SEPTEMBER 2017

ANZCA BULLETIN

Global reach
ANZCA expands its activities overseas

Healthy doctors
College committed to wellbeing

Mortality findings
Key lessons from the latest report

ANZCA CELEBRATING 25 YEARS

38 25th anniversary winners
Honorary Historian Professor Barry Baker remembers some of the high-achieving ANZCA and FPM Fellows awarded prestigious medals over the years.

26 Landmark PNG conference
ANZCA played a key role in a landmark conference held in Port Moresby in September.

46 Future leaders
Attendees at past New Fellows Conferences have gone on to bigger and better things. We profile some of them.

18 Caring for ourselves
ANZCA trainee Dr Phuong Pham asks why doctors are so terrible at looking after their own welfare.

62 Overseas scholarship
Dr Camille Yip, a recipient of an ANZCA overseas aid trainee scholarship, writes about her recent experiences in Inner Mongolia.

Contents

4 President's message
5 Chief executive officer's message
6 Letter and awards
7 Regions fly the flag for ANZCA's 25th anniversary
8 ANZCA and FPM in the news: Fentanyl shortage, sugar and codeine restrictions gain media coverage
10 ANZCA and government: building relationships: Planning for regional training under way
11 Wellbeing and welfare a focus of survey
12 ANZCA's professional documents: What would you do?
17 Doctors' health and wellbeing
24 ANZCA Council citation – Professor Michael Paech
25 Overseas engagement
30 ANZCA National Anaesthesia Day nearly here
32 Safety and quality
38 ANZCA's 25th anniversary: Medal winners a *Who's Who* of anaesthesia and pain medicine
42 ANZCA's 25th anniversary: Citations recognise significant contributions
46 ANZCA's 25th anniversary: Reflections on the New Fellows Conference
52 Centre translates anaesthesia theory into practice
55 Working together during trauma surgery
56 Faculty of Pain Medicine
62 Overseas scholarship: A different kind of developing world
64 Foundation research grants success
65 ANZCA Clinical Trials Network: Coogee workshop a success
66 Museum wins award
66 Anaesthetic history: What would Pugh say?
68 Library update
72 Special Interest Group events
76 New Zealand news
79 Australian news
85 Obituaries
88 Future meetings

ANZCA Bulletin
The Australian and New Zealand College of Anaesthetists (ANZCA) is the professional medical body in Australia and New Zealand that conducts education, training and continuing professional development of anaesthetists and specialist pain medicine physicians. ANZCA comprises about 6000 Fellows and 1500 trainees across Australia and New Zealand and serves the community by upholding the highest standards of patient safety.

Cover: Nora Dai, Deputy Chief Anaesthetist, Southern Region was at the 53rd Medical Symposium hosted by the Medical Society of Papua New Guinea in Port Moresby attended by ANZCA President David A Scott, Overseas Aid Committee Chair Michael Cooper and other key ANZCA Fellows.

Medical editor: Dr Rowan Thomas
Editor: Clea Hincks
Art direction and design: Christian Langstone
Production editor: Liane Reynolds
Advertising manager: Vivienne Forbes

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

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

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

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

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

Copyright © 2017 by the Australian and New Zealand College of Anaesthetists, all rights reserved. None of the contents of this publication may be reproduced, stored in a retrieval system or transmitted in any form, by any means without the prior written permission of the publisher.

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

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

President's message

A sustainable and sustained specialty

There are many aspects to ensuring that we manage our patients to the best of our ability and that we can and will continue to improve to meet the challenges of the future.

To keep us as specialist practitioners in anaesthesia and pain medicine, up to date and fit to practice, we need to ensure that we look after our learning and skills over our entire practicing career. We also need to keep ourselves healthy. Finally, we need to advance knowledge by research and implementing improvements in practice as they are discovered, in our specialty area.

Overall, we are very good at maintaining our skills and knowledge. The ANZCA Annual Scientific Meeting in Brisbane with more than 2000 registrants was testimony to that. With innovative and interactive sessions, such as the live-on-stage "Clot Wars" simulation, and support for those with young families via the on-site crèche, and a plethora of workshops, many different opportunities were created and learning styles catered for.

We all learn in different ways, and the ANZCA Educators Program helps us learn how to teach and help others learn, especially trainees. Regional meetings throughout Australia and New Zealand, including those from special interest groups and often co-run with the Australian Society of Anaesthetists (ASA) and the New Zealand Society of Anaesthetists (NZSA), and online resources including Library Guides, provide year-round opportunities. This has resulted in more than 99.5 per cent of continuing professional development (CPD) participants successfully completing the last triennium.

At the time of writing, we are still waiting on the new overarching Medical Board of Australia CPD standard, but if it is similar to that which has been proposed, and that in New Zealand, then the ANZCA program should be on track.

Keeping ourselves well, so that we can better care for our patients, is not an easy task in our increasingly pressured environments and lives. A range of factors are addressed in this issue of the *Bulletin*.

Things that the College can do to help, for trainees and specialists in public and private practice alike, are to address systemic problems including overwork, poor workplace behaviours, substandard resourcing and ignorance of our important role. Our standards and professional documents are fundamental for much of the workplace advocacy. The college will do what it can to support those with concerns and respond to those with complaints.

Personal health also means being able to consult confidentially with your own GP or specialist, and so it was good to see the benefits of advocacy in the recent Council of Australian Governments recognition that the mandatory reporting laws in most states in Australia need revisiting because they are seen as a barrier to accessing timely healthcare for medical practitioners.

The August Clinical Trials Network (CTN) meeting in Sydney was a great testimony to collaboration in anaesthesia and pain medicine research, with more than 70 research co-ordinators attending in addition to the 90 medical and scientific participants. Our ANZCA CTN is recognised as world leading. The output from collaborative clinical trials has recently been assessed by the Australian Clinical Trials Registry and Australian Commission on Safety and Quality in Health Care as having incredible capacity to improve healthcare outcomes and reduce costs.

There is a barrier, however, and that is translation from publication to practice. When we have high-level evidence that a particular treatment or technique is better than another, then the consideration should be why not choose it? Putting policy into practice is important too, and it is important that we engage with rational policies in the areas where we work, such as for hand hygiene or antibiotic protocols. We should be promoting our expertise, perhaps in name as well?

Are specialist anaesthetists anaesthesiologists?

Around the world, doctors who practice the specialty of anaesthesia are often referred to as anaesthesiologists (or anesthesiologists).

This is a widely understood term and differentiates those doctors from non-specialist, or even non-medical, "anaesthetists". In Australia and New Zealand this distinction is not as essential because our protected name (by the Australian Health Practitioner Regulation Agency or the Medical Council of New Zealand) is "specialist anaesthetist". No one else is able to represent themselves using this term.

A strength of the title "anaesthesiologist" is that an "-ology" represents a discipline based on scientific rigour and research. It is certainly our research which has led to the sophisticated, safe and effective anaesthesia that we practice today.

In 2004, Professor Michael Cousins, as president of ANZCA, commissioned a taskforce to investigate the use of "anaesthesiology" as the name of our specialty. It was concluded at the time that our membership was not ready for such a change.

Changing our name would not be trivial for ANZCA – as the educational and standards setting body for Australia and New Zealand there are a number of regulatory hurdles to consider. Any change would have to be collaborative with the ASA and NZSA.

However, with many global societies and colleges adopting the term, perhaps it is time to have another look. Ultimately, by whatever name, what is important is that our specialty is recognised as being the provider of safe and effective anaesthesia and perioperative care. Think about it – let's start the conversation.

Professor David A Scott
ANZCA President

Chief executive officer's message

Health and wellbeing of doctors

The importance of the health and wellbeing of doctors will be elevated in ANZCA's new strategic plan commencing in 2018.

While the new plan is still being developed, the responses from focus groups, committees and individuals have highlighted that the health and wellbeing of Fellows, trainees and specialist international medical graduates (SIMGs) requires special attention by ANZCA in promoting a long-term sustainable workforce.

In September 2016 I wrote about initiatives of the Medical Board of Australia and Medical Council of New Zealand in encouraging doctors to be mindful of their own health and wellbeing. However we know that the problem and solutions are very complex and are the responsibility of all organisations, including medical colleges as well as individuals.

Regulators, colleges and other doctors' groups around the world have shown consistently in surveys and journals that stress leading to ill health and death among doctors is not just prevalent but may be increasing. At the Victorian continuing medical education event in July, Fiona Nielsen[1] spoke about the concept of clinicians being "second victims" as the result of adverse events and the need for a "just culture" among our health organisations.

The presentation highlighted situations in which clinicians often find themselves, that is a risk averse culture where documentation and reporting are prioritised above the needs of the clinicians who also suffer as the result of adverse events.

Ms Nielsen went on to suggest several ideas to help solve the problem and provide greater support to clinicians[2].

- Increase awareness of the problem.
- Develop a culture of constructive criticism.
- Provide peer support.
- Provide consistent and timely support.
- Build resilience within clinicians to deal effectively with stress.

There are many articles and presentations similar to Ms Nielsen's excellent work. Sadly, they highlight the fact that we work in highly complex organisations and there are many contributing factors to the problem of increasing levels of stress and ill health among doctors.

ANZCA has recognised the challenge and has committed significant resources to addressing this issue over the next several years. Deputy CEO, Carolyn Handley has taken on a new role that will focus on researching doctors' health and wellbeing and developing initiatives for the college to provide support for Fellows, trainees and SIMGs.

Carolyn is well known among Fellows and she has an in-depth understanding of medical colleges and vocational training. She will work closely with Council and the CEO in reaching a greater understanding of the causes of ill health among doctors, building awareness of the scope of the problem and working towards supporting Fellows, trainees and SIMGs.

We understand that complex issues require multiple approaches and many parts of the health system to work together in order to provide solutions. Those solutions are also likely to require generational improvements, but we are making a serious investment to initially build understanding, awareness along with appropriate support mechanisms.

Member service to be enhanced

During September, ANZCA will be creating a focal point within the College to provide a more personalised service to Australian and internationally-based fellows. Fellows frequently have queries about membership requirements, fees, concessions, changes to membership status and so on. We are confident that a single point of contact within the College will provide a better service rather than requiring fellows to speak to several people about different issues.

Once the service is established we will provide more detailed information about the appropriate person to contact, telephone number and email address. New Zealand Fellows already have a single contact point with the NZ office in Wellington and this will not change.

Similarly, Faculty of Pain Medicine Fellows will also continue to receive support from the Faculty office.

John Ilott
Chief Executive Officer, ANZCA

References:

1. Nielsen, Fiona, 2017, Beyond Hearts and Minds: Moving a 'Just Culture' Forward, paper presented to the Winter CME Meeting, Melbourne July 29, 2017
2. Ibid

Letter and awards

Voluntary assisted dying

I refer to "Voluntary assisted dying submission" (June 2017 *ANZCA Bulletin*, page 8).

The College has presumed to speak for its Fellows on assisted dying and to submit a view after consultation with Fellows. The presumption seems to be that anaesthetists should be involved with mercy killing of sick patients.

ANZCA and government

Building relationships

ANZCA will be kept busy in the coming months with several submissions, and the planning and rollout of further training to continue evolving our highly trained workforce.

Australia

STP investment confirmed

May is budget season for state and federal governments in Australia. There were no specific impacts on ANZCA in any of the state budgets, but on May 2, ANZCA CEO John Ilott and General Manager, Policy, Safety and Quality Jo-anne Chapman, represented the College at the Victorian State Budget briefing. Across Australian states, broad investment continues in quality and safety improvements in hospital care, electronic patient records, upgrading infrastructure and research.

The Federal Budget was released on May 9. On May 10, ANZCA participated in a budget teleconference with Commonwealth government officials regarding the next steps with the Specialist Training Program (STP) and the Integrated Rural Training Pipeline (IRTP). The government confirmed it will continue its investment in the STP for another three years to 2020.

Confirmation of continued STP funding for three years provides an opportunity for the College and Faculty to evolve their rural and remote workforce strategy to ensure there is continued support for training positions in both anaesthesia and pain medicine, and for patients accessing surgery and care.

The good news was shared at the STP business meeting hosted at the annual scientific meeting in Brisbane where supervisors of training, the Rural Special Interest Group and FPM representatives and ANZCA regional committee members were invited to discuss the next steps for the planning and rollout across jurisdictions for the next three years.

It was a positive meeting, with lots of ideas shared by Fellows about how best to strengthen training in regional and rural Australia. Over the next quarter, the Policy, Safety and Quality unit will liaise directly with each regional committee, FPM and College committees to engage members in the planning and rollout of STP to 2020.

Safe sedation

Throughout March and April, ANZCA has continued to engage with key stakeholders regarding safe sedation for day and cosmetic surgery procedures. Work continues with the Royal Australasian College of Surgeons for the development of a joint position statement on safe sedation incorporating the standards outlined in *PS09 Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures*.

In South Australia and Queensland, the ANZCA regional committees are liaising with their state-based health departments regarding proposed day care procedure amendments and regulations under State Health acts.

Voluntary assisted dying submission

ANZCA developed a submission to the Victorian government in response to the *Voluntary Assisted Dying Bill* discussion paper. The College made the decision to submit a response, given the government communicated that they would be introducing legislation in the second half of 2017.

As anaesthetists and specialist pain medicine physicians are involved in end-of-life decisions from time to time, the submission was prepared based on feedback from Fellows and trainees provided during the March/April consultation period via College committees and the ANZCA website.

It was no surprise that feedback focused on patient safety and patient-centred care. Key themes for ANZCA's submission included:

- Involvement of specialist medical colleges to ensure specialist medical expertise informs any VAD laws that are developed.
- Patient choice and patient safety.
- Safeguards and legal protections for health practitioners.
- Process for objections by health practitioners.

A copy of the final submission can be found on the ANZCA website at: www.anzca.edu.au/documents/anzca_voluntary-assisted-dying-submission-report_2.pdf

Australian submissions:

- Victoria DHHS – *Voluntary Assisted Dying Bill* discussion paper response.
- COAG Health Council – Independent Review of the Accreditation systems within the National Accreditation scheme for health professionals.
- NSW Health – Credentialing and defining clinical privileges for senior medical and dental practitioners.
- RANZCOG – Maternity Care in Australia: a framework for a healthy generation of Australians.

ACSQHC Osteoarthritis of the Knee Clinical Care Standard

In April 2017, ANZCA endorsed the Australian Commission on Safety and Quality in Health Care's *Clinical Care Standard on Osteoarthritis of the Knee*. ANZCA was given the opportunity to provide feedback on initial consultation in July 2016, followed by the opportunity to endorse the document this year. A copy of this clinical care standard is now available on the ACSQHC website: www.safetyandquality.gov.au/our-work/clinical-care-standards/.

Choosing Wisely

Choosing Wisely held its first national meeting on May 4 in Melbourne. The global initiative aims to improve conversations between clinicians and consumers about unnecessary and potentially harmful healthcare. More than 250 delegates attended the event, which showcased the progress and achievements of Choosing Wisely in Australia since it was launched by NPS Medicine Wise in April 2015. The event was attended by members of the Policy team and Dr Phillipa Hore, Chair, Safety and Quality Committee.

For details on ANZCA's Choosing Wisely recommendations, please go to: www.choosingwisely.org.au/recommendations/anzca.

Essential Pain Management

In April, ANZCA, with input from the EPM Sub-Committee, led discussions and established a partnership with the WSFA for joint trademarking arrangements for Essential Pain Management (EPM).

8 ANZCA Bulletin June 2017

The possible consequences are profound and could include a fracture within the College, which appears to be endorsing VAD. The College has made what I regard as an openly political decision by endorsing, inherently, a stated political aim of the Victorian Government. This may have potential effects regarding tax deductibility of College fees and other income.

Many anaesthetists likely abhor any moves to permit doctors to kill patients, for that is what this is ultimately about. ANZCA risks its members being shunned by other doctors because we appear to condone euthanasia – just as many Dutch doctors have been snubbed by their European colleagues. I am personally opposed to euthanasia (or "voluntary assisted dying") for Hippocratic and religious reasons.

I urge all Fellows who adhere to traditional ethics to make known to ANZCA their opposition to any moves to endorse Voluntary assisted dying.

Dr Jim Wilkinson, OAM, FANZCA
Retired Fellow

ANZCA President, Professor David A Scott, responds

Voluntary assisted dying is a challenging, complex and controversial area, which is why earlier this year ANZCA sought feedback from all anaesthesia and pain medicine Fellows and trainees who are often faced with treating terminally ill people and are sometimes part of the conversation about end-of-life decisions or surgery to provide symptom relief.

In February/March this year we sought the views of a wide range of ANZCA and FPM committees and those of all Fellows and trainees via the March *ANZCA E-Newsletter* and the College website to inform our response to the Victorian Government's *Voluntary Assisted Dying: discussion paper*. This feedback is helping form the basis of our response to the same issue in other jurisdictions.

Our participation is not about questioning legalised voluntary assisted dying for the terminally ill – the Victorian Government has committed to introducing it (and NSW and SA are giving it serious consideration) – or about endorsing voluntary assisted dying.

Nor is it about specialist anaesthetists or specialist pain medicine physicians administering lethal injections. The College's decision to provide this response is so that any legislation formed protects doctors and patients as much as possible. Our response can be found on the ANZCA website at www.anzca.edu.au/documents/anzca_voluntary-assisted-dying-submission-report_2.pdf.

Our purpose is to advise on the best legislation should the bill pass. This is a role the College regularly undertakes to ensure the impact of any proposed law on members is analysed and submitted to advise the government of the day. We do this in the interests of patient safety, which is part of our mission – "to serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine".

Paul Myles wins prestigious research award

Professor Paul Myles, Chair of the Department of Anaesthesia and Perioperative Medicine at The Alfred hospital and Monash University and a member of the ANZCA Clinical Trials Network Executive, is the recipient of the prestigious American Society of Anesthesiologists' 2017 Excellence in Research Award. Since his first publication in 1991, Professor Myles has published more than 275 full articles, including many in top multi-specialty journals. Since 1996 he has obtained more than 25 research grants from the Australian National Health and Medical Research Council totalling more than $A35 million.

Queen's birthday honour

Dr Brian John Shaw from NSW received an Order of Australia Medal in the 2017 Queen's Birthday Honours list for his service to palliative care.

ANZCA's 25th anniversary

Regions fly the flag for ANZCA's 25th anniversary

ANZCA's regions have been marking the College's 25th anniversary at various education events while the Melbourne office is planning to celebrate it at the annual ANZCA president's Christmas function being held in November.

Victoria celebrated the quarter century at its annual continuing medical education (CME) event (held with the Australian Society of Anaesthetists) and annual general meeting held on July 29. Copies of the book, *25 Years of ANZCA Leadership*, were on display, along with the anniversary banner. Regional chair Dr Mark Hurley spoke about ANZCA's achievements in his chair's report to the AGM, accompanied by a slide. A cake was supplied by the Sofitel Melbourne on Collins Hotel who wanted to recognise the length of time that the Victorian Regional Office has held this annual event there.

NSW marked the occasion at its Regional Winter Meeting held on June 24 with meeting convenor and Chair of ACE Dr David Elliot outlining ANZCA's growth and development since 1992.

Tasmania's Regional Chair Dr Colin Chilvers presented an entertaining session about his state's contribution to the formation of ANZCA at Tasmania's Winter Meeting held at Barnbougle on August 26. He paid tribute to original councillors, Dr Stewart Bath (then living in Tasmania, now in the ACT) and Dr Mike Hodgson.

Dr Hodgson provided surprising details on what it was like working at the Royal Hobart Hospital at the start of his career and spoke about how far anaesthesia had developed in a relatively short period of time.

Both Fellows were given a Tasmanian wooden bowl engraved with the 25th anniversary logo and a certificate acknowledging their contribution to ANZCA, before they cut a celebratory cake.

Attendees at Western Australia's Country Conference held at the Cable Beach Resort from June 16-18 were able to enjoy 25th anniversary cake, with mention of the anniversary also part of regional chair Dr John Martyr's opening remarks. Dr Christine Ong and Dr Hamish Mace joined Dr Martyr to cut the cake at the Friday night dinner.

New Zealand plans to acknowledge the anniversary at the NZ Anaesthesia Annual Scientific Meeting being held in Rotorua, November 8-11.

Susan Ewart
Communications Manager, NZ

Above from left: Dr Hamish Mace and Dr Christine Ong join Regional Chair Dr John Martyr to cut the cake at Western Australia's Country Conference; Meeting convenor and chair of ACE, Dr David Elliot, outlining ANZCA's growth and development since 1992 at the opening of the NSW Regional Winter Meeting; Dr Stewart Bath (left) and Dr Mike Hodgson with the certificates and gifts they received acknowledging their contribution to ANZCA at Tasmania's 25th anniversary celebrations; Professor David A Scott, Dr Michelle Horne, Dr Mark Hurley, Dr Irene Ng and Mr John Ilott cutting the anniversary cake at Victoria's celebration during its combined annual CME event.

Fentanyl shortage, sugar and codeine restrictions gain media coverage

The College and the Faculty of Pain Medicine have featured in a range of reports in broadcast media outlets, print and online since the last *ANZCA Bulletin*.

ANZCA President Professor David A Scott was interviewed by the medical reporter for *The Age*, Aisha Dow, for a 500-word article "Patients at risk due to shortage of painkiller" on July 19 that ran on page two and online in *The Age* and *Sydney Morning Herald* about the impact of the shortage of fentanyl in Australian hospitals. The article reached a combined audience of nearly 300,000 people across print and online.

The story was picked up by Melbourne radio 3AW's top rating breakfast program hosts Ross Stevenson and John Burns who did a live interview with Professor Scott. This interview reached 216,000 people. Audio grabs from the interview were used on several 3AW news bulletins and these were syndicated to a total of 150 AM and FM radio stations throughout the country in Victoria, NSW and Queensland. These had a combined audience reach of 1.9 million people. The story developed during the day with the Victorian Minister for Health Jill Hennessy telling 3AW that she had been assured by the Therapeutic Goods Administration that it was doing all it could to relieve the fentanyl shortage.

Professor Scott was also interviewed by ABC Ballarat's breakfast host Kirsten Diprose and this was broadcast across ABC South Western Victoria.

Professor Scott was also interviewed for an Australian Associated Press (AAP) article about anaesthesia in unlicensed cosmetic surgery clinics after a women suffered cardiac arrest following a breast implant procedure in Sydney. The story was syndicated and ran on news.com.au on August 31 with an audience reach of 585,000 people.

The New Zealand launch of the Choosing Wisely initiative was featured in a 450-word article "Patients urged to quiz doctors about care" in the Christchurch *Weekend Press* and another 450-word article "Campaign aims to help health decisions" in the *Dominion Post Weekend*. The articles noted ANZCA had joined the Choosing Wisely campaign with a specific focus on the treatment of patients with "limited life expectancy" – namely

obese and elderly people. The articles highlighted the College's warning that many patients aged over 70 were at high risk for problems after surgery with 20 per cent experiencing complications within five days. These had a combined circulation of nearly 200,000 readers.

Geoffrey Kaye Museum of Anaesthetic History curator Monica Cronin was interviewed by ABC Radio Melbourne's "Saturday Program" host Hilary Harper on August 5 about the "Restoring the apparently dead" exhibition and the Museums Australia (Victoria) award. The seven-minute segment reached an audience of 30,000 people.

ANZCA Fellows Dr Jenny Stedmon and Dr Antonio Grossi featured in ABC radio segments in their home states of Queensland and Victoria. Dr Stedmon took to the airwaves on ABC Radio Brisbane on July 13 as part of the lively, weekly, "Eat the Week" panel segment on Kat Davidson's program. Dr Grossi was interviewed on July 23 by ABC Radio Melbourne's Sunday morning host Libbi Gore for a 10-minute segment on anaesthesia.

The release of Melbourne writer Kate Cole-Adams' book *Anaesthesia: the Gift of Oblivion, the Mystery of Consciousness* prompted several requests for radio interviews with former ANZCA President Professor Kate Leslie and Fellow Dr Tim McCulloch. Dr Leslie was interviewed by ABC Radio Sydney evening program host Josh Zepps on June 7 and Dr McCulloch featured in a 15-minute Radio National *Life Matters* studio segment on June 8 where he answered listeners' questions.

