prescription monitoring programs created some enthusiastic conversations following descriptions of the new Victorian program, Safe Script, by Mr Matthew McCrone and the more established Tasmanian Drugs and Poisons Information System Online Remote Access (DORA) program by Dr Adrian Reynolds and Dr Max Sarma. Dr Justin Vaughan, Group Executive nib Health Funds, helped delegates understand the complexity of the private health insurance sector and how funding models can help or hinder clinical practice.

Armed with a wide range of information, delegates divided into six discussions groups for the final session. They were asked to formulate innovative solutions, a research agenda and identify strategic partnerships. Robust conversations developed a range of recommendations skilfully drawn together by FPM Vice-Dean Dr Mick Vagg which informed the follow up survey and ultimately the Faculty's position and strategy around opioids and chronic pain.

Ms Rustie Lassam had the final words of wisdom at the end of the day:

"We got into this together, we can get out of it together" emphasising the need to continue these conversations with consumers, fellows and trainees, regulators, government and our colleagues in other healthcare disciplines.

Dr Meredith Craigie
FPM Dean

What local research influences the conversation?

Faculty of Pain Medicine fellows outlined a range of strategies at the forum that are now being used to significantly reduce opioid use in their communities.

Geelong-based specialist pain medicine physician Dr Diarmuid McCoy described how a "contract" between the patient and the treating doctor can be a useful tool to help patients reduce and eventually stop using opioids for chronic pain. Dr McCoy used an example of a patient aged in his mid-40s who had been prescribed opioids to manage his pain after an accident. After a few weeks the patient decided he wanted to taper his use of opioids. Dr McCoy explained the process he used with the patient:

"The concept of a contract between the treating doctor and patient is one which has not been utilised much in pain medicine.

Referring to the document – which lays out an agreed series of steps in relation to the use of opioids and persistent pain – as a contract may not be accurate. It is nevertheless an interesting and useful tool in the management of patients and their medications.

The contract does not have to be so detailed that it gets confusing. In fact, simplicity probably makes it more useful. The power of such a document is the laying out in written form of an agreed series of steps that both the doctor and patient sign up to. Opening the document during each and every consultation is also a vital step.

The contract should not only include the demographics of the patient but also the starting dose of the opioid, the form in which it will be prescribed, the frequency of prescriptions and who will provide them and where they will be dispensed.

A document signed by both doctor and patient emphasises that opioids are very powerful medications. It acknowledges improvement in terms of function but also the significant and dangerous side effects and risks associated with prolonged use. Details on how and where the medications can or should be stored should be included regardless of the individual circumstances.

In primary care it would be logical for at least two prescribers to be involved so the supply of prescriptions is not interrupted by leave arrangements. The contract should also include an expectation that the patient will not request early prescriptions or alterations in the prescribing schedule. Prescribers would have the right to refuse to continue providing medication if the conditions of the contract are not met.

A similar document can also be used to track a schedule of weaning and discontinuation of opioids when appropriate. This would allow agreed timeframes to be altered if required.

It is important that all interested parties have a copy of the contract, including the patient's primary care physician and pharmacist and where relevant, their partners, carers or children."

Specialist pain medicine physician Dr Jenny Stevens (above) explained the lessons learnt from the hospital coal face in NSW to reduce opioid prescribing at St Vincent's Hospital in Sydney including the benefits of working with junior doctors who are the ones most commonly prescribing for discharge.

"In hospitals junior doctors are key targets for discharge prescribing change. Giving key surgical junior staff, especially in neurosurgery and orthopaedic terms, access to their own prescribing data compared to historical and current peers along with individual academic detailing is cheap, quick and results in rapid and sustainable change. Targeting these two teams once per term does not take much time but yields results.

In our metropolitan hospital 15 per cent of opioid naive joint replacement patients and 30 per cent of opioid naive spinal patients are still using regular opioids three months postoperatively. As high as this seems it is low in comparison to preliminary results from a current study in a regional area where 35 per cent of opioid naive joint replacements and 65 per cent of those on opioids pre-operatively are still taking regular opioids three months post discharge.

Fifty per cent of all patients presenting for joint replacements in this regional area are already taking regular opioids despite lack of evidence of benefit for lower limb arthritis pain and abundant evidence for harm, including worse orthopaedic outcomes. Data for spinal patients from this study is not yet available.

The rates of accidental death due to drugs are increasing at a much faster pace in regional areas of Australia compared with metropolitan areas. With surgery being an initiation point for inadvertent long term opioid use these high rates of peri-operative use may be a good target for change in regional areas."

Sixth Pugh Day Lecture

On Australia Day 2018 Dr Colin Chilvers was awarded an AM "For significant service to medicine in the field of anaesthesia as a clinician, to medical education in Tasmania, and to professional societies". That citation barely touched on the matters which Colin revealed in his Pugh Day address to an audience of about one hundred at the meeting room at the Inveresk campus of the Queen Victoria Museum and Art Gallery in Launceston in June.

In his introduction he highlighted the point that Dr Pugh had in a sense come to New Holland and ultimately Van Diemen's Land to provide medical aid to Britain's overseas colony of Tasmania. In Launceston Pugh made his mark by providing the first anaesthetics for surgical procedures in Australia in June 1847.

Colin emphasised that there are large parts of the world without access to anaesthesia, much less potable water and safe and reliable electric power. However, on a per capita basis Tasmanian anaesthetists are making major contributions to overseas aid. Twenty-five of the 100 anaesthetists in Tasmania have volunteered to provide overseas aid.

The interest in aid was fostered by the Real World Anaesthesia Course started in Tasmania by Dr Haydn Perndt and Dr George Merridew in Hobart and Launceston and now run out of Darwin. It is almost 20 years since that course commenced.

Colin gave examples of aid in a number of different programs involving Tasmanian anaesthetists. These included short surgical trips to Madagascar with Mercy Ships by Dr Wendy Falloon, teaching programs in Laos by Dr Tom Mohler and Namibia by Dr Andrew Ottaway, and disaster relief in Banda Aceh where Dr Marcus Skinner, as a Royal Australian Air Force reserve medical officer, played a significant role. Colin illustrated some of his own short surgical trips and teaching in East Timor, Vanuatu, and the Solomon Islands as well as humanitarian missions in Nigeria, Pakistan and Yemen.

Humanitarian missions are carried out by Médecins Sans Frontiéres (MSF) in countries which are politically unstable or in conflict and involve significant risk of death or injury to staff. The triage of mass casualties is an essential part of medical care in these areas. Colin said that three operations seemed to be of greatest benefit in saving lives; they were caesarean section, emergency laparotomy and appendicectomy. Blast injuries from bombs and gunshot wounds were common. During his time in Yemen there were numerous bombing raids and in some cases hospitals including MSF-supported ones were targeted.

Growing a beard seemed like a good idea while working in an area of Pakistan formerly known as the North West Frontier, where the Taliban militants ordered all foreigners to leave the country or face targeted attacks. Colin completed his assignment with MSF in that area, giving 191 anaesthetics in the hospital.

Colin's next task is scientific convenor for the ANZCA ASM in Malaysia in 2019. Hopefully armed hostilities will not feature in that assignment.

Some listeners were somewhat stunned by the extraordinary events described in this lecture but the audience thanked Colin with a standing ovation.

The lecture was organised by the Launceston Historical Society and the Launceston General Hospital Historical Committee and supported financially by the Department of Anaesthetics Private Practice Fund.

Professor Paul Myles of Monash University and The Alfred hospital will deliver the seventh Pugh Day Lecture next year on Sunday June 16, 2019.

Dr John Paull
Pugh Day Lecture Convenor

Been wondering how to get that history or heritage project up and running?

ANZCA is pleased to announce a new grant which may help.

"Saint Jerome in his study", oil painting by a follower of Joos van Cleeve. Image courtesy of the Wellcome Collection under Creative Commons licence.

The Anaesthesia and Pain Medicine History and Heritage Grant program is an ANZCA initiative to assist with the research and interpretation of the history of anaesthesia and pain medicine. The program provides up to $A5000 to fellows and trainees of ANZCA to undertake history and heritage projects.

The types of projects supported by the grant program include:

- Recorded oral histories.
- Conservation of objects and records.
- Commissioning of significance statements on objects or collections.
- Development and production of exhibitions.
- Training in collections management.
- Design and production of interpretation panels and heritage walks.
- Digitisation of collection objects.
- Digital storytelling, including podcasts and film.
- Consultancy fees for the provision of specialist skills.
- Museum standard storage cases.
- Purchase of archival quality materials.

For more information about the types of projects the grant program supports and to apply please read through the grant guidelines at www.anzca.edu.au/about-anzca/geoffrey-kaye-museum.

