Focus on Indigenous health

Dr Richard Harris: Insight into the Thailand cave rescue
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Submitting letters and other material
We encourage the submission of letters, news and feature stories. Please contact ANZCA Bulletin Editor, Clea Hincks at chincks@anzca.edu.au if you would like to contribute. Letters should be no more than 300 words and must contain your full name, address and a daytime telephone number. They may be edited for clarity and length.

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ANZCA 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 7400 fellows and 1000 trainees mainly in Australia and New Zealand. It serves the community by upholding the highest standards of patient safety.

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

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ANZCA is a member of the World Health Organization’s (WHO) World Federation of Societies of Anaesthesiologists (WFSA) and the International Anesthesia Research Society (IARS) and is a founding member of the Pan Pacific Anaesthesiology Alliance (PPAA). It is also a member of the ANZCA Foundation, which was formed to promote, encourage and develop anaesthesiology in Australia and New Zealand.

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

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

I have had the privilege of recently attending the Annual Medical Symposium of Papua New Guinea along with Dr John Ilott, the President of the Royal Australian College of Surgeons (RACS). I presented some of our experiences in grappling with the challenges of delivering anaesthesia and pain medicine to far flung rural and remote communities, and shared some of the lessons we have learnt in relation to post-graduate training since we transitioned to our new curriculum in 2013. PNG is our nearest neighbour, with a population of over eight million, which is expected to double by 2030-2035. The recent statements by the World Bank, the World Health Assembly and the Lancet Commission on Global Surgery have underscored the importance of providing universal access to safe and affordable surgery and anaesthesia. The fact that more deaths in PNG are attributed to lack of access to surgery than to HIV (2-3 per cent of the population), tuberculosis and malaria combined will be a surprise to many of us, and highlights the importance of the contribution our college can offer.

The Overseas Aid Committee has been working towards progressing an adequately trained and supported workforce, the availability of appropriate equipment, and the establishment of appropriate standards of professional practice. With only 15 specialist anaesthetists, and 18 trainees for a population of eight million (Australia and New Zealand have well over 6000 specialists for a combined population of 29 million), I am now, somewhat literally, on first-name basis with over half of PNG’s specialist anaesthetists. There is obviously much work to be done, but I have developed a very real respect for the achievements of our colleagues in PNG, and I look forward to working together in partnership with them as collectively we strive for improved equity of access to safe anaesthesia. The close and effective collaboration of our college with our societies in these endeavours is also clearly evident, and another exemplar of how well we can all work together towards a common goal.

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

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

Dr Rod Mitchell
ANZCA President

Abors: Dr Kylea Musgrave leading a tutorial with anaesthetic service officers in PNG.

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

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

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

Doctors’ health

The Australian Medical Association (AMA) has announced that the Doctors Health Services Pty Ltd (DrHS) which is a subsidiary company of the AMA, is working on a proposal for a national telehealth service. DrHS has been awarded $A1 million in Commonwealth funding to develop the service. The DrHS intention is to focus the new service on mental health and to complement existing local services, it is easily accessible and provides strong protection for the privacy of doctors and medical students who use the service. DrHS is also developing a national package for training doctors to treat other doctors, using funds secured from the Medical Board of Australia. The training program will be underpinned by a national curriculum in doctors’ health written by the Australasian Doctors’ Health Network (www.adhn.org.au) which is the umbrella organisation for the doctors’ health advisory services in Australia and New Zealand.

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

Dr Rod Mitchell
ANZCA President

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

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

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

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

This month will see the launch of the Real-time prescription monitoring (RTPM) in Australia.

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

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

• Health ministers have agreed to progress national real-time prescription monitoring as a federated model, with all jurisdictions committed to achieving a national solution.

• The RTPM system will be designed with the ability to prevent cross-border drug shopping abuses.

• Regulators, doctors and pharmacists will be able to interface directly with the RTPM system, enabling the real-time receipt of relevant clinical information such as patient history.

• The Commonwealth is working with jurisdictions on the development and adaptation of jurisdiction-specific regulatory systems to provide a strong technological interface and which will achieve a national RTPM solution.

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

Dr Rod Mitchell
Chief Executive Officer, ANZCA
The relevance of the first item was that Full support for statement. Process not followed.

MARCH

What's in a name?

Some background we should align ourselves with the majority and call "During consideration by the August Anaesthesiology on the use of slow-release opioid preparations in the treatment of acute pain, the document did not follow the process of development proscribed in specialty in Australia and increasingly debated and suggested that it should be undertaken in an open forum. He noted that only the UK, Australia, New Zealand, and the USA are the "anesthesia" in the USA. In Australia and New Zealand this term is still in use. What is an "anesthesiologist"? In Australia and New Zealand this term is still in use. A specific request from Dr John Crowhurst through correspondence to the Australian Society of Anaesthetists' (ASA's) guidelines when there is a need. The process for the development of such professional documents is clearly outlined in the process. The development of this Position Statement did not follow this process. The developers argue that the process is not required as the document simply reflects a "point-of-view", however, the title and formatting imply that the document is actually a Statement of the Position held by ANZCA and the FPM. Of particular concern are AIs 2.8 and 2.11. 1.2. Item 2.8 requires a background paper to be provided 1.2. Item 2.11 requires consultation with relevant groups and committees within ANZCA and the FPM.

There should be a background paper detailing the process of decision-making and the evidence considered. The New Zealand National Committees of FPM and ANZCA were unaware of the statement before its publication. Other interested parties may also have been excluded from the development process. The FPM will not consider making similar recommendations in the future, or make a recommendation to change the name of our specialty. Recommendations made by the college need to be developed using robust processes. The ANZCA and the FPM need to produce high quality, scientifically robust policies and guidelines. The position statement does not provide adequate scientific evidence for its recommendations and therefore, I am concerned about the potential impact of this statement on the public. There is also a need to consider the impact of such changes on the specialty of anesthesiology and pain management in Australia and New Zealand.

Exclusion of one of the partnership countries means that the document cannot accurately reflect the position of ANZCA or the FPM. We welcome a wider debate on this important issue, but Recommendations made by the college need to be developed using robust processes.

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

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

Professor Pam Macintyre NSW FANZCA FFPMANZCA Central North Sydney Hospital

Full support for statement

I write in response to Dr Tim Skinner’s letter published in the Bulletin in June, including the complete text accessible via the link. Acute Pain Management: Scientific Evidence (APMSE) summarises the evidence available for different aspects of acute pain medicine. Mention of that evidence in the text does not indicate support for the use of a specific technique/drug. For example, in APMSE (2003), section 5.1.2 says “Intra-articular bupivacaine...more effective than morphine” in some patients. This does not support the use of intra-articular bupivacaine — see section 5.8.2 and chondrotoxicity risks.

Similarly, mention of slow release (SR) opioid studies is not the same as supporting their use. In fact, section 5.1.2 notes that “CR formulations (also referred to as slow release...) may take 3-4 hours or more to reach peak effect...” analgesic effect of the immediate release opioid preparations will be seen within about 65 minutes. This means that rapid titration to effect is easier and safer with immediate release formulations.” This wording is unchanged from the 2005 and 2010 editions for which I was lead editor.

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

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

Devin Patullo FANZCA FFPMANZCA Director Acute Pain Service Royal North Shore Hospital, Sydney

Slow-release opioids and APMSE

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

Many direct claims made in the document do not have references provided. In particular, this seems to relate to claims of harm caused by SR opioids. For example, the first line “The inappropriate use of slow-release opioids for the treatment of acute pain has been associated with a significant risk of respiratory depression, resulting in severe adverse events and deaths” does not have a reference provided as evidence.