Dr McCulloch's editorial, co-authored with Dr John Loadsman, on fraudulent randomised trials in the journal *Anaesthesia* featured in the story "Journals face retraction after decades of random trials found likely to be fudged" in *The Australian* on June 7. This story had an audience reach of 100,000 people.

Since the June 2017 edition of the *ANZCA Bulletin*, ANZCA and FPM have featured in:

- **7 print reports.**
- **212 radio reports.**
- **50 online reports.**
- **1 TV report.**

Media releases since the previous *Bulletin*:

Thursday August 17:
Pain experts call for codeine-free pain relief

Monday July 10:
We need to talk about sugar

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

An ANZCA media release "We need to talk about sugar" highlighting a presentation by Dr Judith Killen at a rural anaesthesia special interest group meeting in Broome prompted interview requests on July 11 from New Zealand's top rating Mike Hosking breakfast program on Newstalk ZB. Audio segments from the interview were run on Newstalk ZB's news bulletins and syndicated to 25 New Zealand radio stations. The story was also run on scoop.co.nz and Dr Killen was interviewed by ABC Riverina's Breakfast program host Anne Delaney. These reports and interviews had a combined audience reach of 1.5 million people.

FPM Dean Dr Chris Hayes was interviewed on August 31 about the prescribing of fentanyl for chronic pain by AAP in response to the release of the Penington Institute's 2017 overdose report. The report revealed a significant increase in fatal accidental overdoses because of fentanyl, pethidine and tramadol. The AAP report was syndicated to *The Guardian*, skynews.com.au, *The Townsville Bulletin*, and *The Cairns Post*. These had a combined audience reach of 300,000 people.

Dr Hayes was interviewed on Melbourne's 3AW breakfast program on August 18 about codeine alternatives ahead of the drug's February 2018 over-the-counter ban. The five minute segment reached an audience of 205,000 people and followed an AAP interview with Dr Hayes about the ban. An extract from the interview was run in the 3AW, 6PR and Curtin FM midday and afternoon news bulletins with an audience reach of 235,000 people. These were syndicated to 20 regional radio stations across Australia. The AAP interview was syndicated to several print and online news outlets including *The Daily Telegraph*, The *Courier Mail*, *The Adelaide Advertiser*, *The Gold Coast Bulletin*, 9News.com.au and sbs.com.au. These articles had a combined audience reach of 730,000 people.

Dr Hayes also featured in an ABC *Lateline* report (left) on the opioid epidemic on June 22 which attracted an audience of 317,000 people. He was also interviewed by the AAP medical reporter Sarah Wiedersehn, on June 19 in response to a *Medical Journal of Australia* article on the use of acupuncture for pain management in hospital emergency departments. The AAP story was syndicated to sbs.com.au, 9news.com.au, skynews.com.au and healthtimes.com.au and had a combined audience reach of 355,000 people.

Carolyn Jones
Media Manager, ANZCA

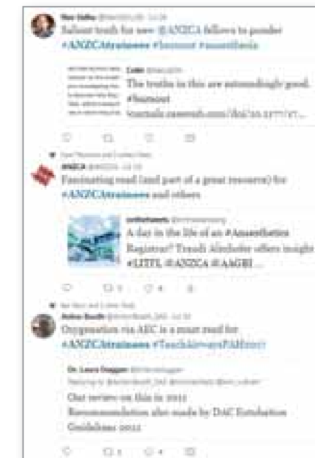
Find out first on social media

Join the thousands of Fellows and trainees who are now following us on their favourite social media platforms.

Both our Twitter account and Facebook page each have more than 3000 followers, and 115 people are subscribed to our YouTube channel. There's really no better way to keep up to speed on what's happening around the College and in the wider medical community.

Here are two examples of how we're using social media

For trainees



The #ANZCAtrainees hashtag is really picking up momentum now. So jump on to Twitter and take a look. And if you have something you'd like to share with your peers, then tag it!

We're also working with the Trainee Committee to set up a secure Facebook group where ANZCA trainees can share information and experiences, so watch this space.

For special interest groups and events

Can't make it to a scientific meeting or SIG event? You can still join the conversation! All of our major events now have their own hashtags, including the upcoming Combined Communication, Education, Welfare and Leadership and Management SIG Meeting (#CombinedSIG17) and the Perioperative SIG Meeting (#PeriSIG17).

And if you're a member of a SIG or even an informal interest group, why not consider setting up a Twitter hashtag or Facebook group?

If this is something you'd like to do, drop me a line at adicks@anzca.edu.au and I'll help you get started.

Al Dicks
Digital Communications Manager, ANZCA

Planning for regional training under way

Australia

Supporting future regional training pathways – Specialist Training Program update

With the Australian government recently confirming continued investment in the Specialist Training Program (STP) for another three years, planning for the next phase of this program has commenced within the College and the Faculty. Key objectives of the STP are to increase the available specialist workforce in rural and remote Australia and develop specialist training arrangements beyond traditional inner metropolitan teaching settings.

The Department of Health has recently released draft revised guidelines for the STP which support an 18 per cent increase in training posts in rural and remote areas across all specialist medical colleges participating in STP. These changes are part of a number of recently announced initiatives by the Australian government aimed at improving health outcomes for regional, rural and remote Australians, including:

- The establishment of 26 regional training hubs around Australia.
- An additional 100 specialist training places targeting rural areas, called Integrated Rural Training Pipeline (IRTP) posts.
- Australia's first National Rural Health Commissioner.

Since July, ANZCA's Policy team has commenced discussions with the College's internal Education unit, regional committees, regional training hubs and other stakeholders to ensure the College and Faculty are well placed to take advantage of the opportunities presented by these initiatives to evolve the College's regional workforce strategy.

At an ANZCA Council retreat on July 21, the Policy, Safety and Quality unit hosted a workshop on a regional workforce strategy where councillors were encouraged to share ideas and thoughts about how the College can strengthen capacity and training support for regional anaesthesia and pain medicine units across Australia and NZ.

A new partnership for Indigenous health

On May 31 President Professor David A Scott attended the signing of the "Partnering for Good Health and Wellbeing for Aboriginal and Torres Strait Islander Peoples" agreement at Parliament House in Canberra. "Partnering for Good Health and Wellbeing for Aboriginal and Torres Strait Islander Peoples" is a collaboration between the Australian government, the Council of Presidents of Medical Colleges (representatives pictured above right) and the National Aboriginal Community Controlled Health Organisation to "closing the gap" in health outcomes between Indigenous and non-Indigenous Australians.

The agreement was signed by the Prime Minister, Malcolm Turnbull and Ken Wyatt (Minister for Indigenous Health), Greg Hunt (Minister for Health), David Gillespie (Minister for Rural Health), Professor Nicholas Talley (Chair of the CPMC) Mr Craig Dukes (Chief Executive Officer, Australian Indigenous Doctors' Association) and Mr Matthew Cooke (Chairman, National Aboriginal Community Controlled Health Organisation).

The collaboration commits to addressing multi-faceted issues from cultural competence, support for Indigenous health workforce through to institutional racism. The agreement asks colleges such as ANZCA to think about other ways they can effect change in the health status of Aboriginal and Torres Strait Islander peoples in addition to education and training strategies.

To ensure ANZCA's approach to Indigenous health across Australia and New Zealand is contemporary and evolving, ANZCA Council supported revision of the Indigenous Health Strategy in July. The strategy will look to explore options across areas such:

- Education and training.
- Indigenous advisers.
- Cultural competence education and experience, promotion of culture.
- Health advocacy.
- Strategic alliances.
- Review and ongoing monitoring of College Indigenous health initiatives.

Developing an Indigenous strategy not only ensures ANZCA complies with national commitments but also becomes a leader among medical colleges in supporting the Indigenous health workforce and implement initiatives to redress health inequity in Indigenous populations across Australia and New Zealand.

Australian submissions:

- Safer Care Victoria – Mandatory reporting of anaphylaxis discussion paper.
- New South Wales Parliamentary Working Group on Assisted Dying – Voluntary Assisted Dying Bill 2017 (NSW) public consultation draft.

New Zealand

Stakeholder meetings – NZNC

In June, Dr Stewart Jessamine from the Ministry of Health attended the FPM New Zealand National Committee (NZNC) meeting to discuss cannabis-based products.

Dr Jessamine's portfolio includes Medsafe, and he has a particular interest in the legislation around cannabis-based products. Dr Jessamine explained that Sativex is the only cannabis-based product approved as a medicine in New Zealand at this stage, as no other products meet the manufacturing standards and consistency of composition to be classed as a medicine, so are instead referred to as cannabis-based products. Soon, regulations will be amended to allow cannabidiol products with maximum two per cent THC to be classed as prescription medicines, rather than controlled drugs.

There are no products that meet this criterion being manufactured in New Zealand, and a limited supply internationally. However, once products are available, they will be treated the same as all other prescription drugs by Medsafe.

Dr Jessamine noted the limited evidence of efficacy of cannabis-based products for use in pain and other conditions. In terms of medico-legal and ethical issues, Dr Jessamine emphasised an informed patient and an informed prescriber are needed when using cannabis-based products.

Prescribers are responsible for understanding what they prescribe, and the rationale for prescribing it. It would be inappropriate to prescribe a cannabis-based product due to patient pressure, and the decision to prescribe must be justified based on the evidence available.

More information about prescribing cannabis-based products is available on the Ministry of Health website, www.health.govt.nz.

Dr Paul Watson from Health Workforce New Zealand (HWNZ) also attended the Faculty's NZNC meeting to provide an update on workforce. HWNZ had recently consulted on a proposal to invest its funding more strategically in vocational training, and the ANZCA and FPM NZNCs had responded emphasising the need for a national workforce strategy and increased funding to support a stable, well-trained health workforce.

Dr Watson noted that HWNZ is analysing the 98 submissions it received on this issue and no substantive changes to the funding model were expected before the 2018/19 financial year or the 2019 academic year.

Jo-anne Chapman
General Manager, Policy, Safety and Quality

New Zealand submissions:

- Ministry of Business, Innovation and Employment – Annual review of the long-term skills shortage list.
- Health Quality & Safety Commission – Patient deterioration programme: feedback sought on the proposed elements of the national recognition and response system.
- Pharmac – Proposal to list ferric carboxymaltose in section B of the Pharmaceutical Schedule.
- Best Practice Advocacy Centre – Contextualised NICE guidelines: Sepsis recognition, diagnosis and early management (NG51).

What would you do?

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

Preoperative fasting

Curtis Lester Mendelson was an obstetrician and cardiologist whose findings on aspiration of gastric contents were published in 1946. Who has read his original article? If not, then I would recommend it as it not only makes for interesting reading but it is responsible for shaping our clinical practice in anaesthesia.

In his study, Dr Mendelson reviewed all cases of pulmonary aspiration that occurred over 13 years in a New York obstetric hospital. During that time there were 44,016 pregnancies and 66 instances of aspiration of gastric contents, representing an incidence of 0.15 per cent. Of these instances there were two deaths, which were immediate, following asphyxia from solids. This study set the scene for preoperative fasting as well as the use of rapid sequence induction, and prophylactic administration of antacids. While there have been some changes in views on fasting, modification of rapid sequence induction techniques, and a range of agents for making gastric pH less acidic, things remained fairly static for almost 70 years.

This brings me to the scenario for your consideration. You are scheduled for an elective paediatric general surgical list consisting of an eight-year-old male for repair of hydrocele followed by a 12-year-old female for repair of an inguinal hernia. You see them for their pre-anaesthesia consultations on admission at 7am with a scheduled starting time of 8am in theatre.

As you commence your consultation with the first boy and his parents, the admitting nurse enters to inform you that the child has had a drink of apple juice from a bottle in his mother's bag. The parents confirm this and the exact quantity cannot be established, although it could have been up to 150ml.

What would you do?

Without hesitation, you would whip out *PS07 Guidelines on Pre-Anaesthesia Consultation and Patient Preparation* and refer to the fasting guidelines in the appendix.

Since the first child is undergoing an elective procedure and it will be less than two hours fasting from clear fluids at the scheduled starting time of the surgery, some will take a conservative approach while others may be willing to proceed given the controversy and debate over current existing guidelines. Those that are more conservative might decide to defer and change the order of the list.

To make things more interesting let us agree to swap the two patients and now the 12-year-old female arrives in the holding bay, where she is noted to be chewing gum. Now what?

There are a number of options ranging from cancelling the list, deferring the start of the list by an hour, through to proceeding with the list as scheduled. Whatever course of action is decided upon it should be evidence-based. It is pertinent at this juncture to qualify that statement, which should be understood to refer to the best available evidence, as emphasised by the President, Professor David A Scott.

The matter of chewing gum is addressed in the *PS07* background paper, which cites data from webAIRS indicating that the presence of chewing gum is not a risk for increased gastric content but rather one of risk of an adverse airway event. As the second patient was noted to have gum in her mouth, the best available evidence would support proceeding as long as the patient was willing to part with her gum. Phrasing the request might require special attention if the patient was chewing multiple gums!

The issue of fasting continues to evolve. The only two deaths in Dr Mendelson's initial paper were due to choking on solid material, and there were no deaths from aspiration in any of the other three cases of solids and 40 cases of fluids. Since then, there have been numerous deaths associated with aspiration of fluid contents linked with, but not limited to, pregnancy. Much research has been undertaken to evaluate risks of aspiration and means of diminishing those risks, and during that time a better understanding has been achieved with regards to the effect of fasting on those risks.

These issues were considered in the review of *PS07* fasting guidelines and were supported by findings and actions of international organisations including the American Society of Anesthesiologists and the European Society of Anaesthesiology. The reason behind having the fasting guidelines as an appendix within *PS07* is that it offers flexibility with the ability to amend them as new evidence emerges, without having to review the entire professional document. So when it comes to withholding food and fluids from midnight, for all patients, *PS07* recommends – not so fast!

Dr Peter Roessler
Director of Professional Affairs, Policy

Professional documents – update

The professional documents of ANZCA and FPM are an important resource for promoting the safety and quality 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. Governments and other bodies refer to ANZCA's professional documents as an indicator of expected standards, including in regards to accreditation of healthcare facilities. Professional documents are subject to regular review and are amended in accordance with changes in knowledge, practice and technology.

Recent releases:

During the July 2017 ANZCA Council and Safety and Quality Committee meetings the following professional document and accompanying background papers was approved:

- *PS61 Guidelines for the Management of Evolving Airway Obstruction: Transition to the Can't Intubate Can't Oxygenate Airway Emergency.*

Professional documents now being piloted:

- *PS15 Guidelines for the Perioperative Care of Patients Selected for Day Care Surgery.*
- *PS51 Guidelines for the Safe Management and Use of Medications in Anaesthesia.*
- *PS58 Guidelines on Quality Assurance and Quality Improvement in Anaesthesia.*
- *PS62 Statement on Cultural Competence.*

Feedback is encouraged during the pilot phase for all professional documents. Queries or feedback regarding professional documents can be sent to profdocs@anzca.edu.au.

All ANZCA professional documents are available via the ANZCA website – anzca.edu.au/resources/professional-documents FPM professional documents can be accessed via the FPM website – fpm.anzca.edu.au/resources/professional-documents.

ANZCA accepts doctors' wellbeing challenge

Medicine is a challenging and usually immensely rewarding profession.

Doctors are highly motivated, intelligent and hardworking people. Doctors are respected and second only to nurses as the most trusted members of the community. Doctors are also knowledgeable in a wide range of clinical knowledge, especially of course in that knowledge which is related to the practice of their specialty.

Why then are doctors themselves the victims of a range of significant medical illnesses and psychological disorders? Why don't or can't doctors help themselves? Stress-related illnesses feature highly in surveys of doctors' health, including specialist anaesthetists and pain physicians (for example, see the Royal College of Physicians of Ireland "National Study of wellbeing of hospital doctors in Ireland" – https://tinyurl.com/ya9mpnas).

Stress itself leads to many physical conditions, especially when added to long hours, fatigue, irregular meals, alcohol excess, and a lack of adequate exercise. This can also progress to "burnout" and contribute to relationship breakdown.

Of course there are a great many other external pressures such as career progression, examinations and assessments, financial security, conflict with others, and bullying, discrimination and harassment (BDSH). It is also easy to see why similar circumstances may lead to depression, and the ultimate tragedy of suicide. Although it has become a cliché, it is also true that a physician who is unwell is not reliably able to provide the best care for his or her patients.

This is not a sustainable situation, and seems to be getting worse. So, what can be done about it?

ANZCA is making an ongoing significant commitment to supporting the health and wellbeing of our trainees and Fellows. Our Deputy CEO, Carolyn Handley, is leading the development of a co-ordinated and collaborative approach to doctors' health and wellbeing. This role will draw on existing programs such as BDSH management, and look to improving the support that the College can recommend or provide.

A working group has already been established to look at the needs and issues facing trainees and new consultants. We are already very fortunate to have the benefit of the resources developed by the tripartite (ANZCA, ASA, NZSA) Welfare of Anaesthetists Special Interest Group. We will also, for the first time, be asking questions on BDSH and wellbeing in the upcoming Fellowship survey.

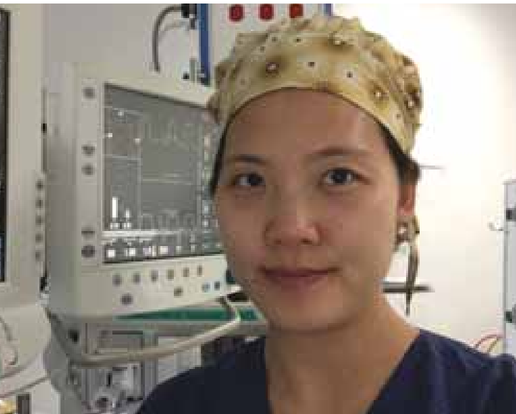
Finally, having a GP who you see regularly, is consistently identified as being really important. A barrier to seeking help for some has been the interpretation of AHPRA's mandatory reporting laws. It appears that the concerns expressed by ANZCA, the AMA and many other professional organisations may lead to change in this area.

If you need help please go to www.anzca.edu.au/resources/doctors-welfare or you may wish to contact ANZCA via ceo@anzca.edu.edu or complaints@anzca.edu.au.

Professor David A Scott
ANZCA President

"Why then are doctors themselves the victims of a range of significant medical illnesses and psychological disorders? Why don't or can't doctors help themselves?"

The search for a new horizon



Dr Phuong Pham, who designed the Primary Examination Mentoring Scheme at Western Health in Melbourne, is passionate about doctors' health. She asks: "Why are doctors so terrible at looking after their own welfare?"

The Welfare of Anaesthetists Special Interest Group (SIG) has been meeting since 1995. Twenty years later, media and community attention focuses on the welfare of the doctor, forcing the medical profession to look in the mirror and dig deep. In digging, we find doctors dying due to suicides, beyondblue studies confirming higher rates of psychological distress and anxiety compared to the general public, and an SBS Insight episode providing honest accounts of stress, burnout and shame among medical trainees. We are forced to ask, why are doctors so terrible at looking after our own welfare?

The definition of wellbeing lacks consensus. Dodge et al (2012) proposes that "stable wellbeing is when individuals have the psychological, social and physical resources they need to meet a particular psychological, social and/or physical challenge". Ryff's Scale of Psychological Well-being is a validated instrument assessing six dimensions of wellbeing: self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth. A deficit in one dimension suggests a neglected resource that may lead to lack of welfare. Here, I would like to consider self-acceptance.

According to a systematic review (2010) commissioned by beyondblue, the suicide rate in doctors is higher compared to the general population. Male doctors have a 26 per cent higher risk and female doctors a 146 per cent higher risk of suicide when compared to the general population.

Paired with this serious vulnerability is the perceived stigma preventing doctors from accessing care. The majority of doctors agree that, for them, being a patient causes embarrassment. Experiencing depression or anxiety is thought to be seen as a sign of personal weakness by other doctors, causing them to think less of you and affecting future job prospects.

In daily work, examples of doctors' lack of self-acceptance are abundant. The medical culture is penetrated by the pressure to be god-like.

We are human but we deprive our human bodies of basic needs such as adequate sleep, regular meals and toilet breaks. We need human connection but forces such as physical distance, limited time and lack of energy drive us away from our support network. We face old age, illness and death just like other humans but we function as if mortality will not touch us. We are every bit the patient like those we care for, but we are ashamed of it. Holding onto the delusion of being superhuman, we deny the existence of our vulnerable human nature.

Vulnerability researcher Brené Brown (2010) asserts that it is impossible to live fully, to feel worthy, loved and connected without embracing one's vulnerability. By numbing vulnerability and rejecting our humanity, we inevitably numb other aspects of our human nature such as joy, gratitude and hope. Emphatically, our attachment to being god-like and our failure to accept weaknesses lead to misery. In mild cases, this manifests as a disgruntled lack of purpose. In the extreme, misery manifests as burn out, anxiety and suicide.

Of vulnerability, the poet David Whyte (2015) writes, "the only choice we have as we mature is how we inhabit our vulnerability, how we become larger and more courageous and more compassionate...our choice is to inhabit vulnerability as generous citizens of loss, robustly and fully, or conversely, as misers and complainers, reluctant, and fearful".

Given the recent focus on doctors' lack of welfare, do we have the courage to admit that the dominant culture in medicine has been the latter rather than the former? Only when we accept this can we begin to cultivate a different culture.

In this new culture, we could choose to live whole-heartedly. We would aim for excellence despite being imperfect. We would try regardless of inevitable failures. We would support rather than condemn. We would accept rather than deny.

The gifts of vulnerability are humility, forgiveness and empathy. What we would gain by embracing our vulnerabilities is so much more than what we would risk. Rather than fearing the lack of respect from patients, we should have faith that our openness will allow us to be more compassionate and loving carers.

"We are human but we deprive our human bodies of basic needs such as adequate sleep, regular meals and toilet breaks."

There is true strength in vulnerability. I believe this vehemently. I draw on the examples of others who have the courage to inspire.

Thank you to my many mentors who role model that making mistakes is normal and asking for help is encouraged. That I am able to write this article is testament to your unceasing support.

Thank you to the brave doctors who spoke out on SBS Insight. Thank you to the courageous families who spoke out after the suicides of their loved ones. Your combined efforts have pressured the health minister to revise mandatory reporting policies and develop a mental healthcare package for the medical profession.

Thank you to the Welfare SIG which has been promoting anaesthetists' personal and psychological wellbeing for the past two decades. Thank you to Dr Jessica Dean, 2017 Victorian State Finalist for Young Australian of the Year for her leadership in launching the Australian Medical Students' Association (AMSA) Mental Health Campaign, to raise awareness of mental health issues among medical students. Thank you to Dr Craig Hassed who pioneered the incorporation of mindfulness training into Monash University's medical curriculum. The path ahead is made easier for the foundation laid by these leaders.

I believe in the power of collective collaboration.

The search for a new horizon is here. Momentum is building. The culture will change.

How will you be part of the change?

Dr Phuong Pham, Anaesthesia Registrar
Western Health, Victoria

References:

Beyondblue (2013) National Mental Health Survey of Doctors and Medical Students

Brené Brown (2010) The power of vulnerability. TED Talk. <https://www.ted.com/talks/brene_brown_on_vulnerability>

Elliott L, Tan J & Norris S (2010) The mental health of doctors: A systematic literature review. Health Technology Analysts Pty Ltd for beyondblue: the national depression initiative

Dodge R, Daly A, Huyton J & Sanders L (2012) The challenge of defining wellbeing. International Journal of Wellbeing 2(3) 222-235.

Malatt A (12 June 2017) Why are doctors killing themselves? MJA InSight. <https://www.doctorportal.com.au/mjainsight/2017/22/why-are-doctors-killing-themselves/>

Ryff CD & Keyes CLM (1995) The structure of psychological well-being revisited. Journal of Personality and Social Psychology 69(4) 719-727.