Submissions, including any supporting documentation, must be received by close of business on September 21, 2018.

Successful applicants will be notified in time for announcements to be made on National Anaesthesia Day, October 16, 2018.

How some of our private practitioners are completing practice evaluation activities

In the last edition of the Bulletin, we acknowledged that more guidance on how to complete the practice evaluation requirements of the program would be appreciated by those continuing professional development (CPD) participants in a private practice setting.

Since then we have contacted some fellows who work in private practice and asked how they go about meeting these CPD requirements, what they identify as the challenges involved, and what ANZCA can do in the future to improve this category for those in a private practice setting.

When asked what was the most challenging aspect of the practice evaluation category, we were told that attendance at morbidity and mortality (M&M) meetings, case conferences and patient surveys were difficult within a practice setting, as well as the time commitment that is required to complete practice evaluation activities within the current structure of the CPD program.

These challenges were overcome by organising monthly M&M meetings within private groups, or by choosing to complete peer review and multisource feedback activities if there were colleagues with similar case profiles available.

When we asked if there were any tips/tricks for other private practitioners who are having difficulty meeting their practice evaluation requirements, it was suggested that patient surveys could easily be conducted through an SMS system via the consultants rooms, collated by the rooms then analysed independently or by a commercial firm such as survey monkey. It was also noted that clinical audits were a useful tool for completing practice evaluation requirements.

We also asked what ANZCA could do in the future to improve this category for those in private practice, and were told that it would be helpful to provide a service for more M&M meetings and case discussions.

Feedback regarding identified challenges or problems with any component of the CPD program is always welcome, and can help to guide the CPD Committee to make improvements for CPD participants. All feedback can be submitted to ANZCA via the CPD team at cpd@anzca.edu.au or via your CPD portfolio dashboard, under Resources using the "Seeking your CPD feedback" button.

Practice evaluation activities snapshot

During the calendar year of 2017:

- 1811 CPD participants completed 2548 peer review activities.
- 660 CPD participants completed 702 Patient experience surveys.
- 1122 CPD participants completed 1183 Multi-source feedback activities.
- 1235 CPD participants completed 1543 clinical audits.

Amendment of the CPD Committee and program name

Council have approved the recent changes to the name of the Continuing Professional Development (CPD) Committee, and CPD program to reflect both ANZCA and FPM participants. They will now be referred to as the "ANZCA and FPM CPD Committee" and the "ANZCA and FPM CPD program". Please contact the CPD team via cpd@anzca.edu.au if you have any questions.

Calling for clinical audit topics and authors

Since launching the CPD program in 2014 the ANZCA and FPM CPD Committee have published 14 clinical audit samples for participants to use as part of their Practice evaluation category. The CPD Committee wish to extend an invitation to all CPD participants to contribute to this valuable resource by becoming an author of a new clinical audit sample.

Guidance is available from members of the CPD Committee, and assistance from the CPD team with the final formatting of the clinical audit guide, data collection form and summary of results forms. If you are interested in writing a clinical audit sample for ANZCA, please contact the CPD team at cpd@anzca.edu.au.

Would you know how to respond in an anaphylaxis emergency?

Dr Helen Kolawole

Dr Sarah Green

Dr Karen Pedersen

Dr Nagesh Nanjappa

Dr Richard Waldron

This edition of the *Bulletin* celebrates the launch of the long awaited Perioperative Anaphylaxis Response online learning course. This e-learning course is the result of the efforts and collaboration of several fellows, members of ANZAAG and the college Education unit. Those involved are to be congratulated on bringing this unique resource to fruition, for the benefit of fellows, and ultimately for the improved safety of our patients.

Perioperative anaphylaxis is a relatively uncommon emergency, but as the most recent *Safety of Anaesthesia* report highlights, anaphylaxis caused more anaesthesia-related deaths in Australia and New Zealand than either aspiration or airway-related deaths. In addition, the morbidity associated with anaphylaxis carries a huge individual and community burden. Any attempt to improve the outcome of anaphylaxis is therefore worthwhile. Like the workshops, the online course encourages the use of specifically designed cognitive aids – the cobadged ANZAAG/ANZCA Anaphylaxis Management Cards – to guide management. The initial emphasis is on the early use of appropriate doses of adrenaline. Familiarity with and the use of cognitive aids, and the early use of adrenaline have been shown to improve the outcome of anaphylaxis. The course leads the participant through several case scenarios to highlight and emphasise the important factors and pitfalls in diagnosis, early management and what to do when things are not improving as expected. Consideration of whether to continue surgery and where to manage the patient after a reaction, and the importance of proper investigation and follow-up are discussed.

It is not expected that the online course will replace face to face workshops – there will always be a demand for the unique learning experience that workshops offer – but it will ease the difficulties that some fellows and GP anaesthetists have had in accessing workshops to complete the mandatory training in emergency responses. This online learning course meets the requirements of the anaphylaxis emergency response standard of the ANZCA and FPM CPD program. It is freely available for all ANZCA and FPM fellows, trainees and CPD participants to access at any time to refresh and maintain familiarity with anaphylaxis management. We encourage everyone to complete this valuable course as we strive towards zero deaths directly attributable to anaesthesia.

ANZCA wishes to acknowledge and thank the following fellows for their dedication, expertise and authorship to develop the Perioperative Anaphylaxis Response course: Dr Helen Kolawole, Dr Sarah Green, Dr Karen Pedersen, Dr Nagesh Nanjappa, and Dr Richard Waldron.

Dr Paul McAleer, Chair, Anaesthetic Allergy Subcommittee and Chair ANZAAG

Medical education – why would I want to do a course about that?!

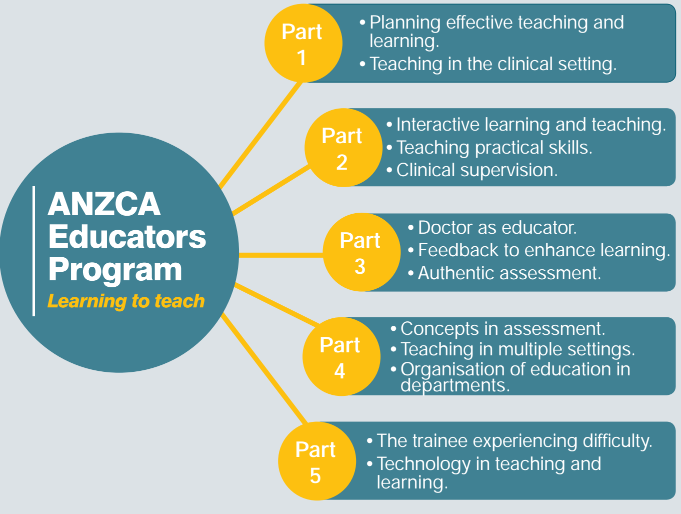
We spend years learning a variety of procedural and clinical skills, management and people management skills to become specialist anaesthetists. During training and beyond into our current and future working lives, we are also expected to teach and supervise a variety of people (trainees, nurses, medical students, other specialities and paramedics) in the clinical environment.

However, we receive no formal training in how to teach at all. It is merely expected of us. Whatever you do clinically, you will still be required to deliver some form of education or teaching at some point, whether you want to or not.

The ANZCA Educators Program has been specifically developed as a practical teaching course that is focused on the application of educational theory to teach in the anaesthesia and pain medicine environment. The program provides continually updated, summarised education best practice ideas and techniques and simple tools that you can use to develop and enhance your own teaching in the theatre or classroom. The program is ideal for anyone with any educational or supervisory role, but the modules are designed to be applicable to all anaesthetists and pain specialists.

The program consists of 13 modules, which are delivered in interactive, small group sessions. The course aims to cover all areas of clinical teaching and education to provide a platform for your own development and make teaching a much more enjoyable and rewarding thing for you to do and an enhanced learning experience for those that you are teaching.

The 13 modules are split into five parts, the modules of which are generally delivered together. These are detailed below:



Above right from top: "How to make a washable nappy", part of Teaching Practical Skills, with Dr Paul Healey and Dr Michael Hicks in the HNE Simulation Centre, Newcastle, NSW; Dr Rob Marr facilitating the Interactive Learning and Teaching module in the HNE Simulation Centre, Newcastle, NSW; Dr Jennifer Hartley and Dr Peter Flynn with "How to throw a frisbee", part of Teaching Practical Skills, at the ANZCA Office, Canberra.

Each of the modules can be completed in any order, whenever you like. It is possible to attend only the modules that are of interest to you as well. I do recommend that you complete the two modules of Part 1 before doing any others though, as these help to set the basis for medical education and will help you to understand, develop and plan better teaching using the skills from the other modules. Further details on the content of the modules is available of the ANZCA Educators Program website www.anzca.edu.au/aep.

