Warning to doctors: Slow-release opioid risks
The dangers of slow release opioids
ANZCA and FPM have issued a warning to all doctors against prescribing slow-release opioids for acute pain in opioid-naive patients because of the risk of respiratory failure and accidental death.

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Learning to live without alcohol
An anaesthetist, writing anonymously, tells how society’s drinking culture helped mask his own problem with alcohol, even though he ‘never want to seem drunk, nor drown drunk’.

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Dr Sancha Robinson was the mother of an eight-month-old baby and training to be an anaesthetist when she received the devastating news that she had metastatic bowel cancer.

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Dr Keith Greenwood, Chair of the Airway Management Special Interest Group, warns of fire risks associated with high flow nasal oxygen devices.

Your feedback
We share the results of the ANZCA Fellowship Survey and the ANZCA Trainee Survey.

#TheatreCapChallenge
Simple initiatives, such as having your name on your theatre cap, is just one initiative being championed by Sydney anaesthetist, Dr Rob Hackett.

Surveys inform key college decisions
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 6,700 Fellows and 1,200 trainees across Australia and New Zealand and serves the community by upholding the highest standards of patient safety. Cover: ANZCA and FPM have commenced an education campaign, warning doctors of the potentially fatal risks of prescribing slow-release opioids when treating acute pain in opioid-naive patients.

Medical editor: Dr Rowan Thomas
Editor: Clea Hincks
Art direction and design: Christie Langstone
Production editor: Loree Reynolds
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Submissions
Letters and other material
We encourage the submission of letters, news and feature stories. Please contact ANZCA Bulletin Editor, Clea Hincks at ch Hincks@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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Contacts
ANZCA
630 St Kilda Road, Melbourne Victoria 3004, Australia
Telephone +61 3 9510 6299 Facsimile +61 3 9510 6786 communications@anzca.edu.au
www.anzca.edu.au

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ANZCA Bulletin March 2018
President’s message

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

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

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

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

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

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

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

Professor David A Scott
ANZCA president

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Chief executive officer’s message

Review of ANZCA’s past five years

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

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

I’m pleased to report that in the recent fellowship survey the importance of the provision of CPD by the college was rated as high or very high by respondents. It was also encouraging to read that 87 per cent of fellows correspondingly rated the online CPD program as good or very good. In 2015 the Faculty of Pain Medicine developed and launched the free opioid calculator, smartphone app and website to promote consistency in converting opioid combinations. This has been widely accepted and adopted around the world since its launch.

ANZCA’s highly successful National Anaesthesia Day (NAD), that attracts widespread media coverage, was re-launched in 2015. Since then, NAD has gone from strength to strength in both countries and is a most effective medium for promoting better understanding of the anaesthesia and anæsthetists to the general community thanks to fellow engagement.

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

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

Electronic voting

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

The electronic voting system will save the college an estimated $15,000 per year at the council election alone as there will be no need to print ballot forms and custom-sized envelopes as well as the saving on postage throughout Australia and New Zealand and many overseas destinations. The new system will be more secure as every fellow will have a unique identifier that will record each fellow’s vote as soon as it is cast. It will also ensure that the number of informal votes as it will not permit voting for more than the specified minimum number of statements.

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

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

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

Visitors from Hong Kong

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

Our Education unit’s Olly Jones and Maureen Kean are visiting the Royal Prince Alfred Hospital in Sydney and observing at the Royal Children’s Hospital in Melbourne. President of the Hong Kong College, Associate Professor Chi Wai Cheung, HKCA board member and ANZCA examiner, Dr Simon Chan and HKCA CEO, Ms Christy Cheung will be attending the ANZCA Annual Scientific Meeting in Sydney in May.

John Iloot
Chief Executive Officer, ANZCA
Anaesthesia – an alternative view

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

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

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

3. I find it hard to believe there are some who complain that patients don’t know that an anaesthetist is a doctor. In some 50 years of practice in anaesthetics I cannot recall any such cause for concern. If the number of such people were in 10, 100 or in that much more than twice that number has an IQ below 90.

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

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

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

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

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

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

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

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

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

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

6. How does the term anaesthesiologist encompass the scope of the specialty more broadly? What is it about the suffix “ology”?

Does it improve our image to join the ranks of astrologists, iridologists and scientologists? To the academic and scientific base of paediatrics and obstetrics not sufficiently reflected in their names? Do physicists feel this insecurity?

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

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

9. The word anaesthesiologist has been in use since 1866. It was a well-chosen term. It has a long history and tradition. I would caution that a symbolic break with our great pioneers in the field could be regretted.

Dr Peter Beahan MBBS FANZCA
Stirling, WA

What’s in a name?

We support a name change from anaesthetist to anaesthesiologist.

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

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

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

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

Dr Wayne Morris FANZCA
Professor Alan Merry ONZM FANZCA FFPANZCA FRCA
New Zealand

Time for change?

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

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

Bravo Dr Brooks.

Dr Michael Allam FANZCA (retired)
ACT

Anaesthesia – your views

The relevance of the first item was that only some anaesthetists were members did not know that anaesthetists that only some anaesthetists were members did not know that anaesthetists that only some anaesthetists were members did not know that anaesthetists. The onus is on those who are not members did not know that anaesthetists. The onus is on those who are not members did not know that anaesthetists.

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Dr Wayne Morris FANZCA
Professor Alan Merry ONZM FANZCA FFPANZCA FRCA
New Zealand

ANZCA Bulletin March 2018

Awards

Fellows honoured on Australia Day

Congratulations to the following FANZCA’s who were appointed as a member of the Order of Australia:

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

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

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

2018 ANZCA National Anaesthesia Day

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

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

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

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

ANZCA will send posters and other material to hospitals in late September. Please contact communications@anzca.edu.au for more information.
The February 1 codeine up-scheduling changes led to several FFM media interviews and an opinion piece by Dean Dr Chris Hayes in The Sydney Morning Herald, The Age, The Canberra Times, The Newcastle Herald, WA Today, and another 125 regional and rural Fairfax Media mastheads. A total of 169 news items in 30 days reached 1.2 million readers and had an advertising equivalent value of $480,000.

Dr Hayes was also interviewed by ABC Radio Sydney Drive host Richard Glover on February 1, Dr Hayes and FFM’s Director of Professional Affairs Professor Milton Cohen were guests on the nationally syndicated Talking Lifestyle. Healthy Living radio program on the Macquarie network in the latest discussion on the restrictions discussing the codeine ban and alternative pain treatments.

Dr Hayes also appeared on ABC Radio Hobart’s breakfast program and ABC Radio Illawarra’s morning program. The Conversation published an article on opioids by FFM Vice Dean Dr Meredith Craige on February 1, which was also published on ABC online. Dr Craige also appeared on ABC Radio Adelaide’s last afternoon program on January 29. FFM’s Chair of the Professional Affairs Executive Committee Dr Nick Vagg was a featured guest on ABC Radio Melbourne’s 774 morning program where he discussed pain management and alternatives to codeine. Dr Vagg was also interviewed and quoted in an article “Teaching for the Codeine Consults” for medical.republic.com.au.

An FFM media release “Clock ticking for over-the-counter codeine sales” on January 6 was followed up by news.com.au, The Daily Mail and news radio stations SAW and 2GB. The radio “story” was then syndicated across Australia to nearly 30 radio stations.

The Age on January 24 published a letter from Dr Hayes, “Codeine must be prescribed”, in response to an opinion piece by Professor Peter Carroll, the President of the NSW branch of the Pharmaceutical Society of Australia. The Age published in The Age and Sydney Morning Herald on Monday January 22 opposing the up-scheduling codeine sales, which received 80,000 readers.

Dr Vagg also featured in several media articles on FFM and Choosing Wisely’s latest information campaign. A joint FFM and Choosing Wisely media release “New healthcare advice: Benzodiazepines will not help low back pain” led to a page one article in The Australian on February 14 which focused on the recommendation to not refer axial lower lumbar back pain for spinal fusion surgery and an Australian Associated Press article that was syndicated in The Guardian, theguardian.com.au, guardian.co.uk, and sydney.com.au. This coverage reached more than 1 million readers.

Australian Anaesthesia (the Blue Book) featured in a Herald Sun page 5 exclusive story on January 16 with a report on the hypnosis in children chapter co-authored by FANZCA’s Dr Allan Cyna and Dr Rob Laylin. The story reached an estimated audience of 1.2 million people and was syndicated to The West Australian, the Gold Coast Bulletin, the Daily Telegraph, the Hobart Mercury, the Cairns Post, the Adelaide Advertiser and the Courier-Mail. The issue was also covered by SAW’s morning breakfast program, ABC Radio Melbourne and 6PR in Perth.

In Tasmania, local media covered the awarding of Australia Day honours to fellows Dr Colin Chilvers and Dr Marcus Skinner for their significant service to medicine, anaesthestiology and medical education. Articles on Dr Chilvers and Dr Skinner were Members of the Order of Australia (AM) were featured in The Mercury and The Examiner. Associate Professor Dr Laurence (Larry) McNicol from Melbourne was also awarded an AM. Tasmanian print and broadcast media also followed the North West Regional Hospital (NWRH) accreditation issue with interest. ANZCA President Professor David Scott was interviewed in Melbourne for WIN TV news in Launceston and The Mercury on November 23 and The Advocate and ABC Radio Tasmania also followed the story.

The role of anaesthetists as part of the volunteer medical team for the world’s largest ocean water swim, the annual Lorene Pier to Pub event, featured in a Herald Sun article on Friday January 12 by health editor Grant McArthur. The article profiled former competitor Howard Fuller who collapsed with a heart attack during the Mt Warning to Surf race in 2013, The quick thinking actions of the medical team, including FANZCA Dr Kevin Moriarty, helped save his life.

