MARCH 2019

ANZCA BULLETIN

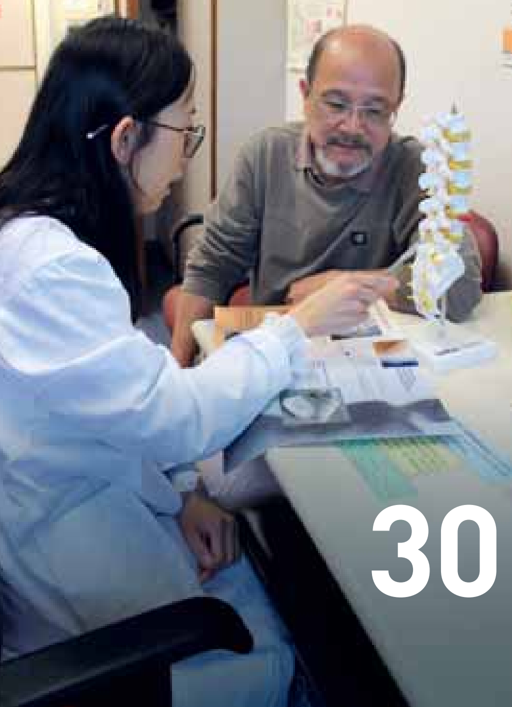
Australian of the year Richard Harris honoured

Perioperative medicine: College takes the lead

Gender equity: ANZCA's commitment

Perioperative medicine

The results of the ANZCA perioperative medicine (POM) survey are in and they reveal that the college has received support to develop POM education offerings. Leading anaesthesia researcher Dr Bernhard Riedel gives his insights into the economics of the perioperative model of care.



Overseas aid

ANZCA's Overseas Aid Strategy features in a *Bulletin* package that highlights the diversity of our fellows' work from Hong Kong, with the roll-out of the Essential Pain Management program, and training opportunities for anaesthesia and pain management in Papua New Guinea.

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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 7300 fellows and 1700 trainees mainly in Australia and New Zealand. It serves the community by upholding the highest standards of patient safety.

Cover photo: Dr Craig Challen (left) and Dr Richard Harris (right) take questions from the media after they were presented with the Medal of the Order of Australia (OAM) and the Star of Courage (SC) by Governor-General Sir Peter Cosgrove, for their role in the Tham Luang cave rescue in Thailand, during an investiture ceremony at Government House in Canberra on Tuesday July 24, 2018. Photo: Alex Ellinghausen, *The Canberra Times*.

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President's message

As a specialist medical college, we are frequently invited to make public comment on issues relating directly or indirectly to health. In recent times we have been asked to comment on climate change, access to medical care for refugees on Nauru, out of pocket expenses, marriage equality, sports-related concussion, voluntary assisted dying, and the threat of nuclear war.

Advocacy

We seem comfortable that the roles of a medical specialist includes that of advocacy. Advocacy is one of six ANZCA Roles in Practice embedded in the ANZCA curriculum. The ANZCA Constitution states that the objectives of the college include to "advocate on any issue that affects the ability of members to meet their responsibilities to patients and to the community" and to "work with governments and other relevant organisations to ... improve health services".

I think it is timely that we, as a college, give further thought to what we mean by "responsibilities to patients and to the community" when considering our remit in contributing to public discourse.

In determining the underlying principles that may guide us in our decision making, I believe there are a number of questions we need to ask ourselves. The first question might be, do we self-identify primarily as specialist anaesthetists/specialist pain medicine physicians, or primarily as doctors, who have specialist expertise in anaesthesia/pain medicine? Following on from that, what are the roles and responsibilities of the reality that we hold a highly privileged and respected position within the community, and that our deliberations do shape public opinion?

I imagine we all agree that we want to do what is right and just, but values-based judgements are often viewed through a prism of personal morals and ethics.

Voluntary assisted dying is a good example. We now have more than 9000 fellows, trainees and staff, which means that sometimes we have more than 9000 different opinions.

Perhaps more challenging though is when there are only two opinions, which are in conflict with each other. I am not a scholar of philosophy, but I do recall de Tocqueville's (and later John Stuart Mills) statement about "the tyranny of the majority". Where a minority view is evident amongst the fellowship, particularly when it relates to ethical-moral considerations, is it fair for the majority to exercise their opinion as representative of the whole? Alternatively, is it reasonable for council to make it clear that on certain issues it is speaking as the leadership body, but it is not presuming to represent the entirety of the membership?

What message do we send if we don't comment on broader health issues? Is it true that "to be silent is to speak"? Is remaining silent to be implicitly endorsing the status quo?

Clearly we have a role in treating disease, but what is our role in advocating to prevent disease? During my years working in central Australia, it was evident that if I wanted to improve surgical outcomes then I had to look beyond my intra-operative skills. I simply could not ignore the complete lack of any Indigenous workforce in the operating theatre, and the socio-economic determinants of health that were contributing so blatantly to my workload, even though these matters fell outside my area of "expertise".

"Where matters pertain directly to anaesthesia, pain medicine and perioperative medicine, we comment as experts, but as medical practitioners I believe our remit extends beyond the operating theatre."

Responsibilities and obligations

My personal (and I use that word pointedly) response is that I consider that we are first and foremost "doctors", with the attendant responsibilities and obligations, who have gained specialist expertise in anaesthesia (including perioperative medicine), and/or pain medicine. Where matters pertain directly to anaesthesia, pain medicine and perioperative medicine, we comment as experts, but as medical practitioners I believe our remit extends beyond the operating theatre.

The socio-economic determinants of health are clearly established and accepted. On issues related to access, equity, and public health, we do well to comment in collaboration with other colleges, so that we are commenting collectively as the doctors within our community.

I accept that as a moderately sized company our college has certain obligations relating to corporate conduct, and also relating to the personal needs and wellbeing of our staff, members and trainees. As a council, and therefore in a leadership role, I believe that we have a responsibility to act, in good faith, in accordance of what we believe to be right and just. Critically, I also believe that our members have a role and responsibility to consider and challenge the decisions made by council. Council then needs to listen and consider, once again in good faith, that feedback.

Where a sizeable minority counter view exists, or an issue relates to a matter which evokes strong ethical and moral responses, I think we need to be very careful to be respectful to that minority view. In those cases where "council" decides to state an opinion as opposed to council speaking on behalf of the college, we need to be clear in drawing that distinction.

When we decline to make public comment on a particular issue, we need to consider when it is appropriate to clearly state that our silence should not be interpreted as indifference, or as endorsing the status quo, but rather it simply reflects our perception of what is or isn't appropriate for us to make public comment on.

The focus of our energies is on education, training and professional standards of practice. Due to resource limitations, we need to be selective as to which issues we comment on. We should only comment where we believe such comment will make a positive contribution to outcomes. There is no role for motherhood statements. We risk diluting our gravitas if we comment too widely. There are many organisations representing any one issue, and we can't support each and every one, even if the issue is worthy.

Council has an obligation in leading our college to demonstrate the culture and values that we wish our profession to be recognised and defined by. At the end of the day, I believe that we do have an important advocacy role, which requires that collectively we act in good faith, to make decisions as specialist medical practitioners that reflect what we believe is right and just in terms of delivering optimal health outcomes to our community. This necessarily involves consideration of the broader determinants of health, and of ongoing constructive and respectful discussion and debate.

I have been impressed with the volume and tone of communications I have received from many fellows on a wide range of health-related matters. Thank you to those of you who have taken the time to convey your views to me.

Go well.

Dr Rod Mitchell
ANZCA President

Fellows honoured on Australia Day

ANZCA fellow **Dr Richard "Harry" Harris** is the joint recipient of the 2019 Australian of the Year award.

Dr Harris won the award with his good friend and diving buddy, retired vet Dr Craig Challen, from Perth for their role in saving 12 boys from a flooded cave in Thailand in July 2018. It is the first time the Australia Day Council has bestowed the honour on two state or territory finalists at once.

HERO ANAESTHETIST GIVES HIS ALL IN THAILAND RESCUE DIVE

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

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

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

Several other ANZCA and FPM fellows were recognised in the Australia Day honours list:

Professor Michael Davies, AM, for significant service to medicine in the field of anaesthesia, and to professional medical bodies.

Dr Penny Briscoe, AM, for significant service to medicine and medical education, particularly to chronic pain management.

Professor Milton Cohen, AM, for significant service to medical education in the field of pain management.

Dr Christopher Dodds, OAM, for his service to medicine as an anaesthetist.

Dr Christopher John Lowry, OAM, for his service to medicine as an anaesthetist.

Dr Harris and Dr Challen made headlines around the world for their role in rescuing a group of boys and their soccer coach from the flooded cave in Chiang Rai, where they had been trapped for more than two weeks.

An experienced cave diver, Dr Harris swam into the cave with a Thai medical team to triage the boys and determine their fitness to make the four kilometre journey through the flooded cave complex to safety. He was one of a group of 19 Australians who helped rescue the children as part of an international team.

Dr Harris administered a sedative to each of the boys before they left the ledge where they sheltered inside the mountain cave to calm them. British divers had requested Dr Harris help with the rescue mission. He left the cave only when the last boy was rescued each day.

See the September 2018 *ANZCA Bulletin* for our interview with Dr Harris: www.anzca.edu.au/communications/anzca-bulletin

Council election

The 2019 ANZCA council election took place from March 8-22. Ten nominations were received for six council vacancies. Results of the ballot will be announced at the ANZCA Annual General Meeting which will be held on Thursday May 2, during the 2019 ANZCA Annual Scientific Meeting in Kuala Lumpur.

Chief executive officer's message

Why gender equity is a good idea

I imagine a family discussion where I am advising my high school-age daughter on career choices. For some of the options that she proposes I have to advise her against because she would not be accepted into the course or worse still, she might do very well academically but would have limited career opportunities. Why? Simply because she is a girl. I can't accept that and nor should she.

Thankfully those days are well behind us – or are they? Women can enrol in any university course they choose, provided they achieve the prerequisite marks. That battle has been fought and won decades ago. But the struggle for career advancement and fair treatment in workplaces still goes on in many places. Every time my daughter interrupts her career to raise her children, her opportunities to work her way up the corporate ladder are diminished. In my subjective view, her company is missing the opportunity to maximise the skills of a highly motivated employee. Does this seem fair? Isn't there a better way to run our businesses?

It's no surprise then that progressive organisations have recognised that they are not making use of the talents provided by slightly more than 50 per cent of our population. They are implementing strategies that help to overcome the traditional barriers to entry and career advancement.

I am convinced of the link between gender equity and the health of the population. We do not question equity of access to healthcare. Nor do we question equity of access to study, career advancement and career leadership roles – but we should. Interrupted careers, family carer responsibilities for both men and women have been shown to be career limiting. This burden impacts on both men and women but statistics show that the bulk of the impact is on women who are more likely to take on the family carer responsibilities.

ANZCA and FPM have adopted a position statement on gender equity that we hope will provide a positive environment for the advancement of women in their chosen careers. Chair of ANZCA's Gender Equity Working Group, Associate Professor Leonie Watterson has written a well-researched article for this *Bulletin*, making the case for economic, academic and social benefits of equity for women.

As we know, medicine has traditionally been a male-dominated profession. However the participation of women in medicine has grown rapidly in the past 20 years and there are now more female undergraduate medical students than male. But what happens following internship and acceptance to specialty training?

ANZCA's fellowship in 2018 had a male to female proportion of 67:33. However the trainee ratio for the same year was 57:43. In pain medicine the fellowship proportion of male to female in 2018 was 72:28 but the pain medicine trainee proportion in 2018 was 51:49.

We have done much over the years to make the training program more flexible and to respond to the family and career needs of trainees. There is always more that can be done and we listen carefully to all suggestions. We have also improved accessibility to continuing professional development and continuing medical education events for fellows with family carer responsibilities.

We still have more to do to improve access to leadership roles within ANZCA. The action plan that we have adopted includes some simple but hopefully effective initiatives. Awareness of potential discrimination is an important step in improving equity. The ANZCA Annual Scientific Meeting Regional Organising Committees for example have been asked to consider increasing the number of women presenters.

I will also be signing the United Nations Women's Empowerment Principles CEO letter of support in partnership with the Royal Australasian College of Surgeons, the Royal Australasian College of Physicians, the Royal Australian and New Zealand College of Psychiatrists and the Royal College of Physicians and Surgeons of Canada at the Tri-Nations meeting in Auckland on March 19.

The principles are:

Principle 1: Establish high-level corporate leadership for gender equality.

Principle 2: Treat all women and men fairly at work – respect and support human rights and non-discrimination.

Principle 3: Ensure the health, safety and well-being of all women and men workers.

Principle 4: Promote education, training and professional development for women.

Principle 5: Implement enterprise development, supply chain and marketing practices that empower women.

Principle 6: Promote equality through community initiatives and advocacy.

Principle 7: Measure and publicly report on progress to achieve gender equality.

Over the past 12 months I have been discussing the principles and application of gender equity with our Australian regional committees and New Zealand National Committee. Where there is scepticism, I have found that people automatically associate the gender equity strategy with an affirmative action initiative.

ANZCA will not be implementing quotas which imply incentives or penalties for reaching or failing to reach targets. Rather, this strategy is focused on building awareness, removing unintentional barriers to career progression and providing women with more opportunities to take on ANZCA and faculty leadership roles.

John Ilott
Chief Executive Officer, ANZCA

Australian of the Year and anaesthesia research attract strong media coverage

Joint 2019 Australian of the Year recipient, fellow Dr Richard "Harry" Harris, featured in blanket national media coverage over the Australia Day weekend. Dr Harris won the award, which was presented by the Prime Minister Scott Morrison at a nationally televised ceremony in Canberra on January 25, with his good friend and diving buddy Dr Craig Challen. The pair made headlines around the world last year for their role in rescuing a group of boys and their soccer coach from a flooded Thai cave where they had been trapped for more than two weeks.

Professor Paul Myles' super sleuthing efforts to investigate World Health Organization guidelines on the administration of highly concentrated oxygen after surgery was reported in *The Guardian* and on Radio 3AW in Melbourne on February 19. Professor Myles, Director of Anaesthesia and Perioperative Medicine at The Alfred hospital in Melbourne and a member of the ANZCA Clinical Trials Network Executive raised doubts about the credibility of data that had led to the WHO guidelines. *The Guardian* story reached an estimated global audience of four million readers.

The results of the general anaesthesia compared to spinal anaesthesia (GAS) study of 700 children worldwide, including Australia and New Zealand, featured in 160 radio news reports in Australia on February 18. The trial, jointly funded by ANZCA, was led by fellow Professor Andrew Davidson and is the first randomised trial to examine whether exposure to general anaesthesia in infancy affects the growing brain. The study's findings, reported in *The Lancet*, found that general anaesthesia is unlikely to have lasting effects on the developing brain. *The New Zealand Herald* ran a follow up story on March 5 featuring an interview with Auckland paediatric anaethetist Dr Niall Wilton who was involved with the study.

The *Herald Sun's* medical reporter Grant McArthur ran an exclusive page one anaesthesia story on December 9 about Professor Bernhard Riedel's $A4.8 million NHMRC grant examining the effect of anaesthetic agents on cancer. An ANZCA media release was followed up nationally by ABC TV and radio news and online, SBS, Nine News, 3AW, 2GB, 6PR and 5AA. The Australian Associated Press version of the story ran in *The Australian* online and Fairfax Media national and regional publications including *The Age* and *The Sydney Morning Herald*, reaching an audience of 2.1 million people.

The medical editor of *The West Australian* Cathy O'Leary ran an exclusive story on the ANZCA Research Foundation grant to WA anaesthetists led by Dr Andrew Toner for their research on lidocaine as a pain reliever for breast cancer surgery. The story, which was based on an ANZCA media release, featured a patient case study and reached an audience of 500,000 people.

ANZCA President Dr Rod Mitchell featured in a 25-minute radio program on 2SER's *Think: Health* program which aired on January 6. The program examined anaesthesia and medicine shortages.

Fellow Dr Thomas Painter was interviewed by the *Adelaide Advertiser* on January 24 about the ANZCA Clinical Trials Network funded ROCKet medical trial to combat post-operative pain with ketamine. The article reached an audience of 115,000 people.

Six media releases were distributed by ANZCA and the New Zealand Society of Anaesthetists (NZSA) for the New Zealand Annual Scientific Meeting held in Auckland on November 8-10. These led to two extended interviews with speakers on RNZ Radio and Newstalk ZB and several stories appearing in Fairfax mastheads *NZME* and *Scoop*. The interviews were with Dr Steve Clendenen from the Mayo Clinic on the opioid crisis, and infectious disease specialist Dr Stephen McBride on antibiotics. A Fairfax health journalist, Ruby Macandrew, attended the full three days of the conference.

WA fellow Professor Stephan Schug was a guest on ABC Radio Perth's *Focus* program hosted by Nadia Mitsopoulos on February 4. The 50-minute segment examined chronic pain management. The broadcast reached an audience of 25,000 people.

Victorian fellow Dr Sanjay Sharma, founder and president of the Friends of India network, was interviewed on ABC Radio Ballarat's breakfast program about the network's support of the national Strike out Stroke campaign. He was also featured in a story in the *Ballarat Courier* on January 18.

An FPM media release calling on the Australian Health Minister Greg Hunt to support a new national pain device register was followed up by ABC radio on November 26. Fifty ABC radio news outlets broadcast the story nationally in their evening radio bulletins reaching an audience of 100,000 people.

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

- **20 print reports.**
- **52 radio reports.**
- **40 online reports.**
- **5 TV reports.**

Media releases since the previous *Bulletin*:

Friday March 1:
Women and medicine in focus for International Women's Day

Thursday February 28:
Pain medicine stories joint winners of ANZCA Media Award

Friday February 15:
General anaesthesia safe for young children: Study

Saturday December 22:
Anaesthetists awarded key grant for pilot study into chronic pain after breast surgery

Wednesday December 12:
NHMRC grant for breakthrough blood research

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

Carolyn Jones
Media Manager, ANZCA

Pain medicine stories by the ABC and *The Age* joint winners of ANZCA Media Award

The ABC and *The Age* are the joint winners of the ANZCA Media Award for 2018.

The ABC's Alison Branley and Rebecca Armitage were recognised for their January 28, 2018 online and TV report "Pain and gain when products pulled from shelves" which examined the removal of codeine as an over-the-counter pain medicine.

"We wanted to make it clear to the Australian public why this change was so important to protect public health and used statistics to support this argument. We also wanted to illustrate that there are new approaches to pain management that incorporate a combination of treatments, that even the most cynical of patients have found to be effective. Overall this was a story that talked to both regular people affected by the change, policy makers and experts in the field," Ms Branley said.

Reporters Liam Mannix and Aisha Dow of *The Age* were also winners for their investigation into the drug Lyrica, one of Australia's most popular pharmaceutical drugs. The investigation led to two stories in November and December 2018 in *The Age* and its sister publication *The Sydney Morning Herald* that revealed the drug was being overprescribed as an alternative to opioids for pain relief and highlighted personal case studies of people who had taken the drug.

"Our investigation – which took several months and involved well over 20 interviews and reading dozens of scientific papers – proved that it was addictive, open to abuse, linked to suicide, and that people were dying. And we showed evidence it might not work for conditions it was being prescribed for. There had been no coverage of the issue in the press at all before our reporting. We also revealed that it was being overprescribed, likely for things that it wouldn't help – and we revealed the systemic flaws in the system leading to overprescription," Mr Mannix said.

The award for the best news story or feature about anaesthesia or pain medicine, was judged by former ABC journalist, lecturer and media training expert Doug Weller, anaesthetist and *ANZCA Bulletin* medical editor Dr Nigel Robertson and Ambulance Victoria media director Tom Noble.

The judges said: "The winning entries demonstrated high quality, accurate journalism on real and serious topics that highlight two key public interest issues. Both entries shone a spotlight on the unintended consequences of best intentions in pain medicine and the importance of accurate and high level research in providing the best care to patients in Australia and New Zealand."

This popular drug is linked to addiction and suicide. Why do doctors keep prescribing it?

Codeine medications: Pain and gain when products pulled from shelves this week

Popular pain drug linked to rise in overdoses, suicides

The articles can be found at:

- www.theage.com.au/national/victoria/this-popular-drug-is-linked-to-addiction-and-suicide-why-do-doctors-keep-prescribing-it-20181129-p50j1x.html
- www.smh.com.au/national/popular-pain-drug-linked-to-rise-in-overdoses-suicides-20181125-p50i6n.html
- www.abc.net.au/news/2018-01-28/codeine-painkillers-pulled-from-shelves-this-week/9364574
- https://youtu.be/JCLxO68qa8o

Carolyn Jones
Media Manager, ANZCA

Letter

Professional identity

As one of the letter-writing protagonists of the anaesthesiologist/anaesthetist debate this time around (given this issue has arisen before), there seems to be some confusion around the main reason why many of us feel the time is right to adopt the "new" terminology.

Indeed, as stated by Dr Philip Brown in your December issue, being called an anaesthesiologist will not immediately change the public perception or impact on our day to day anaesthetic practice, so in view of this, I can appreciate why many think the issue unimportant.

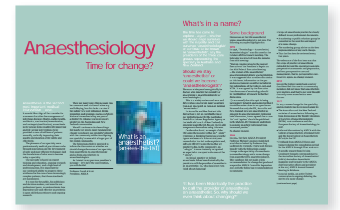
However, the reasons I continue to support and promote the adoption of "anaesthesiologist" are:

- Standardisation – more than 80-90 per cent of the 134-plus member societies of the WFSA (World Federation of Societies of Anaesthesiology) are anaesthesiologists. With increasing international project collaboration, adopting standard terminology would seem reasonable.
- Accuracy – *ology*, defined as "the scientific study of", correctly describes the specialist training of ANZCA fellows. The excellent standard of research carried out by Australian fellows justifies the *-ology* description.
- Career distinction – there are many international "anaesthetists" who do not have the medical degree and specialist training of ANZCA fellows. It is not a matter of which is the better career or healthcare provider, but simply an indication of training background.
- Ease of use – perhaps less important, despite its extra syllables patients seem more adept at getting their tongue around the word "anaesthesiologist".

I am aware many Australian anaesthetists strongly identify with (and remain attached to) their title, as reflected in the correspondence over the past two years.

I do however, hope that when crunch time comes and we are called to vote on this matter, we move with the vast majority of medically qualified anaesthesia providers across the world and become anaesthesiologists providing anaesthesia, working in departments of anaesthesiology.

Dr David Borshoff FANZCA
Western Australia



Anaesthesiologist or Anaesthetist: What's in a name...?

I have been an anEsthesiologist in the USA for many years and still regularly encounter members of the general public who are surprised to learn I am a medical doctor who performs such an important and comprehensive role in perioperative medicine.

Changing the title will alone not erase this ignorance and elevate our public professional standing – even if you retain the additional "A".

Dr Philip Brown, FANZCA
California, US

Rural training focus

Australia

Anaesthetic Provincial Training Workshop

Announced by the Australian Government in December 2015, the Integrated Rural Training Pipeline (IRTP) for medicine initiative aims to link up the rural training system by providing greater opportunities for graduates interested in rural careers to maintain connections to rural communities while they complete postgraduate medical training. The IRTP initiative involved the establishment of 26 regional training hubs across Australia and the creation of 100 additional Specialist Training Program (STP) places specifically targeted to rural areas. ANZCA was allocated three STP-IRTP posts in 2016 (to commence in 2017-18) and a further five posts in 2017 to commence in 2018-19.

With the implementation in 2019 of additional STP-IRTP posts across NSW and Victoria, ANZCA STP staff, along with ANZCA councillor Dr Michael Jones, attended the inaugural Anaesthetic Provincial Training Workshop in Albury in November 2018. Dr Michael Bulman, supervisor of training at Albury Wodonga Health (AWH), was the key driving force behind the workshop, which was hosted by AWH and the Border (Albury Wodonga) Regional Training Hub.

The workshop brought together regional anaesthesia training stakeholders from Victoria and NSW to discuss issues facing training outside traditional settings with a particular focus on site accreditation, trainee rotation models and trainee selection. The day proved extremely valuable as a mechanism to share information, ideas and workshop solutions to common problems. It was agreed that the group would continue to meet twice yearly, with a broader geographic focus on anaesthesia training in all rural areas of Australia. The next workshop is scheduled to coincide with a meeting of regional training hubs in Tamworth in May 2019.

Rural Medical Training Summit

Highlighting the importance placed on rural specialist medical training by the Australian Government, on November 19, 2018 ANZCA CEO Mr John Ilott attended the Rural Medical Training Summit chaired by the Minister for Regional Services, Senator Bridget McKenzie. With approximately 50 attendees representing the Commonwealth, states and territories, universities, specialist medical colleges, the Australian Medical Association, rural medical educators and regulators, the purpose of the summit was to discuss how to improve regionally based medical specialist training.

A key focus of the summit was how to support regionally-based specialist training and establish models where a doctor's specialist training would be substantively rurally based, with short rotations into major cities as required to meet fellowship standards. Key themes to emerge included:

- Matching medical education and training to community need.
- Reducing the reliance on migrating doctors, with a focus on sustainable teaching and training models for future workforce needs.
- Increasing flexibility in accreditation systems, allowing for outcomes-based approaches.
- Tailoring employment conditions for trainees to provide clearer paths to specialist qualification and long-term jobs in communities that need them.
- Collaborating at all levels of government to ensure community need is at the centre of planning.

New Zealand

Chronic pain report sparks ministerial meetings

There has been a lot of interest throughout the health sector following stakeholder engagement around the Sapere report *The problem of chronic pain and scope for improvements in patient outcomes*. The report was commissioned by FPM and details the impact of chronic pain on the population, pointing to a ballooning cost to the country from $NZ15 billion to more than $NZ24 billion over the next 30 years.

The New Zealand National Committee of FPM (NZNC FPM), supported by ANZCA New Zealand National Committee, is taking part in a number of meetings with key stakeholders advocating for more investment in the chronic pain medicine workforce and services. As the *Bulletin* goes to print, meetings are being held with the Minister of Health, the Minister of Accident Compensation Corporation, the Acting Deputy Director-General of Health Workforce, the Ministry's Chief Medical Officer, Treasury and Pharmac to discuss the issues. FPM Dean, Dr Meredith Craigie, is attending the meeting with the Minister of Health, Dr David Clark.

Propofol

ANZCA is working with Medsafe, the Ministry of Health and the Health Quality and Safety Commission in New Zealand on developing an advisory statement on the safe storage of propofol in clinical settings. Internationally, the diversion and misuse of propofol is increasing, and there have been reported cases in New Zealand. While it is important that immediate access to propofol for clinical use is maintained, there is a need to strengthen the security and storage of propofol to address issues of unauthorised access and the potential for abuse.

ANZCA Pharmac Advisory Group

In New Zealand, the first meeting of the ANZCA Pharmac Advisory Group was held on January 23, 2019. The group includes anaesthetists with expertise and experience in the purchasing and use of anaesthesia devices in district health boards and private hospitals. It has been set up to provide advice from a clinical point of view to the ANZCA New Zealand National Committee on Pharmac proposals for national contracts for anaesthesia equipment and consumable devices. At this stage, Pharmac's approach involves developing an inventory of all medical devices currently in use in hospitals. Through providing thoughtful, reasoned statements to Pharmac, the group hopes to ensure that the best equipment is available for anaesthesia.

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.

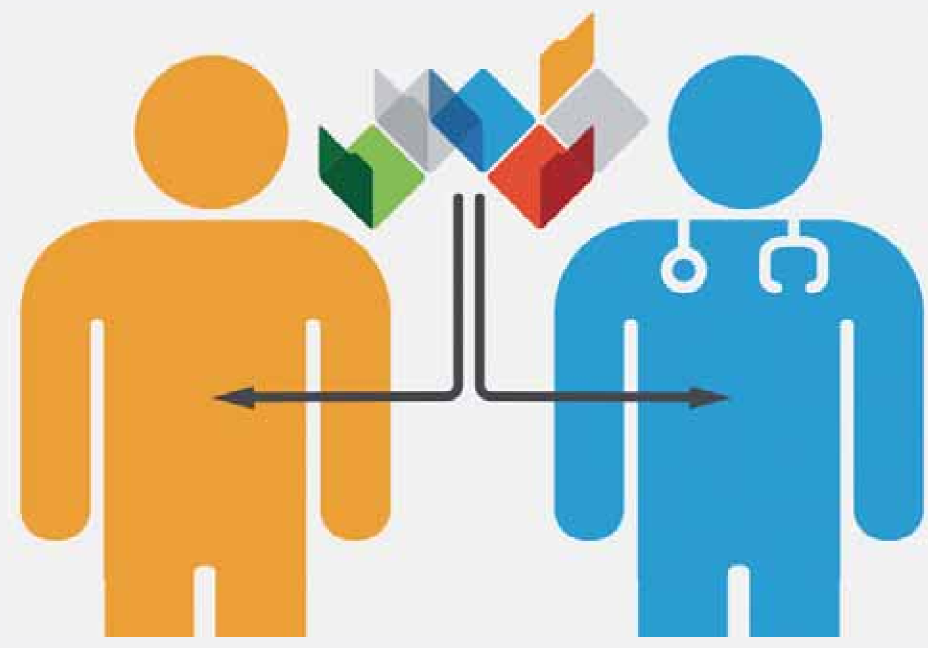
Australia

- Australian Capital Territory Government: Independent review into the workplace culture within ACT public health services.
- Queensland Parliament: Health practitioner regulation national law and other legislation amendment bill 2018 (mandatory reporting).
- Australian Government Department of Health: Shared debt recovery scheme.
- New South Wales Health: Consultation on NSW Health interim music festival harm reduction guidelines.
- Australian Government Department of Health: Commonwealth review of the quality use of medicines program's delivery by NPS MedicineWise.
- Parliament of South Australia Occupational Safety, Rehabilitation and Compensation Committee: Inquiry into workplace fatigue and bullying in South Australian hospitals and health services.

New Zealand

- St John New Zealand: Emergency inter-hospital transfers discussion document.
- Standards New Zealand: Ambulance, paramedicine, and patient transfer services.
- Medical Council of New Zealand: Proposed standards for accreditation of vocational training and recertification.
- Ministry of Health: Stroke clot retrieval action plan.

Digital health



A My Health Record message for anaesthetists

In February, My Health Record was created for all Australians who chose not to opt out of the system. The Australian Digital Health Agency's rollout of My Health Record to healthcare providers was initially focused on GPs, pharmacists, pathologists and diagnostic imaging services.

The agency is now looking to engage more specialists – including anaesthetists.

What does this mean for anaesthetists?

My Health Record is a secure, online health summary where clinicians involved in a patient's care can access their health information. Information available may include a patient's medical history, medicines view (incorporating prescription and dispense records), allergies, adverse drug reactions, immunisations, hospital discharge summaries, pathology results, diagnostic imaging reports, event summaries, advance care plans and custodian information.

