

ANZCA BULLETIN

Perioperative medicine:
Latest update and timeline

Overseas aid:
New project grant scheme



Neural device change alert

New photos in the ANZCA photo library

We have added images from New Zealand to the photo library for fellows' professional use, such as in slides and brochures.

The photo shoot at Wellington Hospital includes Māori patients and anaesthetists.

The free library, which is password protected and for fellows' use only, is divided into five categories:

- Pre/post-theatre.
- Theatre.
- Training.
- Drugs and equipment.
- Obstetrics.

The doctors in the photographs are anaesthetists or trainee anaesthetists and the "patients" are actors. All have consented to their images being used as part of an ANZCA website-based library. The images are available for use in JPG format and will be added to over time.

The ANZCA photo library can be found at www.anzca.edu.au/fellows/benefits-of-fellowship



Photos for FPM fellows

Pain medicine photos are available for fellows' professional use, such as in slides and brochures.

Visit fpm.anzca.edu.au/fellows for images of consultations, procedures and clinics. The doctors in the photographs are specialist pain medicine physicians or trainees and the "patients" are actors. All have consented to their images being used as part of an FPM website-based library.

The images are available for use in JPG format and will be added to over time.



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ANZCA Bulletin

The Australian and New Zealand College of Anaesthetists (ANZCA) is the professional medical body in Australia and New Zealand that conducts education, training and continuing professional development of anaesthetists and specialist pain medicine physicians. ANZCA comprises about 7500 fellows and 1700 trainees mainly in Australia and New Zealand. It serves the community by upholding the highest standards of patient safety.

Cover photo

Neural device change alert: All fellows, including hospital department heads and anaesthesia craft group chairs, should prepare for new spinal, epidural and nerve block equipment.

Photo: Nicola Bailey.

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President's message



I am increasingly struck by the enormous amount of pro bono work that is performed by our colleagues. This collective achievement largely defines who we are as a college, and as a profession.

We have more than 2000 fellows who regularly contribute their time to our college activities, taking into account our committees, examinations, specialist international medical graduates (SIMGs) processes, formal teaching roles and research.

The fact that this workforce offers its services essentially free of charge is a striking feature in a world where supposedly “no one does something for nothing”, and counter-intuitive to traditional economic models of productivity.

This willingness to volunteer in order to progress the work of our profession is humbling, but it also raises important considerations about how this resource can be nurtured and sustained into the future.

To provide the required support for education, training and professional practice that our college provides, we maintain more than 50 committees, each charged with a specific area of governance, and we provide college representation to an additional 50 external committees.

I am intuitively wary of the potential inefficiencies of committees. However, when I examine the list of individual committees that underpin the governance of our college, the impression is not one of largesse, but rather demonstration of the breadth of the work we undertake.

This involves an eclectic range of activities including, among others, the accreditation of almost 200 training sites (all of which are visited at least once in a five-year cycle), advocacy to government on pain medicine initiatives, conducting high-stakes examinations for approximately 800 candidates each year, the regular revision of more than 40 professional documents, and conducting educational workshops for our colleagues in Papua New Guinea.

“....this ‘volunteerism’ reflects a quiet satisfaction derived from helping others and from advancing our profession, and an underlying appreciation of the nature of our work.”

All this committee activity requires countless hours of reading, preparation and follow up “actions” between meetings. It is all achieved by fellows giving up their time to do so.

A volunteer workforce

We are effectively running a significantly-sized educational institution (we now have more than 1700 trainees). It is difficult to quantify the value derived from the fact that we do so with a volunteer workforce, as there are no ready comparisons.

However, an online search reveals that a TAFE qualification to become an anaesthetic technician, which can be completed in 12 months, costs \$A16,000. This compares to the ANZCA annual training fee of \$A3245 a year (notwithstanding that the costs of exams, including preparation courses and travel, and other courses and associated expenses all contribute additional costs).

Our extensive continuing medical education program reflects the goodwill of committed colleagues to prepare and conduct multiple meetings each year. The ANZCA annual scientific meetings typically involve three years of preparation, and include no small amount of anxiety and stress. And yet I am told that invariably the experience is looked back upon “fondly”.

We have working groups exploring how we can advance the evolution of our profession, examples of which include our Perioperative Medicine Steering Committee, our Gender Equity Working Group and our Trainee Wellbeing Working Group.

Our research community is continuously striving to improve the safety and quality of the clinical care that we deliver. Examples include assessing the use of tranexamic acid and a hypotension avoidance strategy to reduce major complications after non-cardiac surgery (POISE 3), the influence of anaesthetic depth on patient outcome after major surgery (Balanced Anaesthesia Study), and whether enhanced observation of moderate risk patients in the immediate postoperative period reduces complications (Advanced Recovery Room Care – ARRC). Research such as this, strongly supported by our college, and vitally important to ensure best practice, invariably consumes a significant amount of the researcher’s own time.

Motivation and commitment

In order to facilitate the ongoing livelihood of this volunteer workforce, we do well to understand what motivates and sustains it. My sense is that this “volunteerism” reflects a quiet satisfaction derived from helping others and from advancing our profession, and an underlying appreciation of the nature of our work. The latter needs to be managed carefully, for if we cease to enjoy our work, then the out-of-hours effort becomes yet another stress in our already-busy lives. We should remember the intent is for this volunteerism to be an enriching and rewarding addition to our clinical work.

We tend to be high achievers, and the correspondingly high standards we set ourselves can often only be accomplished through contributing over and above normal working hours.

Most of us would agree that there is a tradition associated with being a doctor that involves contributing to the greater good, and we seemingly display a tendency to embrace that tradition.

Volunteering does contribute to meaning and purpose, both of which are recognised as being attributes of a good life. (The only caveat perhaps is that meaning and purpose should ideally be the consequences of volunteering, rather than being the reasons for volunteering. I do ponder the difference between doing something meaningful, that makes you feel good, and doing something meaningful because it makes you feel good. Or maybe I think too much.)

No one likes their willingness to contribute to be taken for granted, and we need to ensure that our colleagues realise their efforts are noted and valued. Judging by the number of emails I receive late at night, or on Sunday afternoons, I am also aware that we need to ensure our willingness to contribute our own time does not impinge on a healthy work-life balance. We mustn’t lose sight of the many aspects of life which require due allocation of time and energy.

Fifty per cent of respondents to our most recent fellowship survey indicated a willingness to perform volunteer work for our college. Our significant collective achievements as a college are a reflection of the time and expertise selflessly offered by so many of our colleagues. On behalf of our colleagues and of our patients, thank you to all of you who so readily and freely contribute to this effort to serve our community.

Go well.

Dr Rod Mitchell
ANZCA President

Chief executive officer's message



Procedures in pain

FPM is about to release for consultation a comprehensive clinical care standard for procedures in pain. The goal is to articulate what is considered to be the appropriate and safe use of procedures in the practice of pain medicine.

Chronic non-cancer pain is a common and costly affliction, affecting an estimated one in five adults in Australia and New Zealand. The cost to New Zealand of chronic pain was estimated at more than \$NZ13 billion in 2016, and cost Australia more than an estimated \$A73 billion in 2018, with annual costs projected to rise substantially over coming decades. These cost estimates have been published in reports in both New Zealand (2018) and Australia (2019). The bulk of the costs were attributed to productivity losses and reduced quality of life, rather than directly to healthcare.

FPM has been concerned about the potential for variation in the practice and quality of therapeutic procedures. This was one of the drivers behind the *FPM Position Statement on Procedures in Pain Medicine*. The promulgation of a clinical care standard is the first outcome of the process set out in that FPM position statement available on the website: <http://fpm.anzca.edu.au/documents/fpm-position-statement-on-procedures-in-pain-medic.pdf>.

The draft standards are being considered by the faculty board at its October meeting and they will be promulgated for consultation following that meeting.

I would like to recognise the efforts of FPM's Cassie Sparkes who worked closely with three working groups to produce this unique document for the faculty.

Growth of ANZCA Library services

Demand for services from the ANZCA Library continues to grow steadily with specialist services and the delivery of improved online resources proving popular. We are consistently told that the library is considered one of the most valued aspects of ANZCA membership. Trainees also value the library for exam preparation, research and report writing.

In the past 12 months we have also seen increased demand by ANZCA staff across policy, safety and quality, education and FPM as we continually improve the level of background research for the review and development of our professional documents and other work.

A summary of the library highlights from January to June 2019 show a comparison with 2018:

- 50 per cent more loans.
- 20 per cent more articles supplied to ANZCA users. This has been achieved with a remarkable turnaround time of less than a day for May and June.
- 48 per cent more articles supplied to other libraries.
- 50 per cent increase in literature searches.

The library really is a great service to fellows and trainees. This performance has been a great effort by a small and dedicated team.

ANZCA National Anaesthesia Day

ANZCA National Anaesthesia Day is celebrated each year across Australia and New Zealand on October 16, the anniversary of the day in 1846 that ether anaesthetic was first demonstrated in Boston, Massachusetts. National Anaesthesia Day is always aimed at community education, promoting facts about anaesthesia and the vital role anaesthetists play.

The 2019 theme is "preparing for your anaesthesia" and is aimed at helping the community understand the importance of preparing for their operation – such as getting fit, stopping smoking or discussing any allergies they may have.

To help celebrate, we are developing a package of materials for you to use and share with patients. These include a set of three posters, information fact sheets and a new web-based video that can be used in displays and waiting areas.

I encourage you and your hospital to get involved to spread the understanding of anaesthesia more widely among the community.

Thank you

This is my last column as I will be leaving ANZCA in early October. It has been a privilege serving ANZCA as chief executive for the past four years and I leave with fond memories and a sense of achievement.

Special thanks are reserved for the three presidents I worked with. A strong president-CEO relationship is crucial to the effectiveness of the council and organisation. I have had strong support from all three, Dr Genevieve Goulding, Professor David A Scott, and current president, Dr Rod Mitchell.

Our council continues to be refreshed with new members, new ideas and fresh views of our strategies. Our relationship has been strong and council has always directed me in a respectful and supportive way.

The many interactions I have had with fellows and trainees has been one of the highlights of my job. A welcome has been consistently extended to me in every situation and I hope you have received as much enjoyment from our relationship as I have.

My final and important thanks go to my management team and our staff. We have pulled together, changed many things and consistently looked to improve services. Above all, we are committed to serving the members and future fellows as custodians of this great organisation.

John Illott

ANZCA Chief Executive Officer



Power interruptions and anaesthesia equipment

Thank you to Dr Thomas for raising the important issue of monitoring loss during power interruptions on contemporary anaesthesia machines (June 2019 *ANZCA Bulletin*)¹. Anaesthesia machines are designed with backup battery power to ensure ventilation continues in the event of a power failure. Unfortunately, as highlighted by Thomas^{1,2}, some anaesthesia monitors are especially vulnerable to power interruptions, with even momentary disconnections leading to a processor reboot and a lack of visible monitoring until the system has completed this (even though data is preserved for later analysis). Even the presence of UPS power outlets on the pendant is of no assistance in avoiding this loss of monitoring.

Thomas identifies the utility of a simple change in colour of the relevant cable as a simple and cost-effective means of reducing the likelihood of this event. One simple change in the plug used would potentially reduce the risk of disconnection. As illustrated in the images¹ it is necessary to wind the cord around a hand-rail on the pendant to reduce the likelihood of the plug pulling out due to the effect of gravity, or slight tension (Image 1). A “side-entry” plug (cable exiting at 135 degrees) may further serve to reduce this risk, adding efficacy to an ultra-low cost solution (Image 2).

Such a change in power cabling will only prevent disconnection where the user identifies the colour of the cable as significant, and removes another cable. Returning to first principles, the problem with disconnection arises not just because of a disconnection from the power outlet, but because the short-term loss of monitoring may be harmful, and the



monitor/machine does not provide a solution to this entirely foreseeable circumstance. As identified by Trbovich³, the most effective means of addressing an issue may include equipment/environment redesign. This may be resolved by one of two means. Firstly, the addition of an uninterruptable power supply (UPS) to the anaesthesia machine will provide a (somewhat) higher cost, but improved supply security solution (Image 3). Many anaesthetists may already have installed a similar device on their home desktop computers to save data in the event of interruptions to domestic power supply. Secondly, monitors with their own power backup solution (internal battery) will largely eliminate this risk.

Manufacturers will only create equipment with additional features (beyond regulatory requirements) when there is demand, some manufacturers already have such features in their monitors. Anaesthetists can wait for regulatory requirements to catch up with changes in technology, or they can report incidents, including to manufacturers, talk to company representatives about their needs, indicate they will include such requirements as at least “desirable features” on their next purchase tender, and follow through with such plans when it does come to purchase time. If we don’t ask we won’t receive!

Dr Ian Cox
Staff Anaesthetist
Concord Hospital, Sydney

References:

1. Purple patch for a power problem. Thomas R. *ANZCA Bulletin* June 2019.
2. A Purple Patch for a Power Problem. Thomas R. *Can J Anaesth.* 2019;66:344-345.
3. Root-cause analysis: swatting at mosquitoes versus draining the swamp. Trbovich P, Shojania KG. *BMJ Qual Saf* 2017;26:350-3.



Get ready for ANZCA National Anaesthesia Day

“Preparing for your anaesthesia” is the theme of the ANZCA National Anaesthesia Day on Wednesday October 16, 2019 the anniversary of the day in 1846 that ether anaesthesia was first demonstrated in Boston, Massachusetts.

The aim of the #NAD19 theme is to help the community understand the importance of preparing for an anaesthetic – such as getting fit, stopping smoking or discussing any allergies they may have.

We can inform our patients and the public that:

- All anaesthetists are highly trained specialist doctors.
- After finishing medical school and working for at least two years as a junior doctor, anaesthetists then complete at least five years of training to become a specialist anaesthetist.
- Australia and NZ are two of the safest places in the world to have a procedure under general anaesthesia.

How you can get involved

We need the support of as many fellows, hospitals and private practises as possible. Your activities, such as putting up posters and organising displays, will be complemented by a media campaign co-ordinated by ANZCA's Communications unit.

Some anaesthesia departments have already notified their hospital communications teams. Social media is increasingly playing an important role so please encourage any fellows who are active on social media to support the day and share your activities.

To help celebrate, ANZCA has developed the following materials for you to use and/or to share with patients:

- A set of three 2019 National Anaesthesia Day posters.
- A “Preparing for your anaesthesia” web-based video which can be used at displays and in waiting areas.
- A “Preparing for your anaesthesia” A4 checklist information flyer.
- A “Who is your anaesthetist?” A4 information flyer.
- An “Anaesthesia isn't sleep, it is so much deeper” A4 information fact sheet.

The role of champions

Many hospitals across Australia and New Zealand have nominated “champions” to help run activities and we have already heard from many about their plans.

Many of the larger hospitals are planning interactive displays with anaesthetists on hand to speak with the public during the day.

In Australia, participating hospitals include Royal Perth Hospital, Royal Melbourne Hospital, Sunshine Coast Hospital, Gold Coast Private Hospital, Peter MacCallum Cancer Centre and Lismore Base Hospital. Several anaesthetic practices including the Wakefield Anaesthetic Group, the Perth Anaesthetic Group and the Albert St Anaesthetic Group are also celebrating. In New Zealand 36 hospitals, both public and private, have put up their hands to support the day with displays and posters.

It isn't too late to join in the 2019 National Anaesthesia Day celebrations. Contact communications@anzca.edu.au in Australia or communications@anzca.org.nz in New Zealand.

Carolyn Jones
Media Manager, ANZCA



Images from ANZCA National Anaesthesia Day last year.

Building relationships

Australia

ANZCA joins the National Rural Health Alliance

The college has recently become a member body of the National Rural Health Alliance (NRHA). Based in Canberra, the NRHA receives core funding from the Australian government Department of Health and is the leading national voice for the health and wellbeing of rural and remote Australians. The NRHA is comprised of 41 national organisations representing health consumers, healthcare professionals, service providers, health educators, students and the Indigenous health sector. ANZCA is one of seven medical colleges that are members, along with other key rural health stakeholders.

Fundamental to the NRHA's work is the belief that all Australians, wherever they live, should have access to comprehensive, high-quality, accessible and appropriate health services, and every opportunity for equivalent health outcomes. In 2017 the NRHA helped establish the Parliamentary Friends of Rural and Remote Health co-chaired by Warren Snowdon, Member for Lingiari and Warren Entsch, Member for Leichhardt. Further information about the NRHA including a comprehensive suite of fact sheets on rural health issues can be found at www.ruralhealth.org.au.

Meeting of the Federation of Rural Australian Medical Educators

On May 7 ANZCA staff from the Education and Safety and Advocacy units attended a meeting of Australian Regional Training Hubs as part of the Federation of Rural Australian Medical Educators conference. Hosted by the University of Newcastle (Tamworth), the day provided an opportunity for medical college staff, particularly those managing the Australian government Department of Health Specialist Training Program, to meet with the hubs to discuss the issues facing specialist training in rural areas. Presentations by medical colleges and regional training hubs covered topics such as training pathways, candidate selection and trainee support. Further information about the Regional Training Hubs can be found at www.health.gov.au.

Specialist Training Program updates Intercollege meeting

On July 31 college staff attended a Specialist Training Program (STP) intercollege meeting hosted by the Royal Australasian College of Surgeons. Attended by 13 colleges, the day included an update from the Australian government Department of Health on the progress of STP against program objectives, as well as an update on expected timelines for confirmation of 2021 position numbers and eligibility criteria. Further updates on future STP funding will be made available to existing and interested sites when confirmed by the department in the first half of 2020.

Site visits

During July and August, college STP staff visited sites and regional training hubs in Coffs Harbour, Traralgon and Shepparton, as well as other regional hospitals in New South Wales and Victoria. The visits to these sites not only served to discuss the experiences of current STP trainees and their supervisors in these settings, but also to explore possibilities for closer relationships with regional training hubs and possible program activities in the future. Further visits to training sites appointing STP-funded trainees for the first time in 2019 are planned to occur over the coming months.

Medicines Leadership Forum

Faculty of Pain Medicine Dean Dr Meredith Craigie attended the second Medicines Leadership Forum on August 14 in Canberra. Convened by the Society of Hospital Pharmacists of Australia (SHPA), the forum brought together pharmacy, medical and policy experts to discuss current challenges for medicines in Australian hospitals.

This year's theme, "Hospital discharge and PBS medicines", focuses on the medicines management challenges for patients leaving the acute setting as flagged in SHPA's *Reducing Opioid-related Harm* report.

The program of speakers covered many aspects of the use of PBS medicines, including opioids, in hospitals. Professor Andrew Wilson, Chair of the Pharmaceutical Benefits Advisory Committee (PBAC), spoke about the listing process of PBS medicines. Other topics included pharmacy support for prescribing, gaps in care for patients receiving PBS medicines and support for the transition of care.

Group discussions explored what hospital pharmacists could do to better support doctors working in discharge; patients at discharge; and primary care practitioners.

Standards Australia

College staff attended a consultation session in July on how Standards Australia is planning to take steps towards opening up access to the content it develops. Following an important arbitration win supporting Standards Australia's position that future distribution of its content will not be on an exclusive basis, Standards Australia has been working towards opening up access to its content with the needs of stakeholders and users front of mind.

Standards Australia intends to operate in a multi-channel, multi-segment model, where a number of different distributors are licensed to distribute content. Practically, this model would see partnerships with a number of organisations who have the ability to help deliver content to those who need it, through traditional (hard copy and PDF) products and in new and innovative ways.

For ANZCA, this will likely mean that standards which are referenced in professional documents and college documents can be made more readily accessible. The new distribution and licensing policy is expected to be operational from January 2020.



Submissions

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

Australia

- Australian Health Practitioner Regulation Agency: Consultation on review of the guidelines for mandatory reporting.
- Department of Health: Consultation on the draft National Clinical Quality Register strategy.
- Department of Health: MBS Review Taskforce: report from the specialist and consultant physician consultation clinical committee.
- Medical Board of Australia: Draft revised registration standard: continuing professional development.
- Medical Board of Australia: Good practice guidelines for the specialist international medical graduate assessment process.
- Parliament of Australia: Migration Amendment (repairing medical transfers) Bill 2019.
- Safer Care Victoria: Draft evidence-based guidance strategy.

New Zealand

- Ministry of Health: Health and disability system review.
- Pharmac: Managing fairer access to District Health Board hospital medical devices.
- Medical Council of New Zealand: Draft revised statement on information, choice of treatment and informed consent.
- Health Workforce New Zealand Directorate: Development of health and disability workforce strategic priorities 2019-2024.
- Medical Council of New Zealand: Statement on the maintenance and retention of patient records.
- Ministry of Health: Medicinal cannabis scheme.

SWAPNet serving rural and remote Queensland



The Statewide Anaesthesia and Perioperative Care Clinical Network (SWAPNet), Rural Perioperative Team Training Program (RPTTP) is a multifaceted, multidisciplinary team training program that supports clinicians to deliver and maintain safe, sustainable service delivery in rural and remote Queensland.

It is the final deliverable to come out of the recommendations of the review of anaesthetic service capacity in 28 Clinical Service Capability Framework level 3 facilities undertaken by Dr Mark Gibbs on behalf of the network in 2011/12. Previous deliverables included \$A3 million in standardised anaesthetic equipment, the Rural Generalist Anaesthetic Introductory Program for rural generalist trainees, Transition Support Program – Perioperative for registered nurses and midwives and Transition Support Program – Perioperative for enrolled nurses.

The RPTTP consists of technical and non-technical skills with a focus on team communication. The training scenarios, four based on the ANZCA

emergency response activities and five elective include can't intubate can't oxygenate, cardiac arrest, management of anaphylaxis, management of haemorrhage, management of sedation, management of malignant hyperthermia, local anaesthetic toxicity, general anaesthetic for abdominal emergency surgery and trauma.

Training sites select four scenarios including two core scenarios and additional unidentified scenario/s are added to maximise learning opportunities. The scenarios (tailored to reflect practice at each individual site) are delivered over two days utilising state of the art, "life like" simulation equipment set up in the operating theatre at each facility. Audio visual equipment is used to enable all trainees to identify good teamwork, what went well and what requires improvement in the debriefing sessions following each scenario.

Dr Chris Stonell, RPTTP Chair advised that the original proposal included the delivery of the training to 8-10 sites however due to the demand from rural

and remote communities, it is now being delivered to 17 sites involving 22 facilities by December 2019.

The Rural Perioperative Team Training Faculty of 25 comprises anaesthetists, GP rural generalists, surgeons, perioperative nurse educators and a midwifery educator who are volunteering their time to deliver the training. Multidisciplinary teams of 3-4 faculty members make up the delivery team for each site with the support of the SWAPNet Coordinator and a Clinical Skills Development Service Simulation Coordinator.

"To date we have very successfully delivered the training to seven sites and the remaining 10 staggered over the coming months," Dr Stonell said.

For further information:

<https://clinicalexcellence.qld.gov.au/improvement-exchange/rural-perioperative-team-training-program>.

Above clockwise from left: Rural Perioperative Team Training Program (RPTTP) faculty members; RPTTP scenario in action; audio visual view of RPTTP training.

Anaesthesia research and training, chronic pain, top media topics

Several issues including anaesthesia training and management of chronic pain have dominated ANZCA and FPM media coverage in Australia and New Zealand since the last *ANZCA Bulletin*.

FPM Dean Dr Meredith Craigie appeared on ABC Radio National's Sunday Extra "Round Table" program segment on June 23 which featured a 30-minute discussion on chronic pain. The segment followed the release of the National Strategic Action Plan for Pain Management.

In New Zealand, FPM National Committee Chair Dr Tipu Amir was interviewed on Radio New Zealand's Afternoons with Jesse Mulligan program on August 19 for a 40-minute question and answer session on chronic pain. UK anaesthetist Dr Andrew Klein, keynote speaker at the 2019 New Zealand Anaesthesia Annual Scientific Meeting in Queenstown was interviewed for "Doctoring the data", a double page article on scientific fraud in the health section of the *NZ Listener* magazine on August 24. The article reached an audience of 270,000 readers. Dr Klein also featured on Radio New Zealand's Sundays with Jim Mora, Newshub, Newstalk and Magic FM.

ANZCA distributed three media releases about the keynotes at the New Zealand ASM. Visiting speakers Professor Ed Mariano and Professor Alison Phipps featured on two national Radio New Zealand programs Afternoons with Jesse Mulligan and Nights with Bryan Crump during the conference. Professor Mariano from Stanford University talked about how doctors need to counteract the cacophony of fake news by being active on social media. He was also interviewed on Newstalk and Newshub.

Hobart-based anaesthetist fellow Dr Andrew Ottaway was a guest on ABC Radio Hobart's Statewide Mornings program on August 14 to discuss an upcoming trip to Namibia for the volunteer group Health Volunteers International which he founded in 2017. The group, which includes nurses and doctors from multiple disciplines, teaches and trains Namibian doctors.

Anaesthesia training at John Hunter Hospital in Newcastle was the focus of an article "No blackout blow for the John Hunter" by journalist Anita Beaumont in the *Newcastle Herald* on August 6.

An ANZCA statement provided to the *Newcastle Herald* confirmed that the college had approved accreditation to the hospital to the end of the 2020 hospital employment year and that ongoing discussions were continuing with the hospital.

ANZCA fellow Dr Peter Brendt, senior VMO anaesthetist at Dubbo Base Hospital in NSW, was interviewed by Prime 7 news for a July 5 story on the ANZCA "Can't Intubate, Can't Oxygenate" (CICO) course that was run by the hospital's anaesthesia department and the Royal Flying Doctor Service.

FPM Vice-Dean Associate Professor Mick Vagg was interviewed by *AusDoc* on July 22 about the draft Medical Benefits Schedule Review Pain Management Clinical Committee Report. Professor Vagg said the report was mainly, but not exclusively, about making pain specialists more accessible.

In Perth, paediatric anaesthetist and researcher Professor Britta Regli-von Ungern-Sternberg featured in a Seven Network *Today Tonight* segment "The WA breakthrough making surgeries safer for children." The segment featured Professor Regli-von Ungern-Sternberg's REACT (Reducing anaesthetic complications in children undergoing tonsillectomies) trial for which she received an ANZCA Research Foundation grant in 2016.

Two Auckland anaesthesia fellows were identified as the catalyst for the Faculty of Engineering at the University of Auckland to develop a potentially effective system for capturing anaesthetic gases. The story about what happened when Dr Rob Burrell and Dr Matt Taylor approached Dr Saeid Baroutian was published on *stuff.co.nz* on June 17.

Pharmaceutical giant Mundipharma was accused of misrepresenting the position of FPM and the Royal Australian College of General Practitioners in their promotion of pain medicine for chronic pain. The ABC reported the story "Pharma giant accused of using loophole to falsely promote opioid pain relief" with comments from FPM on July 10 on radio, online and television news broadcasts. The stories reached a combined audience of 700,000 people.

Geelong-based specialist pain medicine physician and anaesthetist, FPM Victorian Regional Committee chair Dr Diarmuid McCoy, was profiled in *The Irish Times*' "Working Abroad" section on August 6 describing how he and his family had made the transition from Dublin to Geelong in 2004. Dr McCoy was the first Irish doctor to be admitted as an FPM fellow.

Carolyn Jones
Media Manager, ANZCA

Since the June 2019 edition of the *ANZCA Bulletin*, ANZCA and FPM have featured in:

- 9 print reports.
- 30 radio reports.
- 28 online reports.
- 3 TV reports.

Media releases since the June *Bulletin*:

Thursday August 22:

Catching the fraudsters in medical research

Better pain management can help New Zealand avoid an opioid crisis

Doctors need to get above the noise on social media

Monday July 29:

ANZCA announces new CEO

Friday July 12:

Medicinal cannabis is no silver bullet

Monday June 17:

Australia's peak pain organisations for health professionals welcome national plan for pain management

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

What would you do?

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

Vigilance

Technology – boon or distraction?

“Hi, what a great weekend. Did you watch the final at Wimbledon?”

Patient care is about delivering services that are patient-centric and targeted to the individual. Performance is the sum total of professionalism and clinical competence and determines the safety and quality of the care provided. Mortality rates are now very low so much of our focus is on minimising both the incidence and severity of morbidity.

Preoperatively, thorough pre-anaesthesia assessment and consultation underpins planning and management of anaesthesia (*PS07 Guidelines on Pre-Anaesthesia Consultation and Patient Preparation*).

Intraoperatively, optimisation and individualisation of care requires assimilation of clinical observation, data from monitors, and situational awareness, which formulate decisions that finally lead to action including selection of medications, timing, and dosage.

Consider the scenario where a young anaesthesia assistant informs you of a situation where a colleague conversed with another party on their mobile phone throughout cannulation, preoxygenation, and induction. Despite monitoring alarms having been triggered and attempts to interrupt, the conversation continued, and the anaesthesia assistant finally felt obliged to offer assistance by preparing medications that might be needed to resolve the problem.

If this was a trainee that you were supervising, or a colleague in the next theatre, what would you do? Would you consider this behaviour acceptable?

The diagram (opposite page) depicts the pivotal essence of vigilance in decision-making and management. It also illustrates that competing visual and auditory inputs may be distractions that adversely impact on vigilance. This raises the issue of the ever-increasing appearance of technology into our working environment and its effect on vigilance in the operating theatre. Rapid and substantial surges in computing power along with progressive miniaturisation have resulted in exponential growth of applications aiding education, research, and clinical practice. In addition, enhancements in communication have offered access to information and data never before experienced.