The “Race medics saved my life” story reached a newspaper print readership audience of 380,000 people. Dr Peter Roessler and Dr Mark MacLennan helped facilitate the story with Dr Moriarty and Mr Fuller. Professor Scott was interviewed by the Sydney Morning Herald for a story about fellow Dr Rob Hackett’s initiative to have anaesthetists and other medical staff identified by name on their theatre caps (#TheatreCapChallenge) to improve patient safety and teamwork. For more on this story see page 28.

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

Professor Cohen was interviewed by Sydney talk back host Steve Price on the top rating 2GB breakfast program on Monday January 8 about the federal government’s decision to allow the export of local medicinal cannabis products. The interview reached an audience of 72,000 people.

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

Carolyn Jones
Media Manager, ANZCA

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

Ms Cole-Adams’ entry “Framing the Gift of Oblivion” was published in the Saturday edition of The Australian on February 11. The article was designed to encourage high-quality reporting on anaesthesia and pain medicine, and to raise the profile of the profession in the community. The judges described Ms Chisholm’s feature as “an engaging, well written, and extensively researched piece that presents highly technical and complex concepts in a way that is accessible to the reader. Donna’s report describes non-pharmacological treatments for chronic pain.”

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

The articles can be found at:
- www.notel.ca.nz/health/health/how-new-technology-helps-patients-combat-pain/

Carolyn Jones
Media Manager, ANZCA
Safe sedation and new Zealand government gets busy in first 100 days

New Zealand

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

Medicinal cannabis
Medicinal cannabis continues to be an issue to watch. In January, the government’s Misuse of Drugs (Medicinal Cannabis) Amendment Bill passed its first reading, and was referred to the Health Select Committee. The bill is open for public comment until March 21. The bill would introduce an exception and a statutory defence for terminally ill people to possess and use illicit cannabis, amend the classification of cannabis so that it is no longer classed as a controlled drug and enable regulatory standards to be set for the manufacture, import and supply of products. The bill is part of the Labour Party’s 100-day plan, after it failed to pass its first reading. The bill went further than the government bill, and would have made a specific exemption for any person with a qualifying medical condition to cultivate, possess or use the cannabis plant and/or cannabis products for therapeutic purposes, with the support of a registered medical practitioner.

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

New Zealand submissions:
• Medical Sciences Council of New Zealand – Revised scope of practice for anaesthetic technicians.
• Pharmac – Proposal to fund pregabalain, and change the funded brand of gabapentin and listing restrictions.
• Pharmac – Proposal to list methylxynolaxone bromide.
• Pharmac – Proposal to list anaesthesia small equipment and consumable devices.

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

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

Australia

ANZCA hosts roundtables on patient safety and sedation
ANZCA is continuing to engage with other colleges and key stakeholders about safe sedation, particularly in private day facilities. ANZCA hosted the first safe sedation roundtable in Australia on February 14, and another in New Zealand on March 8. The aim of the roundtables were:
• To understand the current safe sedation practices in Australia and New Zealand.
• To identify common principles and standards of safe sedation training across professional groups in Australia and New Zealand and identify areas of difference.
• To articulate the ideal safe sedation experience for patients.
• To identify the next steps in making safe sedation safer.

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

ANZCA and government: building relationships

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

In South Australia, licensing for stand-alone private day procedures centres is being introduced on May 1, 2018 under the Health Care Act 2006. All newly licensed facilities will be required to meet standards of construction, facilities and equipment with reference to the Australian Health Facility Guidelines and maintain accreditation against the National Safety Quality Health Service Standards.

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

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

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

Colorectal surgery: ensuring Fiona’s story is not repeated
An Australian patient, Fiona, died from an anesthetic induced myocardial infarction post colonoscopy in 2015. ANZCA’s representative on the national colonoscopy clinical care standard working group, Dr Philippa Hore, Chair of the ANZCA Safety and Quality Committee, helped to influence a positive outcome confirming ANZCA’s leadership in setting standards for sedation. PS09 Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures will continue to be followed. Delivery of IV propofol will only be by medical practitioners and any further ANZCA developed documents on sedation will be regarded as the standard.

Submissions:
• Medical Sciences Council of New Zealand – Revised scope of practice for anaesthetic technicians.
• Pharmac – Proposal to fund pregabalain, and change the funded brand of gabapentin and listing restrictions.
• Pharmac – Proposal to list methylxynolaxone bromide.
• Pharmac – Proposal to list anaesthesia small equipment and consumable devices.

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

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

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

Jo-anne Chapman
General Manager, Policy, Safety and Quality, ANZCA
Doctors’ health and wellbeing – new strategies

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


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

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

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

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

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

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

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

Carolyn Handley
Deputy CEO, ANZCA

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

What would you do?

In pondering over whether my practice is still appropriate or whether it constitutes safe practice, I consider the following risks which are triggered in my mind:

• What are the risks associated with caring for an intubated patient and subsequent extubation?
• What is the state of recovery of laryngeal reflexes in these patients?
• What is the state of reversal of muscle relaxation – (neuromuscular monitoring)?

In the post-surgery setting are intubated patients still considered to be anaesthetised or emerging from anaesthesia?

Should I remain with my patients until they are successfully extubated?

Should I remain in the facility until successful extubation is achieved?

Am I immediately available or have I committed to my next patient?

Have I handed over to another anaesthetist that is immediately available if not going to be immediately available?

Is the PACU nurse specifically trained and adequately experienced?

Are the majority of fellows engaging in this practice?

What are my motives for engaging in this practice?

The two main reasons for delaying extubation are either inadequate recovery from muscle relaxants, or inadequate recovery from anaesthesia. We are all aware that dislodgement of an endotracheal tube that is left in situ due to inadequate reversal poses a major risk, and consequently close monitoring by skilled monitoring practitioners is essential. On the other hand, if the tube is left in situ due to prolonged narcotisation or inadequate recovery from anaesthesia then is the patient deemed to still be anaesthetised? (Refer to definitions in PGY Guidelines on Sedation and/or for Anaesthesia for further detail.)

Are the majority of fellows engaging in this practice?

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

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

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

Dr Peter Roessler explains ANZCA’s professional documents using practical examples.
Slow release opioids – the need for a statement

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

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

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

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

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

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

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

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

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

Dr Kim Hattingh, Professor Pamela Macintyre, Professor Stephan Schug, Dr Meredith Craigie and Dr Philippa Hear

The listed indication for a transdermal fentanyl patch is “the management of chronic pain requiring opioid analgesia”, but note is made that these patches are specifically contraindicated in opioid-naive patients and in the “management of acute or post-operative pain” because serious or life-threatening hypoventilation may occur which can be fatal.

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

1. Addition of a background infusion to opioid administration by IV PCA is known to markedly increase the risk of respiratory depression1,6,7.

Administration of a new slow-release opioid in addition to IV PCA or PRN oral opioids is essentially the same as adding such a background infusion.

2. If sedation/respiratory depression occurs as a result of a combination of “background” slow-release opioids in addition to PCA bolus doses, then excessive sedation/respiratory depression is likely to be more sustained than if an opioid PCA background was ceased when excessive sedation was first noted.

3. Interpersonal variation in pharmacokinetics and response to opioids makes predicting a dose of sustained-release opioid in an opioid-naive person impossible; and if side effects are encountered, they may be of sustained duration.

4. In most patients, pain intensity will decrease reasonably rapidly over a few days. In order to minimise the risk of opioid-related adverse effects, lower doses of IR opioids may be necessary.

5. Long-term opioid use often begins with treatment of acute pain. It is known that a proportion of patients prescribed an opioid for management of their acute pain will still be taking an opioid one or two years after discharge. Prescription of slow-release opioids in the initial treatment of pain is associated with an increased risk of long term opioid use. When opioids are used for acute pain, especially for discharge or in the community, the quantity prescribed should be based on the expected duration of pain which is severe enough to require an opioid1,8.

PRACTICE POINTS

1. The most appropriate initial treatment of acute pain using oral opioids is by titration of immediate-release opioids on a PRN basis. Most immediate-release opioids will reach peak effect within one hour. The peak effect of slow-release opioids will not be seen for some hours.

2. For opioid-naive individuals, the initial PRN dose of the immediate-release opioid should be age-based; for patients transitioning from PCA, PRN dosing can be guided by their previous PCA opioid requirements. Such PRN dosing permits treating acute pain in a targeted way, which is variable, often changes with activity, and is likely to improve with time.

3. There is no safe maximum dose of opioid, therefore the importance of titration of the dose according to effect and adverse effects (especially using sedation scores) should be stressed1,9.

References:
3. In postoperative or post-traumatic patients with prolonged pain states, it may sometimes be useful to introduce a slow-release opioid in a previously opioid-naïve individual on a temporary basis after careful reassessment. Consideration should then be given to opioids with the least sedative (and therefore respiratory depressant) effect, in establishing an appropriate dose, time to steady state should also be considered. As daily opioid requirements may vary considerably in the acute pain setting, the dose should be frequently assessed and reduced appropriately. Communication with the primary service (including rehabilitation services) or general practitioner about the temporary basis of this prescription is essential.

4. Patients, who are already taking a slow-release opioid prior to admission, including those in opioid-substitution programs, are tolerant to and physically dependant on that opioid. After independent confirmation of the drug and dose, their slow-release opioid should be continued. The patient’s acute pain should be treated using multimodal analgesia including titration with PRN immediate-release opioids.

5. Not all pain is opioid responsive. If excessive sedation develops (as a warning sign of impending respiratory depression), but pain is still present, then reassessment should occur, and consideration be given to non-opioid analgesia for patients discharged in a planned timeframe.

6. Psychological and social aspects of a patient in pain need to be addressed in parallel to medical approaches such as analgesics, even in an acute pain setting. Preoperative anxiety, catastrophising and depression or other mental health issues can amplify a patient’s expression of pain, and are associated with increased risk of developing persistent pain. Addressing these may be an important factor in treating acute pain adequately.

Note: The term “slow-release” is used by the Australian Commission on Safety and Quality in Health Care in its National Inpatient Medication Chart and covers all medications that may be referred to as slow-release, sustained-release, extended-release, modified-release and long-acting.