The modules are offered regularly throughout the year across Australia and New Zealand to make them as easy as possible for participants to attend. You can go to a local state program or attend a course in another region and include some holiday time if you'd like to go somewhere away from work.

Dates of all of the courses and venues can be found on the program's event page www.anzca.edu.au/aepcalendar.

The ANZCA Educators Program has been running since 2011 with more than 1000 participants to date. If you've not attended a module yet, then book some study leave before you get left behind. You and your trainees will really appreciate it!

For more information visit www.anzca.edu.au/aep.

Dr Robert Marr
ANZCA Educators Program Subcommittee member and facilitator

Perioperative medicine attracts more trainees

A local arm of a global group is fostering knowledge and skills for anaesthetists and other specialists, writes Dr Richard Seglenieks.

The growing interest and enthusiasm for perioperative medicine among trainees in Australia and New Zealand has led to the establishment of a local arm of the international organisation Trainees with an Interest in Perioperative Medicine (TRIPOM).

TRIPOM ANZ now joins TRIPOM USA as global affiliates of the educational collaborative which was founded in the UK by and for trainees.

As a community-driven initiative TRIPOM is dependent on the input and enthusiasm of trainees to succeed. We are new and growing fast – there's no better time to join us.

Our members include trainees from any specialty that comes into contact with the surgical patient – in line with the ANZCA vision that anaesthetists will "lead but not own" perioperative medicine[1]. We want to foster a multidisciplinary community of like-minded individuals working towards the development of perioperative medicine[2]. To this end, we facilitate the production and sharing of useful educational materials linked to major postgraduate education curricula, as well as providing information about relevant opportunities, such as courses and fellowships.

Members join the international TRIPOM organisation, providing access to all of our educational resources and membership benefits. Members receive both general and local communications with information about the latest developments and opportunities in perioperative medicine in Australia, New Zealand and around the world.

How to join TRIPOM

For more information and to sign up, visit tripom.org/contact-us.

We are also seeking enthusiastic trainees to join the TRIPOM ANZ executive committee – if you are interested or have any questions then please get in touch at tripomanz@gmail.com.

To keep up with the latest, follow us on twitter @TRIPOMANZ.

Our educational output is focused on providing opportunities for trainees to contribute high-quality materials that are shared with other trainees around the world. Our projects include the Perioperative Medicine Tutorial of the Month, Journal Watch (a roundup of relevant articles of interest), and a Perioperative Medicine in a Nutshell series that is published in the *British Journal of Hospital Medicine*. In addition, we are constantly building our directory of perioperative fellowships to help trainees find local and international opportunities and are involved in a number of educational events. Further information is available on our website tripom.org.

The development of TRIPOM grew from the view that as trainees, we should seize every opportunity to further our knowledge and skills in perioperative medicine, not only for the benefit of our patients now, but also for our own future.

Patients undergoing surgery are, on average, getting older and more unwell. Major advances in surgical and anaesthetic techniques, systems and resources allow us to anaesthetise and operate on patients previously considered unfit for surgery. In order to deliver high quality care to these patients, it is becoming increasingly necessary for medical practitioners to develop specific skills in managing the surgical patient before and after their procedure.

Perioperative medicine is a growing field that has developed in response to this need, encompassing the complete care of the surgical patient from the moment of considering surgery until after discharge from hospital. This has the potential to bring about significant improvements in the quality, safety and efficiency of perioperative care and thus improve surgical outcomes.

Given the rapidly developing interest in the field, it will undoubtedly form a growing part of our role as our careers progress. In the words of ANZCA President Dr Rod Mitchell, "We will all be perioperative practitioners, but some of us will be 'perioperative specialists[3]'."

Skills in effective perioperative care are already part of the modern anaesthetist's role and form a prominent component of our curriculum as one of the seven "clinical fundamentals" of training. However, the growing importance and complexity of perioperative medicine to the future of anaesthesia is worth highlighting. The first point in ANZCA's Strategic Plan 2018-2022 states that "ANZCA will LEAD … the development of an effective, integrated and collaborative perioperative care model[1]". Our growing involvement in perioperative medicine has been discussed a number of times by the presidents of ANZCA[1,4], the Australian Society of Anaesthetists[5], the New Zealand Society of Anaesthetists[6], and the Royal College of Anaesthetists[7] – among many others. It is clearly an area of great interest and a structured system of evidence-based care is needed.

"As trainees, we should seize every opportunity to further our knowledge and skills in perioperative medicine."

Internationally, the crucial role perioperative medicine will play in the future of anaesthesia was highlighted in a 2015 editorial in the *British Journal of Anaesthesia*, "Perioperative medicine: the future of anaesthesia?" – which opens with the bold statement that "Perioperative medicine is the future of anaesthesia, if our speciality is to thrive[8]."

The Royal College of Anaesthetists subsequently updated its curriculum to include compulsory units in perioperative medicine and launched its Strategic Plan 2016-2021, featuring aims to "define and implement a vision for perioperative medicine" and to integrate perioperative medicine teaching into medical school curricula[9].

In this context, there is growing interest and enthusiasm for perioperative medicine among trainees. As a new and rapidly evolving field, there are still limited opportunities for trainee engagement outside a handful of fellowships and courses. Not all centres have staff who consider themselves experts in perioperative medicine and open access educational resources are few and far between.

Interested trainees are not always able to readily access information on how to further their knowledge and skills in perioperative medicine so this is where TRIPOM can benefit trainees with an interest in perioperative medicine.

Our goal is to create a truly global community for collaborative learning and engagement to enable equitable access to opportunities and educational resources in perioperative medicine.

Dr Richard Seglenieks
Anaesthesia registrar,
St Vincent's Hospital, Melbourne
Chair, TRIPOM ANZ

References:

1. Mitchell R. President's message. ANZCA Bulletin 2018 June, p. 4.
2. Bampoe S, Whittle J. Trainees with an interest in perioperative medicine (TRIPOM). RCoA Bulletin 2017 January, pp. 60-61.
3. Australian and New Zealand College of Anaesthetists. ANZCA Strategic Plan 2018-2022. www.anzca.edu.au/about-anzca/our-mission,-vision,-and-strategic-plans.
4. Scott DA. President's message. ANZCA Bulletin 2018 March, p. 4.
5. Scott DM. ASA editorial from the president. Australian Anaesthetist 2018 June, pp. 4-5.
6. Kibblewhite D. President's column. NZSA Magazine 2018 April, pp. 4-5.
7. Brennan L. The Royal College of Anaesthetists – also 25 not out. ANZCA Bulletin 2017 March, p. 31.
8. Grocott MPW, Pearse RM. Perioperative medicine: the future of anaesthesia? British Journal of Anaesthesia 2012;108(5):723–726.
9. Royal College of Anaesthetists. The RCoA Strategic Plan 2016-2021. https://www.rcoa.ac.uk/strategic-plan-2016-2021.

Common mistakes in audits or research

Read this before you embark on your study!

Prior to 2013, the Australian state and New Zealand committees were responsible for assessing the Formal Project.

From 2013 this system was replaced by the Scholar Role Sub-Committee (SRSC) with island- and state-based representation.

Between 2013 and 2017 the SRSC assessed all audits centrally. From 2017, local scholar role tutors have assessed the five activities currently constituting the scholar role. The SRSC still has a role in assessing audits (for local calibration or as a second opinion) and research activities that do not lead to publication.

With the insight of the assessors of these activities over many years, we have created a list of common errors that can derail and devalue a project.

Research:

- The hypothesis is not clearly stated and therefore a null hypothesis is absent.
- The primary outcome is not stated.
- The secondary outcomes are not stated. The secondary outcomes erroneously become the primary outcomes (or focus).
- Powering the study to find a difference (if one exists) for the primary outcome is frequently not done.
- It is clear that most trainees get statistical help from a statistician to produce their analysis; suddenly the standard of work shoots way above the rest of the paper. Not a criticism but an interesting (unproven) comment.
- Unrealistic expected effect size difference (which conveniently decreases the numbers needed to test).
- Methods that are hard to reproduce, unclear or uncertain especially in how some cases are handled.
- Using parametric statistical analysis for non-real numbers (eg pain scores, low numbers, non-normally distributed data).
- Poor referencing – references need to be given for statements that are not "common sense" or the authors own thoughts.
- Poor literature reviews that have not critically appraised the articles but merely quoted their results. Discussion that ignores relevant literature. Discussion that does not weigh up how what has been found agrees or disagrees with the literature or appraise the confidence of the findings. It is very tempting to find and discuss positive results when perhaps chance (or design) has played a major role in the outcome.