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

ANZCA and the FPM need to produce high quality, scientifically robust policies and guidelines. The position statement does not provide adequate scientific evidence for its recommendations and therefore, I am concerned about the potential impact of this statement on the public. There is also a need to consider the impact of such changes on the specialty of anesthesiology and pain management in Australia and New Zealand.

Exclusion of one of the partnership countries means that the document cannot accurately reflect the position of ANZCA or the FPM. We welcome a wider debate on this important issue, but Recommendations made by the college need to be developed using robust processes.

Dr Colin Baird FANZCA FFPMANZCA For the Womens Health Pain Team Women’s Health Anaesthesia Auckland City Hospital

Congratulations to new ANZCA President Dr Rod Mitchell on his election to office, and his first editorial in the Bulletin. The editorial came across as being penned by someone who has had the edges knocked off, and is genuine. Our fellow members need our care and, at the same time, we must be spreading Reverend Flynn’s concept of holding the mantle of safety for all patients throughout our States and New Zealand in this millennium. These are great goals for us all to have. Perioperative medicine is a concept whose time has come.

Dr Andrew Bacon FANZCA Victoria
Dr Craigie was interviewed by Macquarie Media national radio host Steve Price for a 5-minute segment about medicinal cannabis on his evening program which is broadcast on 96 stations across Australia including 2GB in Sydney, JVW in Melbourne and 4BC in Brisbane. Dr Craigie told Price that scientific evidence had shown that medicinal cannabis was not beneficial for chronic pain and that the community deserves accurate information. The interview reached an audience of over 100,000 people.

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

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

• 50 radio reports.
• Two print reports.
• 10 online reports.

Media releases since the previous Bulletin:

Tuesday August 28:
Combined use of opioids and benzodiazepines can be fatal, Faculty of Pain Medicine and ScriptWise warn
Friday July 27:
Climate-smart anaesthesia under the microscope
Wednesday June 13:
Australia’s escalating opioid use focus of pain forum
A full list of media releases can be found at www.anzca.edu.au/communications/media

Supporting fellows and trainees through social media

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

We’ve established a range of ANZCA-specific Twitter hashtags to flag content relating to key areas and audiences of the college. For example, we use #ANZCAintra lab to let people know about new publications, apps, and guidelines; #ANZCANtrainees for upcoming courses, events and resources; and #ANZCANZ for everything relating to New Zealand. These hashtags are there for you to use too. Perhaps you want to share something you’ve read? Or ask a question? The Twittersphere’s a busy place, so hashtags help to target your tweets. You don’t have to have a Twitter account to access hashtagged content, so you can always take a look and see if it’s something that might be useful for you. But if you want to join the conversation, you’ll need to create an account. And don’t forget to follow us @ANZCA and @ANZCA_FPM.

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

Australia

Latest report on Aboriginal and Torres Strait Islander health

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

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

• For 2008-2012 the ratio of direct maternal death rates was 2.2 times higher for Aboriginal and Torres Strait Islander women than for non-Indigenous women.

• In 2015-16, the age standardised hospital separation rate for Aboriginal and Torres Strait Islander people was 2.5 times that for non-Indigenous people. The vast majority of the difference in hospital separation rates between the two populations is due to markedly higher separation rates for dialysis among Aboriginal and Torres Strait Islander people.

• The median age at death for Aboriginal and Torres Strait Islander males in 2016 was 55.9 years – nearly 23 years less than that for a non-Indigenous male.

Important regulatory changes effective from July 2, 2018:

What doctors need to know

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

• Prescribers to include the patient’s date of birth on all prescriptions for medicines monitored through the system. Prescribing software should prompt clinicians to include this information for computer generated scripts. The Department of Health and Human Services is engaging with software vendors to support this change.

• Online registration for access to SafeScript will open later this year. The Department of Health and Human Services is working with Australian Health Practitioner Regulation Agency (AHPRA) to fast-track and automate the registration process for access to SafeScript for clinicians.

• To benefit from this automated on-line registration process, it is important that Victorian clinicians ensure their registration details with AHPRA, especially their principal place of practice and email address are up-to-date.

Anthony Wall
Senior Policy Advisor, ANZCA

Australian submissions:

• Department of Health – rural procedural training programs review and reform options.

• Medical Board of Australia – draft revised “Good medical practice: a code of conduct for doctors in Australia”.

• Medical Board of Australia – supervised practice framework.

• National Health and Medical Research Council – “Guidelines for guidelines” draft modules.

• Queensland Health – regulation of general, spinal or epidural anaesthetic; or sedation, other than simple sedation.

Real time prescription monitoring coming to Victoria

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

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

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

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

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

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

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

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

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

Changing New Zealand’s health system

New Zealand’s health system is being put under the microscope with a high-powered review announced by the Minister of Health at the end of May. Some commentators say this could mean a much-needed revolution in health services while the opposition paint it as an example of this government’s “review-it-is”. There is no doubting the grunt behind the broad health and disability review with Helen Clark’s top advisor in the last Labour government, Heather Simpson in the chair. The draft terms of reference are wide but the scattered nature of the health system is singled out for scrutiny. The draft talks about the complicated mix of governance, ownership, business and accountability models. “This complexity can get in the way of ensuring public money is spent to invest in, and provide, healthcare to the public in a coherent and smart way”.

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

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

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

New Zealand submissions:
• Civil Aviation Authority – definition of a crew member.
• Mental Health and Addiction Inquiry – government inquiry into mental health and addiction.
• Medical Council of New Zealand – statement on safe practice in an environment of resource limitation.
• Via the Council of Medical Colleges – draft terms of reference for the Government Review of the Health and Disability Sector.
• Council of Medical Colleges – Professional Behaviours Taskforce.
• Medsafe – Codeine – draft alert communication.
• Medical Council of New Zealand – Consultation on fees payable to the Medical Council.
• Pharmac – Proposal to list a range of Medical Devices supplied by Device Technologies and Medipak.
• Ministry of Health – Proposed changes to the National Health Index (NHI) system.
The group has recommended that the proposed reforms be amended to ensure that current private health insurance coverage is retained and be expanded to include pain management as a basic inclusion across all proposed categories (basic, bronze, silver and gold). More expensive and lesser used chronic pain treatment options could be restricted to silver and/or gold coverage, and these deliberations need to be made in close consultation with pain specialists and consumers.

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

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

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

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

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

Clea Hincks
Director, Safety and Advocacy
What would you do?

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

Golden egg or goose?

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

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

Faced with this invitation what would you do?

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

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

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

After the initial excitement of the invitation an uneasy feeling ensues in the pit of the stomach arising from working in a new and unknown environment. Questions arise including the reference to the administration of general anaesthesia, but these are rationalised by reassuring oneself that all will be well. Indeed, the first three lists go well with nice simple introductory cases, but during a subsequent cosmetic surgical list the surgeon requests deeper sedation. ... anaesthesia. Has this dream become a nightmare? Is the emphasis on avoidance of general anaesthesia ringing alarm bells?

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

It is sobering to contemplate the findings of the South Australian Coroner in regard to the deaths of two obese patients with obstructive sleep apnoea and other co-morbidities treated in a small private hospital in a suburb of Adelaide. The findings included patients being anaesthetised by junior doctors, and anaesthetists not having the ability to care for such patients. The recommendations included excluding patients at risk requiring postoperative monitoring from private hospitals that do not have the facilities for monitoring and managing such patients.

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

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

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

I hear you ask, “So how does one determine whether a facility meets the standards?” If you didn’t ask, then congratulations for being so familiar with our college’s professional documents and the local regulations. For those that did ask I would draw your attention to the following:
- The postoperative requirements are outlined in PS04 Statement on the Post-Anaesthesia Care Unit (currently under revision and due for pilot release in November 2018).