SBS Insight (June 20, 2017) Why are rates of mental illness so high among junior doctors and nurses? <http://www.sbs.com.au/news/insight/tvepisode/critical-care>

Whyte D (2015) Consolations: The Solace, Nourishment and Underlying Meaning of Everyday Words. Many Rivers Press.

Left: A still from the SBS Insight episode providing honest accounts of stress, burnout and shame among medical trainees.

If you are concerned about yourself or a colleague, contact

The Doctors' Health Advisory Service

Hotline

nearest to you

Australia:
New South Wales/Northern Territory +61 2 9437 6552
Australian Capital Territory +61 407 265 414
Queensland +61 7 3833 4352
Victoria 1300 853 338
Western Australia +61 8 9321 3098
Tasmania 1300 853 338
South Australia +61 8 8366 0250
New Zealand: 0800 471 2654

Taking care: Don't let mandatory reporting get in the way

Australia's health ministers are considering changes to mandatory reporting because of concerns about the impact it may be having on doctors seeking help.

Doctors are human. We get sick, sometimes we feel anxious, overtired, or burnt out. We may develop depression or other significant mental or physical illness. There is ample evidence that many of us are not good at taking care of ourselves and not good at seeking appropriate professional help, whether for routine medical care or when we have a problem. This is not good for us, for our patients or for our profession.

There are many reasons for this. We have trouble acknowledging our own vulnerability, we fear stigma and we don't always trust that our colleagues will maintain our confidentiality. A further barrier for some doctors is fear of mandatory reporting.

Australia's health ministers are the only people who can change mandatory reporting requirements. They have responded to widespread concerns about the impact it may be having on doctors seeking help and announced that they will consider possible changes to mandatory reporting by treating health practitioners and then consult with stakeholders.

In the meantime, I encourage all doctors to seek help and support when they need it. We should all have a regular treating GP and take care of our health and wellbeing.

The threshold for requiring a mandatory report is high, only reached when an impaired doctor is *placing the public at risk of substantial harm*.

If you are suffering stress, burnout, anxiety or depression, talk to someone or seek help. A doctor who seeks help for stress or burnout does not meet the definition of impairment under the law unless their capacity to practise is significantly affected.

A doctor suffering from anxiety or depression who is being treated by another practitioner and is following their doctor's advice, does not meet the threshold for a mandatory report. A treating doctor is only required to make a mandatory report if their patient-doctor has an impairment that has placed the public at risk of substantial harm. This obligation does not apply to treating doctors in Western Australia.

> "The threshold for requiring a mandatory report is high, only reached when an impaired doctor is placing the public at risk of substantial harm."

You can access confidential advice and support through the doctors' health advisory and referral services. Contact details for doctors' health services in each state and territory are available on the drs4drs website – www.doctorportal.com.au/doctorshealth. The Medical Board of Australia funds these services which are managed and overseen by an Australian Medical Association subsidiary company, DrHS, at arm's length from the board.

You can read more about mandatory reporting requirements on AHPRA's website – www.ahpra.gov.au/Notifications/Make-a-complaint/Mandatory-notifications.aspx.

You can access confidential support and advice through the drs4drs website.

Dr Joanna Flynn AM
Chair, Medical Board of Australia

Mandatory reporting – the New Zealand position

The reporting to responsible authorities by medical practitioners of concerns about the competence of other medical practitioners was one of the most controversial aspects of the consultation process that led to the introduction of New Zealand's 2003 legislation the Health Practitioners Competence Assurance Act (HPCA Act).

The initial intention was that the new legislation would include a statutory duty requiring practitioners to report colleagues to the relevant responsible authority (such as the Medical Council of New Zealand) when they believed a colleague was practising below the required standard of competence.

The opposition to mandatory reporting of concerns about competence was sufficiently strong that when the HPCA Act was passed in to law, the mandatory reporting proposal had been replaced by a voluntary reporting provision. Insofar as reporting of concerns about competence is concerned, that remains the current position. While the HPCA Act has a provision (section 34) that allows a health practitioner to report another health practitioner in certain circumstances – and protects the practitioner making the notification unless the practitioner has acted in bad faith – there is no requirement in the HPCA Act that a notification is made.

Interestingly, the HPCA Act treats differently concerns that a practitioner's health may be affecting the safety of the practitioner's practice. For health concerns, there is mandatory reporting in New Zealand. If a health practitioner has reason to believe that another health practitioner is unable to perform the functions required for the practice of the profession because of "some mental or physical condition" then the health practitioner holding such concerns must inform the relevant responsible authority (section 45).

The effect of this is that there are different approaches to notifications about competence and health. In short, under the HPCA Act there is mandatory reporting for health; but "discretionary reporting" for competence.

While this state of affairs might be considered less than ideal, the HPCA Act is not the whole story.

The duty practitioners have to comply with legal, ethical and other relevant standards which means that all health practitioners need to look further than the HPCA Act when it comes to identifying the scope of their legal duty to take action when there are reasonable grounds for believing that a colleague's conduct, competence or health may pose a risk of harm to patients.

Few could argue that, in 2017, it is acceptable to "turn a blind eye" to concerns about a colleague's conduct competence or health – particularly where there is a risk to patients. A failure to act, in circumstances where any reasonable practitioner would be expected to take some action, might itself be culpable.

Dr Jonathan Coates
Partner, Claro Lawyers, New Zealand

Welfare advocates critical to doctor wellbeing

Dr Lucky De Silva is one of many anaesthesia welfare advocates in hospitals throughout Australia and New Zealand who is passionate about the wellbeing of colleagues and trainees.

It was while she was working at Oxford University Hospitals Trust in the UK that Dr Lucky De Silva really became aware of the challenges experienced by her peers as they grappled with exam stress, long work hours and trying to maintain a balanced personal life.

She was struck by the high levels of burnout experienced by many of her colleagues there – due largely to a combination of resourcing pressures, staff/patient ratios and workload.

With the realisation that perhaps these issues were a global phenomenon in the medical community she returned in 2015 to a position as visiting medical officer in the anaesthesia department at The Alfred hospital in Melbourne. In 2016 she was nominated by the department as the welfare advocate through an initiative developed through the Welfare of Anaesthetists Special Interest group (SIG).

ANZCA has established a reputation as a leader among Australia and New Zealand's medical colleges in tackling the issue of doctors' welfare and mental health.

An eloquent and passionate supporter of raising the profile of welfare issues in anaesthesia and the wider medical community Dr De Silva reflected on her welfare advocate role over a coffee in the hospital's café. (The Alfred is familiar territory for her as she completed her training there between 2009 and 2013.)

She admits that anaesthesia, especially for those who work independently or in regional or rural areas, can be isolating.

Dr De Silva volunteered for the role after ANZCA approached anaesthesia departments seeking nominations for welfare advocates. She works two days a week at The Alfred and the rest of her working week is spent in private practice. She shares the welfare advocate role with Dr Andrew Ross, a specialist intensivist and anaesthetist with more than 40 years' experience.

The Alfred's anaesthesia department has 29 full-time specialists, 65 part-time specialists and 40 trainees.

"This is not a therapeutic role – compassion is key – and is extremely important," she explained.

"It makes a huge difference when you take on a role such as this knowing you have such a supportive environment. I value being able to share this role with Dr Ross who has many more years of experience."

(continued next page)

"We're now starting to look at the issue more holistically so we can say that people need to be well to be able to work well and to care for others."

Having grown up in a medical family – Dr De Silva's mother is a retired psychogeriatrician and her father recently retired as a GP – Dr De Silva believes she was well prepared for the rigors of medical and specialist training. But for some trainees their journey to medical specialty can be particularly challenging.

"When trainees do confide in me about some of the things they're struggling with my role is to listen and help them work towards a resolution. They might just need to debrief with me as a mentor, discuss strategies to help them better manage their exam and study pressures, develop a plan to help them return to practice after a period of extended leave or it may be a more serious matter that requires mediation.

Above: Dr Lucky De Silva, welfare advocate, The Alfred hospital, Melbourne.

"My role in these cases is to facilitate an outcome and ensure their concerns are listened to. We live it but we often don't see it. I'm pleased that people feel comfortable enough with me to approach me.

"Confidentiality of course is so important. They need to feel safe and know that if they want to pursue a matter or issue that it will not impact on their training. These are not corridor chats by any means and it doesn't just end after they've spoken to me. It really is the start of facilitating an outcome and a resolution."

So how does she ensure that in taking on the role of welfare advocate her own work/life balance is kept in check?

"There's no doubt that it can be challenging but it's important that as mentors and peers we're there to help our colleagues to debrief and to check in whenever they feel they need to. We all know how difficult it can be trying to strike the right balance but I really do believe that we can make a difference."

Dr De Silva welcomes the increased focus on welfare issues in the medical profession from ANZCA and other medical colleges, the media, and state and federal governments.

"It's so important that these issues are talked about widely, and not hidden anymore. We have come a long way but we still have a lot more to do."

The recognition of welfare issues and discussions around mental health in ANZCA's Part Zero course, which gives trainees an induction to anaesthesia, includes presentations on wellbeing and strategies about how to get help in addition to study skills and how to approach exams.

"It's initiatives such as this that provide an opportunity to talk to trainees about these issues before they start their journey," Dr De Silva said.

"There is still a lot of stigma attached and we need to change this. If you break an ankle you get time off – if there are other issues that are affecting how you practice you should also be given time off, it should be no different.

"Unfortunately there is an element of 'you should be able to cope with it and you just need to toughen up' but we all just need to learn to be more compassionate with our colleagues.

"We need to be compassionate all the time – it's not just a switch on, switch off thing."

Dr Marion Andrew, who chairs the Welfare of Anaesthetists SIG said while it was left up to hospital anaesthesia departments to decide whether they wanted to nominate their own welfare advocate, she was encouraged by the response by teaching hospitals in her own state of South Australia and in the Northern Territory (Darwin).

"Six out of the seven hospitals in South Australia and Darwin now have an anaesthesia welfare advocate," she explained.

"These are hospital positions that take a whole model of care approach."

Dr Andrew said the welfare issue was "something that had been very much influencing both medical practice and lifestyle for doctors for quite some time. In the UK for example there is growing recognition of how badly stress and other pressures can affect morale. It affects retention, it affects sick leave and it affects the amount of time people take out for doing other things because their work can be stressful.

"We're now starting to look at the issue more holistically so we can say that people need to be well to be able to work well and to care for others."

Carolyn Jones
Media Manager, ANZCA

Obstetric anaesthetist recognised

The ANZCA Council Citation was established in 2000 and is made at the discretion of the ANZCA Council in recognition of significant contributions to College activities. The scope of the award was recently broadened to include recognition of humanitarian work.

Professor Michael Paech, who recently retired from holding Australia's only chair of obstetric anaesthesia at the School of Medicine and Pharmacology at the University of Western Australia, is one of the latest recipients of an ANZCA Council Citation.

Chair of the WA Regional Committee, Dr John Martyr, presented Professor Paech with the award at the Cable Beach Country Conference in Broome.

Professor Paech has a distinguished, 30-year career in research, teaching, obstetric anaesthesia and acute pain medicine. He is editor-in-chief of the *International Journal of Obstetric Anaesthesia* and is now working part-time at the King Edward Memorial Hospital for Women in Perth.

Above: Dr John Martyr, Chair of the WA Regional Committee (left) presents Professor Michael Paech with his ANZCA Council Citation.

"Despite all of his achievements he remains incredibly humble."

The award recognises Professor Paech's significant contribution over many years to the College and the national and international anaesthesia community through multiple qualifications, awards and international visiting professorships and lectureships.

The ANZCA nomination statement detailed many of Professor Paech's professional achievements which include more than 200 publications, including books and book chapters, and securing $A5.5 million in anaesthesia research grants.

He has held several key examiner and committee roles at ANZCA, including as a College representative at international, national and regional level, ANZCA Final Fellowship examiner and assessor and Obstetric Anaesthesia SIG Chair.

In 2012 Professor Paech was co-convenor of the scientific program for the ANZCA Annual Scientific Meeting in Perth.

The ANZCA Council nomination noted that in addition to his many professional achievements "not least Mike has been a mentor to all of us and is an archetypal 'Australian good bloke' who loves sport and family life".

"Despite all of his achievements he remains incredibly humble."

Professor Paech delivered the Bunny Wilson lecture at the Western Australian Scientific Meeting and Country Conference "Comfortably Numb: Updates in Regional Anaesthesia" which was held in Broome from June 16-18.

In explaining the title of his lecture, "Reflections from Brownridge to Trump", Professor Paech reflected on Dr Peter Brownridge, a mentor and inspiration in his clinical and research career, through to a rather different type of leader "who provides me with scope to try and entertain along my life journey".

Carolyn Jones
Media Manager, ANZCA

ANZCA's role in the global community

We are all part of a global community, to which ANZCA has much to contribute.

In our specialties of anaesthesia and pain medicine, we can benefit others because of what we have to offer in clinical expertise, education and training, and we can also gain ourselves by learning and sharing knowledge with others.

The College has formed an International Liaison Group, chaired by the Immediate Past President Dr Genevieve Goulding, to help integrate and oversee our international relationships.

ANZCA Fellows, often in collaboration with our surgical colleagues, undertake significant outreach activities throughout the Asia-Pacific region, but also extending to challenging areas such as Africa and Mongolia. These activities include education and capacity development as well as expert clinical service provision.

Collaboration is important, which means working with the Australian Society of Anaesthetists, the New Zealand Society of Anaesthetists, and organisations such as Interplast, to realise the value of a co-ordinated approach to supporting and advocating for global health initiatives. In these activities the needs of communities we engage with is paramount.

The ANZCA Overseas Aid Committee, chaired by Dr Michael Cooper, is an important part of this.

As part of our role in advocacy, earlier this year we submitted a joint paper to the Department of Foreign Affairs and Trade to call for our government to increase support for our nearest neighbours to ensure that ongoing education and training would result in a sustainable health workforce.

One of our most wide-ranging initiatives is the Essentials of Pain Management program which provides a resource for education and practice of pain management in 53 countries to date. This was developed by Dr Roger Goucke and Dr Wayne Morriss and is now co-trademarked with the World Federation of Societies of Anaesthesiologists and promoted through the Faculty of Pain Medicine.

There is a tremendous unmet need for effective pain management in both acute and chronic pain in most countries but especially in low and middle-income countries.

Throughout the world, sister colleges and other organisations share similar issues in education and training of medical professionals and specialist practitioners. We are invited participants with over 23 countries in the International Medical Education Leaders Forum held annually in Canada. This group identifies common interests and challenges in meeting the needs across the world in delivering effective healthcare to the billions of people who do not yet have access to timely and safe surgery, anaesthesia and obstetric care, as identified by the Lancet Commission.

Within Australia and New Zealand, we can benefit by sharing with our peer-level organisations. In Asia we have close ties with Hong Kong, Malaysia and Singapore. Although training for FANZCA specialists will not continue beyond 2018 in these regions, we are working to ensure that we still retain strong links and collaborations which reflect our common goals and interests.

In Europe, Ireland and the United Kingdom we have a close relationship with the Royal College of Anaesthetists and the College of Anaesthetists of Ireland. We have regular meetings to discuss joint interests and share educational and policy resources.

We are also developing relationships with the anaesthesiology societies in China, Great Britain and Ireland, and Europe.

Finally, we have close ties through our "Tri-Nation Alliance" with the Royal College of Physicians and Surgeons in Canada. Such collaborations benefit everyone, by sharing resources and expertise we avoid duplication of effort and expense, and by aligning commonalities we increase the opportunities for training experience shared in both directions.

Through all these activities, guided by our international liaison principles, ANZCA is actively working in the interests of all our Fellows and trainees to deliver the best outcomes as part of our membership of the global health community.

Professor David A Scott
ANZCA President

Safe surgery and anaesthesia

ANZCA plays a key role in a landmark conference in Port Moresby that called for the development of a national surgical and anaesthetic strategy for PNG where a lack of access to safe surgery and anaesthesia kills more people than AIDS, tuberculosis and malaria combined.

The surgeon in charge of the Rabaul medical clinic was so stricken with malaria that he could no longer work, leaving paediatric anaesthetist Dr Michael Cooper and a small team to manage as best they could.

Unusually for a provincial clinic in Papua New Guinea (PNG) there were few patients and it soon became clear why. The clinic had just one small oxygen tank – barely enough for a morning schedule of procedures and operations.

"It turned out no oxygen had been delivered for some time and whatever they had they had to keep for a real emergency so we couldn't continue our work. We then had to wait for two days until we could get a flight out," Dr Cooper recalled.

In the years he has spent visiting and teaching at the University of PNG, where he is an adjunct professor of anaesthesiology, Dr Michael Cooper has come to know all too well the country's health and medical challenges.

On his many visits to hospitals in the capital Port Moresby and hospitals and healthcare facilities in rural and remote parts of the country such as Rabaul, Lae and Alotau where 80 per cent of the population live, he has seen firsthand how the lack of access to safe surgery and anaesthesia kills more people than HIV/AIDS, malaria and TB combined.

Provincial hospitals are the only option for the majority of the population and with many not having basic medical equipment, medication or supplies the preoperative paediatric clinics Dr Cooper runs on his visits can be confronting.

"Many of those living in rural and remote areas may be one or two days away by foot or truck to basic medical services," explained Dr Cooper, a senior anaesthetist at The Children's Hospital at Westmead in Sydney.

"Provincial hospitals don't have the intensive care facilities that are needed to ventilate a child after a lung operation or a major abdominal operation. That's really hard – knowing there is something you can do but the facilities aren't there to support it."

As chair of ANZCA's Overseas Aid Committee Dr Cooper is at the forefront of the College's commitment to provide teaching, education and examination support for the speciality in PNG. He first visited the country in 1981 as a medical student in the southern highlands.

He believes deaths caused by trauma, accidents, obstetric and neonatal conditions in PNG are preventable.

"It's about being able to do the ordinary operations – the badly smashed arm or perforated appendix. If these operations are not done properly people die. I've seen children die from appendicitis in PNG and that just doesn't happen in Australia."

Dr Cooper and College Fellows and frequent PNG visitors Dr Chris Acott – a difficult airways specialist who has spent many years working with the PNG Anaesthetic Society – and Dr Yasmin Endlich, consultant anaesthetist at Royal Adelaide Hospital, joined College President Professor David A Scott in Port Moresby recently for the Medical Society of PNG's landmark symposium "Access to safe and affordable surgery and anaesthesia".

The goal of the meeting – to draft a national surgical and anaesthetic strategy for PNG with input and advice from anaesthetists, specialists and surgeons from PNG, Australia and the US including global health policy expert Professor Mark Shrime from Harvard Medical School – was a watershed for the country's underfunded health system.

The meeting, which was formally opened by PNG Prime Minister Mr Peter O'Neill, was timely as it followed the release of significant global health and surgical statements in support of the World Health Organization's guidelines on safe surgery. In 2015, the World Health Assembly pledged to support the strengthening of emergency and essential surgical care and anaesthesia as a component of universal health coverage. The resolution recognised the need to train more anaesthesia and surgical providers to ensure access to safe anaesthesia and surgery.

Another 2015 report by The Lancet Commission on Global Surgery found that a lack of access to safe surgical care had a major impact on the health and wellbeing of tens of millions of people each year. The Lancet Commission identified three "bellwether procedures" that can be used to assess the basic surgical capability level of a nation's healthcare facilities: caesarean section, abdominal surgery and orthopaedic surgery for bone fractures. If hospitals and healthcare centres can perform the three "bellwethers" they are then known to be able to manage other operations and procedures.

It is these "bellwethers" that symposium delegate and local cardiothoracic surgeon Dr Noah Tapaua hopes can ultimately transform the way surgery is supported and funded in his country so lives can be saved.

"The biggest challenge for us as medical specialists is there's simply not enough of us," he told the *Bulletin* in Port Moresby.

"For a population of nearly eight million people there are 121 surgeons, 27 anaesthetists and 40 obstetricians and gynaecologists."

Another 100 anaesthesia scientific officers (ASOs) who have completed a one-year diploma perform most of PNG's anaesthesia services.

"The government here is listening to what we're saying but many of us believe more can be done. That's why this discussion around access to safe surgery and anaesthesia is so important – the government has a national health plan which is geared to primary healthcare but it does not include safe surgery and anaesthesia.

"What we would like to see is a national health plan that recognises the importance of safe surgery and anaesthesia and safe access to everyone."

The proportion of a country's population living within two hours of a hospital is another key global health indicator that is often cited by PNG medical specialists such as Dr Tapaua.

"Consider the case of a woman who is bleeding before birth. If you don't treat that mother within two hours that patient will die. Only 20 per cent of the population live less than two hours from a hospital."

Chair of the symposium scientific committee, Associate Professor Ikau Kevau, said it was important for representatives from ANZCA and other international visitors to work with specialists in PNG so the safe surgery message could be presented to the government.

"The fact is that people living in the remote and rural areas of PNG have limited or no access to safe surgery and this needs to be addressed."

"People are dying because they can't be exposed to surgery and anaesthesia in facilities that are still unable to provide the three bellwether procedures that should be the basic yardsticks for safe surgery and anaesthesia in PNG," Professor Kevau explained.

Dr Cooper believes that programs to improve healthcare and safe surgery and anaesthesia in PNG must respond to local needs. Building local experience and capacity is crucial to the long term health needs of the country.

"He has seen firsthand how the lack of access to safe surgery and anaesthesia kills more people than HIV/AIDS, malaria and TB combined."

"This has got to be driven by the local specialists in PNG," he explained.

"We're there to help them facilitate what they want. We're not there to dictate what we think they need as our way may not work for them. Their local anaesthetists are smart, motivated people who want to do better for their country."

ANZCA's Overseas Aid Committee plays a key role in managing master of medicine and diploma workshops and examinations in PNG and funds PNG anaesthesia prizes for local undergraduates and trainee specialists.

The findings of a 2015 BMJ study of 21 hospitals and health facilities in PNG to determine the country's capacity for essential surgery and anaesthesia provide a sobering snapshot.

The survey found that while major surgical procedures were provided at each of the three national and provincial hospitals and 11 district and rural hospitals fewer than 30 per cent had uninterrupted access to oxygen. Access to anaesthetic machines and blood supplies was severely limited. Many non-hospital health centres provided basic surgical procedures but almost none had uninterrupted access to electricity, running water, oxygen and basic supplies for airway management, resuscitation and obstetric services.

The study concluded that "while much progress has been made in healthcare provision in recent years in PNG...capacity for essential surgery and anaesthesia services is severely limited due to shortfalls in physical infrastructure, human resources and basic equipment and supplies. Achieving...universal healthcare will require significant investment in surgery and anaesthesia capacity in PNG."

Earlier this year ANZCA made a joint submission with the Australian Society of Anaesthetists to the Department of Foreign Affairs and Trade foreign policy white paper review. The submission highlighted the importance of including the health portfolio in Australia's long-term foreign policy planning.

The submission highlighted PNG as an example of the importance of linking foreign policy, health and security and concluded that PNG "may be on the verge of a fast-approaching humanitarian health crisis which may lead to significant security challenges for Australia."

"PNG is Australia's closest neighbour and has the fastest per capita population growth in the region," the submission noted.

"It also has the worst health statistics in the region including maternal mortality and infant mortality."

Carolyn Jones
Media Manager, ANZCA

Anaesthesia in PNG

PNG's population of nearly eight million is predicted to double by 2030. Half the population is younger than 16 years of age and 80 per cent of the population live in rural/remote areas.

- PNG has 0.25 anaesthetists per 100,000 population. Australia has 75 times this number.
- PNG only has five paediatric surgeons for nearly four million children.
- 10 per cent of children need a procedure per year – about 400,000 paediatric operations.
- Currently PNG performs fewer than 50,000 operations a year overall.

Above clockwise from top left: President of RANZCOG Professor Stephen Robson, Professor Mark Shrime, RACS President Dr John Batten and ANZCA President Professor David A Scott; Professor Scott with PNG Prime Minister Peter O'Neill; cardiothoracic surgeon Dr Noah Tapaua; Professor Scott and Dr Michael Cooper with local performers; conference delegates; Dr Michael Cooper with Dr Hilbert Tovirika and PNG chief anaesthetist Dr Duncan Dobunaba.