The ready ability to search resources with the aid of “Dr Google” is unprecedented, as is the ability to ring a colleague/mentor for advice. The proliferation of apps has also seen the development of useful tools. How good is this!

But at what point does this technology become intrusive or counterproductive? What risks does it pose?

ANZCA professional documents and ANZCA's professionalism and performance guide are resources that provide advice and guidance relevant to the potential risks associated with the above scenario.

PS18 Guidelines on Monitoring During Anaesthesia

- Item 5.1 states that clinical observation and assessment by a vigilant anaesthetist is essential for safe patient care during anaesthesia.
- Item 5.2 states that the constant presence of the anaesthetist is essential from induction through to transfer to PACU. Implicit in this is that the presence is mentally as well as physically.

PS51 Guidelines for the Safe Management and Use of Medications in Anaesthesia

- Item 4.4 identifies the importance of medical practitioners providing anaesthesia having an awareness of the contribution of human factors to medication errors and taking steps to manage these.

Supporting Anaesthetists' Professionalism and Performance:

ANZCA Role	Section	Type of behaviour	Example
Communicator (p8)	Developing rapport and trust	Good	Comforts and reassures patients during stressful situation, procedures or during conscious sedation
Leader and Manager (p12)	Setting and maintaining standards	Poor	Is disrespectful to patients, other staff, junior doctors or students
	Leadership that inspires others	Good	Consistently acts with integrity, respect, and fairness
Health Advocate (p14)	Caring with compassion and respect for patient rights	Poor	Gives the impression of being “heartless”, lacking empathy or concern for the patient

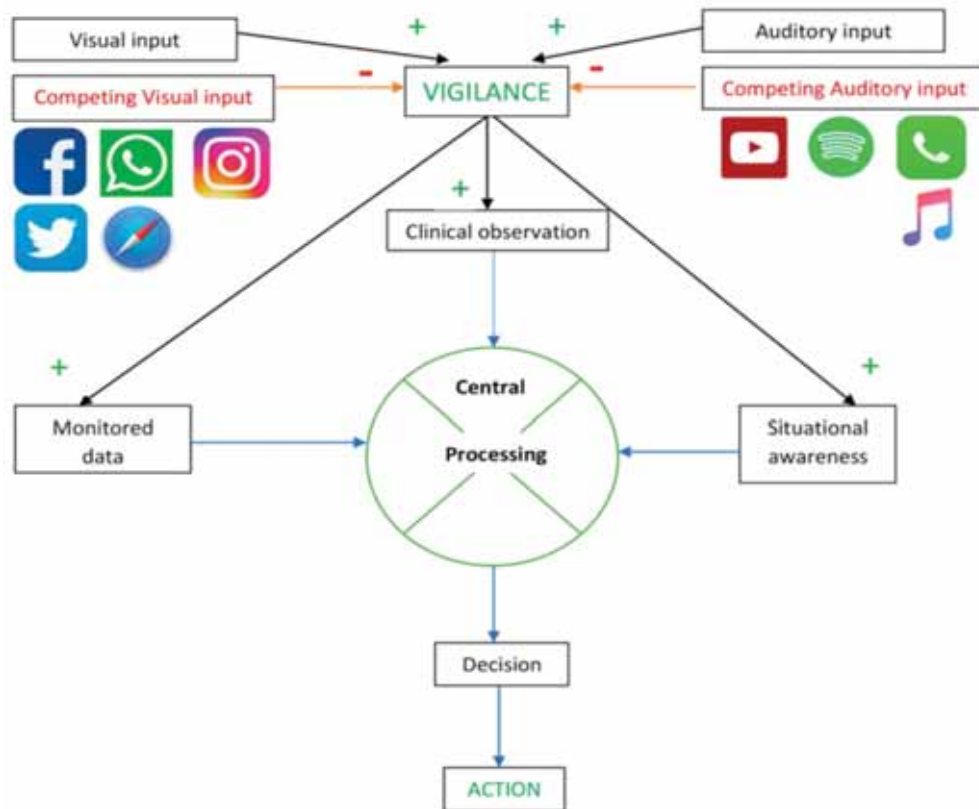
In the last *ANZCA Bulletin* article, I raised the matter of image and professional behaviour. In this context, one wonders how a patient in the above scenario might feel during cannulation and induction when their anaesthetist is “not present”. Eye contact, empathy and compassion at all times are a reflection of respect and care.

Aside from concerns of image and professionalism the impact of such behaviour on vigilance is not insignificant. My solicitations to anaesthesia assistants about use of digital devices in theatre have unsurprisingly resulted in anecdotal responses that the majority, if not all anaesthetists, do so. While the majority of colleagues use digital devices judiciously for the beneficial clinical purposes that they offer it is clear that some colleagues are placing themselves and their patients at risk through inappropriate use, resulting in distractions and impaired vigilance.

This could equally apply to data entry into electronic medical records. Ideally, data should be captured as much as possible without manual input; however, where manual input is required this is best completed at non-critical times.

Care should be exercised when using digital devices to ensure that the boundaries of respect and clinical standards are maintained. Wisdom dictates, as witnessed in the airline industry, that during “take-off and landing” we should buckle up, and use of digital devices should be restricted at these critical times.

Importance of vigilance



Professional documents – update



The professional documents of ANZCA and FPM guide 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 them as indicators of expected standards. In addition, the ANZCA Training Accreditation Committee refers to the professional documents in regard to accreditation of training facilities. The professional documents are subject to regular review and are amended in accordance with changes in knowledge, practice and technology.

ANZCA professional documents are available on the ANZCA website (www.anzca.edu.au/resources/professional-documents). Faculty of Pain Medicine professional documents can be accessed on the FPM website (www.fpm.anzca.edu.au/resources/professional-documents).

Recent update

- Work has commenced on the review of *PS56 Guidelines on Equipment to Manage a Difficult Airway During Anaesthesia* (previously To4), as well as the review of *PS55 Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations* (previously To1).
- Work has also commenced on the development of a new professional document *PS66 Guideline on the role of the anaesthetist in commissioning medical gas pipelines*.

In pilot

- *PS02 Statement on Credentialling and Defining the Scope of Clinical Practice in Anaesthesia* (until November 2019).
- *PS04 Statement on the Post-Anaesthesia Care Unit* (until November 2019).
- *PS65 Guidelines for the Performance Assessment of a Peer* (until September 2019).

Feedback is encouraged during the pilot phase for all professional documents. All comments and queries regarding professional documents can be sent to profdocs@anzca.edu.au.

Neural connector changeover is coming

Devices for neural procedures with internationally compliant connectors are being introduced in Australia and New Zealand and a planned changeover of the new equipment in hospitals will be crucial to ensure that optimal patient care is not compromised. FANZCA Dr Phoebe Mainland, a member of several committees of the International Organization for Standardization (ISO), a body responsible for international standards development, explains the background to the changes and the need for rigorous planning by clinicians, healthcare facilities and hospitals.

In 2001 in Nottingham in the UK, a young man Wayne Jowett died as a consequence of being given an injection of vincristine intrathecally rather than the intended intravenous route.

The report of the investigation of the 18-year-old's death made several recommendations, including that there should be a new design for the connector for spinal needles and syringes which is incompatible with the Luer connector used for intravenous syringes and injection access ports¹. A Patient Safety Alert published in 2009 required in England that "From April 1, 2013 all epidural, spinal (intrathecal) and regional anaesthesia infusions and bolus doses should be performed with devices with connectors that **will not** also connect with intravenous equipment²."

Similarly, in the US, legislation in California requires that from January 1, 2017 connectors for devices used for epidural, intravenous and enteral applications must not "fit into a connector other than the type it was intended for"³. (That date has been delayed as not all equipment was yet on the market.)

These legislative and regulatory edicts have addressed concerns of patient safety that have been documented internationally for several decades regarding administration of fluids via unintended routes (see examples in FDA Medical Device Safety Calendar⁴).

To reduce the risk of unintended connections between medical devices, with potential for errors in administration of substances, the International Organization for Standardization (ISO) developed a series of connectors, so medical devices used for different clinical applications will have a unique connector.

The changeover to medical devices with new connectors is a major undertaking.

The series of ISO international standards are ISO 80369 small bore connectors for liquids and gases in healthcare applications. Part six of this is ISO 80369-6 Connectors for neuraxial applications. The devices intended to be compliant with these connectors are those used in applications for all nerve blocks, both central and peripheral and infusions. It excludes equipment for hypodermic injection and infiltration and ophthalmic blocks. ISO 80369-6 compliant devices may be labelled as NRFitTM.

The design of the ISO 80369-6 connector is similar to the traditional Luer connector with the mating interface slightly smaller than Luer. The orientation of the parts is as usual, that is, the male part is the syringe tip. The male part has a collar around the tip, either non-locking for "slip" facility or threaded for locking devices. A study from the UK confirmed that the design is fit for purpose⁵.



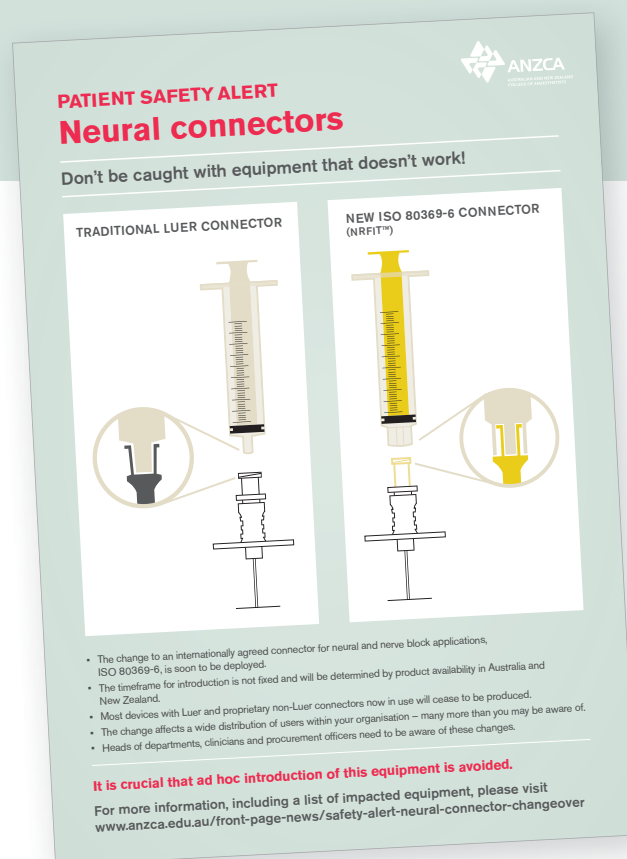
“It is crucial that ad hoc introduction of this equipment is avoided as risks to optimal patient care are significant.”

Manufacturers are now producing devices with ISO 80369-6 compliant connectors for neural applications. The production lines of devices not incorporating these connectors will be shut down thus Luer equipment will not be supplied in the future. ANZCA and the Australian Commission for Safety and Quality in Health Care (ACSQHC) are collaborating to assist with the changeover to devices with the new connector. Some global resources also are available for guidance⁶.

In Australia and New Zealand the changeover to ISO 80369-6 compliant devices will occur although the timeframe is as yet undetermined. The changeover to devices for neural applications with the new connectors in Australia and New Zealand will be a huge task and it is crucial that ad hoc introduction of this equipment is avoided as risks to optimal patient care are significant.

Based on international experiences of changeover to devices with non-traditional connectors the following recommendations are made for best practice implementation of equipment for neural procedures compliant with ISO 80369-6.

- **Planning** – the changeover cannot safely occur without anticipation and planning. Announce a realistic timeframe for the changeover.
- **Leadership** – identification of lead person(s) within an organisation, facility and department who has respect within the environment.
- **Engagement** – with the range of stakeholders including supply, logistics and material management.
- **Different practices** – by auditing, be aware of off label uses of “neural” devices (especially spinal needles) and plan for stock of devices in different locations, for example the radiology department.
- **Communication** – with manufacturers, suppliers and logistics departments is essential as is communication to all end users. Engage the facility education/communications departments for program of targeted messages.
- **Preparation for changeover** – stocktake of all stores of devices for the target procedures in preparation to remove old stock and replace with new equipment. Stock of old devices could be distributed to facilities not yet changing over.
- **Changeover day** – changeover to the new devices for specific procedure should occur on a single day. Do not have both old and new systems in one facility.
- **Check** – ensure that all equipment for a specific procedure, for example, spinal or epidural have the same connector.
- **Adaptors** – are not to be used.
- **Monitoring, audit and risk register** – track and report any incidents including near misses during the changeover.



The development of the new ISO 80369 connectors is based on improving patient safety. However, any change has potential for introducing new hazards particularly at the time of transition.

Heightened vigilance of clinicians is required to reduce such risks. Sharing of experiences will help other clinicians and facilities in their adoption of the new equipment.

Dr Phoebe Mainland, FANZCA

Dr Mainland, a 2015 Churchill Fellow, prepared a report for the Churchill Memorial Trust on how other countries are preparing for the introduction of medical devices with new connectors, and the lessons that can be learned to help Australian implementation. This is available at www.churchilltrust.com.au/media/fellows/Mainland_P_2015_reducing_misconnections_between_medical_devices.pdf

References:

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2. Safer spinal (intrathecal), epidural and regional devices – Part B. NPSA/2009/PSA004B. 24 November 2009. Available at <http://www.nrls.npsa.nhs.uk/resources/?EntryId45=94529>
3. http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_1851-1900/ab_1867_bill_20120827_chaptered.html
4. <https://www.fda.gov/media/75542/download>
5. Cook TM, Wilkes A, Bickford Smith P, Dorn L, Stacey M, Kinsella SM, Sharpe P, Phillips P. Multicentre clinical simulation evaluation of the ISO 80369-6 neuraxial non-Luer connector Anaesthesia 2019 (74) 619–629 doi:10.1111/anae.14585
6. <http://stayconnected.org/neuraxial-nrfit/>

NRFit roll out in New Zealand – learnings from Auckland

Dr Matthew Drake is deputy service clinical director of Women's Health Anaesthesia at Auckland City Hospital and is leading the NRFit replacement for the Auckland District Health Board (ADHB). Here he gives us a rundown of the challenges and complexity of the job.

The potential risk of medication errors related to neuraxial analgesia has been on the risk register for the ADHB for several years. So, with the availability of compatible neuraxial equipment based on the NRFit standard, the organisation was keen to implement NRFit across all hospital sites. However, being one of the first units in Australasia to do this posed some unique challenges.

To set the scene, ADHB serves a population of more than 500,000 people, with a larger proportion than nationally of adults in the 20-40 age range. As well as general medical services Auckland provides regional/national cardiothoracic, neurosurgery, paediatric and obstetric services for patients from other areas of the country. Their maternity service had 6500 births last year, with a labour epidural rate of 58 per cent and a caesarean section rate of 39.1 per cent.

On the face of it, changing to a similar connector for a specific set of medical procedures should be relatively straightforward, but the reality in a large hospital is quite different. Procurement tends to grow organically. This is a product of clinician preference, manufacturer availability of stock and price at any given time that the item was sourced. The result is a hotch potch of needles, syringes and other equipment from many different manufacturers, sometimes with strong clinician opinions on which needle is "best" for any given procedure resulting in several different brands of the same type, size and length of needle.

Some areas of ADHB use equipment which is covered by NRFit for non-neuraxial purposes – interventional radiology and obstetrics require long fine needles, and a Quincke spinal needle neatly fits the bill – and these also require compatible syringes and extension tubing. So the original 10 neuraxial items that needed to be replaced quickly grew to nearer 100.

Prefilled syringes for neuraxial use also need to be replaced with NRFit versions. Manufacture and stability/ingress testing of these takes many months which, if you are the first customer requesting these product, can add a significant time to your implementation timetable.

We have had some unexpected delays with this process. The new syringes had to be sourced for the pharmaceutical company to test, after which they realised their tubing for filling them would need to be adapted, and compatible caps to seal the syringes would also need to be found. Interestingly, despite the origins of NRFit lying in inadvertent intrathecal vincristine injection, our supplier of prefilled chemotherapy syringes currently has no intention of producing these in an NRFit version. So we have had to review processes to ensure all intrathecal chemotherapy can be prepared in-house.

This project affects many different clinical areas, so having a clear communication and collaboration strategy is key.

I decided to break this down by clinical area, asking each department to nominate a clinical lead who would be responsible for leading the NRFit transition in their area. A variety of nurse specialists and medical staff attended workshops to learn about NRFit and to meet our current suppliers to discuss requirements. Each collated a list of affected items from their areas from which we could identify like-for-like NRFit alternatives.

Some of the more specialist items have already been identified as unavailable in an NRFit version. These include nearly all neurosurgical items, as well as some specifics such as the needle used to place spinal cord stimulators. Rather than waiting for these to become available (there is no indication when they will be manufactured) they have opted to exclude neurosurgery from NRFit for the time being.

Choosing an implementation plan caused a significant amount of discussion. We needed to minimise the problems of incompatibility during the transition. Changing one area at a time offered the benefit of a staged implementation and the ability to revert to old Luer stock if significant problems arose, although this did carry some clinical risk for patients moving between areas, particularly those admitted to intensive care.

Whole-of-hospital required a very large input from our supply chain management to change all affected items over a 24-hour period. We opted for the whole-of-hospital, principally because our supply chain did not have the capacity to stock Luer and NRFit items in parallel. When we do change we will keep the old Luer stock for a couple of months in case of unexpected problems.

ADHB is currently working with suppliers to determine reliable stock availability dates (usually a 3-4 month minimum due to sea freighting) but aims to implement NRFit as far as possible early in 2020.

Dr Matthew Drake, FANZCA
Auckland City Hospital

Royal Prince Alfred prepares for changeover

The Institute of Rheumatology and Orthopaedics (IRO) is a standalone elective orthopaedic surgical hospital on the campus of Royal Prince Alfred Hospital (RPAH). At the start of 2019 we were approached to consider trialling the new ISO 80369-6 standard equipment for neural connectors in regional anaesthesia procedures.

We identified that the IRO would be an ideal facility to trial the new equipment and establish some experience with the process of the transition because there are no non-anaesthetic services on the site that would be affected by the change. However, as the largest users of neural blockade equipment, we could effectively trial much of the new equipment with high fidelity.

Early in our assessment of the feasibility for transition, we identified that almost all of our equipment was already available with new connectors and only a very limited number of infrequently used items would need substitution with an alternate product. In our subsequent planning to move to the new connectors, we have followed relatively informal recommendations that had come out of some National Health Service hospitals in the UK during their transition.

We have also worked with Australian Commission on Safety and Quality in Health Care (ACSQHC) to gain their insights and share our experience. The early focus was to work with suppliers to ensure that our equipment had regulatory approval and that they could provide an adequate supply of stock.

Next, we reviewed the range of clinical applications of neural block equipment to ensure that we had an end-to-end solution for all potential clinical scenarios. This process highlighted a few that may have been overlooked, such as the need to include our surgeons periarticular infiltration needles in our procurement and plan how we will manage the patient with a continuous nerve block in situ that requires transfer to our main hospital facility.

Finally, we have turned our focus to a comprehensive pre-introduction education program. We had a special departmental meeting attended by all our suppliers, where anaesthetists and anaesthesia assistants could see the new equipment and share any comments or concerns. Support for the new ISO 80369-6 connector initiative was very positive.

The next phase is to ensure that staff in recovery, the ward, the pain service and surgical departments are aware of the new connectors, the rationale for implementation, and that a transition is approaching.

We are planning to use the poster from the recently published ANZCA safety alert (see www.anzca.edu.au/front-page-news/safety-alert-neural-connector-changeover) to help promote our transition date later in the year throughout the IRO. As recommended, we will be transitioning fully to the new ISO 80369-6 compliant equipment on one day.

Even with our efforts to minimise excessive purchase of existing stock, we have the advantage that surplus supply can be immediately quarantined and removed to our main RPAH campus.

The purchase of new block trolleys to coincide with the transition date will help ensure a swift rollout as well as make the new equipment more identifiable – we found a trolley with yellow drawers!

Finally, we are planning to closely monitor any issues with the new equipment through our existing incident-monitoring systems as well as conduct a post-implementation questionnaire of our staff to gauge satisfaction with the new equipment and seek feedback on our implementation processes.

Dr Andrew Lansdown, Dr Carole Lamond and Dr Michael Paleologos
Institute of Rheumatology and Orthopaedics, RPAH



“The purchase of new block trolleys to coincide with the transition date will help ensure a swift rollout as well as make the new equipment more identifiable – we found a trolley with yellow drawers!”



Perioperative medicine – work continues

Perioperative medicine – definition

Perioperative medicine (POM) is the multidisciplinary, integrated care of patients from the moment surgery is contemplated through to recovery. It involves:

- Preoperative evaluation.
- Risk assessment and preparation.
- Intraoperative care.
- Postoperative care (including monitoring, rehabilitation and post-discharge).
- Communication and handover to primary care or referrer.
- Co-ordination of personnel and systems.
- Shared decision making.

Work on the development of a perioperative medicine qualification continues as planned and the establishment of a patient journey timeline has been completed.

We have also undertaken widespread communication with our non-anaesthetist medical colleagues and other key stakeholder groups including jurisdictional health departments.

Using the now agreed definition of perioperative medicine the co-chair of the Perioperative Care Working Group Dr Jeremy Fernando describes on the opposite page, how this timeline will provide the framework to further define a systematic approach to the development of perioperative medical services.

The Perioperative Medicine Education Group, chaired by ANZCA councillor Dr Sean McManus, is making steady progress on the education package.

The graduate outcome statement (that is, the definition of what a perioperative specialist) is drafted, and the group is now finalising a draft curriculum framework with the aim of presenting this at the Perioperative Medicine Special Interest Group meeting in Brisbane in November.

The college is developing a survey, similar to the one undertaken by ANZCA to gauge the interest in a perioperative medicine qualification and practice, for use by the more closely aligned colleges – the College of Intensive Care Medicine, the Royal Australasian College of Physicians, the Royal Australasian College of Surgeons, the Australian College of Remote and Rural Medicine, the Royal Australian College of General Practitioners and the Royal New Zealand College of General Practitioners. The results of these surveys will be published in due course.

The first *Perioperative medicine communique* was circulated in July following the meeting of the Perioperative Medicine Steering Committee. Interestingly the link to the communique from the August ANZCA *E-Newsletter*



received among the highest number of click-throughs, showing the strong engagement our fellows have with this project.

The college has also developed a *Stakeholder engagement and communications plan* with an associated database of key stakeholders. There are at least 200 groups and individuals in this table, and this will no doubt grow over time.

ANZCA will regularly produce a *communique* to keep stakeholders informed.

Collaboration with these groups is key to the success of this project. A new member of the group is community representative, Ms Heather Gunter, a NZ registered nurse with personal experience of the failings of an unintegrated system.

More information about the activities of the college in this space can be found on the website at www.anzca.edu.au/about-anzca/perioperative-medicine. The committee also welcomes any feedback from fellows or trainees via periop@anzca.edu.au.

Dr Vanessa Beavis
Chair, Perioperative Medicine
Steering Committee

Perioperative medical journey is now mapped

Having developed an agreed definition for perioperative medicine, the Perioperative Care Working Group (PCWG) has now described the patient journey from the contemplation of surgery to recovery.

The perioperative patient journey has many components. To further describe its complexity a timeline has been developed that clearly maps the patient journey through the perioperative medical process.

This timeline is providing the framework to further define and allow a systematic approach to the development of perioperative medical services. The Perioperative Care Working Group (PCWG) is in the process of describing principles and giving general recommendations for those wanting to further develop perioperative medical services.

The results of this work will form the basis of a new resource that will play a core role in the establishment of the new perioperative medicine qualification being developed by ANZCA in collaboration with other key medical groups.

Dr Fernando, a Queensland anaesthetist and intensive care specialist who is the chair of the Perioperative Medicine Special Interest Group and the PCWG says: “Defining the POM timeline is important because there is a lot happening in the perioperative medical space and we need a framework in which we can understand how the components fit together.

“It will also help in the communication between those at various parts of the time, from primary care to rehabilitation. The document will serve as a reference for those wanting to understand what is happening in Australia and New Zealand in perioperative medicine.”

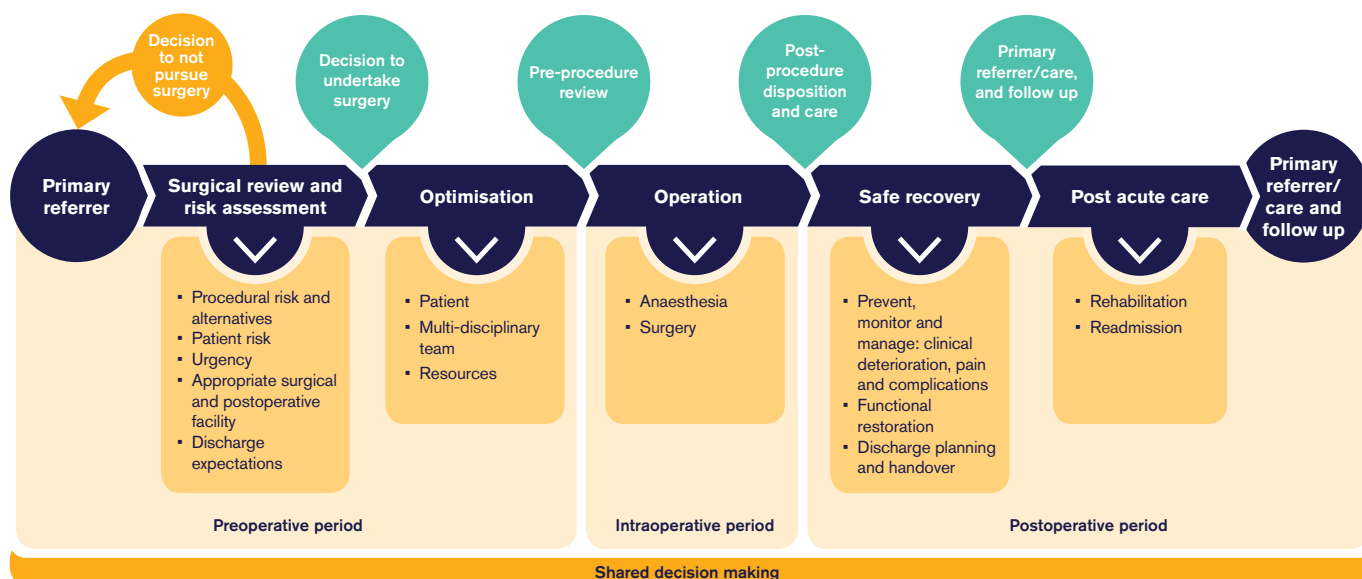
The PCWG is made up of a range of specialists who can bring important perspectives to the patient journey – anaesthetists, intensive care specialists, physicians, geriatricians, general practitioners and a surgeon.

(continued next page)

Perioperative medicine – work continues (continued)

The perioperative medicine timeline

From the contemplation of surgery to recovery



The members of the PCWG have been broken into groups tasked with analysing the seven components of the patient journey. These are: primary referrer and referral, surgical review and risk assessment, optimisation, intraoperative care, safe recovery, post-acute care and primary referrer/care and follow up.

Each group will develop for their component:

- Principles.
- Recommended practices for each principle.
- Examples of recommended practices.
- References.

Eventually the components will form seven chapters and the principles will make up an executive summary of the resource, which is expected to be finalised in early 2020.

Dr Jeremy Fernando
Chair, Perioperative Care Working Group

Perioperative Care Working Group

Dr Jeremy Fernando (Chair)
– ANZCA/CICM, Qld

Dr David Alcock – ANZCA, Tas

Dr Su Jen Yap – ANZCA, NSW

Associate Professor Arthas Flabouris
– ANZCA/CICM, SA

Professor Guy Ludbrook – ANZCA, SA

Dr Simon Reilly – ANZCA/ASA, Vic

Dr Eugene Wong – ACRRM, GPA, Qld

Dr Aisling Fleury – RACP
(geriatrician), Qld

Professor Alison Mudge – RACP
(general physician), Qld

Dr Rachel Aitken – RACP
(geriatrician), Vic

Dr Margot Lodge – RACP
(geriatrician), Vic

Dr Kathy McDonald – RNZGP, NZ

Professor Michael Cox – RACS, NSW

Time for new approach to caesarean births



Caesarean section surgery and obstetric anaesthesia are often omitted from the key areas of research and implementation of surgical outcomes and endpoints for surgery and anaesthesia. Rarely is this surgery and anaesthesia included in the evolving field of perioperative medicine.

Caesarean section surgery is one of the most common surgeries performed in low- to middle-income countries each year³.

In 2015, the *Lancet* Commission on Global Surgery 2030 classified caesarean section surgery as a bellwether operation meaning that it is an essential surgical operation that needs to be able to be performed in all hospitals^{4,5}. As part of equity and reducing maternal mortality and morbidity, access to safe obstetric surgery and obstetric anaesthesia has now been acknowledged as part of universal health coverage and the Sustainable Development Goal 3⁶.