- Equipment
  - PS18 Guidelines on Monitoring During Anaesthesia.
  - PS54 Statement on the Minimum Safety Requirements for Anaesthetic Machines and Workstations for Clinical Practice.

- Standards of clinical care
  - Documentation of anaesthesia care should be guided by PS06 The Anaesthesia Record. Recommendations on the Recording of an Episode of Anaesthesia Care.
  - Facilities should be available to facilitate pre-anaesthesia consultation in accordance with PS07 Guidelines on Pre-Anaesthesia Consultation and Patient Preparation.
  - Above all is the matter of patient selection to ensure that the facility is suited to the patient’s risk profile as outlined in PS15 Guidelines for the Perioperative Care of Patients Selected for Day Care Surgery.

Dr Peter Roessler
Director of Professional Affairs, Policy

Contribute to the development and review of ANZCA professional documents

We are seeking expressions of interest from fellows to participate in upcoming professional document reviews. The review of each ANZCA professional document is undertaken by a document development group (DDG) made up of fellows with expertise and knowledge aligned to the particular document under review. DDG members collaborate to review and update professional documents via email and teleconference at times that fit their schedules. Serving as a DDG member provides a valuable opportunity to contribute to safety and quality of care for patients. The following professional documents are scheduled for review prior to the end of 2018:


If you are interested in being nominated for one of the above DDGs, or for more information, please contact profdocs@anzca.edu.au.
There are a number of areas though where we have clearly identified room for improvement. For example, patient mortality is exceedingly rare in the immediate peri-operative period, but there is seemingly much that needs to be done to address longer term outcomes. Hence our initiatives to further the development of “peri-operative medicine”. And then there are those sectors within our community who do not enjoy the same health outcomes as the rest of society. Most obviously among these sectors are our rural communities, the Indigenous peoples in Australia, and the Māori in New Zealand.

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

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

Above from left: Royal Darwin Hospital specialist anaesthetist Dr Edith Waugh reassures young patient Justine and her mother Alisha as they prepare for Justine’s dental procedure at the Gove District Hospital in Groote Eylandt, East Arnhem Land.

Dr Rod Mitchell
ANZCA President

ANZCA DRIVES NEW INDIGENOUS HEALTH STRATEGY

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

The Indigenous population of Australia is 2-3.3 per cent of the total population, but our Indigenous representation is less than 0.1 per cent of the specialist anaesthesia/pain medicine workforce. In New Zealand the figures are 1.7 per cent and 6 per cent respectively. We can be more proactive in encouraging and supporting young Indigenous doctors into and through training in our specialty. We would do well to ensure the attributes that we consider when selecting trainees mirror those of the community which we serve. Workforce diversity enriches us all. Most of us don’t consider ourselves to be prejudiced. Unconscious (and conscious) bias remains a great challenge that we all need to address. When such bias manifests as racism it can be particularly destructive.

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

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

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

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

Dr Rod Mitchell
ANZCA President

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

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

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

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

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

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

ANZCA INDIGENOUS HEALTH STRATEGY FRAMEWORK

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

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

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

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

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

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

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

"u te rourou, nā ku te rourou, ka ora te ū te rūri, nā kau, nā ku te rūri, ka mate te hoariri.

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

Tātou tātou kou, tātou kou, ka titeretere tātou kou, tātou kou, ka titeretere tātou kou, ka titeretere.

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

In 2016, 35 Indigenous doctors graduated in Australia and another 77 Māori students completed their medical degrees in New Zealand. Seventy-eight Indigenous students started their medical degrees in 2017 in Australia – 2.4 per cent of all Australian commencing medical students. In New Zealand, 112 students started their medical degrees in 2017 – 37.6 per cent of all New Zealand medical degree commencements.

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

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

The path to specialty for Indigenous junior doctors varies among Australia’s medical colleges. Dr Newman and Dr Mills favour a model that provides additional specialist training positions for Indigenous doctors. Most Australian medical schools offer Indigenous entry pathways into medicine either by allocating a percentage of places to suitable Indigenous applicants, a dean’s Indigenous list or an alternative pathway that places less emphasis on the traditional admissions tests.

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

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

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

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

Carolyn Jones
Media Manager

Recognising Dr Rod Mitchell

At a dinner at ANZCA House on July 20, 2018, a number of New Zealand fellows presented ANZCA President Dr Rod Mitchell with a pounamu in recognition of his work with Indigenous people.

The gift was blessed by former ANZCA president Dr Leona Wilson in Wellington Harbour: This is ANZCA Vice-President Dr Vanessa Beavis’ speech.

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

Extremed leaders gathered here today, these times greetings to you all.

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

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

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

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

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

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

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

The timing was special, because last week was Matariki, the Māori New Year, an astronomical event that sets the timing for the planting of crops, and all the seasonal activities for the year.

As it happened, it was also the week in which a rare southern right whale made Wellington Harbour its home for the week. So the omens are good for this pounamu.

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Nun to rourou, nuku to rourou, ka ora te wairua.

Nun to rukau, nuku to rukau, ka mate te hoariri.

With your food basket and my food basket, the people will be healthy.

With your weapons and my weapons, our enemies will be overcome.

Ki ara taitou katoa.

Te aroha, Te whakapono, Me te rangimarie, Tātou tātou.
Darwin team leads Top End response

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

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

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

Jill’s grandmother Barbara Moore had flown to the hospital with Jill from their home in the remote Aboriginal community of Amata near Alice Springs and was staying with her in the hospital. Barbara was concerned with finding her plastic building blocks and eating the apple on her bedside table.

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

Dr Waugh is part of the hospital’s anaesthesia “flying squad” led by the hospital’s Director of Anaesthesia Dr Brian Spain. She is one of several anaesthetists who travel the 2000 kilometre round trip a few times each year to Nhulunbuy in East Arnhem Land for the Gove District Hospital patient lists. Gove Hospital’s catchment area of 50,000 square kilometers, which is about the same size as Switzerland, covers 18,000 people who live in dozens of remote Aboriginal communities.

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

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

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

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

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

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

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

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

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

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

Carolyn Jones
Media Manager

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

ANZCA drives new Indigenous Health Strategy (continued)
Growing up on a farm in north Canterbury on New Zealand’s South Island, Dr Amanda Gimblett mutually describes her childhood as “traditional” but then admits maybe it wasn’t so run of the mill. Her father’s decision to change careers from farmer to pharmacist meant a change in lifestyle. “My dad ended up living in Dunedin for four years studying while we were in north Canterbury… It was a very big move.”

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

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

She knows from talking to others in medicine that being Māori would have meant a very different experience a few decades ago. Delivering culturally responsive care and a focus on equitable outcomes is also on Dr Courtney Thomas’ radar. Following two years behind Dr Gimblett at the University of Otago meant the Central Otago farm girl had a great role model as both frequented the university’s Māori Centre.

Engaging with the Mōari Centre and Te ORA, the Mōari Medical Practitioners Association, were important steps in helping Dr Thomas reconnect with her culture. “The centre was fantastic not only as a place to go but they were really inclusive with tutorials and a mentoring program. It made a difference in the way Dr Thomas saw the world and her place in it. This journey continued during her early years at university and throughout her medical degree. She recalls her family’s experiences with stories of her grandmother “being spanked for speaking Te Reo Māori at school”. Her family’s motivation to find out where they are from and celebrating that identity is important to her and she hopes her own daughter will grow up appreciating their shared mission.