Scholar Role Sub-Committee members

Dr Scott Fortey, NSW representative, Chair

Dr Irene Ng, Victoria representative, Deputy Chair

Dr Jennifer Woods, (South Island), EDEC representative/fellow with education interest

Dr Andrew Messmer, Tasmania representative

Dr Paul Lee Archer, Queensland representative

Dr Kerry Warner, anaesthetist with ethics interest

Dr Nina Civil (North Island), New Zealand representative

Dr Veronica Gin (South Island), New Zealand representative

Dr Paul Burt, ACT representative

Professor Philip Peyton, Chair, Clinical Trials Network Executive

Dr Dale Currigan, Western Australia representative

Mr Oliver Jones, Director, Education

Dr Rod Mitchell, ANZCA President

Mr Andrew Tham, Committee Support Officer

- Conclusions that have no bearing on the initial aims of the study (and always suggest further studies required in the area...).
- Making conclusions from the findings that are clearly not achievable from the work (eg "this proves...." or "this suggests....") followed by advice to change practice. Assuming that because no significant difference was found that the two groups are equivalent (up to 20 per cent error here if beta error is 0.2) or that a technique is "safe".

It is worth consulting CONSORT, STROBE or CARE guidelines for detailed advice on how to report studies.

Audit:

- Not discussing the project with the supervisor first.
- Not following or considering SQUIRE 2 guidelines.
- Not reviewing practice against explicit criteria or accepted best practice.
- Making it "quasi" research. Is it audit or a cohort study (or sometimes just a case series)?

- An audit should influence clinician behaviour, not seek the truth or proof of new knowledge.
- The numbers required in an audit can rarely be chosen to meet power requirements as in research. The errors associated with the sampling are important and need to be stated or estimated.
- Applying statistical analysis to numbers that have so many inherent biases.
- Applying complex statistical analysis when simple statistics would suffice.
- Making conclusions from the findings that are clearly not achievable from the work (eg "this proves...." or "this suggests....") followed by advice to change practice.
- Assuming because no major complication has been found in 100 patients reviewed that a technique is safe (eg spinal opiate). The actual incidence of serious complications could be upwards of 5 per cent! Confidence intervals can be helpful and may be (should be) wide for audit data collection with small numbers).

Consult SQUIRE 2 for details.

Dr Scott Fortey FANZCA
Chair, Scholar Role Sub-Committee

Correction
The list of successful candidates for the final fellowship examination (March/May 2018) in the 2018 June *ANZCA Bulletin* contained an error. Dr Seleen Cheah is a Malaysian graduate but was incorrectly listed as a Hong Kong candidate. Our apologies to Dr Cheah.

Diploma of Advanced Diving and Hyperbaric Medicine

Dr Juan Carlos Ascencio-Lane, a Hobart-based emergency physician, is the first candidate to successfully complete ANZCA's new Diploma of Advanced Diving and Hyperbaric Medicine (DHM) examination on July 27, 2018.

The ANZCA Diploma of Advancing Diving and Hyperbaric Medicine, which was launched in July last year, is a post-specialisation qualification in Australia and New Zealand. Award of the diploma requires completion of DHM training requirements and a specialist qualification. The qualification is the only one of its kind in Australasia.

Above: The ANZCA court of examiners with Dr Ascencio-Lane and ANZCA president, Dr Rod Mitchell. From left: Dr Michael Jones (chair examinations), Dr Rod Mitchell (ANZCA President), Dr Juan Carlos Ascencio-Lane (candidate), Dr David Smart (DHM examination chair), Dr Ian Gawthrope (examiner) and Dr Neil Banham (examiner).

Changes to the TPS

Changes to the TPS will continue to be rolled out in 2018, with major enhancements to the TPS being introduced in late November 2018. Some highlights are:

- New look dashboards for trainees, supervisors of training, rotational supervisors and education officers.
- TPS access for department scholar role tutors and intensive care medicine supervisors.
- Enhanced functionality and clarity of training program requirements.

Changes to regulation 37, the *ANZCA Handbook for Training* and the ANZCA training program curriculum are available on the ANZCA website – www.anzca.edu.au/documents/training-accreditation-handbook and www.anzca.edu.au/documents/anaesthesia-training-program-curriculum.

New Zealand news

New NZNC responsive to government changes

A new government in New Zealand has opened up fresh areas for health policy makers and the New Zealand National Committee (NZNC) will be taking every opportunity to introduce ways the specialty can impact on change according to the chair, Dr Jennifer Woods.

The Health and Disability System Review commissioned by the Minister of Health, Dr David Clark, is examining inequity in the health system and exploring better ways of delivering services. Dr Woods says the new NZNC, which met for the first time in late June this year, has brought together a great range of experience, diversity and expertise.

"Together there are several areas where we can have some influence," she says.

"This government has highlighted inequities in the health system. We know our Māori and Pacific peoples have worse health outcomes and shorter lives and the Health Minister Dr David Clark says that is something we simply cannot accept.

"Our new fellow representative, Dr Courtney Thomas (see page 33 for profile) and new committee member, Dr Nani Aiono-Le Tagaloa bring us valuable perspectives, and the ANZCA Indigenous Health Strategy gives us a mandate to explore ways we can be influential in creating a more equitable health system," says Dr Woods.

The NZNC chair says now is also the time to get perioperative medicine firmly in the narrative of the decision-makers. Perioperative medicine can be considered as co-ordinated, evidence-based, patient focused, multi-disciplinary patient care, resulting in decreased perioperative morbidity and mortality. ANZCA is investigating perioperative education and training and the definition of professional standards.

"For the health policy makers, the multidisciplinary collaboration of perioperative medicine offers a new model that changes outcomes and ultimately means the health dollar is being spent more wisely," she says.

The ANZCA and FPM national committees have been feeding back to government on heavy hitting issues this year, including mental health, medicinal cannabis, and medically-assisted dying, and will continue to engage with government departments and politicians on new policy direction.

"We are also working across ANZCA and other organisations looking at innovative workforce initiatives that could attract funding from a new Health Workforce Development Fund," says Dr Woods.

New Zealand National Committee from left from the front by row: Dr Jennifer Woods (chair), Dr Sally Ure (deputy chair), Dr Jonathan Panckhurst (NZTC chair), Dr Vanessa Beavis (councillor), Dr Rachel Dempsey, Dr Jennifer Taylor (education officer), Dr Hamish Gray, Professor Ted Shipton (FPM NZNC chair), Dr Tom Fernandez, Dr Leinani Aiono-Le Tagaloa), Dr Nigel Robertson (councillor), Dr Rob Fry (safety and quality officer), Dr Geoff Laney, Dr Ralph Fuchs, Dr Kerry Gunn. (Missing: Dr Chris Harrison (chair of the NZ Vocational Registration Panel), Dr Courtney Thomas (new fellow representative) and Dr Lisa Horrell (accreditation officer).

The NZ Annual Scientific Meeting – future proofing

The NZ Anaesthesia ASM on November 8-10 in Auckland is fast approaching and it promises to inspire you with new ideas and new skills.

With the theme "Face the future" the scientific conference program features presentations on current and future anaesthesia techniques, research, drugs and equipment. Delegates will also be able to attend sessions on wellbeing so they can look after themselves and each other and be mindful of the environment in which they live and work.

Here are just some of the reasons why you will want to attend this year's New Zealand ASM:

- World class workshops and speakers.
- Early trauma care – the guidelines have changed.
- App provides evidence for airway emergencies.
- Palliative care in the acute surgical patient.
- Can we do better for Māori and Pacific patients?
- What does climate change mean for the Pacific?
- Can your hospital thrive without THRIVE?
- Science, perception, and manipulation.
- Is more than 21 per cent really that bad? An update on oxygen.
- The tsunami of antimicrobial resistance.
- What is meant by compassion fatigue?

Early bird registration closes on September 30 and workshops are filling fast. For more information visit www.nzanaesthesia.com.

Above: Auckland city at night. Photographer: Chris McLennan.

Opposition health spokesperson updated

ANZCA New Zealand National Committee chair and deputy chair, Dr Jennifer Wood and Dr Sally Ure, along with ANZCA New Zealand national office general manager, Heather Ann Moodie, met with the National Party spokesperson on health, Michael Woodhouse at Parliament in Wellington on September 6. The discussion ranged across subjects including: ANZCA's focus on perioperative care leading to improved patient outcomes; pain medicine and the need to invest in training and services; changing health needs; the impact of technology; and the importance of well trained and highly skilled anaesthetists to ensure New Zealand maintains its level of safe patient care.

Above from left: Dr Sally Ure, Heather Ann Moodie, Michael Woodhouse and Dr Jennifer Woods.

New Zealand news (continued)

Clinical directors meet in Wellington

There's only one chance a year for the heads of the hospitals' departments of anaesthesia in New Zealand to get together and share the big issues that are challenging their turf, and some of the solutions.