For the purposes of this statement, “slow-release” will also refer to transdermal opioid patches and methadone.

References:
Endorsing gender equity

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

With four of the past five ANZCA presidents women and strong female representation of trainees (31 per cent between the ages of 32 and 33), some may wonder if the college has a gender equity problem. We do have much to celebrate but there is more that we can do to ensure equal representation of women and men across our fellowship and in leadership and management positions.

As one of their first initiatives, the working group and ANZCA team sought to understand how gender equity affects FANZCAs and FFPMANZCs using information sourced from ANZCA and FPM databases and responses to the 2017 ANZCA and FPM fellowship surveys. The latter included data from the 1992/3 to 2017 (35 per cent) FANZCAs and 242/396 (31 per cent) FFPMANZCs who responded. All datasets include fellows residing in Australia, New Zealand and overseas.

Cause to celebrate

The historical gender imbalance within anaesthesia and pain management is rapidly diminishing as women enter and complete training. Forty-five per cent of ANZCA trainees are female, indicating more women than previously are being trained.

ANZCA takes an active role in eliminating the incidence and impact of these behaviours for the benefit of all fellows and trainees by developing a working party and position statement on Bullying, Discrimination and Sexual Harassment (BDSH) and more recently through the establishment of the Trainee Wellbeing Working Group. However, the survey results oblige us to address these behaviours as an ongoing strategy.

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

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

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Areas for action

In line with other sectors, female FANZCAs are underrepresented in departmental leadership and, compared with men, female FANZCAs and FFPMANZCs want more opportunities in leadership, education and research.
A number of gender-based preferences for continuing professional development (CPD) are apparent. For instance, interrogation of the ANZCA CPD platform over the last four successive years demonstrates that the percentage of female FANZCAs completing CPD is consistently between 2 per cent and 3 per cent higher than men in eight categories (morbidity and mortality review; team-based scenarios; formal courses; learning sessions, problem-based learning discussions; trainee work-based assessment and cardiac arrest sessions) whereas CPD activities were weighted toward men by between 1 per cent and 2 per cent in two categories (journal reading and patient satisfaction surveys). Delegated registration databases indicate that, relative to their population, women are over represented at ANZCA Special Interest Group meetings (M 53% v F 47%). Analysis of the 2017 Fellowship survey revealed few gender-based differences regarding satisfaction among FANZCAs and FFPMANZCs with a range of CPD activities provided by ANZCA and FPM.

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

Leadership and management
Unbalanced gender representation in senior leadership has received considerable attention within the business and academic sectors. This is not simply because of its association with income, but because it is recognised that the perspective and values of leaders influence working conditions, promotion opportunities and culture within the organisations they lead.4

Within ANZCA accredited hospitals, the head of department roles favour males (M 80% v F 20%) and slightly more men than women report having leadership or management roles (M 52% v F 48%). In contrast, while men outnumber women as ANZCA Supervisors of Training (M 64% v F 36%), the percentage of female SOs is slightly greater than the percentage of female FANZCAs overall. Approximately 47 per cent and 42 per cent of male and female FPPMANZCs report having leadership and management roles, demonstrating women are relatively overrepresented compared to their population within the FPM. Meanwhile, among FANZCAs who are dissatisfied with their practice profile, more women than men want opportunities to advance in leadership (M 13% v F 22%). This is similar for FFPMANZCs.

Research and education scholarship
Among FANZCAs, 36 per cent of men and women report having a research component to their practice. This is less for FANZCAs (M 16% v F 12%). Based on three-year data, gender balance has been achieved within recipients of the ANZCA Foundation grants (M 64% v F 36%), including lead investigators (M 64% v F 36%). Slightly more female than male FPPMANZCs are reported desiring an opportunity to conduct more research (M 70% v F 45%) whereas, no gender differences were reported among FANZCAs.

Approximately 50 per cent of FANZCAs and FFPMANZCs of both genders report having educational roles within their practice and approximately 30 per cent of FANZCAs and 40 per cent of FFPMANZCs report volunteering to ANZCA committees and/or educational initiatives, in some capacity. Here, gender imbalances tend to even out across all roles, which include organiser, lecturer, mentor and facilitator. However, more female FANZCAs report teaching trainees in the workplace (M 85% v F 88%) and seeking more opportunities to advance in educational roles (M 27% v F 22%). This data is similar for FFPMANZCs.

Wellbeing: Bullying, discrimination and sexual harassment
The follow-up survey included questions on quality of life and options to complete the Kessler (Ko) questionnaire and a questionnaire on bullying, discrimination and sexual harassment.

Quality of life is reported as “very good” to “excellent” for the majority of FANZCAs (M 88% v F 88%) and FFPMANZCs (M 86% v F 79%). However, many FANZCAs and FFPMANZCs struggle with work-life balance. For example, approximately one-quarter of FANZCAs (M 25% v F 27%) disagreed or strongly disagreed with the statement “my work situation leaves me enough time for my family and/or personal life”. The percentage was higher for FFPMANZCs (M 34% v F 57%). In another expression of work-life balance, a high percentage of FANZCAs “agreed” or “strongly agreed” that “there were occasions when I think I should have taken time off for illness but did not do so” (M 60% v F 63%). This was similar for FFPMANZCs.

The K10 measures 10 markers of psychological wellbeing and generates a composite severity score in the low, moderate, high and very high range. A small number of FANZCs (M 5.5% v F 1.2%) and FFPMANZCs (M 16% v F 4%) scored in the two highest grades. Fortunately, very few respondents rated any of the 10 individual measures as occurring “most” or “all of the time”. Overall, however, the responses to the quality of life and K10 questions suggest that work-life balance and mental health are important issues for all genders.

The BIDH questionnaire measured fellows’ exposure over a three-year period to a range of unacceptable behaviours. The results, which are more detailed than can be reported here, are concerning overall and in terms of gender imbalance. Here, they reveal that more FANZCAs (M 60% v F 56%) than male FPPMANZCs reported being personally subjected to bullying (M 73% v F 42%), discrimination (M 14% v F 28%) and sexual harassment (M 11% v F 8%). In all categories, more women than men witnessed these behaviours, and felt less adequately prepared and supported to deal with them. The results for FFPMANZCs are not dissimilar.

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

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

A number of gender-based preferences for continuing professional development (CPD) are apparent. For instance, interrogation of the ANZCA CPD platform over the last four successive years demonstrates that the percentage of female FANZCAs completing CPD is consistently between 2 per cent and 3 per cent higher than men in eight categories (morbidity and mortality review; team-based scenarios; formal courses; learning sessions, problem-based learning discussions; trainee work-based assessment and cardiac arrest sessions) whereas CPD activities were weighted toward men by between 1 per cent and 2 per cent in two categories (journal reading and patient satisfaction surveys). Delegated registration databases indicate that, relative to their population, women are over represented at ANZCA Special Interest Group meetings (M 53% v F 47%). Analysis of the 2017 Fellowship survey revealed few gender-based differences regarding satisfaction among FANZCAs and FFPMANZCs with a range of CPD activities provided by ANZCA and FPM.

When considering obstacles to achieving their desired changes in their practice, more female than male FANZCAs reported feeling that they “too busy with family commitments” (M 17% v F 26%) however this was somewhat reversed for FPPMANZCs (M 22% v F 16%). In contrast, female FANZCAs reported feeling that they “lack the necessary skills” (M 5% v F 16%) was slightly more pronounced for female FFPMANZCs (M 6% v F 16%).
Learning to live without the lure of alcohol

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

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

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

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

Like most who have grown up in Britain or Australia, alcohol has been an ever-present part of life. As children we saw it served at every celebration. We observed admired adults enjoying it, apparently responsibly. At university there was a culture of heavy drinking. Alcohol is presented as a prerequisite to enjoyment of life. Articles on “the most liveable cities” show photographs of attractive sophisticates enjoying wine. Medical magazines have sections on wine tasting. It is inescapable. As pharmacological tolerance to alcohol develops, it is predictable that most people, on average, tend to drink a steadily increasing amount as time goes on.

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

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

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

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

I have alluded to some factors that promote denial. In common parlance the term “alcoholic” carries a stigma, and an assumption that one’s drinking has already seriously harmed relationships, dignity, employment and other areas of life. The phrases “alcohol problem” and “problem drinking” are bandied about with no clear definition for most lay people. The language and stigma around alcohol addiction is more than unhelpful, it actively contributes to delays in recognition and seeking help. Many of us have already lost control over our drinking, and are drinking more and more frequently than we want. Society discourages us from addressing this or seeking help until it has already caused serious harm. Like the cardiac arrest last century, help arrives only after the odds of survival have diminished significantly.

Society classifies alcoholics as “different”. As Annie Grace argues in her book This Naked Mind, anyone who drinks is potentially at risk of harm from addiction. The division into us (“responsible drinkers”) and them (“alcoholics”) is comforting for both parties. The “responsible drinkers” are not challenged to address their behaviour – they see no risk of deterioration – and the “alcoholics” are supported in their self-denial. I believe that most drinkers are at risk of descent into addiction, whether that ultimately manifests itself as what we call “alcoholism”, or whether that manifests itself as unhappiness or health problems. This is an unpopular view and I wouldn’t expect to convince readers in a few paragraphs. I encourage anyone who feels they may have lost control over alcohol, or simply wishes to cut down, to read This Naked Mind.

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

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

Anonymous, FANZCA

To protect the personal and psychological wellbeing of its fellows and trainees, ANZCA offers a range of resources. Visit www.anzca.edu.au/resources/doctors-welfare for these resources and to access the free ANZCA Doctors’ Support Program.
Fires outside the airway and in the head and neck region

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

The surgeon should consider if non-alcoholic surgical preparations are suitable. If alcoholic solutions are used, sufficient time to allow the alcohol to evaporate completely is important. Wide surgical drapes should be placed over any fuel areas in the surgical field. Close communication between anaesthetist and surgeon is essential.