As a member of ANZCA’s Indigenous Health Committee, Dr Gimblett is a strong believer in working for equity in the health system. “I know many struggle with the term and may see it as preferential treatment but that is not the case. It is about achieving the same outcome for everyone down the road and if we have to do that in multiple ways then that is what we do.”

Working for equity in anaesthesia will create more diversity in the workforce. But Dr Gimblett says learning to better engage with Māori patients can be explored now. “It was an illustrative time as I got to see anaesthetists as balanced, considerate and holistic people in the way they cared for patients.”

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

Dr Gimblett suggests connecting with Mihi (greeting and engagement), Whakawhānaungatanga (making a connection), Kaupapa (attending to the main purpose) and Poroporoaki (concluding).

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

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

This shows as she takes on her next challenge as chief investigator on a pilot research project assessing Māori patients’ experience of anaesthesia in the perioperative setting. She hopes the findings from this research will enable resource development to assist anaesthetists in delivering culturally competent care to Māori patients. “In part this is about understanding their experiences, what their needs are and how we can meet them”. She says while New Zealand may have a world class health system, health statistics reveal discrepancies in how people access and benefit from healthcare.

Dr Thomas joined the New Zealand National Committee as the new fellow representative in June and is ANZCA’s representative on Te ORA, the Mōari Medical Practitioners Association.
and a half kilometre section – and they were able bodied soldiers so he could teach them to dive and swim out with them. The Thai mission was a quantum leap; much more difficult and complex.

THE CALL

I have been friends with (Perth vet) Craig Challen since 2005. We had both been cave diving explorers and we met up on an expedition to the Kimberley in 2000. We were both good spirits in each other through our interest in exploration so we have been cave diving together for quite a few years.

I was in an operating theatre in Adelaide on the Thursday morning (July 5). I had been chatting with Rick Stanton on Facebook messenger in Thailand that day. He said, “It’s just the Thai kids again.” I said, “Rick, I got one more thing.” He said, “I know you do.” I said, “I want you to get on DFAT and see if they can get two other doctors in there.” He said, “Who are you talking about?” I said, “That’s two for you.”

I asked him to speak to the Department of Foreign Affairs and Trade (DFAT) people on the ground over there. Because I was already a member of AUSMAT I knew quite a bit about it. I thought it was going to be easy. I said I would come but I said I needed Craig with me because you need someone to watch your back and to dive with.

THE LEAD-UP

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

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

The deepest sinkhole in the Mount Gambier area is about 120 metres. Most are up to 50 metres in depth. Some are just big holes in the ground and some fan out in a big slick shape. In contrast, the Thai (Tham Luang Nang Non) cave complex is usually a dry cave with a bit of a stream running through it. In the monsoon season the cave floods and it is hazardous. It’s totally unpredictable. It’s a really dangerous environment.

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

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

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

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

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

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.

Left: Dr Richard Harris, who has been diving since he was 13, on one of his expeditions. Source: Dr Richard Harris.
You don’t need to be a diving pair underwater but it’s good to have a trusted friend in those kinds of situations. It’s important to have someone who can watch your back and do things like get your mask off you if you need a second breather. You need to know someone who you can rely on. It’s important to have someone you can talk to and trust in those kinds of situations. It’s good to have a second person who is looking after you.

I encouraged them to err on the side of being heavy handed because my primary concern was the risk to the rescuers. The thought of one of the kids waking up, thrashing around and causing the death of one of the rescuers was a very worrying issue for me. My AUSMAT training was excellent but my experience in Vanuatu and my pre-hospital and retrieval experience were crucial. I enjoy challenges and working in weird places. I just felt this job was purpose made for me and I feel very privileged to have been part of it.

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

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

THE BREATHING CIRCUIT
As part of the preparation we immersed a local child with a full face mask in a swimming pool so we could make sure that the mask didn’t leak. We tried lots of different types of mask to get the right one. We were looking for something that would give us the best chance of sealing the airway for each child without leaking. Getting a seal to fit on these tiny kids’ faces was a big ask because most commercial diving equipment is made for large men. Eventually a suitable mask was sourced. I had a couple of colleagues in Adelaide who I was also in contact with about the procedure – through them a paediatric anaesthetist, a paediatric psychiatrist and intensivist were also consulted on my behalf. I was pretty sure the kids were going to need (sedation) top ups on their way out of the cave. All up, there were a group of 14 international cave divers stationed throughout the cave complex. I had to teach them how to judge what level of anaesthesia the kids were at and explain that they might need a top up during the 3-4 hour journey out of the cave.

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

The Thai government were very quick to recognise that they needed external expertise and that their military divers didn’t have the specific skill set to do this job. In a different place with a different bunch of people it might not have worked at all. My AUSMAT training was excellent but my experience in Vanuatu and my pre-hospital and retrieval experience were crucial. I enjoy challenges and working in weird places. I just felt this job was purpose made for me and I feel very privileged to have been part of it.

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

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

**“Dr Harris and Dr Challen were awarded the Star of Courage, Australia’s second highest bravery award, and medals of the Order of Australia (OAM) for their roles in the rescue. Six Australian Federal Police members and one navy officer were awarded bravery medals and OAMs for “acts of bravery in hazardous circumstances.”**
Since the Bali bombings in 2002 Australia and New Zealand's medical community has played a key role as emergency responders to many of our region’s natural disasters and medical incidents.

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

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

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

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

The ANZCA Bulletin was given exclusive access to a recent AUSMAT five-day training course in Darwin. The course includes scenarios such as brain trauma, obstetrics, burns, draw-over anaesthesia, ethics, blood transfusions and team management and leadership. Tent shelters that serve as deployable field hospitals complete with emergency wards, operating theatres and high dependency units were erected on an oval in one of Darwin’s outer suburbs to give participants an understanding of what they would expect once deployed.

On the day the Bulletin visited an obstetric scenario was under way with participants watching as two midwives began to “deliver” a baby from a medical mannequin.

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

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

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

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

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

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

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

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

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

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

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

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

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

Carolyn Jones
Media Manager
Fatigue – a cultural and systemic issue

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

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

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

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

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

Dr Marion Andrew

How does fatigue impact on safety and performance?

It is unsurprising that fatigue is a hidden risk factor that can potentially have disastrous consequences. Michael Faramarz’s 2016 editorial in Anaesthesia makes the point that, the keen but fatigued team “go faster” mindset of NASA decision-making likely contributed to the disastrous launch of the US Space Shuttle Challenger. He compares this decision, to the relentless pressure on fatigued doctors to maintain cost-driven targets and avoid patient complaints at the expense of their wellbeing and safety of patients.

Fatigue can contribute to adverse events and critical incidents. Data from other industries has shown fatigue to be a common factor in a bimodal distribution between 3am and 7am and between 5pm and 9pm, when circadian drowsiness is greatest. Studies have found that the decrement in cognitive psychomotor performance after 6-8 hours of sustained wakefulness is equivalent to the performance impairment observed with a blood alcohol level of 0.05 per cent, and after 24 hours to a blood alcohol level of 0.1 per cent. A meta-analysis of laboratory studies of sleep loss in fit young adults who were short-term and chronically sleep deprived demonstrated mean cognitive performance to be 1.37 standard deviations below the mean of the control group. This must impact on clinical decision-making.

Sleep and circadian rhythm

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

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

Doctors cope and continue to provide a high level of care despite these mental and physiological challenges – but at a cost. The normalisation of fatigue, early in a medical career, is likely to contribute to producing a workforce, who are vulnerable to the higher burnout detected by beyondblue in doctors under the age of 30 years as well as reduced physical wellbeing.