It is an additional source of information to support clinical decision making — and does not replace other important information such as the medical records held in a clinical information system, or essential clinical conversations with a patient and other healthcare providers. Clinicians decide who would benefit the most by using My Health Record such as those on multiple medications, complex and chronic patients or patients who travel or are older. Therefore, it will not necessarily be used for all patients.

At this early stage of implementation, a record requires initial activation by its owner or their clinician and may contain little or no information. As more provider organisations connect and healthcare interventions occur, the information gathered in a person's record will grow. To date more than 15,000 healthcare provider organisations, including specialists, GPs, community pharmacies, pathology and diagnostic imaging services, public and private hospitals, and residential aged care facilities have connected.

The system gives clinicians access to their patients' records, however harsh penalties apply for inappropriate or unauthorised use. Patient control is at the core of My Health Record where they can set access controls to limit who can see their record and the information it contains. Additionally, Australians have a choice whether they want a My Health Record and can choose to permanently delete their record and any backups at any time.

Parliament recently passed legislation to strengthen the privacy protections in *My Health Records Act 2012*.

Benefits for anaesthetists

My Health Record aims to support improvements in the safety, quality and efficiency of Australia's healthcare system by allowing timely access to information stored in one place.

What next?

Anaesthetists can access My Health Record as an employee of a healthcare organisation connected to the system. To find out more, anaesthetists can request a digital health education session by contacting ANZCA or the Australian Digital Health Agency at clinicalpartnerships@digitalhealth.gov.au.

Further information on My Health Record and getting connected can be found at www.myhealthrecord.gov.au or by contacting the helpline on 1800 723 471.

Links:

www.myhealthrecord.gov.au/for-healthcare-professionals

www.myhealthrecord.gov.au/for-healthcare-professionals/specialist-practice

Information supplied by the Australian Digital Health Agency

What would you do?

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

The Good, The Bad, and The Ugly

I would like to kick off this first edition of 2019 by promoting professionalism and compassion, not that this is necessarily lacking. My plea is for rigour, transparency, and fairness devoid of bias towards our colleagues who may be facing challenging times.

This article, as with the previous ones, is intended to serve as a conduit to awareness and applicability of ANZCA professional documents.

The scenario below for consideration, should you choose to accept it, is that while in theatre your anaesthesia assistant informs you of a colleague, who you have known for some years, whose performance has been identified as an issue of concern. Your colleague is described as "doing things differently from other anaesthetists and recently one of their patients had suffered some form of mishap". As a result, their clinical privileges had been withdrawn and a notification forwarded to the regulator.

Note that this is not a situation where a practitioner has acted illegally or in a manner considered unprofessional conduct. Such behaviour cannot be condoned and is beyond the scope of this article.

Have you ever been the subject of allegations by a healthcare facility or notification to the regulator? Or do you know anyone that has?

I know of a number of colleagues that have had to endure this stressful process.

The title of this article is intended to reflect the situations that may lead to notifications to the regulator or actions by fellows or healthcare facilities as follows:

- The Good – Astute fellows acting as patient advocates in identifying safety concerns arising as a result of poor performance, whether it be clinical competence, non-technical skills, or inappropriate behaviour. In this setting fellows adhere to a rigorous process to confirm poor performance, and then initiate actions to protect patients in particular, but also staff if they are at risk. Sensitivity and compassion are to be encouraged even in these circumstances and when displayed they demonstrate professionalism and collegial behaviour. Having witnessed this type of approach from a number of my senior colleagues in the past it served as an excellent learning experience for me, and for which I am eternally grateful to them.
- The Bad – Unfortunately there may be times when performance deteriorates and lets us down placing patients and/or staff at risk. Whether it be technical skills or non-technical skills that deteriorate, both are important and constitute grounds for concern and possible escalation. By identifying such concerns, they present an opportunity for remediation.
- The Ugly – This refers to rare situations where motivation for notification is either vexatious or mischievous. It may be the result of a personality conflict, or it may be designed to gain an advantage over a colleague in a competitive environment. It typically portrays only "one side of the story". Such behaviour may be counterproductive and disadvantage the community if it inappropriately leads to the withdrawal of any fellow from the workforce who may in fact be providing quality services.

The ramifications of withdrawal of clinical privileges and of notifications are serious, and although this should not bias any decision, it demands that due process is followed. Failure to verify veracity and accuracy of information leads to decision makers being misinformed and despite the best of intentions, represents a shift from the good to the ugly. Fellows who come to conclusions prior to acquiring all relevant information and then act on those conclusions, even with the best intentions, effectively become complicit in the imposition of inappropriate actions.

On occasions fellows may be approached by legal firms and provided specific selected information for which an expert opinion is sought. This is a very different situation from undertaking a performance assessment for which all relevant information should be sought.

It may be timely to remind ourselves that appearances can be deceiving and that in the absence of the full picture conclusions can be debatable.

Looking at the diagram ... what do you see?

Do you see a duck?

Or do you see a rabbit?

With the available view there may be disagreement but both interpretations could be correct. It is not until one sees the full image that a definite conclusion can be drawn.

Clearly, developing the full picture is essential in any assessment and the process for achieving it needs to be effective. The following is intended to inform fellows of expected standards of performance as well as serving as a guide in assessing performance for those of us that may be involved or called upon to consider a colleague's practice. While I acknowledge that the Australian Society of Anaesthetists, the New Zealand Society of Anaesthetists, and the Special Interest Groups have produced very helpful documents, and I encourage familiarity with them, my focus here is with the ANZCA publications.

Expectations of professionalism and examples of good and poor behaviours are presented in the ANZCA publication *Supporting Anaesthetists' Professionalism and Performance: A guide for clinicians*.

The range of standards spanning clinical practice are scattered throughout ANZCA's professional documents. However, selecting the ones relevant to assessing performance may not be readily distinguishable. In order to facilitate the selection process as well as to standardise performance assessments a new professional document has been developed, *PS65 Guidelines for the Performance Assessment of a Peer*. In addition to the experience gained from performance assessments for jurisdictional authorities and healthcare facilities this document also incorporates the experience gained in assessing Specialist International Medical Graduates (SIMGs), which requires a robust, reliable and rigorous process.

(continued next page)

What would you do? (continued)

PS65 provides recommendations for the review process to ensure transparency and consistency, including establishing terms of reference for any review as well as identifying the relevant prof docs. It was designed specifically for this purpose as there is a demand from healthcare facilities, legal firms, and jurisdictional authorities for college advice or performance assessments. As the college does not undertake such activities it assists under regulation 27 by nominating fellows to undertake the assessments as experts but independent of the college.

The intention of the regulatory authorities in mandating notification of poor performance is to prevent further patient harm, recognising that grounds for notification suggests that there has already likely been some harm.

Where notification occurs in the context of appropriate reporting (the "Good") it offers an opportunity for remediation of the underperforming practitioner during which time collegial support may be invaluable. Insight, which is a component of remediation/learning, may be enhanced through mentorship, emotional support, and empathy.

I would like to stress that patient safety (and quality) is the peak goal of our professional practice, and all actions towards achieving this are to be strongly encouraged. I appreciate that I am preaching to the converted and without intending to sound patronising I genuinely commend the great majority of fellows who behave and act with this in mind. At the same time, respect and honesty towards our colleagues and team members with whom we work are values that contribute to better outcomes for our patients.

Actions by healthcare facilities or regulators have an immense impact on the lives of those practitioners at the centre as well as their families, disrupting their lives and seriously affecting their mental wellbeing. Fellows who have been the subject of withdrawal of clinical privileges or notification as a result of the "Ugly" process suffer severe stress, anxiety, and on occasions have been suicidal. Consequently, not only do they deserve our empathy and collegial support, but they may benefit from being guided towards resources including mentors, the college's Doctors' Health and Wellbeing webpage with links to the Free Doctors' Support Program, services offered through the Welfare of Anaesthetists SIG, or the ASA and NZSA.

For those who may not have seen the movie "The Good, The Bad, and The Ugly" or don't recall it the main characters were Blondie (The Good), Angel Eyes (The Bad) and Tuco (The Ugly). Any resemblance to persons living or otherwise is purely coincidental.

Finally, collegiality and support of our colleagues creates cohesion and strengthens our craft. Our obligations to our patients, the community, and ourselves requires that we act and behave in a professional and empathetic manner.

Dr Peter Roessler
Director of Professional Affairs, Policy

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

Recent updates

- A Documents Working Group has been established to address professional documents due for review, and to examine all other college guidelines and standards (including joint statements, position statements and endorsed guidelines). It will result in transparency about the process for their development and review, and also will classify the documents to simplify categorisation, searching and publication on the website.
- A document development group has been established to review *PS56 Guidelines on Equipment to Manage a Difficult Airway During Anaesthesia* (previously T04).
- Work has commenced on the review of *PS26 Guidelines on Consent for Anaesthesia or Sedation*.

Currently in pilot

- *A01 Policy for the Development and Review of Professional Documents* (until July 2019).
- *PS02 Statement on Credentialling and Defining the Scope of Clinical Practice in Anaesthesia* (until November 2019).
- *PS04 Recommendations for the Post-Anaesthesia Recovery Room* (until November 2019).
- *PS63 Guidelines for Safe Care for Patients Sedated in Health Care Facilities for Acute Behavioural Disturbance* (until April 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.

Obituary: Dr Ralph Reginald Clark, FANZCA

Former dean a pioneer

Ralph Clark graduated in medicine at Melbourne University in 1947, becoming an intern at The Alfred hospital that same year. In 1949 he became a medical officer in the British Commonwealth Occupation Forces in Japan, a year that sparked his interest in anaesthesia.

In 1950 he was appointed the first anaesthetic registrar at The Alfred. Here three notable pioneers of specialist anaesthesia, Robert Orton, Douglas Renton and Geoffrey Kaye, taught him. In 1951 he passed his Diploma of Anaesthesia at Melbourne University. It would have been a busy year for Ralph as he married Lesley Hemley, who was a theatre nurse at that same hospital. Lesley was a great support for Ralph for most of the rest of his life. In 1952 he was awarded a Nuffield Grant for two further years of training at the University Department of Anaesthesia at Oxford University. This department led the world of anaesthesia with such experts as Professor Macintosh and Professor Crampton Smith and Dr James Mitchell. During those years he passed the Diploma of Anaesthesia of the Royal College of Physicians and Surgeons of England and the Fellowship of Faculty of Anaesthetists Royal College of Surgeons. In 1954 Ralph returned to The Alfred as the First Assistant to the Director, Dr Orton. He was then admitted to the fellowship of the Faculty of Anaesthetists Royal Australasian College of Surgeons.

In 1955 he was appointed the first Director of Anaesthesia at St Vincent's Hospital Melbourne, a position he held for 29 years. Dr Clark's exceptional organisational skills were apparent early. He organised an efficient anaesthetic service and set up a training program for specialist anaesthetists, which over the years became one of the best in Melbourne.

Among the many things he introduced to the hospital was the anaesthetic nursing assistance to the anaesthetist, a concept he had seen to be very helpful in Oxford. He also set up the recovery room to care for patients before they returned to their wards. This improved the safety for patients in that early postoperative time.

He set up an area for artificial ventilation which was a precursor to the intensive care unit founded in 1962, the first in Australia. Clinical anaesthesia developed dramatically in Ralph's time and he encouraged his staff to travel overseas to learn about these innovations.

Ralph was particularly supportive of women in the specialty; he appreciated their family requirements and was repaid with their hard work and loyalty. His retirement citation from St Vincent's indicated that he ran a happy, efficient, high standard department with the minimum of conflict. Ralph was a realist with innate courtesy but an unwavering dedication to what was best for the department. Ralph continued in private practice after retiring from St Vincent's, gradually scaling down until ceasing practise at aged 79.

Ralph was the secretary of the Victorian Section of the Australian Society of Anaesthetists in 1954/55 but the next year he was elected to the Board of Faculty of Anaesthetists Royal Australasian College of Surgeons. He was on the board for 12 years and help set up the training and examinations for specialist anaesthetists and set the standard of anaesthetic practice in Australia and New Zealand. He became dean of the faculty in 1968 and he was awarded the Orton Medal in 1975 by the faculty for distinguished service to anaesthesia, the highest award the faculty can make.

Ralph and Lesley had a strong interest in gardening, maintaining a beautiful garden at their residence in Mount Waverley. They actively supported the Cranbourne Botanical Gardens and the Valley Reserve in Mount Waverley. Ralph also had a significant involvement with the scouting movement and camped and sailed with his children. In retirement Ralph and Lesley travelled extensively in Australia and overseas and ran a cashmere goat farm in Poowong. They had three children, Trevor, Janette and Helen and six grandchildren. Lesley died in 2017 and Ralph suffered from failing vision and chronic renal failure in his final years but was able to live reasonably independently with the aid of his children.

Ralph Clark was a pioneer in the early development of specialist anaesthesia, he trained more than 100 specialist anaesthetists, he was a wonderful organiser but most of all he was a dedicated, safe, caring and compassionate anaesthetist.

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

Obituary: Dr Nerida Margaret Dilworth AM, FANZCA

WA trailblazer remembered

Nerida Margaret Dilworth was born in 1927 and grew up in Perth. Nerida won a scholarship to Perth Modern School and was among the top 10 matriculation students in WA in her "leaving" year. Then like other West Australians of her day, she went to the University of Adelaide to study medicine.

Dr Dilworth graduated in 1950 and then spent three years in junior posts at Royal Perth Hospital (RPH) before becoming an anaesthetic registrar. She undertook further anaesthesia training in the United Kingdom and obtained her FFARCS in 1959. Dr Dilworth returned to RPH in 1960 and later that year she was appointed the inaugural Director of Anaesthetics at Princess Margaret Hospital (PMH), a post that she held until her retirement in 1992. She was elected to fellowship of the Faculty of Anaesthetists RACS in 1966.

Following her appointment Dr Dilworth established the first department of anaesthesia at PMH. The ethos was that children were not simply "little adults" but patients in their own rights and with special needs. Nerida was a gifted clinician, a superb organiser, a natural leader and a collaborative worker. Paediatric anaesthesia at PMH flourished under her leadership and guidance. She worked in collaboration with Mr Alasdair MacKellar, the paediatric surgeon, to establish the surgical department, the intensive care unit, the burns unit, the neonatal studies and data collection systems.

Dr Dilworth pioneered the development of the department and steadfastly fought for the required facilities, staff and equipment; as she steered the department to a central and pivotal role in the hospital. Under her leadership the department introduced same day care (abetted by Dr Peter Brine) in the mid 1970s. In the early 1980s they were early and very ardent advocates for adequate pain relief in children. Nerida had always considered that children were an under privileged group in relation to the provision of adequate pain relief. She introduced the early protocols for and during the 1980s published on the management of acute pain relief in children.

Probably the most significant contribution was that from the early 1960s she fought for and started the intensive care unit, initially for the treatment of acute respiratory illnesses requiring intubation. Congenital and acquired airway problems were always a major interest of hers. Nerida had to overcome the intense opposition of the paediatricians and the medical superintendent of the day, who were unwilling to accept that anaesthetists could appropriately care for critically ill patients. That of course was just the sort of challenge that Nerida loved. Her persistence, determination, logical arguments and example (aided and abetted by Dr Peter Brine and the Mr Alasdair Mackellar) won through in the end. They were among the first in Australia to introduce nasal intubations for critically ill children and developed a remarkable service, given the isolation of Perth in the 1960s. Her skill, dedication and extraordinary work ethic, plus the expertise of the staff, that she trained, soon meant that the intensive care under the management of anaesthetists was accepted in the hospital.

From today's perspective many of these developments may sound trite but it must be remembered that at the time they were ground breaking.

Nerida made many other contributions to the PMH community. In addition to teaching students, anaesthesia trainees and nurses she also served on or chaired a legion committees, including the Clinical Staff Association and the Hospital Board. She was even elected as Chair of the Division of Surgical Services and served for six years. They all recognised the astute judgement, integrity, honesty, commonsense, dedication and kindness which accompanied her medical knowledge, clinical prowess and commitment to paediatric patients and the hospital. She retired in 1992 after 32 years as director of the department and in the words of her successor Dr G Mullins, "she left an excellent department of anaesthesia with a national reputation, a well-coordinated team with excellent relationships and respect within the hospital. All created by Nerida".

Dr Dilworth served on the WA Regional Committee of the faculty from 1972-1984, and was the chair from 1974-76. Nerida was a final fellowship examiner for the Faculty of Anaesthetists RACS from 1968 to 1980. Dr Dilworth was elected to the Board of Faculty in 1976 and served until 1984. Her interests while on the board were focused on education, professional standards, patient safety, anaesthesia standards and faculty regulations. From 1979-84 she was the Assessor for the Faculty, a position that was suited to her meticulous attention to detail, her integrity and sense of fairness. This was perhaps best demonstrated in her 1981 submission on "Part-Time Vocational training in Anaesthesia", when she sought to address some of the anomalies that were occurring. Dr Dilworth declined to seek the deanship but there is no doubt that she made major contributions to the faculty at an important time in the development of the specialty and anaesthesia training in Australia and New Zealand.

Dr Dilworth was a consummate clinician and a gifted teacher, who was happy to encourage others to do clinical research. The ASA/Faculty WA Registrar Prize was initiated in 1985 and in 1987 it was decided to name this prize in honour of Dr Dilworth in recognition of her contributions to teaching and the support of research. She has supported the prize over the years and presented the award in person on many occasions. In 1993 Dr Dilworth was awarded Membership of the Order of Australia in recognition of "her services to medicine and particularly the field of paediatric anaesthesia". In 2006 Dr Dilworth was awarded the inaugural ASA Medal in recognition of her contributions to the development of paediatric anaesthesia, paediatric intensive care and the education of several generations of anaesthetists in WA.

Nerida Dilworth will be fondly remembered by her colleagues for her professionalism, judgement, fairness, clinical acumen and skill together with a deep appreciation of the teaching, support, encouragement and advice that she extended to so many of them. The children of Western Australia will continue to benefit from her achievements and contributions, which laid the foundations for paediatric anaesthesia in the state.

Dr Walter R Thompson AM
Former ANZCA President 2006-2008

From left: Dr Nerida Dilwork at the 2008 ANZCA ASM; Dr Lisa Hill receiving the Nerida Dilworth Prize from Dr Dilworth at the 2010 ASM.

Perioperative medicine:

Where we have come from and where we are heading

A key pillar of the ANZCA Strategic Plan 2018-2022 is the development of an effective, integrated and collaborative perioperative care model.

Perioperative medicine (POM) is a developing field aimed at helping all patients but in particular our most vulnerable.

Intraoperative mortality is now extremely rare (1:100,000 cases)[1]. However, post-operative complications cause morbidity and are the third leading cause of death in the developed world. Contributors to these figures include:

- Suboptimal risk assessment.
- Lack of shared decision making.
- Inadequate optimisation prior to surgery.
- Failure to rescue.
- Fragmented post-operative management[2].

ANZCA has committed to improve the care of patients throughout the surgical journey – from the moment the primary care provider refers for consideration of surgery until the completion of rehabilitation and return to the community. The goal is to improve and balance the risk and benefits of surgical and non-surgical options.

The first step commenced with a review and update of the curriculum to enhance our trainees' awareness of perioperative medicine. It is now a training requirement that trainees understand core perioperative medicine issues such as delirium, high risk assessment, prehabilitation and frailty.

In 2014, ANZCA convened a working group to review the current state of POM in the developed world, and proposed a different way of caring for surgical patients for the future. In 2016 the working group reported to ANZCA Council resulting in a decision to progress a formal qualification in POM – a historic decision as ANZCA is the first medical college to formalise the process under the umbrella of a specialist college.

With so many stakeholders in POM including (but not limited to) surgeons, physicians, geriatricians, intensivists, primary care and allied health professionals, ANZCA has taken the lead and is considering a POM qualification, with representation and input from the above colleges and sub-specialty experts reflecting the multi-specialty and multi-disciplinary nature of perioperative medicine.

Our vision

By 2023, the following should be in place:

- **Defendable economic case for perioperative care (POM).**
- **Collaborative lobbying for the advancement of POM.**
- **Government, health sector and community awareness of the benefits of POM.**
- **External courses that support aspects of perioperative medicine are formally recognised.**
- **ANZCA professional documents related to POM.**
- **A formal POM qualification.**
- **Training site accreditation of POM departments.**
- **Patient-centred education and awareness of benefits of POM.**

ANZCA is sourcing and guiding the process, but recognises it cannot be done alone. This qualification will potentially be a post-graduate qualification modelled on the pain fellowship and will have specific training requirements consistent with the best models of medical education now available. Those currently practising in perioperative medicine and who fulfill appropriate criteria will be acknowledged appropriately. The exact format of this qualification is under development and will be informed by the recent POM survey and project group findings.

The college has invested considerable resources into POM and has an internal project team led by ANZCA's Director, Education Olly Jones to co-ordinate the many work streams needed.

POM is a key area of focus for the college, and overall governance is through a steering committee under the leadership of ANZCA Vice-President, Dr Vanessa Beavis. In addition to ANZCA and its Faculty of Pain Medicine, there is multidisciplinary representation from the College of Intensive Care Medicine, the Royal Australasian College of Physicians, the Royal Australasian College of Surgeons, the Royal New Zealand College of General Practitioners, the Royal Australian College of General Practitioners, and the Australian College of Rural and Remote Medicine. Community representation is also being sought.

So where to from here?

We will be consulting widely with ANZCA members and those from other medical colleges to ensure that we craft training options that appeal to various professional stages; flexible modular training, professional standards that support high quality care, CPD integrated into current systems, and specific approaches for those wanting to take time out to do year long (or more) training. The first two have commenced:

- Education development (overseen by ANZCA councillor Dr Sean McManus). This will focus on the development of a statement about what a POM specialist is able to do and a curriculum framework that outlines the skills and knowledge required.
- The development of perioperative care models (overseen by POM Special Interest Group Chair, Dr Jeremy Fernando). This will focus on describing what is happening now in POM in Australia and New Zealand. It will also look to provide a framework on how a hospital/ health service can provide an integrated, evidenced-based perioperative service.

Later work will consider:

- The economic case for POM.
- Professional standards and policies.
- Development of POM CPD.

Summary

Perioperative medicine is an exciting field with huge potential to improve outcomes for our most vulnerable patients. It allows us to learn from and work with other disciplines.

Our patients receive excellent care while in theatre. Now let's see if collectively, we can improve their care before and after.

Dr Jeremy Fernando
Chair, Perioperative Care Working Group

Dr Vanessa Beavis
Chair, Perioperative Medicine Steering Committee, Vice-President, ANZCA

Dr Sean McManus
Chair of the PoM Education Development Working Group, ANZCA Councillor

References:

1. Daniel Sessler, John W. Severinghaus Lecture, 26th October 2016, American Society of Anesthesiologists Annual Meeting)
2. Ferraris, VA, et al (2014) "Identification of patients with postoperative complications who are at risk for failure to rescue" JAMA Surg, Nov;149(11)

POM literature review

ANZCA commissioned a review of recent peer reviewed and grey literature to better identify the coordinated POM care models that are effective in improving patient outcomes and cost efficiency.

The review found that that a co-ordinated and collaborative multidisciplinary and multi-faceted model of perioperative care is effective in providing clinical benefits for patients and in reducing costs for health systems and providers. There are common core elements across the models. These include a multidisciplinary team; collaboration; close working relationship between team members leading to effective teamwork and communication; good leadership; a patient-centred approach (including patient education and shared decision-making); clear protocols and documentation; compliance; audit and reporting.

Key clinical and technical elements of enhanced recover after surgery (ERAS) models have been specified generally and for specific conditions and are documented throughout the literature.

The literature review will inform our work on models of care and education development.

The literature review is available on our website.

Survey – what you think

In October last year, we surveyed all 7751 ANZCA and FPM fellows, trainees and specialist international medical graduates for their views on perioperative medicine (POM) practice today, the skills required for perioperative care and the level of support for the development of POM training.

The survey achieved a 27 per cent response rate (n=2077). POM Special Interest Group members represented about 15 per cent of these responses.

Through the survey, the college has confirmed support to move forward with the development of perioperative medicine education offerings.

Almost two thirds of respondents thought it reasonable to do an extra year of training to become a perioperative medicine specialist. Support was highest among trainees (74 per cent) and lowest in specialists with 20-30 years of experience.

Similarly trainees and provisional fellows (56 per cent and 53 per cent respectively) were more likely to consider doing an additional year of training. Specialists with more than 30 years of experience were least likely to consider any additional training (19 per cent).

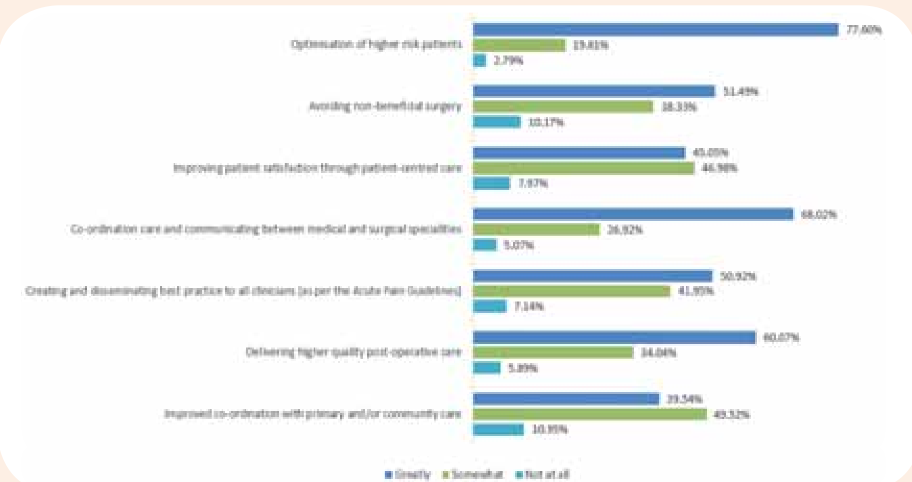
More than 70 per cent of respondents want a POM specialist to have:

- Preoperative management skills to identify and mitigate risk factors.
- Postoperative management skills including consideration of surgical stress response, fluid management, acute and persistent pain, and delirium management.
- Discharge planning and an understanding of intraoperative anaesthesia management.

Most respondents saw a perioperative medicine service and/or specialist adding particular value in optimising care for higher risk patients (77 per cent), co-ordinating care between medical and surgical specialties (68 per cent) and delivering high quality postoperative care (60 per cent).

Value of perioperative services

"In which of the following areas do you see a perioperative medicine service/specialist adding value to your clinical practice? Please rate as greatly, somewhat or not at all."



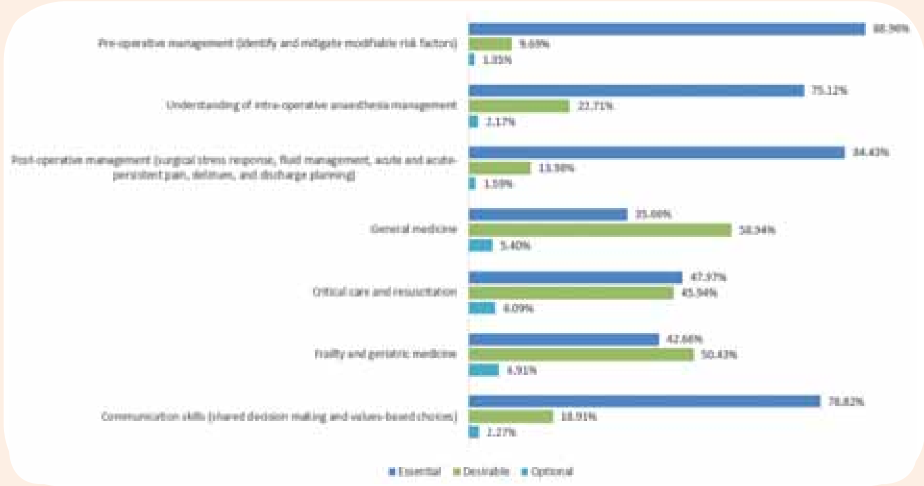
A significantly high 89-97 per cent of respondents saw at least some value in all areas addressed.

Areas rated most highly were "optimisation of higher risk patients" (77.6 per cent rated "greatly") and "co-ordination of care and communicating between medical and surgical specialties" (68.02 per cent rated "greatly").

Those rated of lower value were "improved co-ordination with primary and/or community care" (10.95 per cent rated "not at all") and "avoiding non-beneficial surgery" (10.17 rated "not at all").

Required skills and knowledge

"What additional skills and knowledge does a perioperative medicine specialist require? Please rate as either essential, desirable or optional."



A very high 93-98 per cent of respondents rated all areas as desirable or essential.

Four areas were rated highly as "essential":

- Pre-operative management (identify and mitigate modifiable risk factors) – 88.96 per cent.
- Post-operative management (surgical stress response, fluid management, acute and acute-persistent pain, delirium and discharge planning) – 84.43 per cent.
- Communication skills (shared decision making and values-based choices) – 78.82 per cent.
- Understanding of intra-operative anaesthesia management – 75.12 per cent.

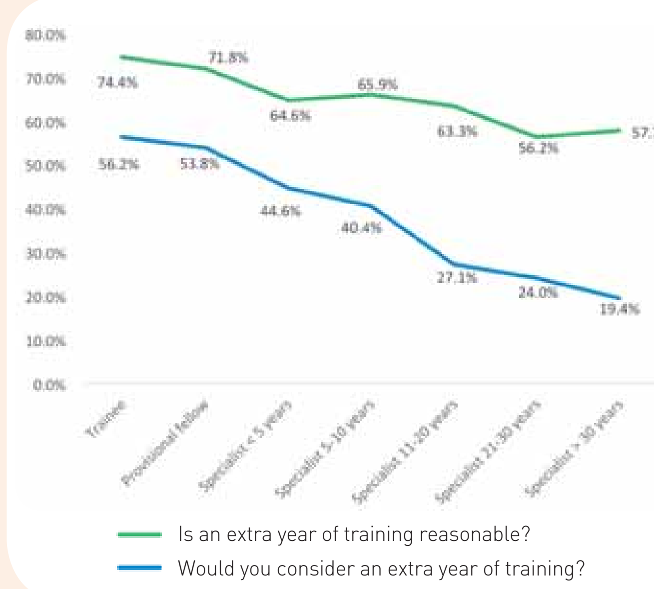
Extra year of training

"Do you think doing an extra year of training is reasonable to become a perioperative medicine specialist?"

63.65 per cent (N=1,322) – Yes.

"Would you consider doing an extra year of training?"

35 per cent (N=727) – Yes.



The value proposition of perioperative medicine

Anaesthetists are at the forefront of local and international perioperative medicine initiatives and programs to deliver value-based care, writes Professor Bernhard Riedel.

It is estimated that one third of the global burden of disease is amenable to surgery.

In fact, when considering patients suffering trauma or a solid organ cancer diagnosis then the proportion of patients requiring surgery exceeds 60 per cent[1]. Current demographic change, with a global ageing population accompanied by an increasing incidence of cancer, likely necessitates a two-fold increase in surgical services by 2035.