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

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

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

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

Airway fires

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

Other fuel sources, which may ignite in the presence of high FiO2, include burn eschar. Many of these fires go unreported and rarely cause patient morbidity. A flame or spark is often observed at the diathermy or laser tip where eschar acts in a similar manner to a BBQ heat bead. Surgical staff may falsely infer that the ignition source has malfunctioned but there has been accelerated burning of burn eschar leading to a flash fire. Although there may be damage to the diathermy insulation, this may be secondary to the flash fire of the eschar due to the oxygen-enriched atmosphere.
It is the anaesthesiologist’s role to ensure the lowest oxygen concentration for patient safety by lowering FiO2 and scavenging any expired oxygen, thereby preventing rapid-insufflation ventilatory exchange (THRIVE). Increasing FiO2 directly increases the risk of ignition and speed of fire propagation while total burn time decreases. This equates to a higher risk of high intensity flash fires. Decreasing FiO2 substantially decreases this risk8,9. The Anaesthesia Patient Safety Foundation recommends reducing the FiO2 to the lowest possible value. This will allow the operator to reduce the FiO2 and scavenging oxygen by suctioning. 

However, extreme caution should be taken when surgical diathermy or laser is being used. The Laser Safety Code and Prevention are essential for patient safety by lowering FiO2 levels. Adequate fire safety training while total burn time decreases14. This will allow the operator to reduce the FiO2 and scavenging oxygen by suctioning. The Anesthesia Patient Safety Foundation recommends reducing the FiO2 to the lowest possible value. This will allow the operator to reduce the FiO2 and scavenging oxygen by suctioning. 


Cannula should be cannula at flows < 6l/min-1 may be used to increase the FiO2 to the lowest possible value. This will allow the operator to reduce the FiO2 and scavenging oxygen by suctioning. The Anaesthesia Patient Safety Foundation recommends reducing the FiO2 to the lowest possible value. This will allow the operator to reduce the FiO2 and scavenging oxygen by suctioning.

If the cannula itself is intended to be used in close proximity to an ignition source it should be removed prior to surgical diathermy or laser use. The Anesthesia Patient Safety Foundation recommends reducing the FiO2 to the lowest possible value. This will allow the operator to reduce the FiO2 and scavenging oxygen by suctioning. The Anaesthesia Patient Safety Foundation recommends reducing the FiO2 to the lowest possible value. This will allow the operator to reduce the FiO2 and scavenging oxygen by suctioning. 

In summary, HFNO’s role in difficult anaesthesia is the determination of oxygen delivery in the presence of an ignition source. HFNO is designed to prevent the formation of a fire. Oxygen must be saturated with the expired oxygen concentration. Anesth Analg 2013; 116: 78-83. 


ALERT: Severe Euglycemic Ketonacidosis with SGLT2 Inhibitor Use in the Perioperative Period

Background

Sodium-glucose co-transporter 2 (SGLT2) inhibitors ("sulfones") are oral medications that act by promoting glucose excretion in urine and are used in the treatment of Type 2 Diabetes Mellitus14,15.

There have been recent reports of patients with type 2 diabetes who are taking these medications developing euglycemic diabetic ketoacidosis (EDKA) leading to severe acidemia requiring ICU/HUD admission during the perioperative period16,17,18. The clinical chemistry features of EDKA include:

- Acidemia: Plasma pH <7.3.
- Metabolic Acidosis – Standard Base excess <5 mmol/L.
- Plasma bicarbonate <15 mmol/L.
- Wide anion gap: anion gap >20 mmol/L (lactate corrected).
- Normal or mildly increased plasma ketones.
- Urinary ketones may be normal or increased. 

Possible triggers for EDKA include:

- Restricted dietary intake (for example, when the patient is eating and drinking and close to discharge (usually 3 days post-surgery). 

SGLT2 inhibitor agents include dapagliflozin (Forxiza), empagliflozin (Jardiance), canagliflozin (Invokana, available in New Zealand but not in Australia), or a combination with metformin (Xigduo, Jardiamet). 

References for practice:

- SGLT2 can be ceased up to three days pre-operatively or in other physiologically stressful situations (the two days prior to surgery and the day of surgery). This may require an increase in other glucose lowering agents during this time.
- Strongly consider postponing other urgent surgery if SGLT2 inhibitors have not been ceased three days prior to surgery.
- Increased ketotic metabolism.
- Have metabolic acidosis on VBG or ABG.
- Have fingerprick ketone (or blood beta-hydroxybutyrate) levels >0.6 in the perioperative period, or >0.5 at any other time point.
- Have metabolic acidosis on VBG or ABG. 

- Patients who have day surgery procedures should only be restarted post-operatively when the patient is eating and drinking and close to discharge (usually 3 days post-surgery). 

- SGLT2 inhibitor agents include dapagliflozin (Forxiza), empagliflozin (Jardiance), canagliflozin (Invokana, available in New Zealand but not in Australia), or a combination with metformin (Xigduo, Jardiamet).
Patient safety: #TheatreCapChallenge goes viral

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

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

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

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

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

Among the projects already under way is a campaign to ban the use of the lightly tinted topical antiseptic solution chlorhexidine in hospitals and replace it with a vividly coloured alternative. Dr Hackett believes this simple change in practice will lead to better patient safety and save lives. In a high profile case in Australia in 2010, a small child who was given an epidural of the antiseptic instead of anaesthetic died. Dr Hackett believes Australia is already a world leader in patient safety but could still be doing more to reduce the number of unnecessary medical errors.

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

“The frameworks we exist in don’t work to deliver safety solutions. The best we deliver is an alert or a reminder that gets lost in a sea of other alerts and policies and we keep making the same errors again and again,” Dr Hackett believes that for patient safety to improve all healthcare stakeholders should develop a better understanding of the “human factors” approach to patient safety.

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

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

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

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

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

“The form was always ticked with this question but it is often never done. And it’s quite sad that it isn’t and even if it is done we forget each other’s names very quickly,” Dr Hackett says.

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

The Bulletin
How a cancer diagnosis taught me the importance of “care always”

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

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

Originally from the UK, I started training as an anaesthetic registrar in Townsville before moving to Newcastle. In 2000, aged 31, I was diagnosed with metastatic bowel cancer. At the time I was in my first year of advanced training, working full time and getting up several times a night to my eight-month-old daughter. There were few symptoms – I found a lump in my right lower abdomen while I was having a shower. In retrospect I was a bit short of breath when I went for a run (I thought I was just a bit unfit), I was tired all the time (that would be the baby!) and I’d lost a bit of weight. The lump didn’t go away, so after a week I went to my GP who couldn’t feel anything, but he ordered an ultrasound scan “just to be sure”. I duly attended the same afternoon and after identifying some abnormal looking golf ball sized black blots I was run through the CT scanner. The clinic was closing up and only a few nurses and the radiologist were left. Just after 5pm on Thursday October 7 I was called into the radiology room. The first thing I noticed was a scan on the light box behind him – I thought to myself “that patient has got something huge in their abdomen and shoulder – I’m done”. As the radiologist started talking I thought to myself, “that’s what I noticed was a scan on the light box behind him – I thought to myself ‘that patient has got something huge in their liver’.” As the radiologist started talking I thought to myself “that patient has got something huge in their liver.”

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

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

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

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

In the end I decided it was absolute rubbish, and the best thing to do accepted how I felt and wallow on the couch. I changed oncologists and, since our first conversation was about hangbags, I knew that she understood me. In May 2011 I had another PET scan which showed no signs of cancer.

Seven years on I remain cancer free. By the time this goes to print my daughter will be eight years old, thriving at school and torturing me with her terrible violin practice. Pilates has fixed my chronic lower legs burned, particularly at night. It was like having the worst hangovers for months on end, sometimes just a few beers kind of hangover (immediately before the next cycle of chemo) and sometimes a whole bottle of tequila kind of hangover (a few days before this was how I spent my birthday and 50th birthday I had done this journey too. Post op I spent a few days in ICU, unconfortably stuck to the bed with dopps, catheters, drains and an epidural. I really wanted my mum to look after me but she was in the UK. So the ICU nurse offered to be my mum for the day. She gave me a bed bath, resulting in a wonderful feeling of cleanliness after being covered in sticky betadine. Every day afterwards it’s still those acts of kindness that I remember the most.

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I consider myself lucky to have these experiences. Being a patient has taught me a lot about being a doctor. That the smallest things you can do to show you “care always” , even for a minute, are incredibly therapeutic for patients.
More than a third of all fellows responded to the recent fellowship survey that seeks feedback from fellows on their attitudes and perceptions and on how the college meets their needs and expectations. Running every three to four years, the survey also assists with the delivery of services to fellows and supports strategic and business planning.

A total of 1934 surveys were distributed to ANZCA and FPM fellows commencing Friday October 27, 2017 and closing December 4, 2017. The overall response rate was 36 per cent for ANZCA and 31 per cent for FPM (dual fellows encouraged to complete the FPM survey) establishing a benchmark for comparison in future surveys. The response rate puts the college in the top 90 per cent when comparing responses with similar organisations.

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

While the majority of fellows who responded to the surveys have commented favourably on the college’s work and staff, there are areas where improvements can and should be made.

As with previous surveys, the college will develop a college-wide action plan to address areas of concern or where improvements have been identified. The action plan (one each for ANZCA and FPM) are being prepared through consultation with college units, committees, working groups and individual fellows and trainees.

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

Where possible, the college will also work with other professional organisations to ensure the interpretation of the feedback and initiatives and resources developed for fellows and trainees are done using expert guidance and practice. Consultation with and the role of the Welfare of Anaesthetists Special Interest Group in both BSDH and health and wellbeing will be integral in ensuring the relevance and integrity of all initiatives and resources. Dissemination of the de-identified findings of the fellowship surveys to college committees will also ensure that there is a broad awareness and understanding of the findings and that where needed work can be undertaken in a consistent and co-ordinated way across committees and college units. Where gender, diversity of location has been identified this too will help support tailoring of initiatives and services.