In Australia and New Zealand caesarean section surgery is a common operation with nearly 115,000 young women undergoing this surgery each year⁷. Maternal mortality is low in Australia and New Zealand and pregnancy morbidity is comparatively low^{8,9}. These low mortality and morbidity figures are fundamentally due to robust healthcare systems that facilitate universal access to high quality obstetric surgery and obstetric anaesthesia.

Despite the substantial numbers of young women undergoing this essential surgery and anaesthesia, caesarean



section surgery and obstetric anaesthesia are often omitted from the key areas of research and implementation of surgical outcomes and endpoints for surgery and anaesthesia. Rarely is this surgery and anaesthesia included in the evolving field of perioperative medicine¹⁰.

ANZCA defines perioperative medicine as “the multidisciplinary, integrated care of patients from the moment surgery is contemplated through to recovery.” Perioperative medicine is already widely applied in the areas of colorectal, urological, hepatobiliary and gynaecological surgery¹¹. In the context of young women considering pregnancy, where caesarean section surgical rates are approaching 30 per cent, what does perioperative medicine mean for them? Have we as a specialty disregarded or simply forgotten obstetric surgery and obstetric anaesthesia when we consider perioperative medicine? The omission of obstetric surgery and obstetric anaesthesia from perioperative medicine disadvantages pregnant women and their babies, and eventually, if not addressed, will leave these two important, and already marginalised populations, behind once again.

The PARRCEL Approach recently published in the article “Sex, suffering and silence – why peri-operative medicine must prioritise pregnant women”¹¹

raised the issue of the importance of perioperative medicine in pregnant women and this approach has already been incorporated into the perioperative medicine courses in Australia and the UK. The PARRCEL Approach focusses on Pre-conception counselling; Antenatal care; Risk stratification and modification; Resuscitation; Collaborative decision making; Enhanced recovery and rehabilitation; and Linkage to community support networks, thereby creating a framework for thinking about perioperative medicine in this population¹¹.

One important difference between perioperative medicine in other surgical areas and perioperative medicine in obstetric surgery is the issue of enhanced recovery after surgery (ERAS). In other areas of surgery this is often synonymous with “early discharge” after surgery. This should not be the case in obstetric surgery.

With significant rates of postnatal depression, low sustained breastfeeding rates, often poor community support, disconnected family supports and sometimes overwhelming pressures on young women, the concept of further reducing hospital length of stay in young women after major surgery needs to be seriously reconsidered.

(continued next page)

Time for new approach to caesarean births (continued)

The issue of early, rapid, or day one discharge from hospital after significant abdominal surgery should not be the aim and instead patient centred outcomes should be considered even for women having elective repeat caesarean section surgery.

For women having their first baby in an emergency setting, with little if any antenatal education about caesarean section surgery and obstetric anaesthesia, this is even more important. Furthermore, until we seriously address the issue of perioperative anaemia in pregnant women, and define the post-hospital based adverse outcomes of postoperative anaemia in young women we may be missing significant opportunities for interventions in the preoperative (antenatal) period. Enhanced recovery after obstetric surgery must consider the issue that increased, rather than shortened, lengths of stay may be overall more beneficial to women, their babies and the community. This a challenging paradigm shifting concept at all levels¹².

The PARRCEL Approach also raises the important issue of the naming of surgery. The shift over time of referring to moderate to high risk surgery (obstetric surgery) as “caesarean section” or the more contemporary term of “caesarean birth” may be falsely reassuring to consumers, and their advocates, and does not ultimately serve to advance the care of pregnant women¹³. The naming of serious surgery as “birth” leads to an underestimation of the risks associated with surgery and importantly an undervaluing of the contributions made by surgeons (obstetricians) and specialised anaesthetists (obstetric anaesthetists) to the excellent maternal and neonatal outcomes for women who undergo this surgery in Australia and New Zealand.

Further marginalisation from mainstream medicine occurs with the assumption that pregnant women’s biological issues are fundamentally different from other adults leading to a reduction in timely access to essential non-obstetric services.

The incorrect assumptions and normalisation of pathology resulting in comments such as “all will be fixed once the woman gives birth” or “the woman doesn’t look that sick therefore we will prioritise her below other patients” suggests a fundamental misunderstanding of contemporary pathophysiology. It also underestimates

the lifelong effects of substandard and separated medical care (non-collaborative) during and immediately after pregnancy that women and their babies may suffer due to ongoing marginalisation.

Embracing the concept of multidisciplinary care requires us to break down the metaphorical and sometimes actual physical barriers and hierarchies that exist between the medical specialities and within anaesthesia itself. Collaborations that put patients at the centre of care without professional arrogance that comes from the belief that one’s speciality or subspecialty is greater than another’s, serves to foster professional respect and understanding, which ultimately leads to better patient care and improved outcomes for pregnant women and their babies.

In 2019, with our obstetric colleagues, as leaders in the safe care of pregnant women in Australia and New Zealand, obstetricians and anaesthetists must embrace the success we have created – a safe environment in which women and their support team can experience the birth of a baby. As a collaborative team we need to change the view that obstetric surgery is somehow a lesser mode of birth or a lesser form of surgery. We must also ensure that the clinical advances that are occurring in perioperative medicine are routinely embedded into the care of pregnant women¹⁰.

As fellows of ANZCA, as national and international leaders in anaesthesia, pain medicine and perioperative medicine, we must also accept the inevitable and luxurious position that societies with low maternal mortality and morbidity can have – that nothing can ever go wrong. Our role is to respect and educate those who should know better, those who have forgotten, and those who have never known what the world looks like without essential obstetric surgery and obstetric anaesthesia, and obstetric perioperative medicine¹⁴.

Associate Professor Alicia Dennis,
FANZCA

NHMRC Fellow

Department of Anaesthesia, Royal Women’s Hospital and the Departments of Pharmacology, Obstetrics and Gynaecology, and Radiology and Medicine, University of Melbourne
Staff Specialist Anaesthetist, Director of Anaesthesia Research

“As a collaborative team we need to change the view that obstetric surgery is somehow a lesser mode of birth or a lesser form of surgery.”

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ANZCA'S NEW HEALTH EQUITY PROJECTS FUND HELPS DRIVE CHANGE IN PAPUA NEW GUINEA

A unique collaboration between ANZCA and Adelaide Health Simulation gave PNG anaesthetist Dr Pauline Wake the opportunity to introduce a series of workshops to final year medical students and anaesthesia registrars in Port Moresby.



When paediatric anaesthetist Dr Pauline Wake spent several months in Australia as a recipient of the ANZCA International Scholarship she was introduced to simulation training as a way of teaching the speciality.

As part of her 2018/2019 scholarship Dr Wake spent five months at Westmead Children's Hospital in Sydney and another three months at the Women's and Children's Hospital in Adelaide.

While living in Adelaide, and after her own experience with simulation there, Dr Wake started thinking about how the simulation model could easily be transferred to the University of PNG's School of Medicine and Health Sciences where she is head of training for anaesthesia.

With support from ANZCA, Adelaide fellows Dr Yasmin Endlich and Dr Chris Acott and Adelaide Health Simulation director Adam Montagu, Dr Wake helped organise a series of basic and advanced life support, airway management, neonatal resuscitation and ultrasound technique simulation workshops in Port Moresby as part of the Medical Society of PNG's 55th Medical Symposium and the Society of Anaesthetists of PNG's annual meeting.

The life support workshops for 30 final year PNG medical students, who also participated in an Essential Pain Management (EPM) Lite course led by PNG anaesthetist Dr Gertrude Marun and Adelaide anaesthetist Dr Johanna Somfleth, featured instructor Adelaide emergency doctor Dr Fern McAllan. The medical student programs were funded by a Flinders University Student Critical Care Society fundraiser. An all day EPM course was also held for PNG clinicians and nurses.

The workshop program was initiated by Dr Endlich, a member of the ANZCA Overseas Aid Committee, through the college's inaugural Health Equity Projects Fund. Dr Endlich, Dr Acott and Dr Somfleth helped run the workshops with Dr Gilberto Arenas, a Royal Adelaide Hospital consultant anaesthetist, Angeliki Marinakis, an anaesthetic nurse at the Women's and Children's Hospital and South Australian Ambulance Service paramedic Bethany Overweel.

Adelaide Health Simulation donated two portable iSimulate machines and five obstetric mannequins while another iSimulate had previously been donated by ANZCA to the medical school. Companies and organisations that donated equipment to the PNG workshops and clinicians include consumables collected from the Women's and Children's Hospital Adelaide nursing staff, Rotary Donations in Kind, Beckton Dickinson (BD) and Karl Storz. SonoSite also provided a demonstration of ultrasound screening for students.

Dr Wake now plans to build on her Australian experience to drive a five-year vision to develop a structured education program with a simulation component for the PNG medical school's students.

PNG is facing a significant challenge in the resourcing of medical and allied health workers. With one of the highest mortality rates in the Pacific region, the country has less than 50 anaesthetists for a population of eight million people and Dr Wake and other local PNG anaesthetists believe quality training of medical human resources is key to expanding the anaesthesia workforce.

(continued next page)

“What we learnt here has given us a much better understanding of what to do in a crisis and knowing what to do to give the best outcome to the patient.”

Above from left: Final year PNG medical students participating in a basic life support simulation in Port Moresby; anaesthetist Dr Gilberto Arenas demonstrates ultrasound equipment; ANZCA President Dr Rod Mitchell with fellow Dr Yasmin Endlich, PNG anaesthetist Dr Gertrude Marun and fellow Dr Chris Acott.

Photography: Rocky Roe and Carolyn Jones.

ANZCA'S NEW HEALTH EQUITY PROJECTS FUND HELPS DRIVE CHANGE IN PAPUA NEW GUINEA (CONTINUED)



Thirteen anaesthesia trainees are now enrolled in the Masters of Medicine (MMED) at the university.

Dr Wake believes anaesthesia training in PNG will benefit from a structured training program that includes simulation and a commitment to mentoring. She also hopes to introduce a weekly simulation program at Port Moresby Hospital for the anaesthesia department staff as both a learning and team building exercise.

“After seeing the simulation centre training when I was in Adelaide I realised how useful this approach would be here in PNG. The simulation method really engages students and gives them that interaction and understanding of how to manage a crisis,” she told the *ANZCA Bulletin* in Port Moresby recently.

“It also helps the students to understand the importance of working together in a team. I became interested in simulation as a teaching technique when I first started teaching at the university five years ago. The medical school in PNG had never had the opportunity to see a real simulation course so when I was in Adelaide I was very excited and interested to see how it would work.

“It’s about mentoring and teaching the students to be good doctors who can recognise a crisis and resuscitation techniques.”

When Dr Wake first started teaching at the university in 2014 she surveyed the medical students about their interest in pursuing specialty training.

“Their main reason for choosing a particular specialty was mentoring followed by role models and a structured training pathway. What I learnt from this was that we need to empower these students by building a structured program for trainees and also supervisors so they can then train others. I hope that this model could then be extended to other disciplines here in PNG.”

Dr Wake is hopeful that a structured pain education program can also be embedded in the anaesthesia curriculum. Her vision also includes the country’s anaesthetic service officers (ASOs). She wants them to be trained in basic research gathering so they can collect data in rural areas that can then be used to present a case to the government for improved health program and infrastructure funding.

ANZCA President Dr Rod Mitchell, a keynote speaker at the symposium, identified a series of measures that would help strengthen the specialty in PNG. These included raising the profile of the specialty to encourage more medical students to consider anaesthesia as a career, improve advocacy to government, encourage mentoring within the specialty and consider the development of a local continuing professional development (CPD) program. The ongoing partnership with ANZCA would also ensure that PNG anaesthetists continued their involvement with the college through the Overseas Aid Committee. Local PNG anaesthetist Dr Nora Dai was recently appointed to the committee.



Dr Endlich said ANZCA initiatives such as the new Health Equity Projects Fund, a grant established to support activities of the college's Overseas Aid Committee and Indigenous Health Committee, would benefit anaesthesia programs in countries such as PNG, Australia and New Zealand to help develop the anaesthesia workforce. The fund is open to all ANZCA and FPM fellows.

"It helps to be able to identify gaps in the country that you can see. Here in PNG for instance basic and advanced life support isn't really taught and even though PNG has one of the highest incidence of oral cancers in the world there is no simulation ultrasound or airway training for anaesthetic service officers. I hope this new fund will encourage other ANZCA fellows to consider what they can do to improve and expand anaesthesia training," she explained.

For final year medical student Malachi Liko the simulation workshops gave him the opportunity to see first-hand how to manage hospital and patient scenarios.

"In our third and fourth year we're taught basic life support but not as a simulation. What we learnt here has given us a much better understanding of what to do in a crisis and knowing what to do to give the best outcome to the patient. If this could be incorporated into our medical curriculum earlier on in our degree that would be of enormous benefit."

Dr Michelle Masta, an anaesthetic registrar at Port Moresby Hospital, also welcomed the simulation workshops as providing a much needed education and training initiative.

"This is something we don't have a lot of access to so being able to access these workshops has helped me further develop my basic life skills training," she said.

"It would be useful if we can incorporate these simulation techniques into our clinical scenarios."

Adelaide Health Simulation instructor Dr McAllan emphasised to the students that it was important to maintain control as a leader during the patient scenarios as they learnt about how to assess circulation, airways and blood sugar levels.

"Delegation of roles is really important," she explained.

"Ensuring all involved are capable, competent and current is crucial when asking team members if they can assist. It's also important that you learn how to interrupt in an appropriate manner if you need to and not be scared about delegating jobs to others in the team."

**More information about the ANZCA Health Equity Projects Fund can be found on the community development page of the ANZCA website.*

Carolyn Jones
Media Manager, ANZCA

"The simulation method really engages students and gives them that interaction and understanding of how to manage a crisis."

Opposite, above left: Participants in the PNG EPM program with their certificates; PNG anaesthetist Dr Pauline Wake (centre) with colleagues. Below from left: Dr Johanna Somfleth in an EPM Lite workshop; PNG's Australian workshop team Bethany Overweel, Dr Yasmin Endlich, Dr Rod Mitchell, Dr Chris Acott, Angeliki Marinakis, Dr Johanna Somfleth and Dr Gilberto Arenas; Adelaide Health Simulation's Dr Fern McAllan leads a life support workshop.



ANZCA'S NEW HEALTH EQUITY PROJECTS FUND HELPS DRIVE CHANGE IN PAPUA NEW GUINEA (CONTINUED)

ANZCA and RACS join forces in PNG



For the first time, ANZCA and the Royal Australasian College of Surgeons (RACS) had a joint presence at the Medical Society of Papua New Guinea's annual medical symposium with a combined booth to promote their respective specialties.

ANZCA Policy Officer Kate Davis (above left) and RACS Senior Program Officer Gwyn Low (above right) managed the joint booth throughout the 2019 symposium in Port Moresby which attracted a record 500 local and international delegates. The booth was a popular destination for PNG medical students and practising clinicians interested in discovering more about how anaesthesia and surgery is practised in Australia and New Zealand.

The theme of this year's conference, which was formally opened by PNG Prime Minister James Marape (above, far right with ANZCA President Dr Rod Mitchell) was "Health Education" and focused on the medical workforce in PNG. With the country facing a significant challenge in health and medical resourcing the symposium drew on a range of speakers and presenters to examine the issue.

Dr Mitchell was joined by Royal Australian and New Zealand College of Gynaecologists President Dr Vijay Roach, Australasian College for Emergency Medicine President

Dr Simon Judkins and RACS past president Professor David Watters for a combined keynote session that examined the role of the Australian and New Zealand colleges in post graduate education in PNG and the Pacific.

Dr Mitchell highlighted the importance of collaboration between ANZCA and PNG anaesthetists, building an ethos of lifelong learning for anaesthetists in PNG, stressing the importance of a healthy workforce and developing stronger advocacy networks to government to raise the profile of the specialty in the country.

Medical Society President Professor Nakapi Tefuarani opened the symposium by outlining the medical workforce challenges now facing PNG. In 2018 the country had 0.97 per cent health professionals per 1000 people compared to the World Health Organization's guideline of 4.45 per cent of health professionals per 1000 people.

The critical shortage of medical human resources in the country is compounded by inadequate building infrastructure and difficulty in attracting and retaining medical faculty staff to teach at the university with limited salary and housing opportunities.



ANZCA awards for PNG anaesthetists

Three PNG anaesthetists were awarded ANZCA prizes at this year's Society of Anaesthetists of Papua New Guinea's annual meeting.

ANZCA President Dr Rod Mitchell presented the certificates and the medal for the Garry Phillips prize at a ceremony in Port Moresby.

Dr Joyce Lawrence (left, with Dr Mitchell) accepted her prize for the best overall performance in the Diploma of Anaesthesia to go into the Masters of Medicine (MMED) program.

Brendan Korowaro received the award for the best overall performance in the anaesthesia module of the School of Medicine and Health Sciences of the University of Papua New Guinea. PNG anaesthetist Dr Elizabeth Inaido accepted the award on Mr Korowaro's behalf.

The Garry Phillips prize, named after a former ANZCA president, was awarded to Dr Lyanne Painap. Dr Lui Apolos accepted the medal for Dr Painap who was unable to attend the presentation.

Indigenous Australians to benefit from pilot pain program



ANZCA and FPM fellows and trainees are trialling a new program aimed at improving health outcomes for Indigenous patients experiencing pain, thanks to support project funding provided through the Australian government Specialist Training Program.

Being taught how to treat pain was not a strong feature of Dr Phillip Kriel's medical training in South Africa, where he started out as a GP.

"I don't know what your medical school training was like, but from 1986 to 1995 I had none in pain – except that 'pain is the most common presenting complaint', and 'babies don't feel pain'," Dr Kriel told a diverse group of healthcare workers undertaking the Essential Pain Management (EPM) Lite program at WA's Joondalup Health Campus in early September.

But since then, after working as a GP and GP anaesthetist, and doing his anaesthesia training in New Zealand, Dr Kriel is now a specialist pain medicine physician, and he finds EPM a good way of having a positive impact on communities that really need help in managing patients in pain.

EPM was first delivered in Papua New Guinea in 2010 and has since spread quickly through the Pacific and across Asia, Africa and the Americas. Workshops have been run in more than 50 countries and there are hundreds of EPM instructors worldwide.

Now, the Australian government through its Specialist Training Program (STP) support project funding has enabled EPM to be taught in Australia, where STP trainees take part in the EPM program and then teach pain management to health workers in Aboriginal medical services. This project also aims to improve the quality of the future specialist workforce by providing registrars with exposure to a broader range of healthcare settings and training experiences.

ANZCA has been working with the National Aboriginal Community Controlled Health Organisation (NACCHO) to co-ordinate the pilot program which supports the development of pain medicine education programs for Indigenous health practitioners and allied staff. There are 23 Aboriginal Community Controlled Health Services (ACCHSs) in WA.

It is hoped that better management of pain conditions in Indigenous populations will contribute to improved health outcomes for Aboriginal and Torres Strait Islander patients.

The pilot project has so far been run in STP training sites in Townsville, Darwin and now Joondalup in WA.

EPM has two parts, usually run over one-and-a-half days (EPM Lite is a modified, shorter version of this program). The first day is an interactive workshop that teaches a system for "recognising, assessing and treating" pain, known as RAT, and addresses pain management barriers. The second part is an instructor workshop, designed to provide the knowledge and skills to become an EPM instructor. Later the new instructors will run EPM courses.

The program encourages early handover to local instructors so that local solutions can be found for local issues.

"This is a way for us to teach the concepts of pain management to people who know the community well and forge stronger links between Indigenous and non-Indigenous healthcare professionals," said Dr Kriel.

At the Joondalup workshop, Dr Kriel and ANZCA fellow Dr Nathan James discussed the RAT system with a group that included trainee anaesthetists and GPs, rural GPs, nurses, physiotherapists and medical students.

They were encouraged to speak openly about their own experiences as medical practitioners and health workers as the first step to exploring pain management for Indigenous and non-Indigenous patients. A number of participants were then encouraged to present to the group.

In November, participants turned new instructors, will run a workshop with the South West Aboriginal Medical Service in Bunbury.

EPM was created by Perth pain specialist Associate Professor Roger Goucke and Dr Wayne Morriss from New Zealand.

First year ANZCA trainee, Dr Hamish Johnston, said the course had been valuable and the broad representation of healthcare workers had provided good insights.

"It was clear and concise. A lot of it was reinforcing what we have been learning through training," he said, adding the course would be extremely useful for rural GP trainees. "This would be absolutely perfect for that."

Angela Libby, a nurse at Joondalup, said the course had been very useful.

"Nurses often spend more time with patients so this will help us in extracting a bit more information," she said. "Often patients say what they think the doctor wants to hear. We wear different hats as nurses. The RAT model helps us refocus on what we're looking at as a whole."

For more information on Essential Pain Management, please go to <http://fpm.anzca.edu.au/fellows/essential-pain-management>.

Above: Undergoing an EPM Lite program at Joondalup Health Campus was a group of trainee anaesthetists and GPs, rural GPs, nurses, physiotherapists and medical students.

Royal honour for fellow



Above from top: Dr Rod Green receives the Royal Order of the Crown from HM King Tupou VI; Members of the Royal Order of the Crown (from left) Dr Rod Green, Graham Hextall, Dr Geoffrey Rosenberg and Dr Mark Ridhalgh.

Dr Rod Green has spent the past 14 years visiting Tonga as part of a volunteer medical team.

NSW fellow, consultant specialist anaesthetist Dr Rod Green, has been honoured by the King of Tonga for his humanitarian work with Orthopaedic Outreach, a non-profit organisation that supports surgery in the South Pacific.

Dr Green was honoured at a ceremony at the Royal Palace in the Tongan capital Nuku'alofa in June with other volunteer specialists, consultant orthopaedic specialist surgeons Dr Mark Ridhalgh and Dr Geoffrey Rosenberg and chief operational manager of Orthopaedic Outreach, Sydney, Graham Hextell.

The charity has provided free specialist surgical care for Tongans for the past 14 years and Dr Green has played a key role as part of the surgical volunteer team.

The team was invested with the Royal Order of the Crown by HM King Tupou VI for their significant charitable work in Tonga.

Dr Green has had 23 volunteer visits since 2005 with Orthopaedic Outreach and in locum roles and has also actively contributed to the safe and efficient delivery of anaesthesia for orthopaedic surgery in Fiji, Kiribati, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu.

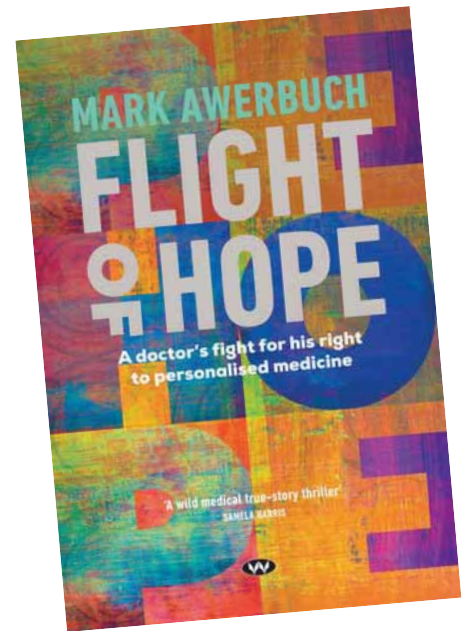
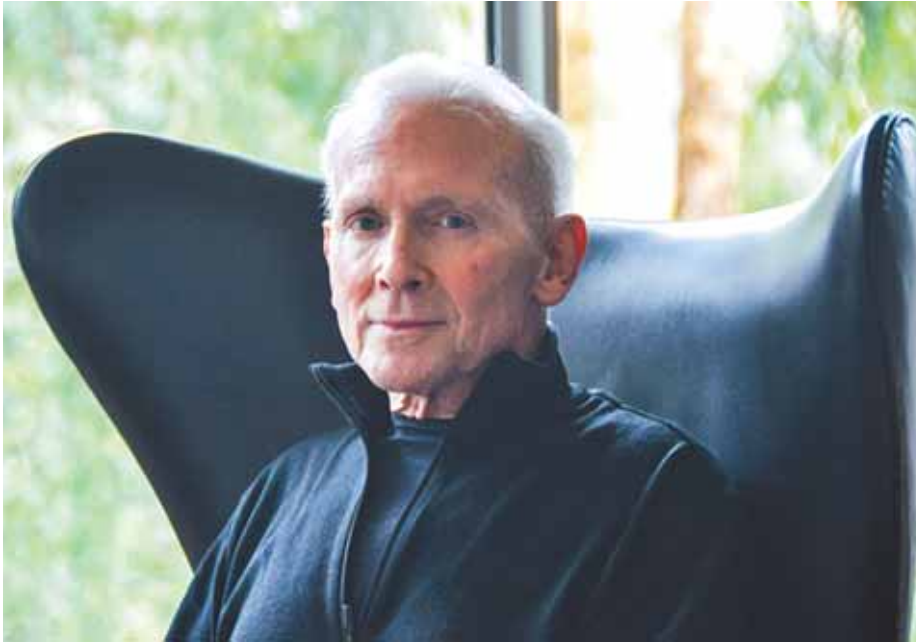
In 2017 the Australian Orthopaedic Association awarded Dr Green Honorary Fellowship (FAOrthA), in recognition of his contributions to Orthopaedic Outreach.

His long association with Tonga started in the early 1980s when he spent an elective term as a medical student there. But it wasn't until his children had grown up that he thought about returning. An orthopaedic surgeon who was making regular volunteer visits to Tonga encouraged him to join the Orthopaedic Outreach team in 2005.

Dr Green not only visits once or twice a year as part of the volunteer team which operates out of the Vaiola Hospital in Nuku'alofa but he also organises the sourcing and transport of donated anaesthetic equipment from Australia with the support of private hospitals and medical technology companies.

He said he was humbled to have received the accolade alongside his surgical peers.

Flight of hope into the unknown



Five years ago FPM fellow Dr Mark Awerbuch refused to accept a terminal diagnosis of acute T-cell lymphoblastic leukaemia and invasive fungal lung disease. In an exclusive article for the *ANZCA Bulletin* based on his new book *Flight of Hope* he describes how his quest for treatment led him to Israel where he was given a bone marrow transplant at a cost of nearly \$A400,000.

Change. It's what makes life so interesting. Especially if it's for the better. But as we all know, life can be capricious. And so it was for me.

February 27 2014. I'm diagnosed with acute T-cell lymphoblastic leukaemia. In my case it's triggered by the rare BCR-FGFR1 fusion gene, first discovered in 2001. By 2013 there are a total of 12 reported people with this mutation, resulting in CML, AML and ALL (three with acute B-cell lymphoblastic leukaemia, one with acute T-cell lymphoblastic leukaemia). It appears I'm only the second case of T-cell ALL

resulting from this mutation. Unlike a work of art where rarity is highly prized, owning a rare medical disorder invariably turns out to be a poor investment. You may never get your life back.

Four days later I'm a hospital in-patient receiving high-dose chemotherapy. After 33 years I've had to close my practice in rheumatology and pain medicine. I'm 66 years old but it's not how I feel biologically.

A bone marrow biopsy shows the chemotherapy has been ineffective.

In August 2014 my haematologist refers me to The Royal Adelaide Hospital. I'm seen by two haematologists over a few weeks, before being told there's to be a meeting of all hospital haematologists to discuss my bone marrow worthiness. I find this strange. Why should haematologists who've not met me or examined me, have a say in what is for me a life-or-death decision? The two haematologists who have seen me indicate they will advocate on my behalf, so I'm not overly concerned. My siblings are not a full HLA match but a matched unrelated donor has been identified on the international bone marrow transplant register. I can't imagine the RAH haematologists denying a medical colleague a potentially life-saving transplantation, especially since there is

no other available option. But I've been wrong before. And I am again.

The reasons I'm given are T-cell ALL in someone of my age and with my mutation has a poor prognosis, and I'm diagnosed with invasive fungal lung disease based on a Galactomannan assay of questionable reliability, in the absence of confirmatory CT or microscopic changes or indeed suggestive symptoms. The RAH decision is irrevocable. That's the thing about bad news. It has the unfortunate habit of turning up when you least expect it, making it twice as bad.

I seek further opinions interstate. The consensus is I'm suitable only for palliative care.

By September 2014 my condition is deteriorating rapidly. My fatigue is intractable, my lymph nodes are now golf ball size and the blast count in my peripheral blood and bone marrow is high. I know I do not have long to live.

I have no treatment options remaining in Australia, but I do have an insistent friend, Brett who pushes me to go to Israel for treatment because while holidaying in the US he'd met a stranger on a plane who'd told him about a haematologist, Professor Slavin in Tel Aviv whom he believed might be able to help me. What you'd describe as hearsay. I'm sceptical, even more so by Slavin's self-promoting website with what I consider distasteful

patient testimonials. I'm advised by email that if I want to be treated I must pay in advance \$A390,000.

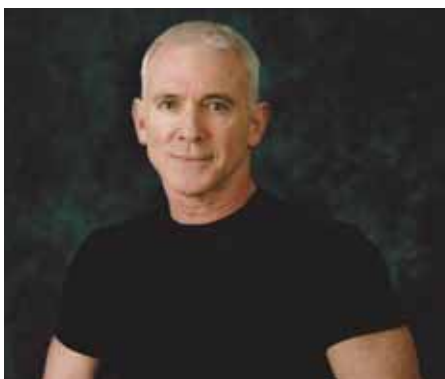
My wife Jill and I meet with Brett at our home. Am I really entitled to spend so much money on myself when the Australian experts have told me my case is hopeless? How will this impact my family's future? I'm seriously conflicted. More so after Slavin emails me he's in Europe and won't be in Israel until mid-October. He directs me to Professor Reuven Or at Hadassah Hospital, a public hospital in Jerusalem, 70 kilometres from Tel Aviv. Brett believes I have no option but to go. "Doc you must go and I'll come with you."