ANZCA hosts the clinical directors' (CDs) meeting in Wellington and this year saw around 30 CDs teasing out some of the pressing challenges in practice and departmental management across the country. The agenda included safety and security of medication use and supply, health equity, an electronic tool for leave management and an update on NetworkZ.

NetworkZ is the first national team training initiative like this in the world. It is a national simulation-based team training program for surgical teams aimed at improving the safety and efficiency of care for patients. It's been implemented around New Zealand in cohorts to have full coverage by the end of 2020.

Project lead Professor Jennifer Weller told CDs there have been more than 7000 claims related to injuries in patients undergoing surgery in New Zealand over the past five years and around half of perioperative surgical events are considered avoidable. Failure in teamwork and communication are seen as important contributing factors to these statistics.

Professor Weller says the backbone of any effective healthcare system is an engaged and productive workforce and working in silos or "tribes" in theatre is not going to create that engagement. NetworkZ, she says, is designed to build the collective competence of operating rooms with challenging scenarios being run in situ with real operating room teams. The Accident Compensation Corporation has funded 3G full body manikins for each District Health Board, and development and supply of surgical models to support the package of 25 scenarios for the different surgical specialties.

Dr Kerry Gunn from the ANZCA New Zealand National Committee (NZNC) brought CDs up to speed on PHARMAC (the government's drug buying agency) and its move to national contracts for all anaesthetic equipment and small devices by 2020. Dr Gunn sought nominations for an advisory group to be set up so anaesthetists can have a strong, common voice in helping make sure that the best products are settled on for those contracts.

The safe storage of anaesthetic drugs exercised the group after a thoughtful presentation from Dr Derek Snelling. The questions were around whether the minimum standards in the professional document *PS51 Guidelines on the Safe Management and Use of Medications in Anaesthesia* were enough to stop drug diversion and misuse. There was a request for the NZNC to look further into possibly initiating stronger national standards for storage and what issues that might create.

Above from top: Professor Jennifer Weller explains the benefits of simulation-based team training; Clinical directors get a chance to get together for wide ranging discussions once a year; NZNC committee member Dr Kerry Gunn talks to clinical directors about setting up an advisory group on anaesthetic devices.

Australian news

Australian Capital Territory

Scan and Ski Workshop success

Blue skies and great snow conditions greeted the 32 delegates who arrived at Thredbo on July 12 for the 2018 Scan and Ski Workshop. The workshop focused on hands-on ultrasound scanning for upper and lower limb, spine, trunk and paravertebral nerve blocks. Seven world-class instructors led the delegates through morning and afternoon scanning sessions, while leaving the middle of the day free for skiing or sightseeing. The superb venue, delicious catering, engaged delegates and supremely knowledgeable instructors made this workshop so successful that we have already locked in a return date for 2020.

The logistics of running an event such as this in an alpine environment are quite onerous. Transportation of the ultrasound machines is a big undertaking and we thank our sponsor Sonosite for their amazing efforts to get everything to the venue. Thank you also to our second sponsor Admedus whose financial commitment to the workshop helps to keep the costs to a minimum for our delegates.

For 2020 we are already looking at ways to improve our workshop with the introduction of new and/or different ultrasound practices and a concurrent emergency response workshop. Watch this space for more information closer to the time.

A big thank you to the seven instructors, Dr Ross Peake, Dr Alwin Chuan, Dr Peter Hebbard, Dr Andrew Lansdown, Dr Brad Lawther, Dr Sam Sha, and Dr Monika Kenig for their commitment to the workshop and enthusiastic teaching over the two days.

Above clockwise from left: Small group sizes meant plenty of scanning time for all delegates; Dr Peter Hebbard demonstrates an upper limb scan; We finished off the workshop with a very informative Q&A session; Two of our wonderful instructors, Dr Monika Kenig and Dr Alwin Chuan.

Victoria

Above from top: Dr John Hewson presenting; Dr John Hewson, Dr Eugenie Kayak, Dr Georgina Imberger and Dr Forbes McGain; Dr Peter Seal (ASA President), Mr John Ilott (ANZCA CEO) and Dr David Bramley (VRC Chair); Session chairs Dr Shiva Malekzadeh (Convenor), Dr Eugenie Kayak, Dr Michelle Horne and Dr David Bramley.

ANZCA/ASA combined CME meeting

Keeping with tradition, this year's annual ANZCA/ASA combined CME Meeting was again held on the last Saturday in July at the Sofitel on Collins, Melbourne, but for the first time we incorporated emergency response workshops that were held the following day. As an extra twist there was also an additional optional temperature audit which attracted a further 20 CPD points.

The meeting theme was "Rising temperatures, the heat is on" and certainly did not disappoint. There were four sessions, chaired by Dr Eugenie Kayak, Dr David Bramley, Dr Michelle Horne, and Dr Shiva Malekzadeh which collectively had 10 presentations on thought-provoking and topical issues, a temperature audit presentation, and a fun and informative debate.

Our keynote speaker was Dr John Hewson, former opposition leader and leading economist, who spoke on "Economic threats of climate change", and we are thankful for his time and all the speakers for the excellent presentations they delivered. They were all very interactive presentations including a very memorable and engaging debate.

The Sunday workshops were also held at the Sofitel on Collins, Melbourne, and included anaphylaxis convened by Dr Raymond Hu, and major haemorrhage convened by Dr Brett Pearce.

The overall feedback from the delegates and our HCI sponsors was very positive and both the meeting and workshops, along with the audit were all very well received with close to 250 attending the meeting, all four workshops being filled with 25 in each, and close to 70 participated in the audit.

Congratulations to the meeting convenor, Dr Shiva Malekzadeh for her tireless efforts in bringing together a wonderful meeting, and on behalf of the VRC ANZCA and ASA we would like to thank everyone involved in contributing to the success of this meeting.

Please mark the last weekend in July in your calendars for 2019 and join us again next year for our 40th Annual ANZCA/ASA combined CME meeting.

Victoria
Save the date!

Quality assurance meeting
Our second quality assurance meeting for the year will be held on Saturday October 20 from 1.30pm to 6pm in the auditorium at ANZCA House, 630 St Kilda Road, Melbourne. The meeting will be convened by Dr Dean Dimovski and presentation topics will be advertised on our website www.anzca.edu.au/vic-events soon.

Victorian Registrars' Scientific meeting
The Victorian Regional Committee invites you to join us on Friday November 16, 2018 from 1-6pm. Once again we are offering a prize for best presentation on the day in each of the two categories: Scientific research project or research project. To participate please send in an abstract of 250 words in either category, and/or you can register online. For further information email the event secretariat Cathy O'Brien, VRC Regional coordinator, at vic@anzca.edu.au or call +61 3 8517 5313.

FPM VRC Victorian Registrars' Scientific Meeting (VRSM)

The annual FPM Victorian Registrars' Scientific Meeting (VRSM) was held at ANZCA House in August.

Hosted by Dr Diarmuid McCoy, Chair of the Victorian Regional FPM Committee, this meeting was to encourage FPM trainees to present as part of their scholar role activities (Progressive feedback: Professional presentations).

Dr Amutha Samuel came to present a case-based literature review on "Pain in spinal cord injury" and Dr Sarah Donovan, an audit of "Naxolone use in the emergency department, lessons learned".

The adjudicators on the night were Professor George Mendelson and Dr Williemena Ong.

The recipient of the prize for the best paper was Dr Sarah Donovan who received a book voucher.

Our warm thanks go to the FPM VRC Chair, Dr Diarmuid McCoy, the education officer Dr Clayton Thomas, the adjudicators, the trainees, our sponsor Seqirus, and all participants who braved the wild and cold weather that night!

Above from left: Dr Amutha Samuel and Dr Sarah Donovan, FPM trainees; Dr Donovan presenting her audit at the FPM VRC VRSM, ANZCA House.

Victoria
Save the date!

An FPM VRC CME evening meeting, will be held on Wednesday November 7 from 6-9pm in the auditorium at ANZCA House, 630 St Kilda Road, Melbourne. The theme for this meeting will be "Emotional and sexual abuse in the genesis of chronic pain: Clinical and legal aspects".
To register your interest email vic@anzca.edu.au or call +61 3 8517 5350.

Western Australia

Country conference at Bunker Bay in October

The WA CME Committee will hold the Country Conference from October 26-28 at the Pullman Resort in Bunker Bay. It is convened by Dr Nirooshan Rooban and Dr Trevelyan Edwards and titled "Modernising crises: Battles shared, battles won". The plenary speakers include Dr Natalie May from Sydney Helicopter Emergency Medical Service (HEMS), who will be part of a panel discussing management in a regional centre, utilising video simulation, along with presenting lectures regarding Sydney HEMS and education.