Precious cargo a lifeline for hospitals

Dr Yasmin Endlich is making a difference to the lives of hospital patients in Papua New Guinea with her regular deliveries – and they all fit into a suitcase.

Most of us try to limit the amount of luggage we take when we're flying somewhere so we have room for those last minute travel purchases and gifts on our return trip home.

But when Dr Yasmin Endlich and her daughter Sarah make the trip from Adelaide to Port Moresby they each make sure they use every bit of their 30 kilogram luggage allowance because they have very precious cargo on board.

Visiting Port Moresby in early September to attend the Medical Society of Papua New Guinea's "Access to safe and affordable surgery and safe anaesthesia" symposium the Endlichs crammed dozens of sterile suture packs, airway equipment and masks, endotracheal tubes, syringes and cannulas into their suitcases.

These surgical and anaesthesia items are a desperately needed lifeline donation for the country's hospitals where often the most basic medical equipment is in short supply or non-existent.

Dr Endlich, a consultant paediatric anaesthetist at Adelaide's Women's and Children's Hospital and a consultant at the Royal Adelaide Hospital, made her first trip to PNG in 2013 for a medical conference in Lae with ANZCA Overseas Aid Committee member and veteran PNG visitor Dr Chris Acott. She has since made several return visits to attend symposiums and lead workshops on airway management and regional anaesthesia.

Sarah, 17, accompanied her mother for the first time last year and couldn't wait to return for this month's visit.

Before each trip Dr Endlich spends several months collecting equipment that Adelaide hospitals are not allowed to use because they have "expired". (Medical equipment manufacturers stamp expiry dates on their products but it does not mean they are no longer sterile or viable). Word of Dr Endlich's efforts has spread and colleagues and medical companies in Adelaide now do regular drops of medical equipment to her home.

As each trip nears, the floor of Sarah's room is covered with much needed sterile equipment ready for packing.

"Anything in doubt I don't take but so much of this would just get thrown away and it is perfectly fine for use," Dr Endlich told the *Bulletin* as she prepared for her visit earlier this month.

While Dr Endlich says the equipment she takes represents just a fraction of the equipment that hospitals in PNG desperately need, she knows it does make a difference.

"It's only a small drop in the ocean but I know that this is much needed and much wanted," she said.

Through the connections she and ANZCA's Overseas Aid Committee have made in PNG over the years she now receives "wish lists" for urgently needed equipment from hospitals and medical staff.

On her many visits she has seen first hand the challenging conditions under which many PNG hospitals operate.

Last year, on a visit to Alotau, the capital of Milne Bay Province, Dr Endlich was struck by the lack of basic medical supplies at the main provincial hospital.

"Hospitals need a lot of a surgical tape to secure cannulas and intravenous drips but all this hospital had was just one roll of surgical tape. It is frustrating for staff knowing they can do more to help their communities if they have the supplies they need. Not being able to help a patient because they lack basic equipment – that must be extremely hard."

"What we're providing is really much wanted equipment. The hospitals have little or no funding so they often run out of essential equipment and supplies."

Dr Endlich distributes some of her cargo when visiting hospitals on clinical trips. Other items are placed on a large table at medical symposiums for local hospitals to take what they need.

Dr Endlich is passionate about her work in PNG and plans to continue with her special deliveries for as long as she can. Her efforts are also supported by several medical companies and organisations including Cook Medical, the DAK Foundation, Laerdal Global Health, Lifebox, Rotary Australia World Community Service, Smiths Medical, SonoSite and STORZ. Last year, these companies and organisations donated more than 200 kilograms of equipment to PNG.

Carolyn Jones
Media Manager, ANZCA

Above from left: Sarah Endlich sorting the donations ready for packing; the Endlichs' luggage arriving in PNG; Dr Chris Acott unpacks the delivery of medical supplies; ASO Wesley Jeffrey selects hospital equipment; ASOs sort through much needed items.

"Hospitals need a lot of a surgical tape to secure cannulas and intravenous drips but all this hospital had was just one roll of surgical tape."

For Dr Keno Temo, a general anaesthetist at Port Moresby General Hospital, being able to find enough medical supplies and equipment for the hospital's medical teams is an ongoing battle. At the recent PNG Society of Anaesthetists specialty meeting in Port Moresby she and other doctors and Anaesthetic Service Officers (ASOs) were able to source much needed sutures, masks and endotracheal tubes for their hospitals and clinics through the supplies provided by Dr Yasmin Endlich.

Dr Temo selected packets of sterile surgical sutures that she knew one of the hospital's paediatric surgeons would be able to use. "These sutures are crucial for our operations and I know the surgeon prefers to use these ones," she explained.

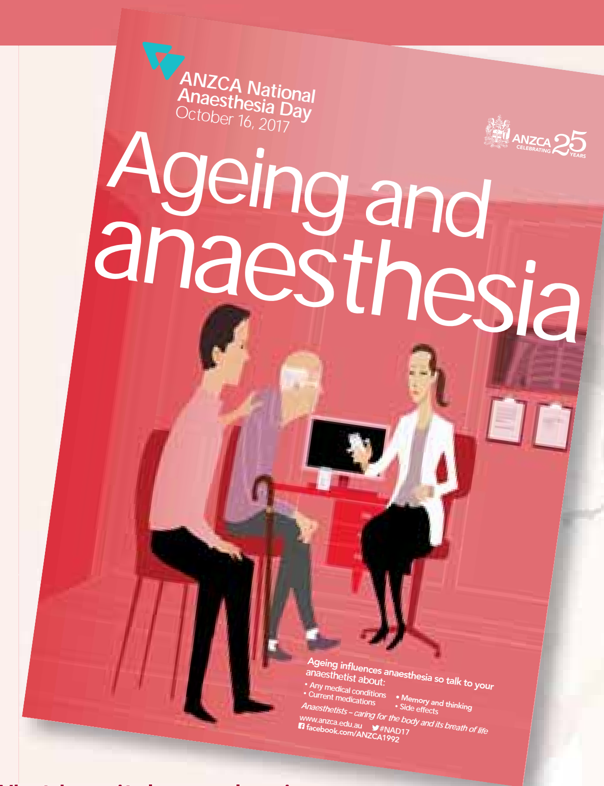
"These are hard to come by at the hospital because of the continuing shortages so anything that helps our patients I'm happy to source for other doctors."

PNG ASO Wesley Jeffrey said his rural hospital in the Finschhafen district, 80 kilometres east of Lae, often ran out of stocks of medical supplies, medications and equipment. Mr Jeffrey is the only ASO at the Braun rural hospital which has five staff including one surgeon.

"We probably do three to four operations a day at the hospital and we are now running low on stocks of supplies. We're now running short of infusion pressure bags so I can now take some of these back to the hospital."

As those attending the meeting broke for lunch Dr Endlich emptied the contents of her suitcases onto a table and a podium platform. By afternoon tea the contents had gone, having been collected by ASOs and doctors to distribute to hospitals and clinics throughout PNG.

ANZCA National Anaesthesia Day nearly here



ANZCA National Anaesthesia Day
Monday October 16, 2017

What are you doing?

For posters and other collateral related to our "Ageing and anaesthesia" theme, contact communications@anzca.edu.au. Printable web-based material can be found at **www.anzca.edu.au/events/national-anaesthesia-day**.

It's not too late to join in!

#NAD17 facebook.com/ANZCA1992
www.anzca.edu.au

While people aged 65 years or older make up about 15 per cent of Australia and New Zealand's population, they account for 41 per cent of hospital admissions in Australia and 30 per cent in New Zealand.

This is why ANZCA National Anaesthesia Day has been themed "Ageing and anaesthesia".

It is to be celebrated on Monday October 16, the anniversary of the day in 1846 that ether anaesthetic was first demonstrated in Boston, Massachusetts.

Our key messages

We are explaining to the community that as they get older, they are more likely to need a procedure that may require anaesthesia and that the natural ageing process can make older patients more sensitive to anaesthetic drugs, more likely to develop complications and infections, and recovery may take longer.

We are encouraging older patients and their carers to talk to their anaesthetist about any conditions they may have or medications they are taking that could affect their anaesthetic.

Older patients are also encouraged to talk to their anaesthetist about whether their memory or thinking may be affected by an anaesthetic so that they can be reassured that any post-operative confusion is usually temporary, affecting fewer than 20 per cent of older patients for longer than three months after anaesthesia.

Another area for discussion – in keeping with ANZCA's Choosing Wisely recommendations (www.choosingwisely.org.au/recommendations/anzca) – is whether an operation is always the best option.

Older patients are also being encouraged to do all they can to prepare for an operation, such as improving their fitness, stopping smoking and eating well.

Promoting ANZCA National Anaesthesia Day

ANZCA's Communications team is busily planning a significant campaign in mainstream media as well as social media to promote the day in Australia and New Zealand.

We are encouraging hospitals to involve their communications or media teams who can liaise with ANZCA (via communications@anzca.edu.au) about what activities can be undertaken at individual hospitals.

We are also preparing a web-based video that can be used for promotion.

What hospitals are planning

Many hospitals across Australia and New Zealand have nominated "champions" to help run activities and later this month ANZCA will be sending posters and other material to them and other hospital anaesthesia departments, encouraging participation.

We have already heard from many about their plans.

In Australia, for example, John Hunter Hospital in Newcastle is planning two foyer displays at each of the hospitals where they will display anaesthesia equipment and demonstrate airway management techniques. They will also display posters in their perioperative clinic, simulation centre and two operating theatre blocks and will demonstrate how physiological reserve declines in the ageing process.

Other hospitals planning activities are Princess Alexandra Hospital in Brisbane, La Trobe Regional Hospital in regional Victoria, QE II Jubilee Hospital in Brisbane, Hollywood Private Hospital in Perth and the Armadale Kalamunda Group in WA.

The Gold Coast University Hospital, and Robina Hospitals in Queensland are keen to promote this theme where older Australians tend to move to retire.

Last year, all but a handful of hospitals got involved in ANZCA National Anaesthesia Day and many have indicated again this year that they plan to celebrate.

Whangarei Hospital, under the Northland District Health Board (DHB) were very active last year and will again be taking part, as well as the Waitemata DHB with North Shore and Waitakere hospitals

Auckland DHB (incorporating Auckland City Hospital L9 and L8, Starship Children's, National Women's and Greenlane Surgical Centre) will again be celebrating as will Counties-Manukau DHB with Middlemore Hospital and the Manukau Centre.

We have also heard from Thames Hospital, the Bay of Plenty DHB with hospitals at Tauranga and Whakatane, Gisborne Hospital, Taranaki Base Hospital, Whanganui Hospital, Palmerston North Hospital, Hutt Hospital, Capital & Coast DHB (Wellington Hospital and Kenepuru Hospital) Wairau Hospital in Blenheim, Timaru Hospital, Grey Base Hospital in Greymouth and Dunedin Hospital.

It isn't too late to join in. Contact communications@anzca.edu.au in Australia or communications@anzca.org.nz in New Zealand.

Clea Hincks
General Manager, Communications

ANZCA National Anaesthesia Day last year.

Mortality report published

The latest edition of the ANZCA mortality report, *Safety of Anaesthesia: A review of anaesthesia-related mortality reporting in Australia and New Zealand 2012-2014*, has now been published. Edited by Associate Professor Larry McNicol, this triennial report is produced by the Mortality Sub-Committee which reports to ANZCA's Safety and Quality Committee. The key findings, recommendations and clinical aspects of category one anaesthesia-related deaths sections are reproduced here.

Key findings

Notwithstanding the effect of jurisdictional differences in methodology for case reporting and classification, this report indicates that anaesthesia mortality rates in modern Australia are low, whether assessed by the number of anaesthesia deaths per million population per annum (2.96) or by the number of anaesthesia-related deaths per number of anaesthesia procedures per annum (one in 57,023). The emerging pattern is that anaesthesia risk is now extremely low in patients who are fit and well (ASA-P 1 – 2).

Most anaesthesia-related deaths occur in older, sicker patients having non-elective surgery. Further reductions in mortality may be achieved by reviewing the timing of surgery to allow better optimisation of such patients. There may have been some cases in which the decision to operate was inappropriate or futile.

It is increasingly important to engage the patient and their carers in detailed discussion about their surgical condition, the treatment options, and their wishes, including any advanced care directives and end of life care planning. This should be undertaken collaboratively between anaesthetists, surgeons, and other specialists in perioperative medicine, geriatrics and intensive care.

It is important to maintain the very high standards of anaesthesia training, enhanced by continuous professional development using interactive workshops and simulation training in airway management, anaphylaxis and resuscitation and other crisis management scenarios. However, the fact that some deaths, such as those due to drug anaphylaxis, are currently deemed unpreventable re-enforces the ongoing need for research to develop better, safer alternatives.

Specifically, the pursuit of safer drugs should include the option of making neuromuscular blocking agents (NMBAs) less likely to trigger anaphylaxis by removing or reducing community exposure to pholcodine with its attendant risk of cross sensitisation to NMBAs.

Recommendations

The ANZCA Mortality Sub-Committee makes the following recommendations:

- Healthcare authorities should recognise that anaesthesia mortality is higher in older, sicker patients having major or urgent surgery. If the decision is made to proceed, appropriate perioperative resources should be provided, including appropriate levels of specialist anaesthetist care and supervision and high dependency facilities (ANZCA professional document *PS59: Statement on Roles in Anaesthesia and Perioperative Care*).
- Healthcare authorities and clinicians must take account of the wishes of elderly and often frail patients and their carers, in collaborative discussion about the potential outcomes from emergency anaesthesia and surgery. This should include consideration of any existing advanced care directives and end of life care plans and aim to reduce the risk of inappropriate and potentially futile intervention.
- The Therapeutic Goods Administration (Australia) and Medsafe (New Zealand) should be approached to remove or restrict community exposure to pholcodine, an ingredient (with no proven efficacy) contained in over the counter cough mixtures, in light of further evidence of its role of increasing the risk of anaphylaxis to neuromuscular blocking agents due to cross sensitisation.
- There should be no option for any single operator proceduralist to administer sedation or anaesthesia (ANZCA professional document *PS09: Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures*).
- The ANZCA Mortality Sub-Committee and the anaesthesia mortality committees in all states and territories of Australia should continue to work collaboratively to establish and maintain robust methodologies to obtain accurate anaesthesia mortality data.
- Patients, healthcare authorities, anaesthetists, other medical specialists and healthcare workers should recognise the role of current anaesthesia training, research, accreditation, continuing professional development and education in achieving and maintaining the highest standards of safety and quality in the practice of anaesthesia in Australia and New Zealand.
- The broader community should be informed that modern anaesthesia care is very safe as indicated by the very low anaesthetic mortality rates in Australia and the ongoing aim to avoid all anaesthesia-related deaths.

"It is increasingly important to engage the patient and their carers in detailed discussion about their surgical condition, the treatment options, and their wishes, including any advanced care directives and end of life care planning."

Clinical aspects of category one anaesthesia-related deaths

For the first time, in the previous and the ninth triennial anaesthesia mortality report, we included clinical information from the 22 deaths (category one) where it is reasonably certain that the death was caused by anaesthesia or other factors under the control of the anaesthetist.

The inclusion of this information was deemed appropriate in order to highlight the major clinical issues involved in the deaths directly related to anaesthesia and it is anticipated this has been achieved without compromise to confidentiality.

In this report, we have again included some brief clinical details for the 23 category one deaths. In this the 10th triennial anaesthesia mortality report for the period 2012-2014, of the 23 direct (category one) anaesthesia-related deaths, seven were due to anaphylaxis, six involved pulmonary aspiration, six involved cardiac arrest of which five were attributed to inappropriate choice or application of technique and inadequate crisis management.

One of these involved a non-anaesthetist single operator undertaking a medical procedure under sedation. Another cardiac arrest was due to local anaesthesia toxicity during a procedure performed by a non-anaesthetist. There were two deaths caused by hypoxia due to failure to secure an airway, and two deaths were due to stroke as a complication of inadvertent arterial placement of central venous catheters.

Anaphylaxis (seven)

There were seven deaths from anaphylaxis, of which five involved suxamethonium and two were caused by rocuronium.

An additional death involved an unexplained cardiac arrest at induction which may have been due to anaphylaxis. Most of these cases were diagnosed rapidly and involved profound hypotension leading to cardiac arrest. Crisis management was appropriate on most occasions and included early and escalating administration of adrenaline and fluids.

Three of these patients were obese and one also had known cardiac disease. In at least three cases, transoesophageal echocardiography was deployed during attempted resuscitation.

Note: Anaphylaxis was the most common cause of "primary anaesthesia mortality" and may be regarded as one of the less preventable causes of anaesthesia-related deaths. However there is emerging evidence that exposure to pholcodine in over-the-counter cough medicines carries a risk of sensitisation to neuromuscular blocking agents and hence there is a strong case for reducing this exposure to a substance with no proven efficacy through regulation of the pharmaceutical industry.

Victorian Consultative Council on Anaesthetic Mortality and Morbidity triennial report 2012–2014

The Victorian Consultative Council on Anaesthetic Mortality and Morbidity (VCCAMM) has recently published its triennial report 2012-2014.

The key findings of the report are:

- Anaesthesia related deaths are more common in older, sicker patients having emergency surgery.
- Anaphylaxis to neuromuscular blocking resulted in four of the nine deaths which were directly attributable to anaesthesia, and 25 cases of life threatening morbidity.
- Obesity was a co-morbidity noted in seven of the 28 anaesthesia related deaths.
- Postoperative respiratory depression is an emerging concern, particularly in vulnerable patients such as those with obesity, obstructive sleep apnoea or renal impairment.

The report can be accessed via www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/consultative-councils/council-anaesthetic-mortality.

Associate Professor Larry McNicol, FRCA FANZCA
Editor
Chair, Victorian Consultative Council on Anaesthetic Mortality and Morbidity

Aspiration (six)

There were six deaths due to pulmonary aspiration, all of which occurred in the setting of emergency surgery, and in five cases involved patients who were critically ill. Two cases involved a poor choice of technique in that a rapid sequence induction was not performed.

Note: Pulmonary aspiration continues to be a leading cause of anaesthesia related death and attention to detail in the choice and application of technique is imperative to mitigate this risk, especially in elderly frail patients.

Cardiac arrest (six)

There were five deaths involving cardiac arrest resulting from inappropriate choice or application of anaesthesia technique. Two cases involved patients who were critically unwell and three others were elderly and at least two of them had significant cardiac morbidity. Contributory factors included inappropriate choice of technique, drug dosage and inadequate monitoring.

Note: Patients who are critically unwell or elderly and frail are at increased risk of perioperative cardiac arrest. Choices regarding the level of monitoring and drug dosage are paramount.

(continued next page)

Mortality report published (continued)

"The Therapeutic Goods Administration (Australia) and Medsafe (New Zealand) should be approached to remove or restrict community exposure to pholcodine."

Airway related deaths (two)

There were two deaths from hypoxia resulting from failure to establish and maintain an airway. One involved a complex patient with a previous tracheostomy who required emergency surgery.

After initially successful intubation, airway bleeding ensued after which the airway was unable to be maintained. The other case involved a repeat endoscopic procedure during which there was unexpected loss of the airway which could not be restored despite supraglottic, laryngoscopic and surgical airway techniques.

Note: Unexpected loss of the airway remains an ever present risk and all anaesthetists must continue to undertake regular crisis management training in airway management techniques including can't intubate/can't oxygenate scenarios.

Stroke (two)

There were two procedure related deaths from stroke caused by inadvertent arterial placement of central venous catheters, and in at least one of these cases, the diagnosis was delayed.

Note: The decision to insert a central venous catheter should take account of a risk benefit analysis on a case-by-case basis. The major risks include vascular injury and bloodstream infection. The traditional indications include assessment of volume status, secure venous access and a safe method for infusion of vasoactive agents. However, it should be noted that there is increasing doubt about the utility of central venous pressure as a marker of volume status. Attention to detail during insertion of central venous catheters must take account of the appropriate methods to prevent inadvertent arterial placement and active management of inadvertent arterial puncture.

Associate Professor Larry McNicol, FRCA FANZCA
Editor
Chair, ANZCA Mortality Sub-Committee

Safety of Anaesthesia: A review of anaesthesia-related mortality reporting in Australia and New Zealand 2012-2014
Access the report via www.anzca.edu.au/documents/mortalityreport_2012-2014-high-res.pdf

webAIRS: Awareness during anaesthesia report

Incident reporting activity is an essential component of professional development and service improvement. webAIRS data continues to give valuable insight into the practice of anaesthesia as well as craft specific educational opportunity. The extensive amount of webAIRS analysis being undertaken has resulted in several articles, the latest of which, themed around awareness and authored by Professor Kate Leslie AO et al, appeared in the July issue of *Anaesthesia and Intensive Care*.

Awareness in anaesthesia is topical and forever intriguing. While relatively rare in occurrence, it is important that we examine awareness-themed incidents because of the potential for distressing outcomes for patients.

From the first 4000 cases reported to webAIRS, 61 potential awareness related incidents were identified and analysed. Defined as "post-operative recall of events occurring during intended general anaesthetic", 16 reports were consistent with intraoperative awareness. Another 31 reports included patients who were at increased risk of awareness, but were not aware. Analysis of the remaining 14 reports suggested that awareness was unlikely, due to the adequacy of anaesthetic agent delivery, and the absence of signs consistent with awareness.

While the most accurate picture of incidents of awareness is to be gained through repetitive, structured interviewing of patient's post operatively, self reporting by anaesthetists gives excellent opportunity for us to gain insights. Of the 16 reports classified as awareness, all were entered into webAIRS following spontaneous patient recall of events. It is important to note that five of the patients reported ongoing distress due to the experience of awareness.

The following associations could be deduced:

- 12 reports (75 per cent) related to low anaesthetic delivery.
- 8 reports (50 per cent) related to signs of intraoperative wakefulness (including movement, tears, sweating, hypertension, tachycardia, high or increasing electroencephalographic readings).

Previously described causal themes are present in the webAIRS analysis. These include, but are not limited to, failure to:

- Check equipment.
- Turn on vaporisers.
- Maintain anaesthesia during difficult intubation and other crises.

Medication errors, including adequate reversal of neuromuscular blockade and syringe swaps, are also prominent in the data. These are well known errors on which future quality improvement initiatives require ongoing focus. In addition, many of the reports suggest that awareness was related to errors in the use of recently introduced anaesthetic equipment (e.g. electronic anaesthetic workstations). This indicates that we must keep vigilant in our teaching and professional development to keep abreast of new technologies and innovations.

With webAIRS we have the opportunity to be proactive about service improvement. Our craft specific incident reporting tool encourages learning with every entry – whether within the local M&M setting, or by contribution to the bi-national data set. Anaesthetists are encouraged to register, report and develop reflective practice by routinely using webAIRS.

Sarah Walker
ANZTADC Co-ordinator/
ANZCA Policy Officer

Reference:
Awareness during general anaesthesia in the first 4,000 incidents reported to webAIRS. K.Leslie, M.D. Culwick, H.Reynolds, J.A. Hannam, A.F. Merry. Anaesthesia and Intensive Care, Volume 45, Issue 4, 441-447 July 2017.

Safety news

Neuraxial connectors

ANZCA and the Australian Commission on Safety and Quality in Health Care have produced a joint statement recommending that ISO 80369-6:2016 be adopted in Australia as part of a global initiative to improve patient safety. The joint statement has also been endorsed by eight organisations. More information and a copy of the statement can be found at www.safetyandquality.gov.au/wp-content/uploads/2017/06/ANZCA-and-Commission-position-statement-on-neuraxial-connectors-2017Mar.pdf

Mandatory reporting of anaphylaxis

Safer Care Victoria through its discussion paper, sought input into the development of a scheme for mandatory reporting of anaphylaxis. The discussion paper stemmed from recommendations by the Coroners Court of Victoria to the Minister for Health and the Secretary of the Department of Health and Human Services following the death of a child from anaphylaxis after consuming mislabelled food. The minister and secretary accepted the coroner's recommendations with the secretary indicating that the department would investigate, consult widely, and formulate a program for mandatory reporting of anaphylaxis. ANZCA's response to this consultation can be found at www.anzca.edu.au/documents/anzca-response_mandatory-reporting-anaphylaxis_fin.pdf

Safe sedation

The Safety and Quality Committee continues to liaise with state health departments on safe sedation procedures as part of consultation with health professions regarding licensing of private health facilities. ANZCA is currently liaising with three state governments.