Two weeks later I'm lying in bed in the bone marrow transplant ward at Hadassah Hospital. My doctors decide that despite my age I'm physically fit for transplantation and most assuredly do not have invasive fungal lung disease, the putative diagnosis of which in Australia was deemed a significant contraindication for transplantation. I am to have a haploidentical (half-matched) transplant using a reduced-intensity conditioning program. My sister who lives in South Africa is the best donor match.

Professor Slavin visits me a few days before my transplant in October 2014. He spends 15 minutes with me. I never see him again. I return to Australia less than three months later.

It's now July 2019. I have not had a recurrence of my T-cell ALL, which raises a number of questions.

Why was it necessary to leave Australia for treatment which was available here?



Why was I never told of a 2011 study in Leukaemia Research describing a patient with acute T-cell ALL and the identical gene mutation, who'd had a successful transplant?

Why were the tenets of personalised medicine, a contemporary holistic approach to healthcare evaluating psychological and physical resilience, overlooked? Likewise, the Guidelines of the American Society for Blood and Marrow Transplantation.

Why was I not told that since 2008 Westmead Hospital in Sydney had successfully been performing haploidentical transplants in older patients with T-cell ALL, using a protocol virtually identical to that which I'd had in Israel, publishing its evidence in 2013 in the *Internal Medicine Journal*? Something I only discovered in 2019.

My journey through the leukaemia maelstrom has been as self-revelatory as instructive. I discover the inherent

"I seek further opinions interstate. The consensus is I'm suitable only for palliative care."

deficiencies in medical empathy training, but remain uncertain whether it's even teachable.

In theory personalised medicine should produce better patient outcomes. The corollary is that one-size-fits all medicine is less likely to result in favourable outcomes.

The IASP binary definition of pain becomes a stark reality. Bone pain, which I experienced, was no less challenging than the emotional turmoil of recalibrating my concept of self. Fortunately we are not wired to re-experience pain or emotional turmoil. We can describe it, but this is declarative memory, very different from the immediacy of the experience. A difference if you like between our "remembering self" and our "experiencing self".

The complexity of medicine means decision making is as fraught for doctors as for patients. Misjudgements are inevitable, but we should remember, their consequences are never equally shared.

**Flight of Hope (Wakefield Press) is now available from booksellers.*

Opposite page: Dr Mark Awerbuch in July this year.

This page: Dr Awerbuch before his diagnosis.

How Christchurch Hospital gave a lifeline to mass casualty trauma patients



On March 15, 2019, a gunman walked into two Christchurch mosques and opened fire. The shootings would leave 51 people dead and 49 injured. Within minutes of the first shots being fired, two of the victims had run across a park to Christchurch Hospital. It was the first warning staff had of what was to come.

The first attack at Al Noor Mosque began at 1.40pm. The shooter then drove to Linwood Islamic Centre where he began shooting at 1.52pm. The Al Noor Mosque is 1.2 kilometres from Christchurch Hospital. Forty-nine people died at the scene of the attacks. Forty-seven patients aged between two and 69 presented to the emergency department (ED).

Dr Ashley Padayachee is the Clinical Director of the Department of Anaesthesia at Christchurch Hospital. He compiled the following account with ANZCA's New Zealand Communications Manager Adele Broadbent.

"I remember going into the theatre (later) where a young girl was being operated on by four surgeons with a vascular surgeon trying desperately to stop the bleeding from an iliac vessel. I remember thinking that she looked a lot like a friend of my son's."

Dr Padayachee had been alerted to the shootings by his service manager and this young girl was to be the first of the victims he saw as he reached the operating theatres (OTs). She was being wheeled into OT with the paediatric surgeon doing cardiopulmonary resuscitation on her.

Minutes earlier, the duty anaesthetist (DA) received a trauma call on his pager. As he was heading down to ED, he was told it was a mass casualty event rather than an isolated trauma. He was immediately confronted in ED by two walking wounded patients who had alerted staff to expect many more patients. Again it was just minutes before the first of the very seriously injured patients arrived, requiring immediate intubation by the DA.

The DA had a decision to make – either stay in ED and help or go back to theatre to co-ordinate theatre resources. He decided first to go back to OT to initiate the theatre response before returning to ED to co-ordinate anaesthetic involvement. All afternoon surgeries were cancelled to ensure availability of theatres. The DA put out the call for staff, anaesthetists and technicians to head to ED as soon as they became available.

Meanwhile Dr Padayachee had headed for ED.

"When I reached ED there were multiple victims. I heard someone say there had been a second shooting and I could see there were police at the doors with large guns," he says. "At some stage the word went out that the gunman was outside the hospital although this proved later to be a false alarm," he says. "While it was unsettling, we had to focus on the task of ensuring we had sufficient resources to deal with the massacre victims. The DA stayed down in ED and I went up to co-ordinate the theatre response."

"What was remarkable in ED was the sense of calm, both from the trauma teams as well as the victims. It was as if the magnitude of the horror was understood by all."

Over the next two hours the DA and the trauma surgeons communicated directly with Dr Padayachee who was co-ordinating theatre. "We set up the Post Anaesthesia Care Unit (PACU) as a secondary triage area for those patients returning from CT scans and ED. Available doctors from around the hospital helped with the secondary survey."

"The trauma teams in ED were decisive on the management of the critically injured patients, sending them straight to theatre or for imaging prior to OT. They communicated well with the OT co-ordinator on what surgery was required – vascular, laparotomy or thoracotomy. At one stage we had three cardiac surgeons performing thoracotomies in three different theatres."

“What was remarkable in the emergency department was the sense of calm, both from the trauma teams as well as the victims. It was as if the magnitude of the horror was understood by all.”



The teams regrouped at various stages over the next 48 hours to decide what resources were required, which patients required surgery and what needed to be done. Those types of meetings occurred regularly over the next week.

Mass casualty – earthquakes versus shootings

For a department that had been through two major trauma events in the September 2010 and February 2011 Christchurch earthquakes, March 15 was a different experience.

Dr Padayachee explains:

“Our personal safety was not under threat. The world around us was not shaking and we felt safe to continue with our work. Hospital and schools were in lockdown so we knew our children were safe.”

And there were other differences.

- Forty-one critically injured patients arrived in the emergency department in the first hour. The Al Noor mosque was 1.2 kilometres away so the decision to “scoop and run” was made. This allowed patients to get medical intervention in a timely fashion.
- The earthquake victims were mainly crush victims more aligned to multi-trauma that we see with road traffic accidents whereas the mosque attacks were all shooting victims, some of them with multiple gunshot wounds.
- The shootings occurred just after lunchtime. This meant the afternoon lists that were about to start were cancelled, so 14 out of the 16 OTs were available in the first hour.

- Christchurch Hospital is a single site institution, where ALL specialties are available in the one hospital.
- Most of the staff, as medical professionals, had been involved in trauma management following the earthquakes and were therefore experienced in mass casualty management.
- Hospital management empowered senior clinicians to make the necessary decisions and made all resources available to support staff and the work required.

Welfare – a priority

Dr Padayachee says they were also fortunate to have the department welfare officers on duty on the day of the shooting. With the service manager, they made an active plan to provide immediate and ongoing support for staff.

“We started talking about the welfare of our staff early in the piece. Emotions were still raw and it was difficult for individuals to talk about the event and their experiences,” he says. “There were dedicated continuing medical education sessions over the weeks following the shootings to encourage staff to talk about their experiences.

“We knew that the entire anaesthetic community was behind us.”

Dr Padayachee has never been prouder of his staff’s “complete professionalism” on March 15 and the weeks that followed.

“The universal support was also humbling. We were overwhelmed with offers of anaesthetists willing to come to Christchurch to help. Thank you to all those who reached out to us. We deeply appreciated your offers of support. We knew that the entire anaesthetic community was behind us.”

“On behalf of the Christchurch Anaesthetic Department, we remember the victims and the families deeply affected by the shooting.

Our hearts and prayers go out to them. We are one.”



Trauma timeline

The first two patients presented to Christchurch ED at 1.55pm. They ran the 1.2 kilometres from the Al Noor Mosque to the ED. They had minor injuries and warned staff that more patients were to follow. Many more.

A “trauma call” was declared and the duty anaesthetist as well as staff from the intensive care unit (ICU), and surgery presented to ED on the ground floor to assess. Multiple severely injured patients began arriving. The duty anaesthetist went back upstairs to the first floor to facilitate making theatres available immediately before returning to ED. Several theatres were immediately available as the afternoon lists that were about to start were cancelled. Two long elective surgery cases continued unhindered during the event.

Along with ED, ICU and surgeons, anaesthetists and technicians were involved in the initial assessment and treatment of patients in ED, and were able to maintain continuity of care for patients from ED to theatre.

Of the 47 patients that presented to ED, 16 patients required surgical input before midnight. One patient required more than one theatre event during this time. Surgical patients were triaged into three categories: life threatening, limb threatening and soft tissue exploration.

By midnight, a total of six laparotomies, two thoracotomies, two combined laparotomy/thoracotomies, one vascular reconstruction, two fracture fixations and six soft tissue exploration/debridements were conducted.

(continued next page)

Trauma timeline (continued)

The massive transfusion protocol was running concurrently for nine patients in ED and theatre. Blood products were sourced from Christchurch and additional resources were mobilised from Auckland, Wellington and Hamilton. On the first night 179 red cell units, 17 platelets, 113 fresh frozen plasma (FFP) units and 46 cryoprecipitate units were used.

Twelve acute theatres were utilised initially. Five theatres were running until just after midnight, and three theatres until early the next morning. The following day a further 21 procedures were conducted. Seven of these were “re-look” procedures.

Thirteen of the 47 patients were admitted to ICU for ongoing ventilatory and haemodynamic support. Twelve of these patients required surgical intervention in theatre.

Of the 47 patients that presented to ED, one patient died in ED due to unsurvivable injuries and one patient died 48 days later.

With input from Dr Charlie Richards, FANZCA, Anaesthetic Trauma Fellow



Christchurch Hospital is a 500-bed tertiary level hospital. The Emergency Department has 52 beds. The operating theatre, radiology department and ICU are directly above.

There are 16 operating theatres, two interventional radiology suites, and two CT scanners. All surgical specialties including cardiothoracic are available at the one facility. The ICU has capacity for 24 ventilated patients.

The Anaesthetic Department at Christchurch Hospital employs 71 consultant anaesthetists, six anaesthetic fellows and more than 30 registrars and senior house officers.

Reverse swing helping to strike out stroke

Ballarat anaesthetist Dr Sanjay Sharma is spearheading a local campaign to reduce the incidence of stroke in the community.

It wasn't until Dr Sanjay Sharma's mother Vijay suffered a stroke while visiting her son and his family in the regional Victorian town of Ballarat last year that he understood how real the risk of stroke can be.

Dr Sharma, deputy director of the Department of Anaesthesia at Ballarat Base Hospital is one of the local faces of the Australian Strike Out Stroke campaign in the large regional centre, 100 kilometres north west of Melbourne.

A few weeks after arriving in Ballarat from her New Delhi home to stay with her son and his family Vijay, 76, had gone to bed at her usual time. It was only when she didn't get up the following morning that her family realised something was wrong. She had a stroke while she slept and spent four months in rehabilitation in Ballarat before returning to India where she is now cared for by her daughter and live-in carers.

Dr Sharma said his mother's blood pressure and diabetes were well controlled and monitored by doctors in New Delhi after she had a heart bypass several years ago. But the fact that an estimated one in six Australians will be affected by stroke during their lifetime prompted Dr Sharma to get involved in a stroke prevention awareness program.

Dr Sharma is the co-founder and president of the Friends of India Network, a Ballarat-based organisation that promotes Indian culture and awareness and fosters links between Indian-born residents and the local community. When he and his wife Dr Deepika Monga, an obstetrician, arrived in Ballarat in 2000 from Malaysia with their two young children Jai and Arunditi there were about a dozen Indian families in the town. Now, Dr Sharma estimates there are 500 families.

The network has raised nearly \$A30,000 over the past three years for causes in Ballarat and India including maternal and children's healthcare programs, domestic violence initiatives and the Strike Out Stroke Foundation.

Each year in February the network runs an annual fundraising T20 morning cricket match that pits the Ballarat Indian Lions against the Ballarat Raiders. A gala fundraising dinner is also held to coincide with the annual Diwali festival of lights celebration.

As part of the network's commitment to stroke prevention Dr Sharma played a key role in rolling out an eight-week program earlier this year which gave free blood pressure checks at the Ballarat and Sebastopol libraries. The network raised \$A10,000 for the program and blood pressure monitoring devices which can also detect heart flutters and fibrillation.

"These are very easy things to do and yet we don't pay enough attention to the incidence of stroke in the community," Dr Sharma explained.

"The statistics reveal just how prevalent it is. One in six people in their lifetime will go on to have a stroke and this is quite alarming. The easiest thing people can do is to have a blood pressure check and that's why this program is so important.

"We all think we are invincible but it took my mother's experience for me to realise how important it is to create awareness about the prevalence of stroke and more importantly the signs to watch out for."

"It's only when you or someone close to you has had that experience that you become more aware of it. Even as medical professionals we read about a lot about these conditions and we see patients who have survived a stroke yet we still don't pay enough attention to it."

Dr Sharma said having settled in Ballarat to make a new life with his family he wanted to give something back to the local community while still maintaining a strong connection with his homeland. After joining with other like-minded Indian professionals in the town the Friends of India Network was born.

Dr Sharma moved to Australia from New Delhi via Kota Bharu in north-eastern Malaysia where he spent a decade at the university hospital.

"It was a hard decision to make to move to Ballarat because we had a settled life in Malaysia but we knew Ballarat was a great opportunity for us," he explained.

When he first started working in Ballarat as an anaesthetist a work life balance was hard to achieve and he was on call every one in three or four days. Now the department has eight full-time anaesthetists and another 30 visiting anaesthetists.

Dr Sharma and Dr Monga's children have now also followed their parents and have chosen medical careers. Their son Jai is a doctor in Melbourne and daughter Arunditi is a dentist.

Carolyn Jones
Media Manager, ANZCA

www.strikeoutstroke.org.au/about/

www.facebook.com/friendsofindianetwork/





“We all think we are invincible but it took my mother’s experience for me to realise how important it is to create awareness about the prevalence of stroke and more importantly the signs to watch out for.”

Above clockwise from left: Dr Sharma assesses the blood pressure of his Ballarat Base Hospital colleague, anaesthetist Dr Tony Lim (Photo: Carolyn Jones); The Ballarat Raiders; The Ballarat Indian Lions.

Unintended intra-arterial injection of propofol

Case presentation

A child presented for a dental extraction and was initially allowed to breathe nitrous oxide with oxygen while a venous cannula was inserted. The type of cannula inserted had a new feature named “blood control (BC)” which is an automatic check valve, designed to stop the flow of blood after the trochar is removed. The cannula is almost identical to another cannula from the same company without the BC feature. There were no difficulties noted during the insertion of the cannula but shortly after the injection of propofol during induction there was sudden severe pain in the arm. It was assumed that an intra-arterial injection of propofol had occurred. The induction was completed with sevoflurane and the cannula re-sited. In stage two recovery the patient reported a burning pain down the arm (that is, distally from the injection site towards the hand) when going to sleep. There was no evidence of ischaemic changes following the injection. Even though intravenous propofol in a small vein can also cause pain up the arm, which is sometimes severe, the anaesthetist submitting the report believed that this was an intraarterial injection.

Other cases in the webAIRS database^{1,2}

The webAIRS data¹ was interrogated and there were nine other cases of suspected unintentional arterial injection identified in the database. One of these was a suspected intraarterial injection by an oral surgeon and this will be analysed separately as it is a different aetiology. This leaves eight for analysis in this report.

Case	Status	Cannula type	Location	Used for injection	Substance and outcome
1	Confirmed with transducer	18g Insyte Autoguard with BC	Dorsum Hand	Yes	Intraoperative drugs and fluids. No harm.
2	Confirmed visually	Not specified	Not specified	Yes	Antibiotics and propofol. Pain but no other harm.
3	Suspected	Insyte Autoguard with BC	ACF	Yes	Propofol. Pain but no other harm.
4	Confirmed visually	Not specified. One-way valve attached.	ACF	Yes	Propofol and suxamethonium. No harm.
5	Confirmed visually	Not specified.	ASB	Yes	Vancomycin via infusion pump. Temporary Harm.
6	Confirmed visually	Not specified.	ACF	No	Recognised when connected to iv fluids. No harm.
7	Confirmed with ultrasound	PICC line	ACF	Yes	TPN. No harm.
8	Confirmed visually + ABG	IA cannulation using US	Not specified	No	Recognised immediately. No harm.

* Abbreviations: Intra-arterial – IA. Ultrasound – US. Arterial Blood Gases – ABG. Blood Control Valve – BC. Anterior Cubital Fossa – ACF. Anatomical Snuff Box – ASB. Total Parenteral Nutrition – TPN. Peripherally Inserted Central Catheter - PICC.

In four cases the ante-cubital fossa (ACF) was the site of the cannulation and in a fifth case it was the anatomical snuff box (ASB) in the hand³.

The anatomical snuff box (ASB) and the ante-cubital fossa (ACF) are both a high risk for inadvertent arterial cannulation. In six of the eight cases the cannula was used for injection before it was recognised to be intra-arterial. The three cases involving propofol did not exhibit signs of temporary ischaemia but the case of vancomycin showed dusky skin for 10 minutes followed by redness which was treated with a heparin infusion. TPN was infused in one case and unspecified intraoperative drugs plus fluids in the other case. Temporary harm was noted in three cases. Two cases extracted had pain in the limb after anaesthesia and one experienced ischemia. In the other cases no harm was apparent at any stage. None of the cases experienced permanent harm.

Risk factors identified

In these cases there were two main risk factors that were identified. The first was the proximity of an artery to the cannulation site (ACF). The second was that the use of a one-way valve or a check valve that might have prevented recognition of a greater than usual backflow of blood. It is also not unusual for a well perfused child to have venous blood that resembles arterial blood in colour.

What we already know

- Arterial anatomy in the upper limb is variable.
- Intra-arterial injections may cause blockage of distal vasculature^{4,5}.
- Ischaemia or necrosis of distal tissue might require debridement, skin grafting or amputation of areas affected.
- 5% thiopentone solution has been known to cause ischaemia or gangrene. The 2.5% solution appears to be safer.
- Intra-arterial injections of propofol may cause distal pain but there do not appear to be any reports of tissue or limb loss⁶.
- Intra-arterial injections of benzodiazepines appear to have a high risk of morbidity^{4,5}.
- Propofol injection can cause severe pain in a small vein.

What is new in this report

There were two reports involving a check valve incorporated into cannula design which might obscure a warning sign that the cannula is intra-arterial⁵. The manufacturer was contacted for a response and supplied the following information.

“The IV catheter that was used on this patient had a blood control valve mechanism to reduce risk of blood exposure. This valve is designed to prevent blood leakage from the IV catheter for 10 seconds after venous insertion with normal venous pressure. It will not stop blood leakage at pressures higher than 60-70 mmHg. This means that at arterial pressures with a systolic pressure greater than 70 mmHg, the blood control system does not prevent leakage.”

However, the lower limit of normal blood pressure for a child is 97 mmHg with a range of 97-155. Also, the application of a venous tourniquet proximally would reduce the distal arterial pressure and if the catheter tip was against the wall of the artery then this would also reduce the pressure at the blood control valve. There is also the possibility that the opening pressure of the valve might be higher than the design pressure due to variability during manufacture.

The second point noted in this series of case reports was that a one-way valve in the intravenous line or attaching a device to a syringe driver or a small diameter catheter such as PICC line, also have the potential to obscure a flashback of bright red pulsatile blood indicating arterial cannulation.

Discussion

Propofol injection causing severe pain could be experienced with an intravenous injection. However, in the initial case reported, the pain was from the injection site to the periphery whereas, normally, pain with intravenous propofol is from the injection site up the arm. Inadvertent intra-arterial injection is an uncommon event and there is no definitive evidence-based protocol for management of which the authors are aware. There is a systematic review which gives detailed

information of the current knowledge regarding these events⁴. There is also an article describing complications that might arise⁵. All of the medications that were injected in this series were a low risk for harm after injection other than pain, and no patient suffered from any permanent sequelae.

Lessons that might be learnt for future cases

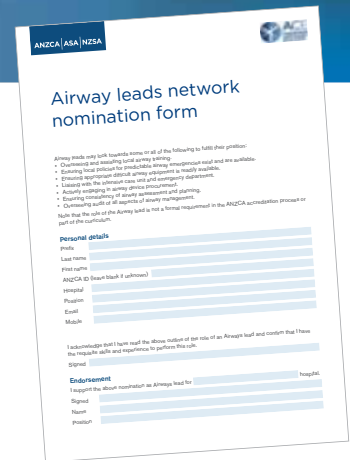
It may be difficult to detect arterial cannulation when using devices with back check valves (cannulas), one-way valves, or pumps in the intravenous delivery system.

Anaesthetists should have a high index of suspicion if a patient complains of distal pain, or duskiness, on injection. Areas of high risk include, but are not limited to, the ante-cubital fossa and the anatomical snuff box of the hand.

Dr James Derrick, Dr Martin Culwick and the webAIRS Case Report Writing Group

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Be the airway lead for your hospital!

Following the lead of the UK and New Zealand, the Airway Management Special Interest Group is calling for nominations for airway leads, with the aim of establishing one in every Australian hospital.

The network of newly appointed airway leads will focus on promoting safe airway management for all patients.

If you are interested in nominating yourself you will need the endorsement of your director/head of department or equivalent, and to complete this form. Alternatively, you may wish to encourage another anaesthetist to nominate.

For further information on airway leads, read “Introducing airway leads in Australia” from the June 2019 edition of the *ANZCA Bulletin*, on the ANZCA website.

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.

Risks with new diabetes drugs

As an anaesthetist with diabetes (Type 1) I have a strong interest in perioperative care of patients with diabetes. The challenges of caring for this group of patients has further increased with the new class of diabetes drugs: sodium-glucose co-transporter type-2 inhibitors: SGLTIs or gliflozins. The currently available drugs include dapagliflozin, empagliflozin, canagliflozin, and ipragliflozin but not all of these are available in Australia or New Zealand. SGLTIs have a range of tradenames complicated further by also being available in combination with other drugs such as metformin. Unfortunately, there's a lot of uncertainty about the SGLTIs in the perioperative period.

What we do know is that SGLTIs help control blood sugar in people with Type-2 diabetes through increasing excretion of glucose in the urine. These drugs may also become available for those of us with Type-1 diabetes. Glycosuria and other effects not only lead to improved blood glucose control, but also improved cardiovascular outcomes for patients taking these drugs. It is also likely that the SGLTIs improve renal outcomes in patients with existing chronic kidney disease. These drugs may also reduce the severity of fatty liver disease and enhance weight loss. For these reasons these drugs are very popular among diabetes experts.

Anticipated effects include increased urogenital infections and decreased total body water. A severe, but probably rare, unanticipated side-effect is euglycaemic diabetic ketoacidosis (euDKA). Euglycaemia is defined as a blood sugar less than 14 mmol/L but technically means normal concentration of glucose in the blood. Some argue that a better name would be Diabetic ketoacidosis without hyperglycaemia which is both more accurate and understandable. Irrespective of the name, this condition which can be precipitated by disease or surgery, particularly major surgery, is a challenge for those of us providing perioperative care. There are now many scenarios involving these drugs that require a thoughtful approach.



Based on the SGLI pharmacokinetics, guidelines are now recommending that these drugs are ceased at least three days before surgery before surgery, where day of surgery is day three. However, the optimal duration is unclear. Also unclear is when to best restart these drugs after procedures.

Many of these clinical situations where there is currently no "right" answer require considering goals of care in collaboration with patients, surgeons, positions, and GPs. Detecting and monitoring for euDKA involves measuring blood sugar, blood ketones and acid base status, notably looking for metabolic acidosis. The physiological stress of emergency surgery is likely to be an important precipitant of euDKA. Therefore, one challenging scenario is the patient who presents for emergency surgery who is on an SGL T2o. Current thinking is that a key factor in the pathogenesis of euglycaemic diabetic ketoacidosis, is an insulin deficiency relative to hormones such as glucagon and the catecholamines. Even in the absence of both raise plasma key tones and metabolic acidosis a key feature of managing patients on these drugs is to stimulate endogenous insulin with glucose or more reliably to use an insulin infusion to enhance Plasma insulin levels. This will often necessitate a glucose infusion as well.

The ANZCA Safety and Quality Committee is working with groups representing Australian and New Zealand diabetologists to issue a joint statement on detecting and managing euDKA. Dr Roger Traill FANZCA from Sydney has played an important role in this collaboration with our diabetologist colleagues. This statement addresses both patients with ongoing SGLTI therapy at increased risk of euDKA as well as patients deteriorating with euDKA.

Professor David Story
Chair of Anaesthesia
University of Melbourne

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Look-alike ampoules

On May 3, Melbourne consultant anaesthetist and patient safety advocate Dr Nicholas Chrimes addressed the ANZCA Annual Scientific Meeting in Kuala Lumpur about the well-known potential for serious patient harm associated with look-alike ampoules.

Dr Chrimes is the Australian co-ordinator of the global EZdrugID campaign that has been lobbying for changes to drug packaging (www.ezdrugid.org/). Proposed strategies to reduce error include colour coding of packaging according to the class of medication, and where practical, standardisation of the type of packaging (vials, glass or plastic ampoules) for different classes of injectable medications.

This ongoing safety and quality issue has been explored at length in previous editions of the ANZCA *Bulletin*. The September 2015 issue (<https://anzca.edu.au/documents/anzca-bulletin-september-2015-final.pdf>) featured articles on medication errors and the EZdrugID campaign by Dr David Bramley and Dr Chrimes.

More recently, the September 2018 *Bulletin* (www.anzca.edu.au/documents/bulletin-sep-18-final-spreads.pdf) included a safe labelling feature with contributions by several authors on human factors of medication handling, administration of blue dyes perioperatively, and warnings on neuromuscular blocking agents.

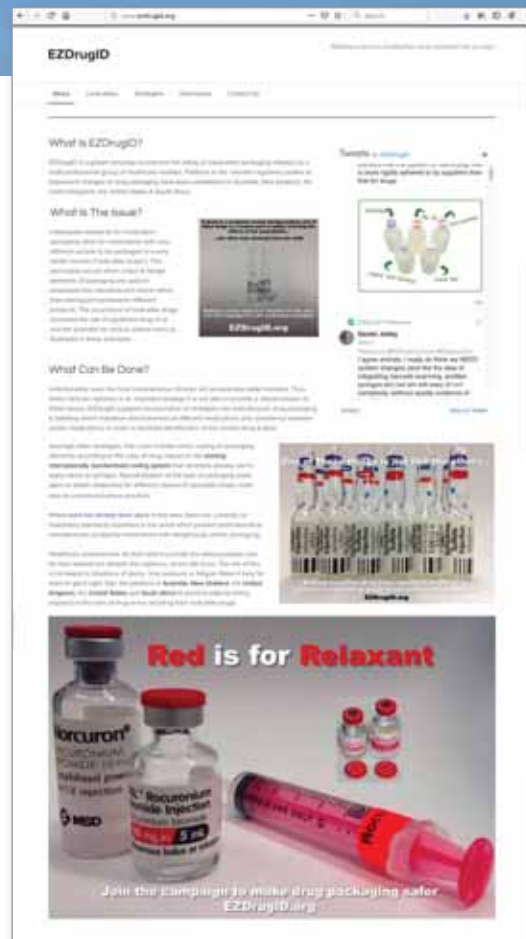
The college has been actively involved in advocating for improvements in medication labelling. Key achievements include:

- The introduction of the *National Standard for User-applied Labelling of Injectable Medicines, Fluids and Lines* in 2015, supported by ANZCA and the Australian Commission on Safety and Quality in Health Care (the Commission).
- The introduction by the Therapeutic Goods Administration (TGA) in Australia in July 2018 of mandatory packaging standards (a red warning statement) on the labels and packaging of neuromuscular blocking agents, following several years of advocacy by ANZCA in collaboration with other organisations.

Last year, the college also updated its professional document, *PS51 Guidelines for the Safe Management and Use of Medications in Anaesthesia* (www.anzca.edu.au/documents/ps51-2009-guidelines-for-the-safe-administration-o.pdf).

PS51 contains recommendations relating to the labelling, packaging, storage and administration of medications including:

- Consideration of the clarity of labelling and the avoidance of look-alike packaging or labelling when making purchasing decisions.
- Storage of medications in ways designed to facilitate their identification and minimise the risk or error of misidentification, in particular with ampoules, vials or packages that look similar, have similar names, or have labels that are difficult to read or are of similar appearance.



PS51 may provide fellows with a useful tool to facilitate discussions with purchasing departments/bodies in relation to reducing potential medication errors.