The inability of developing nations to deliver essential surgical services to their populations is estimated to account for an estimated 17 per cent loss in gross domestic product (GDP)[2], which in turn negatively impacts the ability to fund such essential surgical services — a catch-22 situation.

In contrast, in the developed world an unsustainable growth in the percentage of GDP that is spent on healthcare is unsustainable (ranging from about 10 per cent for Australia and about 17.5 per cent for the US).

This is compounded by the fact that the current aggregate of healthcare system performance delivers suboptimal value (value = patient outcomes + safety + satisfaction ÷ cost). This is illustrated by the Institute of Medicine estimating that loss in healthcare expenditure could be as high as 25-30 per cent in the US — largely attributed to waste (for example, unco-ordinated and inefficient healthcare systems and high variability in care delivery) and preventable adverse events (for example, postoperative complications such as venous thromboembolism (VTE) and wound infection…)[3]

There is no reason to believe that this loss in healthcare expenditure is substantially less in Australia. Consider repeated pathology tests due to inability to access external results, waiting lists and preventable complications. Australia, with an annual GDP of about $A1.2 trillion, spends approximately 10 per cent of its GDP ($A120 billion) on healthcare. Loss in healthcare expenditure, through waste from inefficient systems and preventable complications, could be about $A30 billion (2.5 per cent GDP) per annum – funding that could be utilised more efficiently with improved systems.

Postoperative complications, many of which are preventable, are common. The National Surgical Quality Improvement Program, a national (and increasingly used internationally) benchmarking tool administered by the American College of Surgeons, estimates that between one in four and one in six patients suffer all-cause or major postoperative complications across various hospitals[4].

(continued next page)

The value proposition of perioperative medicine (Continued)

Strikingly, the incidence of morbidity was similar between participating hospitals, but they reported a two-fold inter-hospital variation in mortality in patients that suffered postoperative complications. This "failure to rescue" from postoperative major complications likely reflects substantial variability in the quality of care delivery by individual hospitals. Variability in care delivery at clinician level is an important contributory factor in postoperative morbidity and mortality. This is illustrated for example by a 20-fold variation in volume of intravenous fluid administered by anaesthesia providers within the first hour of elective laparotomies[5].

Similarly, Australian data demonstrated significant variability in clinical outcomes between high-volume and low-volume surgeons performing pancreaticoduodenectomy, with estimated hospital costs ranging between $A38,000 and $A80,000, respectively, per episode of patient care[6].Not surprisingly these data demonstrated a strong correlation between number and grade of postoperative complications, length of hospital stay (LOS) and total cost of care (patients with no complications: average LOS = eight days and in-patient cost = $A28,000 vs. patients with complications: average LOS = 13 days and in-patient cost = $A57,000). However, there is more to delivering value-based care than removing individual clinician variability.

An important study by Glance et al[7] assessing feasibility of report cards for measuring quality of care delivery for cardiac surgery by anaesthetist and surgeon showed limited impact of individual practitioners on the composite outcome of major complication or death (albeit for few outlier surgeons on either end). Rather, they reported that more than one third of institutions had significantly higher adjusted odds ratio for postoperative major complications or death. This reflects the sum of the parts, whereby each member of a multidisciplinary team adds incremental harm/value, outweighing the individual talent of an anaesthetist or surgeon.

Centres of excellence are underpinned by high volume practice, with multidisciplinary teams centred around disease entities. Such centres are process driven, for example, prehabilitation and enhanced recovery after surgery (ERAS) teams, with infrastructure to be successful in quality improvement initiatives, including on-going closed loop audit and engaged executive teams with clinician leadership.

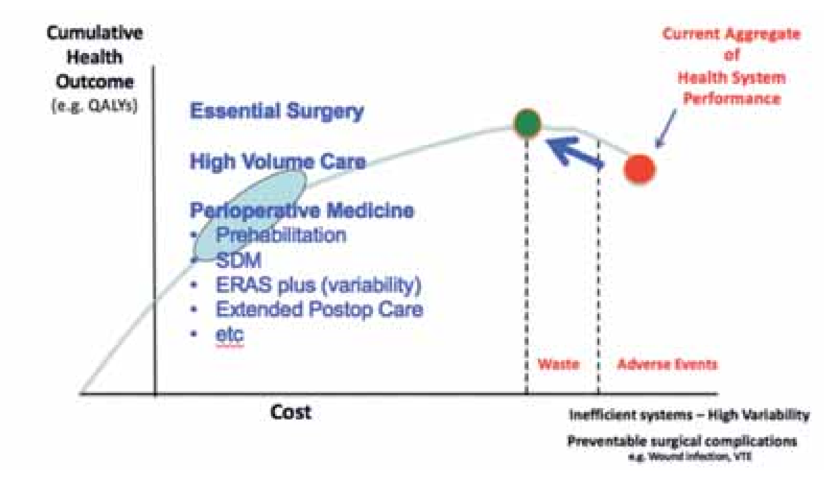


Figure 1. The Value Proposition Curve illustrating how components of Perioperative Medicine are on the steep part of the value curve—delivering increased value at lower cost.

Perioperative medicine is increasingly recognised as a multidisciplinary strategy to deliver on the value proposition (high-quality, high-value) within healthcare.

Perioperative medicine, underpinned by strategies such as redesigned perioperative care pathways to ensure timely and accurate risk stratification (identifying the ~20 per cent of patients that utilise ~80 per cent of healthcare resources), with early referral for prehabilitation to target modifiable risk (anaemia, malnutrition, deconditioning.).

ERAS pathways, shared decision-making to avoid unnecessary surgery, surgery school to engage patients in their care journey, extended postoperative recovery units, postoperative perioperative medicine team-led rounds to prevent MET calls and failure to rescue, and rehabilitation into the community after surgery will all provide the opportunity to shift the value proposition curve (health outcomes [for example quality adjusted life years (QALYs)] versus healthcare cost) leftward and upward (see figure 1). If such a co-ordinated multidisciplinary approach reduced major complications (estimated at 15 per cent) by one fifth it creates the potential to harness a substantial proportion (possibly more than $A1 billion) of the $A120 billion that is spent on healthcare per annum in Australia, allowing for significant expansion of healthcare services, and research.

The multifaceted approach to perioperative medicine illustrates how incremental savings could amount to these cost saving estimates. For example, a recent review on preoperative malnutrition, a modifiable risk factor, suggests that two out of three patients presenting for gastrointestinal surgery are malnourished, with three-fold increased risk of morbidity and five-fold increase in mortality[8].

"It was estimated that for every $US1 spent on nutritional therapy the hospital would save $US52 in health costs."

It was estimated that for every $US1 spent on nutritional therapy the hospital would save $US52 in health costs. Yet, only one in five hospitals have formal nutritional screening processes and only one in five patients receive preoperative nutritional intervention.

Other modifiable risk factors include loss of functional capacity (deconditioning; with three- to five-fold increase in postoperative complication rates in patients that have anaerobic threshold <11 mL/kg/min), anaemia, smoking and alcohol, etc[9].

Small randomised controlled trials of prehabilitation with exercise report that in patients having major abdominal surgery the overall complication rate was halved (RR = 0.5; 95% CI 0.3-0.8; p=0.001)[10].

Similarly, a bundle of preoperative respiratory care, including patient education, was also accompanied by halving in postoperative pulmonary complications (HR = 0.48; 95% CI 0.30 – 0.75; p=0.001)[11].

Implementation of a colorectal ERAS program across a provincial (Alberta, Canada) healthcare system resulted in significant reduction in LOS by 1.5 days and net cost savings of between $US2806 and $US5898 per patient[12].

Perioperative medicine promises to deliver high-value care to health care systems. It describes the practice of patient-centered, multidisciplinary, and integrated medical care of patients from the moment of contemplation of surgery until full recovery[11].

Perioperative medicine requires expertise to leverage the collaboration between purchasers, policy makers, all healthcare craft groups (including anaesthesia, surgery, pain medicine, general practice; medical specialties including haematology, cardiology, respiratory medicine; allied health including physiotherapy, exercise physiology, nutrition, psychology; and nursing including pre-anaesthesia clinics, and ERAS), the patient (shared decision-making, education, for example, surgery school and ERAS, community gym) and his or her support structure (motivation, accountability).

Key opportunities for increasing value through perioperative medicine include collaborative decision-making, lifestyle modification before and after surgery (prehabilitation to improve physiologic reserve and thereby reducing perioperative risk and rehabilitation and comorbid disease optimisation), standardised in-hospital perioperative care, and process mapping and audit to drive quality improvement initiatives[13].

Anaesthetists are entering an exciting period with the opportunity to play a central role in this global initiative to deliver value-based care.

Numerous examples can be found at national level such as the Royal College of Anaesthetists through its perioperative medicine initiatives[13],the American Society of Anaesthetists through the Perioperative Surgical Home, and with ANZCA and the Perioperative Medicine Special Interest Group initiatives in Australia and New Zealand, while at institutional level clinicians are actively undertaking systems redesign on behalf of their patients[14].

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"Implementation of a colorectal ERAS program across a provincial (Alberta, Canada) healthcare system resulted in significant reduction in LOS by 1.5 days and net cost savings of between $US2806 and $US5898 per patient."

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HOW ANZCA'S OVERSEAS AID STRATEGY IS WORKING TO IMPROVE HEALTH OUTCOMES

ANZCA has a long history of training, education and related support initiatives in low and middle income countries. Formal educational assistance was first provided by the Faculty of Anaesthetists (Royal Australasian College of Surgeons) in the 1960s through the Australian government's Department of Foreign Affairs and Trade's Colombo Plan.

In the early 1990s Professor Garry Phillips became involved in teaching in Papua New Guinea (PNG) and arranging for registrars from PNG to work in posts in Australia. In 2007 an ANZCA PNG working party was formed and this group was formalised in 2010 as the ANZCA Overseas Aid Committee.

In 2017 the Overseas Aid Committee commenced the development of a new five-year strategic plan to guide activities from 2018-2022. The committee undertook a comprehensive review of the broader policy landscape including contemporary global health issues and Australia and New Zealand's foreign aid policies. This highlighted a number of issues that impacted the committee's considerations in determining strategic priorities.

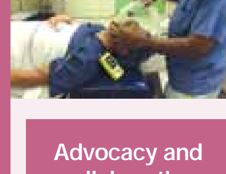
Workforce remains a major challenge, with low- and middle-income countries facing a substantial and widening mismatch between the number of health workers needed to provide essential services, the availability of health professionals and the country's capacity to employ them. According to the World Health Organization (WHO) there is a global shortage of 7.2 million healthcare workers, a number that will increase to 12.9 million by 2035 if it is not addressed. During 2015-2016 the World Federation of Societies of Anaesthesiologists conducted a global anaesthesia workforce survey. The results show that the majority of Australia and New Zealand's neighbouring countries reported a total physician anaesthesia provider number of less than five per 100,000 population (compared with 23 per 100,000 population in Australia and 21 per 100,000 people in New Zealand).

Maternal and child health in low- and middle-income countries is another area where the health outcome disparities are clear. For example, Australia has a maternal mortality rate of six per 100,000 live births, compared with a rate of 215 in neighbouring Papua New Guinea and Timor-Leste. WHO suggests approximately 99 per cent of all maternal deaths occur in low-income countries.

Left: Hong Kong FANZCA Dr Debriel Or Yin Ling, an EPM trainer, with Alice Ho Miu Ling Nethersole Hospital pain clinic patient Simon Tam. Photo: Carolyn Jones

ANZCA's 2018-2022 Overseas Aid Strategy

Training and education
Support training and education in PNG and other low and middle income countries in the western Pacific rim such as Timor-Leste, Fiji, Tonga, Cook Islands, Samoa.



Medical and educational equipment
Support the donation of medical and educational equipment and safety initiatives for low-middle income countries.

Advocacy and collaboration
Developing partnerships with key government and non-government agencies, specialist colleges and other stakeholders to expand opportunities, raise the profile of ANZCA's overseas aid work and ensure greater collaboration.

Evaluation
Evaluation of ANZCA's overseas aid activities.

ANZCA's Overseas Aid Committee has, and continues, to make a real difference to people in living in Australia and New Zealand's nearest neighbours in the western Pacific Rim. As an educational college, teaching and vocational training is at the core of the committee's activities – fostering and developing a sustainable, local health workforce. Other initiatives to support training and education include:

- The ANZCA International Scholarship which allows an anaesthetist or pain medicine physician to spend up to 12 months in an Australian or New Zealand hospital.
- Prizes and awards in anaesthesia at the undergraduate, diploma and final master of medicine level in PNG.
- In-country support in PNG for anaesthesia training and examinations to both physician and non-physician anaesthesia providers, including at the annual PNG Medical Symposium.
- Lifebox initiatives and WFSA Fund a Fellow support.
- Close collaboration with other surgical and anaesthesia bodies including RACS, ASA, NZSA, WFSA.

Looking ahead, the committee identified four areas to frame strategic priorities for 2018-2022 as shown above.

In addition to training and education, the committee supports the donation of medical and educational equipment. Of note here is Essential Pain Management (EPM), a short, easily deliverable and cost-effective training program designed to improve pain management and train local health workers to teach EPM. ANZCA fellows Associate Professor Roger Goucke and Dr Wayne Morriss developed EPM following discussions about the lack of training opportunities for pain management with anaesthetists in Papua New Guinea. In 2010 they ran a pilot program assisted by local anaesthetists Dr Gertrude Marun and Dr Harry Aigeeleng in Lae and Port Moresby and since then EPM workshops have been delivered in 53 countries (and counting).

ANZCA's Overseas Aid Committee provides support for education, training and development of safety and quality in anaesthesia in the Asia-Pacific region, made possible through the generous donation of both time and resources from the college community. The following pages highlight just a small part of the committee's work and I encourage you to visit the ANZCA website and review the committee's 2018-2022 strategy for further information.

Dr Michael Cooper
Chair, ANZCA Overseas Aid Committee

SPOTLIGHT ON ESSENTIAL PAIN MANAGEMENT IN HONG KONG

ANZCA's leadership in introducing Essential Pain Management (EPM) to Hong Kong's health system is already paying dividends. We joined one of the program's developers, Associate Professor Roger Goucke, on his recent trip there to see how role play scenarios are engaging participants in EPM workshops.

Simon Tam was riding his motorbike to meet a friend for breakfast near his Hong Kong home when he had a head-on collision with a car. From that moment in 2006 the management consultant's life changed. He was rushed to hospital and spent a week in the intensive care unit. With a shattered pelvis, numerous fractures and other injuries he has since endured more than 20 operations.

Over the next decade he lived in a medicated "fog" having been prescribed a cocktail of opioids and other pain medicines to help relieve his severe back pain and sciatica.

Now retired, and having experienced the benefit of being cared for and treated by a multi-disciplinary pain medicine team, the 62 year-old volunteers as a patient counsellor at the Alice Ho Miu Ling Nethersole Hospital Pain Clinic in Hong Kong. The clinic, the first of its kind in Hong Kong, was established in 2002 by ANZCA and FPM fellow Dr Phoon Ping Chen.

Mr Tam now shares his own experience with patients at the clinic to help them cope with their conditions.

"I'm now giving back by helping patients with how to live with their pain. For years and years I was living in so much pain and was always looking for a solution which meant having operation after operation. The doctors would keep giving me pain medication and I was taking up to 30 pills a day and sleeping pills on top of these. I so wanted to be pain free. I was a very active person before the accident, I ran my own business and went on motorbike trips with friends but that moment (of the accident) was when everything stopped for me."

A "board of appreciation" greets visitors at the clinic's entrance featuring dozens of photographs and testimonials from former and current patients, including Mr Tam.

After being told by an orthopaedic specialist that he was at the "maximum medical improvement" stage the specialist mentioned to Mr Tam and his wife Wendy that he could refer him to the pain clinic.

"I really had no hope but the team were very patient with me, they listened to me and they understood me and they could see how much pain I was in," Mr Tam explained.

Mr Tam worked with the clinic's team of specialist pain medicine physicians and the allied health team over several weeks so he could wean himself off medication and commit to an exercise and stretching program.

"I learnt to concentrate on the things I enjoyed doing rather than focusing on the negatives and this motivated me."

An associate consultant at the clinic, Dr Debriel Or Yin Ling, says Mr Tam's experience highlights the benefits of using a multi-disciplinary approach for pain management. In addition to pain medicine physicians, the team includes occupational therapists, clinical psychologists and nurses.

Providing multidisciplinary pain management education in Hong Kong – the place of EPM

Dr Or is one of several ANZCA and FPM fellows who are playing a key role as champions for the roll out of EPM in Hong Kong under the leadership of Professor Roger Goucke, a former FPM dean. ANZCA is responsible for EPM program support, implementation and funding in Australia, New Zealand, South-East Asia and the South Pacific Islands. The program is supported as an initiative of the college's Overseas Aid Strategy. The World Federation of Societies of Anaesthesiologists (WFSA) is responsible for EPM in Europe, Africa and the Americas.

Speaking on the sidelines of a recent series of EPM Instructor and EPM Lite workshops for allied health staff in Hong Kong, Professor Goucke explained how the program was evolving there. More than 700 allied health staff have completed the EPM program in Hong Kong since its introduction in 2017 and 20 EPM courses are held there each year with support from the Hong Kong Department of Health and the Hong Kong Hospital Authority.

For the first time the Hong Kong EPM workshops used a role play, or simulation, approach so participants felt more engaged with the program and its recognise, assess, treat (RAT) principle. The participants use group role play sessions to "assess" patient case studies.

Professor Goucke said the response to the simulation approach by participants at the recent Hong Kong sessions had been very encouraging.

"One of the challenges with introducing the program in Hong Kong has been how we can best motivate the workshop participants and embed the RAT approach at the local level. By introducing simulation or role play as part of our delivery of the program the concept is embedded," he said.

"By emphasising the multi-disciplinary approach to pain management it means we get input and experience from many different practitioners and specialties. This means doctors and allied health professionals learn from each other when designing individual treatment plans for each patient."

"By formalising the role play approach we can better teach EPM and it means participants are more confident in using the program," Professor Goucke said.

Although the EPM program is designed to teach the RAT principle in low- and middle-income countries the program has been so successful in the UK that 18 of the UK's 44 medical schools are now using it in their pain medicine teaching modules.

The half-day workshops were held at the Hong Kong Health Hospital Authority building in Kowloon. The first "train the trainer" instructor session for 14 participants included anaesthetists, specialist pain medicine physician trainees, social workers, physiotherapists and nurses.

At the EPM Lite session the following day 24 participants were introduced to the RAT principle. Physiotherapists, occupational therapists, nurses, podiatrists and pharmacists worked together in groups for a series of sessions.

"By formalising the role play approach we can better teach EPM and it means participants are more confident in using the program."

EPM champion Dr Fiona Tsui, an ANZCA Hong Kong fellow and pain medicine physician explained how the key to the program's support in Hong Kong was its emphasis on the basics of pain management at the local level.

"Our aim is to improve pain management in Hong Kong by working with health professionals at the local level to improve their pain knowledge and provide a simple framework for managing patients' pain. The goal of EPM is to promote the RAT approach concept of pain management so our health staff can recognise, assess and treat pain."

The concept of pain management as a separate medical discipline is now recognised in Hong Kong but the number of practising specialist pain medicine physicians is low compared to Australia. Of the 51 fellows of pain medicine of the Hong Kong College of Anaesthesiologists (15 of whom are FFPMANZCAs), 34 work in the public sector.

"We hope that EPM will help contribute to a broader recognition of the importance of specialist pain medicine in Hong Kong and to the wider medical and allied health community," Dr Tsui explained.

Workshop participant Dr Ara Li, an anaesthetist and specialist pain medicine physician at Hong Kong's Prince of Wales Hospital said she hoped the program would contribute to a better understanding and recognition of pain medicine in Hong Kong.

"I'll now be able to promote this in the hospital as part of a broader education program," she said.

Another participant, Dr Olivia Ng, an anaesthetist and pain medicine trainee said Hong Kong's cultural differences meant some patients just accepted their pain and did not seek advice or treatment from specialists.

"If it's not life threatening, many patients, particularly older patients, will not seek treatment so this will be useful to raise awareness about the pain management options that are available."

For local Hong Kong physiotherapist Winny Lee the workshop gave her a better understanding of pain medicine.

"The program is good. Physiotherapists already have their own systems for assessing pain in patients but this has been useful as it emphasises the importance of the multi-disciplinary approach and learning how to recognise chronic and acute pain. The role play has been helpful too because often when you just listen to a lecture you don't digest the information in the same way. The role play is more practical and it makes the RAT concept easier to understand and deliver."

Carolyn Jones
Media Manager, ANZCA

Clockwise from left: Workshop participants Dr Ara Li, Dr Alfred Chan (sitting) and Dr Olivia Ng; EPM workshop participants get ready for their first session with Associate Professor Roger Goucke; Alice Ho Miu Ling Nethersole Hospital pain clinic patient Simon Tam with advanced practice nurses Marlene Ma and Anne Woo; Associate Professor Roger Goucke presents workshop participant, physiotherapist Winny Lee, with her EPM certificate. Photos: Carolyn Jones

WHAT IS ESSENTIAL PAIN MANAGEMENT?

Essential Pain Management (EPM) is a short, easily delivered and cost-effective training program designed to improve pain management worldwide. EPM provides a systematic approach for managing patients in pain and also a system for teaching others about pain management.

EPM aims to:

- Improve pain knowledge.
- Teach health workers to "recognise, assess and treat" pain (the "RAT" approach).
- Address pain management barriers.
- Train local health workers to teach EPM.

Good pain management is similar to good trauma management. Health workers are all familiar with the airway, breathing, circulation (ABC) approach in trauma management but until now, there has been no similar approach in pain management. RAT offers this systematic approach.

EPM is cost effective, multidisciplinary and encourages early handover of teaching to local instructors. It is designed for any health worker who comes in contact with patients who have pain. The RAT approach can be applied to all types of pain and can be used by all types of health workers including doctors, nurses, clinic workers and pharmacists.

Following initial piloting in Papua New Guinea in 2010, EPM was further developed with ANZCA and is supported by the World Federation of Societies of Anaesthesiologists (WFSA), the International Association for the Study of Pain the Australian Society of Anaesthetists and the Royal College of Anaesthetists (UK). EPM has been taught in over 50 countries around the world.

There are two EPM programs – Standard EPM and EPM Lite.

Standard EPM comprises two parts to the EPM program – the EPM workshop and the EPM instructor workshop. Typically, a "one day—half day—one day" course structure is used. Day one is the EPM Workshop, a program of interactive lectures and group discussions. Participants learn the basics of pain management, apply the RAT approach during case discussions and problem-solve pain management barriers. Day two is the EPM Instructor Workshop, a half-day program designed to provide the EPM workshop participants with the knowledge and skills to become EPM instructors. Participants learn the basics of adult learning, practise teaching skills and plan their own EPM workshops. On day three, the EPM Instructor Workshop is followed by one-day workshops taught by the new instructors with the help of the visiting team.

EPM Lite is designed for medical and nursing students and is a modified version of the one-day workshop. The program can be delivered in four to five hours and covers the basics of pain management as well as how to use the RAT approach.

For more information visit **www.essentialpainmanagement.org**.

RAT
Recognize
Assess
Treat

80% of the world's population lacks adequate access to pain treatment.

SPOTLIGHT ON ESSENTIAL PAIN MANAGEMENT IN PAPUA NEW GUINEA

Unrelieved pain is a major global healthcare problem – the World Health Organization (WHO) estimates that five and a half billion of the world's seven billion people lack access to treatments for moderate to severe pain.

In July 2018 a series of EPM workshops was held in Lae and Madang, Papua New Guinea. PNG's territory encompasses tropical islands, high mountain ranges, grasslands and dense rainforest. It has a population of eight million people and is one of the most culturally diverse countries in the world. PNG Pidjun (tok pisin) and, to a lesser extent English, are shared languages for many, but there are over 850 known languages in total. More than 80 per cent of the population live outside urban centres. This cultural, lingual and geographical diversity adds considerable challenges to a stretched healthcare system.

EPM was initially developed in response to a request from Dr Gertrude Marun, a PNG anaesthesiologist, who wanted to support doctors and other health professionals in understanding and providing effective pain management. The first EPM workshop was held in Lae in 2010 and since then 38 courses have been run in centres throughout PNG and around 700 health care providers have received training.

On a recent visit to PNG, a standard one-day EPM workshop was run in Lae and an EPM Lite workshop was held in Madang. At Angau Hospital in Lae EPM course instructors Dr Wayne Morriss, Dr Marun, Dr Jess Lim and registered nurse Jacqui Morriss ran an instructor workshop for 10 participants (five doctors and five nurses). The following day, these 10 newly-trained instructors ran an EPM workshop for 21 participants.

Underscoring the value of EPM training, a show of hands at the commencement of the workshop highlighted that none of the participants had received any formal undergraduate training in the multidisciplinary management of pain and only three of the 21 felt confident in being able to manage pain after having qualified. Barriers to pain management included:

- Patient factors such as late presentation and misconceptions.
- Health worker factors including limited staff and inadequate pain management training.
- Medication factors such as poor or erratic supply and expired or damaged stock.
- System factors such as limited funding and logistics.

In Madang, an EPM Lite workshop was held in the morning followed by an EPM Lite instructor workshop in the afternoon on the same day for a group of 14 lecturers and tutors from the MBBS program at the Divine Word University. The EPM Lite program is adapted from the EPM workshop and is designed for incorporation into undergraduate medical and nursing curricula. On the following day, these 14 instructors delivered an EPM Lite workshop to 20 third year medical students.

Given EPM's history in PNG and the large number of workshops conducted there, the opportunity was also taken during this visit to speak with past EPM workshop participants to gain qualitative insights into how EPM had changed their management of pain. Their responses, such as:

"It has greatly improved my practice, especially recovery times for post-op patients. I get them to sit up and walk sooner than expected, most obviously because of the good pain management I learned at the workshop."

and

"Many patients come out of surgery and they yell and scream. I assess the patient and ask the anaesthetist to give them something to relieve the pain. Before we didn't do that because we thought it was part of the surgery."

will form part of an EPM in PNG evaluation report. The responses indicate that EPM has led to improvements in pain management for patients in PNG, particularly in the post-operative environment.

This year marked a new phase in the governance of EPM with the establishment of a new joint ANZCA/World Federation of Societies of Anaesthesiologists steering committee to oversee the guidance and coordination of EPM globally.

Jacqui Morriss
Registered Nurse (RN)

Anthony Wall
Operations Manager, Policy, Safety and Quality, ANZCA

Above: Scenes from recent EPM workshops in Papua New Guinea.

ANAESTHESIA IN PAPUA NEW GUINEA

"The value of having the college president attend the symposium with its 2018 focus on rural health services to "support practitioners who do basic solo surgery in remote and difficult circumstances" was "extremely valuable to the anaesthesia community in Papua New Guinea."

Dr Michael Cooper, Chair, ANZCA's Overseas Aid Committee.

ANZCA President Dr Rod Mitchell joined members of ANZCA's Overseas Aid Committee in Madang, on the north coast of Papua New Guinea (PNG), for the 2018 54th Medical Symposium late last year.

Dr Mitchell is the second ANZCA president to visit PNG. Immediate Past President Professor David A Scott was a guest at the 2017 PNG Medical Symposium in Port Moresby which focused on safe surgery and anaesthesia.

The chair of ANZCA's Overseas Aid Committee, Dr Michael Cooper, said the value of having the college president attend the symposium with its 2018 focus on rural health services to "support practitioners who do basic solo surgery in remote and difficult circumstances" was "extremely valuable to the anaesthesia community in PNG".

Committee member Dr Yasmin Endlich joined with former committee member Dr Chris Acott at the symposium along with other anaesthetists from the Royal Adelaide Hospital and the Women's and Children's Hospital, Adelaide.

The symposium included workshops on a range of topics including ultrasound guided regional anaesthesia and airway management for anaesthetic scientific officers and senior paediatric and emergency doctors. Lectures on airway devices were held along with presentations on rural health and Lifebox.

The ANZCA group donated 15 syringe drivers to Papua New Guinean attendees and these were distributed to five hospitals in Port Moresby, Lae, Madang, Alotau and Kundiawa.

Dr Yasmin Endlich
Member, ANZCA Overseas Aid Committee

Above: Dr Yasmin Endlich (left) presenting a session for delegates at the symposium in Madang; Dr Endlich leads a workshop for delegates.

BUILDING FUTURE LEADERS AND TEACHERS OF ANAESTHESIA IN LOWER INCOME COUNTRIES

With five billion people unable to access safe and affordable anaesthesia and surgical care when needed, and more than 2.2 million additional anaesthetists, obstetricians and surgeons needed by 2030, it is essential that more is invested in high quality training programs in the countries that need it most. The publication of the World Federation of Societies of Anaesthesiologists (WFSA) Global Anaesthesia Workforce Map in 2017 (www.wfsahq.org/workforce-map), an online resource tool mapping the total number of anaesthesia providers worldwide, highlighted one of the biggest challenges in global anaesthesia: Workforce shortages.

The WFSA has worked to improve anaesthesia human resource capacity through training and education programs in five continents. The WFSA fellowship program, established in 1996, is the association's longest-standing program. The aim of this initiative is to upscale the quality of anaesthesia care of existing anaesthetists, developing their skills and knowledge in a particular sub speciality in order to become the future leaders and teachers of anaesthesia in their home countries. Being able to learn new techniques and approaches is a vital part of a WFSA fellowship to improve the knowledge and skills of junior anaesthetists. This will, however, have a limited impact if the country and resources of the fellowship is different to those in the fellow's home context. With this in mind, the WFSA ensures that the countries and candidates chosen for the fellowship will have similar resources levels and contexts for both parties while allowing for some degree of disparity to learn different approaches and to use new technology.

Since the program's inception 356 fellows have been funded to undertake fellowships in 17 different countries. The WFSA has 52 fellowships across Latin America, Asia, Europe, Africa and Pan-Arab, and North America. Dr Wayne Morriss, WFSA Director of Programs (and ANZCA Overseas Aid Committee member) says that the WFSA fellowships offer "incredible value for money – we work with an enthusiastic and committed group of voluntary program coordinators and mentors to train the leaders and teachers of tomorrow."

The Fund a Fellow initiative

In 2016, on the 20th anniversary of the first WFSA fellowship, the WFSA launched the Fund a Fellow fundraising campaign, with the aim to train 500 fellows and reach over one million patients by the end of 2020. This fundraising campaign has given anaesthetists the opportunity to support the development and learning of their peers. The demand for these fellowships is high, and the limited spaces are oversubscribed. Fellows are selected on merit, but can only access these opportunities if supported with their travel and living expenses.

The WFSA has been overwhelmed by the generosity of Fund a Fellow supporters, including the many anaesthetists globally who volunteer their time. ANZCA supports the WFSA Fund a Fellow initiative through its Overseas Aid Committee.