Mitigating strategies such as use of alcohol or self-prescribed drugs, can reduce sleep latency time, but result in poorer sleep quality and can lead to substance abuse and further health issues – including suicidal thoughts. Disruption of circadian rhythms and sleep cycles is aggravated by ageing, and in addition to short-term cognitive impairment may contribute to neuroinflammation and, if persistent, to neurodegeneration.

Fatigue: Whose responsibility?

With unpredictable 24-hour healthcare demands, fatigue is an inevitable human factor. However when fatigue and emotional exhaustion become the norm in our working cultures, we risk losing the ability to detect it and do what’s required to protect our patients, our colleagues and ourselves. The responsibilities of anaesthetists in managing fatigue are set out by ANZCA in their professional statement PS17 Statement on Fatigue and the Anaesthetist (2017) on the website – this document is currently being revised and updated. The AMA also provides a national code of practice in addition to a useful fatigue risk assessment tool (ama.com.au/article/2016-ama-safe-hours-audit).

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

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

Dr Kate Harding podcast

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

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

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

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

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

What action is required?

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

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

A cultural change is needed as well, to encourage and support good clinical practice and alter the perception that “carrying on” when there are reasonable options is not “heroic” and is not in the best interests of ourselves or our patients.
Fatigue – a cultural and systemic issue (continued)

Are there fatigue management interventions that you can introduce in your department or practice?
We can begin by looking at our own departments and see how we can work with hospital management to make facilities available where doctors can rest or sleep.

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

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

Dr Marion Andrew FANZCA
Chair, Welfare of Anaesthetists
Special Interest Group
Professor David A Scott FANZCA FFPMANZCA
Immediate Past President, ANZCA

References:

Tips for managing fatigue

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

Resources

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

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Human factors of medication handling

I know we think we read the label, but what do we really do when we select and check medications prior to administration? There’s plenty of evidence that drug errors happen more frequently than we’d like to admit in anaesthesia. Indeed, some estimates put the rate of adverse medication errors as high as one in every 20 anaesthetics depending on the definition.

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

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

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

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

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

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

We can make these cues more obvious and use them to our advantage if we are strategic. ANZCA’s professional document PS5 (Guidelines for the Safe Management and Use of Medications in Anaesthesia) describes the principles and best practice for the purchase and handling of anaesthetic drugs.

Ensuring that there are as few medications that look similar to each other as possible is important, as is the communication of any change in presentation from the purchasers to the purchasers to the clinicians. Emergency medications such as adrenaline/epinephrine must be easily accessible but should be away from commonly used drugs to prevent inadvertent administration. Muscle relaxants are of course the most feared of accidental ampoule switches and the solution of keeping these medications in a separate box may help prevent their accidental use.

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

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

“Around shape for the landing gear control and a flat shape for the flap controls were immediately obvious when felt and represented the items they affected. We have a similar system with many anaesthetic machines that uses the same principle.”

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

Ordering of the position of the syringes on a clean surface provides yet another cue and helps prevent “syringe swaps.” A cognitive aid in the form of a pre-designed compartmentalised tray such as that recently described by Almghairbi ensures that if more than one anaesthetist is involved in the case there is a common understanding of the syringe layout. A more economical solution is a laminated strip that can be produced cheaply and easily wiped with disinfectant between cases. "Like many aspects of care in anaesthesia, safe practice requires vigilance and a constant effort to prevent mishaps. However, there are systemic changes and routines we can all adopt to prevent as many errors as possible."

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

References:

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

"Our eyes and brain often trick us into believing what we expect to see is what we actually see."
Different shades of blue

The ANZCA professional document PS53 Guidelines for the Safe Management and Use of Medications in Anaesthesia highlights the importance of the five Cs of medication administration: correct medication, patient, dose, route and time. Occasionally situations can arise in clinical practice where satisfying these five Cs prior to drug administration can be challenging.

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

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

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

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

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New warnings on labels of medicines containing neuromuscular blocking agents

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

The new requirements are described in Therapeutic Goods Order No. 91 – Standards for labels of prescription and related medicines (TGO 91), under section 6 and subsection 16(5A). They specify that if a medicine contains a neuromuscular blocking agent then the primary packaging and the label on the container must include the statement “Warning: Paralyzing agent” or “Warning: Paralyser”.

The new labelling and packaging requirements are not a panacea for medication errors within our speciality, but are an acknowledgement of the role careful design may have in improving safety. The demonstrated advantages of design innovations in our anaesthesia work stations such as pin-indexing, colour coding of gas pipelines and fluted oxygen flow controls are well understood. Employing visual design principles that exploit known habitual and cognitive interactions with the environment can provide additional cues to help practitioners select the correct medications in demanding settings. These are further supported by the safe storage and handling principals articulated in PS53 Guidelines for the Safe Management and Use of Medications in Anaesthesia.

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

Dr Christine Piroone
Advanced Trainee

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

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: web.anzca.edu.au/fellows/safety-and-quality/safety-alerts.

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

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

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

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

Reference:
The road to success

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

Keynotes

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

In-depth proposals

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

ANZCA Research Foundation Novice Investigators Prize session

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

Anaesthesia Research Coordinators Network

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

Emerging research leaders workshop

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

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

Wrap up

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

Karen Goulding
CTN Manager
Foundation update

New ANZCA Melbourne Emerging Researcher Scholarship

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

Professor Scott also presented the fourth annual ANZCA Melbourne Emerging Researcher Award of $A50,000, to Dr Rachel Chapman (far right), Royal Adelaide Hospital, for her project “A pilot study of current anaesthetic practice and outcomes for children undergoing adenotonsillectomy at the Royal Children’s Hospital”.

Provisional/New Fellow Research Award 2019

This award, conferred in alternate years by the ANZCA Research Committee, was designed to support ANZCA emerging researchers, and is made possible by generous donations in 2014 and 2015 from Professor Barry Baker. The ANZCA research committee has allocated the second award to Dr Courtney Thomas from Auckland City Hospital, for the study “Most engagement with anaesthesia in the perioperative setting: A qualitative assessment”. Income generated by Professor Baker’s generous endowment will again be matched from ANZCA’s annual research funding contribution for novice investigators resulting in a $A20,000 grant for the award.

Encouraging new scholarship donors

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

Medibank Better Health Foundation [MBHF]

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

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

Member Advantage

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

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

Supporting professional development for research coordinators

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

Thank you foundation donors

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

Rob Packer
General Manager
ANZCA Research Foundation

To donate, or for more information on supporting the foundation, please contact Rob Packer, General Manager, ANZCA Research Foundation on 041 3 837 5306 or email rpacker@anzca.edu.au. Gifts can be made via www.anzca.edu.au/fellows/foundation.
When her mother’s recovery from an operation didn’t go according to plan, Lauren Whittle, a Charles Sturt University student, realised the value of medical libraries.

Throughout most of June this year, my mother was in and out of hospital for severe appendicitis. Even after the successful operation to remove the offending appendix, complications wreaked havoc with her body.

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

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

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

When I first contacted the ANZCA Library about undertaking a placement, my main reason for doing so was that I thought medical libraries would be interesting, and would present a challenge that I wouldn’t find in a school or public library. Because of the experience with my mother, by the time I actually arrived, my reasons had shifted from mere interest to finding out exactly what medical libraries can do for their users.

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

At the end of three weeks, I’m glad I made this decision. I was challenged, I was exposed to a wide world of discovery and resources. I was given the opportunity to research and evaluate resources that were not only searchable in the print database, but also discoverable through Google Scholar.