ANZCA is committed to continuing to advocate for improved patient safety, including better drug labelling. However, this issue presents a significant challenge in an era of frequent disruptions to medication supply. The clinician is required to adhere to a standard when labelling medications that are drawn up from ampoules or vials but, apart from neuromuscular blocking agents, no such mandate exists for manufacturers. When there are medication shortages, suppliers often need to source drugs from different companies and there is little global uniformity in presentation or labelling of specific classes of medication. It will ultimately lie with the regulators to mandate change.

ANZCA media release: www.anzca.edu.au/communications/media/media-releases-2019/clearer-drug-labels-needed-to-avoid-medication-mix

ASM media coverage: www.smh.com.au/healthcare/look-alike-drugs-a-disaster-waiting-to-happen-anaesthetist-warns-20190503-p51jx7.html

CPD update

CPD program review

In keeping with June's *ANZCA Bulletin* article, the ANZCA and FPM CPD Committee and CPD team will continue to provide updates on the impending formal process to review the CPD program.

This review of the CPD program and standard is due to:

- Medical Board of Australia's (MBA) proposed Professional Performance Framework.
- Medical Council New Zealand's (MCNZ) recertification document and draft model.

There are no confirmed changes to the CPD requirements or standard. We ask that all CPD participants keep up to date with regular communications in college publications and if changes are required ANZCA will communicate this to all CPD participants.

MBA-proposed PPF

ANZCA President Dr Rod Mitchell, CPD Committee Chair, Dr Debra Devonshire and college representatives attended the MBA stakeholder forum on June 25. The main areas of interest to CPD was the professional performance framework (PPF) and proposed changes to the CPD standard. Implementation will occur following a final proposal to be advised in 2020. Further information about the PPF can be found on the MBA's website at www.medicalboard.gov.au/Registration/ProfessionalPerformance-Framework.aspx.

MCNZ recertification – draft model and attendance at NZNC

MCNZ representatives presented at the NZNC on May 30 regarding the developments on recertification, specifically the April release of the draft model. A 2022 implementation timeline was communicated and the core elements were discussed as:

- Moving away from a time-based program; supporting participants to choose activities of most value to their scope of practice.
- Cultural competency.
- Strong emphasis on the annual conversation.
- Annual CPD plans; strengthening the planning function and supporting a clinical perspective.

Further information about the:

- MCNZ recertification discussion document can be found at www.mcnz.org.nz/assets/News-and-Publications/Consultations/2018-Discussion-document-strengthened-recertification-FINAL.pdf.
- MCNZ draft model for recertification requirement for vocationally-registered doctors practising in New Zealand can be found at www.mcnz.org.nz/news-and-publications/consultations/strengthening-recertification-for-vocationally-registered-doctors-in-new-zealand/.

Difference between clinical audit (20 credits) and report of clinical audit findings (2 credits)

The ANZCA CPD standard recognises two different activities under the practice evaluation category that can be claimed for either completing or reporting on a clinical audit. It has recently come to the attention of the ANZCA and FPM CPD Committee that there may be confusion among participants as to which CPD activities may be claimed.

The CPD handbook identifies the difference between the two; details below. Furthermore, the CPD handbook's appendix 10 clinical audit guidelines, sets out instructions on the description, examples, approach and recording of this CPD activity. Appendix 10 can be found at www.anzca.edu.au/documents/appendix_10_guidelines_for_clinical_audit.pdf.

Participants who devote time to either presenting or participate in the presentation of the Clinical audit findings will be able to claim two credits per hour, further details below. If CPD participants feel they require further clarification, or any assistance when allocating their CPD activities, are requested to contact the CPD team cpd@anzca.edu.au or matters be referred in writing to the CPD chair or committee members.

Clinical audit of own practice or significant input into a group audit of practice (Clinical audit)

Credits: 20

Participants complete a systematic analysis of an area of practice to improve clinical care and/or health outcomes, or to confirm that management is consistent with the available evidence or accepted guidelines. An identified standard is used to measure current performance and outcomes are documented and discussed with a colleague. The process may be repeated on a regular basis (for example, every few years) in a cycle of continuing quality improvement. A clinical audit may involve one practitioner or a group of practitioners in single or multiple disciplines (for example, an anaesthetist and surgeon working together could jointly undertake an audit. For resources on the conduct of the audit, refer to appendix 10 or refer to the clinical audit templates for both anaesthesia and pain medicine published on the ANZCA website.

Evidence: A summary of audit results (including topic and any comparative standards) plus contact details of the colleague with whom you discussed the results.

Report of clinical audit findings

Credits: Two credits per hour, for both participant and presenter

Documentation of clinical audit results, including recommendations and implemented changes as a result of an audit conducted. This may also include time devoted to presentation of findings locally or more widely at a meeting or conference.

Evidence: Short summary of recommendations and implemented changes, front page of report or correspondence regarding confirmation of presentation.

Committee has new chair



Dr Debra Devonshire

I am honoured to have been appointed chair of the ANZCA and FPM CPD Committee. I hope to serve the ANZCA community to the best of my abilities and look forward to working with our dedicated and highly qualified CPD team to assist anaesthesia colleagues maintain

transparent academic and clinical competency.

However, I also hope to promote involvement in CPD as a motivation to colleagues to explore, be curious and enjoy adult learning as a privilege and not a chore. My thanks to the previous chair, Dr Nigel Robertson, the committee members and the CPD team who have worked tirelessly to deliver and enhance the CPD program.

The CPD program is governed by the CPD committee, which comprises members from Australia and New Zealand, from a variety of practice settings in both public and private practice and at different career stages to ensure the program is feasible and user-friendly.

The Medical Board of Australia (MBA) and the Medical Council of New Zealand (MCNZ) require all registered medical

practitioners to participate in CPD relevant to their scope of practice. For anaesthesia and pain medicine, the CPD standard is set by ANZCA. The CPD program is designed to help and support participants to fulfil the requirements of this standard.

The convenience of the online CPD portfolio, allows for quick and easy data entry and with the ability to store evidential documentation, facilitates auditing either by ANZCA, MBA/Australian Health Practitioner Regulation Agency or MCNZ.

Many fellows have received practical advice from committee members and the CPD team, either via phone or email. If required, assistance is only a phone call or an email away – +61 3 9510 6299 or cpd@anzca.edu.au.

Clarification of cover for QP

The Federal Department of Health, in Australia currently grants Commonwealth qualified privilege (QP) protection to the following four practice evaluation activities through the Commonwealth Qualified Privilege Scheme: Patient experience survey, multi-source feedback (MsF), peer review of practice, clinical audit of own practice or significant input into group audit of practice. This does not include the Report of clinical audit findings activity.

New resource: DHM clinical audit sample

A new diving and hyperbaric medicine (DHM) specific clinical audit sample has now been made available for use in the ANZCA and FPM CPD Program:

- Prevention of Middle Ear Barotrauma (MEBT) during compression for hyperbaric oxygen therapy (HBOT).

This clinical audit sample includes a clinical audit guide, data collection form and summary of results and can be found at www.anzca.edu.au/fellows/continuing-professional-development/handbook-and-resources/clinical-audit-samples.

The ANZCA and FPM CPD Committee would like to thank the author, Professor Michael Bennett, FANZCA, Chair DHM Sub-Committee.

Reminder alert: 2017-2019 end of triennium due December 31, 2019

The ANZCA and FPM CPD Program is approaching its largest cohort for the 2017-2019 triennium with more than 3200 participants. The final submission date for this triennium is December 31.

The CPD committee and team encourage participants within this triennium to promptly update their CPD portfolio and take steps to proactively ensure they will meet their CPD requirements.

PQAA update for New Zealand CPD participants

The ANZCA and FPM CPD Program's registration for Protected Quality Assurance Activities (PQAA), under section 54 of the Health Practitioner Competence Assurance Act 2003, was finalised on August 9. This cover is for the entirety of the CPD program and maintenance through the online CPD portfolio.

The loss of PQAA cover occurred from May 4, 2019 to August 9, 2019. Participants are advised that information entered into the portfolio during this period will not be covered. This principally relates to the aspects of the CPD program which require reflection and personal review of performance.

Details of the CPD PQAA gazette notice can be found at <https://gazette.govt.nz/notice/id/2019-dl3620>.



Faculty of Pain Medicine

Dean's message



“Unfortunately, despite strong advocacy by the faculty’s New Zealand National Committee (NZNC) following the release of the FPM-commissioned Sapere report into the cost of chronic pain in New Zealand, gaining support for a comprehensive national approach for pain remains a challenge.”

Professor Ted Shipton, Dr Duncan Wood, Dr Tipu Amir and Dr Paul Vroegop, well supported by ANZCA NZNC Chair, Dr Jennifer Woods and Dr Sally Ure, have attended many meetings, including with the Minister of Health, District Health Board (DHB) chief medical officers, DHB general managers, Funding and Planning, the Accident Compensation Corporation (ACC) chief clinical adviser and the chief executive officer of the Health Quality and Safety Commission.

In addition, media coverage since I visited the NZNC in March has put a spotlight on the increasing number of opioid-related deaths in New Zealand, previously thought not to be a problem like that in Australia. Poor access in regional areas to multidisciplinary pain clinics or even a specialist pain medicine physician and lack of a national strategy for pain management add to the list of concerns. It seems the funding structures of the New Zealand health system also work against developing a national approach. However, the changing landscape around opioids and pain management in Australia may well assist in raising the level of government concern in New Zealand in the near future.

Finally, I would like to express the faculty’s heart-felt thanks to Ms Heather Ann Moodie, as she retires as General Manager ANZCA New Zealand for her unfailing support and excellent advice for the faculty’s NZNC, fellows and trainees. We wish Heather Ann all the best for her retirement.

Internal relationships

While faculty relationships with external organisations are important and consume a lot of time and attention, having a very good relationship with the college internally is critical for the faculty’s survival and ability to prosecute its ambitious 2018-22 strategic plan. The ANZCA Council is directly responsible for the faculty and through regulation 40, has delegated power to the board to conduct faculty business.

However, as a relatively young organisation, the faculty is still in an active growth phase and resourcing has become stretched. To address these and future needs of the faculty, a joint ANZCA Council/FPM Board/ANZCA Senior Leadership Team retreat was held on July 20 between the scheduled July council and board meetings. Discussions focussed on strengthening relationships, improving communication channels and future support for the faculty. Most importantly, the retreat was an opportunity for board and council members along with the senior leadership staff to get to know each other at a personal level and to understand respective concerns and constraints that may be impediments to the faculty achieving its goals.

I hope that the many open and respectful conversations from that day will lead to mutually beneficial changes in the ways the faculty and the college work together. There is no doubt that FPM and ANZCA are both stronger working together.

Dr Meredith Craigie
Dean, Faculty of Pain Medicine

Twelve months on and prescription opioids remain in the news. However, changes are on the horizon as Australian Federal Health Minister, Greg Hunt, announced several key changes at the Society of Hospital Pharmacists of Australia’s Medicines Leadership Forum on August 14. The Australian government had asked the Therapeutic Goods Administration (TGA) to assist in addressing escalating pharmaceutical opioid-related harms. The TGA has published a statement about the proposed regulatory changes (www.tga.gov.au/alert/prescription-opioids) noting that: “Every day in Australia, nearly 150 hospitalisations and 14 emergency department admissions involve opioid harm, and three people die from drug-induced deaths involving opioid use.”

The changes are the result of extensive work by the TGA including its public consultation process in early 2018 and establishing the Opioid Regulatory Advisory Group (ORAG). As members of the group, I as the dean and several faculty fellows along with our partners, the Australian Pain Society and Painaustralia among others, provided advice and participated in the roundtable meetings held over the past 12 months. The key changes will include smaller pack sizes, black box warnings, consistent warning messaging on Consumer Medicine Information (CMIs), clarification of indications for use in Product Information documents (PIs), tightening of indications for fentanyl patches in particular, restricting them to patients with cancer, in palliative care and in exceptional circumstances. The TGA will run a communication campaign through a range of media to advise the community about the changes and will be encouraging consumers to return unused medication to pharmacies for destruction.

These changes are intended to align with other Australian government initiatives to support more holistic pain care as recommended in the National Strategic Action Plan for Pain Management (NSAPPM). The plan was launched in June by Painaustralia following approval by Minister Hunt and the Federal Department of Health. After consultation with the faculty’s regional committees to identify region-specific issues, ANZCA President Dr Rod Mitchell and I have written letters to each of the state health ministers urging them to support the NSAPPM. We also requested further discussions with the minister or his/her representatives about those region-specific issues.

Need for an NZ national pain approach

Unfortunately, despite strong advocacy by the faculty’s New Zealand National Committee (NZNC) following the release of the FPM-commissioned Sapere report into the cost of chronic pain in New Zealand, gaining support for a comprehensive national approach for pain remains a challenge.



Acute Severe Behavioural Disturbance roadshow

The Acute Severe Behavioural Disturbance in the adult patient (ASBD) emergency response standard was introduced into the ANZCA and FPM Continuing Professional Development program this year. This is the first emergency response standard that is tailored to specialist pain medicine physicians.

FPM CPD Officer Dr Stephanie Oak, FRANZCP, FFPMANZCA led the development of the standard and facilitated these workshops at the Annual Scientific Meeting in Kuala Lumpur. She is now delivering a roadshow of ASBD workshops across Australia and New Zealand.

The first regional workshop was held in Sydney on Saturday August 3 and received excellent feedback. Fellows wishing to attend a workshop can register via the website at www.fpm.anzca.edu.au.

Upcoming workshops:

- October 6, Canberra.
- October 18, Bryon Bay at the FPM Spring Meeting.
- October 23, Wellington.

New fellows

We congratulate the following doctors on their admission to FPM fellowship through completion of the training program:

Dr Febbie Chung, FANZCA, FFPMANZCA (Hong Kong).

Dr Mazyar Danesh, FANZCA, FFPMANZCA (Victoria).

Dr Sharon Keripin, FAFRM (RACP), FFPMAZCA (SA).

Dr Rachel Sara, FANZCA, FFPMANZCA (New Zealand).

Dr Tuan Van Vo, FAFOEM, FFPMANZCA (SA).

We also congratulate the following doctors on their admission to FPM fellowship via the election to fellowship pathway:

Professor Chi Wai Cheung, FHKAM (Anaes), FHKCA (Anaesthesiology), FFPMANZCA (Hong Kong).

Dr Ho-Shan Steven Wong, FANZCA, FFPMANZCA (Hong Kong).

We also congratulate the following doctor on his admission to FPM fellowship by completion of the FPM Specialist International Medical Graduate (SIMG) pathway:

Dr Stephen Gilbert, FANZCA, FFPMANZCA (Queensland).

Training unit accreditation

The following hospitals have been accredited for pain medicine training:

- Fiona Stanley Hospital, WA.
- Pain Matrix Geelong, Victoria.
- Sir Charles Gairdner Hospital, WA.

Above: Dr Charlotte Johnstone, Dr Glen Sheh, Associate Professor Paul Wrigley, Dr Peter Snowdon, Dr Marc Russo, Dr Willem Volschenk, Dr Gavin Pattullo, and Dr Michael Davies; Deputy Chair FPM NSW Regional Committee Dr Glen Sheh thanks Dr Stephanie Oak.

New classification for chronic pain

At the World Health Assembly in May, the World Health Organization (WHO) adopted ICD-11, the latest revision of its International Classification of Diseases, including a new classification system for chronic pain.

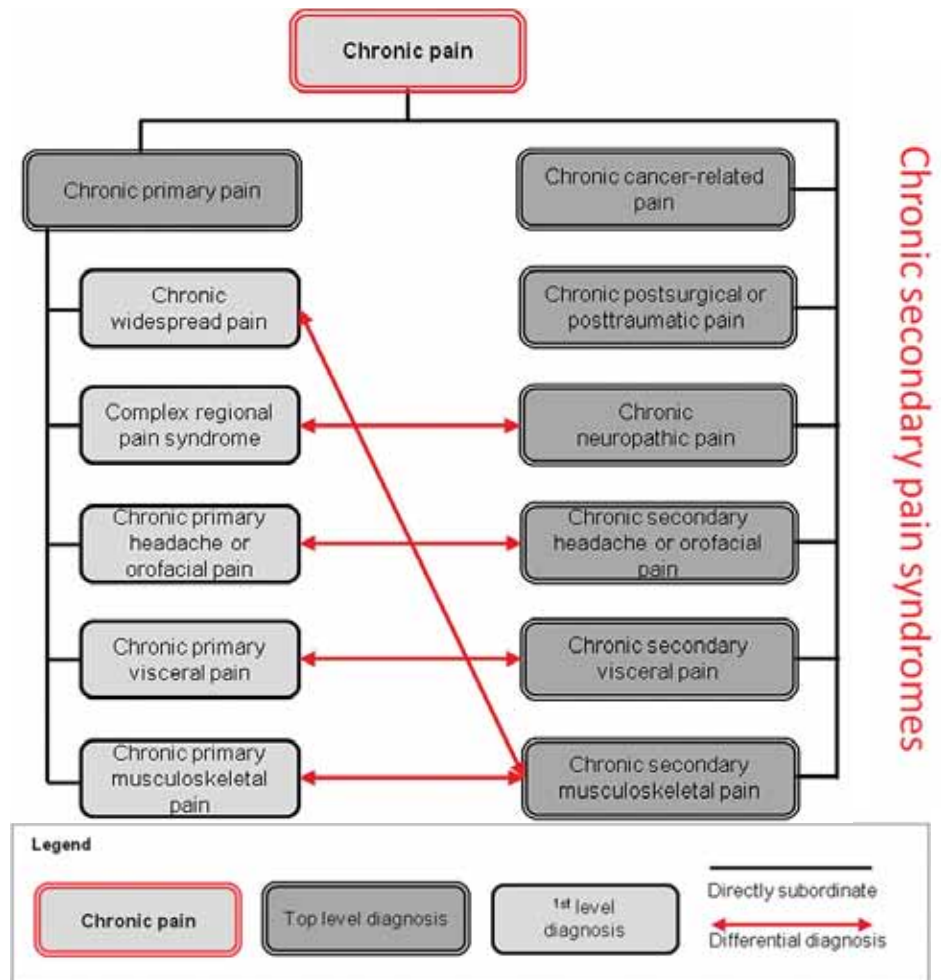
The new classification is a direct result of six years of work by an International Association for the Study of Pain (IASP) Taskforce, co-chaired by IASP Past-President Professor Rolf-Detlef Treede and Professor Winfried Rief, both from Germany. Australia and New Zealand were well represented on that taskforce by FPM fellows Professor Stephan Schug (WA), Professor Michael Nicholas (NSW) and Professor Milton Cohen (NSW).

Until now chronic pain conditions had not been represented systematically in the ICD. This has been despite the evidence from the Global Burden of Disease Studies over the past three decades that have consistently shown that chronic low back pain is the largest cause of “years lived with disability” (YLDs). YLD is determined by the prevalence multiplied by a disability-weighting factor for a broad range of diseases and injuries in 188 countries.

The second greatest cause of YLDs is major depressive disorder, while other frequent causes include chronic neck pain, migraine, osteoarthritis, other musculoskeletal disorders, and medication overuse headache¹. Furthermore, in many modern healthcare systems referral for specific treatment such as multimodal pain management is dependent on suitable ICD codes as indications. The lack of appropriate codes has contributed to the paucity of clearly defined treatment pathways for patients with chronic pain. Now, for the first time, ICD will include diagnostic codes for chronic pain itself, along with codes for the most common and clinically relevant groups of chronic pain conditions.

Chronic pain is defined simply in ICD-11 as pain that lasts or recurs for longer than three months^{2,3}. This temporal definition is the “parent” category for seven others that comprise the most common clinically relevant groups of chronic pain conditions, including the

Figure 1. The major division of chronic pain into chronic primary pain and chronic secondary pain.



new construct of chronic primary pain (see Figures 1 and 2).

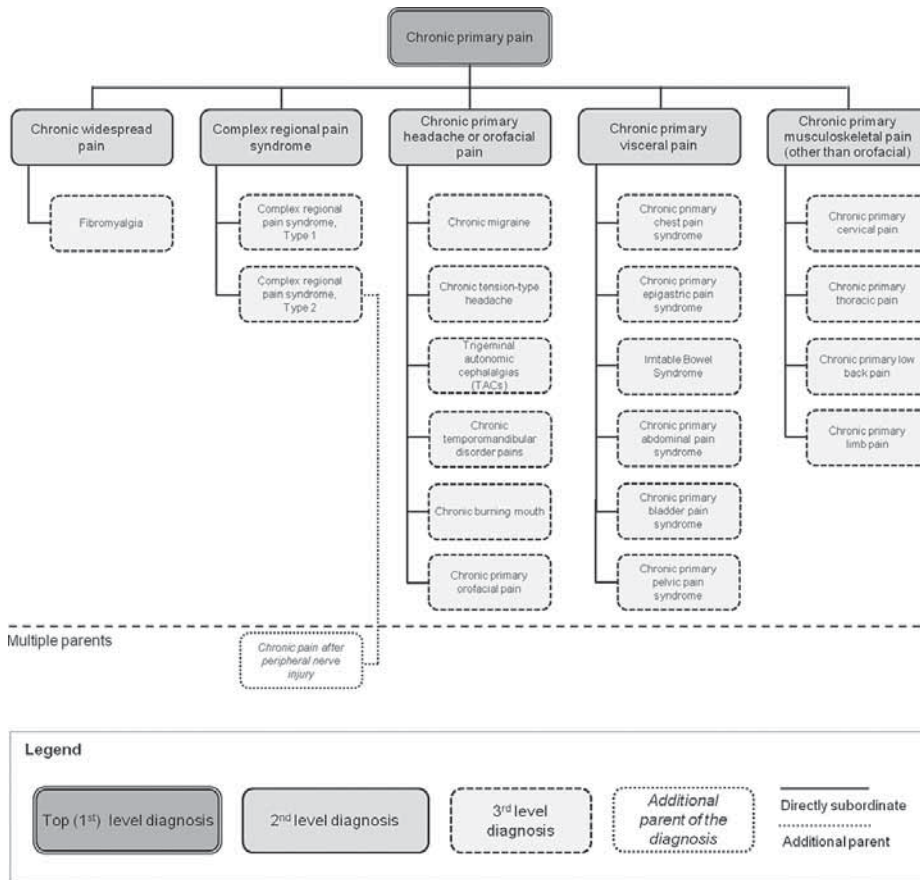
Chronic *secondary* pain syndromes are linked to other diseases as the underlying cause, for which pain may have been regarded initially as a symptom but now is recognised as a problem in its own right, requiring specific attention. In many cases, the chronic pain may continue beyond successful treatment of the initial cause; in such cases, the pain co-diagnosis will remain, even after the diagnosis of the underlying disease is no longer relevant.

These secondary pain syndromes have been classified pragmatically in accordance with WHO criteria that give first priority to aetiology, followed by underlying pathophysiological mechanism, and finally the body site in which pain is experienced:

- Chronic cancer-related pain (categorised by aetiology)⁴.
- Chronic post-surgical and post-traumatic pain (categorised by aetiology)⁵.
- Chronic neuropathic pain (categorised by mechanism)⁶.
- Chronic secondary visceral pain (categorised by mechanism)⁷.
- Chronic secondary headache or orofacial pain (categorised by body site)⁸.
- Chronic secondary musculoskeletal pain (categorised by body site)⁹.

Also employed is the WHO principle of “multiple parenting,” which allows any one example to be included under more than one category. For example, chronic

Figure 2. Chronic primary pain syndromes.



neuropathic pain following chemotherapy for cancer has two “parents”: chronic cancer-related pain and chronic neuropathic pain.

Chronic *primary* pain is defined as “pain in one or more anatomic regions that persists or recurs for longer than three months – hence, “chronic” – and is associated with significant emotional distress (such as anxiety, anger, frustration, or depressed mood) and/or significant functional disability (interference in activities of daily life and participation in social roles) and that cannot be better accounted for by another chronic pain condition”¹⁰.

In Figure 1 this can be seen to parallel some secondary conditions (headache and orofacial pain, visceral pain and musculoskeletal pain), to include complex regional pain syndrome and to introduce chronic widespread pain. These are expanded upon in Figure 2, where

the subcategorisation tends to be based on body site, necessarily as “primary” implies that aetiology and mechanism are not known.

Does this mean that chronic pain has now been accepted as a disease? Not at all¹¹.

Acceptance of chronic pain as a condition in its own right – albeit a complex, multifactorial condition – does not elevate it to the status of a disease. This is not just a semantic problem. In the same way that headache is a *taxonomic* entity without implying any particular cause, pathology or pathophysiology, so now is chronic pain. Similarly, just as headache (unqualified) is not a valid diagnosis, so too is chronic pain not a diagnosis *per se*. The condition of chronic pain needs to be parsed clinically into its biomedical, psychological and social dimensions; the first two of these might attract more conventional diagnostic

terms, some of which may relate to diseases (as in the secondary taxonomy above) but all are parts of a whole.

The ICD-11 taxonomy for chronic pain conditions will come into effect on January 1, 2022. However it is already fit for many uses in addition to mortality and morbidity statistics, including clinical recording, primary care, patient safety, resource allocation, reimbursement and casemix. It will transform patient care and pain research worldwide, by facilitating multimodal pain treatment, by boosting efforts to measure the quality and effectiveness of care, and by generating new research on the prevalence and effects of chronic pain.

Professor Milton Cohen, FFPMANZCA
FPM Director of Professional Affairs
Chair, FPM Learning and Development
Committee

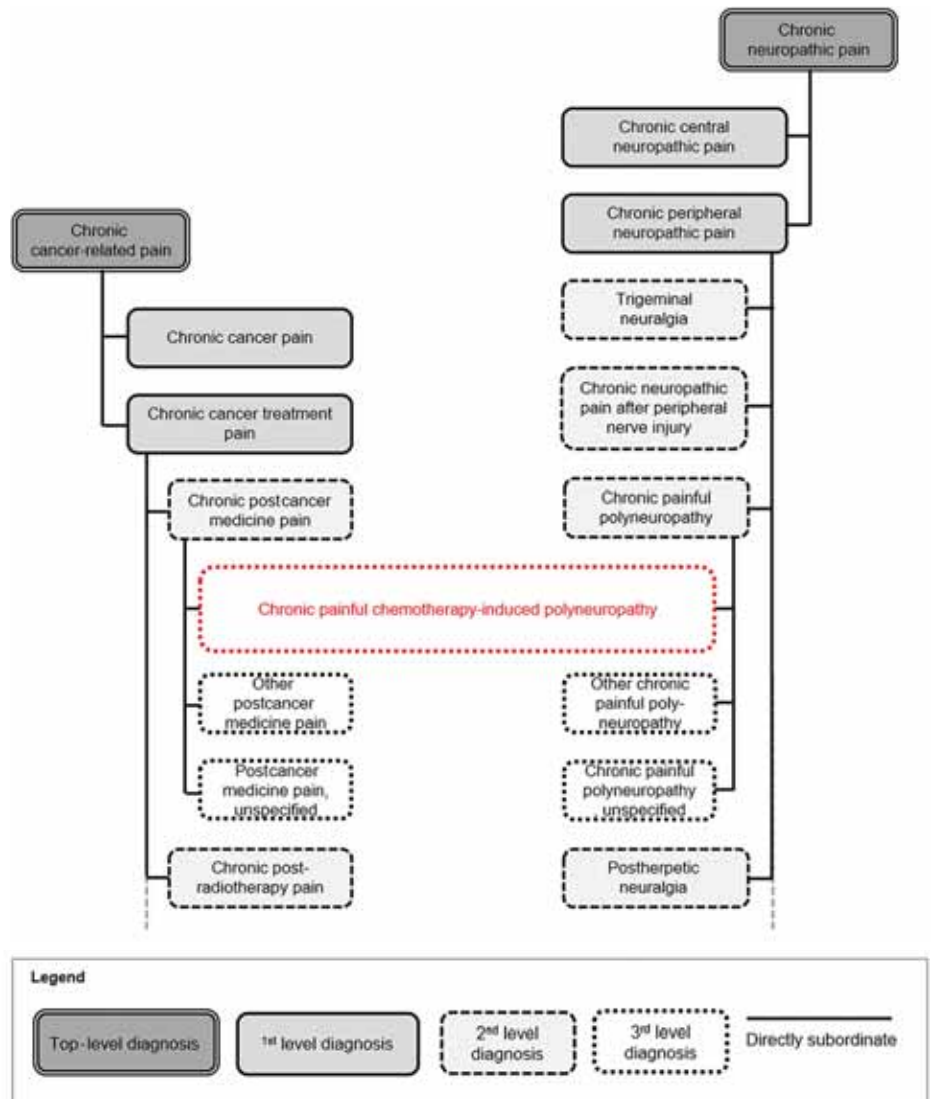
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New classification for chronic pain (continued)

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8. Benoliel R, Svensson P, Evers S, Wang SJ, Barke A, Korwisi B, Rief W, Treede RD, The IASP Taskforce for the Classification of Chronic Pain. The IASP classification of chronic pain for ICD-11: chronic secondary headache or orofacial pain. *Pain* 2019; 160:60-68.

Figure 3. The concept of “multiple parenting”, for example, how “chronic painful chemotherapy-induced peripheral neuropathy” can be coded under “chronic cancer-related pain” and “chronic neuropathic pain”.