Consider funding a fellow and help train 500 fellows and reach over one million patients by 2020! For further information or to donate please visit www.wfsahq.org/get-involved/as-an-individual/fund-a-fellow.

Annabel Higgins
Advocacy and Communications Officer, WFSA

Anthony Wall
Operations Manager, Policy, Safety and Quality, ANZCA

"During my clinical attachment, I learnt the mechanics of proper needle-to-probe alignment and the reason why the needle is best visualised in that plane. This made a world of difference. I continued to learn sonoanatomy not only of the supraclavicular and infraclavicular brachial plexus approach but also interscalene and axillary among other blocks."

Dr Faith V Moyo, WFSA fellow from Zimbabwe who undertook the WFSA Regional Fellowship in Kumasi, Ghana.

"The fellowship has built my confidence in handling paediatric patients. I have learned how to build rapport with them and make them smile, which helps me take them into the operating room calmly."

Dr Pranita Mandal was a WFSA/SPANZA Paediatric Anaesthesia fellow at Christian Medical College, Vellore, Tamil Nadu, India.

Above: Dr Pranita Mandal, a WFSA/SPANZA Paediatric Anaesthesia fellow in Tamil Nadu, India.

SUPPORTING ANAESTHESIA AND PAIN MEDICINE LEADERSHIP

Since 2013, Anaesthetic Services, an association of anaesthetists working in private practice in Victoria, has generously funded a scholarship for an anaesthetist in a low and middle income country to attend a relevant anaesthesia or pain medicine conference.

Administered by ANZCA, the scholarship is designed to address the lack of continuing professional development opportunities faced by many anaesthetists in low and middle income countries and provides an opportunity for the recipient to advance their understanding of anaesthesia and pain medicine for the benefit of their community.

Past recipients of the scholarship have rated their experience highly and strongly believe it has helped both them and their colleagues and patients in their home community. When asked to nominate the key benefits of attending a scientific meeting, common themes highlighted include:

- Learning about new techniques and the latest evidence.
- Exposure to equipment not routinely available in their local community.
- Opportunities to present to colleagues and participate in workshops.
- Meeting and making connections with practitioners from around the globe.

Furthermore, the learning and networking works both ways and there is a strong interest from Australian and New Zealand specialists in hearing about how anaesthesia and pain medicine is practised in resource-limited environments.

The value of providing anaesthetists and specialist pain medicine physicians from low and middle income countries with the opportunity to connect with, and learn from, their international colleagues and take these lessons back to their local communities cannot be overstated. ANZCA, along with our colleagues at the Australian Society of Anaesthetists (ASA) and New Zealand Society of Anaesthetists (NZSA) looks forward to continuing to facilitate these opportunities through the generous support of sponsors such as the Anaesthetic Services group in Victoria.

Dr Michael Cooper
Chair, ANZCA Overseas Aid Committee

What scholarship recipients said:

"The Beyond Basic Mechanical Ventilation workshop exposed me to higher learning aspects of mechanical ventilation in intensive care. I acknowledge my shortfalls in the intensive care regarding mechanical ventilation, in the local system's non-availability of medical equipment and importantly, the need to implement national ICU protocols for patient and worker safety."

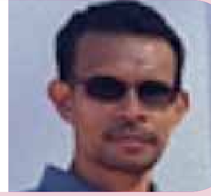
"The Anaesthetic Services scholarship granted me the rare privilege and honour of meeting hard-working professionals who are also colleagues from the international community, including the neighbouring Pacific Island nations; to know that similar goals are shared globally and that there are shortfalls encountered in world anaesthesia."

"I learned the power of networking, this is a skill which is not learned overnight but its impact is enormous when appropriate people are approached. In the local setting, networking with appropriate authorities has resulted in positive outcomes to patients' care in anaesthesia."

"My own clinical experience was challenged in many ways and this has helped me to clearly identify the dogmas and superstitious aspects of clinical care I am surrounded by and constantly engaged to in my daily work. This will help me to contribute more meaningfully towards the activities of my department."

ANAESTHETIC SERVICES SCHOLARSHIP RECIPIENTS

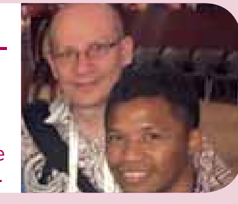
2013
Dr Greg Tokwabilula
(Consultant, Papua New Guinea) attended the ANZCA ASM in Melbourne.



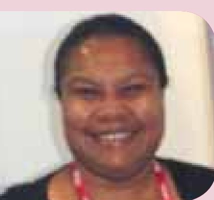
2014
Dr Mungun Banzar
(Consultant, Mongolia) attended the WFSA 14th Asian Australasian Congress of Anaesthesiology in Auckland.

2015
Dr Pauline Wake
(Consultant, Papua New Guinea) attended the ANZCA ASM and the New Fellows Conference in Auckland.

2015
Dr Oliver Adams
(Consultant, Papua New Guinea) and Dr Alu Kali (Registrar, Papua New Guinea) attended the combined ASA and NZSA National Scientific Congress in Darwin with assistance of additional funding from the ASA and NZSA.

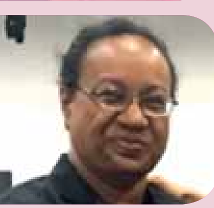


2016
Dr Maria Moguna
(Consultant, Papua New Guinea) attended the World Congress of Anaesthesiology Conference in Hong Kong.



2017
Dr Hilbert Tovirika
(Registrar, Papua New Guinea) attended the ANZCA ASM and the oung Fellows conference in Brisbane.

2018
Dr Nancy Kwara
(Consultant, Papua New Guinea) attended the ASA National Scientific Congress in Adelaide.



Action on gender equity

In 2017, ANZCA and FPM created a Gender Equity Working Group (GEWG) to support its commitment to gender equity.

Gender inequity affects people from all genders and from all sectors of society. Gender inequity negatively impacts upon quality of care and health outcomes for patients and several key measures of professional success for anaesthetists and pain medicine specialists, including promotion and income[1-3].

Meanwhile, gender equity if achieved, is predicted to have broad economic, academic and social benefit to fellowship and the community[4-5].

Gender Equity Position Statement

The Gender Equity Position Statement articulates the college's enduring commitment to gender equity. Recognising that all careers in anaesthesia and/or pain medicine are different, and acknowledging personal choice, the position statement seeks to achieve visible gender equity for trainees, specialist international medical graduates (SIMG) and fellows of all genders across the span of their careers in the following areas:

- Entry to and completion of training in anaesthesia and pain medicine.
- Access to clinical anaesthesia and pain medicine practice across public and private healthcare sectors that is safe, rewarding, appropriately remunerated and compatible with work-life balance and well-being.
- Recognition and advancement in research and education.
- Representation and influence within broader professional roles, including leadership, management and health advocacy.
- Participation in high-quality continuing professional development that supports clinical and non-clinical roles.

There was general agreement within the working group that the position statement should be supported by evidence of need, and action oriented. In developing this document, the working group first evaluated the status of gender equity within anaesthesia and pain management[6]. This revealed that many measures of gender equity, based on proportional representation, are broadly on par with the current women to men ratios of 32 per cent to 68 per cent (anaesthesia) and 25 per cent to 75 per cent (pain medicine) within the all ages population.

Focus areas from the tool kit

Focus area	What does this look like?
Inclusive and equitable culture	Active inclusion, attention to equity and acceptance of "difference" in others, to enable everyone to reach their full potential.
Diverse and representative workforce	Policies and practices that promote equal participation in the workforce at all stages and in all domains of practice and decision making
Flexible and empowering workplace	Workplace policies and management practices that enable gender equity in part time work, primary and secondary parental leave and other flexible work practices.
Attention to gaps	Identification of areas where substantial gender-based disadvantage exists and managing opportunities to close gaps.
Strategic and accountable leadership	Strategic planning aimed at ensuring the sustainability of gender equity including measuring and reporting against benchmarks, making people accountable to carry out gender equity initiatives and communicating effectively to trainees, SIMGs, fellows and other stakeholders.

However, these are predicted to fall into imbalance unless increases in female representation keep in step with the rapidly increasing proportion of women in anaesthesia and pain medicine; women represent 49 per cent of new ANZCA fellows. Notable gaps are evident in some areas including women advancing to leadership roles and men accessing and participating in parenting roles.

Subsequently, the working group consulted widely to become informed about the key causes of gender inequity and successful strategies that are being undertaken to address it. Gender inequity in anaesthesia and pain medicine appears to result from the same factors that affect people in many other occupations[7-10].

Recurring themes include: gender stereotyping, unconscious bias and a lack of inclusivity in the way people at all levels within organisations think and behave; inflexible employment arrangements and processes that preclude people who have parenting and carer roles to fully participate and take advantage of development opportunities; and failure by organisational leaders to fully grasp the benefits that flow from achieving diversity within their respective workforces and leadership teams. These form the basis of five focus areas identified for action.

The Gender Equity Action Plan

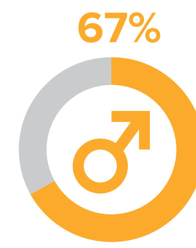
The Gender Equity Action Plan sets out how ANZCA and FPM will implement their strategy for gender equity across all aspects of anaesthesia and pain medicine practice over the period of the current strategic plans (2018-22).

The action plan is structured according to the five focus areas (see above), each of which is elaborated with a series of objectives, strategies and outcome measures.

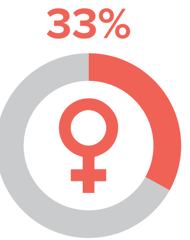
(continued next page)

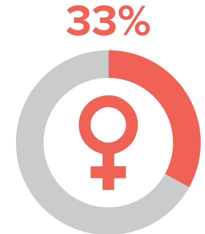
ANZCA fellows male female ratio
as at February 2019

67%



33%

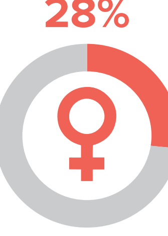




FPM fellows male female ratio
as at February 2019

72%

28%



Action on gender equity (continued)

> "Notable gaps are evident in some areas including women advancing to leadership roles and men accessing and participating in parenting roles."

Work has already commenced on implementing the action plan and we are pleased to report the following achievement from the last 12 months.

- The 2019 ANZCA Annual Scientific Meeting Regional Organising Committee (ROC) has incorporated best practice guidelines for selection of speakers and panellists into its convenors' guidelines. Future speakers and convenors will be invited to take the Male Champion of Change "panel pledge" (see https://malechampionsofchange.com/commit-to-the-panel-pledge/) in which they pledge to inquire about the gender representation of speakers and panellists. At the 2019 ASM a parents' viewing room will be available and an inaugural "Women in STEMM" (science, technology, engineering, mathematics and medicine) breakfast will be held.
- Time-based eligibility criteria for the Emerging Leaders Conference have been clarified to take into account parental leave.
- ANZCA has committed to signing the United Nations Women's Empowerment Principles CEO letter of support in partnership with the Royal Australasian College of Surgeons, the Royal Australasian College of Physicians, the Royal Australian and New Zealand College of Psychiatrists and the Royal College of Physicians and Surgeons Canada at the Tri-Nations meeting in Auckland on March 19.
- The GEWG has established a dedicated page on the ANZCA website (www.anzca.edu.au/about-anzca/gender-equity) for reporting gender equity metrics.2019 National Women's Day was celebrated on March 8 with a Women In Medicine symposium at ANZCA House.

One of the focus areas within the Gender Equity Resource Kit

FOCUS AREA	OBJECTIVE	EXAMPLES OF STRATEGIES
Diverse and representative workforce	Set benchmarks for gender equity that take into account the current and future fellowship population and fellows' preferences.	Aim to achieve: • Equal proportional representation of men and women among trainees and SIMGs. • Proportional representation within groups that is not less than current population-based gender representation. • Proactive management of group membership to ensure proportional gender representation keeps in pace with that of the changing ANZCA and FPM populations. • Equal representation as the long-term target.

Gender Equity Library Guide

The ANZCA Library team has created a comprehensive LibGuide (http://libguides.anzca.edu.au/home) containing a large range of resources on gender equity including reading lists, links to articles, podcasts and multimedia.

Gender Equity Resource Kit for trainees SIMGs and fellows

The college also recognise that numerous people and groups influence gender equity within the fellowship but are outside the direct remit of ANZCA and FPM.

The Gender Equity Resource Kit is a guide to organisations, groups and individual trainees, specialist international medical graduates (SIMGs) and fellows who wish to contribute to achieving gender equity within their workplaces, professional roles and or personal lives.

The Gender Equity Resource Kit's structure mirrors that of the action plan and is deliberately comprehensive to provide users with ideas and choices.

Gender equity and merit-based advancement

Some people feel concerned that gender equity initiatives erode merit-based selection and promotion processes, particularly when these are implemented with quotas for proportional representation.

The college will continue to endorse merit-based values and processes. The strategies presented in the position statement and related resources chiefly aim to address inequities in opportunity where these exist, such that all genders can compete equally in merit-based processes. The two are not mutually exclusive.

Merit-based promotion can mask the cumulative negative influence that disadvantage brings to skills development and acquisition of experience, over time. It is well established that inequity can amplify across one's career, whereby the impact of apparently minor, relative disadvantage in development and promotion opportunities may be cumulative over time and result in measurably diminished achievement.

ANZCA trainees

Year	Male	Female
2017	55%	45%
2018	57%	43%

FPM trainees

Year	Male	Female
2017	45%	55%
2018	51%	49%

ANZCA Council members: male 71%, female 29%

ASM presenters 2019: male 68%, female 32%

FPM Board members: male 69%, female 31%

This is referred to as the "leaky pipe effect".[4,5] The position statement has a strong emphasis on addressing gaps through development opportunities, for this reason.

Working with proportional representation

The resource kit encourages everyone to measure gender equity within their groups. This is greatly assisted by setting benchmarks for proportional representation.

The college does not endorse quotas per se which imply incentives and or penalties for reaching, or failing to reach, targets. However, targets do endorse benchmarked targets to drive monitoring and goal setting as recommended by the Australian Commonwealth Gender Equality Workforce Agency[6].

Clinical Associate Professor Leonie Watterson
Chair, Gender Equity Working Group

Acknowledgements

Special thanks to the members of the GEWG and the Fellowship Affairs unit for their energy and dedication to this initiative; to ANZCA's Communications team for support with publications; to ANZCA's Professional Affairs Executive Committee as project sponsors, and all people and groups who have provided feedback to date.

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The Gender Equity Working Group

Associate Professor Leonie Watterson, NSW (chair)

Co-opted members:
Dr Vanessa Beavis, NZ
Dr Bridget Effeney, Qld
Dr John Leyden, NSW
Dr Nicole Phillips, NSW
Dr Mark Priestley, NSW
Dr Lindy Roberts, WA
Professor Kate Leslie, Vic
Dr Mike Todd, trainee, NZ
Dr Suzanne Cartwright, FPM, SA

ANZCA Fellowship Affairs Unit:
Ms Jan Sharrock, Director, Fellowship Affairs
Ms Hannah Sinclair, Membership Manager
Ms Kate Galloway, Committee Support Officer
Ms Gabby White, Membership Services

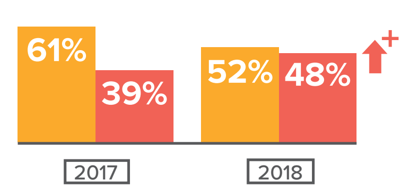
For more information: www.anzca.edu.au/about-anzca/gender-equity

Take the first step toward gender equity – assess your department or group.

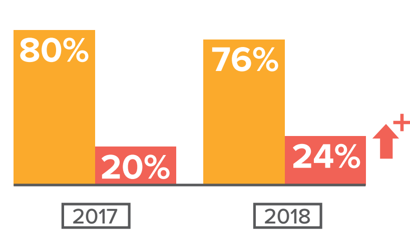
Each of us can contribute. You can take the first step by completing the Gender Equity Quick Self-Assessment Quiz.

Complete the Gender Equity Quick Quiz to evaluate gender equity in your department or group – go to www.anzca.edu.au/about-anzca/gender-equity).

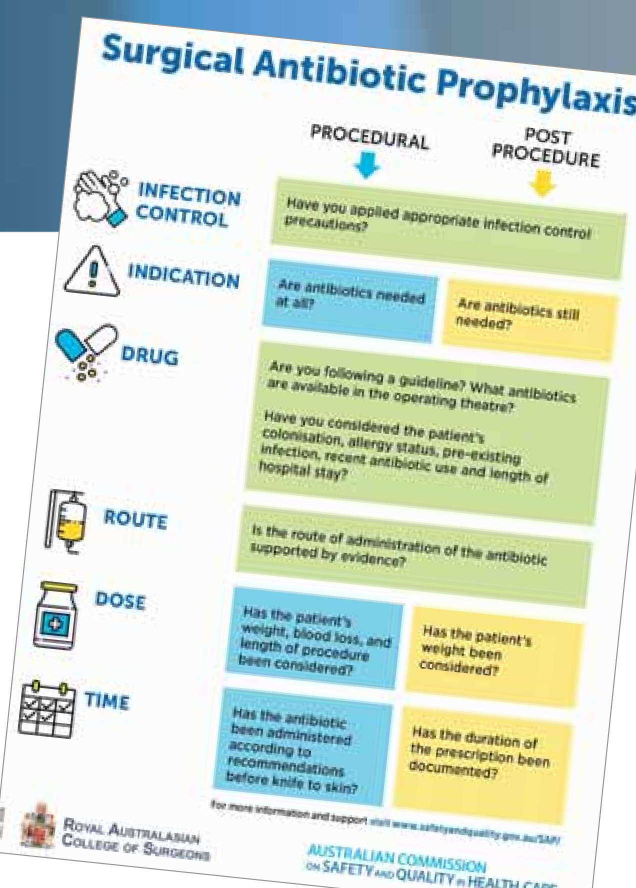
ANZCA/FPM supervisors of training male female ratio



ANZCA/FPM heads of departments male female ratio



Surgical antimicrobial prophylaxis



Surgical site infection is a potential risk of surgery that needs to be managed effectively as part of good patient care. Appropriate surgical antibiotic prophylaxis in concert with oxygenation, glycaemic control, surgical anti-sepsis and advances in clinical practice has reduced surgical site infections. However, the increase in antimicrobial resistance (AMR) across the globe is limiting the ability of the antibiotics we have at our disposal to provide safe and effective care for patients.

The overuse and misuse of antibiotics, wherever this occurs, impacts the efficacy of surgical antibiotic prophylaxis. Many current infections are no longer responsive to first line antibiotic choices. Complex infections are now being treated with potentially more toxic, costly and complicated regimens than in the past due to emerging antimicrobial resistance, which creates additional risks for patients.

The Australian Commission on Safety and Quality in Health Care coordinates the Antimicrobial Use and Resistance in Australia (AURA) Surveillance System, which provides a range of AMR and antibiotic use surveillances, and a platform for voluntary standardised audits of surgical prophylaxis through the Hospital National Antimicrobial Prescribing Survey (NAPS) framework. Data from participating hospitals in 2017 showed that 30.5 per cent of surgical prophylaxis prescriptions for inpatients extended 24 hours beyond the time of surgery. This is despite guidelines generally recommending surgical prophylaxis durations of less than 24 hours. Commonly, surgical antibiotic prophylaxis was found to be too broad or too narrow for the likely organisms, inconsistent with guidelines, or the wrong dose was prescribed.

Variation in surgical antibiotic prophylaxis prescription is often the result of individual clinician preferences. There may be a perception of reduced adverse outcome with longer and broader spectrum intravenous courses. Topical or deep surgical site administration has also been reported. Despite evidence to the contrary, some of these perceptions remain[1,2].

The increased healthcare-associated complications of prolonged or novel intra-operative antibiotic use, also need to be considered, particularly where the evidence base for alternative practices is poor.

Process issues still account for many variations from guidelines-based practice. Improved standardisation could harmonise our practice towards more consistent and reliable delivery of antibiotic prophylaxis. There are many opportunities for improvement including:

- Consistency in documentation of fixed antibiotic duration.
- Development and adherence to evidence- or consensus-based guidelines.
- Administration timing for optimal concentration during the procedure.

It is well established that the timing of prophylactic antibiotics is crucial. Anaesthetists are well placed to have a significant impact on this aspect of surgical antibiotic prophylaxis. The optimal timing is dependent on the pharmacokinetics of the antibiotic utilised. For example, cefazolin should be commenced within 60 minutes of knife to skin to optimise tissue concentrations. Vancomycin (and antibiotics with a longer half-life) should be commenced within 120 minutes of knife to skin, and the infusion does not have to be completed prior to the commencement of surgery. Vancomycin, when administered rapidly, can cause red man syndrome.

Anaesthetists play an important role in delivering appropriate surgical prophylaxis determining the appropriate dose of the antimicrobial in relation to the patient's weight and co-morbidities and the requirement for redosing for longer procedures. Collaboration between anaesthetics and surgical specialties regarding the choice of antibiotics for surgical prophylaxis may aid in more consistent administration practices within organisations[3].

Under the National Safety and Quality Health Service (NSQHS) Standards, every hospital is required to have a local antimicrobial stewardship program to optimise use of antimicrobials and improve the use of surgical antimicrobial prophylaxis within hospitals. This may include facilitating audit and feedback procedures or dedicated quality improvement projects. We all want the same outcome – safe and effective care for our patients. To achieve this, we need to understand how to balance the risks and benefits of antimicrobial use by utilising specialty knowledge.

The commission is working with ANZCA to provide you with resources to assist in this. Go to www.safetyandquality.gov.au/our-work/healthcare-associated-infection/antimicrobial-stewardship/surgical-antimicrobial-prophylaxis/ to find out how you can improve surgical antibiotic prophylaxis in your organisation.

Dr Robert Herkes (Commission CMO) and **Dr Bridget Langley** FANZCA, Surgical Antimicrobial Prophylaxis Working Group, Australian Commission and Safety and Quality in Health Care

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WebAIRS news

WebAIRS is an anaesthetic incident reporting tool available to all anaesthetic departments throughout Australia and New Zealand. The system was developed by the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC).

Susan Considine joined us as the new ANZTADC Coordinator in January. Susan has a background in health information management, with experience in clinical coding, and has previously worked at the Geelong Hospital, the Melbourne Clinic and the Peter MacCallum Cancer Centre.

Strategy

Last year webAIRS refined the website to provide more information to users via the five green buttons on the home page. In 2019 we plan to continue to provide regular feedback with a number of initiatives including increasing the number of safety alerts and incident case reports in the *ANZCA Bulletin*.

Case report from webAIRS

An incident was reported recently relating to the failure of an anaesthetic circuit following a collision with the operating table. This is a summary of the original report: "Shortly after commencing an ENT procedure the surgeon asked that the patient be positioned head up and the operating table rotated 180 degrees. As the table was being repositioned a large leak occurred after contact with the anaesthetic circuit. It was found that the HME filter had broken off. However the broken end of the filter remained in the anaesthetic circuit which made rapid replacement impossible. This required the use of a self-inflating bag to ventilate the patient until the circuit could be repaired. Fortunately no harm resulted to the patient."

This incident identifies two key hazards areas: the risks of moving operating tables and the lack of backup equipment in a timely manner. Another issue was the need for clear plans to address failures in the anaesthetic delivery system.

Have you had a similar event during the adjustment of an operating table? Please report it to webAIRS.

Planned newsletter

WebAIRS is considering the publication of an individual webAIRS newsletter several times a year which would include cases like the one above and we would value your feedback on the usefulness of this information.

This would be in addition to the current arrangement of articles within the e-news and the *Bulletin*.

Please email your feedback to anztadc@anzca.edu.au. Find out more about ANZTADC/WebAIRS at **www.anztadc.net/**.

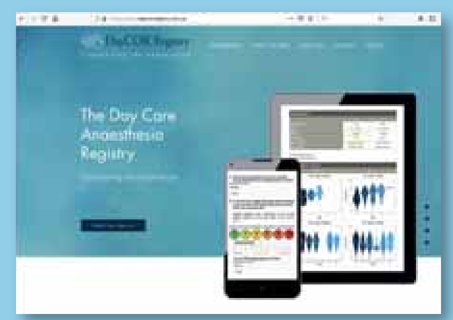
Are you contributing to quality improvement in anaesthesia? Register yourself on webAIRS: **www.webairs.net**.

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.**

DayCOR Registry website now live



The Day Care Anaesthesia Registry website has gone live, and promises to be a vital resource for not only advice, but the dissemination of outcome results and improvement in care. Dr Ken Sleeman, Chairman of the ACE Day Care Anaesthesia Special Interest Group, welcomes feedback from interested fellows, via the website – **www.daycorregistry.com.au**.

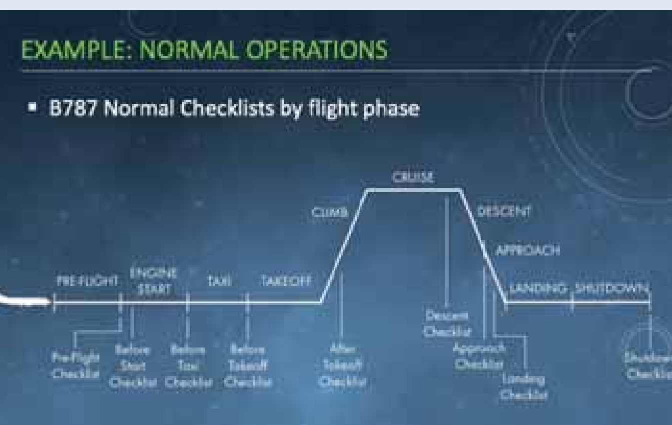
Patient Safety Movement Foundation annual summit

On January 19, Immediate Past President, Professor David A Scott and Audrey Curtis, patient advocate and a former patient of Professor Scott, participated in a panel discussion on delirium at the Patient Safety Movement Foundation's 7th World Patient Safety, Science & Technology Summit in Huntington Beach, California. Delirium in elderly patients following anaesthesia and surgery is frequent, often undiagnosed and is a significant source of short and long-term morbidity and mortality and increased cost of care. About half of the estimated 2.6 million patients affected by delirium in the United States is estimated to be preventable.

Professor Scott also announced the college's formal commitment to the Patient Safety Movement Foundation and how the college will contribute to the movement for zero preventable deaths through promoting professional standards, to promote education and to advance the study of anaesthesia, perioperative medicine and pain management.

For more information visit patientsafetymovement.org or view the delirium panel discussion, ANZCA's commitment message or any of the other presentations on YouTube.

Aircraft pilots give anaesthetists a flying start



Fellows Dr Stuart Marshall and Dr John Copland believe anaesthetists can learn a lot from aviation especially when it comes to the development of critical care checklists. Here they explain how their approach, which includes a session in an Airbus A320 flight simulator so they can observe pilots in routine and emergency situations, can benefit the specialty.

Of course, anaesthesia is nothing like flying an aircraft really is it? We've all heard the comparisons. There's no operating manual for a human and if the conditions aren't perfect in anaesthesia we can't choose to not "take off". However, we do know that many of the safety breakthroughs introduced into health in the last few decades have their foundation in aviation. The use of checklists or "cognitive aids" is one set of interventions that has had a profound effect on the way we practice. Research into the World Health Organization (WHO) Safer Surgery (or "Time out") checklist and books such as Atul Gawande's *The Checklist Manifesto* have brought these tools to the forefront of our minds.

Despite difficulties with their implementation in some organisations, there is general agreement that they are an inexpensive and potentially effective method of risk management in surgery. But what if there are other lessons we can learn from aviation or perhaps even other industries that have to manage risk on a regular basis?

One morning while pondering these questions in the anaesthesia office we wondered if there would be another way to introduce the concepts of cognitive aids and human factors engineering to an anaesthetic audience. We wondered if, by observing and listening to pilots and human factors researchers, we might get a better understanding about how cognitive aids fit in with our broader work environment and improve safety.

What if we could not only understand how checklists were used, but also sit in the cockpit and see them used?

Only a few months later we had the opportunity. The Airbus A320 flight simulator was booked and the course was planned. Over a dozen participants including anaesthetists, surgeons, and perioperative and pain nurses descended on the facility at Tullamarine for an evening discussing the development of cognitive aids in critical care, psychological aspects of crisis management, anaphylaxis and the failed airway.

Nick Copland, an Airbus A320 and Boeing 787 pilot covered the types of checklists pilots use and when they use them. The "Call and Response" is used mainly in "normal" operations where one crew member reads and the other responds. These checklists are performed after all actions have been done as part of the normal "flow" of work and serve to double check that nothing has been forgotten. The "read and do" checklists are mostly for "non-normal" and emergency situations where the crew conduct critical tasks in a defined order. In emergencies the early critical items are performed from memory with the remainder from a checklist. These memory-based actions in high stress situations are reinforced by repeated high-fidelity simulation training.

Just as in anaesthesia there is little room for error. All participants were stunned to learn that in the event of a rapid decompression of a Boeing 787 at maximum altitude of 43,000 feet, the pilot has only five seconds of consciousness (or "time of useful consciousness") to don an oxygen mask, alert the crew and initiate a rapid descent. Instinctive action from repetitive training is essential if the pilots are to respond appropriately.

Dr Matthew Thomas, a human factors academic and practitioner shared some of his observations of working in the aviation, rail and health sectors. Simply introducing a cognitive aid or checklist is not a standalone solution. The environment also has to be carefully designed to support the decision making of the person undertaking the work and the relevant teams. Cognitive aids need to be designed into the system as a whole, rather than just as an add-on. Dr Thomas gave several examples from different industries. These included train crashes that could have been avoided by mindful design of the work and cognitive aids, and how pilots react under stress. We discussed how anaesthetists modify their environment to improve their prospective memory, guard against fixation error and the effects of cognitive aids on individual and team function.

Before entering the A320 simulator we all underwent a safety briefing and an explanation of what we were going to see. One pilot was flying from the right-hand seat and another operated the simulator. In pairs we were able to sit in either the left hand (captain's) seat, or "jump seat" behind and between the two pilots. Our seatbelts were secured low and tight and with very little delay we were off!

Starting on the runway at Sydney airport we saw normal, pre-take-off checks, and the "non- normal" actions during a severe windshear event on climb out, then later an engine bleed failure alarm on approach. Despite all this activity there was still plenty of opportunity for a scenic tour of Sydney Harbour in the 20-minute flight. All too soon though, we could feel the wheels locking into place below us, the runway loomed and we could feel the braking as we came to a halt.

So what did we learn from this? Was it worthwhile?

Most of us are familiar with algorithms and checklists in critical care but the different ways in how aviation uses them and repeated simulation training and checking were of considerable interest and very reassuring!

In contrast, it's clear that anaesthesia is substantially ahead of rail transport in adopting safe systems and cognitive aids. The value of understanding and comparing why systems work the way they do certainly helped us identify how we can improve.

The use of checklists and other cognitive aids are becoming more widespread and accepted in all areas of critical care. From the routine World Health Organization Surgical Safety "time out" checklist to the ANZCA/Australian and New Zealand Anaesthetic Allergy Group anaphylaxis cards, cognitive aids are here to stay and are improving outcomes for our patients. Aviation has shown us that repeated immersive simulation using cognitive aids is a realistic way of improving our performance for those rare, but dangerous times.