Victoria

In July, representatives from the Department of Health and Human Services (DHHS) met with Dr Phillipa Hore, Chair of the ANZCA Safety & Quality Committee, Dr Peter Roessler, Director of Professional Affairs and members of the Policy unit. DHHS consulted with ANZCA to seek its views on the licensing of private health facilities in response to the Health Legislation Amendment (Quality and Safety) Bill 2017. Discussion centered on definitions and the spectrum of sedation, doses of local anaesthesia, pre-admission screening, building codes, and ANZCA guidelines. ANZCA is pleased to have been involved in the consultation at its preliminary stage.

New South Wales

The NSW Ministry of Health invited ANZCA to provide comment on its Draft Private Health Facilities Regulation 2017. In the current legislation anaesthesia is defined as excluding sedation provided in connection with dental procedures. As the risks associated with dental sedation are not insignificant, ANZCA does not support excluding dentists from the definition of anaesthesia, and this was relayed in our submission letter along with other comments on the draft regulation. The submission letter is available on the ANZCA website at www.anzca.edu.au/communications/advocacy/submissions/submissions-2017.

South Australia

The South Australian parliament is looking to introduce legislation to address safety issues around surgical procedures being performed in stand-alone health care facilities, where concerns have been expressed in relation to complexity of surgery, need for intravenous sedation, and/or need for potentially large doses of local anaesthetic. The purpose is twofold, being (a) to identify those procedures which should be performed in a "licensed" premises, and (b) to facilitate safety and quality in procedures performed in stand-alone health care facilities. The government is working in good faith with ANZCA, RACS and the AMA to ensure legislation that promotes safe practice, without creating unnecessary obstacles for those practitioners who are only performing "lumps and bumps" surgery, and/or already have well developed safety and quality processes in place.

Open disclosure vital for patient safety

New Zealand's Health & Disability Commissioner (HDC) recently reviewed a case (16HDC00882 on www.hdc.org.nz) that involved a medication error by an anaesthetist (Dr B).

The pertinent points of the case are that Dr B inadvertently administered an additional 6mg (in addition to the intended 2.5mg) of epidural morphine to a patient having a spinal decompression for spinal stenosis.

No patient harm resulted from this error.

The error was discovered during the subsequent case when Dr B realised that an epidural morphine syringe was missing.

Medication errors are not uncommon in anaesthesia so there are lessons from this case relevant to all Fellows:

- Despite the patient complaint and subsequent HDC finding that Dr B had breached the patient's right to services with reasonable care and skill, the commissioner noted that "Dr B took immediate and appropriate action following his error". In addition to notifying the hospital (including completing an incident form), notifying the patient and the patient's family at the time of the error, Dr B wrote to the patient apologising, explaining the medication error in detail and detailing the changes he had implemented in his practice as a result.
- Although no "harm" occurred following this event, all relevant medical professional bodies, including ANZCA, support open disclosure following an adverse event (including a drug error). The Medical Council of New Zealand has a statement on Disclosure of Harm as does the HDC, *Guidance on Open Disclosure Policies*.
- ANZCA has a professional document in pilot phase on the *Guidelines for the Safe Management and Use of Medications in Anaesthesia*, (*PS51*). All Fellows are advised to read this document: in particular, section 5.4 "Drawing up and checking drugs before administration" and the information in the background paper for an understanding of the difference between "open" and "closed" practice environments.
- The HDC noted that "it is inherently risky to place epidural syringes for two patients in close proximity on the drug trolley". The hospital where this incident took place is developing a policy that will "recommend that only one patient's medications be prepared at one time". The HDC considers this to be appropriate remedial action.

In summary, Fellows are reminded that open disclosure is "the right thing to do" whenever an error or adverse event takes place, irrespective as to whether actual patient harm occurs. Preparing drugs for more than one patient at a time has inherent risks that need to be mitigated by robust and safe practice systems.

Dr Hamish Gray, FANZCA
Christchurch Hospital

Safety and Quality Committee response

In the wake of concern that the HDC decision in this case could have a "chilling" effect on open disclosure, ANZCA's NZ National Committee (NZNC) referred this case to ANZCA's Safety and Quality Committee (SQC). SQC Chair Dr Phillipa Hore wrote to the NZNC saying open disclosure should be encouraged where there had been an adverse event or error.

"The process of open disclosure may be stressful but it may also lead to important changes in practice and institutional changes to assist in safer patient management.

"Medication errors are common (one in 20 to one in 130 anaesthesia episodes). *PS51: Guidelines for the Safe Management and Use of Medications in Anaesthesia*, has recently been revised and is currently in pilot. It states that clean trays should be used for each patient but does not specifically detail that medications for different patients should not be stored in close proximity. We will strengthen this concept in the document.

"The first 'general principle' of *PS51* is that the aim of safe administration of medications in anaesthesia is to 'administer the correct medication to the correct patient, in the correct dose, by the correct route at the correct time'. No doubt this is the way every anaesthetist intends to practise. Environmental measures and behavioural routines are largely successful in achieving this aim."

The SQC commended the anaesthetist's actions subsequent to discovering the error, saying that he had acted "most appropriately". It also said it was unfortunate that the patient had laid a complaint with the HDC, despite suffering no long-term adverse sequelae, but that having done so, the HDC was bound to investigate it.

Unacceptable mortality rates among the poor and Māori

The sixth report of New Zealand's Perioperative Mortality Review Committee (POMRC) considers two new topics for the period 2010-2014 – the relationship between socioeconomic deprivation and perioperative mortality, and 30-day mortality following abdominal aortic aneurysm repair.

The POMRC identified "unacceptable discrepancies in the mortality rates for New Zealand's most deprived populations" and, along with the mortality review committees' Māori Caucus, it has made recommendations that support the reduction of inequities in perioperative mortality as well as emphasising the need to improve access to medical and surgical care, and the quality of that care, both before and after surgery.

The POMRC reviews deaths related to surgery and anaesthesia that occur within 30 days of an operation, and advises and makes recommendations on how to reduce these deaths and make surgery safer for patients.

It found that people living in the most deprived areas had a higher rate of perioperative mortality (0.63 per cent) than people living in the least deprived areas (0.39 per cent). They were also almost twice as likely as the other group to have emergency surgery, and had 14 per cent more elective operations.

When adjusted for the effects of other socio-demographic and clinical factors, those in the most deprived areas had a 1.18 times greater risk of mortality after elective surgery than those in the least deprived areas. For acute surgery, this increased to 1.46 times.

POMRC Chair Dr Leona Wilson said the disparities were glaring and work was needed urgently to find out why they existed and to reduce them, "as every person in New Zealand has the right to expect the same standard of healthcare regardless of their socioeconomic situation".

Other recommendations emphasised the need to record a patient's ASA status; and cover the need to consider and discuss with patients the risks and benefits of various options for patients needing an elective abdominal aortic aneurysm repair; and the need to discuss the risk of dying perioperatively (and of serious complications) with all patients contemplating an operation with a significant risk.

In addition to the two special topics, mortality for the selected tracking procedures and clinical areas from previous reports are extended here for 2010-2015. These tracking procedures and clinical areas include: same or next day mortality following general anaesthesia; 30-day mortality following general anaesthesia; perioperative mortality for those classified as ASA 4 and 5; perioperative mortality for those classified as ASA 1 or 2 following an elective admission; weekend versus weekday mortality; cholecystectomy; hip and knee arthroplasty; colorectal resection; coronary artery bypass graft; and percutaneous transluminal coronary angioplasty.

The POMRC has also woven a number of composite case stories into the report for the clinical lessons they can provide to strengthen the quality of postoperative care and help prevent perioperative deaths.

Perinatal and maternal mortality and morbidity

The latest report from the Perinatal and Maternal Mortality Review Committee (PMMRC) also notes a continuing inequity between Māori and non-Māori, and calls for a greater focus on outcomes for Māori mothers and infants.

Its 11th report considers perinatal and maternal mortality and morbidity from January 1 to December 31, 2015; perinatal mortality from 2007 to 2015; maternal mortality from 2006 to 2015; and babies with neonatal encephalopathy from 2010 to 2015.

The maternal mortality rate for Māori mothers is almost double that of New Zealand European mothers, with Māori women being over-represented among maternal suicides. The main contributory factors to these deaths continue to be barriers to access and/or engagement with care, which PMMRC says it will work with the sector to improve.

It says that the outlying causes of stillbirth and neonatal death among babies of Māori mothers are spontaneous preterm birth, antepartum haemorrhage, maternal conditions (mostly diabetes-related), and hypertension.

New to the PMMRC report is the work of the Maternal Morbidity Working Group (MMWG), which transitioned from the Severe Acute Maternal Morbidity (SAMM) research group based at Otago University. The MMWG, which will be active to June 2019, is responsible for nationally reviewing the incidence of women who are pregnant or have recently delivered who are also very ill, and developing quality improvement initiatives alongside the maternal health services.

The perinatal related mortality rate in 2015 is the lowest reported since the PMMRC began collecting data in 2007 and is significantly lower than the rate for the years 2007-2014 combined.

The PMMRC also reported a statistically significant reduction in foetal deaths (stillbirths and late terminations of pregnancy combined) from 2007 to 2015, and an ongoing statistically significant reduction in stillbirths.

However, the neonatal death rate had not changed significantly in New Zealand from 2007 to 2015, though there had been significant reductions in the UK, Australia and Scandinavia. The PMMRC says this will be a key area of investigation for 2017-2018.

Other recommendations in the PMMRC report relate to:

- The need for ethnicity data to help address ethnic inequities.
- Better recording of parity, body mass index and smoking data to help account for mortality variations.
- Clinical practice guidelines about when induction might or might not be appropriate.
- The need for district health boards with significantly higher rates of perinatal-related mortality and neonatal encephalopathy to keep reviewing this and identify areas for improvement.
- The Health Quality & Safety Commission (HQSC) establishes a permanent Suicide Mortality Review Committee, and that its Child and Youth Mortality Review Committee consider including information about whether female suicide cases were pregnant in the 12 months prior to their deaths.
- Improved awareness of and responsiveness to the increased risk for Māori women, including comprehensive risk assessment, better management of mental health issues, and better communication and co-ordination between all levels of providers.

Both reports are available through the HQSC website: www.hqsc.govt.nz.

Susan Ewart
Communications Manager, NZ

Medal winners a *Who's Who* of anaesthesia and pain medicine

Some of the biggest names in anaesthesia and pain medicine are recipients of the Orton and ANZCA medals.

The Orton Medal, ANZCA's most prestigious award, recognises distinguished service to anaesthesia, perioperative medicine and/or pain medicine, and pre-dates the formation of the College in 1992.

In the past, the citation specifically included intensive care medicine prior to the separation of the Joint Faculty of Intensive Care Medicine to form the College of Intensive Care Medicine.

This award was first established by the Faculty of Anaesthetists, Royal Australasian College of Surgeons (RACS) in 1967, and the first five medallists were Dr Gretta McClelland OBE of Melbourne for her foundational work in paediatric anaesthesia, Dr Eric Anson OBE of Auckland as the pioneer specialist anaesthetist in New Zealand, Dr Harry Daly CMG of Sydney for his fostering of anaesthetic education and the foundation of the Faculty of Anaesthetists RACS, Associate Professor John Ritchie, OBE, of Dunedin for his work for safety and standards of anaesthesia and innovations in equipment, and Dr Geoffrey Kaye of Melbourne also for his work on safety though mortality and morbidity studies, his drive to establish the specialty in Australia and his historical teaching collection of anaesthetic equipment which provided the basis for the College's Geoffrey Kaye Museum.

The ANZCA Medal, established as the Faculty Medal in 1979, recognises major contributions to the status of anaesthesia, perioperative medicine and/or pain medicine, including but not limited to, outstanding service to the College, and previously included intensive care medicine. It was first awarded to Dr Peter Penn of Melbourne who was the first honorary curator of the Geoffrey Kaye Museum of Anaesthetic History.

While there have been years when the College awarded neither an Orton nor ANZCA Medal, in other years there have been recipients of both. The list of Orton and ANZCA Medal recipients reads as a "Who's Who" of the speciality in Australia and New Zealand and includes former ANZCA presidents and Faculty deans, and many others who have contributed to anaesthesia and its closely related specialties, and often to college or professional societies. Many of the recipients of both awards have featured in Commonwealth or national honours lists as well.

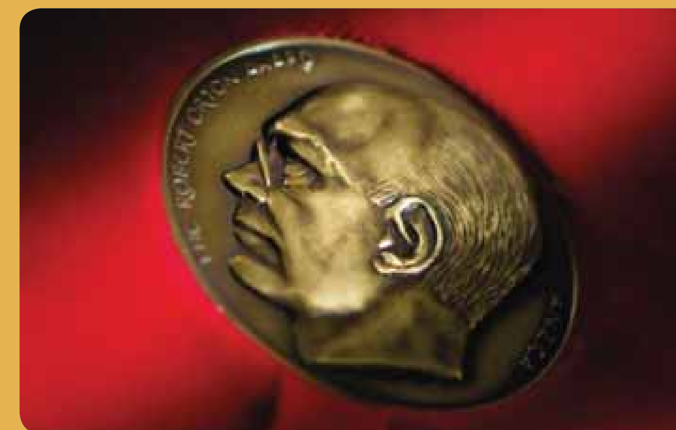
Forty distinguished anaesthetists, over the 25 years of the College, have been awarded the Robert Orton Medal and/or the ANZCA Medal, with 24 receiving such medals from the former Faculty of Anaesthetists as well as a Faculty Medal awarded in 1987 to Ms Nancy O'Donnell the former administrative officer of the Faculty.

Just three ANZCA Fellows, Professor Alan Merry, ONZM, of New Zealand, and two NSW anaesthetists Dr Graham Fisk and Dr Gwen Wilson have received both awards. Professor Merry, chair of ANZCA's Research Committee and a passionate advocate for cultural awareness and patient safety, received the ANZCA Medal in 1997 and the Orton Medal in 2016. Dr Fisk received the 2004 Orton Medal and the RACS Faculty of Anaesthetists Medal in 1990 for his work in College education and assessment, and paediatric anaesthesia, and Dr Wilson was awarded the Orton Medal in 1990 and the RACS Faculty Medal in 1988 for her outstanding research into and publications on the history of Australian anaesthesia.

The last Orton Medal awarded by the former Board of the Faculty of Anaesthetists was to Dr Kester Brown AM in 1991 who led paediatric anaesthesia from his position as director at the Royal Children Hospital, Melbourne, in teaching, examining and research, and with his widely-read text on *Anaesthesia for Children* co-authored with Dr Graham Fisk.

In 2005 the Orton Medal was awarded to Dr Cindy Aun, an honorary professor of anaesthesia at the Chinese University of Hong Kong, to Professor Pamela Macintyre, one of Australia's leading pain medicine specialists and director of the Acute Pain Service at the Royal Adelaide Hospital, and to Professor Garry Phillips AM, a former College President, for fostering the development of the specialties of intensive care and emergency medicine as well as anaesthesia, and for his College activities in many roles including being ANZCA's inaugural director of professional affairs.

These 2005 awards are the only time two women have received either the Orton or ANZCA Medal in the same year. With the exception of Dr Cindy Aun and Dr Datuk, Dr Lim Say Wan (ANZCA Medal 2001), a former president of the World Federation of Societies of Anaesthesiology and of the Malaysian Society of Anaesthesiologists and of the Malaysian Medical Association, the Orton and ANZCA Medals have only been awarded to ANZCA Fellows from Australia and New Zealand.



> "Forty distinguished anaesthetists, over the 25 years of the College, have been awarded the Robert Orton Medal and/or the ANZCA Medal."

Others to have received the Orton Medal for fostering intensive care medicine are Professor Teik Oh (2007) also a former College president, and Dr Geoff Clarke, AM, (1996) the first Dean of the Faculty of Intensive Care Medicine, ANZCA, which has now evolved into the College of Intensive Care Medicine.

Professors Oh and Merry are the only medal recipients who have also been appointed deans of their respective university's faculties of medicine – Oh at the Chinese University of Hong Kong and Merry at Auckland University.

Several former ANZCA presidents and past deans of the Faculty of Anaesthetists have been recognised. Professor Barry Baker, AM, Dean of the Faculty from 1987 to 1990 received the Orton Medal in 1994. His predecessor as dean, Dr Robin Smallwood, received the Orton Medal in 1987 for his workforce and education research, and Professor Ross Holland, AM, the dean before that, was awarded the Orton Medal in 1993 particularly for his landmark studies in anaesthetic mortality.

Earlier deans – Dr Ralph Clark, Dr Kevin McCaul, Dr Brian Dwyer, AM, Dr Maurice Sando, Dr Bill Crosby, Dr Noel Cass, and Professor Douglas Joseph, AO, – were also recipients of the Orton Medal in the 1970s and 80s, and Dr Len Shea (1979) and Dr Jack Watt, OBE (1982) received the then Faculty Medal.

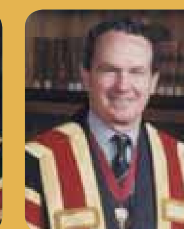
Other recipients of the Orton Medal in the safety and standards area were Professor John Russell (1999) and Professor Bill Runciman (2014). The Orton Medal awarded to Dr Charles Sara (1975) acknowledged his pioneering physiological research, that to Associate Professor John Rigg (2004) recognised the pioneering clinical trials work he achieved, and that to Professor Paul Myles acknowledged his world standing in clinical anaesthetic trials as well as being the founding Chair of ANZCA's Clinical Trials Group (now the Clinical Trials Network).

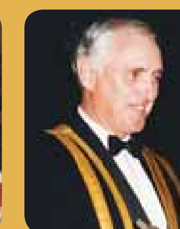
(continued next page)

Orton Medallists since 1992

Ross Beresford Holland, NSW
1993

Arthur Barrington Baker, NSW
1994


Peter David Livingstone, Qld
1995


Benedict John Barry, NSW
1995

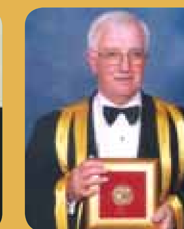
Geoffrey Malcolm Clarke, WA
1996

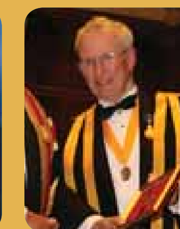
Jeanette Rae Thirlwell Jones, NSW
1997

Walter John Russell, SA
1999

John Raymond Archdall Rigg, WA
2004

Graham Chudleigh Fisk, NSW
2004


Francis Xavier Moloney, NSW
2004


Garry David Phillips, SA
2005

Pamela Macintyre, SA
2005

Cindy Aun, HK
2005

Teik Ewe Oh, WA
2007

Medal winners a *Who's Who* of anaesthesia and pain medicine (continued)

Regional leaders in the field of pain medicine also feature prominently, notably medical pioneer and former dean of the Faculty Professor Tess Cramond, AO, OBE, who received the Orton Medal in 1987, and Professor Michael Cousins, AO, a former ANZCA President whose world-renowned ground-breaking work in pain medicine has improved the lives of many people living with pain, was awarded the Orton Medal in 2008.

Prominent New Zealand Fellow and long-serving ANZCA councillor and assessor Dr Steuart Henderson, who now has an ANZCA award named after him, was presented with the ANZCA Medal in 2015. Also in the education field Associate Professor Don Harrison (Orton Medal 1989) was recognised for his development and publication on the educational objectives for anaesthesia and intensive care, and Professor Peter Kam (Orton Medal 2009) for his College examination and tutoring roles as well as for his many excellent literature reviews helping both trainees and specialists to keep abreast of both basic and applied research.

Thus all three Nuffield Professors of Anaesthetics at the University of Sydney (Professors Joseph, Baker and Kam) have been recipients of the College's Orton Medal.

Two of ANZCA's female past presidents, Professor Kate Leslie, AO, a former chair of the Committee of Presidents of Medical Colleges and a Fellow of the Australian Academy of Health and Medical Sciences, and Dr Leona Wilson, ONZM, currently ANZCA's Executive Director of Professional Affairs, were consecutive Orton Medal recipients (2014, 2012) as no medal was awarded in 2013.

In 1995 Queensland Fellow Dr Peter Livingstone, OAM, who has the unique distinction of being the last dean of the Faculty of Anaesthetists and ANZCA's first president from 1990-92, received the Orton Medal.

Queensland specialist Dr Di Khursandi, a founding member of the Welfare of Anaesthetists Special Interest Group, has played a leading role in raising national awareness about doctors' welfare and was recognised for her contributions to anaesthesia with the ANZCA Medal in 2009. Also that year the ANZCA Medal was awarded Dr Robert Wong of Western Australia for his dedicated pursuit of excellence in hyperbaric and diving medicine.

Other Queensland anaesthetists awarded the ANZCA Medal are Dr Vic Callanan, AM, (2012) and Dr Barrie McCann (2007), with Professor John Gibbs (2004) who can claim allegiance to both Queensland and New Zealand. Dr Basil Hutchinson (1989) and Dr Margaret Smith (2002) were other NZ anaesthetists to receive the ANZCA Medal. Former Faculty board members or councillors who have also received the ANZCA Medal are Associate Professor John Mainland (1999), Dr Vic Dreosti (2001) and Dr Ian Rechtman (2002). Dr Peter Lowe (1997), Dr Bill Fuller (1998) and Dr Sally Drew (2003) have also received ANZCA Medals.

Dr Frank Moloney, AO, was awarded an Orton Medal in 2004 for his promotion of rural anaesthesia and support for GP anaesthetists, and Dr Duncan Campbell in 2011 for his innovations in anaesthetic equipment particularly the Campbell ventilator.

Dr Ben Barry (1995) and Dr Jeanette Thirlwell Jones (1997) were awarded Orton Medals for their most successful establishment of *Anaesthesia and Intensive Care*, the journal of the Australian Society of Anaesthetists (ASA). Dr Barry was also a former ASA President, as were Dr Patricia Mackay, OAM, and Dr David McConnel, OAM, who received ANZCA Medals in 1999 and 2003 respectively. Other former ASA presidents who received medals were Dr Harry Daly, CMG, Dr Len Shea, Dr Gretta McClelland, OBE, and Dr Brian Dwyer, AM.

In a first for the College in 2016, though done before as a Faculty of Anaesthetists in 1968 when the Orton Medal was introduced, the Orton Medal was presented to three recipients. Professor Stephan Schug, a pain medicine specialist and researcher, and Professor David Story, a founding member and Chair of the ANZCA Trials Group (now ANZCA Clinical Trials Network) and inaugural Chair of Anaesthesia at the University of Melbourne, joined Professor Merry in receiving their awards at the 2017 jubilee ASM in Brisbane.