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FPM committee membership

The FPM committee memberships for 2019-2021 were confirmed at the New Board Meeting held in July 2019.

Executive Committee

Dr Meredith Craigie, Dean

Associate Professor Michael Vagg, Vice Dean and Chair, Professional Affairs Executive Committee (PAEC)

Dr Kieran Davis, Chair, Training and Assessment Executive Committee (TAEC)

Ms Helen Morris, General Manager

Professional Affairs Executive Committee (PAEC)

Associate Professor Michael Vagg, Chair

Dr Chris Hayes, Chair, Research & Innovation Committee

Dr Diarmuid McCoy, Chair, Professional Standards Committee

Dr Jennifer Stevens, Chair, Scientific Meetings Committee

Professor Milton Cohen, Director of Professional Affairs

Ms Dorothy McLaren, Community Representative

Ms Helen Morris, General Manager

Dr Meredith Craigie, Dean (*ex officio*)

Professional Standards Committee (PSC)

Dr Diarmuid McCoy, Chair

Dr Stephanie Oak, FPM CPD Officer

Dr Susie Lord, FPM Safety and Quality Officer

Dr Jordan Wood, FPM Mentoring Program Officer

Dr Matthew Bryant, Qld Regional Representative

Professor Michael Veltman, WA Regional Representative

Dr Bruce Rounsefell, SA Regional Representative

Vacant, Vic Regional Representative

Vacant, NSW Regional Representative

Dr Nina Loughman, Tas Regional Representative

Dr Tipu Aamir, NZ National Representative

Dr Meredith Craigie, Dean (*ex officio*)

Research and Innovation Committee

Dr Chris Hayes, Chair

Associate Professor Carolyn Arnold, FPM ePPOC representative

Dr Suzanne Cartwright, Better Pain Management Officer

Associate Professor Brendan Moore, PDIR Officer

Dr Marc Russo, Clinical Research Representative

Professor Stephan Schug, APMSE editor

Professor Andrew Somogyi, Basic Science Representative

Vacant, Outreach Portfolio

Dr Meredith Craigie, Dean (*ex officio*)

Scientific Meeting Committee

Dr Jennifer Stevens, Chair and FPM ASM Officer

Dr Chris Orlikowski, Deputy Chair

Dr Glen Sheh, 2019 Spring Meeting Convenor

Dr Alison Kearsley, 2020 FPM ASM Scientific Convenor

Dr Jacquelyn Nash, 2020 Spring Meeting Convenor

Dr Noam Winter, 2021 FPM ASM Scientific Convenor

Dr Clayton Thomas, Vic CME Co-ordinator

Professor Andrew Somogyi, SA CME Co-ordinator

Professor Michael Veltman, WA CME Co-ordinator

Dr Duncan Wood, NZ National Committee representative

Dr Meredith Craigie, Dean (*ex officio*)

Training and Assessment Executive Committee (TAEC)

Dr Kieran Davis, Chair

Professor Milton Cohen, Chair, Learning and Development Committee

Professor Michael Veltman, Chair, Training Unit Accreditation Committee

Dr Melissa Viney, Assessor

Dr Charlotte Johnstone, Supervisor of Training Advisor

Ms Helen Maxwell-Wright, Community Representative

Ms Helen Morris, General Manager

Dr Meredith Craigie, Dean (*ex officio*)

Examinations Committee

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Associate Professor Charles Brooker

Dr Porhan Kang

Dr Kok Khor

Dr Venugopal Kochiyil

Dr Rajiv Menon, New Fellow Representative

Dr Clayton Thomas

Dr Jane Thomas

Dr Melissa Viney

Dr Aston Wan

Dr Meredith Craigie, Dean (*ex officio*)

Learning and Development Committee

Professor Milton Cohen, Chair

Dr Timothy Brake

Dr Harold Eeman

Dr Olivia Ong

Dr Paul Vroegop

Dr Kate Drummond, Co-opted member, Trainee representative

Ms Juliette Whittington, Operations Manager, FPM

Ms Margaret Kerr, Operations Manager, Learning and Development

Ms Teri Snowden, Operations Manager, Strategy and Quality

Dr Cassandra Sparkes, FPM Education and Research Development Co-ordinator

Dr Meredith Craigie, Dean (*ex officio*)

Training Unit Accreditation Committee (TUAC)

Professor Michael Veltman, Chair

Dr Kieran Davis, Deputy Chair

Dr Louise Brennan

Dr Newman Harris

Dr Kim Hattingh

Dr Winnie Hong

Dr Diarmuid McCoy

Dr Pavla Walsh

Dr Duane Anderson, New Fellow Representative

Dr Meredith Craigie, Dean (*ex officio*)

ANZCA Educators Program (AEP) facilitation – opinion

One of the perks (or chores depending on your viewpoint) of our jobs as anaesthetists is our expectation to teach.

We can do this in many ways. I remember many a registrar day when I had to “guess” what the consultant of the day would want me to do in a particular situation. Most of this would be through non-verbal hints. Some of the consultants’ expectations would be stated explicitly and others would be picked up through watching and role modelling. I would quickly learn what was the “right” way of doing things with this particular consultant. What was often lacking was the non-judgemental discussion which ideally would include the “thinking frame” that had led to that choice in the consultants’ mind.

Now having been a consultant myself for close to 10 years I feel that I am slowly getting better at teaching registrars. I am by no means the ideal “teacher” and am constantly battling to improve my interactions with other learners while striving to continue learning myself.

This, I feel is one of our major goals as an anaesthetist.

Learners come in all shapes and sizes: registrars, residents, medical students, nurses, technicians, patients, family members, general public, and of course, our surgical and anaesthetic colleagues. Becoming one of the ANZCA Educators Program (AEP)’s facilitators has been a fascinating journey and the ongoing support in my learning journey from the ANZCA Education unit and AEP colleagues has been amazing.

AEP consists of 13 modules and completion of the course involves attending a minimum of eight modules and submitting a post-course activity. Each individual chooses the modules most relevant to them and may enrol in single or multiple modules. The modules are highly practical for the busy clinical anaesthetist.

For those who want to improve, there are many tips and techniques that can be utilised in your everyday practice. For those who feel they are already well on the way to being great teachers and would like to contribute, we’d love for you to join your AEP colleagues as facilitators.

Great quotes from Albert Einstein:

- “The more I learn, the more I realise I don't know.”
- “Insanity: doing the same thing over and over again and expecting different results.”

Dr Emelyn Lee, FANZCA
ANZCA Educators Program Facilitator

Challenges of feedback



As a supervisor, do you find it hard to give feedback to people, in particular if it's not what they are hoping for?

Feedback conversations have the potential to enhance learning and improve performance but this is one of the most challenging and often misunderstood aspects of our work as educators, supervisors and leaders.

As part of a feedback conversation it is important to assist the learner to identify learning goals and to consider approaches to achieve these. The GROW model is a simple approach to engage the learner in a conversation. You assist them to develop a goal based on their current situation and to commit to a realistic plan to work towards achieving this.

Feedback conversations don't always go to plan so it is necessary to have awareness of the factors likely to contribute to establishing an effective learning conversation. Good planning includes establishing psychological safety, having an appreciation individuals may have a different perspective or frame in the same situation, so be curious. Unproductive behaviours may become a barrier and it may be necessary to bring these to the learner's attention and finally strive to get the learner to commit to a plan towards achieving their goal.

The ANZCA Fundamentals of Feedback (FoF) e-learning course provides a conversational framework and strategies to apply in all aspects of your daily practice. It includes seven interactive modules with activities and videos for pairs or small groups to work through together but we have also tailored the modules to cater to those wishing to progress through individually. We strongly encourage everyone involved in feedback (and debriefing) conversations to complete the course not just those in leadership or supervisory roles.

Access the course free at anzca.edu.au/networks/feedback.



Mentoring matters: connect to success

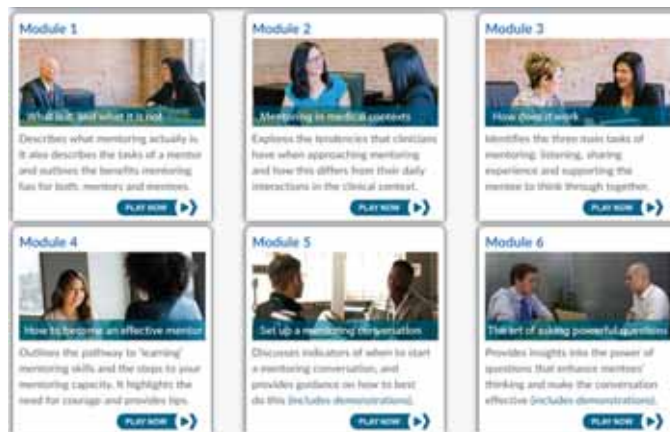
Entering practice in any profession offers a major challenge. Training is a formative period where knowledge, skills and attitudes are acquired or applied in practice. It can be a stressful time emotionally as new demands are placed on trainees and they strive to reach the ultimate goal of fellowship. External impacts such as workforce changes and other everyday trainee concerns or personal issues further complicate the journey¹. Throughout training and soon after (as a recently graduated fellow) are key periods requiring guidance and support in order to stay on track and develop competence and confidence. All trainees, SIMGs, new fellows and even senior fellows could benefit from having a mentor and being a mentor.

We understand the power of mentoring but how to do it effectively can be challenging. ANZCA's newly launched mentoring support resources, Fundamentals of Mentoring, aim to provide a training framework specifically for mentors and mentees in anaesthesia and pain medicine with practical guides on effective mentoring.

The resources are freely available to ANZCA and FPM fellows, trainees and SIMGs on Networks. Access now at anzca.edu.au/networks/mentoring to explore the value of mentoring and how you might develop productive and satisfying mentoring relationships.

Reference:

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Scholar role update

The scholar role, one of seven ANZCA Roles in Practice, is a component of the training curriculum. Since the curriculum change in 2013, the formal project has been replaced by the scholar role, which allows greater clarity and diversity of activities. It has continued to evolve in the past few years. It aims to facilitate the development of trainees as teachers and learners, teach them to critically assess data and sources of evidence before applying to clinical decision making, and contribute to quality assurance activities. There are currently five assessed scholar role activities (SRAs) and a volume of practice to complete during training.

1. Teach a skill	Complete two before the end of basic training and all before the end of advanced training
2. Facilitate a small group discussion/tutorial	
3. Critically appraise a paper	
4. Critically appraise a topic	
5. Complete an audit	
Attend two regional or greater meetings (exclude courses)	Complete by the end of provisional fellowship
Participate in 20 quality assurance meetings/activities	

The Scholar Role Subcommittee (SRSC) oversees the scholar role, including reviewing the assessment process, and evaluating the relevance of the activities in relation to the learning outcomes of scholar role. Each hospital department should have a nominated Departmental Scholar Role Tutor (DSRT), who can assess and approve each of the SRAs without going through the SRSC. However, application for exemption or recognition of prior learning needs to be approved by the SRSC (no exemption for audit). The SRSC provides support to DSRTs to champion the scholar role through direct advice and the provision of education resources.

We encourage trainees and DSRTs to engage in the ANZCA Networks learning platform, which contains important scholar role support resources, including 14 e-learning modules. The modules are also useful for ANZCA fellows, who could be nominated by the DSRT to assist in assessing trainees' SRAs within the department (except for audit). The evaluation forms and the associated guidelines provide additional information to support the assessment. Finally, this comprehensive learning platform is invaluable for ANZCA fellows who would like to learn more about education theory, critical appraisal technique and how to undertake an audit.

We welcome any feedback or suggestions for improvement from trainees and consultants regarding scholar role activities. Contact can be made via the regional SRSC Representative, or via Tracy Le, the committee administrative officer.

Committee members

Chair and Victoria Representative	Dr Irene Ng
Deputy Chair and New Zealand (North Island) Representative	Dr Nina Civil
Clinical Trials Network Executive Representative	Professor Philip Peyton
EDEC Representative and Fellow with Education Interest	Dr Jennifer Woods
Australian Capital Territory Representative	Dr Paul Burt
New South Wales Representative	Dr Scott Fortey
New Zealand (South Island) Representative	Dr Veronica Gin
Northern Territory and South Australia Representative	TBA
Queensland Representative	Dr Paul Lee Archer
Tasmania Representative	Dr Andrew Messmer
Western Australia Representative	Dr Dale Currigan
Fellow with Ethics Interest	Dr Kerry Warner
ANZCA President (ex officio)	Dr Rod Mitchell
Administrative Officer	Mrs Tracy Le

Dr Irene Ng, FANZCA
Chair, Scholar Role Subcommittee

Dr Nina Civil, FANZCA
Deputy Chair, Scholar Role Subcommittee

WBA workshop: The change is happening

In response to feedback received through numerous evaluation channels, the workplace-based assessments (WBAs) have been relaunched in 2019 to re-emphasise and re-educate the ANZCA community on further optimising the use of WBAs as feedback and learning tools.

The college has appointed 29 WBA leads throughout Australia and New Zealand. Their role is ongoing within their region, to promote WBAs as learning tools as well as provide education and support to individual departments.

Following a WBA lead training workshop in March, the leads are now delivering the workshops in their local regions – and every ANZCA accredited hospital is scheduled to be delivered a workshop, with the purpose of reinvigorating the WBA message at a local level. Fifty-nine workshops have been held so far, with nearly 1000 trainees and fellows attending. Of these, more than 60 participants have expressed their interest in the supporting role of WBA advocate. A WBA advocate is the local WBA voice and continues to embed WBA education and messaging within their hospital. Early feedback has been very positive on how the workshops have improved WBA philosophy and processes and particularly the use of WBAs as tools to enhance learning.



**Dr Sofia Huddart, FANZCA
WBA Lead, New Zealand**

The first WBA workshop I delivered was to a group of pre-fellowship trainees. The usual AV equipment hiccups, late start and overrun notwithstanding, the workshop was a success and the feedback was that they “felt enlightened” and “it has changed the way I teach”.

Since then I have delivered two more workshops at hospitals in NZ and one at the ANZCA ASM. As part of the workshop we use video examples of trainee encounters and ask the participants to give actionable feedback on the scenario. Even though I have watched these videos a number of times I am constantly surprised by the different nuances that have been picked up by the audience.

The workshop changes subtly every time I deliver it based on the feedback I get from the participants – actionable feedback in action! I am heartened by the enthusiasm shown by the participants and even more heartened when I hear that the workshops have made a real difference to the way they approach WBAs and the way they teach.



Dr David D'Silva,
FANZCA
WBA Lead, NSW



Dr Jessica Lim,
FANZCA
WBA Lead, NSW

The WBA relaunch is re-energising our use of WBAs to ensure we are all getting the most out of WBAs. The workshops are a great opportunity to reflect on the role of WBAs, how best to give actionable feedback and explore barriers and possible solutions to performing WBAs. Below are some common misconceptions and suggestions to overcome barriers which have been raised in workshops.

From a fellow's perspective:

Barriers and misconceptions	Solutions
Negative feedback may adversely affect trainee progression	Feedback is core in improving practice and performance – helps trainees to become better anaesthetists. The numerical global assessment score is a reflection of level of supervision, not a pass/fail measure.
Too much paperwork	With the new WBA forms you only need to fill in the parts you think are most relevant and you can leave the rest blank.
It takes too much time	WBAs are a way of documenting the learning and feedback experiences that occur during a normal clinical day. Practical solutions: Complete the WBA form online at the time of the clinical encounter, or discuss main feedback then fill in the form later.

From a trainee's perspective:

Barriers and misconceptions	Solutions
I've already done my VOP	The more feedback you get, the more you learn, the better you will be. Can learn a lot from doing the same WBA with different people, in different settings
I'm prioritising exams	WBAs are important learning opportunities which can assist with exam preparation.
I don't feel ready to do this WBA yet	WBAs are important at all stages of learning , particularly early on, to help refine your practice and technique.



Dr Su May Koh, FANZCA
WBA Lead, Victoria

WBAs are an important part of ANZCA training and are potentially being under-utilised. Through the 45-minute WBA workshops, we hope to encourage ANZCA fellows and trainees in doing WBAs with actionable feedback including providing tips about how to make them more manageable. We are also keen to recruit WBA advocates (fellows and trainees) across Australia and New Zealand, who will champion WBAs within departments. Please come along and support the WBA workshops!

The current state and future of anaesthesia education

Since the first demonstration of anaesthesia in the late 19th century, anaesthesia has become significantly sophisticated and advanced as a specialty.

Advances in drugs, monitoring, and the use of technology have allowed for effective care of patients with increasing pathophysiology and burden of disease. The role of the anaesthetist has expanded beyond the delivery of just an anaesthetic, to include perioperative care of the patient. While early anaesthetists were self-taught today's anaesthetists have primarily utilised the multiple master-apprentice form to train anaesthetists and current teaching is firmly adherent to this philosophy. This philosophy was based on a belief that the "trade" was best learnt and taught by experts of the trade.

Concomitant with the advances in anaesthesia and medicine was the development of educational theory. Early in the last century learning was explained by behaviourist theories. Recognition that the brain and memory are important in learning led to cognitivist views and methods. This gave way to constructivism theory, in which it was recognised that people construct their own learning on the basis of their prior "knowing" and experience. Teaching was viewed as helping the learner make meaningful views of anaesthesia. Complex concepts and techniques in education developed with greater understanding of learning and teaching. Concepts such as zone of proximal development, scaffolding, and learner centeredness directed the design, planning of teaching, and facilitation.

Assessment changed from recall of knowledge, to include application of knowledge, and included portfolio-based learning and competence-based training. Despite these advances, anaesthesia was quite late in recognising that a technically good anaesthetist was not necessarily a good teacher, and that principles of education had to be learnt to become an effective teacher.

Colleges and tertiary educational institutions have recently responded by developing education units and courses in education for the practising specialist.

The ANZCA Educators Program is an example of such a course, which is conducted by the ANZCA Educators Subcommittee (AESC). There is some recognition of the need to have an academy of anaesthesia education, with the roles and responsibilities of training anaesthetists defined rather than well-meaning anaesthetists.

Change is a constant process of life in current times.

Anaesthesia is not immune to the forces of change. While the future is always difficult to predict, some insight can be obtained by examining current trends:

- There is an increased demand for surgery and anaesthesia requiring increasing efficiency and efficacy. This will reduce the time available to teach in the clinical arena and threatens the master-apprentice model.
- There is an increasing need for safety. Anaesthesia should aim for minimal deaths from anaesthetic services.
- Incorporating new technologies such as artificial intelligence to the equipment will change the way anaesthesia will be delivered in the future.

The view of knowledge and learning theory has significantly altered in the digital age. Information is changing at an accelerating rate and the half-life of knowledge is now less than the training period. The use of social media and digital devices mean that trainees have greater control over their own learning. Trainees may benefit from possessing techniques to convert information to working knowledge rather than memorising facts. Connectivism will become the new norm in learning theory. Methods of teaching will need to significantly change from current practices.

Trainees in the future will not only be digitally native, they will also be social media native and will learn for immediate application rather than life-long learning. Anaesthesia may only be one career of many in their working lives.

Technology development can now be considered as the third industrial revolution. It will significantly alter life in the present century.

These challenges can be met with changing attitudes in anaesthesia education. Curriculum needs to be dynamic rather than have static five-yearly reviews, assessment will need to focus on learner performance rather than formal exams, anaesthesia education techniques will need to be just-in-time training and the currency of fellowship may need to be demonstrated at regular intervals.

This is both an exciting and challenging time for the college and requires good leadership so as not to be left behind.

Associate Professor Kersi Taraporewalla, FANZCA
2019 Steuart Henderson Award recipient

Diploma of Advanced Diving and Hyperbaric Medicine June/July 2019



Four candidates have successfully completed the 2019 ANZCA Diploma of Advanced Diving and Hyperbaric Medicine examination:

Iestyn Marc Lewis, Tasmania
Alicia Fleur Tucker, Tasmania
Paul Jason Schaper, Western Australia

Gregory Adrian van der Hulst, New Zealand

Court of examiners with the candidates from left: Ian Gawthrope (examiner), Alica Tucker (candidate), Professor David Smart (DHM examination chair), Iestyn Lewis (candidate), Greg van der Hulst (candidate), Glen Hawkins (examiner), Paul Schaper (candidate) and Susannah Sherlock (examiner).

Performing your own literature search

Literature searching involves capturing the key literature for a particular topic – each year the ANZCA Library undertakes a large number of searches for the purposes of patient care, research, presentations and study – with more than 120 searches completed in 2018.

However in today's "Google" world, searching online sources and databases is becoming more familiar, so the library is focusing more attention on supporting and guiding fellows and trainees about how to conduct their own literature searches.

The following article is based on workshops given at the 2018 and 2019 ASMs, and gives an overview of the process involved in creating a self-directed literature search.

Steps:

1. Composing your search.
2. Where to search.
3. Collating the results.



1. Compose your search

Before you even begin your search, take the time to work through the topic.

A. Define your topic/problem

- Precisely define your topic
 - *Don't include too many concepts.*
 - **PREOPERATIVE ASSESSMENT FOR CHILDREN UNDERGOING BARIATRIC PROCEDURES**
- Define your potential search terms
 - *Think about the individual parts that comprise the topic, and keep the terms concise.*
 - **PREOPERATIVE + ASSESSMENT + CHILD + BARIATRICS**
- Define the order of importance for the elements of the search
 - *This will help you when linking your search terms together or if you need to drop terms to increase the number of results.*
 - **BARIATRICS**
 - **ASSESSMENT**
 - **PREOPERATIVE**
 - **CHILD**
- Define your scope
 - *Consider broadening or narrowing your search terms.*
 - **PREOPERATIVE: Broader term = PERIOPERATIVE PERIOD**
 - **BARIATRICS: Broader term = OBESITY**
 - **BARIATRICS: Narrower term = BARIATRIC SURGERY**
- Consider the use of related or alternate terms
 - **ANAESTHESIA = ANESTHETICS**
 - **CHILD = PAEDIATRICS**

B. Create your search terms

- Subjects versus keywords
 - Where possible, try mapping your search term to a subject heading, as this will help yield the maximum number of results.
 - **BARIATRIC PATIENT = BARIATRICS**
 - **PREOPERATIVE = PREOPERATIVE PERIOD**
 - **ASSESSMENT = PATIENT OUTCOME ASSESSMENT or TREATMENT OUTCOME**

Tip: Check the subjects and keywords of already relevant articles to identify additional terms.

Tip: Use keywords where no comparable subject heading exists.



- Spelling

- Many databases utilise American spellings which can be tricky when searching for keywords however some databases allow the use of wildcards: ? and * can often be used to indicate optional characters.
- ANAESTHESIA = **ANESTHESIA**
- ANAESTHESIA, ANESTHETICS, etc. = **ANESTH***
- PAEDIATRICS = **PEDIATRICS**
- PAEDIATRICS = **P?EDIATRICS**

C. Building your search

- Build your search incrementally (one step-at-a-time)
 - *One term at a time will indicate if and where a search may need tweaking.*
 - BARIATRICS
 - BARIATRICS **AND** ASSESSMENT
 - BARIATRICS **AND** TREATMENT OUTCOME **AND** PREOPERATIVE PERIOD
 - BARIATRICS **AND** TREATMENT OUTCOME **AND** PREOPERATIVE PERIOD **AND** PEDIATRICS
- Use **Boolean** search logic to expand/narrow your results
 - *This tends to be where most searchers make critical mistakes – be careful when joining terms together, try grouping ANDs or NOTS, and try not to join too many together at once (and remember BODMAS).*
 - **OR** = expand the search results: PREOPERATIVE PERIOD OR PREOPERATIVE CARE
 - **AND** = narrow the search results: BARIATRICS AND PREOPERATIVE PERIOD
 - **NOT** = exclude certain terms: CHILD NOT ADULT
 - Use brackets to prioritise the order: BARIATRICS **AND** (PREOPERATIVE PERIOD **OR** PREOPERATIVE CARE)
- Be sure to **include subheadings** when searching
 - In Medline, this is called *exploding the term*.

D. Limiting your search results

- **Add your limiters** incrementally (one step-at-a-time)
 - *You can use additional subject terms to limit your search, but be careful not to use terms that are too narrow or that do not return many results in their own right – remember to start broad, and then narrow your results.*
 - Broad term = **HUMANS** [this would eliminate articles about animals]
 - Narrower term = **CHILD**
- Limit your results to a particular **date range**:
Publication year = **2000 to current**
- Limit your search by **language**: Language = **English**
- Limit your search to a **type** of article: Publication type = Review articles
- Limit your search by **age range**: Age group = **All Child**
 - *This latter term can be used as an alternative to adding a limiting subject heading.*
- **Focus** your terms = returns only those articles where the term is a major focus
 - *This can be very useful when using generic terms that return a large number of results.*

Tip: Use keywords to highlight terms in the citation (or use CTRL-F to highlight terms in a result list).

Performing your own literature search (continued)

2. Where to search

There are a large number of databases and collections that can potentially be utilised when searching for medical literature, depending on what topic and type of information you are seeking. The following databases are considered a good place to start, but this list is, by no means, exhaustive.

- **Ovid Medline**
While there are many platforms for searching Medline/PubMed, the Ovid platform is considered the best for advanced searching.
- **Ovid Embase** [where available]
An excellent adjunct to Ovid Medline with a focus on European content and proceedings. Does not use MeSH, but its own unique thesaurus, Emtree.
- **PubMed**
There is now very little difference between the content found on PubMed and Ovid Medline - both search the content of the MEDLINE database). Use for keyword searches only, as the advanced search/subject mapping requires expert training to utilise effectively.
- **Informit Health Collection**
Covers more than 190 titles from Australasia (including ANZCA publications).
- **ERIC**
An online library of education research and information.
- **Cochrane Library**
Excellent source for evidence-based publications and systematic reviews.
- **TRIP Database**
One-stop searching for guidelines and evidence-based material from around the world.
- **eTG Complete – Therapeutic Guidelines**
- **Google Scholar**
Keyword search only and downloaded citations do not contain abstracts. Possible to directly access ANZCA Library full-text through Library Links feature.
- **ANZCA Library Discovery Service**
Search the books, e-books, journals, e-journals and articles available via the ANZCA library. Contains the full MEDLINE index, MeSH searching is available via Advanced Search, and it is also possible to search Libraries Worldwide.

3. Collating the results


There are a number of reference tools available for collating and managing your search results – both paid and freely available.

Most databases allow users to export their search results in a number of different formats for loading to these reference tools. The most widely accepted format for loading is RIS.

The following are some of the more well-known reference tools.

- **EndNote:** A paid reference management software package, used to manage bibliographies and references when writing essays and articles. A free web-based version with limited features, EndNote Basic, is also available.
- **RefWorks:** A web-based paid reference management software package.
- **Zotero:** A free open-source reference management software used for managing bibliographic data and related research materials (such as PDF files).
- **Mendeley:** A free desktop and web program produced by Elsevier for managing and sharing research papers, discovering research data and collaborating online.

The ANZCA library has produced number of guides that provide additional information about all of the above reference tools, as well as links to comparison tables for selecting the best tool for you.

 For further information on undertaking literature searches and managing references, see the Literature Searching library guide: <https://libguides.anzca.edu.au/litsearch>

What's new in the library

New books for loan

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

Developing anaesthesia textbook: guidelines for anaesthesia in developing countries V.1.6

Prescod, D. – Ashburton, Vic. : J.L. Publications, 2010.

My career in anaesthesia: 1970-1988

Gibb, D. – Woolwich, NSW : David Brunton Gibb, [2019]. *Kindly donated by the author*

Obstetric anaesthesia for developing countries

Clyburn P, Collis RE, Harries S. – Oxford; New York: Oxford University Press, 2010.

QBase Anaesthesia. Volume 6, MCQ Companion to Fundamentals of Anaesthesia

Pinnock C, Jones R, Maguire S, Barker JM, Mills S. – Cambridge: Cambridge University Press, 2015 [online publication date]; 2000 [print publication date].

The social prescription: how savvy doctors leverage online platforms for professional success

Marjorie Stiegler M. [Place of publication not identified] : [publisher not identified], 2018. *Kindly donated by the author.*

Understanding paediatric anaesthesia

Jacob R. – New Delhi: BI Publications Pvt, 2008.



New eBooks

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

1,000 Practice MTF MCQs for the primary and Final FRCA

Ebrahim H, Clarke M, Susnerwala I, Pierson R, Pierson A, Bindal N, eds. – Cambridge: Cambridge University Press; 2019.

Ferri's Clinical Advisor 2020

Ferri FF. – Philadelphia, PA: Elsevier; 2020.

Physics, pharmacology, and physiology for anaesthetists: key concepts for the FRCA

Cross, ME Plunkett, EVE – Cambridge: Cambridge University Press, 2014.

New subject guide



A new Drug Information library guide is now available.

The guide has been designed for anaesthetists, pain specialists and medical professionals interested in obtaining drug information about medications, anaesthetics and analgesics, and brings together a wide variety of resources including AusDI, the new Ovid Drug Search Builder, Australian Medicines Handbook, state-by-state legislation, websites, journals (like *Journal of Opioid Management*), books, e-books (like *Katzung's Basic and Clinical Pharmacology* and *Goodman & Gilman's The Pharmacological Basis of Therapeutics*) and much more.