(The course was run in January by Peninsula Health Department of Anaesthesia and we hope to repeat it a couple of times a year. Many thanks to all of the staff who assisted in making it a success.)

Dr Stuart Marshall, FANZCA
Dr John Copland, FANZCA
Nick Copland
Dr Matthew Thomas

Above from left: In-flight training facility with several simulators at Tullamarine, Melbourne; checklists used at different phases of flight; Tasmanian anaethetist Dr Chris Wilde over Sydney Harbour.

New CPD emergency response standard

New emergency response standard for 2019:
Acute Severe Behavioural Disturbance
ANZCA AND FPM CPD PROGRAM

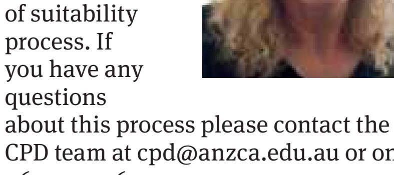
A new emergency response standard on Acute Severe Behavioural Disturbance (ASBD) in the adult patient has been developed, tailored for FPM fellows, and was approved for implementation in the ANZCA and FPM CPD Program from January 1.

This is the first pain medicine specific emergency response standard. It has been developed by Dr Stephanie Oak FRANZCP, FFPMANZCA, FPM CPD Officer (pictured right), in liaison with the ANZCA and FPM CPD Committee and the FPM Professional Standards Committee.

The ASBD emergency response standard is the fifth emergency response activity available to participants of the ANZCA and FPM CPD Program, and ensures all faculty fellows can fully undertake the CPD program relevant to their scope of practice.

What does this mean for participants of the ANZCA and FPM CPD Program?

- The triennial CPD requirement remains at two emergency response activities per triennium, for participants with the clinical practice type. This new activity gives participants an extra option to choose from, to achieve this requirement.
- CPD participants under the non-interventional (neither administer anaesthesia and/or sedation; nor work in a practice environment where it would be expected that the practitioner would be able to respond to an emergency situation) and non-clinical (not involved in direct patient care) practice types are not required to undertake emergency responses.
- Application to deliver an ASBD emergency response activity is via the existing recognition of suitability process. If you have any questions about this process please contact the CPD team at cpd@anzca.edu.au or on +61 3 9510 6299.



- Participants of the ANZCA and FPM CPD Program may claim a recognised ASBD workshop/course as an emergency response activity from January 1, 2019.

How can I attend an ASBD workshop/course with recognition of suitability?

Dr Stephanie Oak is scheduled to facilitate two inaugural ASBD workshops at the 2019 ASM in Kuala Lumpur. These two-hour workshops will focus on assessment and management of acute behavioural disturbance in a range of settings, including interventions to de-escalate aggression and the safe care of patients who require sedation. Please visit www.asm.anzca.edu.au to register.

It is also anticipated that Dr Oak will undertake a roadshow to different states in the second half of 2019 and offer the workshop as part of the national/regional FPM CME evenings. Please key an eye out for further details in upcoming communications.

The ASBD emergency response standard will have a pilot period of 12 months, providing an opportunity for instructors and participants to review and give feedback.

For more information on emergency response activities or to review the new ASBD standard, please visit the ANZCA website, emergency response activities via the link www.anzca.edu.au/fellows/continuing-professional-development/emergency-response-activities.

CPD emergency response standards review completed

The standards for the ANZCA and FPM CPD Programs Emergency Response activities are regularly reviewed to ensure currency and accuracy is maintained. This review was last completed in 2018, and the emergency response recognition of suitability application forms and standards were last updated on October 1, 2018.

Confirmation of the revised standards was sent on October 1 to recognised course providers running emergency response education sessions (workshops/courses). These providers were advised that they need to meet the updated standards by December 31, 2018. The CPD team sent regular email communication to course providers recorded as having applied for recognition of suitability as an ongoing emergency response activity.

Course providers who have successfully submitted a declaration form or a new emergency response application have been provided a valid emergency response recognition code starting with ER-19-XXXX-YYY.

If your recognition code does not begin with ER-19-XXXX-YYY, please contact the CPD team at cpd@anzca.edu.au immediately to discuss your options.

CPD participants should continue to record recognised emergency response activities in their CPD portfolio as usual. For more information please visit the ANZCA website at www.anzca.edu.au/fellows/continuing-professional-development/emergency-response-activities or contact the CPD team.

A unique program takes off

What started as a seemingly simple idea sparked by the death of a patient has turned into a ground breaking multi-agency program to get patients fit for surgery.

The "Fit for surgery, fit for life" program in New Zealand has taken years of negotiation and co-ordination by Whanganui anaesthetist Dr Marco Meijer and a number of local agencies.

The program was launched late last year by the Whanganui District Health Board and Sport Whanganui and is already boasting success. Through the program, hospital staff and GPs refer patients with a Body Mass Index (BMI) above 40 who are preparing for surgery to Sport Whanganui. Patients are then assessed by registered nurse and navigator Christine Taylor who develops each patient's individual care plan and referrals to fitness coaches, dieticians and psychologists.

The journey started three years ago when Dr Meijer, the clinical director at Whanganui Hospital, began searching for solutions after an obese middle-aged patient died of complications a few days after routine orthopaedic surgery.

"We identified we were sending a lot of patients back to their GPs with uncontrolled blood pressure or diabetes – a 'to and fro' which is unnecessary and frustrating for patients."

"The complications (for morbidly obese patients) such as deep wound infection, often come months after surgery. In the case of a deep wound infection, patients often need a year of antibiotics, and two to three operations which could cost hundreds of thousands of dollars. And, the anaesthetist may never know about it. When everyone is working in their little silos it's hard to see the bigger picture and what's happened down the track."

Getting everyone to recognise the problem and work together to solve it proved to be a bigger hurdle than Dr Meijer first anticipated.

"It sounded so easy… you are setting up a program, you want people to lose weight. It's simple, it's one thing, and surely it's not that hard to do. Everyone agreed it was a good idea but we found it was easier said than done," he explained.

"It was important we made sure the processes of, firstly, the hospital surgeons and anaesthetists aligned to make this work, and then also to do the same between the hospital and general practitioners (GPs) which proved a harder task than we had imagined."

Dr Meijer says he presented the data to hospital surgeons and managers to show that the patients who experienced deep wound infections of the hip and knee joints, following replacement surgery, were all obese patients.

"I was quite amazed that at first the surgeons were not convinced. They did not really think obesity was a problem at all so I had to inundate them with literature until at last they acknowledged the problem and that we should do something.

"GPs were also unaware of the criteria for surgery in the anaesthesia pre-admission clinics. We identified we were sending a lot of patients back to their GPs with uncontrolled blood pressure or diabetes – a 'to and fro' which is unnecessary and frustrating for patients."

Offering a solution to time-short GPs meant buy-in. "We told the GPs we were going to give them a clear outline of all our minimum anaesthetic criteria. It's a fit for surgery checklist," says Dr Meijer. The checklist has now been rolled out to all GPs surgeries so that they can optimise the patient prior to referring them for surgery, therefore reducing the patients bouncing backwards and forwards between primary and secondary services.

One of the guiding principles of the program is co-design. That means getting the patient's perspective from the beginning. As well as having a consumer representative on the program's steering group, patients were interviewed about their needs from the program.

"As well as using co-design, we also felt that Fit for surgery, fit for life also needed to 'live' in the community and use community-based and funded programs as much as possible," says Dr Meijer. "It had to be holistic, or multi-modal, and it had to target bringing about a permanent lifestyle change."

Getting Accident Compensation Corporation (ACC) funding for proof of concept has helped see the program up and running with 50 patients taking part in the pilot.

Dr Meijer says it has taken around three years to set up the program but it's been worth it.

"It's been very hard work but very satisfying. I now understand complexity a lot better and the need for the many links and networks we have built across the community. You meet a lot of interesting people and everyone is very excited about the potential."

Dr Meijer believes he may have come up with a unique and effective model which he hopes could be rolled out in other hospital settings. "We want to brand it and export it to other hospitals but first we need the evidence, and already we are getting a lot of good results," he says.

"It's quite a novel concept and fits with that idea of perioperative care and prevention of complications rather than treating it afterwards."

Dr Meijer says the navigator role is key. The navigator monitors the patient's progress before and, crucially, after surgery. "It's about the idea of lifestyle change so they maintain their weight afterwards."

The program also fits in well with work being done around perioperative medicine. Dr Meijer says while many of the perioperative medicine conferences he's attended may emphasise fit for surgery for cancer patients, many are not discussing the optimisation of obese patients. "Understandably, it can be a sensitive topic which I'm glad is slowly starting to be talked about more."

Dr Meijer believes his program is unique. "I don't know of anyone else who does a community-based multi-modal exercise and weight reduction program pre surgery. There might be some out there but I haven't heard of them. It's quite a novel concept and fits with that idea of perioperative care and prevention of complications rather than treating it afterwards."

Adele Broadbent
Communications Manager NZ, ANZCA

A patient's story

50-year-old Julian Ratapu-Wanoa is determined. He knew that with his weight tipping 138 kilograms and his type 2 diabetes and high blood pressure he could be worse off after his planned hip replacement operation. But it had been 17 years on and off the waiting list and he needed to get it done.

When Dr Meijer offered him a place on the "Fit for surgery, fit for life" program, it was a chance to make a lifetime change.

"Now I'm heading in the right direction whereas before I was just existing," he told the *Bulletin*.

He says the difference for him is that it is someone other than family helping. "The family just crack jokes, 'fat this and that'. Having someone outside of the family giving me the real outcomes [of surgery without losing weight and getting fit] was a real eye-opener. Having them give me regular input and putting a team around me makes all the difference."

The program navigator, Christine Taylor, says she's noticed a big difference in Mr Ratapu-Wanoa in just a few months.

"I notice it in your face," she tells him. "You're healthier and more vibrant looking."

And he knows it.

"The figures don't lie," he says proudly detailing plummeting blood pressure, blood glucose tests and weight. He's dropped the carbohydrates and is in the pool up to five days a week with the activity coordinator tweaking his program as he progresses. That's not to say it's not difficult at times. Mr Ratapu-Wanoa is busy looking after a daughter with cystic fibrosis and a wife who has been bed-ridden for three years since a stroke.

But he has his eye on success which means "being able to tie my shoelaces. In the last 17 years I've been working at the freezing works. My work footwear are gumboots and these (he nods to his plastic slip-ons) are my everyday footwear, so there was no reason to bend down to do anything."

Mrs Taylor had a background in the fitness industry before becoming a nurse and spending time as a mental health nurse. She is passionate about the program and she is proud of what Mr Ratapu-Wanoa has achieved. She says the real progress is not just that he has lost weight but that his average blood glucose level (HbA1c) has fallen from 65 to 42.

Mrs Taylor is in regular contact with the patients face-to-face, by phone, sms and by motivational email for those who live in remote areas. "Once they hit their goal BMI, the patients go back on the waiting list and then I'll be in contact with them again after surgery," she says.

"I've had patients in their 50s and 60s come in who haven't addressed their weight in a long time. Then they have a light bulb moment, and from then on they are really motivated to make a difference."

Adele Broadbent
Communications Manager NZ, ANZCA

Above: Julian takes a break from his pool work out to talk to the program's navigator, Christine Taylor.

Doctor makes his mark in marine world

Queensland anaesthetist and intensivist Dr Michael Corkeron embraces life in Townsville where he has a long-standing fascination with a particular species of jellyfish that has potentially lethal symptoms.

He's an anaesthetist who's spent the past 18 years investigating the intricate marine world of jellyfish so it's not all that surprising when Dr Michael Corkeron lets slip that he was actually stung a few years ago while windsurfing near his north Queensland home in Townsville.

Dr Corkeron was lucky – he came away unscathed from his brush with one of our most venomous animals, the box jellyfish, thanks to being almost completely covered in protective clothing.

The ANZCA and College of Intensive Care Medicine fellow has a longstanding interest in the Irukandji syndrome, which is caused by a range of jellyfish (though typically by carybdeid or four-tentacled cubozoan jellies) and involves severe muscle cramps, vomiting, headaches, hypertension, widespread pain, a sense of impending doom and sometimes severe cardiac dysfunction. It develops on average about 30 minutes after the sting. Symptoms can last from hours to weeks, often require hospitalisation and occasionally intensive care unit (ICU) admission. Australia has had two confirmed deaths from Irukandji syndrome.

Dr Corkeron has been researching treatment for the syndrome since the early 2000s. While his research has had to take a back seat to his clinical work at Townsville Hospital he is still involved in a collaborative research project led by the hospital's emergency department.

"We're now seeing fewer jellyfish stings than 10 years ago so the prevention programs really do seem to have been effective. The lifeguards drag the beach every day and if they find any evidence of jellyfish they will close the beach and put up appropriate signage."

The project is studying the impact of magnesium as a treatment for Irukandji syndrome, a type of treatment he has been involved with since its inception and initial publication.

Thanks to the community awareness and stinger prevention efforts of Queensland's surf lifesavers, James Cook University biologists and a network of interested medicos, there has been a dramatic reduction in cubozoan stings in North Queensland.

"We're now seeing fewer jellyfish stings than 10 years ago so the prevention programs really do seem to have been effective. The lifeguards drag the beach every day and if they find any evidence of jellyfish they will close the beach and put up appropriate signage," Dr Corkeron explained.

"What this means though is that it's now harder to get the numbers we need for research studies but that's a good thing!"

"While the Irukandji pack an impressive punch the species that kills most people is the larger box jellyfish Chironex fleckeri. It can kill them right there and then on the beach, and more than 75 people have died from these incredible but deadly animals. That message does get lost sometimes while people focus on Irukandji syndrome. Chironex fatalities are avoidable with protective enclosures, protective clothing and when needed, good CPR on the beach, which are messages we really need to continue to push.

What will happen in the context of rising sea temperatures remains to be seen but the past couple of years have seen what seems to be increasing numbers of Irukandji syndrome from further south which is a real concern."

The Director of Anaesthesia at Townsville Hospital wears several hats. He's not only a Group Captain with the Australian Defence Force in the Royal Australian Air Force Reserve and editor of the journal *Anaesthesia and Intensive Care* but is also a CICM final examination examiner and practising intensivist.

Opposite: A jar of Irukandji jellyfish (Source: ABC).

Below: Dr Corkeron with Professor Callanan (right); Dr Corkeron windsurfing; Dr Corkeron (left) with Russell Blanchard, Senior Lifeguard for Townsville, and a specimen of Chironex fleckeri.

Dr Corkeron has spent most of the past 20 years in Townsville. A self-confessed "army brat" he and his family moved throughout Australia and Papua New Guinea before he started his medical studies at the University of Queensland and completed his ANZCA training at Sir Charles Gairdner Hospital in Perth.

Dr Corkeron nominates the support and mentoring provided by anaesthetists Dr Vic Callanan (an ANZCA Medal recipient in 2012 and the long-serving former head of Townsville Hospital's anaesthesia department) and Dr Neville Davis, college president from 1995-96, as significant role models for him. Dr Callanan, an early advocate of vinegar to treat box jellyfish stings and co-developer of stinger-protective suits, is still a regular contributor to the department of anaesthesia's Friday morning continuing medical education meetings.

Work and life balance is important for Dr Corkeron so any spare time is spent windsurfing, diving or snorkelling with his wife, geologist Dr Maree Corkeron, and their three children at their hideaway beach shack on Magnetic Island.

As an RAAF Reservist Dr Corkeron has had extensive frontline experience as an anaesthetist and intensivist in long-range medical retrievals of trauma patients in Kuwait, Afghanistan and Germany and spent three months on deployment in Afghanistan at the Australian military base in Tarin Kowt. Working in a team of surgeons and nurses he regularly treated local Afghanis for severe trauma injuries alongside injured military coalition troops.

"The main difference is that in Australia we don't have to treat blast injuries and we have a relatively low incidence of penetrating trauma such as gunshot wounds. In Afghanistan that was a substantial part of our trauma work. It's a challenge for anybody, whether in civilian life or here and it can be very confronting," he revealed.

"I was lucky to have been surrounded by an amazing perioperative team. Having a really supportive team to work with is crucial."

Having been appointed Director of Anaesthesia nearly two years ago Dr Corkeron has had to devote less time to the RAAF Reserve and focus more on his work at the hospital where he oversees 78 staff including consultants, visiting medical offers and registrars. The hospital supports a catchment population of nearly 750,000 people across North Queensland through to the Northern Territory border.

Dr Corkeron is committed to extending perioperative care in the anaesthesia department and this year he plans to start rolling out a perioperative care model that is tailored for patients in remote areas and seeks to proactively screen for frailty and delirium risk.

"Our focus has become much more than just giving people a safe anaesthetic. We now want to ensure that patients have a very smooth ride during the perioperative course (of treatment) and prevent problems before they occur."

Asked to nominate a significant development he has experienced as a specialist in his years of practise Dr Corkeron nominates perioperative medicine and advanced care planning for people at risk as a "huge change with anaesthetists now being involved in the whole perioperative course for patients."

Dr Corkeron is also a passionate advocate for involving GPs in community care and the preoperative preparation of patients, especially in Indigenous communities. His department plans to roll out a new perioperative assessment and optimisation trial later this year with the support of Queensland Health.

"I see being in a regional centre as an opportunity rather than a barrier to clinical excellence and the ability to innovate. I get to deal with great people in a great location and am incredibly thankful for that."

Carolyn Jones
Media Manager, ANZCA

Faculty of Pain Medicine

Dean's message

Starting a new year is always an opportunity to reflect on the last and refresh our goals for this and future years.

This year's theme for the International Association for the Study of Pain's (IASP) Global Year Against Pain is "Pain in the Most Vulnerable" which invites us all to reflect on the pain care available for those persons least able to articulate their needs or at high risk of their pain being underestimated and undertreated. This includes what we as pain medicine physicians offer our patients as well as advocating for better care for vulnerable persons in other care settings.

The launch of the Australian Pain Society's publication *Pain in Residential Aged Care Facilities: Management Strategies, 2nd Edition* by the Minister for Senior Australians and Aged Care, Minister for Indigenous Health, Ken Wyatt at Parliament House on February 20 is particularly timely considering the Royal Commission into Aged Care Quality and Safety commenced in January. FPM General Manager Ms Helen Morris and I had the pleasure of representing the faculty at the launch. In addition, Painaustralia delivered The National Strategic Action Plan for Pain Management to the federal Health Minister Greg Hunt late last year ready for endorsement by the COAG Health Council. Thank you to the faculty fellows who have contributed to these major initiatives that have great potential to improve pain care, especially for the most vulnerable groups highlighted by the IASP. Resources developed in collaboration with APS, the New Zealand Pain Society and FPM can be found at fpm.anzca.edu.au/resources/global-year-against-pain.

These reflections lead into the faculty board's considerations of its structure which has expanded into a broader discussion of the structure not only for the board but across our organisation to best lead the faculty for the next 10-20 years. For example, staff member, Ms Alex Charles-Ffrench has brought marketing expertise into the faculty which has resulted in a contract with publishing company QxMD giving our Better Pain Management program international reach. We need to think about what other new skills we might need in the future. My thanks to the fellows who have sent feedback on the initial board restructure proposal.

The faculty prides itself on being the world leaders in the field of pain medicine. However, other international jurisdictions are working hard to improve their educational offerings and expanding their influence into countries close to us which traditionally have been aligned with our college and faculty. These external influences are increasing rapidly, prompting the faculty to strive to be even better both in our educational offerings, training and research opportunities as well as building strong relationships with our closest neighbours.

We have been working with the Hong Kong Board of Pain Medicine towards accrediting a third training site and on holding the 2020 Spring meeting there. This year's Annual Pain Medicine Symposium (formerly known as the Refresher Course Day) and Annual Scientific Meeting being held in Kuala Lumpur is another opportunity to build the relationship with our Malaysian colleagues. The ANZCA International Liaison Group, on which I represent the faculty, is working towards stronger relationships with colleagues in China as well.

As we consider the longer term, leadership of the faculty is critical to its survival into the future. This starts with the board. It was pleasing to see six fellows have nominated for three positions and two new fellows for the new fellow position on the board.

Each year the goals of the faculty's ambitious 2018-2022 Strategic Plan are reviewed and modified depending on the changing needs of the faculty and the broader healthcare environment. With this in mind, Helen Morris and I will visit the national and regional committees starting in New Zealand on March 6 followed by Queensland on March 11 and Tasmania on April 4. We are keen to hear about the issues fellows and trainees face and their perceptions of future directions in healthcare in their workplaces and local jurisdictions as well as thoughts about national issues and how the faculty can support them. This information helps to guide the faculty's advocacy efforts so that our limited resources are used most effectively.

Strong advocacy in New Zealand by Professor Ted Shipton and the New Zealand National Committee informed by the Health Economics Report commissioned by the faculty has led to an invitation for us to meet with the NZ Minister of Health Dr David Clark on March 7.

In Australia, strong advocacy for pain services in north-west Tasmania is on-going. I would like to highlight the hard work of our Tasmanian fellows and especially ANZCA fellow Dr Colin Chilvers and the ANZCA Regional Committee in leading this effort showing that our anaesthesia colleagues are also passionate about improving the standards of pain care available for vulnerable persons living in rural Tasmania.

The faculty is still the only multidisciplinary academy for education and training in pain medicine and leads the world in the sociopsychobiomedical approach to curriculum and training program development. A key goal for 2019 in maintaining this leadership is completion of the procedures in pain medicine project. Three working groups are now addressing the development of standards, curriculum and training for practice development stage trainees and CPD offerings respectively. Besides this project, there are many other opportunities to participate in faculty activities. If you feel passionate about pain medicine and want to improve care for our patients who really are among the most vulnerable members of our society, get involved either in advocacy in your workplace, join your local regional committee or look out for more targeted faculty activities.

I look forward to continuing our conversations throughout 2019.

Dr Meredith Craigie
Dean, Faculty of Pain Medicine

News

New fellows

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

Dr Enrique Collantes Celador, FRCA, FFPMANZCA (NSW).

Dr Thor Timothy, Anuntapon Chutatape, MMed(Sing), FFPMANZCA (Singapore).

New emergency response standard

A new emergency response standard Acute Severe Behavioural Disturbance in the adult patient has been developed specifically for faculty fellows. This standard is the fifth emergency response activity available to participants of the ANZCA and FPM CPD program, and ensures all FPM fellows can fully undertake the CPD program relevant to their scope of practice. Please see page 54 for further details.

Trainee and new fellow lunch

All pain medicine trainees and new fellows registered for the ASM are invited to attend a complimentary lunch on Tuesday April 30 from 12-1.30pm. This is an opportunity for FPM trainees to get together and meet with the leaders of our profession. Please indicate if you would like to attend when registering for the ASM.

New pain medicine resource on physical examination skills

A series of videos has been recorded to guide trainees and other practitioners to examine patients with pain conditions. The videos are available within the Pain Medicine Learning section of Networks under the Examination of patients who present with pain issues. Thank you very much to Dr Charlotte Johnstone, Associate Professor Damien Finniss and Dr Alix Dumitrescu for developing these resources.

News

Pain in Residential Aged Care Facilities launch

The FPM Dean, Dr Meredith Craigie and FPM General Manager, Ms Helen Morris were pleased to attend the launch, by the Minister for Senior Australians and Aged Care, of the Australian Pain Society's publication Pain in Residential Aged Care Facilities: Management Strategies, 2nd Edition in Canberra on February 20, 2019. Following the launch, FPM was represented in a meeting of key stakeholder groups to discuss the Aged Care Royal Commission, the National Strategic Action Plan for Pain Management and aged care issues.

Caption: Ms Carol Bennett, CEO Painaustralia, Mr Ken Wyatt, Minister for Senior Australians and Aged Care, Minister for Indigenous Health, Ms Fiona Hodson, President, Australian Pain Society, Dr Meredith Craigie, Dean, Faculty of Pain Medicine and Associate Professor Roger Goucke.

Essential Pain Management (EPM) workshops

The Essential Pain Management (EPM) program that was developed with the assistance of ANZCA and FPM has been taught in more than 50 countries. Burundi's first EPM workshop was held in December, and was facilitated by ANZCA fellow Dr Wayne Morriss and Jacqui Morriss. An instructor workshop was also held in the former capital of Bujumbura in December. Seventy-eight health workers participated, with 14 of the health workers becoming EPM instructors. Participants came from all over Burundi and included nurses, physicians, physicians and non-physician anaesthetists, midwives and a pharmacist.

In January 2019, two of the newly trained instructors organised another EPM workshop at Kibuye Hope Hospital in the centre of Burundi. There are future plans to do an audit of current pain management practices in Burundi and roll-out EPM to other health care facilities.

FPM fellow Associate Professor Roger Goucke attended EPM workshops in Hong Kong in January. Since 2017, 80 EPM instructors have been trained in Hong Kong. After the workshop, 98 per cent of the participants felt that the EPM content was practical for use in their workplace, and they felt more confident and competent in managing patients with pain. The faculty thanks the Hong Kong hosts for supporting the EPM program and participating in the strategy to improve pain management worldwide.

Left from top: Participants at the January 2019 Burundi EPM workshop; Associate Professor Roger Goucke (fourth from right) at the Hong Kong EPM workshop at Polytechnic University.

Trainee survey results

Your feedback creates better services

Have you ever wondered what happens after you press "submit" and send off your views on college programs, services and activities in the trainee survey?

First and foremost we take survey results and your comments seriously.

Secondly we use an independent consulting firm, KPMG Acuity, to ensure your results are analysed rigorously.

We identify common threads and then engage our committees and business units to work out what can be done to acknowledge and maintain valued services, tweak areas that are not optimal and address deficiencies. We do this using an action plan that helps to track what's happening with survey results.

The 2017 ANZCA Trainee Survey results, for example, have been considered and incorporated into the college services.

Bullying, discrimination and sexual harassment

The bullying, discrimination and sexual harassment (BDSH) findings have been shared with the Trainee Welfare Working Group (TWWG), informing recommendations in the TWWG report.

The findings strengthen and confirm that our continuing work to implement the recommendations of the BDSH Working Group are heading in the right direction.

Furthermore, the BDSH findings are now being incorporated into the ANZCA Doctors' Support Program, covering the professional life cycle of anaesthetists.

The NZ National Committee has commenced work to address BDSH education in NZ and are considering mandatory courses signed off as clinical time, rather than leave.

The doctors' health and wellbeing framework, that outlines strategies that protect, promote and support better health and wellbeing for across the professional life span, has been approved by council. Our website now includes the framework, resources and details of our collaboration with the ASA in the "Long Lives, Healthy Workplaces" initiative.

We have established an online assistance process to handle complaints that come from fellows and trainees.

We continue to promote the "Operating with Respect" e-learning module on the Networks platform. The module describes appropriate behaviours in medical practice and the workplace.

Simplifying training program documentation

Based on trainee comments and survey result for many years, the training portfolio system (TPS) has been updated to ensure easier and more intuitive reporting and documentation.

The updated TPS was release in November 2018; so far trainees and supervisors are finding it easy to use.

Indigenous trainees

In 2018 ANZCA launched a new Indigenous Health Strategy. The strategy provides a framework to guide the college's work to contribute to the achievement of health equity for Aboriginal and Torres Strait Islander people in Australia and Māori in New Zealand. You can find the strategy at www.anzca.edu.au/fellows/community-development/indigenous-health.

We have also developed an action plan to increase the number of Indigenous trainees and collecting data on trainees who identify as Indigenous.

We have used the trainee survey results to validate other college data sources on Indigenous trainee numbers. This year, there are five Aboriginal and Torres Strait Islander and 18 Māori trainees in ANZCA.

Rural trainees

Knowing the proportion of trainees with a rural background and who would consider rural practice is part of the college's benchmarking to support and encourage rural practice.

More than 70 per cent of trainees have lived in a regional, provincial or remote location and a similar proportion would consider working rurally.

2018 ANZCA Trainee Survey – highest response rate ever

Overall, trainees are positive about the training program, with satisfaction levels at 90 per cent, up from 70-75 per cent in previous years.

The online survey attracted the highest response rate in four years, with 740 participant (49 per cent of all trainees). The three-week survey was launched on August 28 and 1501 trainees were invited to participate.

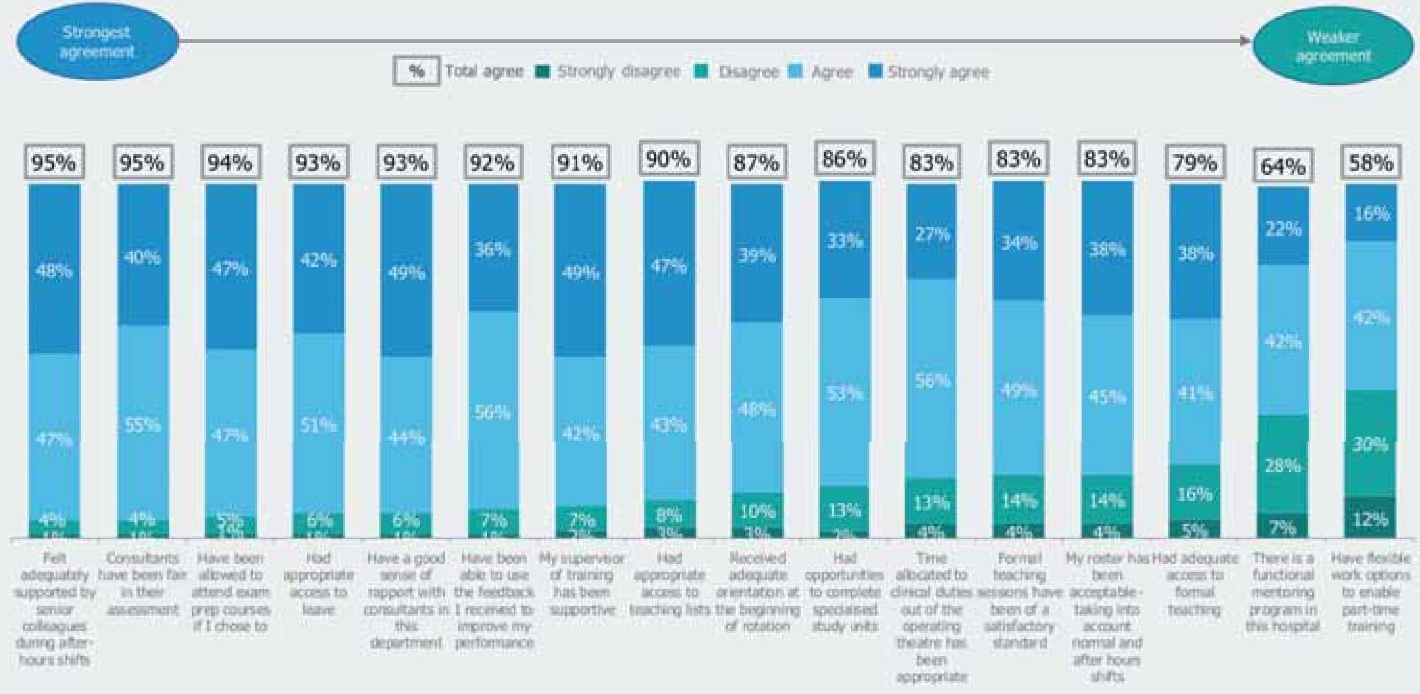
The good news from the 2018 survey include:

- Nine in 10 respondents are positive with key aspects of the hospital training environment including being supported by senior colleagues after hours and their supervisors generally, that supervisor assessment are fair and that they have access to exam preparation.
- 92 per cent of trainees find ANZCA Library resources valuable, particularly e-books and e-journals (91 per cent).
- While 27 per cent of trainees would consider a career in research, 82 per cent are interested in medical education careers.