Dr Simon Hendel is also a plenary speaker from The Alfred hospital in Melbourne, and will be part of a panel discussing trauma management in a tertiary centre, utilising video simulation, along with presenting on coordination and logistics for ECMO retrieval. Dr Scott Teasdale will provide a GP anaesthetist discussion regarding sedation. Dr Chris Cokis will present developments in thoracic organ transplantation and Dr Michael Luniewski will present on "Pain: Minimising opioid use".

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

Australian news (continued)

Queensland

ACE conference

The Queensland ACE Conference was held on Saturday June 30 at the Brisbane Convention and Exhibition Centre. The theme this year was "The occasional anaesthetist" with presentations providing both anaesthetic and surgical perspectives on how to manage various subspecialty emergency cases, and the tips and tricks for anaesthetists who only occasionally experience these cases to step out of their comfort zone.

Delegates were treated to a beautiful sunny winter's day, with great food, great company and a fantastic line up of local speakers. The engaging topics included Dr Patrick See and Dr Maurice Stevens who presented "Can you cover my (ENT) list?"; Dr Masha Jukes and Dr Rumal Jayalath on "The nuts and bolts of emergency neuroanaesthesia"; Associate Professor David Sturgess and Dr Juanita Muller on "Going out on a limb: after hours vascular anaesthesia"; and Dr Greg Lock on "An anaesthetist's guide to airway radiology".

A variety of workshops were held during the afternoon including "The occasional paediatric anaesthetist" by Dr Amanda Harvey, Dr Gregory Moloney and Dr Barbara Fulton; Dr David McCormack on "Obstetric anaesthesia masterclass"; Dr Joann Rotherham on "Troubleshooting the occasional troublesome pain patient"; and Dr Lucas Edwards, Dr Jodie McCoy and Dr Tony Miller-Greenman facilitated the ultrasound block workshop.

Feedback from the day has been very positive with attendees embracing the joint anaesthetist/surgeon lectures. We greatly appreciate all who contributed to the success of the conference.

Dr David McCormack
Convenor, Queensland ACE Conference 2018

Other news

The Queensland Anaesthetic Rotational Training Scheme process for recommending trainees to the 2019 hospital rotations, occurred between June and August. More than 220 new applications were received, the shortlisting and assessment process was a busy time, which concluded at a meeting with directors of anaesthetics on August 24.

Courses

It has been a busy time in Queensland facilitating the many pre-exam courses. The Primary Exam preparation course was held from May 28 to June 1, convened by Dr Bronwyn Thomas, and received great feedback from all participants. The second Final Exam preparation course for the year was held from July 9-13, with support from AVANT, medical indemnity insurance provider. The Semester 2 Primary Lecture Program started on Saturday July 14, with regional participants remotely connecting to the lecture titled "Pharmacological Basis of Poisoning/IV Induction Agents". With thanks to all of the convenors and lecturers who provide the trainees with these learning opportunities.

FPM CME evening meetings

The Faculty of Pain Medicine Queensland Regional Committee have hosted another two CME evening meetings this year. In May Dr Alison Grimaldi (Titled Sports Physiotherapist) presented on "Gluteal Tendinopathy – Early diagnosis and why physio and not corticosteroid injection should be the first-line treatment"; and in July Dr Aston Wan (Medical Director of the Metro South Health Persistent Pain Management Service) presented "Medication overuse headache – recent literature review". Both evenings were very well received. The last FPM CME evening meeting for 2018 will be held on Monday September 24 – save the date!

Above: Dr Marc Maguire presenting his talk on Trauma/ICU on the last day of Final Exam preparation course.

South Australia and Northern Territory

Part Zero course

The mid-year Part Zero course was held on July 14 with five introductory trainees attending. It was a relaxed, informative day where trainees met with Dr Perry Fabian (ANZCA SA & NT Regional Committee Chair), Dr Christine Hildyard (Education Officer), Dr Sam Willis (Rotational Supervisor), and Dr Agnieszka Szremska (Part One Convenor) and gained insightful knowledge of what to expect in anaesthetic training.

Above: Dr Joanne Tan (Trainee Committee), Dr Munib Kiani (Chair, SA and NT Trainee Committee), Dr Rebecca Madigan, Dr Alyssa Gardner, Dr Tim Hall, Dr Sophie Boast, Dr Tu Nguyen.

Joint meeting with Addiction Medicine Specialists

A joint CME meeting with the Addiction Medicine Specialists was held on June 25. Dr Chris Holmwood and Associate Professor Mike McDonough from Drug and Alcohol Services South Australia (DASSA) presented on the trends in prescribing of opioids, gabapentinioids and medicinal cannabis. Dr Say Yang Ong also gave an update on the FPM position statement on medicinal cannabis. It is hoped ongoing liaison with the Chapter of Addiction Medicine will continue in the future.

Above: Dr Vidya Shirumalla and Dr Medhat Wahba.

Combined ANZCA/ASA SA CME Meeting

Professor Guy Ludbrook presented "Postoperative care – what's broken and (how) can we fix it?" at the first CME meeting of the 2018 series, held at the historic Lion Hotel in North Adelaide in May.

Professor Ludbrook's presentation highlighted that postoperative adverse events and complications are, by number, the fourth largest disease in this country, and worldwide. The cost to patients, and the health system, is substantial and unsustainable. For these complications it is increasingly clear who is at risk, of what, and when. Importantly, we are gradually gaining a better understanding of how this endemic problem can be managed, through both prevention and cure.

Critical to the solution is increased involvement of the specialty of anaesthesia, and strategies on how this can be developed, proven, and implemented. It is not an issue that will ever be "fixed", but is one that anaesthetists can make substantially better.

The presentation was professionally recorded and distributed to remote South Australian and Northern Territory anaesthesia hospital departments for their training and CPD purposes.

Above: Dr Heather Stevens and Professor Guy Ludbrook.

ANZCA Educators Program

Dr Agnieszka Szremska, Dr Rachelle Augustes and Dr Min-Qi Lee presented modules one and two of the ANZCA Educators Program in Adelaide on August 3, 4 and 6. The program is designed to teach the practical application of educational theory to create positive learning experiences.

Above from left: Dr Agnieszka Szremska, Dr Cheryl Chooi, Dr Alison Tjhia, Dr Mei-Quin Tan, Dr Tanya Przybylko, Dr Jam Sadullah and Dr Carolyn Arnold.

Australian news (continued)

New South Wales

Australian Medical Association Junior Doctors Conference

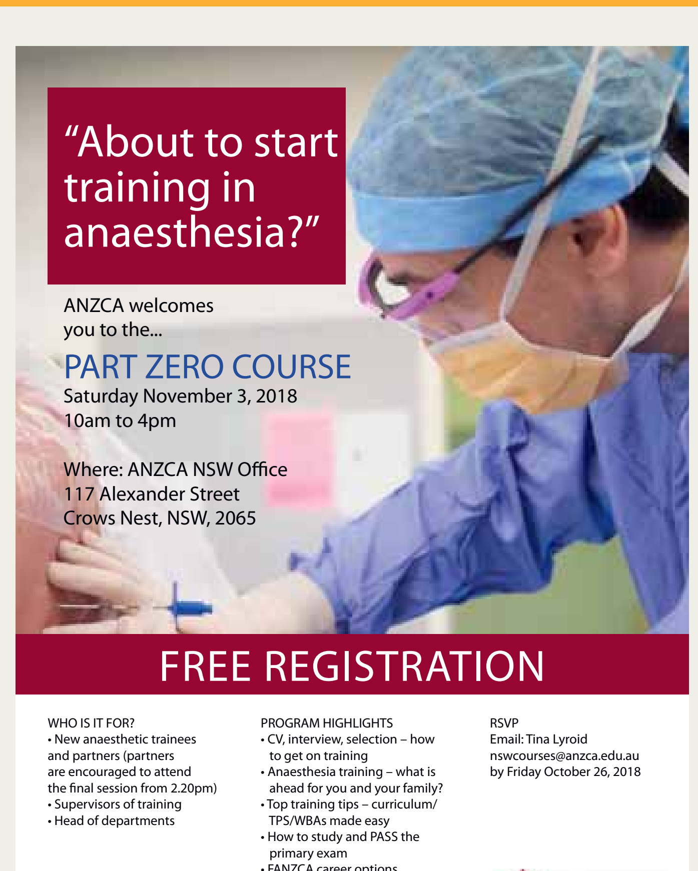
Members of the ANZCA NSW Trainee Committee attended the NSW AMA Junior Doctors Conference on Saturday June 9 at the SMC Conference and Function Centre in Sydney. The day was designed to introduce the various careers available to junior doctors. About 150 doctors attended the event.