ANZCA and FPM publications discoverable on Google Scholar

In the past 18 months, users of the Informit database/collection (all the universities in Australia, along with TAFEs, government departments, organisations, libraries and hospitals) have produced:
- 83k hits on Acute Pain Management: Scientific Evidence (fourth edition).
- 400 hits on editions of Australian Anaesthesia.
- Both APM:SE and Australasian Anaesthesia (the “Blue Book”) are not only searchable in the database/collection itself, but also discoverable through Google Scholar.

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

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

Recent contributions to AIRR:

The ANZCA Library maintains a number of library guides that are designed to bring together key resources to support particular aspects of pain medicine. There are guides are based around:
- Particular specialist/subject areas – for example airway management, paediatric pain, and many more.
- Guidance on searching specific databases – for example: Ovid MEDLINE and PubMed.
- Supporting the growing number of ANZCA-subscribed apps including Read by QxMD, ClinicalKey, BrowZine and Audio-Digest.


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


Basic and clinical pharmacology

Pain killer: an empire of deceit and the origin of America’s opioid epidemic

New eBooks

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

Anesthesiology: a practical approach

Atlas of common pain syndromes

Atlas of ultrasound-guided procedures in interventional pain management

Atlas of ultrasound-guided regional anesthesia

Essentials of equipment in anaesthesia, critical care, and peri-operative medicine

Essentials of pain medicine

Modern anesthetics

Oxford textbook of anaesthesia for oral and maxillofacial surgery

The anaesthesia science viva book

Short answer questions in anaesthesia

Contact the ANZCA Library
www.anzca.edu.au/resources/library
Phone: +61 3 9093 4967
Fax: +61 3 9093 2166
Email: library@anzca.edu.au
Dean’s message

Over the past three months the faculty has been engaged in a range of issues of national importance over and above the regular work of the FPM staff and committees. Engagement around the problem of opioids in chronic pain has been extensive. Several FPM fellows attended the Therapeutic Goods Administration opioid forum on June 1 at which I presented the faculty’s current position. It was an opportunity for the faculty to have a say in the potential regulatory changes aimed at reducing opioid related harms. I also represented FPM at the Society of Hospital Pharmacists of Australia (SHPA) Medicines Leadership workshop on July 31 where the focus again was on opioids, this time looking at the hospital setting and the interface with the community. The faculty’s own forum “Opioids and chronic pain – continuing the conversation” on June 16 was an opportunity for fellows and trainees to engage with an excellent panel of invited speakers and guests from diverse backgrounds. Fellows had input in progressing the faculty’s strategy on this issue during the workshop on the day and in the follow up survey. These outcomes will inform the board’s discussions about revising professional document FPM04 Recommendations regarding the use of opioid analgesics in patients with chronic non-cancer pain – 2015 and direct engagement with other professional organisations and the community.

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

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

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

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

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

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

Dr Meredith Craigie
Dean, Faculty of Pain Medicine
News

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

• Duane Elijah Anderson, FANZCA, FFPMANZCA (Western Australia)
• Babak Far, FAFRM(RACP), FFPMANZCA (Victoria)
• Benjamin James Manton, FAFRM(RACP), FFPMANZCA (Queensland)
• Jonka Meyer, FANZCA, FFPMANZCA (Victoria)
• Vincenzo Mondello, FRANZCP, FFPMANZCA (Western Australia)
• Yvonne Murray, FRCPC, FFPMANZCA (New Zealand)
• Olivia Ong, FAFRM(RACP), FFPMANZCA (Victoria)
• Hima Shailaja Venugopal, FAFRM(RACP), FFPMANZCA (South Australia)
• Vincenzo Mondello, FRANZCP, FFPMANZCA (Western Australia)

This takes the number of fellows admitted to 477.

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

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

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

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

This position statement is being piloted for a period of six months and will be reviewed again in December 2018.

References:

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

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

Correction
A caption on page 55 of the June 2018 ANZCA Bulletin contained an error. A photo of Ms Gai Brodtmann, MP, was incorrectly captioned as Ms Nola Merino, MP. We apologise for the error.
“Opioids and chronic pain” was the theme of the third forum held by the Faculty of Pain Medicine on June 16. Australia is facing a major public health issue with opioid harms escalating and the annual death toll from prescription opioids now double the national road toll. New Zealand does not seem to have the same problem – at least not yet, hopefully never.

Professor Evan WALLACE, CEO of Safer Care Victoria, opened the forum and set the scene for a great day attended by 55 delegates in the newly refurbished ANZCA auditorium with another ten participants joining remotely.

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

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

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

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

Simple education of trainee GPs about appropriate opioid use in chronic pain management was the focus of the second session. Associate Professor Mark Doghlas, Director of Addiction Psychiatry, Royal Brisbane and Women’s Hospital, highlighted the challenges of problematic analgesic use compared with opioid addiction and the association of opioid use and depression.

Robust conversations developed a range of recommendations skilfully drawn together by FPM Vice-Dean Dr Mick Vagg which informed the follow up survey and ultimately the Faculty’s position and strategy around opioids and chronic pain. Ms Russet Lassam had the final words of wisdom at the end of the day:

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

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

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

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

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

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

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

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

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

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

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

“In hospitals junior doctors are key targets for discharge prescribing change. Giving key surgical junior staff, especially in orthopaedics and orthopaedic terms, access to their medication data along with targeted one-to-one education proved to be beneficial in changing behaviour in situations faced by patients.

In our metropolitan hospital 15 per cent of opioid naive joint replacement patients and 30 per cent of opioid naive spinal patients are still using regular opioids three months post discharge. Fifty per cent of all patients presenting for joint replacements in this regional area are already taking regular opioids despite lack of evidence of benefit for lower limb arthritis pain and abundant evidence for harm, including worse orthopaedic outcomes. Data for spinal patients from this study is not yet available.

The rates of accidental death due to drugs are increasing at a much faster pace in regional areas of Australia compared with metropolitan areas. With surgery being an initiation point for inadvertent long term opioid use these high rates of post-operative use may be a good target for change in regional areas.”
However, on a per capita basis Tasmanian anaesthetists are making major contributions to overseas aid. Twenty-five of the 100 anaesthetists in Tasmania have volunteered to provide overseas aid. The interest in aid was fostered by the Real World Anaesthesia Course started in Tasmania by Dr Haydn Perndt and Dr George Merridew in Hobart and Launceston and now run out of Darwin. It is almost 20 years since that course commenced.

Colin gave examples of aid in a number of different programs involving Tasmanian anaesthetists. These included short surgical trips to Madagascar with Mercy Ships by Dr Wendy Falloon, teaching programs in Laos by Dr Tom Mohles and Namibia by Dr Andrew Ottaway, and disaster relief in Banda Aceh where Dr Marcus Skinner, as a Royal Australian Air Force reserve medical officer, played a significant role.

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

Growing a beard seemed like a good idea while working in an area of Pakistan formerly known as the North West Frontier, where the Taliban militants ordered all foreigners to leave the country or face targeted attacks. Colin completed his assignment with MSF in that area, giving 991 anaesthetics in the hospital.

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

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

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

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

Dr John Paull
Pugh Day Lecture Convenor

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

The types of projects supported by the grant program include:

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

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

Submissions, including any supporting documentation, must be received by close of business on September 21, 2018. Successful applicants will be notified in time for announcements to be made on National Anaesthesia Day, October 16, 2018.
This edition of the Bulletin celebrates the launch of the long awaited Perioperative Anaphylaxis Response online learning course. This e-learning course is the result of the efforts and collaboration of several fellows, members of ANZAAG and the college education unit. Those involved are to be congratulated on bringing this unique resource to fruition, for the benefit of fellows, and ultimately for the improved safety of our patients.