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

Jan Sharrock
General Manager, Fellowship Affairs, ANZCA

**Surveys inform key college decisions**

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

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**Experience with college staff**

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<thead>
<tr>
<th>Experience with College Staff Among the 54% of Fellows Who Have Had Contact</th>
<th>Very Good + Good</th>
<th>55%</th>
<th>Very Good</th>
<th>36%</th>
<th>Very Good + Good</th>
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Fellows’ experience with college staff has been increasingly positive (89 per cent, up from 81 per cent), with significantly more reporting that their experience was very good (55 per cent, up from 36 per cent).

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

A total of 85 per cent of fellows are aware of the work and focus of the ANZCA Research Foundation with some work needed on promoting the support of overseas aid and Indigenous health activities.

**Future intentions: With regards to voluntary roles**

**ANZCA roles: Importance versus performance**

**ANZCA publications and communications: Trend results**

Sixty per cent of respondents are currently undertaking a voluntary role with the college. 48 per cent of all respondents indicated a preference to undertake a voluntary role in the future, with the most desirable roles being examiner, accreditation visitor, lecturer and supervisor of training. Interest was highest among new fellows (72 per cent) and those aged under 40 (50 per cent).

The performance of Networks, the learning management system used by the college was not rated highly by fellows with 20 per cent of respondents indicated they had not used Networks, or that its performance was average or below. The college committed to undertaking work to enhance and improve the system and the fellow experience.

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

**Key findings – ANZCA**

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

**Commentary**

Support is offered by graph where available to better highlight responses and in some instances shows the breakdown of either age, region or gender.

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

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

**General**

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

**ANZCA’s survey – what we covered**

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

**ANZCA’s roles: Importance versus performance**

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

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

**Communications**

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**Future intentions: With regards to voluntary roles**

**ANZCA roles: Importance versus performance**

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

As was the case in 2014, a strong majority of fellows (steady at 83 per cent) say the current amount of ANZCA email communications is about right. It is evident that while social media (Twitter and Facebook) is used well at events and conferences there is more work to be done to engage with fellows using this communication channel.

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

Fellows’ perceived usefulness of CPD events has significantly increased since 2014, particularly those who find events very useful (52 per cent up from 17 per cent) with a majority (72 per cent) of fellows overall finding the CPD events useful.

**CPD Portfolio: Ease of use**

![Ease of Using CPD Portfolio](image)

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

### New approaches to learning and assessment

The majority (39 per cent) of fellows support the inclusion of online learning and courses in CPD activities and value highly peer review, multisource feedback, access to the ANZCA Library, workshops and the CPD dashboard when completing their CPD requirements.

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

### Workforce

Fellows have indicated that there has been an increase in the number of hours worked (up 5.6 hours since 2014, from 39.1 to 44.7). A majority of fellows rated their quality of life, general health and psychological levels positively, one in four disagree their work situations leaves them enough time for family/personal life and six in ten indicate they have worked through illnesses.

### State of practice

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

Nine in ten fellows (91 per cent) are satisfied with their practice profile, with two in three being very and quite satisfied (68 per cent). The most common change to the practice profile desired by fellows is to work less overall (59 per cent) with the one in four fellows (25 per cent) who feel that their clinical workload is a barrier to changing their practice profile.

### Provincial and regional work

**Key findings – FPM**

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

**General**

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

### Perceptions of FPM overall

**FPM’s Performance Overall:**

![FPM’s Performance Overall](image)

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

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

**FPM roles: Importance versus performance**

![FPM roles: Importance versus performance](image)

While four in five fellows rated FPM’s performance as good or very good in the provision of education (85 per cent), FPM Training Program (82 per cent), and CPD (81 per cent) there is room for improvement in regard to quality and safety standards, profile of the profession and advocacy. Work is being done in these areas however it seems that greater communication of what is being done and the outcomes is needed.

Around three in four (72 per cent) fellows have undertaken voluntary roles within the faculty with the most frequently reported roles, a committee or council member (58 per cent), followed by lecturer (32 per cent), mentor (27 per cent), supervisor of training/practice development stage (26 per cent), and examiner (25 per cent). Fifty-one per cent of fellows indicated they would be interested volunteer roles in the future.

### Voluntary roles undertaken within FPM

![Voluntary roles undertaken within FPM](image)

**Communication**

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

The publications most highly rated by fellows were Acute Pain Management (90 per cent good or very good), Synapse (81 per cent), and the ANZCA Bulletin (76 per cent). The vast majority of fellows were unsure of how to rate Twitter (81 per cent), Facebook (86 per cent), and YouTube Channel (89 per cent).

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

**Advocacy**

More than one in five fellows suggests that the faculty could advocate for the profession to a greater extent (15 per cent) and better represent all members, rather than a select few (14 per cent) for example, advocating the importance and uses of pain medicine to government so that the role and value of the profession is better understood.
Surveys inform key college decisions (continued)

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

Locally organised CPD events
Three in four Fellows find the locally organised CPD events either Very Useful or Quite Useful (73%), with fewer than 30% rating them Not Useful. 7% rate them Other useful.

Practice profile: Distribution of hours

Usefulness of CPD Events

<table>
<thead>
<tr>
<th>Usefulness</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very useful</td>
<td>30%</td>
</tr>
<tr>
<td>Quite useful</td>
<td>44%</td>
</tr>
<tr>
<td>Not very useful</td>
<td>15%</td>
</tr>
<tr>
<td>Not at all useful</td>
<td>3%</td>
</tr>
<tr>
<td>Don’t use</td>
<td>9%</td>
</tr>
</tbody>
</table>

The CPD activities that fellows cited as most beneficial to their practice and CPD were meetings and workshops (57 per cent), lectures and conferences (35 per cent), and ASM/scientific meetings (24 per cent).

Workforce
FPM fellows are working an average of 40.5 hours per week, with more than one in two (55 per cent) working more than 40 hours per week. Nearly half (46 per cent) of all fellows expect to retire within the next 10 years and the majority of fellows (86 per cent) practice in a metropolitan area. Half of all fellows’ practice hours (57 per cent) are spent working in chronic non-malignant pain services, with only 8 per cent of hours spent working in acute pain services, and 4 per cent in cancer pain services.

Quality of life and general health

The majority of fellows rated their quality of life positively, with nearly nine in ten (90%) saying that their quality of life was very good or excellent. Similarly, general health was rated positively by the majority of fellows.

Work-life balance

One in two fellows strongly agree or agree their work situation leaves them enough time for family/personal life (54 per cent), although one in four (28 per cent) disagree or strongly disagree. Six in ten fellows (65 per cent) say they worked through illness when they should have taken time off.

Health and wellbeing and bullying, discrimination and sexual harassment

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

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

Quality of life

Very Good + Excellent: 74% (125); How good or excellent is your life?; How would you rate your quality of life?

Excellent Very good Fair Poor

Very Good + Excellent: 74% (125)

Strongly agree Agree Neutral Disagree Strongly disagree

Strongly agree Agree Neutral Disagree Strongly disagree

Wellbeing

Strong or Very Strong. Fellows with lower levels of satisfaction in career choice are those based overseas, in countries other than New Zealand.

Although the clear majority of fellows fall into the low or moderate category of psychological distress (89 per cent), one in ten fellows is experiencing some higher levels of distress. There is a sentiment among fellows that there is stigma attached to divulging mental health issues (89 per cent agree or strongly agree). Two in three Fellows (65 per cent) would not want people to know if they were suffering from mental health issues.

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

Desire to practice medicine

Very strong 41% 45%

Strong 41% 28%

Lukewarm 12% 13%

Weak 0% 1%

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

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

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

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

Health and wellbeing of Fellows – 2018

The fundamental aspects of wellbeing include: Work-life balance, Health and wellbeing and bullying, discrimination and sexual harassment.
Surveys inform key college decisions (continued)

Summary of key results: Reported BDSH occurrence

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

Know how to report or seek help regarding

- Bullying: 33% experience, 57% witnessed
- Discrimination: 20% experience, 26% witnessed
- Sexual harassment: 5% experience, 11% witnessed

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

FPM health and wellbeing

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

Work-life balance

- 51% experience, 52% witnessed
- 41% experience, 38% witnessed
- 47% experience, 45% witnessed

Mental health and the Kessler Scale

- Low + Moderate Psychological Distress: 86%
- High + Very High Psychological Distress: 14%

Overall results show that 25 per cent of fellows responding to the survey personally experienced workplace bullying with 58 per cent personally witnessing it; 11 per cent personally experienced workplace discrimination and it was witnessed by 17 per cent and 4 per cent personally experienced workplace sexual harassment with 7 per cent personally witnessing it.

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

FPM - BDSH

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

Summary of key results: Reported BDSH occurrence

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

Know how to report or seek help regarding

- Workplace Bullying: 29% experience, 58% witnessed
- Workplace Discrimination: 11% experience, 17% witnessed
- Workplace Sexual Harassment: 4% experience, 7% witnessed

When looking at gender specific results there is a significantly greater incidence of bullying being personally experienced and witnessed by fellows who are female and they feel significantly less prepared to deal with bullying behaviours in the workplace.

Female fellows experience a significantly greater incidence of discrimination, two times more likely than males and are also more highly represented when it comes to sexual harassment in the workplace.