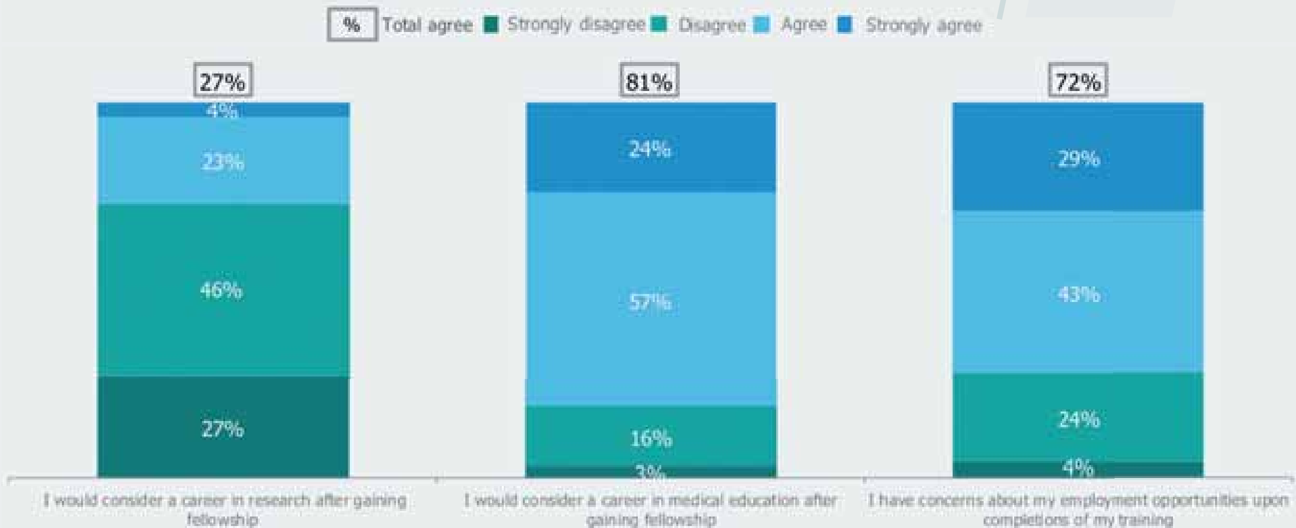
There is variation in the results for individual hospitals; individual feedback has been provided to the heads of departments at most accredited training sites. This feedback has also been provided to regional and national committees for their consideration and further action.

For the first time, in 2018, the Kessler Psychological Distress Scale (K10) was included in the survey. The validated tool is designed to measure non-specific psychological distress in the anxiety-depression spectrum.

Summary of hospital training environment



Summary of career opportunities



Trainee survey results (continued)

A moderate proportion of trainees agree that their quality of life and general health is good or excellent.

Close to eight in 10 (78 per cent) of trainees agreed that there is stigma about divulging mental health issues. Consequently, most would not want other people to know if they experienced such issues (71 per cent agree/strongly agree).

And opinions are divided concerning work-life balance. About one in three (31 per cent) trainees feel that their work situation leaves enough time for family and/or personal life; 41 per cent disagreed. One in four (24 per cent) were undecided.

The survey has also provided us with opportunities to improve the way we provide services and provide quality teaching and education.

Fewer than one in three trainees have access to a functional mentoring program in their hospital (35 per cent).

Only 49 per cent of trainees found Networks (e-learning platform) useful for learning resources.

Forty per cent of trainees disagreed with the statement that workplace-based assessments (WBAs) enhanced their training experience.

A number of these issues have already been noted, and projects are in the pipeline to address your concerns, including:

- Creation of an online mentoring resource module, comprising a number of video tutorials which help explain the mentoring relationship as well as the multitude of benefits such programs can produce.
- The utility of WBAs is being addressed via the WBA lead project, which is set to be rolled out in 2019.

Summary of workplace BDSH occurrence

Summary of quality of life and general health

This year's survey has also identified issues with the training environment that warrant ongoing monitoring and action to help improve the training experience.

While few trainees appear to be suffering from psychological distress, there were three areas that require monitoring; feelings of tiredness for no good reason (23 per cent feel like this "all of the time" or "most of the time"), everything being an effort (12 per cent) and nervousness (11 per cent).

Roughly two in three (67 per cent) trainees indicated that they worked through illness and didn't take time off work when they should have.

And stubbornly, the percentage of trainees experiencing or witnessing bullying in the past 12 months has not changed significantly; around one in four trainees (28 per cent) have experience bullying and 45 per cent have witnessed it.

There is more to be done. In 2018, as in 2017, we have distributed individual results to hospitals, regional and national committees. All education committees will consider relevant results in early 2019. The Education unit will work with the ANCA Trainee Committee and the Education Development and Evaluation Committee (EDEC) to oversee the development and implementation of an action plan to ensure your comments are acted upon.

Thank you for your contribution to making the college training program better.

Dr Simon Bradbeer
2018 Chair, ANZCA Trainee Committee

"Mirror, Mirror on the wall..." Self-assessment in ANZCA training

After evaluating the initial implementation of the WBA forms, including feedback from trainees and fellows, the college has released updated WBA forms in time for 2019. While Consultants and trainees will notice improvements that aim to trigger more specific feedback and help trainees to generate action plans, the addition of trainee self-assessment is arguably the biggest change Consultants and trainees will face when doing WBAs in 2019. Here we explain why it's important and how it should work.

What is the benefit of having trainees assess their own performance?

Being able to self-assess has positive effects on academic performance, commitment and engagement with learning, and an individual's belief in their ability to achieve goals[1]. Self-assessment is integral to the development of self-regulated learning. Self-regulated learning has been linked to improved patient safety and better patient care[2,3], and is essential for successful lifelong learning and professional development[1,2], one of the aims of ANZCA training. Like many useful abilities, self-assessment needs to be learned, and WBAs provide an excellent opportunity for trainees to try out this new skill.

Why have we introduced self-assessment now?

Self-assessments were not included in the 2013 WBA forms, although some fellows will remember that they were a feature of the earlier ITA forms. When the 2013 curriculum was developed, there was a general understanding in medical education that self-assessment was not working and was poorly correlated with the judgements of others[4]. Studies examining its effect had poor results, and the prevailing wisdom was that doctors were not good at assessing their own performance. These studies were designed to test whether learners could guess what score an assessor was going to give them[4]. It turns out this is a really difficult task and so it is unsurprising we are not good at it. Educators have also discovered that framing self-assessment as guessing what score you are going to get reflects a very simplistic notion of what self-assessment is and why we might do it. Our understanding of self-assessment has advanced since these studies were performed. We know expert practitioners do make judgements of their own ability all the time and use these judgements to inform their practice. Including self-assessment in the revised WBA forms is a practical way of helping our trainees learn this valuable skill.

What is self-assessment?

Self-assessment is best thought of as a learning strategy rather than as an assessment. A useful definition of self-assessment is:

"A process of interpreting data about our own performance and comparing it to an explicit or implicit standard"[5].

A number of elements of self-assessment can be deduced from this definition. The standard for comparison needs to be determined, information on performance must be gathered from internal and external sources, and these must then be evaluated to come to a judgement.

While self-assessment requires skills that can be learned, it is important to note that it is situational, in that the circumstances in which we use it are constantly changing[6]. In part, this is because self-assessment is expertise-dependent. Although we can become more aware of what is required for self-assessment and more practiced in its application, as we get better at a task we also get better at assessing our own performance in that task. Ideally then, when we are learning a task we should also be learning to assess our own performance in that task.

How do we determine the standard in self-assessment?

In order to self-assess, we need to determine the standard we are measuring ourselves against. There are two aspects to this – choosing the aspects of performance that are most pertinent in a particular case or task, and then choosing the level of performance we are aiming for.

For example, it is easy to imagine a case where airway management is anticipated to be difficult and clinical judgement and technical expertise might be the most important aspects of performance. In another situation, such as when you are assessing how well you helped a patient with autism have a good perioperative experience, you would focus on different aspects of performance. In WBAs, consultants can highlight the aspects of performance they considered important in making their judgement about that particular case and trainees can then compare this to their own views.

When deciding on the level of performance we are aiming for, we need to consider the nature of the task and how important or how difficult we perceive it to be. For a task we intend to perform often, we generally aim for a high degree of precision and fluency. For a difficult task we are going to perform infrequently, we may have a more realistic goal of remembering and applying rules so we perform it slowly yet safely. In WBAs, consultants can communicate their view on the required level of performance and trainees can compare this to their own views.

How do we get information to inform our self-assessment?

Generally, we get information on our performance from internal and external sources. Internal sources include our feelings and emotions related to our performance, such as confidence and certainty, or anxiety and discomfort. Mentally checking how we perform against our own standards can also provide important information. External inputs can come from monitoring the outcome of our work, for example checking your patient is comfortable in recovery after performing a caudal block. We can also seek feedback information from others who observe our performance – patients, peers, colleagues and supervising consultants. WBAs obviously provide a great opportunity for trainees to request information on their performance from consultants and a framework for consultants to use when providing it.

How do we interpret the information when we self-assess?

As we use multiple different sources when we collect information on our performance and determine the standard we are aiming for, we need to process the information before we come to a judgement. Reflection is an important part of self-assessment where we synthesise and weigh up the various pieces of information and integrate them into our own judgement of our performance. Information from different sources may align or conflict, and it can be particularly challenging when our own views on our performance differ from those of others. Working out how to respond to these discrepancies in the information we receive is an important aspect of self-assessment and one where WBAs allow trainees to practice this and discuss it in detail with a consultant.

When do we self-assess?

The most obvious time when we think of assessing our performance is, after we have completed a task, when we reflect on our performance and decide what we might do differently next time. While this is important, we also use our self-assessment skills before and during task performance as well. While we are working, we can monitor our progress and whether our work is producing the results we expect. We sometimes do this unconsciously, but we may consciously remind ourselves of what we think are important aspects of performance in a particular case and monitor whether we are achieving the outcomes we want. Monitoring our work during the task allows us to adjust to changing circumstances and make corrections if our actions are likely to be ineffective.

Similarly, we routinely compare our own perceived capability with the requirements of a planned case in deciding whether we take it on or not. Trainees routinely do this before requesting assistance or embarking upon a case with distant supervision. To make this assessment we need to be aware of the important aspects of performance for that case and the level of proficiency that is acceptable, and compare that to the information we have of our own capability.

How does self-assessment differ from assessing others?

Consultants reading this description of self-assessment may have noticed that most of the principles discussed could apply equally to assessing the performance of others. Only the self-directed nature of obtaining information on performance and the use of internal information sources are unique to self-assessment. Otherwise, learning to self-assess is good practice for learning to assess others as well. Given trainees are our future consultants, helping our trainees learn self-assessment is an investment in the future of our profession.

So how should this work in WBA?

The WBA form changes aim to facilitate trainees learning self-assessment. First, there is a new box where trainees indicate what they hope to learn from the experience. This indicates to the consultant what aspects of performance the trainee wants feedback information about, and hence reflects what aspects of performance the trainee thinks are important in evaluating their performance in this particular case. Given trainees have not had to do this in the past, they may need coaching in how to do this, so it might be helpful for trainees and consultants to discuss this before the case.

Second, trainees are asked to complete the same overall rating for the case that the consultant will be asked to complete. The scale is based on how much supervision is required, which should align with judgements trainees and consultants need to make every day. Remembering that self-assessment is best thought of as a learning strategy, it should be obvious that there is no "right" or "wrong" score – the trainee's self-assessment reflects their own judgement of their performance in that particular case. Evidence from other systems suggests this will often differ from the consultant's score, especially initially, and the value lies in the discussion this provokes. Comparing different views on what underlies the scores, including discussing the important aspects of performance in a case and the level to be obtained, as well as different impressions on how the case went, will provide trainees with valuable information to calibrate their own judgement of performance.

Conclusion

Learning to assess our own performance is a crucial skill for lifelong learning and one of the aims of ANZCA training. In adding self-assessment to our WBAs, we hope to foster the development of self-assessment within the safety net of the training environment, and enhance the range of skills used by trainees and consultants to inform their professional development.

Dr Damian Castanelli FANZCA
Chair, ANZCA Education Development & Evaluation Committee
Education Officer, Victoria

Dr Jennifer Woods FANZCA
Deputy Chair, ANZCA Education Development & Evaluation Committee
Chair, New Zealand National Committee

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WBA Relaunch 2019: Harnessing the potential of WBAs to enhance feedback and learning

Workplace-based assessments (WBAs) have been an integral part of our ANZCA training program since 2013. The intent of the WBAs is to provide valuable and structured learning opportunities through focused observations by specialists and a subsequent feedback conversation.

However, it has become clear that we are currently not optimising the potential that WBAs offer to enhance trainees' learning. A recent analysis of WBAs in the Trainee Portfolio System (TPS) showed that nine out of 10 completed assessments provided minimal feedback comments to help guide the trainees' development. It also highlighted that most trainees did not document any reflections on the WBA encounter or formulate action plans for future encounters.

WBA Relaunch Project 2019

The WBAs are being relaunched in 2019 to re-emphasise and re-educate the ANZCA community around some key messages. The overarching goal is to further optimise the use of WBAs as feedback and learning tools.

WBA leads

This month sees the start of a multi-pronged relaunch, with the coming together of the WBA leads for a training workshop in Melbourne. ANZCA has appointed 29 WBA leads from throughout Australia and New Zealand who have been selected for their enthusiasm, commitment to WBAs together with their educational expertise. Their role will be ongoing within their region, to promote and advocate for WBAs as learning tools as well as provide WBA education and support to individual departments.

Local WBA workshops and advocates

In 2019, every ANZCA accredited hospital will be able to access a workshop delivered by their regional WBA lead with the purpose of recalibrating and reinvigorating the WBA message at the local level. The workshops are designed so that specialists and trainees can learn more about the WBA philosophy and processes together while ensuring that the key messages are the same. It is hoped each hospital will also have a recognised departmental WBA advocate to continue the work started at the workshop.

Online support resources and promotion

The rollout of the WBA Leads, and the workshops will be accompanied by updating of online WBA support resources on Networks plus Australasian wide promotion events later in 2019. Watch this space!

Updated WBA forms

The relaunch has been timed to coincide with the introduction of the updated WBA forms, which went live in the TPS in November 2018. The new assessment forms were the result of feedback received from fellows and trainees, work from the 2015 curriculum review project, and supported by ANZCA's own research and evidence in the medical education literature.

The key messages of the WBA relaunch

WBAs are tools for learning

WBAs are about facilitating learning through feedback, with each assessor providing a unique perspective to guide the trainee's developing clinical practice. Their primary purpose is for trainees to be observed in practice and then engage in a feedback conversation about their performance. In turn, this will help facilitate their development of the skills and attributes necessary for independent practice as a specialist.

WBAs are not pass/fail assessments

Unlike the primary and final examinations, WBAs are not focused on pass/fail. Instead, each WBA provides feedback from a specialist or assessor about a trainee's performance during a single clinical encounter. Based on this feedback the trainees can identify any deficiencies or areas of practice that need further development and formulate an action plan to guide their ongoing learning. This feedback is transparent to both the trainee and SOT.

In undertaking multiple WBAs a rich portfolio of feedback is created that trainees and their supervisors can later refer to. Supervisors of training can use the aggregated WBA data to tailor the specific learning experiences of the trainee at their hospital and provide specific support if required. The aggregated data also allows the SOT to make more robust and defensible progress decisions.

Selection of WBA cases to optimise learning

Despite not being a pass/fail assessment, we know that some trainees wait until they have sufficient experience before doing WBAs. However, this can significantly limit their potential learning opportunities. The best learning occurs when trainees select cases at the edge of their capabilities and use the focused feedback they receive to plan their future learning experiences.

Trainee selects a focus for learning

When undertaking an assessment, the trainee will consider and choose a specific focus of learning. This is an area they would like to concentrate and receive feedback on during the assessment. This area then becomes central to the feedback conversation between the assessor and the trainee and allows the feedback delivered to be more specific to their needs at a particular time.

Provision of specific, actionable feedback

The most common feedback comments in the TPS are variations on the theme of "do more". These comments provide trainees with no guidance as to what they can do to improve their performances the next time. Increasing the specificity of comments can be achieved by explaining what exactly they need to do more of, highlighting how they might access that experience and suggesting ways they can increase their knowledge in the area. This enables trainees to reflect and to create action plans with the increased likelihood of improved future performances.

Both the verbal and written feedback is of equal importance. However, without the record of key points documented within the TPS the trainee doesn't have the information available to reflect upon, nor are they able to create a specific action plan to drive improvement in future performance. Good quality written feedback also allows the SOTS keep informed of a trainee's progress and identify areas that they may want to discuss further with them.

Development of self-assessment and reflection skills

Trainee self-assessment, reflection and formation of an action plan are all new features in the updated WBA forms. These skills are necessary for trainees to develop self-regulation of their own learning and they need to be learned. Self-assessment is explored further in another article in this edition of the *Bulletin* on page 68.

We are excited about the roll out of the WBA leads, the new WBA workshops and resources. This is a great opportunity to not simply bolster the number of WBAs trainees do, but to also increase the focus and quality of the feedback conversations, and improve the written feedback documented in the TPS. In doing so, we can harness the full potential of the WBAs and improve the learning experiences for our trainees and future colleagues.

Dr Jennifer Taylor
Education Officer NZ

Dr Christine Hildyard
Education Officer SA/NT

Co-chairs of the WBA Relaunch Project Working Group

Fundamentals of Mentoring video package – launching soon

The Mentoring Project Working Group started in 2017 as an offshoot from the Trainee Wellbeing Working Group, in order to focus specifically on improving the provision of mentoring to anaesthetic trainees across Australia and New Zealand.

The Mentoring Project Working Group has devised the Fundamentals of Mentoring video package, which has been designed to support and develop existing hospital mentoring schemes by providing a training framework for mentors and mentees in anaesthesia and pain medicine. These videos will be available from April via the Networks platform. Viewing these training videos is eligible for CPD points too!

Some of the topics covered in the modules include:

- What mentoring is and what it is not.
- How to build and maintain a mentoring relationship.
- How to start a mentoring conversation.
- What mentees can expect from a mentoring relationship.

Completing such a large project requires a significant amount of time and work from many people. I'd like to thank all the members of the Mentoring Project Working Group for their time and commitment – Dr Maryann Turner, Dr Bishoy Moussa, Dr Marni Calvert, Dr Cath Purdy, Dr Nav Sidhu, Dr Shanthi Pathirana, Dr Gary Divine and Dr Jordan Wood from the Faculty of Pain Medicine (FPM). I'd also like to thank Dr Adriana Bibbo and Dr Michelle Haeusler for volunteering to star in the videos. Thank you to the ANZCA staff on the working group – Olly Jones, Helen Ho, Margaret Kerr, Lily Lian and Bernadette Peace. A special thank you to Colin Lynas for his video editing. Thank you to Dr Stefan Fothe, our external development consultant, who devised the modules in accordance with our specific needs.

I hope you all enjoy the videos!

Dr Tabara Dione
Chair, Mentoring Project Working Group

To supervise, or *How* to supervise – that is the question

"When is it okay for me to leave the registrar unsupervised to do procedure XYZ?" is a common question that gets asked at the start of a new hospital year, with new fellows and trainees starting in new and different hospitals around Australia and New Zealand.

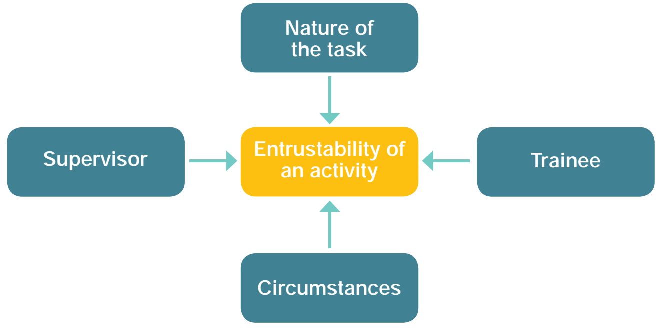
ANZCA Educators Program
Learning to teach

The short answer to the question is – it depends. The entrustability of a task or procedure at hand is dependent on these four factors (Ten Cate 2013):

- Attributes of the trainee (tired, confident, level of training).
- Attributes of the supervisor (lenient or strict, own confidence in doing the procedure).
- Context (circumstances, environment, time of day, facilities available).
- Nature and complexity of the task (easy versus complex, common versus rare).

Consideration of the four factors below will assist you in diagnosing the supervisory needs of the trainee and therefore provide the right level of supervision at the right time.

Right level of help, at the right moment



If you are interested in learning more about being an effective supervisor and clinical teacher, the ANZCA Educators Program (AEP) is a practical teaching course that is focused on teaching in the anaesthesia and pain medicine environment.

The upcoming courses include:

Dates	Location
March 26-29	Townsville, Qld
May 13-16	Perth, WA
May 20-22	Wellington, NZ
June 4-6	Melbourne, Vic
June 18-21	Darwin, NT
July 17-19	Brisbane, Qld
July 22-24	Sydney, NSW
September 2-5	Auckland, NZ
September 16-18	Adelaide, SA
September 16-19	Newcastle, NSW
October 22-24	Perth, WA
October 29-31	Melbourne, Vic

Further information is available at anzca.edu.au/AEPcalendar. Register today to stay ahead!

Dr David Law
ANZCA Educators Subcommittee Member and Program Facilitator

Maurice Hennessy
ANZCA Learning and Development Facilitator

Discover the world with the library's new discovery service

Can't we just Google that? The ANZCA Library now on Google!

Google scholar

It is now possible to configure Google Scholar to access full-text via the ANZCA Library.

Google Scholar provides a simple way to broadly search for scholarly literature. From one place, you can search across many disciplines and sources: articles, theses, books, abstracts and court opinions, from academic publishers, professional societies, online repositories, universities and other web sites.

And now Google Scholar can be easily configured to show you which of the search results are available from ANZCA Library. Once you've configured your browser using the steps below, just look for the Full text @ ANZCA link when using Google Scholar.

[HTML] ... in the patient receiving antithrombotic or thrombolytic therapy: American Society of Regional Anesthesia and Pain Medicine Evidence-Based Guidelines — [HTML] lww.com — Full text @ ANZCA

[CITATION] Inventing pain medicine: From the laboratory to the clinic

ASRA practice advisory on neurologic complications in regional anesthesia and pain medicine — [HTML] nih.gov — Full text @ ANZCA

1. Access Google Scholar: https://scholar.google.com.au/.
2. Select the Settings icon in the top-left of screen.
3. Select Settings from the Google Scholar menu.
4. Select the Library links section of the Settings menu.
5. Type anzca into the search box and click the Search button.
6. Select the Australian and New Zealand College of Anaesthetists – Full text @ ANZCA tick box
7. Click the Save button when complete.

For more information, see our dedicated Google Scholar library guide: **https://libguides.anzca.edu.au/google**

New subject guides

Two new library guides are now available for Ophthalmic Anaesthesia and Ear, Nose and Throat (ENT).

The guides are designed to bring together key resources (books, e-books, journals, articles, websites and more) that support particular aspects of anaesthesiology and pain medicine, including those available via the ANZCA Library.

These guides and many others can be accessed via library guides page: http://libguides.anzca.edu.au/

Contact the ANZCA Library
www.anzca.edu.au/resources/library/contacts
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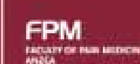
Calling all ANZCA and FPM researchers – promote your research and publications!

AIRR ANZCA Institutional Research Repository



Launched in May 2018, the ANZCA Institutional Research Repository (AIRR) has been developed to collect, preserve and promote the significant amount of important research published by ANZCA and FPM fellows and trainees.

Figure 1: AIRR entry

In addition to creating a centralised repository where ANZCA's published research can be easily accessed, content submitted to AIRR is now discoverable via Google and the Libraries Australia Trove initiative. This not only increases the visibility and discoverability of many publications, but also makes many other items discoverable via the web for the very first time.

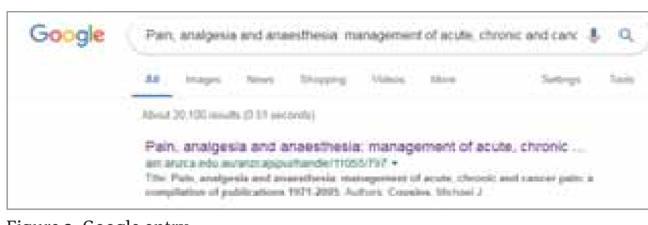


Figure 2: Google entry

Figure 3: Trove entry

What is Trove? Trove is a National Library of Australia initiative that brings together content from libraries, museums, archives, repositories and other research and collecting organisations big and small. And now content submitted to AIRR is automatically being loaded Trove, where it can be discovered as part of millions of other Australian resources.

And soon it will also possible to search for AIRR content in the library's new discovery service! Integration work is already underway and is expected to be completed by the end of March 2019.

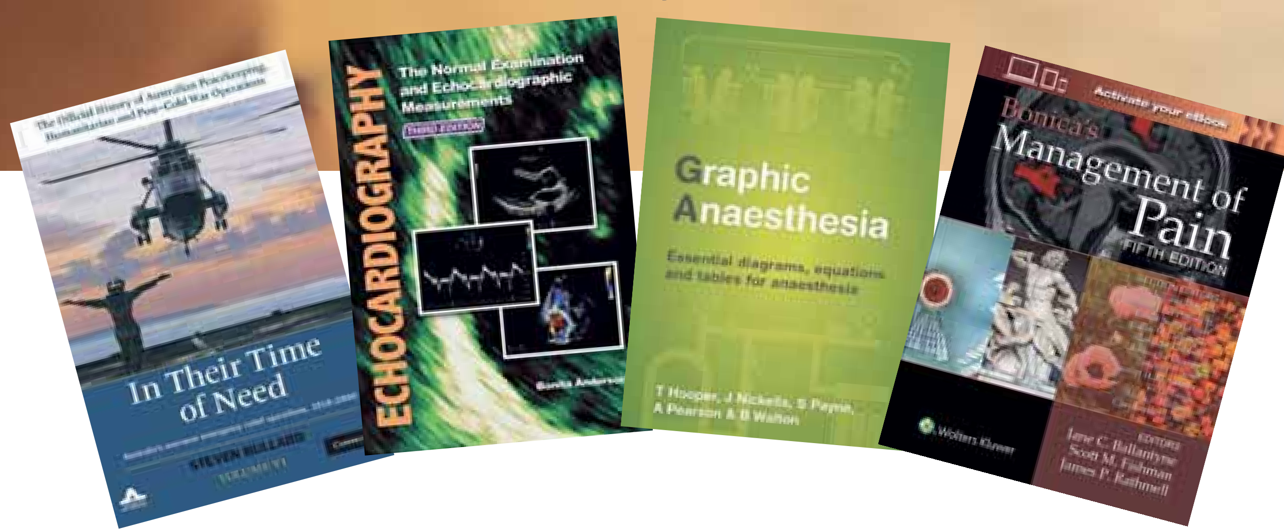
http://airr.anzca.edu.au

Recent contributions to AIRR:

- White RA, Hayes C, Boyes AW, Chiu S, Paul CL. Therapeutic alternatives for supporting GPs to deprescribe opioids: a cross-sectional survey. Bjgp open. 2018;Bjgpopen18x101609:101609.
- Holliday S, Hayes C, Jones L, Gordon J, Harris N, Nicholas M. Prescribing wellness: comprehensive pain management outside specialist services. Australian prescriber. 2018;41(3):86-91.
- Story DA, Tait AR. Survey Research. Anesthesiology 2019;130(2):192-202.
- Weller JM, Jowsey T, Skilton C, et al. Improving the quality of administration of the Surgical Safety Checklist: a mixed methods study in New Zealand hospitals. BMJ Open 2018;8(12):e022882.

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

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

In their time of need: Australia's overseas emergency relief operations, 1918-2010
Bullard S. -- Cambridge: Cambridge University Press; Campbell, Australia: Australian War Memorial, 2017.

Echocardiography: The normal examination and echocardiographic measurements
Anderson B. -- Australia: Echotext Pty Ltd, [2017].

Graphic anaesthesia: Essential diagrams, equations and tables for anaesthesia
Hooper T, Nickells J, Payne S, Pearson A, et al. -- Banbury: Scion, 2015.

New eBooks

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

Absolute obstetric anesthesia review: The complete study guide for certification and recertification
Wasson C, Kelly A, Ninan D, Tran Q. -- Cham, Switzerland: Springer, 2019.

Adult critical care medicine: A clinical casebook
LaRosa JA [ed]. -- Cham, Switzerland: Springer, 2019.

Advances in diagnosis and management of cutaneous adverse drug reactions
Shear NH [ed], Dodiuk-Gad RP [ed]. -- Singapore: Adis, 2019.

Airway stenting in interventional radiology
Han X [ed], Wang C [ed] -- Singapore: Springer, 2019.

A practical handbook on pediatric cardiac intensive care therapy
Klauwer D [ed], Neuhaeuser C [ed], Thul J [ed], Zimmermann R [ed].-- Springer, Cham: 2019.

Atlas of fetal imaging: Abdomen
Vijayaraghavan SB. -- Singapore: Springer Science and Business Media: Springer, 2019.

Bonica's management of pain, 5th ed.
Fishman S [ed], Ballantyne JC [ed], Fishman SM [ed], Rathmell JP [ed]. -- Philadelphia: Wolters Kluwer Health, [2019].

Hensley's practical approach to cardiothoracic anesthesia, 6th ed.
Gravlee GP [ed], Shaw AD [ed], Bartels K [ed]. -- Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins Health, [2019].

Cardiovascular surgery: A clinical casebook
Almeida RMSSA [ed], Jatene FB [ed]. -- Cham: Springer, 2019.

Chronic headache: A comprehensive guide to evaluation and management
Green MW [ed], Cowan R [ed], Freitag FG [ed]. -- Cham : Springer, 2019.

Co-existing diseases and neuroanesthesia
Prabhakar H [ed], Singhal V [ed], Gupta N [ed]. -- Singapore: Springer, 2019.

Education in anesthesia: How to deliver the best learning experience
Bowe EA [ed]. – Cambridge: Cambridge University Press, 2018.