Professor Barry Baker
Honorary Historian

Orton Medallists since 1992 (continued)

Michael John Cousins, NSW
2008

Peter Kam, NSW
2009

Paul Stewart Myles, Vic
2010

Duncan Islay Campbell, NSW
2011

Leona Fay Wilson, NZ
2012

Kate Leslie, Vic
2014

William Ben Runciman, SA
2014

David Andrew Story, Vic
2016

Stephan Alexander Schug, WA
2016

Alan Forbes Merry, NZ
2016

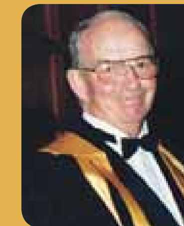
Orton Medallists prior to 1992

Year	Name
1991	Thomas Christopher Kenneth Brown, Vic
1990	Gwenifer Catherine Wilson, NSW
1989	Noel Morris Cass, Vic
1989	William Moncrieff Crosby, Vic
1989	Gordon Alfred Harrison, NSW
1988	Douglas Joseph, NSW
1987	Teresa Rita Cramond, Qld
1987	Robin William Smallwood, Vic
1985	Maurice James Wilson Sando, SA
1983	Brian Eric Dwyer, NSW
1976	Kevin McCaul, Vic
1975	Ralph Reginald Clark, Vic
1975	Charles Ashur Sara, NSW
1974	Geoffrey Kaye, Vic
1973	John Russell Ritchie, NZ
1968	Harry John Daly, NSW
1968	George Frederick Anson, NZ
1968	Margaret McClelland, Vic

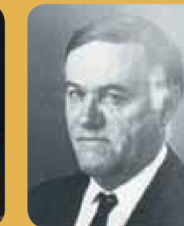
ANZCA Medallists since 1992

Alan Forbes Merry, NZ
1997

Peter Anderson Lowe, Vic
1997


William Rayner Fuller, SA
1998

Patricia Mackay, Vic
1999


John Francis Mainland, Vic
1999

Aldo Victor Dreosti, SA
2001

Lim Say Wan, Mal
2001

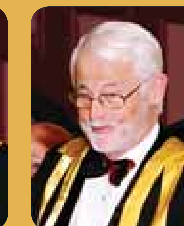
Margaret Stuart Smith, NZ
2002

Ian Rechtman, Vic
2002

David Henry McConnel, Qld
2003

Sally Elizabeth Drew, SA
2003

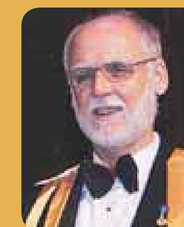
John Aubrey Henry Williamson, SA
2004


John Michael Gibbs, Qld
2004

Barrie Thomas McCann, Qld
2007

Diana Coraline Strange Khursandi, Qld
2009

Robert Manching Wong, WA
2009


Victor Ian Callanan, Qld
2012

Steuart Henderson, NZ
2015

ANZCA Medallists prior to 1992 (Recipients, Faculty of Anaesthetists, RACS Medal)

Year	Name
1990	Graham Chudleigh Fisk, NSW
1989	Basil Rockliff Hutchinson, NZ
1988	Gwenifer Catherine Wilson, NSW
1987	Miss Nancy A O'Donnell, Vic
1982	William John Watt, NZ
1979	Leonard Thomas Shea, NSW
1979	Peter Penn, Vic

Citations recognise significant contributions

ANZCA Citations have been awarded 37 times since 1992; to Fellows who have contributed to education, assessment and examinations through to non-Fellows and even a hospital department ravaged by an earthquake.

Since 2000 the ANZCA Council has awarded 37 citations that recognise significant contributions to particular activities of the College.

With the scope of the citation recently broadened to include humanitarian contributions the list of recipients provides a rich insight into the world beyond the traditional Western clinical hospital setting, often in the wake of major disaster or conflict.

In a first for the College, in June 2012 ANZCA Council awarded a citation to a hospital department rather than to an individual. College Fellows and staff hailed the council's decision to recognise Christchurch Hospital's department of anaesthesia in the aftermath of the 2011 Christchurch earthquake. Nearly 200 people died in the magnitude 6.3 earthquake on February 11 that year. In the aftermath of the tragedy the anaesthesia department's staff worked with other specialists to treat the injured, many of whom were orthopaedic trauma patients.

A recent council citation recipient includes Dr Megan Walmsley who in November 2016 was recognised for her work (then as a College trainee) as a volunteer medical officer at the Mt Everest base camp medical facility during the April 2015 avalanche that killed 22 people. Another is Queensland Fellow Dr Jenny Stedmon, who has spent more than 20 years as a medical volunteer in countries ravaged by diseases, civil war and natural disasters, was recognised earlier this year for her global humanitarian work in countries including Nepal, Sierra Leone and Cambodia.

Just one citation has been awarded posthumously – to New Zealand Fellow Dr Campbell Barrett in February 2006 for his significant contributions to anaesthesia and intensive care in New Zealand. Dr Barrett played a key role in establishing the first intensive care unit at Wellington Hospital and was a former president of the NZ Society of Anaesthetists.

Inaugural awards in April 2001 were to Dr David McCuaig and Dr William Woodhouse of Victoria and Robert Wong of Western Australia, all for contributions to the former Faculty of Anaesthetists, the College and to anaesthesia. And in September 2001 to Dr Lindsay Worthley of South Australia (the only citation for intensive care contributions), and to Dr William Beresford (academic anaesthesia), Dr John Hankey, Dr Maxwell Sloss, and Dr Donald Stewart of Western Australia (all for contributions to Faculty and College activities in WA).

Subspecialties of anaesthesia have also been recognised in the ANZCA Citations over the years including diving medicine and safety, hyperbaric medicine and rural anaesthesia. Leading hyperbaric medicine specialists Professor Michael Bennett of the Prince of Wales Clinical School at the University of New South Wales, Associate Professor John Williamson, AM, who headed the Diving and Hyperbaric Medicine Unit at Royal Adelaide hospital and Dr Peter McCartney, who founded the department of diving and hyperbaric medicine at Royal Hobart Hospital have all been recognised. Another diving medicine expert though not an ANZCA Fellow, Dr Carl Edmonds of WA, was recognised for his contributions to diving medicine and safety through his role at the Royal Australian Navy School of Underwater Medicine in 2003.

Several ANZCA Citations have been awarded to Fellows for their contribution to education, assessment and examinations in WA, SA, NZ, Victoria, Queensland, and include Dr Victor Callanan, AM, Dr Malcolm Futter, Dr Alison Holloway, Dr Roman Kluger, Dr David McConnel, OAM, Dr Rupert McArthur, Dr Kenneth McLeod, Dr Elizabeth Maycock, Dr Anton Neilson, Dr Peter Platt, Dr Ian Rechtman, and Dr Peter Roessler. Another Queenslander Dr John Board was recognised in 2002 for his contributions to paediatric anaesthesia and liver transplantation.

Pain medicine pioneer Professor Tess Cramond, AO, OBE, was recognised in 2009 for her contributions to the specialty in Queensland while other Queensland Fellows Dr Mark Gibbs and Dr Kenneth McLeod were both recognised for their contributions to rural anaesthesia, and Dr John Archdeacon for his contributions in Queensland. Dr Kandasamy Vijayakumar of Alice Springs was also recognised in 2003 for his contribution to rural anaesthesia.

Dr Patricia Mackay, OBE (Vic), Dr Michael Paech (WA) Dr Hugh Spencer (NZ) and Professor John Gibbs (NZ and Queensland) have all been recognised, among other reasons, for their wide-ranging College activities in their regions.

The citation is not limited to Fellows of the College and in October 2005 Lorna Berwick was awarded a citation in recognition of her 27 years of service to the New Zealand National Committee as administration officer at ANZCA and the Faculty of Anaesthetists' New Zealand office in Wellington. Dr Edmonds, Dr Vijayakumar and Dr Walmsley were other non-Fellow citation recipients.

Professor Barry Baker
Honorary Historian

> "College Fellows and staff hailed the council's decision to recognise Christchurch Hospital's department of anaesthesia in the aftermath of the 2011 Christchurch earthquake."

25 years of leading contributions

Some prominent names in anaesthesia and pain medicine have been recognised over the past 25 years with distinguished awards.

ANZCA Citations

Year	Recipient
2017	Jennifer Stedmon, Qld
	Michael Paech, WA
2016	Elizabeth Maycock, Qld
2015	Mark Gibbs, Qld
	Peter Rostron Platt, WA
2012	Christchurch Hospital Department of Anaesthesia, NZ
2011	Victor Ian Callanan, Qld
	John Archdeacon, Qld
2009	Tess Cramond, Qld
2006	Kenneth McLeod, Qld
	Campbell Barrett, NZ
	Roman Kluger, Vic
2005	Rupert McArthur, SA
	Lorna Berwick, NZ
2004	John Williamson, SA
	Peter McCartney, Tas
	Hugh Spencer, NZ
	John Gibbs, Qld
2003	Kandasamy Vijayakumar, NT
	Patricia Mackay, Vic
	David McConnel, Qld
	Anton Neilson, Qld
	Carl Edmonds, WA
2002	Malcolm Edward Futter, NZ
	Ian Rechtman, Vic
	Peter Roessler, Vic
	Michael Heywood Bennett, NSW
	Alan John Board, Qld
	Alison Mary Holloway, Qld
2001	David Ian McCuaig, Vic
	William Woodhouse, Vic
	Robert Manching Wong, WA
	William Beresford, WA
	John Reed Hankey, WA
	Maxwell Sloss, WA
	Donald Stewart, WA
	Lindsay Ian (Tub) Worthley, SA

Conference a spring-board for our future leaders

For 25 years, the New Fellows Conference (NFC) has been a springboard for many leaders in our College and profession. Once known as the Younger Fellows Conference – and to be named the Emerging Leaders Conference in 2018 – the meeting aims to identify future leaders and develop their leadership capabilities.

With themes such as "Professional responsibility" (1994) and "Looking after ourselves" (1997) to "Inspiring the future" (2016) and "Thinking big as a leader" (2017), organisers developed conference programs that emerging leaders would relate to.

The NFC is limited to a small delegation and the organisers hold the meeting outside city centres prior to the annual scientific meeting to allow for open discussion on a range of topics. During the NFC, delegates meet leaders of the profession and College, including the College president, councillors and FPM Board members. Friendships are established that last well beyond the end of the conference.

Delegates from previous NFCs have gone on to bigger things. Alumni include ANZCA presidents (Professor Kate Leslie, Dr Lindy Roberts), presidents of ASA (Dr Guy Christie-Taylor) and NZSA (Dr Annette Turley, Dr David Kibblewhite) and many heads/directors of departments and contributors to our College and profession.

Having been fortunate enough to be involved with the NFC as a delegate, a co-convenor and as ANZCA new Fellow councillor, each conference I have attended has provided me with new ideas and new inspirations, as well as new friendships.

I encourage all new Fellows to consider the opportunity to attend the Emerging Leaders Conference in 2018.

Dr Scott Ma
New Fellow councillor

Reflections on the New Fellows Conference

The *Bulletin* asked a group of former new Fellows for their reflections on what the New Fellows Conference – the Emerging Leaders Conference from next year – meant to them.

Dr Phoebe-Anne Mainland, 1997

Visiting medical officer, The Alfred; Honorary Clinical Associate Professor, Department of Anaesthesia and Intensive Care, Chinese University of Hong Kong

"The idea of attending a meeting exploring in depth a non-clinical topic, with other new Fellows from different ANZCA jurisdictions was very appealing. I was honoured to be chosen to attend, and I was not disappointed in the conference. Learning and teaching methods engaged during the week were inspiring and thought provoking, not only personally, but also as to how these could be incorporated into College activities.

The program was intense, and participants were motivated, intelligent, thoughtful and reflective; friendship and support developed quickly. Contact with other new Fellows and the College councillor was an introduction to me of the diversity of the ANZCA community and interests, the workings of ANZCA, and encouraged contribution to the College.

I now represent ANZCA on the national standards committee, Standards Australia (SA) and via SA, represent Australia on committees of the International Organisation for Standardisation (ISO), reporting to the Safety and Quality Committee of the College.

Expanding my focus on patient safety and international standards, for my project investigating international preparation of the introduction of medical devices with new connectors, to reduce misconnections, I was awarded a Churchill Fellowship. I am most grateful for the College for supporting my application.

My New Fellows Conference experience helped me feel welcome to engage with the College in following these interests."

Associate Professor Leonie Watterson, 1998

Director, Sydney Clinical Skills and Simulation Centre, Royal North Shore Hospital

"My mentor, Michael Cousins, brought the NFC to my attention and recommended I apply. At the time, I was 12 months post-FANZCA and had recently commenced an appointment in simulation. Consequently, I was eager to understand issues relevant to patient safety and education for anaesthetists.

The themes of the NFC in 1998 centred on ethical practice and the future of anaesthesia. I learned a lot about ethics and discovered how inadequate some aspects of anaesthetic practice were, in relation to end of life care. I also recall being highly impressed by both the calibre of the senior anaesthetists who facilitated the conference and by ANZCA's commitment to the process. The conference was facilitated in a manner that really made us young delegates feel like we were 'at the table' discussing important issues and influencing how the ANZCA Council would approach these issues in the future.

These days, I practice clinical anaesthesia half time and continue to work in simulation, where I am director of the Sydney Clinical Skills and Simulation Centre at Royal North Shore Hospital. The non-clinical component of my practice involves a blend of education, management and academic work. In 2009, I was appointed as a clinical associate professor by the University of Sydney based on my educational and leadership achievements. I am currently deputy chair of the ANZCA Professional Affairs Executive Committee.

Attending the NFC definitely helped me on my journey by giving me confidence that I could contribute meaningfully within the anaesthesia and broader healthcare communities. It was highly valuable for me at an early stage of my career to be able to interact with leaders and leading academics and to understand who they are as people and to see firsthand how they bring people together in a community and facilitate activities such as the NFC. By being exposed to the process, it also showed me how to get involved. For instance, I have and continue to sit on various ANZCA committees, working groups, special interest groups and educational workshops. These activities have enabled me to develop skills and experience that have benefited other aspects of my practice."

Reflections on the New Fellows Conference (continued)

Dr Brian Spain, 1999

Director of Anaesthesia, Royal Darwin Hospital

"My anaesthesia specialist career as a new FANZCA kick-started at Royal Darwin Hospital in 1997. At that stage, the Northern Territory was somewhat of an orphan in regional committees, but was under the auspices of South Australia and Professor Garry Phillips from SA had been to Darwin to help support the development of our department from a College perspective. I'd been to the ANZCA ASM in Newcastle in 1998 and had a great time, so when the SA Regional Committee invited me to apply as a waif from the NT for the NFC associated with the Adelaide ASM in 1999 I jumped at the chance.

The NFC reinforced that there were many other aspects to a career in anaesthesia to which I could contribute other than solely clinical work. Not only could it involve improving things for both patients and staff in the NT, but I could also to be part of a network of people progressing anaesthesia as a career overall.

I'm still in Darwin, having taken on head of department a couple of years after the NFC. Many of our current and itinerant past staff specialists have attended the NFC when they were eligible and supported by the now SA and NT Regional Committee that more formally incorporates the NT.

Attending the NFC helped connect me with many other people interested in progressing anaesthesia around Australia, some of whom went on to hold major leadership roles in ANZCA, including president, as well as leadership roles in their clinical departments. This network has helped bridge the professional isolation that could otherwise easily develop in my far-flung home town."

Dr Simon Jenkins, 2005

Director, Department of Anaesthesia, Lyell McEwin Hospital

"I was fortunate to be selected to attend the 2005 NFC in New Zealand. At the time, I did not know what to expect from the NFC. I had applied out of curiosity, not really being involved in many College activities up to that point. I had been a good trainee and passed all of my exams, but had not really been involved in my earlier years. I had been asked to join the regional committee in SA/NT and I had only just started to appreciate the breadth of work the College does for its members.

The NFC was a great opportunity to share stories about the challenges of being a junior specialist in a rapidly changing field. It was a chance to meet like-minded enthusiastic people, and to find out how they all solve the problems facing us in different, but equally successful, ways. We spoke about all kinds of challenges – medical, professional, managerial, political and even ethical – in an environment I found to be safe and sympathetic. I still remember a story about a young registrar who had, in the height of the SARS epidemic, resuscitated a patient only to discover that they had themselves been exposed to the virus in the process. Would I have stayed at work, or gone home to my family?

After the NFC, I spent some time leading simulation-based education and research in Adelaide and am currently running a medium-sized department. I am always working to improve how we, as a profession, can help our patients more, and have most recently been working on other areas in the healthcare system as well. I have just been re-elected to ANZCA Council and love the challenge of advancing our mission.

Thinking back to the NFC, it was not so much what was said at the meeting, but the way it was said. I found a fantastic group of young up-and-comers who stimulated my interest to just get involved and, in doing so, made my professional career very much richer."

Dr Sean McManus, 2006

Senior specialist, Department of Anaesthesia, Perioperative Medicine and Intensive Care, Cairns Hospital

"Genevieve Goulding, who was on the Queensland Regional Committee in 2005 asked me to apply for the NFC. I had organised the 2005 Queensland ANZCA/Australian Society of Anaesthetists Meeting in Port Douglas earlier that year, so must have done an okay job.

I took away so much from the NFC in 2006. It was called "Dialogues for professionalism" and was run by Martin Lum and Tracey Tay. We had to do an EQ assessment prior and to my surprise, I topped the class (even higher than the intensivists who argued the validity of the test). We spent a lot of time discussing the 'soft skills' that aren't formally taught, but are essential to thrive in a complex environment. At the end of the meeting the group entrusted me to give a presentation to the ANZCA Council outlining our vision for the future of ANZCA.

I'm now on the ANZCA Council and I'm a board member at Cairns and Hinterland Hospital and Health Service and finally finished my intensive care training and became a Fellow of the College of Intensive Care Medicine. I have continued my interest in leadership, management and mentoring and led a number of projects – the 2009 ANZCA Annual Scientific Meeting, reinvigorating our senior medical staff association and taking an active interest in mentoring younger doctors.

Attending the NFC changed the course of my professional career."

Dr Natalie Smith, 2007

Senior staff specialist anaesthetist, Wollongong Hospital

"I applied to attend the NFC as it sounded like a good way of becoming involved with ANZCA. I had not long finished my training overseas, where I was surrounded by others who were involved with the college there and I was keen to do the same here.

The NFC was an opportunity to network and getting to know a group of really interesting new people from all over Australia and New Zealand. I'm sure the content was interesting at the time but I don't remember it now!

I'm now working as a full time senior staff specialist, active in both education and research. My involvement with the College did grow from that initial NFC, to the point where I have actually stepped back from a few duties over the past years. The College has been a great support in a number of ways over that time.

The NFC definitely helped me to get where I am now."

Dr Sally Ure, 2008

Deputy Director, Wellington Hospital

"I had recently taken up the appointment of supervisor of training at Wellington Hospital and discovered just how much I didn't know about College affairs! I was lucky enough to have an office just down the corridor from Dr Leona Wilson (then president-elect of the College) who encouraged me to apply (for the NFC). I was extremely fortunate to have been selected, especially as I now know from being part of the selection process on the New Zealand National Committee (NZNC), that the calibre of applicants' CVs seems to have increased exponentially since then.

The theme of our conference was broadly around professionalism and ongoing professional development. That has sparked an ongoing interest and I now run a professionalism tutorial for our final exam trainees. The conference was a fantastic opportunity to network with like-minded Fellows and share the challenges we were experiencing. There have been some enduring connections, as many of us have crossed paths again later in various College and management roles. Finally it helped me grasp the place of the College in the bigger picture – as a trainee I think it's easy to develop a skewed impression that it is all about fees and exams, when in fact the College has a much wider role.

I'm now deputy director at Wellington Hospital, deputy chair of NZNC and deputy Education Officer (EO) in NZ (always the bridesmaid and never the bride). I'm the outgoing chair of the EO network and have been appointed to the Health Practitioners' Disciplinary Tribunal.

The NFC gave me a sense of how I could contribute, and gave me the support and motivation to get involved with College affairs."

Reflections on the New Fellows Conference (continued)

Dr Pauline Wake, 2015

Anaesthetist and lecturer at the University of PNG

"I did not directly apply to attend. Instead I was recommended and my name was put forward by the ANZCA Overseas Aid Committee because they saw this as an opportunity for me to develop in non-clinical but other important areas. At the same time, I was already in a leadership role in my country so it was useful that I attend.

The theme was "Cultivating a culture of change in anaesthesia and pain medicine". I learnt a lot from the discussions, particularly the presentation on the Process Communication Model. I learnt about different personalities and what appropriate communication should be applied.

I am in PNG, working as a lecturer at the School of Medicine and Health Sciences, University of Papua New Guinea. I also provide anaesthesia at the major hospital in PNG, Port Moresby General Hospital.

The lessons learnt about communicating with the different personalities of my colleagues has helped me a lot in the progress of training in PNG. Communication has opened an avenue of trust and consequently the development of training especially the postgraduate training for anaesthetists. It has also helped me improve my communication with trainees as a group and as individuals.

I learnt that cultivating a culture of change happens when we ourselves are willing to accept the change, apply the change and in doing so, witness the change in our area of influence."

Dr Harry Eeman, 2016

Specialist pain medicine physician at the Barbara Walker Centre for Pain Management, Melbourne

"The NFC was something I was keen to do as I wanted to learn more about the governance aspect of the Faculty of Pain Medicine in addition to clinical practice and it was a great opportunity to connect with other pain medicine specialists.

The NFC confirmed my interest in pursuing my practice as a pain medicine specialist and learning more about the College. But it was also useful in terms of my own self-reflection and personality and my strengths and weaknesses.

I'm now on the board of the Faculty of Pain Medicine and I am a specialist pain physician at the Barbara Walker Centre for Pain Management at St Vincent's Hospital in Melbourne.

While attending the NFC probably didn't influence my current position it did help confirm that the direction I was heading was the right one for me."

Centre translates anaesthesia theory into practice

A Centre for Excellence and Innovation in Anaesthesia was recently launched in Queensland. It is a joint venture between the Royal Brisbane and Women's Hospital and The University of Queensland.

Each year more than 350 million paediatric and adult patients worldwide undergo general anaesthesia for major surgery, and an unknown number of patients undergo diagnostic procedures under sedation, provided by anaesthetists.

Day by day, anaesthetists have mastered skills to monitor all vital parameters, administer general, regional and local anaesthesia, provide airway management and fluid therapy (including blood management). Simultaneously they must treat the multiple side effects that may arise from surgery, including haemodynamic imbalance, nausea and vomiting, and pain, all while helping the surgeon perform optimally by administering muscle relaxation if needed.

Indeed, anaesthetists are experts in anaesthesia and pain relief, and maintain balance between optimal anaesthesia care and avoiding toxic reactions, side effects and complications. Without the dedication of anaesthetists, a number of surgical interventions would not be possible.

Anaesthetists are expected to take care of all patients, independent of age and urgency of operation; regardless of a patient's fitness, illness, co-morbidities and systemic diseases; including diabetes and obesity, posing extra problems. It is clear anaesthetists face myriad stressful situations. Furthermore, studies have demonstrated that stress results in an increased incidence of clinical error by 25 per cent.

Stressful incidents, serious complications and catastrophes have serious adverse effects, not only for the patient, but also for the anaesthetist's wellbeing. Human factors play a huge role (>75 per cent) in critical incidents in complex organisations, the aviation industry and healthcare.

Pilots are trained extensively on simulators to master flying a specific aircraft including how to solve any problem on board. We, as anaesthetists, have a morning list of say four different "planes" and an afternoon list of another four different "planes", and yet, we do not have the opportunity to be trained in "flying" all these different patients. We can and must do a better job.

Anaesthesia should learn from and emulate the aviation industry by implementing continuous virtual reality training in anaesthesia.

The Centre for Excellence and Innovation in Anaesthesia (CEIA) fills this gap. Officially opened at the Royal Brisbane and Women's Hospital (RBWH) on June 6, the aim of the centre is to translate theory into practice and focusing on five essential pillars that improve patient care:

- Teaching.
- Simulation and training of technical and non-technical aspects of anaesthesia.
- Testing of anaesthesia equipment.
- Quality and safety improvements through audits and incident reporting.
- Research.

The CEIA was opened by the 2017 Australian of the Year Professor Alan Mackay-Sim with officials from RBWH and The University of Queensland in attendance. It was a celebration of the Department of Anaesthesia and Perioperative Medicine's completed vision to provide a state-of-the-art facility for teaching, training, research and innovation, in the area of clinical anaesthesia.

The University of Queensland (UQ) recognised the value of these aspirations and in 2014, Professor van Zundert's concept of the CEIA was awarded the university's best innovation award.

The CEIA provides an essential part of training for medical students, nurses, anaesthesia assistants, trainees and specialist anaesthetists, with the purpose of advancing and improving the level of treatment and care given to patients.