This guide and many others can be accessed via the library guides page: <http://libguides.anzca.edu.au/>.

Contact the ANZCA Library

www.anzca.edu.au/resources/library/contacts

T: +61 3 9093 4967

F: +61 3 8517 5381

E: library@anzca.edu.au

Building funding streams

Since June, the foundation has continued to work on building funding streams to strengthen the sustainability of ANZCA's crucial support for fellow and trainee-led medical research, and resilience to funding variability. Thank you to our wonderful committed foundation donors, who are vital to the ongoing sustainability of support for innovative research led by ANZCA and FPM fellows and trainees.

At the same time, we have been busily working to increase support for ANZCA overseas aid activities aimed at saving and improving lives in parts of the world where clinical skills and services are in desperately short supply.

ANZCA research grants for 2020

In 2019, ANZCA received 55 grant submissions for a diversity of innovative studies in 2020, including 17 from first-time applicants and 23 from female principal investigators. Submissions were assessed by the ANZCA Research Committee at its meeting on September 6, and applicants will be advised of the outcomes towards the end of September. Full details will be announced in the December *ANZCA Bulletin*. The foundation sincerely thanks all applicants and grant reviewers, and looks forward to an exciting round of newly funded studies commencing in 2020.

Medibank Better Health Foundation (MBHF) grant

The new MBHF Regional Anaesthesia Outcomes Grant process is progressing well, with applications received and reviews now completed. The successful application, based on both the grant-specific and ANZCA Research Committee peer review criteria, was determined at the committee meeting on September 6. MBHF will provide \$A50,000 to the foundation for the inaugural grant, and we sincerely thank the Medibank Better Health Foundation for supporting research in this important area of perioperative medicine.

CSL Behring

CSL Behring is a gold member of the foundation's Leadership Circle supporter group, and grants \$70,000 biannually to support an ANZCA investigator-led study in coagulation, major joint replacement, gastric or transplantation surgery. We are currently discussing which applications for 2020 ANZCA grants could be suitable for the next CSL Behring ANZCA Research Award. We greatly appreciate their generous support, and are seeking to continue this long-term grant funding relationship to further enhance the sustainability of ANZCA-supported research.

Norman Beischer Medical Research Foundation Foundation has been invited to apply

Following meetings with NBMRF the foundation has been invited to submit an innovation grant application for an obstetrics-related study for the funding round that closed on September 12. The foundation applied for funding support for a highly relevant study already submitted in the current ANZCA funding round, and the NBMRF funding will be contingent on both ANZCA Research Committee approval and success in the NBMRF process.

New scholarship grants

The foundation also advises potential applicants that the NBMRF has advised that their new Clinical Research Fellowship and Scientific Research Fellowship commencing in 2020 are now open for applications. Each will award \$A600,000 over three years, and are aimed at early- to mid-career researchers within seven years of their PhDs. The target areas are women's reproductive health, babies and infants, obstetrics, gynaecology, neonatology, and prevention, control and treatment of pregnancy complications, gynaecological diseases and related problems.

Application information can be found at <http://nbmrf.org.au> and applications close on Friday October 25.

AMERS scholarship and AMEARA grant



From left: Dr Steven McGuigan, Dr Peter Lowe and Dr Sebastian (Bae) Corlette.

The ANZCA Melbourne Emerging Researcher Scholarship and ANZCA Melbourne Emerging Anaesthesia Researcher Award were conferred by Melbourne Medical School Chair of Anaesthesia Professor David Story, at the Winter Anaesthesia Meeting in Melbourne on July 26. The scholarship went to Dr Sebastian (Bae) Corlette of the Royal Children's Hospital, to support a PhD at the University of Melbourne examining frailty in critical illness and perioperative care, while the research award went to Dr Steven McGuigan, Maroondah Hospital, for his project "Comparison of the effects of xenon and sevoflurane anaesthesia on neurofilament light and tau protein in patients undergoing lithotripsy: a pilot study". The foundation warmly congratulates Dr Corlette and Dr McGuigan, and sincerely thanks Dr Peter Lowe once again whose ongoing vision supports both of these important emerging investigator awards.

Research committee strategy meeting

This meeting was held on August 9 and focussed on progressing the Research Strategy Committee succession planning, and the establishment of a network for mixed methods educational research.

(continued next page)

Building funding streams (continued)



Dr Pranita Mandal from India was a WFSA/SPANZA Paediatric Anaesthesia Fellow at Christian Medical College, Vellore, Tamil Nadu, India for six months.



Dr Faith V Moyo, World Federation of Societies of Anaesthesiologists (WFSA) fellow from Zimbabwe who undertook the WFSA Regional Fellowship in Kumasi, Ghana for three months.

Fund-a-Fellow

The foundation has established easy ways to donate to help train much-needed high-quality anaesthetists in the developing world, through ANZCA's support of the Fund-a-Fellow overseas aid program of the World Federation of Societies of Anaesthesiologists.

We can accept single gifts via the foundation's donation webpage, or arrange regular automatic giving for interested donors. There is a general Fund-a-Fellow option, as well as a dedicated fund in memory of Perth anaesthetist Dr Alistair Davies. Such funds can be established for any interested hospital.

Further information is available on the foundation website section. To make a tax-deductible donation, please go to anzca.edu.au/research/foundation.

Global Safer Surgery Fund

This exciting new fund has been established through the generous gifts and commitments of past ANZCA president and foundation chair, Dr Genevieve Goulding. The first grant will be allocated via the Overseas Aid Committee through the Colleges of Medicine in South Africa to a vital obstetric study which is a part of the African Surgical Outcomes Study. Anyone interested in donating to this fund should contact the foundation.

Congratulations Ian and Mary Rechtman

Warm congratulations to retired fellow Dr Ian Rechtman and his wife Mary, two long-term friends of the foundation, who both recently celebrated their 80th birthdays at the college. We particularly thank Ian and Mary for asking their guests to support the foundation resulting in almost \$1000 raised to date.

Member Advantage

The foundation will soon provide a special newsletter just for ANZCA Member Advantage program members, with the latest news on special exclusive member offers.

A regular link will also be provided within the *ANZCA E-Newsletter*, as another easy access option for anyone interested in special offers and savings for members on a range of popular lifestyle products and services and in supporting the foundation.

Leadership Circle

On June 14, the foundation held its second Leadership Circle lunch event for 2019, generously hosted by Mr Rob Bazzani, National Managing Partner Enterprise, and Leadership Circle Chair Mr Ken Harrison, at KPMG's Melbourne office boardroom.

Once again guests from business and philanthropic organisations, including the Princes' Trust (UK), CSL Behring, Medtronic, Edwards Lifesciences, Norman Beischer Foundation, and the Alfred Foundation, attended as part of widening the foundation's support network. Guests learned about research into general anaesthesia and the neurodevelopment of the infant brain through a fascinating presentation from leading expert Professor Andrew Davidson, from the Royal Children's Hospital in Melbourne.

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.

Pugh lecture no laughing matter



The eighth Pugh Day lecture “A vexed history of laughing gas: a cycle out of depression” was delivered on Sunday June 16 by fellow Professor Paul Myles to more than 80 members and guests of the Launceston Historical Society.

It was on June 7, 1847 that Dr William Pugh performed surgery on a patient under the influence of ether in his private hospital in Launceston – a first for Australia.

Launceston Historical Society President Marion Sergeant welcomed guests and Dr John Paull, convenor of the Pugh Day lecture introduced guest lecturer Professor Myles, Director of the Department of Anaesthesiology and Perioperative Medicine at The Alfred hospital in Melbourne and Monash University. He is an Australian National Health and Medical Research Council (NHMRC) practitioner fellow, and fellow of the Australian Academy of Health and Medical Science, an editor of the *British Journal of Anaesthesia* and an editorial consultant for *The Lancet*. He has published more than 300 articles, and been awarded more than 25 NHMRC grants totalling more than \$A35 million. The main focus of his research has been on patient quality of recovery, avoidance of postoperative complications and large multicentre trials in perioperative medicine. In 2017 he received the Excellence in Research Award from the American Society of Anesthesiologists.

In his lecture Professor Myles reviewed the early history of the discovery of nitrous oxide by Joseph Priestley in 1772, its use in stage shows, dentistry and the role of Horace Wells in popularising its use in dentistry and surgery. He also told the story of Wells’ tragic death and said Wells deserved recognition for his role in establishing nitrous oxide as an anaesthetic agent.

The early users of nitrous oxide did not appreciate that if inhaled without air or oxygen it would prove rapidly fatal and a number of patients died because of this misunderstanding. Once ether and chloroform were introduced as anaesthetic agents in 1846 and 1847 it became customary to administer safe concentrations of nitrous oxide as part of the anaesthetic.

While the use of nitrous oxide appeared to be very safe, concerns began to emerge that its long-term use could lead to disability and death because of its effects on haematopoiesis. In 2014, Professor Myles and five other colleagues published a report based on an analysis of 138 abstracts selected from more than 8000 journal abstracts. The conclusion was that at that time, scientists did not have robust evidence for how nitrous oxide used as part of general anaesthesia affected mortality and cardiovascular complications.

Over a number of years Professor Myles and other researchers reported the results of the large ENIGMA trial and its successor ENIGMA II which attempted to identify adverse effects of nitrous oxide use during general anaesthesia. One conclusion was that nitrous oxide was safe to use in non-cardiac surgical patients.

Professor Myles concluded the lecture by revealing that inhaling nitrous oxide in safe concentrations reduced depressive symptoms in psychiatric patients.

Deanna Ellis, president of the Launceston General Hospital Historical Committee invited questions from the audience and Ms Sargent presented Professor Myles with a bottle of Tasmanian wine and a hard cover, signed and numbered copy of Dr John Paull’s annotated transcription of Dr Pugh’s diary of his 1835 four month voyage from England to Van Diemen’s Land, long thought to have been lost.

Dr John Paull, FANZCA

CTN Annual Strategic Research Workshop



The 11th Annual Strategic Research Workshop was held from August 8-11 in beautiful Manly, allowing delegates to take advantage of morning walks ahead of a busy schedule. It was our largest meeting to date.

Professor Philip Peyton warmly welcomed delegates and speakers to the meeting, including special guests from the Australian Clinical Trials Alliance (ACTA), directors Professor Judith Trotman and Mr Kieran Schneemann, and general manager Ms Simone Yendle. They were joined by Ms Masha Somi, Assistant Secretary, Health and Medical Research Office in the Health Systems Policy Section of the Federal Department of Health, as part of ACTA's program to engage policy-makers in the important work of clinical trial networks. As part of ANZCA's commitment to enhancing collaboration and sharing of clinical research and knowledge with the Chinese Society of Anaesthesiologists (CSA), we were also delighted to have two CSA members, Dr Xu Xiaohan and Dr Xiao Wei, attend the meeting.

In the welcome presentation, Professor Philip Peyton and Ms Karen Goulding reflected on 25 years of CTN achievements, from MASTER through to the RELIEF, of multicentre clinical trials overturning prevailing myths and providing reliable evidence to guide clinical practice, with many more trials near or at completion, including the PADDI and BALANCED anaesthesia trials.

The meeting showcased a mix of new research proposals from paediatric trials HAMSTER and BAT trials by Dr Susan Humphreys and Professor Britta Regli-von Ungern-Sternberg, through to trials in remote medicine (CLIP-II by Professor Michael Reade), hyperbaric medicine (SHOOSH by Professor

Michael Bennett), and pain medicine trials (Dexmedetomidine vs Ketamine vs Fentanyl for Patient Controlled Analgesia by Professor Yahya Shehabi). We heard updates from investigators of CTN-endorsed studies and had the opportunity to ask questions about VAPOR-C during the information session led by Ms Sam McKeown and Professor Bernhard Reidel.

This year Professor Val GebSKI, from the NHMRC Clinical Trials Centre, delivered an advanced stats presentations on outcomes and endpoints, and the importance of adapting to novel trial designs. Keynote presenter Dr Felicity Flack, from the Population Health Research Network, discussed the types of administrative data available prior, throughout, and after the perioperative period, that are available to link data for our studies. Advice from Dr Flack included how to apply to access datasets and what's involved.

Professor Andrew Davidson from the Royal Children's Hospital, enlightened us with his keynote presentation on the lessons learned from the GAS trial, in particular the many challenges we face to run international clinical trials. He left the audience a little wary of which international sites to consider for CTN trials, but more knowledgeable about which countries are efficient and cost-effective in trial delivery.

Dr Tom Poulton, Dr David Highton, Dr Jennifer Reilly, Professor David A Scott and Professor Philip Peyton discussed the important work of trainee research networks including the work by UK and Australian and New Zealand networks for national audits, such as the UK National Emergency Laparotomy Audit (NELA) and its Australian and New Zealand equivalent ANZELA.

While a few fit delegates took to part in the City2Surf on Sunday morning, the third day started with Professor Tim Short presenting the landmark results of the BALANCED anaesthesia trial. It was an opportunity to thank the investigators and co-ordinators many of whom were in the room for their perseverance and dedication to the trial. BALANCED recruited in 74 centres across eight countries.

Keynote presenter, Dr Janelle Bowden (CEO and founder of Research4Me) gave us insight on the state of play of consumer involvement in clinical trials in Australia, including barriers and enablers, and how CTN can go about undertaking greater consumer engagement. Dr Bowden emphasised the need for CTN to first work out “why” we want to involve consumers before going about doing so. The discussion continued with a panel convened by Professor Philip Peyton, consisting of Dr Janelle Bowden, Professor David A Scott, Ms Jan Sharrock and Associate Professor Rachael Parke, discussing the public profile of anaesthesia research and of the specialty in general, with interesting views put from many in the panel and audience.

At the end of the meeting, Professor Philip Peyton thanked speakers, delegates, and the ANZCA CTN and events team for organising another highly successful meeting, and took the opportunity to also thank the outgoing ARCNSub-committee members for their contribution to the research coordinators network.

Anaesthesia Research Co-ordinators Network (ARCNS) news

The ARCNS Sub-Committee met ahead of the meeting to revise its strategic plan and plan activities for the next two years. Their vision is “to support, co-ordinate and implement world-class anaesthesia research and practice.” We welcomed new committee members, which now have regional and specialty representation across Australia and New Zealand.

Some of the key achievements of the network in the past year include providing monthly inservice sessions where approximately 30 research co-ordinators dial in for education sessions and troubleshoot challenges related to their work. There’s a couple of very exciting projects under way to better estimate research co-ordinator time and therefore true costs associated with recruiting patients to CTN trials led by Ms Anna Parker and Ms Jaspreet Sidhu, and focus group sessions to determine barriers and enablers for the research coordinator role for new and experienced coordinators led by Ms Gillian Ormond.

The ARCNS meeting, convened by Ms Dhiraj Bhatia Dwivedi, was a very interactive meeting with more than 70 delegates attending. Ms Davina McAllister, BALANCED Anaesthesia Trial Manager, talked us through the trial and tribulations of the trial, and along with Ms Pauline Coutts, WA PADDI trial co-ordinator, gave us an indepth insight to the behind the scenes work to collect and clean data, and the importance of source verification and endpoint adjudication. Keynote speaker, Dr Felicity Flack,

from the Population Health Research Network, along with Ms Sofia Sidiropoulos, ROCKET Trial Manager, taught us how data is linked, and more importantly, what research coordinators need to know to consent patients to link their Medicare and Pharmaceutical Benefits Scheme data. Mrs Samantha Bates led a vignette of entertaining role plays by ARCNS Sub-Committee members on challenging consent and recruitment scenarios. Delegates were able to share their experiences and provide tips on dealing with non-legal guardians trying to give consent for a child, obstructing family members, and dealing with a busy admissions team.

Ms Allison Kearney from Princess Alexandra Hospital was appointed as the new ARCNS Sub-Committee Chair. Allison has a background in science and experience with facilitating a number of CTN-endorsed trials. Her leadership skills will be a true asset for the new committee. Thank you to Ms Lauren Bulfin for her invaluable work as outgoing chair and to all outgoing committee members. We are pleased that Lauren will continue on the committee. Thank you to Dhiraj who was acting chair during this time.

The research co-ordinators networking event is an important event on the ARCNS calendar. It gives opportunity for research coordinators, many of whom work in isolation, to meet with their peers and mentors. This year’s event, hosted by Ms Margie McKellow, was held on the foreshore of Manly Beach and was thoroughly enjoyed by research co-ordinators.

Emerging research workshop

The workshop co-convened by CTN Executive members gave fellows and trainees the opportunity to share experiences and tips for undertaking research higher degrees (RHDs). The program began with presentations by two of Australia’s leading academic anaesthesia researchers and former CTN chairs, Professor David Story, University of Melbourne, and Professor Paul Myles of Monash University, who gave a “top down” view of the RHD landscape, the value and importance of a RHD to a research career in anaesthesia, and the key elements of success for candidates. The second session, titled “Into thin air”, was ably led by Professor Kate Leslie, who chaired a panel of former and current RHD candidates, Professor Britta Regli-von Ungern-Sternberg, Associate Professor Nicole Phillips, Dr Paul Lee-Archer, Dr Jennifer Reilly, Dr Daniel Frei, Dr Viraj Siriwardana, Dr Matthew Doane, and Dr Julia Dubowitz. In this wide-ranging discussion, the panellists shared their experiences of the challenges and rewards, personal, family, financial and professional, of engaging in a RHD while pursuing training and a career in anaesthesia.

Opposite clockwise from top left: Dr Xu Xiaohan and Dr Xiao Wei; Delegates at the research co-ordinators workshop; Associate Professor Nicole Phillips, Dr Jennifer Reilly, Dr Paul Lee-Archer, Dr Julia Dubowitz, Dr Viraj Siriwardana and Dr Daniel Frei; Delegates at the workshop opening; Ms Masha Somi, Professor Val GebSKI, Dr Felicity Flack, Professor Philip Peyton, Professor Judith Trotman, Mr Kieran Schneermann and Ms Simone Yendle; Professor Paul Myles, Professor Britta Regli-von Sternberg-Ungern, Dr John Loadsmann and Professor Kate Leslie AO.

Home and abroad: In pursuit of safe anaesthesia and surgery

Professor Alan Merry gave the inaugural Alan Merry Oration at the New Zealand Anaesthesia Annual Scientific Meeting (ASM) in Queenstown on August 22. Professor Merry, a former ANZCA councillor, is head of the School of Medicine at the University of Auckland and chair of the New Zealand Health Quality & Safety Commission. Here is an extract from his presentation which examines how visionary leadership and commitment to high standards has helped make New Zealand one of the safest places in the world to have a procedure under general anaesthesia.

The history of modern anaesthesia began on September 30, 1846, with the administration of ether by William TG Morton at the Massachusetts General Hospital in Boston. Less than one year later, on September 27, 1847, the administration of Aotearoa New Zealand's first general anaesthetic by Mr Marriot (not a doctor, or even any other sort of trained anaesthesia provider) took place at the Colonial Gaol, Wellington. Later the same day, a tumour was removed from the shoulder blade of a Māori chief, Hiangarere, in the newly built Wellington Hospital. Fortunately, the outcomes were excellent on both of these historic days. Sadly, this honeymoon period for anaesthesia did not last. The first reported death attributable to anaesthesia occurred only months later, in London on January 28, 1848, when Hannah Greener, aged 15, died during the administration of chloroform for the removal of an infected toenail. The coroner exonerated the surgeon for the death, ushering in a period during which it was widely believed that anaesthesia was inherently dangerous and that it was inevitable that from time to time patients would die, mysteriously, "from the anaesthetic".

Theory is critical in research and quality improvement. My theory is that our patients are amazingly safe today in no small part because the very high standing of our specialty affords us the ability to recruit the best trainees and to influence funders and employers. This high standing reflects professionalism, evidenced by commitment to excellence in clinical practice underpinned by training and CPD, an emphasis on teamwork, mortality review, incident reporting and audit, research and engagement in the wider challenges confronting healthcare at home and abroad. By contrast, as with that first anaesthetic in Wellington, many anaesthetics in other countries are still given by people who have no relevant qualifications and inadequate training, drugs and equipment. As with Hannah Greener, the consequences are often tragic. Moreover, these practitioners, although often highly dedicated, are poorly placed to improve the standard of anaesthesia care provided in their countries.

The story of the advance of anaesthesia in Aotearoa/New Zealand to its current international level of standing and safety reflects the contributions of many individuals, and also of two organisations – the New Zealand Society of Anaesthetists (NZSA) and the Australian and New Zealand College of Anaesthetists (ANZCA, formerly the Faculty of Anaesthetists of the Royal Australasian College of Surgeons), including its former Faculty of Intensive Care and its current Faculty of Pain Medicine.

The first person to seriously challenge the flawed theory that many anaesthesia deaths were simply inevitable was Professor (later Sir) Robert Macintosh, who was born and educated in New Zealand. In 1948, in a scathing paper published in the *British Journal of Anaesthesia*, he argued that many anaesthesia deaths were the result of obvious physiologic derangements such as airway obstruction, hypoxemia, and overdose – and therefore preventable.

He advocated better training and during his career contributed to improving the standards of anaesthesia not only in the UK, but also in the global context, including New Zealand via many kiwis who trained in Oxford.

An essential part of this story was the establishment (and then the re-establishment) of a committee for learning from anaesthetic (and then perioperative) deaths. A series of prosecutions of health professionals (including anaesthetists) for manslaughter arising from the tragic deaths of patients through simple errors in their care created a challenge to progress, but the passing of the Crimes Amendment Act of 1997 (after several years' work by me, Dr Leona Wilson, Dr Ross Blair and Mr (now Judge) Bruce Corkill) pressed a reset button on this country's approach to accountability and learning when things go wrong in healthcare. Since then, a progressive evolution towards a just culture has been increasingly apparent in New Zealand.

The leadership shown by anaesthetists within their specialty has been exemplary. As an example, I was attracted to the specialty by the strength of the departments established by Dr (now Professor Emeritus) Mike James in Zimbabwe and by Dr Jack Watt, Dr Tony Newson and others in Auckland. Among many other examples, I note the contribution of Dr Jack Watt, Professor Barry Baker, (and other members of the once very strong academic department in Dunedin), Professor John Gibbs and Dr Leona Wilson (Dr Wilson was ANZCA's first New Zealand president and first woman president).

Many anaesthetists have extended this leadership beyond the limits of their specialty (for example Dr David Sage, Dr Vanessa Beavis, Dr Gary Hoggood, Dr Tom Watson and Dr Donald Mackie). Expert assistance to the anaesthetist is central to safety. The contributions of Dr Andrew Warmington and Dr Malcolm Stuart stand out in establishing the role of anaesthesia technicians as health professionals in New Zealand.

Over the years, a substantial body of world-class research conducted by New Zealand anaesthetists has advanced both patient safety and the standing of the specialty. This has included pure science (for example, Professor Brian Anderson's work on pharmacokinetics and pharmacodynamics of simple analgesics and Professor Jamie Sleigh's work on the mechanisms of anaesthesia), aspects of clinical practice (work by Dr Basil Hutchinson and Dr Tony Newson on the mechanisms of gastric emptying, and by Professor Tim Short and Dr Doug Campbell on the depth of anaesthesia and on outcomes of anaesthesia) to major quality improvement initiatives (work by Professor Simon Mitchell, Professor Jenny Weller, Dr Jane Torrie, Dr Kerry Gunn, myself and others related to the World Health Organization (WHO) Checklist, simulation training and teamwork, blood conservation and medication safety).

Emerging researchers are critically important, and include Dr Courtney Thomas, whose work is examining the Māori experience of anaesthesia in the perioperative setting.

New Zealand is now grappling with the implications of colonisation and failures to honour its founding document, the Treaty of Waitangi on healthcare outcomes. Dr Stuart Walker and Dr Ted Hughes are contributing importantly to ANZCA's Indigenous Health Committee. Our president, Dr Rod Mitchell, is a role model for healthcare leadership in this regard, as reflected by the college's new Indigenous Health Strategy.

Many New Zealand anaesthetists (including Dr Alan Goodey and Dr Indu Kapur) have made substantial contributions to the formidable challenge of providing safe surgery beyond our borders, working through the NZSA, the World Federation of Societies of Anaesthesiologists (WFSA) and other organisations. Lifebox and the "International Standards for a Safe Practice of Anaesthesia" emerged from my time as chair of the WFSA Quality and Safety Committee and involvement with the WHO initiative to establish the Surgical Safety Checklist. The work by Dr Peter Kempthorne and Dr Wayne Morriss on the WFSA Global Anaesthesia



Workforce Survey has been a major contribution, which informed the important WFSA position statement on anaesthesiology and universal health coverage and facilitated engagement between WFSA and WHO.

Today in Aotearoa/New Zealand the standards of anaesthesia are among the highest in the world. I believe this overview of the development of our specialty supports the theory that these high standards reflect the enviable standing of our specialty in this country.

This, in turn, reflects the professionalism of many anaesthetists, manifest individually and via the NZSA and ANZCA over many years. This professionalism has been based on an understanding that patient safety in anaesthesia depends on high standards of individual clinical care underpinned by extensive training and ongoing professional development informed by high quality research.

Furthermore, there has been a culture of working effectively with our colleagues in interprofessional teams and with each other to maintain our own mental and physical wellbeing within an inclusive community of colleagues and friends. I have long been grateful for the privilege of being an anaesthetist in New Zealand.

MEWS – reducing maternity emergencies

A national maternity early warning system (MEWS) is being introduced throughout New Zealand over the coming year as a tool to prompt early recognition of and response to deterioration through abnormal vital signs.



The nationally consistent vital signs chart is a key part of MEWS and will be used in hospitals for all women requiring repeated observations (excluding routine intrapartum use) from the time they test positive for pregnancy until six weeks after the pregnancy ends, and in all areas where pregnant women may be inpatients (not just maternity wards).

Fellow Dr Matthew Drake, from the National Women's Hospital in Auckland, is the anaesthetic lead for MEWS with the Health Quality & Safety Commission. "It's really exciting to be involved in a quality improvement project that will enhance safe maternity care across the whole country," says Dr Drake. "We developed MEWS with input from all disciplines across the country. My hospital, along with Nelson Marlborough and Northland District Health Boards (DHBs), tested and refined MEWS. Having a standard



recognition and response system across the country will make life easier for staff and locums moving between organisations and provides a consistent communication of a woman's condition between referring centres."

Like the adult national early warning system (NZEWS), the MEWS chart includes the mandatory escalation pathway to respond to deterioration in a graded manner. The chart also includes a modification box to account both for stable chronic disease and time-limited amendments such as awaiting treatment to take effect or for a neuraxial anaesthetic to wear off. Like the adult system, a single extremely abnormal parameter, or several more minor physiological derangements, can trigger a high-level escalation. However, the maternity version has different thresholds for escalation to reflect the normal physiological changes of pregnancy and the ability of this population to compensate for acute illness. The maternity chart also includes diastolic blood pressure as an additional scored parameter, reflecting the importance of hypertensive disease in pregnancy.

The Maternal Morbidity Working Group 2018 annual report showed that in New Zealand, the leading causes of admission to intensive care units during or shortly after pregnancy continued to be haemorrhage, hypertensive disease and sepsis. The report concluded that around half the reviewed cases of sepsis that resulted in admission to higher level care could have been avoided. The leading contributing factors to the deterioration of these women across disciplines are failure to recognise the severity of illness, delay in treatment, and inadequate communication. Early recognition and response systems have been identified as valuable for women if their condition acutely deteriorates while in hospital, reducing the severity of deterioration and improving recovery.

Severe morbidity in pregnancy can have lasting effects for women. In addition to the long-term physical and psychological effects of severe illness, there may be separation from their newborn, anxiety for their partner and other children, as well as potential impacts on breastfeeding success and future fertility.

The maternity vital signs chart deliberately has a similar layout and colour scheme to the adult chart, leveraging off Australian human factors research on vital signs chart design. Added to the chart, MEWS has a robust pathway to respond to deterioration.

"Although recognition and response systems have been shown to reduce outcomes such as cardiac arrest and in-hospital mortality, their effectiveness in maternity has not been demonstrated," says Dr Drake. "So, it was really encouraging to see a significant and sustained reduction in the emergency calls to maternity wards in Auckland during the MEWS trial, even though we already had a maternity-specific vital signs chart at the Auckland District Health Board."

Dr Drake says staff are really embracing the change to the new national MEWS. "They feel it is a useful tool both to objectively measure deterioration, and to obtain a medical review where appropriate. At the other end of the scale, the system can give confidence at times when medical intervention is not needed."

MEWS should be implemented across all DHBs in New Zealand by mid-2020.

For more information visit www.hqsc.govt.nz/our-programmes/patient-deterioration/workstreams/maternity-early-warning-system/.



2019 New Zealand Anaesthesia ASM – a record-breaker

The New Zealand Anaesthesia ASM, which joined with the Annual Queenstown Update in Anaesthesia (AQUA) on August 21-24, was a record-breaker on a number of fronts but it was the quality of the speakers that wowed the delegates.

The NZ ASM sold out in record time, weeks before the early-bird closed. More than a third of delegates were from across the Tasman with others from as far afield as Finland and Qatar. ANZCA President, Dr Rod Mitchell skied for the first time in 40 years (which has to be some sort of record)!