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

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

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

In the last edition of the Bulletin, we acknowledged that more guidance on how to complete the practice evaluation requirements of the program would be appreciated by those continuing professional development (CPD) participants in a private practice setting. Since then we have contacted some fellows who work in private practice and asked how they go about meeting these CPD requirements, what they identify as the challenges involved, and what ANZCA can do in the future to improve this category for those in a private practice setting. When asked what was the most challenging aspect of the practice evaluation category, we were told that attendance at morbidity and mortality (M&M) meetings, case conferences and patient surveys were difficult within a practice setting, as well as the time commitment that is required to complete practice evaluation activities within the current structure of the CPD program.

These challenges were overcome by organising monthly M&M meetings within private groups, or by choosing to complete peer review and multisource feedback activities if there were colleagues with similar case profiles available. When we asked if there were any tips/tricks for other private practitioners who are having difficulty meeting their practice evaluation requirements, it was suggested that patient surveys could easily be conducted through an SMS system via the consultants rooms, collated by the rooms then analysed independently or by a commercial frm such as survey monkey. It was also noted that clinical audits were a useful tool for completing practice evaluation requirements.

We also asked what ANZCA could do in the future to improve this category for those in private practice, and were told that it would be helpful to provide a service for more M&M meetings and case discussions. Feedback regarding identified challenges or problems with any component of the CPD program is always welcome, and can help to guide the CPD Committee to make improvements for CPD participants. All feedback can be submitted to ANZCA via the CPD team at cpd@anzca.edu.au or via your CPD portfolio dashboard, under Resources using the “Seeking your CPD feedback” button.

Calling for clinical audit topics and authors
Since launching the CPD program in 2014, the ANZCA and FPM CPD Committee have published 14 clinical audit samples for participants to use as part of their Practice evaluation category. The CPD Committee wish to extend an invitation to all CPD participants to contribute to this valuable resource by becoming an author of a new clinical audit sample. Guidance is available from members of the CPD Committee, and assistance from the CPD team with the final formatting of the clinical audit guide, data collection form and summary of results forms. If you are interested in writing a clinical audit sample for ANZCA, please contact the CPD team at cpd@anzca.edu.au.

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

Would you know how to respond in an anaphylaxis emergency?

Dr Helen Kolawole  Dr Sarah Green  Dr Karen Pedersen  Dr Nagesh Nanjappa  Dr Richard Waldron

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

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

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

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

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

Part 1
- Planning effective teaching and learning
- Teaching in the clinical setting

Part 2
- Interactive learning and teaching
- Teaching practical skills
- Clinical supervision

Part 3
- Doctor as educator
- Feedback to enhance learning
- Authentic assessment

Part 4
- Concepts in assessment
- Teaching in multiple settings
- Organizations of education in departments

Part 5
- The trainee experiencing difficulty
- Technology in teaching and learning
- The learner experiencing difficulty

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

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

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

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

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

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

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

Skills in effective perioperative care are already part of the modern anaesthetist’s role and form a prominent component of our curriculum as one of the seven “clinical fundamentals” of training. However, the growing importance and complexity of perioperative medicine to the future of anaesthesia is worth highlighting.

The first joint in ANZCA’s Strategic Plan 2018-2022 states that “ANZCA will lead the development of an effective, integrated and collaborative perioperative care model”. Our growing involvement in perioperative medicine has been discussed a number of times by the presidents of ANZCA, the Australian Society of Anaesthetists, the New Zealand Society of Anaesthetists, and the Royal College of Anaesthetists among many others. It is clearly an area of great interest and a structured system of evidence-based care is needed.

### References

5. Scott SM. ASA editorial from the president. Anesthesia 2018 April, pp. 4-5.
6. Kibblewhite D. President’s column. NZSA Magazine 2018 April, pp. 4-5.
Common mistakes in audits or research

Read this before you embark on your study!

Prior to 2013, the Australian state and New Zealand committees were responsible for assessing the Formal Project. From 2013 this system was replaced by the Scholar Role Sub-Committee (SRSC) with island- and state-based representation. Between 2013 and 2017 the SRSC assessed all audits centrally. From 2017, local scholar role tutors have assessed the five activities currently constituting the scholar role. The SRSC still has a role in assessing audits (for local calibration or as a second opinion) and research activities that do not lead to publication.

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

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

Audit:
• Conclusions that have no bearing on the initial aims of the study (and always suggest further studies required in the area…).
• Making conclusions from the findings that are clearly not achievable from the work (eg “this proves…”, “this suggests…”) followed by advice to change practice. Assuming that because no significant difference was found that the two groups are equivalent (up to 20 per cent error here if beta error is 0.2) or that a technique is “safe”.
• Conclusions that have no bearing on the initial aims of the study (and always suggest further studies required in the area…).
• Applying statistical analysis to numbers that have so many groups are equivalent (up to 20 per cent error here if beta error is 0.2) or that a technique is “safe”.
• Applying complex statistical analysis when simple statistics would suffice.
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New Zealand news

New NZNC responsive to government changes

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

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

"Together there are several areas where we can have some influence," she says. "This government has highlighted inequities in the health system. We know our Māori and Pacific peoples have worse health outcomes and shorter lives and the Health Minister Dr David Clark says that is something we simply cannot accept."

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

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

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

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

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

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The NZ Annual Scientific Meeting – future proofing

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

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

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

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

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

Opposition health spokesperson updated

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

Blue skies and great snow conditions greeted the 32 delegates who arrived at Thredbo on July 12 for the 2018 Scan and Ski Workshop. The workshop focused on hands-on ultrasound education in the Australian Alps. In total, 16 participants were divided into 3 groups of 8 and 2 groups of 4. The workshop was led by 6 experienced instructors, who reviewed various aspects of ultrasound and its applications, including this, a cardiac ultrasound machine. The logistics of running such an event in an alpine environment are complex. The delegation of over 40 participants for 3 days needed a considerable amount of planning, coordination, and logistics.

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

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

Australian news

Clinical directors meet in Wellington

There’s only one chance a year for the heads of the hospitals’ departments of anaesthesia in New Zealand to get together and share the big issues that are challenging their turf, and some of the solutions. ANZCA hosts the clinical directors (CDs) meeting in Wellington and this year saw around 30 CDs teasing out some of the pressing challenges in practice and departmental management across the country. The agenda included safety and security of medication use and supply, health equity, an electronic tool for leave management and an update on NetworkZ.

NetworkZ is the first national team training initiative like this in the world. It is a national simulation-based team training program for surgical teams aimed at improving the safety and efficiency of care for patients. It’s been implemented around New Zealand in 90% of hospitals to have full coverage by the end of 2020.

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

Professor Weller says the backbone of any effective healthcare system is an engaged and productive workforce and working in silos or “tribes” in theatre is not going to create that engagement. NetworkZ, she says, is designed to build the collective competence of operating rooms with challenging scenarios being run in situ with real operating room teams. The Accident Compensation Corporation has funded 90 full body manikins for each DHB, and development and supply of surgical models to support the package of 25 scenarios for the different surgical specialties.

Dr Kerry Gunn from the ANZCA New Zealand National Committee (NZNC) brought CDs up to speed on PHARMAC (the government’s drug buying agency) and its move to national contracts for all anaesthetic equipment and small devices by 2022. Dr Gunn sought nominations for an advisory group to be set up so anaesthetists can have a strong, common voice in helping make sure that the best products are settled on for those contracts.