The NSW ANZCA table was well attended and questions ranged from "How do I become an anaesthetist?" to "How do I pass the primary exam?" and "How do I get a trainee job?".

Many thanks to NSW ANZCA staff and doctors who gave up their Saturday to talk about anaesthetics.

NSW trainees' Facebook group

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



New South Wales
Primary refresher course in anaesthesia

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

Date: Monday December 3 to Friday December 7, 2018
Venue: Northside Conference Centre
Corner Pole Lane and Oxley Street,
Crows Nest, NSW
Fee: $A330 (including GST)
Applications close on Monday November 19, 2018 (if not already filled). The number of participants for the course will be limited. Preference will be given to those candidates who will be sitting the primary examination in the first part of 2019. Late applications will be considered only if vacancies exist.

For information contact: Tina Lyroid
ANZCA New South Wales Regional Committee
117 Alexander Street, Crows Nest NSW 2065
nswcourses@anzca.edu.au
+61 2 9966 9085

New South Wales
Part Two refresher course in anaesthesia

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

Date: Monday December 10 to Friday December 14, 2018
Venue: Northside Conference Centre
Corner Pole Lane and Oxley Street,
Crows Nest NSW
Fee: $A363 (including GST)
Applications close on Monday November 26, 2018
(if not already filled). The number of participants for the course will be limited.

Preference will be given to those candidates who will be sitting for their final fellowship examination in the first part of 2019. Late applications will be considered only if vacancies exist.

For information contact: Tina Lyroid
ANZCA New South Wales Regional Committee
117 Alexander Street, Crows Nest NSW 2065
nswcourses@anzca.edu.au
+61 2 9966 9085

Tasmania

Another successful winter workshop

The Tasmanian ANZCA/ASA Midwinter Meeting was held for the second year in succession at Barnbougle Resort, on the Bass Straight coast of north eastern Tasmania on Saturday August 25, 2018. The sparkling sunshine was out and the meeting was fully subscribed, with 50 delegates attending, half from Tassie and half from various mainland states, and even one from New Zealand. The theme, "Traps and hazards", reflected the specialty we practice as well as this world-renowned golf course.

The meeting co-convenors – Dr Karl Gadd and Dr Lokesh Varadiah-Anand – were pleased with the positive feedback received and greatly appreciated the effort the speakers had put into their presentations. All presentations were of a high quality, and included: THRIVE with spontaneously breathing IV inductions for difficult airway management, blood pressure management in major surgery, pitfalls of regional anaesthesia, and acute pain management for the opioid tolerant patient. A number of delegates also attended the two anaphylaxis workshops convened by Dr Mat Yarrow.

The scientific program was balanced with an enjoyable social evening at the resort's Lost Farm Restaurant, watching the sunset over the water. Some delegates also tested their golf swings among the dunes the next morning. The meeting will likely revisit Barnbougle again in future years, as it is a most loved destination. Before then though, next year's meeting will be held at the famous Josef Chromy Winery, Launceston, booked for Saturday August 24, 2019.

CPD in a day – A one-stop shop for all your ANZCA emergency response workshops

The Tasmanian ANZCA and ASA Committees are delighted to announce a great CPD opportunity. Our "CPD in a day" workshop presents all ANZCA CPD emergency response workshops in one place on one day. Get all your emergency response activities completed together. One venue, one day, all the workshops, and most importantly all your CPD emergency response points – Cardiac arrest, CICO, anaphylaxis, major haemorrhage.

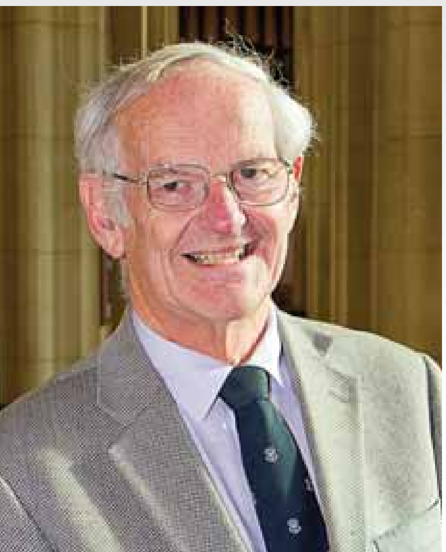
We have a terrific set-up with a broad range of experienced facilitators, quality equipment and great physical facilities at the University of Tasmania Medical Sciences Precinct. Catering and a barista are provided. After the workshops we will hold the ANZCA and ASA AGMs for the Tasmanian committees.

CPD in a day will be held in beautiful Hobart, Australia's smallest but best capital city. From the waterfront to Mount Wellington Hobart is packed with natural beauty and attractions. In the evening there will be a social function where people can share a laugh and a chat, and maybe a drop of Tasmanian gin to the backdrop of our wonderful city. The Tasmanian ANZCA and ASA Committees invite you to the Tasmanian "CPD in a day" Workshop on Saturday March 2, 2019.

We look forward to seeing you there.

Dr Mike Challis and **Dr Lia Freestone**
Convenors

Professor Geoffrey Ronald Cutfield, FANZCA 1948 – 2018


Aitken Photographic – Dunedin, New Zealand

Professor Geoff Cutfield had a very distinguished career as a clinician, academic, teacher, researcher and mentor both in anaesthesia and in intensive care, and in both Australia and New Zealand. His professional life encompassed Dunedin, Oxford, Sydney and Newcastle where in each place he left many friends who were all touched by his humanity and enthusiasm for life.

Geoff was born in Wanganui, New Zealand, in 1948 and educated briefly at Rotorua Boys High School and then Te Puke High School, and later Otago University from which he graduated MB ChB in 1973. His house surgeon and anaesthetic register years were spent at Dunedin Hospital culminating in his FFARACS in October 1979. In September 1977 he won the Renton Prize for top marks in that primary examination. In 1980 he obtained a MRC (NZ) Overseas Research Fellowship that enabled his study at New College in the University of Oxford, and the Nuffield Department of Anaesthetics, where he was awarded his DPhil in 1983 for a thesis on "The effects of anaesthesia and its interaction with critically reduced coronary perfusion upon myocardial function".

Geoff Cutfield had suffered as a child with neurosensory deficit to his right lower leg, with trophic ulceration from spina bifida occulta. He required three operations to solve these issues – a forefoot operation at 13 years of age, a Syme operation through the ankle six months later, and a below knee amputation when a medical student in 1969. His artificial leg was never allowed to hinder his energetic participation in activities, and from time to time he was known to use the prosthesis to surprise onlookers. I remember my first meeting with Geoff when I was newly in Dunedin in 1975. I went to visit Jim Clayton, the Deputy Director of the Department, in an operating theatre where Geoff was assisting Jim as a second year house surgeon. They had been having trouble turning on an oxygen cylinder, and as I walked into the theatre Geoff just said stand back and immediately lashed out with his artificial leg hitting the cylinder wrench mid-tibia. My initial thought was "these Kiwis are tougher than I thought"! Only to discover later the true fact. Geoff joined the anaesthetic department the following year as a trainee and immediately declared his dedication, enthusiasm and willingness to contribute widely to departmental activities. Following his successful completion of training he departed for Oxford. In 1982 towards the end of his DPhil research I had a sabbatical leave year in Oxford and was able to observe first hand Geoff's research mastery, including early starts to set up the experiment, breakfast sourced for the team from Browns in the Woodstock Road and often late finishes. That year also saw Geoff suffer another major medical complication which required an ICU stay of several days – a severe haemorrhage from a Meikel's diverticulum, a congenital variation in the small intestine occurring in 2 per cent of the population with complications in approximately 5 per cent of those people. Talk about chasing the small print!

Following Oxford Geoff spent a month as a Visiting Professor in the College of Physicians and Surgeons of Columbia University NYC, before returning to Dunedin as Senior Lecturer and Consultant Anaesthetist and Intensive Care Specialist. His time in Dunedin was notable among many things for his immaculate anaesthetic charts and ICU records. These were so notable that one of the cardiac surgeons managed to deliberately spray blood all over one of his charts when cannulating the aorta. Thereafter there was a clear competition to repeat this manoeuvre while Geoff took evasive action, eventually moving the charting well away from the active area! This flare for neatness and clarity was also a hallmark of his teaching notes and diagrams. During this period one of his memorable clinical moments was the meticulously planned medical evacuation to Harefield Hospital, UK, of New Zealand's first heart-lung transplant patient, Ann Crawford, for her operation that was later recorded in her 1986 book *Pumps and Bellows*.