The meeting, with the theme “Aspirations into Actions” was hosted by the ANZCA New Zealand National Committee (NZNC), the New Zealand Society of Anaesthetists (NZSA) and the Joint Anaesthesia Faculty of Auckland (JAFA). It boasted an exceptional line up of top speakers to match the breathtaking scenery of the alpine tourist town nestled on the shores of Lake Wakatipu and surrounded by dramatic mountain ranges.

It was opened with a pōwhiri (Māori welcome) from Ngāi Tahu and also included a session on cultural considerations. UNESCO Chair in Refugee Integration through Languages and the Arts at the University of Glasgow,

Professor Alison Phipps, addressed the complications of using translators in health environments. The delegates also heard about health equity and cultural safety with a presentation by the new ANZCA New Zealand General Manager, Kiri Rikihana, who has just completed five years as a senior executive of Health Quality & Safety Commission.

Professor Ed Mariano, one of the top 10 anaesthesiologists on Twitter, came from Stanford University in the US with a megalo-load of ideas and enthusiasm to match. Dr Mariano urged delegates to get active on Twitter to dispel the unnerving growth of anti-science chatter on social media.

Dr Andrew Klein, editor-in-chief of *Anaesthesia* revealed the prestigious UK journal is uncovering scientific fraud using the Carlisle Method that is triggering international investigations at the rate of one every two weeks. In his presentation in Queenstown Dr Klein discussed how the medical research sector can clean up the scientific record and get rid of “fake data”.

Both Professor Mariano and Dr Klein prompted a lot of media attention with eight requests for radio interviews and a *Listener* article.

To launch the new ANZCA Alan Merry Oration, Professor Merry gave the NZ ASM opening address (see page 76).

The Clinical Director of Christchurch Hospital, Dr Ashley Padayachee, looked at the impact of the March 15 mosque attacks in his presentation on dealing with a mass

casualty event from the Christchurch Hospital perspective (see page 38) for more on this story).

Dr David Choi from Counties Manukau District Health Board (CMDHB) walked away with the ANZCA Trainee Prize and the NZSA Ritchie Prize for his paper “Characterisation of aluminium release by the Englow® Fluid-Warming System in crystalloids and blood products”. “The effect of perioperative slow release opioid use at the time of total knee arthroplasty on long term opioid use following surgery” was the title of Dr Nicholas Lightfoot’s winning poster prize awarded jointly by ANZCA and NZSA. Dr Lightfoot is also with CMDHB.

There will not be an Aotearoa/New Zealand ASM in 2020 but plans are under way for a two-day leadership and research hui to be held at the Waitangi Treaty Grounds in the Bay of Islands in November. Watch this space.

The 2021 Aotearoa New Zealand ASM will be held in Christchurch from November 18-20 with the theme “The truth is out there”.

Above from left: ANZCA President, Dr Rod Mitchell, and Heather Ann Moodie, who recently retired as general manager of the ANZCA New Zealand Office, on the slopes of Coronet Peak in Queenstown; Ngāi Tahu welcome the delegates to the conference; Dr Andrew Klein, editor of the journal Anaesthesia (left) with Professor Alan Merry; ANZCA NZNC Chair, Dr Jennifer Woods, NZSA President, Dr Kathryn Hagen and the recipient of the ANZCA Trainee Prize, Dr David Choi.

Australian news

South Australia and Northern Territory



“Hot topics in the tropics”

The Royal Darwin Hospital Department of Anaesthesia and Perioperative Medicine welcomed delegates to the biennial NT anaesthesia continuing education conference on Saturday, June 1.

Keynote speaker, Dr Robyn Gillies presented on the changing nature of the presentation of malignant hyperthermia with a range of other local and guest speakers on other “hot topics”.

During the afternoon, delegates had the opportunity to complete advanced life support and can't intubate, can't oxygenate emergency response workshops while nursing staff attended a nursing “blood sports” workshop.

Above from top: Dr Robyn Gillies, NT ACE conference keynote speaker; Delegates attending the NT ACE Conference Advanced Life Support Workshop.

SA FPM evening lecture

There was a great turn out from FPM members and allied health pain unit staff for the June continuing medical education meeting. Linda Dirkzwager from Return to Work SA, updated members on a new community awareness media campaign that will raise the awareness of the dangers of long-term use and/or misuse of prescription opioids, and encourage enquiry into alternatives to opioids for safe and effective pain management. This was followed by FPM Dean Dr Meredith Craigie and FPM General Manager Ms Helen Morris, who have been visiting all the regions, updating on faculty topics and seeking member input regarding the National Strategic Action Plan for Pain Management (NSAPPM) and faculty matters.

Above from top: Dr Meredith Craigie, Ms Helen Morris and Dr Bruce Rounsefell (Chair SA FPM Regional Committee); Dr Michelle Harris and Dr Tuan Van Vo.

Part Zero Course

New Adelaide-based trainees attended the Part Zero Course at the college on July 13. The course is run twice each year and covers topics such as the curriculum, welfare, tips for training and the exam. We are very grateful for the support of the fellows, trainees and members of the SA/NT Trainee Committee who take time out of their busy schedules to welcome new trainees and provide guidance and support for the next stage of their training.

Queensland

June CME evenings

The Queensland evening lecture series continues for 2019, with another two fantastic evenings held in June.

Emeritus Professor Maree Smith presented “Biased ligands as potential next generation opioid analgesics” at the FPM June evening on June 10. The evening was very well received.

Congratulations again to Professor Smith on being recognised in this year's Queen's birthday honours list, for eminent service to science through pioneering research and innovation in the treatment of neuropathic pain, to gender equity, and as a role model.

The ACE June evening was held on June 25, with Dr Susannah Sherlock and Dr Carolyn Jack exploring the “ups and downs of hyperbaric and altitude physiology”. It was a very interesting and insightful evening for attendees, with both presentations examining the effects of pressure on the body in extreme conditions.

Over the past year we have been working to make our evening lectures more accessible to regional fellows and trainees who are unable to attend in person. Every lecture has a limited number of remote registrations available for live viewing from the comfort of your home or office. For more information on how you can join us remotely for one of our evening lectures, please email us at qldevents@anzca.edu.au.



QARTS

The Queensland Anaesthetic Rotational Training Scheme (QARTS) process for recommending trainees to the 2020 hospital rotations occurred between June and August. The shortlisting and assessment process was a busy time, with more than 240 new applications. Thank you to the QARTS Co-ordinating Committee for contributing their time in making this process a success.

Interviews were held over four days, with 121 candidates interviewed. Thank you to Dr Mark Young for leading the interviews, and to all the interviewers who assisted with this process.

The process concluded with the QARTS Selection Meeting held on Friday August 23.

Courses

The Final Exam Prep Course was held from Monday July 29 to Friday August 2 for trainees sitting their final examination in August. Thirty-six trainees attended the course, with 18 fellows presenting throughout the week. Thank you to convenor Dr Stuart Blain for coordinating the course, and to all the presenters for contributing to the successful program.

The Primary Lecture Program continues for Semester 2, with 17 candidates attending the lectures held across five Saturdays between June to November.

The Primary and Final Practice VIVA Nights for Semester 2 were held in early September. Once again this course was well attended, and positive feedback was received. Thank you to all the mock examiners who assisted trainees in preparing for their viva examinations.

Above: Dr Paul Lee-Archer and Dr Christopher Slattery; Dr Nadia Koehler-Vargas presenting to the Final Exam Prep Course group.

Australian news (continued)

Victoria



Melbourne Winter Anaesthetic Meeting

Keeping with the tradition, this year's 40th Annual ANZCA/ASA combined CME meeting was again held on the last weekend in July at the Sofitel on Collins, Melbourne.

The program stretched over two days with a full day of education and a new quality assurance session on the Saturday followed by an expanded offering of emergency responses on the Sunday. For the quality assurance session, attendees were broken into smaller groups for the final session of the day. Delegates were invited to discuss their own cases on the day with colleagues and this session attracted points from the CPD practice evaluation component. This was in line with our approach to anaesthesia and crises in the current environment: modelling a collaborative and supportive culture of ongoing learning and professionalism in anaesthesia care. The program itself had a bit of an obstetric and pain theme running through it. The topics covered were relevant to most anaesthetists' practice, be they public or private, metro or regional. The emergency response workshops held on the Sunday morning included major haemorrhage, obstetric haemorrhage and anaphylaxis.

The overall feedback from the delegates and our HCI sponsors was very positive and both the meeting and workshops including the quality assurance session were all very well received with close to 270 attending the meeting, and all six workshops were filled, with many on a waitlist.

Congratulations to the meeting convenor, Dr Michelle Horne, 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 2020 and join us next year.

Above from top: Quality assurance session, small group table discussions; Session panel discussion; Dr Mandy Baric, sessional chair, Dr Michelle Horne, convenor and Dr Matt Blair, presenter.



Victorian Registrars' Scientific meeting

Join us on Friday November 15 from 1-6pm for the Victorian Registrars' Scientific meeting. Once again we are offering a prize for best presentation on the day in each of the following two categories: Scientific research project or Audit research project. To participate please send in an abstract of 250 words in either category, and/or you can register online. For more information and to register visit anzca.edu.au/vic-events or contact the event secretariat: Cathy O'Brien, VRC Regional Co-ordinator, +61 3 8517 5313, vic@anzca.edu.au.

Quality assurance meeting

Our second quality assurance meeting for the year will be held on Saturday October 19. The lecture topics will be "Of mice and men...Theory underlying the field of onco-anaesthesia" presented by Dr Julia Dubowitz and "Can anaesthetists RIOT to improve cancer outcomes after surgery" presented by Dr Rani Chahal. Following the lecture series the group breaks into small group table discussions and then come back together for a group summary session. The meeting is convened by Dr Dean Dimovski and Dr Gareth Symons. For more information and to register visit anzca.edu.au/vic-events.



Embley Memorial Lecture

We welcomed international speaker Dr Lisa Leffert from Boston to the college on Wednesday September 4 and she gave a talk on "Regional anaesthesia in patients receiving anticoagulant therapy".

The topic was well received and we had close to 70 registering prior the night. The evening went well with those attending in person and many dialling in from across the states and NZ to partake in the meeting too.

On behalf of the Victorian Regional Committee we would like to thank Dr Lisa Leffert for her time and commitment to deliver this talk while visiting Australia.

Above: Dr Dean Dimovski, convenor, Dr Maggie Wong, co-convenor and Dr Lisa Leffert, guest speaker.

Australian news (continued)

Australian Capital Territory



Dr Richard Harris in Canberra

Dr Richard “Harry” Harris needed no introduction when he joined us in Canberra on August 1 to recount his experience surrounding the extraordinary rescue of 12 young Thai soccer players and their coach from the Tham Luang cave in northern Thailand. Over 18 days in June and July 2018, thousands of people – Thai government police, military and civilians, and a team of international divers and rescue workers – scrambled to save the soccer team from the cave complex.

Dr Harris’ presentation at the Hotel Realm was attended by more than 150 delegates – a wonderful turnout for an ACT evening CME – and the feedback has been overwhelming. Suffice to say that Harry’s work to administer the life-saving sedation to the team and their coach was an amazing story to hear. For his efforts during the rescue, Dr Harris was awarded the Star of Courage Award, the Medal of the Order of Australia, and in January 2019 was named joint Australian of the Year.

A special thank you to Dr Harris for coming to Canberra to share his story with our local fellows and trainees.

Art of Anaesthesia

In 2019, the annual Art of Anaesthesia scientific meeting will be held over the weekend of October 5-6. This coincides with the renowned Floriade festival on the shores of Lake Burley Griffin and is a beautiful time to visit the nation’s capital. The meeting is themed around “research” and will once again be held at the modern National Museum of Australia. The convenors, Dr Girish Palnitkar and Dr Carmel McInerney, have been working tirelessly to bring you a wonderful program including international keynote speaker Professor Andrew Klein, Professor of Anaesthesia at Royal Papworth Hospital and editor-in-chief of *Anaesthesia*. Other confirmed invited speakers include Professor Jamie Sleigh (NZ), Associate Professor Victoria Eley (Qld), Dr David Highton (Qld), Dr Danielle Volling-Geoghegan (Qld), Dr Ianthe Boden (Tas) and Dr Paul Smith (ACT). On the Sunday morning, two emergency response workshops will be run – Advanced Life Support (ALS, Cardiac Arrest) and Acute Severe Behavioural Disturbance (ASBD). Registration for the workshops and the meeting is now open, check the ANZCA ACT website for details.

Above from top: A record attendance for an ACT evening CME; ACT ANZCA Chair Dr Girish Palnitkar, Dr Richard Harris SC OAM and Dr Phillip Morrissey ACT ASA Chair; Delegates enjoying the opportunity to chat with “Harry”.

Western Australia



Perioperative pearls in Cable Beach

The “Perioperative Pearls” Country Conference was held at the Cable Beach Resort in Broome from June 14-16 and convened by Dr Thy Do from the Royal Perth Hospital. The resort is set near one of the most beautiful beaches in the world, with only a short drive from the world-famous Kimberley region, and delegates had the opportunity to experience camel riding at sunset.

The key speaker was Professor Philip Peyton from Melbourne who discussed the trials and tribulations on uncertainty in daily clinical practice in anaesthesia. Local speakers included Professor Eric Visser who discussed complex patients within the acute pain service and practical methods of acute pain management following surgery. Dr Mei-Mei Westwood spoke on a reduction in length of stay by 12 days after redesigning the pathway to surgery at Fiona Stanley Hospital. Dr Yayoi Ohashi provided a practical workshop on ultrasound skills and Professor Michael Paech and Dr Matt Rucklidge provided a workshop on obstetric pearls and perils.

Dr David Forster and Dr Christine Grobler provided the ALS2 Workshop and Dr Natasha De Silva and Dr Nicholas Chrimes provided the CICO workshop, both which were facilitated offsite at Broome Hospital. Professor Stephan Schug, in collaboration with the Medical Illustrations Department at Royal Perth Hospital, provided two high-quality videos on “Opioid tapering in the postoperative period” and “Ketamine in the postoperative period”.

The social events were a success with 160 guests at an Arabian-themed dinner on the Friday evening by the resort pool where delegates had a short belly dancing lesson! A black and white themed “pure opulence” dinner was held on the Saturday evening with 100 guests by the ocean pool. Willie Creek Pearls were a major sponsor and kindly loaned their beautiful pearls to the conference secretariat for the weekend. Willie Creek also donated a pearl which was auctioned during the Saturday evening dinner. The proceeds of the auction were donated to Fair Game; Fair Game is a health promotion and community development charity that donates recycled sports equipment to deliver fitness, health and wellness programs to underserved communities in the region.

Thank you to the 122 delegates who made the trek from all regions of Australia, New Zealand and Vietnam; and a big thank you to our major sponsors Avant Insurance and Willie Creek Pearls for their support. And a big thank you to Royal Perth Hospital and all of the anaesthetic specialists, resort venue staff and volunteers who put in a vast amount of effort and time into making this conference a successful one.

The WA CME Committee will not convene the Autumn Scientific Meeting in 2020 due to the ANZCA 2020 Annual Scientific Meeting. The Perth Children’s Hospital will convene the Country Conference from October 18-20, 2020 at the Pullman Resort in Bunker Bay.

A congratulations to Dr Catherine Nguyen who was awarded the Gilbert Troup Prize on August 26 at the University of Western Australia. Thank you to Dr Christine Grobler who attended the ceremony and represented ANZCA WA.

Above from left: Dr Thy Do welcoming delegates; Ultrasound-guided regional anaesthesia workshop; Gilbert Troup Prize presented to Dr Catherine Nguyen by Dr Christine Grobler, Dr Linda Vine and Dr David McCoubrie.

Australian news (continued)

Tasmania



Meeting among the vineyards

On a cool and cloudy Saturday in Launceston, 65 delegates and speakers gathered together for a one-day meeting at the stunning Josef Chromy Winery. Delegates were challenged and captivated by an array of knowledgeable and entertaining speakers on issues relating to an ageing patient base (the individual patient, greater social and also economic considerations of providing anaesthesia and surgical care), as well as an ageing workforce.

Prior to the start of the main meeting, a breakfast ALS workshop took place, led by Dr Malcolm Anderson. Dr Anderson (convenor of the workshop) as well as faculty – Dr Sam Walker and Dr Greg Bulman – provided their time and expertise for the ALS session. The main meeting had visiting expert speakers Dr Sean McManus from Brisbane, Dr Jai Darvall and Dr Debra Leung from Melbourne, as well as Dr Andrew Mulcahy and Dr Guy Bannink from Hobart.

Dr Darvall commented that the venue had the best scenery of any conference he had ever attended. Dr Lokesh Anand (co-convenor) said that the high-quality presentations, combined with the beautiful setting, fabulous food and time to relax with colleagues, made the meeting a day to remember. The scientific program ended with a lively and thought-provoking panel session with the guest speakers contributing, as well as Tasmanian surgeons Dr Mary Self and Dr John Batten, and our Tasmanian ANZCA Councillor Associate Professor Deb Wilson. Discussion included surgery for the frail, and patients near end-of-life; communication; how families are affected by treatments and decisions made; as well as doctor suicide and welfare. One delegate commented that it was the first time he had attended a meeting where doctor suicide and welfare were so frankly and passionately discussed.

Relaxed drinks, canapes, and a delicious three-course dinner, with plenty of networking rounded out a fantastic winter meeting. The chairs of the ANZCA Tasmanian Regional Committee (Dr Lia Freestone), and the Tasmanian ASA Committee (Dr Mike Challis) advised that planning for the next winter meeting in August 2020 is already under way.

Updates from the chair of the Tasmanian Regional Committee

Thank you to Dr Karl Gadd and Dr Lokesh Anand as co-convenors of the winter meeting. Dr Karl Gadd is stepping down from the role of CME Officer with the TRC and the committee would like to recognise and thank him for his hard work and wish him all the best.

An educational officer/supervisor of training professional development day was held on Wednesday July 31, 2019. Feedback to the Enhance Learning workshop was a highlight on the day, presented by Mr Maurice Hennessy from the college. The meeting was attended by EOs, all SOTs, and some SSU supervisors. Those attending found the workshop very useful: “great workshop, well received, useful tips on importance and practicalities of feedback from fellows to trainees and trainees to fellows.”

Above from top: Dr Greg Bulman leading one of the workstations at the ALS workshop; Dr Debra Leung presenting at the Tasmanian Winter Meeting; Question time, from left: Dr Holly Sturgess, Ms Fleur Dewhurst, Dr Debra Leung and Dr Sean McManus.



Promoting anaesthesia and pain at the AMSA National Convention

ANZCA was among 18 other professional displays at the recent Australian Medical Student Association National Convention 2019 held in Hobart in July at the Grand Chancellor.

Staffing the display for the day was chair of the Tasmanian Trainee Committee Dr Bronwyn Posselt and Regional Co-ordinator Janette Papps supported by chair of the Tasmanian Regional Committee Dr Lia Freestone during the very busy morning tea break and chair of the Tasmanian ASA Committee of Management, Dr Michael Challis during the conference lunch break.

The booth proved very popular with the students as it provided hands-on opportunities to try a videolaryngoscope for intubation and a fiberoptic bronchoscope with “Dexter” the dexterity training model. More than 70 students tried using this equipment, which for many, was a first-time experience. Many students were interested in the possibility of pursuing anaesthesia as a career with many also asking questions regarding pain medicine.

Dr Posselt was pleased with the interest shown in the booth and was also surprised at the knowledge that many students had of the Opioid Calculator app that has been developed by the Faculty of Pain Medicine.



Save the date: Saturday February 29 to Sunday March 1, 2020

What better way to spend next year’s leap day in Hobart than at the Tasmanian combined Annual Scientific Meeting! Enjoy the international, national and local speakers, the weather, the food, the location – all combined with opportunities to socialise and relax.

Put aside these dates in your calendar and LEAP into a scientific program that focuses on Learning and Excellence in Anaesthesia and Pain.

The Saturday is an update in anaesthesia and pain, helping us pursue excellence in our own practice, and that of our trainees. Sunday builds on this by offering several workshops, including accredited emergency response workshops, regional anaesthesia, and giving and receiving feedback. It is an opportunity to share, refresh and expand our knowledge.

In 2020 we are extremely fortunate to have some excellent international, interstate and local speakers including Mount Sinai’s Professor Meg Rosenblatt (ambulatory total joint replacements, first use of lipid rescue) as well as Professor Kirsty Forrest, Dean of Medicine at Bond University, leading sessions on the key skills of communication and feedback.

The meeting will also provide ample opportunities to meet ANZCA CPD requirements.

A cocktail function will again be a highlight and will be held on Saturday evening at the impressive The Lounge by Frogmore Creek. Delegates will enjoy drinks and canapes as the sun sets right on the Hobart waterfront.

The Annual Trainee Day precedes the ASM on Friday February 28 and will feature some of the ASM’s invited speakers presenting on topics of particular interest to trainees, as well as a panel question-and-answer session.

Mark the dates in your calendars now: Registrations open late October.

Above: Dr Mike Challis and Dr Bronwyn Posselt demonstrating to medical students at the ANZCA display.

Australian news (continued)

New South Wales



ANZCA Educators Program

The AEP course was conducted from Monday July 22 to Wednesday July 24, 2019. A special thank you to facilitators Dr Jane Jaumees, Dr Su May Koh and Dr Scott Fortey who dedicated their valuable time in creating an excellent teaching course.



NSW Primary Refresher Course

The NSW Regional Committee conducted a very successful NSW Primary Refresher Course from July 1-5. There were 47 participants on the course, with 53 per cent from NSW.

The course was designed to help prepare candidates sitting the primary exam in August. It included some didactic teaching sessions, which focused on areas which candidates commonly find difficult. Most of the course was taught in an interactive style, including the use of many practise SAQs. Friday was entirely viva-focused using small groups of six.

There were 12 tutors from seven hospitals teaching on the course. A special thanks goes to all the tutors who devoted a huge amount of time and effort in assisting the candidates to prepare for their primary examinations, and especially to the course director, Dr David Fahey.

Special interest group event

Developing leaders with 20:20 vision



The 2019 Combined Special Interest Group meeting was held from July 26-28 at the Novotel Manly Pacific, Sydney. The theme of the meeting was “Developing leaders with 20:20 vision” and a record 175 participants from five countries came together to be challenged and inspired.

During the conference, we held six sell-out workshops including a masterclass for heads of department facilitated by Dr Ian Graham and Dr Roelof van Wijk and “Returning to work after significant injury” facilitated by Dr Dinesh Palipana OAM and Dr Blair Munford. This year, we also held a full-day pre-conference workshop facilitated by Toastmasters on improving presentation skills.

After an inspiring Welcome to Country from Mr Michael West of the Metropolitan Local Aboriginal Land Council, we spent the first day being challenged. Dr Marjorie Stiegler and Dr Dinesh Palipana OAM started the meeting on issues of inclusion and diversity, particularly focusing on gender equity and disability. We were then made even more uncomfortable by the truth-telling from Dr Owen Sinclair, a Māori paediatrician speaking on systemic racism in New Zealand, and Professor Juanita Sherwood, a Wiradjuri woman and Associate Dean (Indigenous Strategy and Services) for the Faculty of Medicine and Health at the University of Sydney who spoke on cultural safety. ANZCA President, Dr Rod Mitchell, ended the day with an update on what the college is doing in the Indigenous health space.

The second day was about growing after being challenged by the first day of speakers. We heard from Dr Carmen Huckel Schneider who gave us a brief introduction to health policy in the Australian context, Dr Teresa Anderson AM, Chief Executive of the Sydney Local Health District speaking on how clinicians can engage, and our own Dr Tracey Tay on her experiences moving into a clinician manager role. The day ended with dinner at Q Station, followed by a ghost tour for the brave among us.

On the final day, we closed the meeting with a focus on support. We heard from Dr Marjorie Stiegler about the need to face the reality of social media, Professor Judy McKimm on the importance of mentoring in leadership and Dr Andrew Czuchwicki on how mindfulness can provide self-awareness and clarity for good leadership.

Alongside our plenary sessions, we had a number of well attended concurrent sessions throughout the meeting. Highlights included an update on “Long Lives Healthy Workplaces” in the Welfare of Anaesthetists SIG session, an entertaining technology session with speakers Dr Pieter Peach and Dr Tanya Selak, and a powerful story from Dr Kate Harding who then joined us live via videoconference from the UK in the Leadership and Management SIG session. Following on from last year’s successful research session, Dr Damien Castanelli provided some tips on qualitative research in our free-paper session.

The 2019 meeting recorded the largest attendance in the meeting’s history, but that wasn’t all it will be remembered for. We aimed to reduce our environmental impact by reducing waste through minimising use of single-use plastics, we committed to the panel pledge with two out of three of the speakers, session chairs and workshop facilitators being women, and we encouraged participants to share their experiences on social media which resulted in #CombiSIG19 being used in more than 3000 tweets and 7 million impressions!

It was an absolute pleasure producing the 2019 program and convening the meeting. I want to thank our sponsors, BOQ Specialist, Juno Pharmaceuticals and Priority Life, and the ANZCA Events team, particularly Sarah Chezan and Kirsty O’Connor, for their assistance in delivering another high-class event.

Dr Scott Ma
Convenor

Above from left: Dr Scott Ma, Dr Dinesh Palipana OAM, Mr Michael West and Dr Marjorie Stiegler; Pre-meeting workshop – Presentation skills by Toastmasters; Masterclass: Anaesthetic department and leadership – style, substance and sustainability.

John Knight (FFARACS), FANZCA, Dip DHM, RFD 1930-2019



John studied medicine at Cambridge University (Gonville and Caius College) and at St Bartholomew's Hospital, London, qualifying in 1954. In 1955, he took a short service commission in the Royal Navy, visiting Melbourne during the 1956 Olympic Games while serving on *HMS Newcastle* as it toured the Far East. This was when he decided that Australia would become his home, and in 1959, he, his first wife Gillian and infant son John Henry arrived on the *SS Iberia*, settling first in Millicent, South Australia and then in Morwell, Victoria.

As a general practitioner, he became concerned about the quality of anaesthesia being provided in the Gippsland region and in the latter period of his time there served as an anaesthetist at the Morwell Medical Clinic. The family (now also with children James and Liz) moved in 1965 to Melbourne, where John held anaesthesia positions at the Royal Melbourne Hospital, The Alfred hospital, St Vincent's Hospital, the Royal Victorian Eye and Ear Hospital and the Repatriation General Hospital in Heidelberg, receiving his FFARACS in 1969. He had also joined the Grey Street Anaesthetic Group in Melbourne in 1966, and in 1982 was appointed Director of Anaesthesia at the Royal Victorian Eye and Ear Hospital until his retirement from clinical practice in 1994.

John was a member of the Royal Australian Naval Reserve (RANR) for more than a quarter of a century. This was the genesis of his interest in diving medicine. He was promoted through the ranks of the RANR, becoming captain in 1980 and was awarded the Reserve Forces Decoration. In the 1990s, he also ran the Diving Medical Service, providing medicals to occupational divers.

He was a regular correspondent and contributor, publishing in the *Australian Medical Journal*, *British Medical Journal* and *Lancet*, as well as the *South Pacific Underwater Medicine Society Journal*. For some time after arriving in Australia he wrote a regular column in the *Lancet* called "A view from Australia" comparing the British and Australian health systems. Following two tours to Vietnam (once with an Alfred hospital team and again with an army team; 1967 and 1969 respectively), he wrote a number of articles for the *Lancet*, *Anesthesiology*, *British Journal of Anaesthesia*, *British Journal of Surgery* and, *Resuscitation*, based on his experiences.

John was a member of the South Pacific Underwater Medicine Society (SPUMS). Having joined the society in 1972 he went on to serve on the executive committee for 27 years in a variety of roles, including secretary from 1975-1979, president from 1979-1983, and public officer (the predecessor of the education officer) from 1990-1995. He became editor of the society's journal in 1990, serving in that capacity until 2002. An article written by John and well worth reading on the history and development of the *SPUMS Journal* can be found on the Rubicon Foundation website¹. In addition, he created a searchable database of all *SPUMS Journal* issues, each as a pdf file accompanied by a searchable tab-separated index from the first issue in 1971 (a newsletter) to 2002. His efforts to promote the journal resulted in its first indexing on the Elsevier EMBASE medical database in early 2001. Now, its successor, *Diving and Hyperbaric Medicine*, is indexed on Medline and all original articles since 2017 are archived in PubMed Central. This has only been achieved because of John's hard work during his time as editor.

Among his additional contributions to diving safety he was instrumental in the design, promotion and distribution of the original "safety sausage" and in the creation of a set of recreational air dive tables based on decompression limits developed by Bruce Bassett.

In retirement John indulged his significant skills in carpentry and woodworking before moving into aged care where he passed away on May 9, 2019, aged 89, just missing out on becoming a great grandfather. John was an intelligent, warm and highly ethical man with a strong social conscience, who will be greatly missed by those close to him.

He has left an enduring legacy in diving medicine in Australia, New Zealand and beyond.

Associate Professor (retired)

Michael Davis, FANZCA

Associate editor

Diving and Hyperbaric Medicine

Reference:

1. Knight J. The history and development of the South Pacific Underwater Medicine Society Journal. *SPUMS Journal*. 2001;31:215-20. [cited 2019 June 11]. <http://archive.rubicon-foundation.org/xmlui/handle/123456789/7746>.