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

New Zealand news (continued)

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

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New Zealand news (continued)

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ANZCA/ASA combined CME meeting

Keeping with tradition, this year’s annual ANZCA/ASA combined CME Meeting was again held on the last Saturday in July at the Sofitel on Collins, Melbourne, but for the first time we incorporated emergency response workshops that were held the following day. As an extra twist there was also an additional optional temperature audit which attracted a further 25 CPD points.

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

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

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

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

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

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

FPM VRC Victorian Registrars’ Scientific Meeting (VRSM)

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

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

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

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

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

Quality assurance meeting

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

Victoria

Save the date!

Victoria Regions Scientific meeting

The Victorian Regional Committee invites you to join us on Friday November 30 from 4pm to 6pm to present at our Scientific meeting, to be held in the auditorium at ANZCA House, 630 St Kilda Road, Melbourne. The theme for this meeting will be “Pain: Minimising opioid use”. To register your interest email vic@anzca.edu.au or call +61 3 8517 5350.

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

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

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Australian news (continued)

Part Zero course

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

South Australia and Northern Territory

Combined ANZCA/ASA SA CME Meeting

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

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

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

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

Queensland

ACE conference

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

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

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

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

Dr David McCormack
Convenor, Queensland ACE Conference 2018

Other news

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

Courses

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

FPM CME evening meetings

The Faculty of Pain Medicine Queensland Regional Committee have hosted another two CME evening meetings this year.

In May Dr Alison Grimaldi (Titled Sports Physiotherapist) presented on “Global Tendinopathy – Early diagnosis and why physio and not corticosteroid injection should be the first-line treatment”; and in July Dr Anton Wan (Medical Director of the Metro South Health Persistent Pain Management Service) presented “Medication overuse headache – recent literature review”. Both evenings were very well received. The last FPM CME evening meeting for 2018 will be held on Monday September 24 – save the date!

Joint meeting with Addiction Medicine Specialists

A joint CME meeting with the Addiction Medicine Specialists was held on June 26, Dr Chris Holmwood and Associate Professor Mike McDonough from Drug and Alcohol Services South Australia (DANSKA) presented on the trends in prescribing of opioids, gabapentinoids and medicinal cannabis. Dr Say Yang Ong also gave an update on the FPM position statement on medicinal cannabis. It is hoped ongoing liaison with the Chapter of Addiction Medicine will continue in the future.

ANZCA Educators Program

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

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

Australian Medical Association Junior Doctors Conference
Members of the ANZCA NSW Trainee Committee attended the NSW AMA Junior Doctors Conference on Saturday June 9 at the SMG Conference and Function Centre in Sydney. The day was designed to introduce the various careers available to junior doctors. About 70 doctors attended the event.

The NSW ANZCA table was well attended and questions ranged from “How do I become an anaesthetist?” to “How do I pass the primary exam?” and “How do I get a trainee job?”. Many thanks to NSW ANZCA staff and doctors who gave up their Saturday to talk about anaesthetics.

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

Tasmania

New South Wales

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

Date: Monday December 3 to Friday December 7, 2018
Venue: Northside Conference Centre
Corner Pok Lame and Oxley Street
Crows Nest, NSW
Fee: $A925 (including GST)
Applications close on Monday November 19, 2018 (if not already filled).

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

CPD in a day – A one-stop shop for all your ANZCA emergency response workshops
The Tasmanian ANZCA and ASA Committees are delighted to announce a great CPD opportunity. Our “CPD in a day” workshop presents all ANZCA and ASA emergency response workshops in one place on one day. Get all your emergency response activities completed together. One venue, one day, all the workshops, and most importantly all your CPD emergency response points – Cardiac arrest, ICU, anaesthesiology, major haemorrhage.

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

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

We look forward to seeing you there.

Dr Mike Challis and Dr Lia Freestone
Convenors

Australia news (continued)
Geoff Cutfield had suffered as a child with neurosensory deficit to his right lower leg, with trophic ulceration from spina bifida occulta. He required three operations to solve these issues -- a forehead operation at 13 years of age, a Syne operation through the ankle six months later, and a below knee amputation when a medical student in 1969. His artificial leg was never allowed to hinder his energetic participation in activities, and from time to time he was known to use the prosthesis to surprise onlookers. I remember my first meeting with Geoff when I was newly in Dunedin in 1977. I went to visit Jim Clayton, the Deputy Director of the Department, in an operating theatre where Geoff was assisting Jim as a second year house surgeon. They had been having trouble turning on an oxygen cylinder, and as I walked into the theatre Geoff just said stand back and immediately lashed out with his artificial leg hitting the cylinder wench mid-ith. My initial thought was “these Kiwis are tougher than I thought!” I was later to discover later the true fact.

Geoff joined the anaesthetic department the following year as a trainee and immediately declared his dedication, enthusiasm and willingness to contribute widely to departmental activities. Following his successful completion of training he departed for Oxford. In 1982 towards the end of his DPhil research I had a sabbatical leave year in Oxford and was able to observe first hand Geoff’s research mastery, including early starts to set up the experiments, fresh baked bread sourced for the team from Browns in the Woodstock Road and often late finishes. That year also saw Geoff suffer another major medical complication which he was required an ICU stay for several days – a severe haemorrhage from a Meckel’s diverticulum, a congenital variation in the small intestine occurring in 2 per cent of the population with complications in approximately 1 per cent of those people. Talk about chasing the small print!

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

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

Geoff’s major research and teaching interests were in applied cardiovascular physiology. It was a shame that his many clinical and academic activities limited his research time, as his research particularly on the effects of volatile agents on the coronary circulation indicated his flare for research. With his strong interest in the cardiovascular system it is sad to note that his sudden death was due to cardiac tamponade from a dissection in his thoracic aorta. During the latter part of his time in Newcastle (2008-2009) he also became involved in establishing the Joint Medical Program for medical students in the School of Rural Medicine at the University of New England in Armidale, as he believed passionately in supporting the rural areas.

In 2009, with the intent to live in a cooler climate for his wife Libby’s health, Professor Cutfield returned to Dunedin and Otago University from which he graduated MB ChB in 1973. His house surgeon and anaesthetic registrar years were spent at Dunedin Hospital culminating in his obtaining the FRANZCA in December 1979. In September 1977 he won the Renton Prize for top marks in that primary examination. In 1981 he obtained a MRCOG Overseas Research Fellowship that enabled his study at New College in the University of Oxford, and the Nuffield Department of Anaesthetics, where he was awarded his DPhil in 1983 for a thesis on “The Effects of anaesthesia and its interaction with myocardial coronary blood flow upon myocardial function”.

**Obituary**

Professor Geoffrey Ronald Cutfield, FANZCA

1948 – 2018

Steuart Henderson recounts that Geoff quite rightly regarded as harsh. In particularly hard winters holly berries are at their most abundant and Geoff would particularly delight in them. “Winters” were indeed hard, but the “holly” fruited lavishly and enriched the lives and understandings of so many.

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

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

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

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

All Baker Emeritus Professor, University of Sydney Honorary Historian, ANZCA
Obituary

Dr Vilim (Bill) Stanisich, FANZCA
1935 – 2018

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

Bill studied medicine at the University of Melbourne and graduated in 1962. He completed his internship at Warrnambool Hospital in 1962 and then moved to Geelong Hospital where he probably developed his interest in anaesthesia. Bill started his anaesthetic training at St Vincent’s in 1958. In 1964, after a “grand tour” of Europe, he settled in London and passed two fellowships, those of the Faculty of Anaesthetists Royal College of Surgeons of Ireland, and the Royal College of Surgeons. He was later elected to fellowship of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons in 1975. The awarding of these three fellowships made Bill the most qualified anaesthetist on the staff at St Vincent’s.

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

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

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

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

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

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