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

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

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

Differentiating nociception and pain

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

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

Procedural implications

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

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

Outcome measurement

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

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

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

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

The challenge ahead

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

Dr Chris Hayes
Dean, Faculty of Pain Medicine
New Fellows

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

Dr Alette Bader, FRACGP, FFFMANZCA (Queensland)
Dr Anthony Carrie, FANZCA, FFFMANZCA (New Zealand)
Dr Megan Eddy, FRACGP, FFFMANZCA (Victoria)
Dr Roopa Gawarikar, FRANZCR, FFFMANZCA (ACT)
Dr Christopher Jones, FANZCA, FFFMANZCA (New Zealand)
Dr Jamie Young, FAFRM (RACP), FFFMANZCA (Victoria)
Dr Yuen Chuan Leow, FFRACGP, FFFMANZCA (Queensland)
Dr Joseph Khiever, FRACGP, FFFMANZCA (Queensland)
Dr Yuen Chuan Leow, FRACP, FFFMANZCA (NSW)
Dr Sonya Ting, FANZCA, FFFMANZCA (WA)

This takes the number of fellows admitted to 461.

Steppe out – dealing with chronic pain in Mongolia

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

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

He’s presently analysing the data that has been gathered already from the first few batches of questionnaires with some of the most complex cases. “The patients are not too dissimilar to New Zealand patients so together we need to think about similar chronic pain treatment programme as we have here.”

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

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

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

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

He urges fellows who get the chance to do a passing conversation with a colleague from Western Australia a few years ago has led to an ongoing relationship with counterparts in Mongolia for a New Zealand pain medicine specialist.

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

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

Lifebox is evolving to deliver other programs and education initiatives to make every operating room a safer place for patients and healthcare providers. In addition to donating pulse oximeters and educating staff in their use, Lifebox is working to improve surgical safety in other ways, such as helping hospitals to introduce the World Health Organization’s Surgical Safety Checklist. The Clean Cut program now being piloted in Ethiopia takes this a step further to improve peri- and post-operative care. Checklists in the operating theatre reduce the risk of errors and are known to save lives. The ‘Clean Cut’ program is based on the surgical safety checklist, which has been shown to reduce complications, decrease infection rates, and improve patient outcomes.

Dr Hoang K. Khiatuli works at the Gaubin Rural Hospital on Karkar Island, Papua New Guinea where he deals with some of the challenges of providing medical care in rural and remote areas of PNG. For two years, Dr Khiatuli was the only medical officer at the hospital on Karkar – an island of 80,000 people. The hospital has only recently received a Lifebox pulse oximeter and there are no staff trained in anaesthesia apart from Dr Khiatuli and the anaesthetic training he received during his residency.

The hospital has just received a Lifebox pulse oximeter and there are no staff trained in anaesthesia apart from Dr Khiatuli and the anaesthetic training he received during his residency. In order to improve the hospital’s surgical capability, Dr Khiatuli decided to perform a hysterectomy to save the patient’s life, despite never having undertaken this operation before. Having performed a blood transfusion with blood donated from the patient’s family and clinic staff, Dr Khiatuli then removed the blood clots from the abdomen — itself a challenge in the absence of electric suction or foot pumps. Next, the source of the bleeding was located and clamped and the ruptured uterus was removed. As Dr Khiatuli explained: “I didn’t know how to do the hysterectomy so I told my MO to hold the open medical text book while I read what was in the book and applied it. I had no time to feel undecided or worry because two lives were at stake. I read how to do the operation and physically did it at the same time.” Since word of the story spread, Dr Khiatuli has become known as ‘the Text Book doctor’. "Lifebox is evolving to deliver other programs and education initiatives to make every operating room a safer place for patients and healthcare providers."

**Recent Lifebox ANZ highlights**

**Myanmar**

In 2017, the Myanmar Society of Anaesthesiologists coordinated the donation of 50 oximeters to 15 hospitals throughout Myanmar. For the first time in Myanmar, education was conducted by local instructors. An ongoing project will place a further 700 oximeters in hospitals in Myanmar to join the 190 oximeters donated to date.

**Papua New Guinea**

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

**Pacific**

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

**Bhutan**

Dr Steve Kimnarr, an anaesthetist and Lifebox volunteer from Adelaide introduced Lifebox to Bhutan in 2013 while assisting with anaesthesia teaching. He has returned to Bhutan each year, and has continued to teach oximeter use and support the local anaesthetists.

**PNG’s ‘Text Book doctor’**

Dr Hoang K. Khiatuli works at the Gaubin Rural Hospital on Karkar Island, Papua New Guinea where he deals with some of the challenges of providing medical care in rural and remote areas of PNG. For two years Dr Khiatuli was the only medical officer at the hospital on Karkar – an island of 80,000 people. The hospital has only recently received a Lifebox pulse oximeter and there are no staff trained in anaesthesia apart from Dr Khiatuli and the anaesthetic training he received during his residency.

Referral to the nearest hospital with an anaesthetist is only possible during daylight hours (an outboard motor for boat transfer is only available between 7am and 5pm), and is also dependent on the ability to arrange land transport on the mainland.

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

One extraordinary story in particular highlights the challenges Dr Khiatuli faces. A woman in labour was brought into hospital in September 2015. She was pregnant at 40 weeks and was in distress due to a ruptured uterus.

Dr Kiafuli quickly assessed complications. The patient had gone into shock from blood loss due to a ruptured uterus and the baby was lying outside the uterus and was within the abdominal area causing pain and bleeding. As it was after 6pm, transfer to a larger hospital was not possible.

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

How you can help

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

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

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

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

The 2017 online survey, launched on August 30, invited 1479 trainees to participate. The survey ran for three weeks attracting 966 responses (65 per cent). In 2016 and 2017, the trainee survey asked about respondents’ experience of the specialist training program, supervision and the hospitals learning environment across Australia and New Zealand. In 2017 we extended the survey to explore Indigenous identification, how trainees use social media, and think about rural, remote and private practice.

Hospital training environment
Like 2016, trainee respondents were positive about their hospital placement experience. Trainees were invited to identify up to three recent hospital placements resulting in information on 1121 hospital placements in 2017. Over 90 per cent of respondents agreed with the following:
- There were allowances made to attend part 1-2 courses (92 per cent agree/strongly agree).
- They had appropriate access to leave (93 per cent).
- They felt well supported at their workplace (92 per cent).
- Their supervisor of training was helpful and actively engaged in their training (96 per cent).

However, a notable number of respondents either disagreed or strongly disagreed that they:
- Had a balanced roster (for example, hours, overtime, weekends et cetera) (9 per cent).
- Had adequate formal teaching (tutorials etc) (12 per cent).
- Had opportunities to complete specialised study units (16 per cent).

Around half of respondents (55 per cent) reported that they worked between 41-50 hours a week, with 9 per cent working more than 61 hours a week on average.

Supervision and feedback
Trainees were positive about supervision and feedback with high rates of agreement (82-95 per cent) with the following:
- The supervision I receive is appropriate to my level of training (94 per cent agree/strongly agree).
- I am able to use the feedback I receive in the workplace to improve my performance (92 per cent).

Training program
Trainees were overall positive about the training program with satisfaction levels at 70-75 per cent; however the response rate suggests there is room for improvement in relation to:
- Satisfaction with the overall usability of the training portfolio system (70 per cent).
- Completing the workplace-based assessments provides feedback I can use to improve (73 per cent).
- The volume of practice targets describe appropriate minimum experience to prepare me for consultant practice (75 per cent).
- The learning resources on ANZCA Networks are helpful for my learning (72 per cent).

There was a significant increase in agreement (agree/strongly agree) in the past 12 months that the volume of practice targets describe appropriate minimum experience to prepare for consultant practice (75 per cent). This is up from 65 per cent in 2016, driven by NSW/ACT (72 per cent up from 61 per cent in 2016), Victoria/Tasmania (76 per cent, up from 63 per cent), Queensland (82 per cent, up from 71 per cent) and South Australia/Northern Territory (80 per cent, up from 64 per cent).

Use of social media
Facebook is the only form of social media that trainees are using regularly, with one in two (47 per cent) reporting that they use it often and an additional one in five (20 per cent) using the site occasionally.

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

Intention to work in private practice
Upon achieving fellowship, more than five in six (85 per cent) trainees are considering working in private practice. NZ trainees are significantly less likely to be considering work in private practice (75 per cent versus overall 85 per cent).

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

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

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

Various ANZCA units are developing action plans in response to the 2017 survey results. Some of the practical changes currently in process include:
- Improvements to the TPS, with the first release of new functionality available in late March 2018 and further enhancements by the end of the year.
- New Workplace-Based Assessment support resources available on Networks, including practical tips, checklists and a comprehensive list of frequently asked questions. There are also resources for trainees, WBA assessors and supervisors of training to help everyone understand the philosophy of WBAs and how these enhance learning. A rollout of local training is also being planned.

Thank you to all of the trainees who participated in the survey. We encourage those of you who didn’t get a chance to respond in 2017 to engage with the 2018 survey so that your voice can be heard by the college and your feedback used to continue to improve our world class training program.
Results suggested that there has been an increase in those experiencing and witnessing workplace discrimination and/or sexual harassment since 2016.

There were decreases in reports of experiencing (30% to 29%) and witnessing workplace bullying (54% to 47%, significant) from 2016.

**Workplace bullying**

One hundred and fifty (29 per cent) trainees indicated they had personally witnessed workplace bullying in the past 12 months and 47 per cent have personally witnessed workplace bullying. This is a decrease in reports of experiencing (59 per cent to 29 per cent) and witnessing workplace bullying (54 per cent to 47 per cent) from 2016.

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

**Workplace discrimination**

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

Twenty-five per cent of trainees have received formal education and training in identifying, managing and preventing workplace discrimination and 65 per cent feel adequately prepared and supported to deal with it.

**Workplace sexual harassment**

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

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

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

**What happens now**

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

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

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

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

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

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

Dr Maryann Turner and Dr Shanthi Pathirana

Co-Chairs, ANZCA Trainee Committee (2017)
Supply and demand issues are ongoing concerns for younger anaesthetists, writes Dr Richard Seglenieks.

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

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

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

The April 2014 issue of Australian Anaesthetist focused on workforce issues, with articles highlighting the importance of avoiding both oversupply and undersupply of anaesthetists and outlining the role of increasing the number of medical schools in Australia to create a more stable workforce.