Effective treatments for pain in the older patient
Pollard BJ [ed], Kitchen G [ed]. -- Boca Raton, Florida; London [England]; New York: CRC Press, 2018.

Handbook of clinical anaesthesia
Pollard BJ [ed], Kitchen G [ed]. -- Boca Raton, Florida; London [England]; New York: CRC Press, 2018.

Mechanical ventilation in emergency medicine
Creutzfeldt CJ [ed], Kluger BM [ed], Holloway RG [ed]. -- Cham: Springer, 2019.

Neuropalliative care: A guide to improving the lives of patients and families affected by neurologic disease
Creutzfeldt CJ [ed], Kluger BM [ed], Holloway RG [ed]. -- Cham: Springer, 2019.

Pain after surgery
Carr DB [ed], Arendt-Nielsen L [ed], Vissers KCP [ed]. -- Philadelphia, PA: Lippincott Williams & Wilkins, 2019.

Practical operating theatre management: Measuring and improving performance and patient experience
Pandit J [ed]. -- Cambridge, United Kingdom; New York, NY: University Printing House, 2018.

Ultrasound guided regional anesthesia, 2nd ed.
Grant SA [ed], Auyong DB [ed]. -- Oxford University Press, 2016.

Foundation update

Clockwise from left: Mr Jason Russell, CSL Behring, Ms Helen Maxwell-Wright, OzChild and Juvenile Diabetes Research Foundation, Dr Peter Lowe, Life Patron, and Mr Brian Little, President's Patron; Professor David A Scott, President's Patron Mr John Gross and CEO Mr John Ilott; Mr Ken Harrison AM outlines the role of the Leadership Circle; Professor Bernhard Riedel.

Leadership Circle

The foundation's Leadership Circle is a program in which individual and organisational philanthropists and sponsors may become closely involved in supporting significant projects and programs in medical research and education through the foundation.

February lunch – supporting onco-anaesthesia research

Professor Bernhard Riedel, Head of Anaesthesia Perioperative and Pain Medicine at the Peter MacCallum Centre in Melbourne, gave an inspiring presentation on the topic at the foundation's Leadership Circle lunch on February 26, outlining the development of his team's extensive research program in onco-anaesthesia.

The existence or otherwise of relationships between postoperative cancer outcomes and anaesthetic technique has generated significant debate and inquiry in recent years, yet evidence gaps and unanswered questions persist.

In ANZCA CEO John Ilott's welcome address, he summarised the fundamental importance of the college's support for fellow and trainee-led research, and noted the strong record of foundation donor-supported grants in leveraging large government grants for clinical trials to generate new evidence to inform clinical practice.

Leadership Circle Chair Ken Harrison AM followed with remarks on the importance of research philanthropy in empowering good health outcomes for future patients.

After an eloquent introduction by ANZCA Research Committee Chair and Immediate Past President Professor David A Scott, Professor Riedel outlined the development of his team's extensive research program. In December 2018, the team won an NHMRC project grant of $A4.9 million for a new international, multicentre clinical trial that will investigate the relationship between anaesthetic approach and postoperative cancer metastasis.

The VAPOR-C trial will compare outcomes associated with volatile versus total intravenous anaesthesia (TIVA). At the start of the program, the team reviewed literature around micro-metastasis, surgery-induced stress, neuro-inflammation, immune suppression and anaesthesia. Emerging from the review was an important but yet to be adequately answered research question: whether significant reductions in metastasis rates might result from the use of TIVA versus inhalational anaesthesia.

With a clear evidence gap and potential to benefit up to 20 per cent of patients requiring cancer resection, the program commenced with the goal of adding new evidence to existing high standards of onco-anaesthesia practice to further improve patient outcomes.

(continued next page)

Foundation update (continued)

Crucial foundation support
Professor Riedel outlined the trial's objectives and design, as well as crucial prior stages of the research program lifecycle starting with literature review and meta-analysis. Several ANZCA and foundation grants throughout the program's development were critical precursors to eventual competitive funding success.

These smaller grants supported initial laboratory studies on comparisons of different combinations of anaesthetic and analgesic protocols, further examination of the roles of beta-blockers and gene expression in metastasis reduction, essential mechanistic studies and pilot data, and finally the completion of the feasibility study that was critical for the NHMRC funding submission.

ANZCA Clinical Trials Network Support
The VAPOR-C trial has been endorsed by the ANZCA CTN, known for its capability in the conduct of large multicentre trials. Benefits of ACTN endorsement include helping researchers negotiate myriad study design, recruitment and implementation challenges across multiple sites, leading to quality outcomes. The ACTN's track record helps researchers secure and manage new competitive funding, and the high historical rate of peer-reviewed journal publication and presentation of ACTN studies assists the translation process – with valuable impacts on clinical practice. The ACTN is a part of ANZCA's proven infrastructure for nurturing robust, well targeted scientific and clinical research supporting clinical excellence, giving donors the confidence that their contributions will make a real and lasting impact.

Member Advantage
ANZCA Member Advantage provides attractive lifestyle benefits for ANZCA members and now has more than 3000 members. Members wanting to join should contact Anna Smeele at asmeele@anzca.edu.au to opt in. Anna will add your name to our monthly upload of new members to the service provider, Member Advantage.

Thank you foundation donors
The foundation warmly thanks all donor and patrons for your support, especially all who gave recently through the subscriptions appeal, which has raised almost $60,000 to date.

Rob Packer
General Manager,
ANZCA Research Foundation

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

New multicentre studies in the pipeline

NHRMC announcements

Professor Kate Leslie and Dr Thomas Painter have been awarded a $A1.2 million project grant from the National Health and Medical Research Council (NHMRC) in the 2018 grant round for the PeriOperative ISchemic Evaluation-3 Trial (POISE-3). This five-year study will be coordinated in Australia and New Zealand at the CTN office in Melbourne under the leadership of Dr Tom Painter.

Professor Bernhard Riedel was awarded a $A4.88 million project grant in the 2018 grant round for the Volatile Anaesthesia and Perioperative Outcomes Related to Cancer study (VAPOR-C), to definitively answer whether general anaesthesia with inhaled volatiles associates with reduced cancer-free and overall survival when compared with total intravenous anaesthesia (TIVA) with propofol for patients undergoing colorectal or lung cancer surgery. This four-year study will be co-ordinated at the Peter MacCallum Cancer Centre in Melbourne.

Professor Michael Reade was awarded a $A1.85 million project grant in the 2018 grant round to run for the Cryopreserved platelets for surgical bleeding trial (CLIP-II). This is a definitive trial to determine if cryopreserved platelets are as safe and effective as liquid-stored platelets in high-risk adult cardiac surgery patients.

These three large grants have been endorsed by the ANZCA CTN and builds on the successful track record of the CTN in securing multi-million dollar grants to run investigator-led clinical trials.

Karen Goulding
CTN Manager

Funded multicentre clinical trials starting in 2019

PeriOperative ISchemic Evaluation-3 Trial (POISE-3)

Professor Kate Leslie AO and Dr Tom Painter

POISE-3 is an international, multi-centre randomised controlled trial of tranexamic acid and hypotension-avoidance to prevent cardiovascular complications and death in 10,000 adult patients with or at risk of cardiovascular disease having major noncardiac surgery.

The trial has been developed and is being run internationally by the Population Health Research Institute in Canada and lead by Dr PJ Devereaux.

We have been fortunate enough to secure $A1.2 million from the most recent funding round of the NHMRC to run POISE-3 in Australia and New Zealand. This equates to a generous per-patient payment of $A900. POISE-3 is being co-ordinated in Australia and New Zealand by Dr Tom Painter, assisted by Professor Kate Leslie and Ms Gill Ormond who is based at the ANZCA CTN office. The trial has been approved under the National Mutual Acceptance system and Gill is in the process of assisting sites with both governance and any additional ethical approvals.

POISE-3 will answer two extremely important questions in perioperative medicine and we aim to include as many patients from Australia and New Zealand as possible. Please contact Gill if you would like to participate: gillian.ormond@monash.edu. We would like to thank Ms Jaspreet Sidhu and Ms Karen Goulding from the CTN office for their assistance.

Study design: Multicentre, international, randomised controlled trial of tranexamic acid (TXA) versus placebo and, using a partial factorial, of a perioperative hypotension-avoidance versus hypertension-avoidance strategy in adults undergoing noncardiac surgery.

Primary outcomes: The co-primary efficacy outcome for the TXA trial is a composite of life-threatening bleeding, major bleeding, and critical organ bleeding 30 days after randomisation.

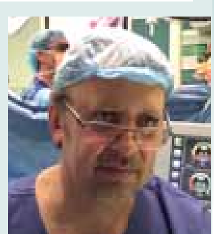
The co-primary safety outcome for the TXA trial is a composite of myocardial infarction (MI), non-haemorrhagic stroke, peripheral arterial thrombosis, and symptomatic proximal venous thromboembolism (VTE) 30 days after randomisation.

The primary outcome for the BP management trial is a composite of vascular death, and non-fatal MI, stroke, and cardiac arrest 30 days after randomisation.

Study duration: Five years.

VAPOR-C (Volatile Anaesthesia and Perioperative Outcomes Related to Cancer) Study

Professor Bernhard Riedel



Surgery is a primary treatment for more than 60 per cent of patients with cancer, with consequent exposure to anaesthesia. Alarmingly, retrospective clinical cohorts suggest that general anaesthesia with inhaled volatiles associates with reduced cancer-free and overall survival when compared with total intravenous anaesthesia (TIVA) with propofol. Our preclinical mouse models confirmed these findings and also demonstrate that intravenous lidocaine reduces cancer progression. Factors may include the pro-inflammatory, pro-angiogenic, pro-survival, and immunosuppressive properties of volatile anaesthesia. Our survey of Australian practice found that more than 80 per cent of anaesthetists routinely use inhaled anaesthesia and less than 50 per cent of respondents felt that anaesthetic technique impacts cancer outcomes. This lack of clinical consensus on optimal anaesthesia for cancer surgery reflects the urgent need for a definitive randomised clinical trial. This definitive study will inform international anaesthesia guidelines and the findings rapidly translated as these drugs are generic, cheap, and available worldwide. We anticipate that this study will have a dramatic effect on individual well-being, population health, and health care costs.

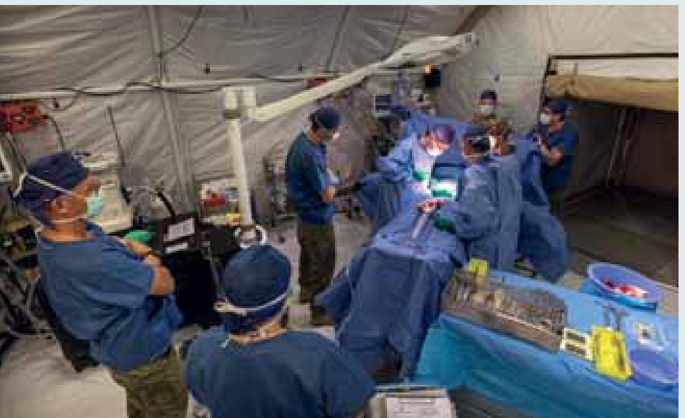
Study design: International, randomised, event-driven trial, with 2x2 factorial design (volatile/TIVA x lidocaine/placebo) and aims to study two primary hypotheses in patients undergoing colorectal or lung cancer surgery.

Primary endpoints: Propofol-TIVA and lidocaine increases disease-free survival compared with volatile anaesthesia.

Secondary endpoints: Will explore impact of anaesthesia on postoperative complications, quality of recovery, return to adjuvant therapies and incidence of chronic pain.

Study size: An estimated total sample size of 5736 (1434 per group) patients is required to achieve 957 events (failed disease-free survival within three years)

Study duration: Four years.



Cryopreserved platelets for surgical bleeding: CLIP-II

Professor Michael Reade FANZCA

Platelets are stored at 22°C to prolong circulating time after transfusion. This risks bacterial growth, limiting shelf-life to five days. Freezing, using dimethylsuphoxide (DMSO) as a cryoprotectant, extends shelf-life to two to four years. However, despite development by the US Navy in the 1970s, only one clinical trial, in which only 24 patients received cryopreserved platelets, has been published. This small study found cryopreserved platelets were safe and more effective than liquid-stored platelets. Funded by an ANZCA Academic Enhancement Grant, the CLIP investigators (a collaboration of the Australian Defence Force, the Australian Red Cross Blood Service led by Dr Denese Marks, and civilian hospital clinicians around Australia) have just completed the CLIP-I pilot trial, demonstrating the feasibility and safety of a protocol comparing frozen and liquid platelets in cardiac surgery patients. New Zealand colleagues led by Dr Shay McGuiness FANZCA and Richard Charlewood are testing a slight modification of the platelet preparation protocol. The CLIP investigators have now been successful in securing $A1.85 million to run a definitive trial in 10 to 12 Australian and New Zealand hospitals. If cryopreserved platelets are as safe and effective as hypothesised, the study will change the way platelets are stored worldwide, and make platelet transfusions possible in the many small hospitals that currently have no platelet blood bank.

Study design: Randomised, double-blind non-inferiority phase III clinical trial in high-risk adult cardiac surgery patients.

Study size: 808 patients randomised to achieve 202 patients transfused platelets (101 in each group).

Primary outcome: Volume of post-surgical bleeding in the first 24 hours.

Secondary outcomes: Transfusion and fluid resuscitation requirement; Bleeding Academic Research Consortium composite bleeding outcome; adverse effects (specifically: DMSO toxicity; infection; venous thromboembolism; arterial occlusion; need for surgical intervention; and acute respiratory distress syndrome); total estimated healthcare cost.

Study duration: Four years.

Above from top: Colonel Reade using the ADF's Deployable Anaesthesia System at the ANZAC Role 2E hospital, Taji, Iraq, 2016; operating theatre at the ANZAC Role 2E hospital, Taji, Iraq, 2016; units of cryopreserved and liquid platelets used in the CLIP-I pilot clinical trial.

General anaesthesia safe for young children

Groundbreaking research led by ANZCA fellow Professor Andrew Davidson shows general anaesthesia is unlikely to have lasting effects on the developing brain.

Landmark international research into the effect of anaesthesia on young children led by Melbourne anaesthetist and ANZCA Clinical Trials Network executive member Professor Andrew Davidson has found that general anaesthesia is unlikely to have lasting effects on the developing brain.

The results of the general anaesthesia compared to spinal anaesthesia (GAS) trial published in *The Lancet* on Friday February 15 concluded that one brief general anaesthetic in early childhood is unlikely to be harmful to long-term neurodevelopment but the safety of longer exposures remains unclear.

Professor Andrew Davidson, head of Anaesthesia Research and Medical Director of the Melbourne Children's Trials Centre, at the Murdoch Children's Research Institute and Royal Children's Hospital led an international group of paediatric anaesthetists and other specialists for the study which is the first randomised trial to examine whether exposure to general anaesthesia in infancy affects the growing brain.

ANZCA jointly funded the GAS trial with the Australian National Health and Medical Research Council (NHMRC), the Murdoch Children's Research Institute and leading international bodies and research groups including the Health Technologies Assessment-National Institute for Health Research UK and the Canadian Institutes of Health Research.

The trial involved researchers and doctors at 28 hospitals in Australia, New Zealand, the US, Canada and Europe between February 2007 and January 2013. The trial tested the neurobehavioural and cognitive development of more than 700 infants who underwent hernia surgery (one of the most common operations of early childhood) at two years of age and then at five years. The children were allocated either a general anaesthetic or a regional (local) anaesthetic.

"The trial provides the strongest evidence to date that one hour exposure to anaesthesia is safe in young children," Professor Davidson said.

"Nearly half the general anaesthetics given to infants are used for less than one hour, therefore our findings should reassure health professionals and the millions of parents whose young children undergo surgical or diagnostic procedures with anaesthetic drugs worldwide every year."

Professor Davidson said the findings meant children no longer needed to be subjected to the potential medical and developmental risks of delaying surgery, and anaesthetists did not have to avoid general anaesthetics in favour of less well established anaesthetic techniques.

The Lancet 2019 paper reports the final results of the GAS trial at five years of age after child psychologists assessed children's IQ scores and other cognitive measures such as memory and attention.

It follows interim 2016 GAS results which found that neurodevelopmental outcomes at 2 years of age did not significantly differ between the children who were given general anaesthesia and regional anaesthesia.

Millions of young children have an anaesthetic around the world each year for a range of surgical, medical and diagnostic procedures. In Australia alone, more than 70,000 children under four years of age have an anaesthetic each year.

The Lancet paper reports that the results showed no significant difference in IQ scores between the children exposed to general anaesthesia (average IQ score 98.87) and regional anaesthesia (99.08), after adjusting for age at birth and country, and accounting missing data. There were also no differences in a range of other tests of neurobehavioural and cognitive function.

The report's authors noted that 84 per cent of the study participants were male and said more research was needed to confirm the findings in girls and children with prolonged exposure to anaesthesia.

Carolyn Jones
Media Manager, ANZCA

New Zealand news

The road to fellowship

It's been a bumpy ride to fellowship for one of the recipients of the 2018 BWT Ritchie Scholarship, Dr Felicity Dominick, but the award will pave the way for many learning opportunities in anaesthesia and intensive care with Uppsala University Hospital in Sweden.

Dr Dominick interrupted training to head to Sweden a year after her partner, Otto Strauss, moved there to take up a position as a postdoctoral researcher. Dr Strauss, had been motivated to relocate to Scandinavia in part to access effective medication for his multiple sclerosis. He had been in rapid decline since he completed a marathon in 2014 and at the beginning of 2017 he struggled to walk more than a kilometre.

After arriving to Sweden in February 2018, it didn't take long for Dr Dominick to secure a fellowship. "I learned that the ANZCA training program is highly respected in Sweden among anaesthetists and they were keen to offer me a position as a fellow… I managed to secure a temporary special authority license for a 12-month fellowship that started in September 2018."

During the months she had to wait, she set out to study Swedish full-time to be prepared for her time at Uppsala University Hospital. Although most of the hospital staff can understand English, all of the medicine and medical correspondence is in Swedish so a level of fluency in the Swedish language is essential. "The hospital is one of two burns units in Sweden and it's a tertiary referral centre for complex plastic surgery. This will be highly relevant to my work when I return to take up a position as a consultant at Middlemore Hospital, the national referral centre for major burns and plastic surgery in New Zealand," says Dr Dominick.

In the meantime, the medication Dr Dominick's partner has received in Sweden has now been approved by Medsafe (but not funded) in New Zealand. "Although the cost of treatment will be expensive when we return, at least the option of effective treatment is now available," she says.

The other recipient of the BWT Ritchie scholarship is Dr Chris Badenhorst who is a provisional fellow (paediatric anaesthesia) at Wellington Regional Hospital. Dr Badenhorst has secured a highly competitive fellow position at to British Columbia Children's Hospital (BCCH) in Vancouver, Canada starting June this year.

As the father of three boisterous girls who arrived during his medical school years, Dr Badenhorst is no stranger to tight budgets and balancing work/life commitments but Vancouver was a tough proposition for the family of five. It is reportedly one of the most expensive cities to live in on the planet. But Dr Badenhorst, who is a strong advocate for quality child healthcare, believes it will be well worth it as he further develops his clinical and technical skills to be transferred back to a New Zealand setting.

The purpose of the BWT Ritchie scholarship is to relieve financial hardship encountered due to personal circumstances, or following a field of study that is not remunerated, that is, unpaid research positions or poorly paid clinical fellowships.

Above: Dr Chris Badenhorst; Dr Felicity Dominick (right) and Otto Strauss in Sweden.

New Zealand news (continued)

Te ORA Hui-ā-Tau – equity on the agenda

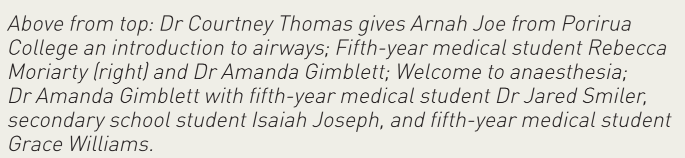
Two Māori ANZCA fellows represented the college at the Te Ohu Rata o Aotearoa – Māori Medical Practitioners Association's (Te ORA) Hui-ā-Tau and scientific conference held at Te Wānanga o Aotearoa ki Porirua, Wellington in late January.

During the career expo part of the Hui, fellows Dr Amanda Gimblett and Dr Courtney Thomas engaged with Māori secondary school students and medical students introducing them to anaesthesia. They also spoke as part of a session examining what colleges are doing in the health equity space.

The theme of the 2019 Hui-ā-Tau was "Hāpaitia te mana". "Hāpaitia" acknowledges Indigenous intelligence, and the inherent mana this brings to health in all dimensions, both nationally and internationally. Te ORA says "Hāpaitia" encourages leadership in attaining equity, demonstrating the skills Māori have. A sub-theme was nāu te rourou, nāku to rourou, ka ora te iwi – Māori health equity – what's the prognosis?

Dr Curtis Walker, the newly elected chair of the Medical Council of New Zealand who sits on the Te ORA Board, issued a challenge to all medical colleges. "We need culturally safe colleges producing culturally competent doctors who can deliver culturally safe care." he said. To that end, Te ORA has been working with the Medical Council of New Zealand looking at indigenous health and cultural competency in the standards and accreditation process.

Dr Jonathan Newchurch, a board member of the Australian Indigenous Doctors' Association (AIDA), also addressed the Hui giving a comprehensive picture of the association's history and aspirations.



Above from top: Dr Courtney Thomas gives Arnah Joe from Porirua College an introduction to airways; Fifth-year medical student Rebecca Moriarty (right) and Dr Amanda Gimblett; Welcome to anaesthesia; Dr Amanda Gimblett with fifth-year medical student Dr Jared Smiler, secondary school student Isaiah Joseph, and fifth-year medical student Grace Williams.

Get in quickly – NZ ASM 2019 Queenstown

There are limited places for the New Zealand Anaesthesia Annual Scientific Meeting (NZ ASM) being held in Queenstown from August 21-24 this year so get your skis on and register now!

Earlybird registration opened on March 20 for this hot ticket event which sees the NZ ASM joining with the Annual Queenstown Update in Anaesthesia (AQUA) to bring you an unmissable line-up of keynotes and social activities.

Top speakers include Professor Mary Dixon-Woods from Cambridge, a true champion of quality improvement, Professor Ed Mariano from Stanford, a world leader in regional anaesthesia, and Dr Andy Klein from Papworth, the editor-in-chief of *Anaesthesia*. Professor Alan Merry will present at the opening session to introduce the 2020 inaugural New Zealand Anaesthesia Education Committee (NZAEC) Alan Merry Oration.

That's just a taste of what's on offer at the 2019 NZ A ASM + AQUA in Queenstown. Book now at www.nzanaesthesia.com.

The 2019 NZ ASM is jointly hosted by the ANZCA New Zealand National Committee, the New Zealand Society of Anaesthetists (NZSA) and the Joint Anaesthesia Faculty Auckland (JAFA).

Above: Night skiing is one of the social events on offer at the NZ ASM in Queenstown in August.

Future thinking and welfare – front and centre for trainees

Visiting Professor Warren Sandberg, Chair of the Department of Anesthesiology at Vanderbilt University in Nashville, gave an outline of perioperative systems design when he spoke at the ANZCA-sponsored Annual Registrars' Meeting (ARM) in Auckland in December.

Professor Sandberg has a particular research focus on using medical information systems for process monitoring, decision support and process control.

He followed his talk by co-judging the nine trainee presentations. Dr Jee-Young Kim of North Shore Hospital in Auckland was the winner of the 2018 ANZCA Prize for Best Scientific Presentation. Her presentation was called "Gastric antral screening to determine residual internal contents (GASTRIC-1) study – ultrasound determination of gastric volume following water ingestion in healthy, starved volunteers".

ANZCA New Zealand National Committee Welfare officer, Dr Rob Fry, outlined the status of mental health and wellbeing in anaesthesia. As part of his talk he covered techniques for keeping well through times of stress, and outlined resources available for anaesthetists to help themselves and their colleagues.

ARM organiser, Dr Nicola Broadbent, got trainees to think past attaining fellowship. She spoke about spending time thinking through life priorities and how that might impact on where they might want to work as a specialist.

Above: Professor Warren Sandberg with ANZCA prize-winner, Dr Jee-Young Kim.

New Zealand news (continued)

QAC proves its worth

The Quality Assurance Coordinators (QAC) network for departments of anaesthesia around New Zealand was only launched in February two years ago but by its fifth meeting late last year, it had proved to be an invaluable forum for quality improvement.

Above: Dr Era Soukhin from Auckland City Hospital presents on CADENZAA.

Not only has it given confidence to those in the quality assurance roles in their departments to introduce and expand new systems for improvement for perioperative patients, it has initiated conversations which have encouraged a more in-depth look at what data is being recorded and to investigate if it is yielding the needed results, according to the chair Dr Rob Fry.

Across the day of the QAC meeting, members from Whangarei in the north to Dunedin in the south shared their experiences of surveys and audits. This included Dr Tim Starkie from Waikato who looked at results of perioperative normothermia audits from four different hospitals. He came out of the exercise with a challenge. "The ANZCA clinical audit guide may need reviewing if it is going to add to quality improvement." It is very difficult (if not impossible) to achieve meaningful, reliable and sustained quality improvement using labour intensive, paper driven audits with small sample sizes (30-50 patients were suggested in the guide) according to Dr Starkie. "We should move away from these and push for hospitals to provided electronic data capture systems that can continuously monitor and record patients' physiological variables, allowing us to analyse contemporaneously, the outcome of interest and how interventions might have affected it."

Dr Era Soukhin from Auckland City Hospital went through the results of the CAre DElivery in NZ for Acute Abdomen (CADENZAA) organisational survey. Dr Soukhin says the survey has resulted in the collection of valuable baseline data which will allow hospitals to be compared appropriately, depending on the resources available. "We hope that this can help drive policy changes for further investment in infrastructure based on regional inequities in resourcing," she says.

Australian news

South Australia and Northern Territory

Clockwise from top left: Dr Richard Harris presenting; Dr Sandy Hancock, Dr Richard Harris and Dr Tony Pearce; Dr Aileen Craig, Dr Christie Lang, Dr Christine Hildyard and Dr Anisha Kulkarni; the Adelaide-based fellows and registrars who attended the Thai cave rescue meeting.

Thai cave rescue – anaesthesia in the dark

South Australian fellows and registrars were very fortunate to have Dr Richard "Harry" Harris present "The Thai cave rescue – anaesthesia in the dark" at the November ANZCA/ASA continuing education meeting, held at the Sanctuary Adelaide Zoo on November 8, 2018.

Not surprisingly, the meeting drew the largest-ever attendance of fellows and registrars for an Adelaide CME event who were all eager to hear more details about the extraordinary international rescue of 12 young soccer players and their coach, from a remote cave in Thailand.

The room was spellbound as Harry, in his typical low-key fashion, shared details of the dangerous rescue mission and his pivotal role in the decision to swim the team out of the cave to safety, even though he was unsure the plan would succeed.

Harry and fellow expert Aussie cave diver, Dr Craig Challen have since earned themselves a Star of Courage Award (awarded for acts of conspicuous courage in circumstances of great peril), a Medal of the Order of Australia, and are the first-ever dual recipients of the Australian of the Year award.

South Australia and Northern Territory

Save the date! Biennial Anaesthesia CME Conference

Saturday June 1, 2019
Darwin Convention Centre, NT

For further information please email sa@anzca.edu.au or call +61 8 8239 2822.

Australian news (continued)

South Australia and Northern Territory (continued)

FPM Continuing Medical Education Meeting

Dr Danielle Ko, Palliative Care Consultant, Clinical Ethics Lead at Austin Health and member of the Victorian Voluntary Assisted Dying Review Board gave an informative presentation updating members of the changing landscape of end-of-life care which will be implemented in Victoria in June 2019. Palliative Care Specialists were invited to attend the event, which was held in the SA Regional Office on November 12, 2018.

Part Zero Course

The SA and NT regional office held the Part Zero Course for introductory trainees commencing the training program on Saturday January 19. The orientation course included presentations from eight fellows and included information about the training portfolio system, workplace based assessments, exams, mentorship and work/life balance.

Trainee dinner

The SA and NT annual trainee dinner was a great success with 37 delegates enjoying their evening at the Delicatessen Kitchen and Bar on November 3, 2018.

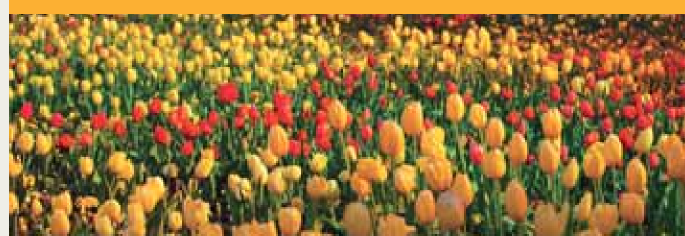
Guest presenter Dr Yasmin Endlich regaled the trainees about the formalities of classical medical training in Austria along with the development of the specialty in Central Europe. This was followed by an honest presentation of the (dearth of) equipment and need on our doorstep in Papua New Guinea as well as the opportunity for all doctors to make a large difference in medical care by volunteering to teach even basic skills.

Dr Endlich's gift was foregone, a donation to Lifebox, which made her inordinately happy.

Dr Munib Kiani, Chair SA and NT Trainee Committee

Clockwise from top left; CME meeting delegates Dr Matthew Green, Dr Tim Semple, Dr Michelle Harris and Dr Danielle Ko; SA/NT trainees attending the trainee dinner; Course attendees from left: Dr Andrew Chong, Dr Angela Matthew, Dr Henry Upton, Dr Joel Krause, Dr Hayley Adams, Dr Julia Rouse, Dr Daniel Ly, Dr Kevin Yu and Dr Ally Lu.

Australian Capital Territory

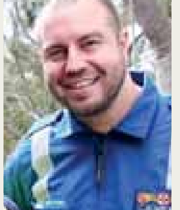


Art of Anaesthesia – save the date

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 will again be held at the modern National Museum of Australia and the convenors Dr Girish Palnitkar and Dr Carmel McInerney already have many wonderful ideas to make this year's Art of Anaesthesia meeting bigger and better than ever. Of particular note is confirmation of our international keynote speaker Professor Andrew Klein, Professor of Anesthesia at Royal Papworth Hospital and Editor-in-Chief of *Anaesthesia*.

Save the date now – October 5-6!

CME evening meetings



We are delighted to announce two CME evening meetings to be held in Canberra in 2019. Dr Geoff Healy, consultant anaesthetist at RNSH and retrieval physician from SydneyHEMS, will deliver our first event on June 21 with a presentation on the role of the anaesthetist in a trauma team. This event is open to ACT trainees and fellows and will be held in the John James Theatrette, Deakin. Our second CME evening will be delivered by Dr Richard Harris SC OAM. "Harry", who needs no introduction, will deliver his riveting presentation on the Thai cave rescue in Canberra on August 1. Registration for this event will open soon, check the ACT ANZCA website for more details.