Anaesthesia staff can learn anaesthesia techniques and invasive monitoring in the most optimal way, on mannequins. Technical and non-technical skills can be practised to result in more efficient and confident anaesthetists. Simulation affords clinicians time to train and debrief issues, which is not always possible when dealing with the reality of patient care. When they are fully trained, qualified and certified, anaesthetists can implement their new knowledge and technique on safely and competently patients.

Developing the CEIA has been a complex journey. In conjunction with financial support from the RBWH and UQ, the department has invested significant time and money to realise this project. We have appointed a nurse manager to enable efficient use of this facility. Our nurse manager co-ordinates the use of our education rooms, simulation equipment, audio-visual resources and dedicated staff, to train the current and future generations of outstanding anaesthetists.

The RBWH/UQ CEIA will initially target the 200 on-campus anaesthesia staff, and are already expanding through collaborates with other Queensland hospitals and disciplines in simulation and education. Medical students and interns use our facility for simulation and education.

Ultimately we aim to provide education and simulation services to clinicians in south-east Queensland, across the state and nationally. The CEIA is a principle example of the relentless efforts anaesthetists are willing to make, to ensure surgery is safe for all patients. Our entire department has reaped the benefits of our facility and will continue to prioritise the wellbeing and safety of our patients. We advocate other major teaching institutions to establish similar centres for excellence and innovation in anaesthesia.

Professor André van Zundert, Professor and Chair Anaesthesiology

Associate Professor Kerstin Wyssusek, Director

Ms Lizanne Dalgleish, CEIA Manager and Research Nurse

Ms Cienwen Town, Research Nurse

Associate Professor Victoria Eley, Research Lead

The Royal Brisbane and Women's Hospital, Department of Anaesthesia & Perioperative Medicine, and The University of Queensland, Brisbane.

"The CEIA is a principle example of the relentless efforts anaesthetists are willing to make, to ensure surgery is safe for all patients."

Above from left: The surgical and anaesthesia team in a simulation action at the CEIA; Professor André van Zundert with Australian of the Year 2017 Professor Alan Mackay; Minister for Health and Minister for Ambulance Services Cameron Dick and Professor van Zundert; periarrest session; Dr Amanda Dines (CEO RBWH), Professor van Zundert (Chair CEIA), Associate Professor Kersi Taraporewalla (head, simulation) and Professor Stuart Carnie, Dean, Faculty of Medicine, University of Queensland; Professor van Zundert, Associate Professor Kerstin Wyssusek and Lizanne Dalgleish, Manager CEIA.

Working together during trauma surgery

A new course addresses decision making by surgeons, anaesthetists and perioperative nurses during a major trauma.

Intraoperative management of a critically-unwell trauma patient is one of the most important times for anaesthetists and surgeons to share a common mental model of treatment priorities and understand the interaction of each other's concerns and plans.

Shared understanding between surgeons, anaesthetists and perioperative nurses in major trauma is essential and time-critical, but is prone to error and distractions from essential tasks. The Early Management of Severe Trauma course introduced common terminology and priorities to the emergency department phase of trauma care.

Until recently, there has been no follow-through to the substantially more complex decision-making required before and during surgery. The addition of an anaesthesia component to the International Association for Trauma and Intensive Care (IATSIC) Definitive Surgical Trauma Care (DSTC) course addresses this deficiency.

The core curriculum for DSTC was defined in 1999, with courses now running worldwide including in Auckland, Brisbane, Melbourne, Perth and Sydney. The DSTC course is recommended by the Royal Australasian College of Surgeons for all surgeons participating in trauma care. Recognising that the surgeon always works as part of a team comprising scrub and circulating nurses, in 2004 the first Definitive Perioperative Nursing Trauma Care (DPNTC) course was added.

Much of the DSTC/DPNTC courses involve practical instruction in operative techniques using cadavers or anaesthetised porcine models; anything other than expert scrub nursing support would substantially devalue the educational experience by divorcing this training from reality.

However, anaesthesia support was historically provided by veterinarians. Although providing excellent animal care, a key component of the operating theatre team was missing.

Building on the recent experience of European Definitive Anaesthesia Trauma Care (DATC) courses, and also the Australian Defence Force Military Anaesthesia (MilAn) courses that have been integrated with the Sydney DSTC since 2014, in July/August 2017 the first combined DSTC/DATC/DPNTC courses were held in Sydney and Auckland.

Over three days, approximately three quarters of the courses comprise multidisciplinary sessions that include brief didactic tutorials, case discussions, small group "fireside chat" discussions of controversial points, and a full day of simulated operating that requires constant communication between surgeons, nurses and anaesthetists.

The remaining quarter of the courses comprise discipline-specific teaching, which for anaesthetists includes the "can't intubate can't oxygenate" and massive transfusion ANZCA Emergency Response modules. In Sydney, the Australian Defence Force continues to sponsor an additional whole day DSTC/DATC Military Module, focused on blast and ballistic trauma and the consequences of austerity, which civilians are encouraged to attend.

Although the anaesthesia aspects of trauma care are a main DATC focus, at least as important is the opportunity to understand and influence surgical decision-making. As one participant reflected, "I've been to many anaesthesia continuing medical education courses that mostly reinforced what I already knew; DSTC/DATC made me understand trauma care from the entirely different perspective of the surgeon".

In its infancy, we consider DATC a good idea for ANZCA Fellows and senior trainees involved in trauma care; in time we hope it will attain the semi-mandatory status equivalent to the DSTC for trauma surgeons.

The 2018 course dates are Brisbane – February 19-21, possibly Perth – June 13-15, Sydney – July 23-25, Auckland – July 30-August 1 and Melbourne – November 11-13. Registration and updates are listed on https://dstc.com.au/.

Michael Reade FCICM FANZCA, Joint Health Command, Australian Defence Force. Chief instructor, ADF Military Anaesthesia Course/Sydney DATC Course Director

Chris Bleeker MD LLM MSc DM, Radboud University Nijmegen Medical Clinic, The Netherlands International DATC Chairman

Kerry Gunn FANZCA, Auckland City Hospital/Auckland DATC Course Director

Above from left: Anaesthetists and surgeons discuss how the physiological trajectory should influence surgical decision making during the laboratory teaching session. DATC/DSTC Auckland, August 2017; Course participants discuss key anaesthetic and surgical decisions in an illustrative case with the guidance of senior course faculty. DATC/DSTC Auckland, August 2017.

Faculty of Pain Medicine

Dean's message

The National Strategic Framework for Chronic Conditions (NSFCC) challenges us to consider the future of pain medicine and its place within the healthcare systems of Australia and New Zealand.

The document has been recently released by the Australian Health Ministers' Advisory Council with the aspirational goal of helping people to "live healthier lives through effective prevention and management of chronic conditions".

The high-level guidance seeks to co-ordinate a national response to chronic conditions and shift the focus away from disease-specific approaches to one that considers shared determinants, risk factors and multimorbidities.

Eight principles are listed: equity, collaboration/partnerships, access, evidence base, person-centredness, sustainability, accountability/transparency and shared responsibility.

There is a call for generic chronic condition programs in primary care that integrate with condition specific programs based in specialist practice. This brings both challenge and opportunity for FPM.

We have extensive experience in multidisciplinary care, implementation of group programs, management of multimorbidity and the difficult task of supporting behavioural change. We thus have an opportunity to partner with and support primary care organisations to deliver multidisciplinary programs for chronic conditions.

We recognise that disease specific biomedical treatment differs across the chronic conditions however there is commonality in the management strategies that arise from addressing physical activity, psychological factors, social connection and nutrition. The NSFCC encourages us to consider application of our pain specific learnings to the broader context of chronic conditions. Paired with this is encouragement for us to develop greater clarity about patient selection and articulation of the degree of complexity which might warrant referral from primary to specialist care and from a generic to a condition specific approach.

There are important workforce considerations. For example, might staff from a tertiary public hospital unit spend time working in primary care to facilitate development of chronic condition programs in that setting? Perhaps these staff might deliver a pain management session as a component part of the broader program.

In addition, might the Faculty's educational offerings assist to train the primary care workforce? Better Pain Management is well positioned to play a role. If the Faculty moves ahead to establish the proposed clinical certificate in pain medicine, might that become core training for a GP wishing to work in a chronic condition program?

The NSFCC represents a desire on the part of government to see improved integration of healthcare systems and efficient use of resources that recognise the shared determinants of many chronic conditions. From the Faculty perspective we need to consider carefully the potential risks to our organisation if we work in an independent, siloed fashion that does not recognise the vision of government.

The developing FPM 2018-2022 Strategic Plan has significant alignment with the NSFCC document.

Expansion of condition specific multidisciplinary pain services is a key aspect of our strategic plan. However this is within the context of improved integration with primary care services and collaborative development of an appropriate model of care. Growth of research expertise is another fundamental aspect of the strategic plan. Our experience here can help to inform measurement of outcomes from model of care interventions be they early phase pilot studies or more developed programs.

Expansion of our educational offerings is also an important aspect of our planning for the next five years. There is a substantial role that such offerings might play in training the future workforce for both condition specific and generic chronic condition programs.

A particular point of interest, relevant to our collective identity as specialist pain medicine physicians, comes from the feedback of Fellows as part of the FPM strategic planning process. The view has been expressed by multiple Fellows that it is highly desirable to maintain a single unified FFPMANZCA qualification and not dilute this by offering separate qualifications such as diplomas in paediatric or interventional pain medicine.

This unified approach will, I believe, give us a firm foundation as we collaborate with partners in primary care and other areas of specialist practice to develop resource efficient, integrated models of care. A single specialist pain medicine physician qualification strengthens our reputation and influence. It does not preclude development of sub-specialty skills – particularly in the second year of pain medicine training – that might mesh with hospital credentialing systems.

Dr Chris Hayes
Dean, Faculty of Pain Medicine

News

Training unit accreditation

The following hospitals have been accredited for pain medicine training:

- Singapore Hospital.
- Royal North Shore Hospital, NSW.
- Peter MacCallum Cancer Centre, Vic.

At the July FPM Board meeting it was resolved to withdraw accreditation for training in the core training stage from Westmead Hospital, NSW.

New Fellows

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

- Dr Raj Anand, FRACP (NSW).
- Dr Irina Hollington, FANZCA (SA).
- Dr Maartje Tulp, FANZCA (NZ).
- Dr Christopher Woodgate, FAFRM RACP (Vic).
- Conrad Engelbrecht, FANZCA (NZ).

This takes the number of Fellows admitted to 452.

Better Pain Management

Since the launch of the Better Pain Management in May, 2017 there has been a promising uptake from specialists and allied health professionals from a range of specialty areas. One of the biggest sectors interested in pain management learning are nurses, with growing interest from professionals overseas also. The most popular course in the program is the BPM Complete Program covering all 12 modules, a reflection of the need we can fulfil and the comprehensiveness of the program.

Cannabis forum

Are you curious about medical cannabis?

Many pain medicine consultants will be well aware of the recent changes occurring in Australia regarding the use of medical cannabis, with regulatory change – from the Commonwealth via Therapeutic Goods Administration, from changes in scheduling, from state legislatures, and from consumers in many health settings seeking access to medical cannabis.

Every week in my practice patients are inquiring and seeking more information and access to medical cannabis.

Are you curious and wanting to understand more on this topic?

It's a very confusing area at present. FPM in its position statement has highlighted its hesitation and concerns about inadequate research into the clinical effectiveness of medical cannabis, but many feel this is too harsh. Some Fellows are involved in advisory roles.

We are very keen to engage our Fellows and trainees in a broader discourse on this subject, to gauge your opinions, to develop patient information, to explain the regulatory changes, and explain the practicalities if you seek to trial medical cannabis for selected patients.

And we want to develop a research agenda, given the poor evidence base in this area.

So please consider participating in the "Considering medical cannabis for chronic pain forum" for pain medicine Fellows and trainees on Saturday October 7. We have very informative speakers and will promote discussion on all the above issues.

Speakers include Professor Wayne Hall (Centre for Youth Substance Abuse, University of Queensland and Australian Advisory Council on the Medicinal Use of Cannabis); Professor Jenny Martin (Chair of Clinical Pharmacology, University of Newcastle); Adjunct Professor John Skerritt (Deputy Secretary for Health Products Regulation, Department of Health, ACT); Associate Professor Philip Peyton (Chair, ANZCA Clinical Trials Network Executive, Victoria) as well as specialists in addiction medicine, consumer representatives and Fellows of the Faculty.

We greatly value everyone's contribution. Come along and bring your questions!

Associate Professor Carolyn Arnold
FPM Medical Cannabis Forum Convenor

Pain procedures forum

Interventional pain medicine outcomes forum

FPM is planning a forum "Procedures in pain medicine: How are they best done?" for Friday, October 20.

This forum, comprising representation from Faculty Fellows, professional organisations, and regulatory bodies marks the beginning of a new phase of engagement by FPM in the area of procedural pain medicine.

Attendees will hear presentations concerning current debates about cost effectiveness and efficacy of defined procedures, remuneration for procedures, and the role of the Faculty in providing training and potentially credentialling units that represent the best practice that our new Fellows should be trained in.

As well as the presentations, there will be multiple opportunities for engaging in discussion and this constructive interaction is likely to clarify and further refine the direction that the Faculty takes over the next five-year strategic planning period.

We encourage Fellows with a strong interest in the provision of high quality procedures as part of the practice of pain medicine to reserve Friday October 20 in their diaries so that we having have the broad as well as possible representation to provide input into this discussion.

This forum is the beginning of a process that will be ongoing over the next few months. The quality of the discussion and therefore of the further work which FPM undertakes in this arena can only be as good as the contribution of our Fellows.

I look forward to seeing you there!

Dr Michael Vagg
Chair, Professional Affairs Executive Committee
Convenor

News

Shortage a focus for FPM NZNC

The Faculty's NZ National Committee (FPM NZNC) has been undertaking advocacy with New Zealand's opposition parties in the lead-up to the general election on September 23, having previously had discussions with health ministers and the Ministry of Health.

In particular, members of the committee have met with health spokespeople to talk about how the critical shortage of pain medicine specialists and the lack of funding for pain medicine training in New Zealand seriously constrains the ability to deal effectively with the country's high number of chronic pain sufferers.

The meetings have also covered the topic of cannabis-based medicinal products – a discussion that showed both the minister and Faculty were on common ground in supporting the availability of only those products that research had shown were clinically sound.

These topics were also key items on the agenda of the FPM NZNC meeting held in Wellington on June 30.

Health Workforce New Zealand's Manager Strategy and Policy, Dr Paul Watson, joined the meeting to discuss the best way to progress the urgent need for better funding for pain medicine training in New Zealand, and how to overcome the serious shortage of specialist pain medicine physicians.

Dr Stewart Jessamine, Director of Protection, Regulation and Assurance, at the Ministry of Health also attended the June meeting to discuss the situation with cannabis-based medicinal products. He spoke about the impending change to the regulations that would allow doctors to prescribe approved cannabis-based products for up to three months' supply, as they do other prescription medicines, rather than these products being classified as controlled drugs. (The regulatory change came into force on September 7.)

However, only one such product was available in New Zealand. Otherwise, the Ministry was watching overseas trials to see if any other products should be made available.

A different kind of developing world

Dr Camille Yip, a recipient of an ANZCA overseas aid trainee scholarship, recently returned from Inner Mongolia where she participated in a week-long visit with the No Pain Labour and Delivery – Global Health Initiative (NPLD-GHI).

The NPLD program

On June 10 I headed off to Baotou in Inner Mongolia, China, for the 2017 No Pain Labour and Delivery – Global Health Initiative (NPLD-GHI) program visit to Baogang No. 3 Hospital for staff and workers.

The aim of the 10-year obstetric anaesthesia "train the trainer" program is to help Chinese hospitals establish obstetric anaesthesia systems that will provide safe and effective neuraxial labour analgesia for all parturients. This is in response to China's high caesarean birth rate (estimated to be more than 50 per cent of all births) with the infrequent use of neuraxial analgesia being one of the contributing factors.

Each year, a number of hospitals in China are visited by a multidisciplinary program team comprising anaesthetists, obstetricians, midwives, neonatologists and interpreters. During the week-long site visit the team participated in education and exchange with their Chinese counterparts using a structured curriculum covering epidural analgesia, neonatal resuscitation, intrapartum care, and emergency caesarean section.

Baotou

Baotou is an industrial city in the Inner Mongolia autonomous region of China. Its metropolitan area has a population of approximately two million. It has been one of the beneficiaries of the technological boom, and is currently the top source of rare earth metals in the world. It is on the edge of the Gobi Desert and is about a 90-minute flight from Beijing.

Baogang hospital

At Baogang Hospital there are approximately 10,000 births each year. In 2003 an epidural service was introduced. An estimated 50-80 per cent of parturients now use epidural analgesia in labour.

During the week the NPLD team members spent time with their Chinese colleagues and shared their clinical experiences. Other activities included an expert panel public Q and A forum, an obstetric emergency simulation scenario and lectures and tutorials.

The highlight of the week was a chronic pain consult of a patient with unilateral lower leg weakness, numbness and pain by team member Dr Pamela Flood. The patient had been bedbound for three months after being given an emergency caesarean under spinal anaesthesia. Extensive investigations apparently revealed no significant neurological or vascular pathology. After a thorough two-hour consultation and review by Dr Flood the patient was diagnosed with complex regional pain syndrome. After explanation and reassurance the patient agreed to mobilise. For the first time in months she finally walked. The local specialists were particularly impressed with the degree of patience, empathy and understanding shown towards the patient.

My general impression is while there is technical expertise to provide a 24-hour obstetric anaesthesia service they would benefit from better resources. They currently practice intermittent anaesthetist manual bolus top-up for maintenance of epidural analgesia which is labour intensive and has an apparent high rate of epidural failure with long labours. Having enough syringe drivers and/or pumps would allow delivery of better quality analgesia. However, systemic differences in the scope of midwifery responsibilities (midwives did not participate in the monitoring of epidural analgesia, that is, sensory/motor blockade) meant attendance by an anaesthetist every one to two hours seemed to be a safer option.

Successes, challenges and reflections

The local doctors were very friendly and open towards us, were very eager to learn and had many questions for us. They were also very helpful. On one occasion they helped us assemble a simulation delivery suite bed space and operating theatre with all the equipment we asked for within a short period of time to facilitate the "obstetric anaesthesia emergency" scenario.

While my other NPLD team members were busy teaching technical skills such as neonatal resuscitation, surgical techniques in lower segment caesarean section and the use of birthing balls I found there was little to add to their technical expertise in terms of performing neuraxial anaesthesia and subsequent management. As they were adept at labour epidurals, our involvement was mainly in regards to safety and quality aspects of providing care, such as strategies to prevent systemic error.

One such example was the labelling of syringes in operating theatres, where all clear-colorless drugs were labelled with the drug name written on the syringes with the same marker pen.

Doctor-patient relationships tend to be a paternalistic one in China and the role of the family is different. Husbands gave consent for their wives' epidurals, and while they were able to accompany their wives during labour they were not present during the actual birth (which occurred in an adjoining room with other parturients naked from the waist down), nor were they allowed into the operating theatre for elective or emergency caesarean sections.

"My general impression is while there is technical expertise to provide a 24-hour obstetric anaesthesia service they would benefit from better resources."

Visiting hours in the neonatal intensive care unit were very short and parents rarely got to hold their premature newborns. Speaking to the local doctors about the high caesarean rate it seemed there were multiple factors at work. Both patients and obstetricians are risk-averse – the women did not want to take the perceived "risk" of a failed epidural, or the "risk" of a failed trial of labour, or the "risk" of an emergency caesarean section – therefore arriving at the "more definite" solution of an elective caesarean section. This may sound odd but does have to be taken in the socio-political context, as most patients have to pay for their own healthcare, and for an entire generation women only had to give birth to one child.

The week passed very quickly and, regrettably, due to a tightly-packed schedule of round-table discussions, lectures, briefings and debriefings there was limited clinical time spent on the labour ward to observe our local anaesthesia colleagues' day-to-day routine. I felt this was important because it is part of a needs assessment for our subsequent work during the week. In one case – during the debriefing of our emergency obstetric scenario (which included a difficult intubation event) we were asked about intubation as part of the obstetric rapid sequence induction – it turned out the local practice was to induce the patient, continue face-mask ventilation and let the surgical team immediately deliver the fetus, before taking time to secure the airway with an endotracheal tube. Their rationale was so that anaesthesia time did not contribute to delay of delivery of the fetus we then had to have a discussion on the importance of maternal oxygenation and aspiration risk.

Hopefully, exchange programs such as NPLD will help developing countries like China improve their standard of care, through exposure to contemporary practices. At the same time, we also have much to gain by observing others, to uncover assumptions and flaws in our own practice in order to improve for the benefit of our patients.

Dr Camille Yip, FANZCA
Originally trained in Sydney, Camille has been working in Singapore since her provisional fellowship training year in 2016. She will be returning to Sydney later this year.

Reference:
Hu, L. Q., Flood, P., Li, Y., Tao, W., Zhao, P., Xia, Y., ... & Wong, C. A. (2016). No Pain Labor & Delivery: a global health initiative's impact on clinical outcomes in China. Anesthesia & Analgesia, 122(6), 1931-1938

Above from left: Baotou city view from hotel window; inside the Baogang Hospital; NPLD team and Baotou heads of department (front row); local anaesthetists/obstetricians/nursing and neonatology staff (middle and back row).

Foundation research grants success

The ANZCA Research Foundation was advised in June this year that it had been successful in securing three new funding grants, from Perpetual Trustees and CSL Behring, for research led by ANZCA Fellows.

Perpetual Trustees IMPACT philanthropy grants

In June 2016, the foundation received $A76,009 from Perpetual Trustees' "IMPACT Philanthropy" funding round, for the cancer-related research project: "Reducing anxiety and breast cancer metastasis risk at the time of surgery using blood pressure medication" (Dr Jonathan Hiller, Peter MacCallum Cancer Centre, Vic).

In December, two further medical research funding submissions were lodged for Perpetual Trustees' 2017 funding round, and both submissions were approved for funding in June.

The first successful project was "Understanding the impact of anaesthetic technique on cancer outcomes", led by Dr Julia Dubowitz, Peter MacCallum Cancer Centre, Melbourne, which received the full amount requested of $A84,423. The second submission was for the study "Cyanotic congenital heart disease – the role of nitrogen species in adaptation to hypoxaemia", led by Dr Jonathan De Lima, Westmead Children's Hospital, Sydney, which also received the full amount requested of $A68,498.

With grant success in two consecutive years, a third grant in 2018 would automatically qualify the foundation to be included in a small group of organisations invited to apply for Perpetual Trustees' major "signature" philanthropic grant of $A1 million.

CSL Behring ANZCA research award

After more than 12 months of dialogue, $A70,000 was received in July from CSL Behring, the Australian government-contracted national blood fractionator, for a new research award for an ANZCA investigator-led research project in the area of coagulation, orthopaedic or gastric surgery.

The grant, which is consistent with the new ANZCA partnership and sponsorship policy, will be reviewed, selected and awarded at the discretion of the ANZCA Research Committee. CSL Behring and the foundation have agreed that this will be an ongoing bi-annual grant, pending successful review, as part of a long-term partnership. This is good news for enhancing the sustainability of our research funding program in the longer term.

Further donation from foundation cocktail reception

Inspired by Professor Barry Baker's generous donation of $A25,000 announced during the foundation's cocktail reception at the 2017 annual scientific meeting in Brisbane (bringing his total endowment for the Provisional/New Fellow Research (PNFR) award and Joan Sheales Staff Education Award to $100,000), another generous Fellow who attended has donated $A26,000.

The foundation is extremely appreciative of the many generous donations received from Fellows in the period following the function, and from those who have kindly donated with their subscription payments.

New CTN presenter award

Dr Peter Lowe, who is also the founding donor for the ANZCA Melbourne Emerging Anaesthesia Researcher Award, has donated again to provide $A1000 for an award for the best emerging researcher presentation at the ANZCA Clinical Trials Network workshop in August.