Competition has long been a part of the medical career path, however, simply by numbers alone this is far greater now than it has tended to be in the past. Anecdotally, I have noticed significant anxiety around securing both training positions and consultant work. Many junior doctors are undertaking time-consuming and expensive further education, such as the various Master of Medicine degrees on offer, where previously they may have opted to focus their additional efforts on clinical work, study or the often-neglected necessities for self-care (spending time with family and friends, exercising, sleeping, etc.).

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

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

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

“I have noticed significant anxiety around securing both training positions and consultant work.”

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

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

References:

ANZCA Bulletin March 2018
Website redesign

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

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

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

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

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

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

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

Alan Dicks
Digital Communications Manager, ANZCA

The website in numbers

- Age in website years: Seven
- Age in human years: c120
- Number of unique visits in 2017: 285,000
- Number of page views in 2017: 3,500,000
- 2141 pages
- 3406 PDFs
Cooper presents the donated Diamedica ventilator to the hospital.

Dr David Wilkinson, the immediate past president of the World Federation of Societies of Anaesthesiologists, called on his medical and anaesthesia contacts to secure essential equipment for Papua New Guinea. It took him nearly half a century but more than 40 years after an Australian colleague suggested he make the long trip from London to Papua New Guinea (PNG), Dr David Wilkinson finally achieved his goal last year.

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

Using his own money and donations secured through the WFSA, its treasurer Professor Alan Merry and a British-based charity, Save Anaesthesia Worldwide, Dr Wilkinson funded a British-based company that makes anaesthesia equipment for developing countries. The charity Safe Anaesthesia Worldwide threw in a thousand pounds and I talked to the WFSA and the treasurer Professor Alan Merry, I learnt on Alan a bit and they donated another thousand, which was almost half the cost, and I put in the rest.

“Michael delivered the ventilator to the hospital in September and it’s been used many times since then.”

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

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

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

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

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

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

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

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

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

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

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

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

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

Carolyn Jones
Media Manager, ANZCA

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

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

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

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

Above from left: The Wilkinsons are welcomed to Alotau; Dr Michael Cooper presents the donated Diamedica ventilator to the hospital; Above: From left: The Wilkinsons are welcomed to Alotau; Dr Michael Cooper presents the donated Diamedica ventilator to the hospital.
The Anaphylaxis eLearning Project Steering Group is developing four experiential case studies to demonstrate the management of anaphylaxis crises in perioperative care.

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

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

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

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

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

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

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

Lee Cheers
Learning and Development Lead, ANZCA

Above: from left: Dr Rod Mitchell and Dr Nagesh Nanjappa prepare a monitor simulation for an eLearning module, Queen Elizabeth Hospital, SA; Excerpts from the latest eLearning module prototype for Perioperative Anaphylaxis Response: Case A – Total Knee Replacement.
Throughout the 19th century, women slowly emerged from their private and domestic lives. Many began to look to professions such as medicine to enable them to perform public roles.

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

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

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

The School of Medicine at the University of Melbourne opened in 1862 and it took 25 years to admit women. These women displayed great academic ability but were then publicly condemned for trying to complete their qualifications with hospital residencies. Dr Janet Greig graduated in the top six of her year at the University of Melbourne in 1896. Traditionally, the top six graduates automatically qualified for a residency at Melbourne General Hospital. The idea of women residents met with much opposition, playing out in the newspapers of the day. Eventually, hospital management voted 13 to six in favour of taking on the “lady graduates”.

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

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

Better searching for anaesthesia- and pain-related articles

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

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

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

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

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

**Contraindications**
A condition or factor associated with a recipient that makes the use of a drug, procedure, or physical agent improper or inadvisable. Contraindications may be absolute (life threatening) or relative (higher risk of complications in which the use of a drug, procedure, or physical agent improper or threatening) or relative (higher risk of complications in which use of a drug outweigh its risks). They are intended to prevent the abuse of such substances by the patient, or their transfer to recreational users and drug dealers.

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

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

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

**Therapeutic Guidelines (NEW Trial)**
As with previous years, the ANZCA Library will be conducting two workshops during the 2018 ANZCA ASM in Sydney.

Beyond Google: an introduction to the ANZCA Library

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

The undiscovered country: advanced searching using MEDLINE

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

AudioDigest: LDI Clinical Compendia Anaesthesiology (NEW)

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

TFerapeutic Guidelines (NEW Trial)

ANZCA Library is trialling Therapeutic Guidelines (eTG Complete) throughout 2018.
Therapeutic Guidelines (eTG complete) is a leading source of accurate, independent and practical treatment advice for a wide range of clinical conditions. It includes explicit instructions for therapy, assisting practitioners in making decisions to ensure their patients receive optimum treatment.

Make the most of your ANZCA Library!

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Therapeutic Guidelines (eTG complete) is a leading source of accurate, independent and practical treatment advice for a wide range of clinical conditions. It includes explicit instructions for therapy, assisting practitioners in making decisions to ensure their patients receive optimum treatment.
Finding it difficult to keep up-to-date with your readings?

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

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

BrowZine

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

*Note: Some back-files are excluded.

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

Patient information and consumer health resources

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


New books for loan

Abundance: the future is better than you think


Australasian anaesthesia 2017: invited papers and selected continuing education lectures


Diagnostic and statistical manual of mental disorders: DSM-5


The fundamentals of surgical instruments: a practical guide to their recognition, use and care


Hooked: how to build habit-forming products


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

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

CSL Behring becomes first corporate leadership circle gold member
After attending the launch of the leadership circle, CSL Behring Head of Sales, John Russell has announced that CSL Behring, the Australian Government’s contracted national blood fractionator, will increase its support to just over $25,000 per annum over three years to qualify for membership as an ANZCA Research Foundation Leadership Circle Gold Member.

CSL Behring has already provided $2,500 in 2017 for a new research grant over two years, and the ANZCA Research Foundation thanks CSL Behring for this exciting new level of commitment.

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

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

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

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

Foundation subscriptions appeal
Each year many fellows generously donate with their subscription payments to help the foundation provide more support to more projects. A total of $412,496 has been received. Last year, fellows donated a record amount of $46,165 with their subscriptions.

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

Bob Parker, General Manager, ANZCA Research Foundation

ANZCA Research Foundation

Good start for emerging researchers in 2018

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

2018 ANZCA Melbourne Emerging Researcher Award
Dr Lowe also again provided $15,000 for this award in 2018 which was awarded to Dr Rachel Chapman for her project “A pilot study of current anaesthetic practice in children undergoing adenotonsillectomy at the Royal Children’s Hospital”. Dr Chapman is the fourth recipient of this award.

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

Leadership circle members commit to donate $10,000, $25,000 or $50,000 annually over three or more years, reflecting the time and minimum funding required for many medical research projects from design to completion and publication.

To donate, or for more information on supporting the foundation, please contact Bob Parker, General Manager, ANZCA Research Foundation on +61 3 8373 9306 or email rparker@anzca.edu.au. Gifts can be made via www.anzca.edu.au/fellows/foundation.

“Saving lives, improving life”
Anaesthesia in Zambia

Fellow Dr Monique McLeod spent six months in Lusaka working with local anaesthetists with support from ANZCA’s Overseas Aid Committee. Until recently, there had not been a single anaesthetist trained in Zambia since 1964. It is easy to envisage the significant impact this had, and still has, in addressing the ongoing burden of surgical illness in Zambia. This lack of trained doctors spurred the development of a project called the Zambia Anaesthesia Development Program (ZADP) in which I have been privileged to be involved.

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

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

I worked in Zambia for six months as part of the program with support from the ANZCA Overseas Aid Committee. There are typically between four and six anaesthetic doctors from around the world that volunteer to help train Zambian anaesthetists under the program. Our role is to provide clinical teaching and supervision as well as initiating quality improvement programs, addressing systemic issues and establishing change with the generation of self-sufficiency, which is the definitive goal.

As with most things, there were positive aspects within my role though there were also challenges. Successes included initiating multidisciplinary neonatal resuscitation training and creating and coordinating a Neonatal Resuscitation Committee. This committee continues to convene and is currently addressing staff communication issues, documentation, equipment provision, a triage system for caesarean sections and a call system for neonatal resuscitation. The aim of the committee, through these different avenues, is ultimately to reduce neonatal mortality.

Learning about a different culture, where people are inherently friendly, hearing their stories and making new friends were highlights of the placement. I also appreciated the opportunity to develop skills for anaesthesia in a resource poor setting. In addition, I found developing and facilitating a seminar on ethics and professionalism with local anaesthesia trainees very rewarding. There had not been much education or support in these areas, particularly with maintaining a patient-centred model of care.

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

Handing over quality improvement projects slowed their progress as new teams addressed the same challenges. Similarly, the Zambian anaesthesia trainees warm to and trust people only to have them rotate through again every three to six months. Other participants had slightly different roles and focused on developing and delivering the anaesthesia curriculum and examinations, ophthalmic anaesthesia, or airway management in ICU. As with most things, there were positive aspects within my role though there were also challenges.

In the neurosurgical theatre a yellow bucket collects rainwater from a hole in the roof.

The cultural perception of the hospital also made it difficult at times to build trust with the local community. People would present to traditional healers when they became unwell or end stage when patients arrived and further perpetuated the cycle of late presentations with many believing the hospital is a place where patients die.

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

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

Implementing potential future improvements is fraught. Funding and resource allocation would clearly benefit the system and improve patient care, though finding, maintaining and directing these resources can be challenging. Family, professional and financial resources limit how long people are able to stay, and so where it may be beneficial to have longer placements it may just not be feasible. A longer in-country cross-over period may aid handover, however, this also presents a challenge with different start times for different levels of training. Ongoing online communication, however, and in depth involvement of local trainees, and hence consistency, would support transitions and is currently being encouraged.

Another future direction that is evolving is people who have previously undertaken the placement often remain involved in different capacities. Participants return as consultants, offering exam practice, subspecialty teaching or continue to contribute remotely by helping with recruitment and funding opportunities.