ACT Trainee Committee

In 2019 we welcome a new trainee committee and look forward to working closely with them over the next year. The committee members are: Dr Daniel Foong, Dr Holly Manley, Dr Cameron Maxwell, Dr Stuart McKnown, Dr Sifi Vattakunnel, Dr Roy Bartram (co-opted) and Dr Ryan McCann (co-opted). We look forward to working closely with the committee during 2019.

Queensland

Courses

Queensland courses are well under way for 2019. The Part Zero Course for introductory and basic trainees was held on Saturday February 16, followed by the Final Exam Prep Course from February 18-22. Both courses were filled to capacity, and received great feedback. The Primary Lecture Program will run across five Saturdays from February through to June, with the first session being held on February 23. Once again we would like to offer our sincere thanks to all the convenors and presenters for their time and commitment to our academic activities. Please visit the ANZCA Queensland web pages for all other 2019 trainee course dates.

Trainee Committee

We welcome Queensland Trainee Committee members for 2019: Dr Anna Pietzsch, Dr Simon Porter, Dr Claire Maxwell (co-chair), Dr Georgina Cameron (co-chair), Dr Stephanie Cruice, Dr Larissa Cowley, Dr Kathryn Meldon, Dr Romitha Ranasinghe, Dr Hannah Bellwood, Dr Sofia Padhy, Dr Zach Tappenden. We look forward to working with the committee during 2019.

Save the date – ACE Regional Meeting

In 2019 the Queensland ACE Regional Meeting will be held over the weekend of August 31 – September 1 at the vibrant QT Gold Coast. The theme this year is "Anaesthesia through the looking glass". The organising committee is finalising the program and further details will be available shortly. Please keep an eye on the ANZCA website for the latest updates. We look forward to seeing you there.

Above: Queensland Part Zero Course convenors Dr Kathryn Meldon, Dr Hannah Bellwood and Dr Stephanie Cruice delivering their talk to introductory trainees.

Australian news (continued)

Victoria

Final fulltime course

This five-day course was held in the auditorium at ANZCA House from February 11-15. We had 57 trainees attend this sitting, the majority from Victoria but some joining from interstate and New Zealand. There were 22 lectures given is this intensive one-week program which covered many of the core curriculum topics that are potentially included in the final exam. It is specifically designed to assist and prepare candidates in their preparation for both the written and oral examinations. The trainees were also given some updates from ANZCA library and exam staff members during the program. To the convenor, Dr Glenn Downey, and all of the valued presenters of the course, we would like to give our sincere thanks for their time and commitment to our academic activities.

The final fulltime course for the second sitting will be held from June 17-21.

Final anatomy course

Following on from the final fulltime course, the anatomy course was also held at the college the following Monday, February 18. There were four anatomy-based lectures in lower and upper limb, anatomy of the spine and its attachment, head and neck, and anatomy of the heart and lungs. Our many thanks to each of the presenters for their time, commitment and the valuable experience they bring to each of the attending trainees within this course.

The next final anatomy course will be held on Monday June 24, 2019.

For further information on our trainee courses contact Anne Gordon via viccourses@anzca.edu.au or +61 3 8517 5350.

Part Zero Course

The Victorian Part Zero Course was held at ANZCA House on Friday February 22. The one-day course was our largest to date and attended by a healthy balance of new Victorian introductory trainees and resident medical officers aspiring to be trainees and anaesthetists. The trainees were welcomed by the VRC Chair, Dr David Bramley, along with co-convenors and trainees Dr Andrew Goldberg and Dr Adam Sutton. The presentations covered welfare of anaesthetists, an introduction to TPS/WBAs, curriculum, updates on college resources, Victorian Trainee Committee, ASA, and survival guides – hearing stories from other trainees. A significant part of the course was run by trainees for trainees. There was also an interactive question and answer sessions with supervisors of training and the day finished with group airway sessions aimed at teamwork and team learning. The highlight for the day is the opportunity for trainees to network and forge friendships.

Many thanks to all the valued presenters, SOTs and workshop facilitators for their contributions, and also thank you for the support of the convenor, Dr Lucky De Silva, and co-convenors Dr Andrew Goldberg and Dr Adam Sutton for their help to bring this meeting together.

New South Wales

ACE regional meeting

We held the NSW ACE regional meeting in November last year in the idyllic setting of Byron Bay.

The meeting was attended by more than 100 delegates and speakers. The location and meeting certainly did not disappoint! From inspirational lectures to some of the most advanced workshops we have held, the delegates were exposed to outstanding and passionate speakers.

We thank Dr Sharon Tivey and Dr Sally Wharton for convening, as well everyone who attended, for making this such a wonderful weekend and we look forward to welcoming you at the next regional meeting this year in Bowral.

Above clockwise from left: Dr Genevieve Goulding and Professor Keith Greenland; More than 100 delegates attended the meeting; Dr Jo Cowan facilitating the CICO workshop.

NSW Part II Refresher Course

The NSW Regional Committee conducted a very successful Part II Refresher Course in anaesthesia at Northside Conference Centre from December 10-14.

The exam-focused course included presentations and discussions on core topics, as well as preparation for the different components of the final examination. Speakers included many current and past examiners, as well as trainees who provided advice and spoke of their recent examination experience.

A highlight of the course was the anatomical workshop held at the Department of Anatomy and Histology, University of Sydney, conducted by seven lecturers in a hands-on workshop.

A special thanks to all the speakers who devoted a huge amount of time and effort in assisting the candidates to prepare for their final examination, and especially to Dr Sally Wharton.

From top: Lecturers from the anatomy workshop from left: Dr Jane Standen, Dr Mike Ross, Dr Luke Bromilow, Dr Mariko Hylands, Dr Roma Steele, and Dr Matthew Ho; Dr Ben Dal Cortivo (participant), Dr Sally Wharton (course convenor), Dr Nishan Yogendran (participant), and Dr Tiffany Fulde (participant).

New South Wales (continued)

NSW Primary Refresher Course

The NSW Regional Committee conducted a very successful NSW Primary Refresher course at Northside Conference Centre from December 3-7. There were 50 participants on the course, with 72 per cent from NSW.

The course was designed to help prepare candidates sitting the primary exam in March. 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 practice SAQs. Friday was entirely viva-focused using small groups of six.

There were 14 tutors from nine 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.

"Anatomy for Anaesthetists" workshop

The anatomy course in November was well received with 37 delegates attending. Many thanks again to Elizabeth O'Hare, Jo McGuiness, Kevin Russel, Paul Bertolino, Rob Crocket, Gurdial Singh, Luke Bromilow, Andrew Amstrong and Su Ann Wan who dedicate their valuable time in creating such an excellent and educational workshop.

Western Australia

News from Western Australia

The Autumn Scientific Meeting will be held on March 23, 2019 at the University Club at The University of Western Australia. The key speaker is Dr Lachlan Miles who is a Staff Specialist in Anaesthesia at Austin Health, an Honorary Consultant at Peter MacCallum Cancer Centre and an Honorary Fellow of the Centre for Integrated Critical Care at the University of Melbourne. Dr Miles will present on "Updates in Perioperative Medicine". The scientific meeting is also offering all four emergency workshops including CICO, ALS, major haemorrhage, anaphylaxis as well as an obstetric advanced life saving workshop. There will be three separate panel discussions which will invite opinions from the audience on topics including substance abuse, regional anaesthesia and paediatrics. Registration is available via the ANZCA calendar.

The Country Conference will be held at the Cable Beach Resort in Broome from June 14-16, 2019, and convened by Dr Thy Do from the Royal Perth Hospital. The keynote speaker is Professor Philip Peyton from Melbourne, and local speakers include Professor Eric Visser and Professor Richard Riley. The program and registration will be available in March.

The airway cadaver workshop of WA (ACWA) will be held on September 14, 2019 at the CTEC Skills Lab at the University of Western Australia. This is a comprehensive half-day airway workshop utilising fresh frozen cadavers, many of which have been modified to recreate various difficult airway scenarios such as airway swellings and bleeding tonsils. Registration for this workshop is available via the ANZCA Calendar.

The Part Zero Course is run yearly in all regions and New Zealand to welcome new trainees into the ANZCA training program. The course is a face-to-face, full day event aimed at providing introductory trainees with information that is relevant to them and their training. It is also a fantastic opportunity to meet other trainees in the training program and build friendships and connections.

This year WA invited 22 new trainees to the Part Zero Course and we once again welcomed guest speakers including trainees, supervisors of training, consultants and executive officers to discuss professionalism and performance, ANZCA resources, the Training Portfolio System, welfare, mentoring and training. ANZCA would like to thank the following speakers for their contributions throughout the day: Dr Angela Palumbo, Dr Joseph Ong, Dr Steve Myles, Dr Xiao Liang, Dr Brendon Dunlop, Dr Aria Lokon, Dr Ryan Juniper, Dr Archana Shrivathsa, Dr Marion Funke, Dr Natalie Akl and Dr Maya Cavert. We would like to offer our sincerest thanks to Dr Jay Bruce for her time and efforts in facilitating the Part Zero Course, the extensive mix of experience she provided, has given the trainees with a greater understanding of role expectations and what the trainee positions will involve.

Tasmania

Foundation Day and Part Zero Course

A busy start to the year began with a Foundation Day on February 15 which was followed the next day by a Part Zero Course. These courses were both held in Hobart and convened by Dr Joey Walsh with the support of an organised and dedicated group of fellows.

Ten registrars attended the Foundation Day, facilitated as part of the TATP program, which is coordinated by each of the public hospitals. This day is designed and created to increase ANZCA trainees' knowledge in areas needed for their training, have the opportunity to get to know each other as well as senior staff in a friendly, relaxed and positive learning environment. The day was divided into four workshops including advanced life support, airway emergencies, preoperative assessment and obstetrics.

The Part Zero Course followed the Foundation Day with 12 participants and included SRMOs with an interest in anaesthesia. The course was held at the historic Hadley's Orient Hotel and was also well supported.

Feedback on the courses was very positive. The convenor, Dr Joey Walsh was pleased how the days went and is grateful for the teaching and presentation support she received: "It's important that the trainees have a positive start to their training and these courses provide vital essential information and an opportunity to socialise and get to know each other as well as senior staff."

Above from top: Dr Malcolm Anderson leading an ALS workshop at the Foundation Day; Part Zero Course held at the historic Hadley's Orient Hotel.

Save the date for an upcoming invigorating meeting

"Ageing" is often seen as a negative concept but it's a subject that needs to be examined both at a professional work level with an ageing workforce as well as from the perspective of an ageing population and what that means for anaesthetists. The Tasmanian winter meeting will be held at Josef Chromy on Saturday August 24 2019 and this theme and the issues around it will be explored by an array of interstate as well as local expert speakers. Subjects include geriatric patient management, shared decision making (to avoid decisional regret and prevent non-beneficial surgery), and frailty in anaesthesia and ICU. There will also be an opportunity to gain important CPD points as there will be an ALS breakfast workshop and for the first time at a winter meeting, a point-of-care TTE workshop.

Being held at one of the top wineries in Tasmania (not far from Launceston), ageing is also pertinent to wine. Listed as one of the Top 10 Cellar Doors of Australia, the venue is the stunning Josef Chromy Winery. This vineyard is famous for producing award-winning wines, which are matched with superb cuisine prepared from fresh locally-sourced produce where you can enjoy also exquisite views of the picturesque lake and hillside vineyard. We expect you will come away updated and invigorated.

Save the date in your calendar. Online registrations are expected to open in May and a strong demand is anticipated.

Annual Trainee Day and Tasmania's inaugural CPD in a day

The trainee day held on Friday March 1, 2019 was attended by 21 registrars who enjoyed a broad range of topics presented by excellent local and interstate speakers.

Topics included workforce issues in anaesthesia; anaesthesia for bariatric surgery; opioids through the ages; anaesthesia, emergence and then dying; scholar role requirements of the ANZCA training program; the role of the college in promoting equity; professional citizenship; perioperative medicine; and diabetes management in elective and emergency surgery. The "how did I get to here" career panel provided an informal yet informative opportunity to discuss career paths and work/life balance with a diverse group of anaesthetists from many regional centres. A great finish to a dynamic and thought-provoking day.

The co-convenors of the trainee day, Dr Hamish Bradley and Dr Alistair Park were pleased with how the day went and grateful for the quality of the presentations and honoured that the president of ANZCA and acting president of the ASA attended.

The CPD in a day workshop was held the following day on Saturday March 2, 2019. The day included all emergency response workshops and was developed to provide opportunities for delegates to gain all of their emergency response CPD points.

The Tasmanian annual scientific meeting has been postponed to 2020 due to Tasmanian fellows being involved in organising the Kuala Lumpur meeting, but it was considered important to still run workshops.

Being the first meeting of its kind in Tasmania, the day was a big success and all positions on the workshops were fully subscribed with 104 delegates attending. Altogether each 90 minute workshop (ALS, CICO, Anaphylaxis and Major Haemorrhage) was held three times throughout the day – a massive effort by the instructors. It was again held at the University of Tasmania Medical Science Precinct which provides a modern, open facility – perfect for holding scientific meetings and workshops.

The convenor of the meeting, Dr Mike Challis, thanked the trade and faculty for supporting the day and stressed that without their involvement days like the CPD day couldn't happen.

A relaxed "drinks and canapés" function on the waterfront gave attendees time to socialise, unwind and enjoy the views and local produce on offer after a productive day.

Above from left: The panel session at the Tasmanian trainee day from left: Dr David Alcock, Dr Colin Chilvers, Dr Rodney Mitchel (ANZCA President), Associate Professor Deborah Wilson, Dr Suzi Nou (ASA Acting President), with the two MCs standing – Dr Hamish Bradley and Dr Alistair Park; CICO workshop at the CPD day; Associate Professor Deborah Wilson presenting at the Tasmanian Trainee day.

Obituary

Dr Ian Hamilton McDonald, FANZCA 1923-2019

Ian McDonald, pioneering paediatric anaesthetist and international cricketer, died on February 5, 2019, aged 95. Known as "Skeet" to his colleagues and "Doc" to his cricketing friends, he made a lasting impression on all those who knew him, through his kind nature, big smile and friendly advice.

Born in Melbourne, Ian was educated at Scotch College, where he showed great interest in mathematics, physics and Australian history, while engaging in scouting and cricket. When awarded a scholarship to enter Melbourne University in 1941, he chose to study medicine in the compressed wartime medical course. He graduated in 1946 with honours in surgery, obstetrics and gynaecology, and gained blues in cricket and hockey.

He spent a year as Resident Medical Officer at the Royal Melbourne Hospital, and later, in 1947 moved to The Children's Hospital in Carlton, later to become the Royal Children's Hospital (RCH). Thus began a career-long association with the Children's Hospital, at the same time as he developed a lifelong association with the Melbourne Cricket Club.

Having decided on a career in anaesthesia, Ian stayed at the Children's Hospital until 1953, becoming the first anaesthetic registrar there, then gaining his Diploma of Anaesthetics and becoming assistant to Margaret McClelland, the Senior Visiting Anaesthetist, later the first Director of Anaesthesia.

All the while, Ian was also pursuing his passion for cricket. From 1946 to 1953, he was the wicket keeper for the MCC first XI, as well as for the Victorian XI when colleagues could cover his hospital duties.

He met his other life passion, Dorothy Hogg, a theatre nurse at the hospital, in 1949. He remained devoted to "Dotty" through 64 years of marriage, until she passed away in 2014.

In 1953, Ian played for Australia against South Africa at the SCG, before heading to Oxford on a Nuffield Fellowship. He spent two years at the Radcliffe Infirmary under Sir Robert Macintosh, and spent time with Gordon Jackson-Rees in Liverpool. He and Dorothy and their baby daughter spent any spare time travelling and met up with many other RCH expatriates while in the UK.

Ian returned to Melbourne in 1955, and having been awarded the fellowship of the Faculty of Anaesthetists of the RACS, he established his practice in paediatric anaesthesia. He was a Senior Visiting Anaesthetist at the Royal Children's Hospital until retirement in 1988. At the same time, Ian had a busy private practice with colleague paediatric surgeons from the Children's Hospital, maintaining a small adult practice as well.

Ian was regularly consulted on difficult cases at Melbourne's private hospitals, and long before any neonatal transport service, he was known to transport intubated high-risk babies to the Children's Hospital by private car!

Ian was intimately involved in the development of prolonged nasotracheal intubation for infants and children with severe breathing difficulties. Following earlier work by Bernard Brandstater in Beirut, and Tom Allen and Ian Steven in Adelaide, he and John Stocks undertook a trial of 50 neonates and children, who remained intubated for between one and 14 days. The results, published in the *British Journal of Anaesthesia*[1] in 1965 heralded a revolution in the management of airway obstruction in children, previously condemned to tracheostomy.

Ian served as the Victorian State Chairman of the Faculty of Anaesthetists, was a keen teacher of trainees, and continued to give wise counsel to many colleagues. He retired from all anaesthesia practice in 1991.

Ian never relinquished his love of cricket, and was a member of the Melbourne Cricket Club for 79 years, serving on the committee from 1958 to 1968. In 1956, he founded the MCC XXIX Club (the 29ers), devoted to friendly cricket in Victoria, and now around the world. In 1959-60, he toured Pakistan and India with Richie Benaud's Australian XI, as the Medical Officer. He took to the field when there weren't 11 healthy men available!

Ian helped establish the Hockey Section of the MCC and played competitively for many years. He chaired the section from 1961-1969.

The MCC honoured Ian with its two most prestigious awards, The Ebeling Award in 1986, and Honorary Life Membership in 2000. He continued service with the MCC as a guide. Introduced to golf in 1990, by his dear friend and surgical colleague, Durham Smith, Ian continued playing twice a week until just before his death. He became a keen member of Kew Golf Club, helping secure the Over 80s Stewart Cup in 2004 and 2014, and managed a "hole in one" in 2008.

Ian was a keen skier and adventurer. He and Dorothy took numerous treks and tours, to such places as the Himalayas, Kashmir, South America, and the Trans Siberian Railway. They also covered most of outback Australia by 4WD.

Ian is remembered fondly by all of his many colleagues. Ken Sleeman recalls with pleasure the honour of awarding him his 50 year ASA membership while Chairman of the Victorian Section in the early 1990s.

Ken also remembers working in an adjacent theatre to Ian in the 70s and early 80s at the Mercy Private where he conducted "his small adult practice" with Richard Newing, a plastic surgeon from St Vincent's. Dorothy ("Dottie") was by his side as anaesthetic nurse and his ruminations at morning tea required compulsory attendance for Ken.

Rod Westhorpe remembers his firm but gentle advice regarding public speaking early in his career. In subsequent years of presentations both here and overseas, his wise advice has never been forgotten.

Ian attended the annual XXIX (29ers) Grand Final week dinners every year conducting their "anthem" set to the tune of "There is a tavern in the town". At last year's dinner he made a special presentation of a cap he had from when he played in the UK, on which the XXIX Club based its cap. He did say he wanted to present it in case that dinner was his last...

Ian is survived by his and Dorothy's three children and their families.

Dr Rod Westhorpe, FANZCA
Dr Ken Sleeman, FANZCA

Reference:
1. McDonald IH and Stocks JG. Prolonged Nasotracheal Intubation, A Review of its Development in a Paediatric Hospital. BJA 1965, 37:161

Obituary

Dr William Thomas Raeburn Ward, FANZCA 1937-2018

Died on July 23, 2018 aged 80, from septicaemia.

Bill was the first specialist anaesthetist to be appointed to Southland Hospital in 1971. Over the next 40 years he worked tirelessly to establish a consultant-based service with ANZCA recognition for registrar training.

In the 1980s intensive care was an integral part of anaesthesia and Bill, almost single-handedly, created a modern six-bed intensive care unit.

His work ethic could not be faulted. Several times during his career, he put family and his many other interests to the side in order to keep the anaesthesia service going. This was particularly so one year when Bill and a colleague were forced to do the work of five to six specialist anaesthetists. Whenever there was extra work to be done, Bill was the first to volunteer which inspired his colleagues both junior and senior to follow his example whatever the inconvenience.

During his career Bill went from seeing chloroform used the same way as it had been in the 1850s, to the accomplished use of ethyl chloride and ether. He actively participated in the evolution of anaesthesia to today's practices of regional anaesthesia, sophisticated monitoring and total intravenous anaesthesia.

Despite several life threatening illnesses and injuries Bill continued to work till he was 67.

In his limited spare time he farmed sheep on his lifestyle block and supported his wife Brenda with her horse riding. This even involved borrowing a small bulldozer and building a full-sized dressage arena.

The other interests which blossomed again after his retirement included flying, mainly in a glider. Once the broken bones had mended after a bad crash he bought a microlight and continued flying for the rest of his life.

He was a dedicated musician, with great tenacity, playing the piano, tin whistle, recorder and bagpipes. As a child, while the rest of the family would come and go, Bill would be focussed, practising relentlessly. Once retired, he played in the Clann nan Gael pipe band also enjoying sequence dancing, chamber music concerts, film society and the University of the Third Age.

Born on December 28, 1937, Bill was brought upon a dairy farm near Waimate. After school in Waimate and Timaru he worked on his father's farm and as a farm hand at Matamata and Tokaroa. Back in Timaru he took a job as a truck driver and learned fitting and turning in night classes.

His brother Ian remembers Bill as the "serious one"; "big words Bill" was the nickname in the family. He bought a bicycle, a new Raleigh. It had three gears, a stand and a dynamo with lights front and back; nothing unnecessary. Like Bill it was solid and dependable. He needed it, he paid for it and it lived in his bedroom.

Eventually the night classes progressed to University Entrance and Otago Medical School. Under the terms of his health department bursary, he was committed to three years' service on graduation. After a year as a house surgeon in Timaru, he was sent to Southland Hospital and then to Tokanui as a general practitioner.

In 1968 he started his anaesthetic training in Dunedin and after two years moved to Australia for posts at the Royal Women's Hospital, Royal Children's Hospital and The Alfred hospital. He then returned to Invercargill as a specialist where he was the department of anaesthesia for many years. As the department expanded, he strongly supported his colleagues in their roles in the hospital, the college and the New Zealand Society of Anaesthetists.

His understanding of physics and electronics was both outstanding and invaluable, as comprehensive monitoring slowly evolved. Even after retirement he had a thirst for knowledge being a keen subscriber to *New Scientist*, always wanting to learn something new.

He was a very special partner and colleague with a character beyond reproach.

Bill was predeceased by his wife Brenda in 2004 and leaves two sons, two grandchildren and his partner, Else.

Dr Joe Sherriff FANZCA, MBChB ,FRCA
with assistance from Bill's family.

Dr Frederik Jacobus Steyn, FANZCA 1947-2019

Frederik Jacobus Steyn was born on May 24 1947 to Johanna and Frederik Jacobus Steyn at Stellenbosch, South Africa. He was the eldest of two boys. His childhood and schoolyears were spent on an American Airforce Base. In 1966 he started his medical training in Pretoria University. In 1974 he enrolled in Anaesthesia and Intensive Care Medicine in Kalafong Hospital Pretoria, qualifying with honours. From 1978 to 1980 he trained in Intensive care Medicine in Bloemfontein. He went on to join the very competitive world of private practice in Johannesburg. He married Analida and went on to have four children.

His love for the land saw him investing in a large holding which he started developing into a productive orchard and cattle farm. He declared quite vehemently that he never butchered any of his animals, they were too much like friends! He had grand plans of developing his property into a game farm, all the while he continued to work as a very successful and busy anaesthesiologist!

South Africa was changing, many were leaving the country. Derik kept putting off this difficult decision, hoping that all would soon be well with his country. Perhaps his greatest regret was that he gave in to pressure from his family and left his beloved country, selling his farm to a neighboring farmer at cost price, well before his dream game farm could be realised.

In 1993 Derik immigrated with his young family to New Plymouth, New Zealand. He joined the department of Anaesthesia and Intensive Care Medicine in Taranaki Base Hospital. His experience in intensive care medicine did not go unnoticed, he was asked to help set up the new ICU, which he did. It was then that the realisation hit him that he would never go back to South Africa again. He made the decision to qualify as a FANZCA, moving to Brisbane Australia in 2002. At the age of 55, Derik went back to becoming a registrar at the Mater and PA Hospital, the age at which many anaesthetists start thinking of stopping on call duties!

In 2004 he joined the QEII Jubilee Hospital, Brisbane as a staff specialist in the department of Anaesthesia and Acute Pain Management. He soon went on to become the Supervisor of Training.

He was dedicated to his profession, his colleagues and patients. He was a mentor to many. He was happiest standing by, keeping a watchful eye on his trainees, encouraging them to learn the tricks of the trade by doing it themselves. He had a wealth of wisdom from his years of experience, to pass on to trainees and younger colleagues alike.

Derik was a thorough gentleman. While none remember him ever raising his voice or ever being rude, many remember him drawing himself up to his full height to stand up to a particularly intimidating and difficult surgeon on a matter of principle, not one to back off!

Derik was very particular about keeping his work environment clean and tidy, his meticulously tidy Morgan trolley would put many an anaesthetist to shame.

During these years his wife, Analie was diagnosed with dementia. It was his strong faith in God that helped him continue to be her carer and keep working. Analie passed away in 2008.

A few months after this, one morning Derik walked into the department and announced, "I am tired of being sad, I have decided to be happy from now on"! His happiness was to come in the form of a lovely lady named Jenny whom he married in 2012. They shared much love and joy, travelling extensively all over the world.

About eight months after his treatment began, the prognosis became grave, Derik faced it full on with great dignity, refusing any further futile treatment, accepting the inevitable, his strong faith in Jesus once again stood by him. He smilingly told us of the diagnosis, he was in a "happy place", his face glowed and he told us the story of his life, remembering all his mentors by their names, from over 40 years ago!

Shortly after that, on January 14 he left us to join his Heavenly Father, leaving behind his wife Jenny and her two children, his four children and two grandchildren.

Derik lived a full and rich life. His funeral was attended not just by anaesthetists but also by surgeons, nurses, orderlies and administrative staff.

What a top bloke you were Derik, the department will forever miss you!

Dr Madhuri Kishore, FANZCA,
Senior Staff Specialist, QEII Jubilee Hospital, Brisbane, Queensland

Dr David Carne, FANZCA 1946-2018

Dave was born in Newcastle in 1946 and grew up in New York and Melbourne before going to university in Western Australia, finishing his medical degree in 1969. He worked at the Royal Perth Hospital until 1972 when he moved to Tasmania with his wife Donna. In Tasmanian fashion, Dave was granted an expeditious interview with the Medical Superintendent at the Royal Hobart Hospital as Donna had previously babysat the superintendent's children! Once at the interview, Dave impressed the superintendent and was given a job as an accredited trainee despite only having had a few months of anaesthesia under his belt.

Once finishing training Dave was appointed as a consultant at the Royal Hobart Hospital in 1976, and soon after was made Acting Director.

Later, in July 1976 he joined the Hobart Anaesthetic Group in private practice, and was a VMO at the Royal Hobart Hospital for the next 20 years. He continued giving anaesthetics in the private sector for the Hobart Anaesthetic Group for the next 41 years until he retired in November 2017.

Dave was very efficient in the theatre. He was the first to theatre (often before nursing staff) and would pace up and down the corridor in his overalls with his moustache bristling as he waited for his patient. The surgeons knew they were to be there and ready to start on time, and not disappear between cases. His efficiency was also seen in meetings he chaired. For more than 19 years he was the chair of the St Helens/Hobart Private Anaesthetic Sub-Committee and on the MAC. Any of these meetings, and practice meetings, that he chaired, were run well and on time.

His overall case load was remarkable. He worked 5-6 days per week, and for 16 years worked every second Sunday, planning his holidays around these lists, unable to take more than 14 days off at a time. Dave kept records of all the anaesthetics he had given and incredibly at the time of retirement had performed more than 10,000 anaesthetics in the public sector and 60,000 in the private sector. Dave was therefore a very skilled and experienced anaesthetist and in recent years I found CPD peer-review with him most interesting and enlightening.

The earlier years of his private practice, with fewer practice members, meant considerable on-call commitment, so in more recent times with a growth in practice members Dave would articulate his displeasure with younger practice members if there was any hesitancy voiced about on-call, by reminding us that for "years and years" he had done every Friday night on-call, and it was now our turn.

His work ethic also carried over to fitness – he would go to the gym daily, bike regularly and in fact on one day a week before he died, despite his illness, he had two swims and completed 18,000 steps.

Dave was very keen on his tech and for many years was an enthusiastic member of the Mac users' group in Hobart. He would complain that his children would take his machines, however he felt this gave him an excuse to buy a newer, better one. Retirement gave Dave more time to indulge in a newer passion – his drone, which he enjoyed immensely. He would assiduously keep up with the newest tech and bought the latest iPhone only a few weeks before he died.

Dave had, at times, an aura of grumpiness that may have stemmed from the fact that anything Dave thought was inefficient or wasteful of time or money annoyed him, and he would let you know about it. Although there was the time he fell over and had a subdural haematoma and kept working for two weeks without anybody noticing any change in his irritable behaviour!

He was, however, a kind and caring man, and was concerned about others' difficulties, even when his own troubles were overwhelming. Dave did have a larrikin streak, throwing nurses into scrub sinks and playing practical jokes, such as the time he put betadine in a surgeon's cup of tea, but this backfired on Dave as the surgeon feigned anaphylaxis to betadine, frothing at the mouth and pretending to choke!

Dave's parents were long lived – his father died at the age of 100 and his mother is alive and well at 97 – with Dave's work practices corresponding to this, so it was quite unexpected when he was diagnosed with prostate cancer at the age of 60. Dave continued to work until he was told it was time to start caring for himself rather than his patients. He spent his retirement well, catching up with old friends, and with visits to and from his children and grandchildren.

Dave had the three "As" of private medicine (availability, affability and ability) and was a consummate professional, but more importantly he was a kind, caring, gentle and generous man who adored his wife Donna, his five children Matt, Imogen, Jeremy, Alistair and Caitlin, and his grandchildren, and was loved in return.

Dr Cameron Gourlay, FANZCA, FFPMANZCA
Tasmania

Dr Arun Mukhopadhyay, FANZCA 1939-2018

The senior medical staff at Wairau Hospital were saddened to hear of the passing of our colleague and friend. Dr Arun Mukhopadhyay died in Blenheim on June 10, 2018 aged 79.

Those of us who worked at Wairau Hospital (in Blenheim) in the early 90s remember with affection a true gentleman. Arun was always the consummate professional. Wairau Operating Theatre lost someone special when he retired as one of the senior anaesthetists.

He was, we are sure, proud to leave the department of anaesthetists in a such a good state of professional health. The department has now grown to a complement of six.

Arun will always be regarded as one of the "founding fathers" of the modern Wairau Hospital.

The staff offers our condolences to the Chandrima and the Mukhopadhyay family.

Mr Rick Wilson, MB. ChB, FRACS
Wairau Hospital Orthopaedic Consultant