In 1989 Dr Cutfield accepted an associate professorial position in the UNSW at St Vincent's Hospital (Sydney) as a specialist in anaesthesia and intensive care, mainly with cardiac surgical patients. In 1992, the inaugural year of the college, he was ANZCA's first Australasian Visitor to that year's annual scientific meeting (ASM). In 1993 he was appointed as professor of anaesthesia and intensive care at the University of Newcastle, NSW, and senior staff specialist in anaesthesia and intensive care at the John Hunter Hospital. Geoff was attracted to the University of Newcastle because of its reputation and excellence in undergraduate teaching, and his obvious ability to contribute strongly to this teaching area. His tenure at Newcastle was most successful and he thoroughly enjoyed his time there. Unfortunately in 2000 at the college ASM in Melbourne he suffered a moderate cerebral bleed that again required a period in hospital followed by a longer rehabilitation phase. Fortunately he made a very good recovery from this misfortune, and returned to full clinical and academic activities including riding his motorcycle. His one complaint from this stroke was that he was no longer able to walk and talk. His teaching had to be done standing still! One of his Newcastle colleagues who suffered his own medical problems was often reminded during his own rehabilitation of a "60-year-old man, with a prosthetic leg, residual deficit from a major stroke, and bilateral hearing aids, getting on his motor bike at some ungodly hour of the night to come into the Mater to help me intubate a patient – always with a smile, and usually with some teaching, delivered in his lovely Kiwi accent!"

Geoff's major research and teaching interests were in applied cardiovascular physiology. It was a shame that his many clinical and academic activities limited his research time, as his research particularly on the effects of volatile agents on the coronary circulation indicated his flare for research. With his strong interest in the cardiovascular system it is sad to note that his sudden death was due to cardiac tamponade from a dissection in his thoracic aorta.

During the latter part of his time in Newcastle (2008-2009) he also became involved in establishing the Joint Medical Program for medical students in the School of Rural Medicine at the University of New England in Armidale, as he believed passionately in supporting the rural areas.

In 2009, with the intent to live in a cooler climate for his wife Libby's health, Professor Cutfield returned to Dunedin and Otago University as Associate Professor in Medical Education and Specialist in Intensive Care Medicine at Dunedin Hospital. He retired from the university and from clinical activities at the end of 2015, though he continued with two half days per week of medical student teaching.

Professor Cutfield loved teaching, and his students – undergraduate, postgraduate and collegial – loved his teaching which was always clear, correct and completely understandable. As mentioned these sessions were often accompanied by immaculate diagrams in slides or on an overhead or blackboard. His teaching, mentorship and interest in students and colleagues were legendary, and extended to home dinners or debriefing drinks following examinations, and to which Libby contributed in equal degree. He had often been asked to be an examiner for the college examinations but always declined – stating that he much preferred to be involved in developing trainees' knowledge than in accrediting its acquisition.

Geoff had wide interests outside of medicine particularly in the Anglican Church and in English church music. In earlier days he sang with the Marama Singers, and he was an active member for more than 20 years in the choir of St Paul's Cathedral, Dunedin. As an anaesthetic trainee he sang a solo in that cathedral at the inauguration of Bishop Peter Mann in 1976. From time to time he also sang with the Schola Cantorum of Dunedin. He was Dean's Warden of that same cathedral at the time of his death. During his time in Newcastle he held a number of positions in the Diocese of Newcastle including Bishop's Nominee on Diocesan Council (1997-2000) and member of Diocesan Social Responsibilities Committee (1997-2009), and he sang with the Newcastle Tudor Singers.

In his younger days he was a keen competition sailor, and on one memorable occasion while a trainee he arranged to skipper a large borrowed yacht to cruise the Otago Harbour to entertain the department's Otago Savings Bank Visiting Professor, Wolfgang Sporel from London Ontario. The yacht's dingy broke loose (not Geoff's fault!) and Geoff immediately stripped to his underpants, discarded his prosthetic leg, and swam after the dingy subsequently towing it back to the yacht. Thus saving all the rest of us a very wet disembarkation.

Steuart Henderson recounts that early in training Geoff entered an essay competition on metabolic responses to severe illness, which he entitled "Of Holly Berries and Hard Winters". This title was criticised by the assessors as unscientific and irrelevant, which Geoff quite rightly regarded as harsh. In particularly hard winters holly berries are at their most abundant and spectacular, providing optimal food for the birds – living things adjust to provide not only greater resilience, but more lavish provision. As Steuart commented it was not only apposite but almost certainly autobiographical. Some of Geoff's and Libby's "winters" were indeed hard, but the "holly" fruited lavishly and enriched the lives and understandings of so many.

Geoff had a magnificent ability to treat everyone equally. He, however, developed a special bond with those who worked closely with him, and there were very many who valued strongly his friendship. He was dedicated to his family but equally they shared him with all his other friends. Speaking as a very long standing friend, I can say that we are all very grateful to Libby, and his children Lisa, Derek, Jimmy and Abby to have been able to share his friendship with them, to extend our sincere condolences to them, and thank our good fortune in our various associations with such a positive, energetic and good man.

AB Baker
Emeritus Professor, University of Sydney
Honorary Historian, ANZCA

Dr Vilim (Bill) Stanisich, FANZCA 1935 – 2018

Bill Stanisich was born at St Vincent's Hospital Melbourne in 1935. Little did he know that he would later spend most of his professional career at that same hospital. He was the first-born child of his Croatian parents who had immigrated to Australia after the First World War. They had experienced tough times and instilled in Bill the importance of hard work, education and always doing your best. These were qualities that would underpin his anaesthetic career. He was an accomplished pianist, having been instructed at a young age by the Viennese-born pianist and composer, Leo Schramm. Bill was educated at Parade College in East Melbourne, again not far from St Vincent's.

Bill studied medicine at the University of Melbourne and graduated in 1962. He completed his internship at Warrnambool Hospital in 1962 and then moved to Geelong Hospital where he probably developed his interest in anaesthesia. Bill started his anaesthetic training at Queen Victoria hospital in Melbourne in 1964. He then embarked on training over the next four years at the Royal Children's, Royal Women's, Royal Melbourne and Prince Henry's hospitals. In 1968, after a "grand tour" of Europe, he settled in London and passed two fellowships, those of the Faculty of Anaesthetists Royal College of Surgeons of Ireland, and the Royal College of Surgeons. He was later elected to fellowship of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons in 1975. The awarding of these three fellowships made Bill the most qualified anaesthetist on the staff at St Vincent's.

In 1970 Bill returned to St Vincent's as a staff anaesthetist and he remained in that position until his retirement in 1999. His major clinical interests were anaesthesia for orthopaedic surgery and plastic surgery. Bill's major contribution to clinical anaesthesia was that associated with the development of microsurgery. He worked with Mr Bernard O'Brien, a world leader in this area. This surgery was prolonged lasting anywhere from 12 to 18 hours. The potential problems of pressure sores and deep venous thrombosis as well as anaesthetist's fatigue were all worked out by Bill. Bill wrote the definitive chapter on anaesthesia for microsurgery in the first book about this surgery written by Bernard O'Brien in 1977. Bill became our expert on difficult endotracheal intubation in the days before fibre optics. His skill came to the fore in this situation. He was careful, meticulous in his preparation and unhurried. Thus, he was successful when others struggled.

Bill had a number of administrative duties in the department, but by far was his skill with night and weekend rostering for staff and trainees. He was meticulously fair, making everyone do an equal share of these sometime arduous tasks. Complaints were few but usually ignored because the staff would know that his fairness was legendary. Bill was in charge of the theatres every Friday, a difficult day because the surgeons would always want to squeeze in cases before the weekend. He would frequently exclaim that the day "was a disaster". Occasionally it was. Bill was acting director or deputy director on a number of occasions and always carried out these tasks well.

Bill was a very private person and he rarely talked to the other staff about his interests or his activities. It has been revealed that he was an excellent cook, that he played the piano right up until his last months of life and retained a passion for classical music. His retirement dinner was held at the Victorian Artists' Society Galleries in East Melbourne. He exhibited 50 of his paintings, mostly copies of Vincent van Gogh, Margaret Preston and Sali Herman, all superbly painted. In his retirement he was commissioned to paint something for the department and chose to depict a Formula One car crash. He equated an anaesthetist's role as similar to a Formula One car driver. Each was only one mistake from disaster.

In recent years Bill was suffering from Parkinson's disease but he managed to continue playing the piano, reading, enjoying classical music and the antics of the family's dogs. He had two cardiac events in the past year, succumbing to the second. He is survived by his sister who is 10 years younger and who looked after him in the last two years of his life.

St Vincent's celebrates 125 years of caring this year; Bill certainly made his contribution to that caring for patients.

Dr Michael Davies MD FANZCA
Director of Anaesthesia
St Vincent's Hospital, Melbourne
(1984-2009)