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

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

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

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

"The aim of this project is to train local Zambian anaesthetists and set up a self-sufficient anaesthesia department and training program in Lusaka.”
The Obstetric Anaesthesia Special Interest Group (SIG) is facilitating standardised data collection in obstetric anaesthesia, with the release last month of their quality assurance datasets (available via www.anzca.edu.au/fellows/special-interest-groups/obstetric-anaesthesia).

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

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

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

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

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

Associate Professor Victoria Eley
Chair, Obstetric Anaesthesia Special Interest Group
v.eley@uq.edu.au
Dr Guy Godsall
Sunshine Coast University Hospital
guy.godsall@health.qld.gov.au

Reference:
New Zealand news

NZ National Obstetric Anaesthesia Leads (NOAL) turns two

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

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

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

NOAL has a cloud drive to share guidelines, charts and other related documents. Previously each DHB developed these in isolation leading to a large amount of duplicated effort and unnecessary variation in practice. This has proved particularly useful for anaesthetic input into national guidelines, such as the forthcoming revision of the Ministry of Health’s National Consensus Guideline for treatment of Postpartum Haemorrhage. One meeting each year includes a joint session with obstetric and midwifery clinical leaders. This allows exchange of perspectives and joint solutions to shared problems, such as how best to provide women with adequate unbiased information on labour analgesia, issues with the forthcoming electronic National Maternity Record, and coordinating a national approach to managing the growing obesity epidemic among parturients.

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

The art of fellowship and presentation at the ARM

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

Dr Deng also took the Caduceus Prize for Excellence in Anesthesiology Research for her single-centre, randomised controlled pilot trial comparing performance of direct laryngoscopy for endotracheal intubation in surgical patients. A morning session for the trainees focused on professional development. Dr Jonathan Fanchurkhorst, chair of the ANZCA Trainee Committee, updated the trainees on the role of the Committee and issues of relevance for the trainees. Dr Rob Buller from Counties Manukau DHB gave a thought-provoking talk on Sustainability and Anaesthesia which covered topics including recycling of operating room waste, the environmental effect of anaesthetic agents and how his DHB has reduced its carbon footprint.

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

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

Dr Lara Hopley and Dr David Sidebotham delivered the third of the lectures looking at the state of health IT in New Zealand through a post-election lens. Please visit www.anaesthesiaeducation.org.nz/lectureship for more details.

TIVA, IT & opioids – lectures to the regions

The New Zealand Anaesthesia Education Committee’s (NZAE) visiting lectureship program is making some stimulating presentations available to the regions this year. Dr Ian Williams practice-changing presentation – a personal journey, my experience with TIVA – outlines why total intravenous anaesthesia (TIVA) remains a minority anaesthetic in many practices. The presentation includes observations and examples of best practice, including his experiences during the past three years of administering over 5000 TIVAs. Dr Williams hopes that with better understanding of the techniques and monitoring equipment available, this excellent form of anaesthesia will be utilised more often.

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

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Scholarship paves the way

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

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

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

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

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

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

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Save the date – ACE conference

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

Art and mindfulness

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

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

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

Courses

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

Other news

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

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

Anatomy course

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Scan and Ski Workshop

After the great success of our inaugural Scan and Ski Workshop in July 2016 we are delighted to announce that we will be running the event again in 2018. The workshop will be held from Friday July 13 to Saturday July 14 at the Thredbo Alpine Hotel in the Kosciuszko National Park. Dr Ross Peake will again convene the workshop, together with world-renowned ultrasound specialists Dr Alwin Chua, Dr Peter Hebbard, Dr Andrew Lansdown, Dr Brad Lawther, Dr Harmeet Anjea and Dr Sam Sha.

The workshop will run over two days, using the morning and evening sessions for hands-on ultrasound scanning and instruction, and leaving the middle of each day free for skiing or sightseeing in the beautiful NSW Snowy Mountains. The workshop will cover upper limb blocks, lower limb blocks, trunk and spinal blocks, among other topics.

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

ACT Trainee Committee

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

The Autumn Scientific Meeting has opened for registration and will be held at Joondalup Resort on April 7, 2018. The theme “We are all in this together – volunteerism, self-care and responsible anaesthesia” includes presentations on sustainability, practical aspects of volunteering and the Bunny Wilson Lecture by Dr David Perlman. Workshop options include “can’t intubate, can’t oxygenate” facilitated by Dr Scott Douglas, “How to write, run and mark a mock viva” by Dr Prani Shrivastava and team, and a “SafeTALK: suicide prevention training workshop” by Ms Lorna Hirsh. There are places available in the workshops, contact the WA office for registration or register via the ANZCA online calendar.

In 2018 the WA CME Committee will hold the Country Conference from October 26-28, 2018 at the Pullman Resort in Bunker Bay. It is convened by Dr Nirooshan Rooban and Dr Trevelyn Edwards, a program and registration will be available later in the year.

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

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

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

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

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

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

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

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

Welfare and Professional Behaviour are increasingly important areas. The support structure for trainees in Tasmania of peers, mentors, departmental welfare officers and ANZCA trainee and fellow committee representatives was outlined.

Feedback from Tasmanian trainees was generally very positive. The feedback reflected the quality of CME activities in the state. The quality of workshops and not missing any of the presentations.

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

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

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

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

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

Tasmanian Annual Scientific Meeting

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

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

- Associate Professor Philip Ragg on “Adult congenital heart disease – you can run but you can’t hide”.
- Dr Lachlan Miles on “Perioperative management for non-cardiac surgery in the adult cardiac or pulmonary transplant recipient”.
- Dr Catherine Olweny on “Help, my patient has a myopathy! Understanding muscle disorders”.
- Dr James Griffiths “Zen and the Art of Communication for the Anaesthetist”.
- Dr Jeff Aytont from the Antarctic Division; Dr Lizzie Elliott and Clinical Professor David Smart shared their knowledge and experience in Antarctica with their talk on “Antarctic Gases”.

A panel discussed and debated “Challenges and practices of paediatric anaesthesia in regional areas, especially the associate credentialing issues. “You can’t do that! Credentialing challenging clinical need” saw five panelists including Professor David A Smart; Associate Professor David M Smart, Dr Bruce Newman, Dr Jeremy Sutton, Dr Sarah Boardman and Dr Catherine Olweny.

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

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

Feedback on the day was largely very positive with delegates enjoying the variety of quality speakers as well as the associate credentialing issues. The SA and NT trainee dinner was held at The Store, North Adelaide on Saturday, November 4, 2017. Guest speaker Dr Peter Carlin gave an engaging presentation and perspective on anaesthetics, training and general life advice. It was a good night, with good food and good company.

Part Zero Course

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

Annual SA and NT trainee dinner

The annual SA and NT trainee dinner was held at The Store, North Adelaide on Saturday, November 4, 2017. Guest speaker Dr Peter Carlin gave an engaging presentation and perspective on anaesthetics, training and general life advice. It was a good night, with good food and good company.
Dr Martin Elvis Lum, FANZCA 1959–2017

In 1990 Martin moved to Sydney where he started working at Liverpool Hospital. Between 1991 and 1993 he also worked at CareFlight as a specialist in retrieval medicine where he was acting medical director for two years. Martin played a key role in helping to embed critical care retrieval as an essential and accepted component of ambulance, trauma and critical care services in NSW.

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

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

In 1993 Martin left CareFlight to devote more time to his role as Director of Anaesthesia and Recovery at Liverpool Hospital. With his lifelong passion for postgraduate continuing education he embarked on an MBA.

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

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

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

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

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

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

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

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

Dr David Lum, FANZCA, Westmead Hospital, and family

Dr Andrew Hill, FANZCA, Liverpool Hospital and CareFlight

Dr Tracey Tay, FANZCA, John Hunter Hospital

Dr Vanessa Beavis, FANZCA, Auckland District Health Board

Dr Blair Munford, FANZCA.

Ms Anna Burgess, DHiCS Victoria

Obligatory Richard Harding, FRCA FANZCA 1970–2017

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

Richard qualified from Nottingham Medical School in 1991 and, after completing house jobs, decided to work in Brisbane, Australia, where he stayed for just over a year before returning to the UK to embark on specialty training in anaesthesia and intensive care. During his specialty training Richard spent time in Edinburgh and in Yorkshire. On gaining his certificate of completion of training (CCT), the pull of the southern hemisphere saw Richard journey back to Australia, where he spent a year working in Perth before crossing the Tasman Sea to take up a consultant position in Dunedin, where a love affair with New Zealand began.

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

In 2011 he also took on a part-time role at the Queen Elizabeth Hospital, Birmingham, working in ICU, which he greatly enjoyed. In due course, the lure of the New Zealand lifestyle became too strong to resist, and in 2016 Richard moved to Northland with his wife Kate, a GP and hospice doctor, and their teenage children Amy and Jake.

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

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

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

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

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

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

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

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

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

Dr Martin Elvis Lum, FANZCA 1959–2017

Obligatory
Obituary

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

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

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

After attending Terrace End Primary and Wanganui Collegiate, Bruce graduated MB ChB from Otago in 1948. House surgeon years in Wellington were followed by anaesthetic training in the US (at Cleveland) and then the UK. While in Britain he managed to fall between the DA and the FFARCS allowing him to return to New Zealand with both qualifications.

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

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

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

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

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

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

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

This love of language was reflected in his pithy anaesthetic aphorisms, known as “Cookisms” and long remembered with affection by his former registrars. These included pearls of wisdom such as: “Surgery is like sex – it’s a non-spectator sport.” “Signs of a surgeon in trouble: adjust lights; adjust table; ask for more relaxation.” “Moving an operating light results in the surgeon placing the back of his head in the focus point.” “Surgery begets surgery.” “Three essentials for a safe anaesthetic: a tube in the trachea; a needle in the vein; a roll of one inch sticky tape.”

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

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

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

Bruce Cook: physician; raconteur; scholar; gentleman.

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