Dr Andrew Couch Memorial Fund

This fund was established at the request of Dr Nicole Phillips and Dr Mark Priestley, Dr Couch's supervisor of training at Westmead hospital, Sydney, following Dr Couch's tragic death this year. Just over $10,000 has been received in in memoriam gifts from Dr Couch's family and friends. These funds will support research to improve the lives of future patients. The foundation is grateful to be a part of honouring Dr Couch's memory.

ANZCA Melbourne Emerging Researcher Scholarship (AMERS)

Retired anaesthetist Dr Peter Lowe and the foundation established a new emerging researcher scholarship for a PhD student at the Melbourne Medical School, with the first of five pledged annual gifts of $A20,000 received in July.

We have now finalised the scholarship, grant design, and application review process, with agreement between the ANZCA Research Committee, Dr Lowe, the foundation and Professor David Story at the Melbourne Medical School.

Leadership circle

Board of Governors member Mr Ken Harrison is working with the foundation to develop the new ANZCA Research Foundation Leadership Circle program, and will lead a process as Leadership Circle Chair to identify prospective donors who would like to make a significant difference to improving patient outcomes through high-quality research and education. An initial function at the College for prospective members is planned for later this year.

Improving patient outcomes in perpetuity

Two significant bequests in the past two years now support major ongoing prestigious ANZCA research awards, and several Fellows have recently expressed interest in leaving bequests in their wills. To discuss making bequest, please contact the foundation.

Rob Packer
General Manager, ANZCA Research Foundation

"Saving lives, improving life"

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

Coogee workshop a success

ANZCA Fellows, trainees, research co-ordinators and allied health professionals from New Zealand and Australia came together for the ninth annual strategic workshop from August 11-13 at Coogee Beach, NSW.

The CTN meeting aims to develop multicentre research proposals, enable emerging researchers, and support Fellows and trainees getting involved in current Clinical Trials Network (CTN) research.

For the first time, the Anaesthesia Research Co-ordinators Network (ARCN) Sub-Committee convened the ARCN workshop to discuss key topics in clinical research under their chair, Lauren Bulfin from Monash Health. Ms Bulfin inspired the audience with recent achievements of the network and key objectives from the ARCN Sub-Committee planning session facilitated by sub-committee member, Jaspreet Sidhu.

The formal meeting opened with a keynote presentation by Associate Professor Rachael Morton from the National Health and Medical Research Council (NHMRC) Clinical Trials Centre. She spoke about the methodology health economists use to prioritise research questions including the use of the value of information analysis. Every year the CTN Executive invites a trial statistician who can challenge the minds of the audience with the latest clinical trial methodology. This year, Professor Julie Simpson from Melbourne University discussed common mistakes in analysis of change from baseline in studies, and repeated continuous outcome measures in clinical trial methodology.

We heard CTN progress reports on current trials, PADDI, Balanced Anaesthesia Study, ITACS and RELIEF. The session finished with Dr Chris Bain (Alfred Health) who presented his PADDI genomics study and Dr Claire Furyk (Townsville Hospital) who described the recruitment challenges faced in her feasibility study of prehabilitation in frail patients undergoing colorectal surgery.

The CTN Executive was pleased to host the inaugural ANZCA Research Foundation Novice Investigator Prize session Saturday afternoon. Dr Peter Lowe, retired anaesthetist and long term supporter of the ANZCA Research Foundation, generously donated $A1000 prize for the best scientific presentation delivered by an emerging researcher. We heard four outstanding presentations from Dr Jai Darvall (Royal Melbourne Hospital), Dr Lachlan Miles (Austin Health), Dr Viraj Siriwardana (Westmead Hospital) and Dr Kristine Owen (Fiona Stanley Hospital). Professor Alan Merry and a Toastmaster judge Max Evers adjudicated the presentations based on presentation style and scientific merit. The winner, announced at the close of the meeting, was Dr Kristine Owen for her study "Improving functional outcomes and return home by reducing delirium in elderly surgical patients."

On Saturday afternoon, delegates had the opportunity to attend startup meetings for the ROCKet and TREX Trials, which are the latest trials to receive large NHMRC grants in the current funding round and to build on the excellent track record of the CTN.

While the meeting continued bright and early on Sunday morning with a keynote address from Professor Paul Myles on novel trial design to improve efficiency in recruiting participants to clinical trials, some of our active delegates joined the ANZCA "Trial Blazers" team to compete in the Sydney City2Surf.

During the morning, Ianthe Boden who is a postdoctoral student and physiotherapist from Launceston General Hospital, impressed delegates with her inter-profession collaboration to undertake a multicentre observational study to measure chest infections following major non-orthopedic surgery. Our final keynote presentation was from Professor David Story (NHMRC councillor) who spoke about key players in the NHMRC and the proposed changes to the grant program.

Professor Story discussed the importance of having the voice of a clinical triallist as a councillor to advocate on behalf of clinical trial networks and investigators. This keynote address was followed by an open panel session with leading researchers to discuss the pros and cons of small trials and their contribution to the science of anaesthesia.

Karen Goulding, CTN Manager

Above from left: Dr Lachlan Miles presenting at the inaugural ANZCA Research Foundation Novice Investigator Prize session; Professor Julie Simpson, Professor David Story, Professor Kate Leslie AO, Professor Andrew Davidson and Professor David A Scott; some of our active delegates joined the ANZCA "Trial Blazers" team to compete in the Sydney City2Surf.

Museum wins award

Left: Dr Chris Ball at the Museums Australia (Victoria) museum awards. Supplied by Simon Fox, Deakin University via Museums Australia (Victoria).

The Geoffrey Kaye Museum of Anaesthetic History has won its category of volunteer museum (one fulltime equivalent paid staff) at the recent Museums Australia (Victoria) museum awards for its suite of online projects.

The judges were impressed that the museum had recognised the difficulties of its widely dispersed primary audience (ANZCA Fellows and trainees), and taken direct measures to ensure virtual visitation was effortless and rewarding.

The development of online projects was in recognition that the museum's primary audience was a network of 7000-plus Fellows and trainees scattered throughout all parts of Australia and New Zealand. It wasn't feasible to expect them all to be able to visit a small museum in Melbourne, no matter how fascinating or interesting the exhibitions. The only way to combat this was to provide other opportunities for visitation.

At the end of July, the museum has had 377 onsite visitors, with an additional 6500 virtual visitors. So, what are they looking at?

In 2015, *Trailblazers & Peacekeepers: Honouring the ANZAC Spirit* was produced as an exhibition over three platforms. It was a physical exhibition with a companion book and an online version, which was a mixture of historical and contemporary accounts of anaesthetists and pain medicine specialists in war, peacekeeping and emergency relief zones.

Later that year, we launched *Lives of the Fellows: 1952* which highlighted the professional lives of the 40 foundation Fellows of the Faculty of Anaesthetists at the Royal Australasian College of Surgeons. The idea was to provide biographical snapshots and while all of the Fellows are represented, not all of them have a biographical snapshot. There is certainly an opportunity for people to become involved with the research required to complete this project.

In 2016, we produced From *Snake Oil to Science: The development and labelling of pharmaceuticals for the treatment of pain*. The exhibition looked at the way many contemporary pharmaceuticals had their origins in the herbalists' gardens of long ago. It also examined some of the issues surrounding labelling and advertising.

At this year's ASM we launched *Lives of the Fellows: 1992* as part of the College's 25th anniversary celebrations, as well as a new exhibition, *Restoring the Apparently Dead: The search for effective resuscitation techniques*.

In addition to the online exhibitions, the museum also has its own Twitter handle (@GKMuseum) and a blog, called Pins & Needles. In combination, these online projects allow stories from the history of medicine, with a particular emphasis on anaesthesia and pain medicine, to be told to a wide audience. In making sure Fellows and trainees had access to the collections and exhibitions, we have been able to tap into a much larger and more diverse audience as well.

The analytics for these projects also provide some interesting insights to our visitors, telling us that 8-9pm on Thursday nights is a time of high traffic, and, for some reason we have a growing audience in Argentina.

To see the online exhibitions, go to www.anzca.edu.au/about-anzca/geoffrey-kaye-museum.

Monica Cronin
Curator, Geoffrey Kaye Museum of Anaesthetic History

What would Pugh say?

Professor Milton Cohen delivered the sixth Pugh Day Memorial Lecture on June 18 in the meeting room of Queen Victoria Museum and Art Gallery in Launceston. Professor Cohen, a former Dean of the ANZCA Faculty of Pain Medicine is a specialist pain medicine physician and rheumatologist on the St Vincent's Hospital Sydney Campus. He is a Fellow of the Royal Australasian College of Physicians. Professor Cohen has been a leader in the development of pain medicine as a discipline, in the education and training of pain physicians and in raising the profile of "pain" in the broader medical community.

His lecture "What Would Pugh Say? Reflections on pain, practice and propriety" was delivered to an audience of more than 80. He emphasised the fact that Pugh was a polymath, a surgeon, public health officer, medical examiner, hospital manager, school founder, magistrate, migration agent, and natural scientist, meteorologist, innovator and social activist.

He presented a number of alarming data from Access Economics pointing out that 3.2 million people suffer chronic pain and the cost to the community is measured in the billions of dollars. He also presented to the audience the prescient comments of Isaac Aaron, surgeon and editor of the *Australian Medical Journal* on July 1, 1847, on the role of ether in medicine.

Aaron stated that "medical practitioners ... should investigate its effects coolly and philosophically, so that it may not ... come to a premature end through discredit thrown upon it by its abuse". Professor Cohen then demonstrated that a similar philosophy should be applied to medicinal cannabis, pointing out that based on current evidence, medicinal cannabis is not going to revolutionise the treatment of chronic pain for those without cancer.

He then went on to discuss what he described as the "opioid epidemic" as demonstrated by the massive increase in consumption of oxycodone in Australia between 1991 and 2012.

Acupuncture, spinal steroid injections and the role of the placebo were then considered.

Professor Cohen concluded his lecture by asking "what would Pugh do 170 years later?" He suggested that he would be asking "What does good management of pain require?" and suggested that it required a reframing of the problem, a recognition of the context and respect for the nervous system. His final slide was of a latter-day Aladdin with his magic lamp, being advised by the genie, "I recommend using your third wish to prevent joint pain in later years".

The audience was then given an opportunity to ask questions and expressed its appreciation of Professor Cohen's presentation with sustained acclamation.

Dr John Paull, FANZCA
Pugh Day Lecture Convenor

Above: Dr John Paull with keynote speaker Professor Milton Cohen.

What's new in the library

New and updated Library Guides

The ANZCA Library continues to add new and updated library guides following a recent refresh of the "look and feel" of our existing guides.

Need help with using ANZCA Library databases?
The library is developing a series of guides to better assist ANZCA Fellows and trainees in the use of our premium databases (*MEDLINE*, *PubMed* and *ClinicalKey*).

The first guide to be available is for *Ovid MEDLINE*. The guide provides the following information:

- An overview of the database.
- A *PubMed* versus *Ovid MEDLINE* comparison.
- Information on how to effectively search *Ovid MEDLINE* (includes video tutorials).
- Instructions on how to create a personal account.
- Instructions on how to create saved searches and alerts (includes a video tutorial).
- Links to additional support and training resources.

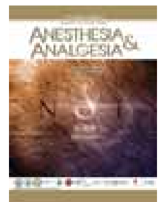
Development of the new guides is ongoing. The new dedicated *Ovid MEDLINE* guide can be accessed at: http://libguides.anzca.edu.au/medline

Anaesthesia Essentials

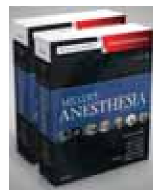
The library has recently developed a new guide to provide an overview and greater awareness of the core (non-specialist) resources available for ANZCA Fellows and trainees.

The guide aims to draw together journals, books, databases and other resources with a broader focus, and provides a useful adjunct to our existing subject-specific guides, which concentrate on resources within specialist fields.

Examples of the sort of content that can be found in the guide:



Anaesthesia & Analgesia. Published monthly by the International Anesthesia Research Society (IARS) and includes peer-reviewed, original clinical and research articles, providing practicing physicians, researchers and allied medical personnel in anaesthesiology and related fields with a wealth of information to keep them up-to-date with the latest issues and advances in the field.



Miller RD, et al. *Miller's Anesthesia*, 8e. Philadelphia, PA: Elsevier Saunders, 2015. "Miller's Anesthesia continues to serve as the most in-depth review textbook of contemporary anesthesia". Reviewed by: Genevieve Lalonde on behalf of Canadian Journal of Anesthesia. [May 2015. 62(5):558-559.]

ClinicalKey (Australian edition). ClinicalKey is a medical search engine and database tool that offers access to the Elsevier medical library. The service aims to provide a source of clinical answers and includes online books, journals, videos, drug information and procedures.

The new Anaesthesia Essentials guide can be accessed at: http://libguides.anzca.edu.au/essentials

Keeping current

Fellows wanting to keep up-to-date and maintain continuing professional development can find more resources and supporting tools through the recently revised Keeping Current guide.

Find out about:

- Setting up alerts for new journal table of contents or topics of interest.
- Apps for keeping current at your fingertips.
- Self-assessment tools.
- Aligning your professional development activities to the ANZCA CPD Program.

Development of the revised guides is ongoing.
The revised Keeping Current guide can be accessed at: http://libguides.anzca.edu.au/current.

New books

New books for loan

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

Anesthesia: A comprehensive review
Hall, Brian A. [ed]; Chantigian, Robert C. [ed]. – 5th ed. – Philadelphia, PA: Elsevier, 2015.

Anaesthesia: The gift of oblivion the mystery of the consciousness
Cole-Adams, Kate. – Melbourne, Vic: Text Publishing Company, 2017.

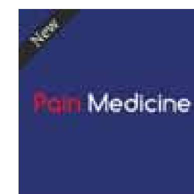
Choosing Wisely in Australia: 2016 report
Choosing Wisely Australia; NPS MedicineWise 2016. – Surrey Hills, NSW: Choosing Wisely Australia, 2017.

Good medical practice: Professionalism, ethics and law
Breen, Kerry J; Cordner, Stephen M; Thomson, Colin JH. – Kingston, ACT: Australian Medical Council Limited, 2016.

LIME good practice case studies: Volume four 2017
Leaders in Indigenous Medical Education Network (LIME)./Australian Government Department of Health; Medical Deans, Australia and New Zealand.; The University of Melbourne. – Parkville, Vic: The University of Melbourne, 2017.

Physician assistants: Policy and practice
Hooker, Roderick S; Cawley, James F; Asprey, David P. – 3rd ed –Philadelphia, PA: F.A. Davis Company, 2010.

Read ANZCA Library journals from your mobile device



Pain Medicine – recently updated
Oxford have released a new version of their Pain Medicine app, replacing the previous version which was made non-functional due to updates to the Oxford journals platform earlier this year.

The *Pain Medicine Journals* app enables you to read both online and offline on your iOS device.

Development of the new app is ongoing, so be sure to check out our dedicated Pain Medicine app guide for further information including full access details at: http://libguides.anzca.edu.au/apps/painmed

Follow the #ANZCALibrary on Twitter

Want to stay up to date with the latest news and resources from the ANZCA Library? Follow @ANZCA on Twitter and you will see weekly updates from the Library using the **#ANZCALibrary** tag. The library spotlights online resources, new books and articles of particular interest as soon as they hit the collection.

New eBooks

New eBooks

eBooks can be accessed via the library website: www.anzca.edu.au/resources/library/online-textbooks

Anaesthetic emergencies handbook
Rathie, Lachlan. – Queensland Edition – Queensland: [self published], 2016.

Basics of anesthesia
Pardo, Manuel, Jr [ed]; Miller, Ronald D [ed]. – 7th ed – Philadelphia, PA: Elsevier, 2018 [2017].

Case studies in pain management
Kaye, Alan D [ed]; Shah, Rinoo V [ed]. – Cambridge, UK: Cambridge University Press, 2014.

Clinical anesthesia
Barash, Paul G [ed], et al. – 8th ed – Philadelphia, PA: Wolters Kluwer, 2017.

Essence of anesthesia practice
Fleisher, Lee A [ed]; Roizen, Michael F [ed]; Roizen, Jeffrey D [ed]. – 4th ed – Philadelphia, Pennsylvania: Elsevier/Saunders, 2018[2017].

The first year: what you should know after a year of anaesthesia training
Rathie, Lachlan. – Toowoomba: [self published], [2016].

Oxford textbook of obstetric anaesthesia
Clark, Vicki [ed]; Velde, Marc van de [ed]; Fernando, Roshan [ed]. – Oxford: Oxford University Press, 2016.

Practical ambulatory anesthesia
Raeder, Johan [ed]; Urman, Richard D [ed]. – Cambridge, UK: Cambridge University Press, 2015.

Sedation: a guide to patient management
Malamed, Stanley F. – 6th ed – St. Louis, Mo: Mosby Elsevier, [2018].

Stoelting's anesthesia and co-existing disease
Hines, R L [ed]; Marschall, K E [ed]. – 7th ed – Philadelphia, PA: Elsevier, 2018 [2017].

OPML back pain
Chong, Sam [ed]; Cregg, Roman [ed]; Souter, Andrew [ed] – Oxford: Oxford University Press, 2012.

OPML cancer-related bone pain
Davies, Andrew [ed] – Oxford: Oxford University Press, 2011.

OPML cancer-related breakthrough pain
Davies, Andrew [ed] – 2nd ed – Oxford: Oxford University Press, 2012.

OPML chronic pain
Dickman, Andrew [ed]; Simpson, Karen H. [ed] – Oxford: Oxford University Press, 2011.

OPML long-term pain: a guide to practical management
Lee, John [ed]; Baranowski, Andrew [ed] – Oxford: Oxford University Press, 2007.

OPML migraine and other primary headaches
MacGregor, Anne [ed]; Jensen, Rigmor [ed] – Oxford: Oxford University Press, 2008.

OPML neuropathic pain
Bennett, Michael [ed] – 2nd ed – Oxford: Oxford University Press, 2008.

OPML opioids in cancer pain
Forbes, Karen [ed] – Oxford: Oxford University Press, 2011.

OPML opioids in non-cancer pain
Stannard, Cathy; Coupe, Michael; Pickering, Tony – 2nd ed – Oxford: Oxford University Press, 2013.

OPML pain in older people
Crome, Peter [ed]; Main, Chris J. [ed]; Lally, Frank [ed] – Oxford: Oxford University Press, 2007.

OPML visceral pain: clinical, pathophysiological and therapeutic aspects
Giamberardino, Maria A. [ed] – [Oxford]: Oxford University Press, 2013.

Vascular anaesthesia
Thompson, Jonathan [ed]; Telford, Richard [ed]; Howell, Simon [ed] – [Oxford]: Oxford University Press, 2014.

Contact the ANZCA Library
www.anzca.edu.au/resources/library
Phone: +61 3 9093 4967
Fax: +61 3 8517 5381
Email: library@anzca.edu.au

Special Interest Group events

Extreme perioperative cardiorespiratory support meeting triumphant over NZ extreme weather!

A record 151 anaesthetists and perioperative staff attended the biennial meeting of the Cardiac Thoracic Vascular and Perfusion SIG in Queenstown NZ from July 23-26, 2017. Traditionally a laid back tropical conference in the school holidays, this CTVP SIG meeting was a bit of a gamble being in NZ winter and out of school holidays. However, the allure of the NZ ski fields and an epic combination of speakers, research session, debates and workshops paid off with bumper attendance.

However, it wasn't plain sailing as things started off badly with a severe weather storm hitting the South Island with more than 200mm rain overnight, submerging towns, roads and closing the airport the day before the meeting started. Luckily the convenors Associate Professor David Canty and Dr Matt Chacko had arrived early, but by Saturday it looked like they might be the only people attending! The ACE team, many speakers and attendees had their flights delayed or redirected. One attendee reported an aborted landing where the oxygen masks dropped from the ceiling and the pilot announced "brace"! Like a NZ bungee jumper, the weather bounced back quickly and somehow everything fell into place leaving some fresh snow and glorious blue sky and spectacular scenery for après-ski. It was no miracle that it worked out, it was the two years of planning and intensive work put in by the ACE and CTVP Executives along with the valiant effort from partners, delegates, healthcare industry staff and supportive partners who pitched in to make it a success.

The theme of "extreme cardiorespiratory support" worked well, bringing in a perioperative team approach with each rapid-fire session having an anaesthetist, surgeon, intensivist and a cardiologist. This made for frenetic and exciting discussions enhanced with the mobile app, and displayed live voting for the two exciting debates between Prince Charles Hospital Director of Cardiology Darren Walters and Monash Cardiothoracic anaesthetist Jethro Dredge and Royal Melbourne Hospital Deputy Director of Surgery Alistair Royse. The audience were witness to a riveting scientific program with bombshells such as Associate Professor Paul Forrest bringing back the dead with ECMO (eCPR), Professor David McGiffin predicting pig heart in human transplantation within two years, and Professor Alistair Royse predicting a shift in treatment of coronary artery disease to total arterial revascularisation over percutaneous and traditional surgery.

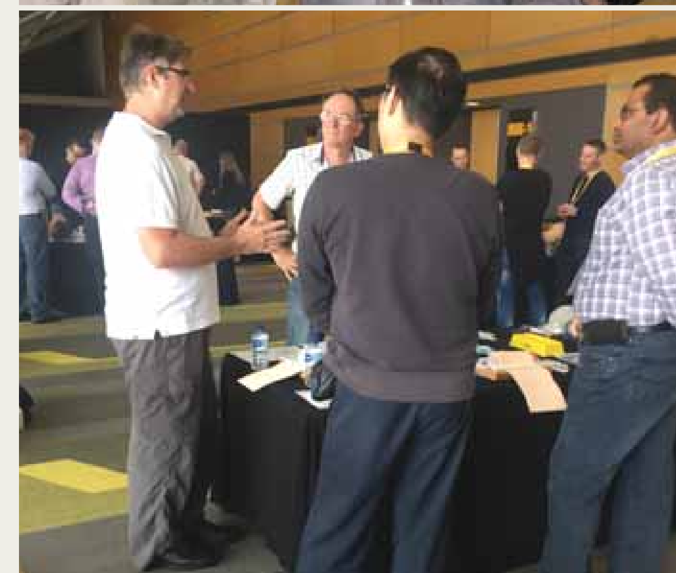
Despite the very high standard of local talent, the international speakers still made a major impact. Professor Andre Denault from Quebec demonstrated how organ failure can be diagnosed and corrected with "whole body oximetry and ultrasound". Professor Stan Shernan, SCA president-elect from Boston, again took echocardiography to a new level, where he is re-writing the echo rules and put on a great 3D echo workshop. The pig hearts only just arrived in time for the echo-wet lab, which was a huge success, thanks to the dedication from Bruce (REM Systems), anaesthetists Matt Chacko, David Daly, Stan Shernan, and surgeons David McGiffin, Julian Gooi, Will Shy and Alistair Royse. Professor Colin Royse and his team from Ultrasound Education Group were a major contributor, delivering ultrasound talks and ultrasound simulator workshops. Another highlight was the original research session that had seven Australian and NZ contributors. First prize went to Dr Rukman Vijayakuma from The Royal Melbourne Hospital on his observational study on the learning curve of Focused Cardiac Ultrasound. The convenors Associate Professor David Canty, Dr Matt Chacko and the CTVP SIG Executives and ACE committee thank all the speakers and delegates who attended and contributed to such a successful meeting

The next planned biennial CTVP meeting will be held in 2019. The inaugural CTVP Echo meeting and workshop is being held at the ASA NSC Adelaide in October 2018. The CTVP will be hosting a "Masterclass in CVC insertion" and ultrasound guided CVC and train the trainer workshop at ANZCA ASM in Sydney in May 2018.

Associate Professor David Canty
Chair of the CTVP SIG
Convenor, 2017 CTVP SIG Meeting

Above from left: Maori welcome; Delegates in session; Wetlab workshop led by Professor Stan Shernan.

Answers to the BIG AIRWAY questions



Dr Tish Stefanutto (Chair, Airway Management Special Interest Group), Dr Keith Greenland and Professor André van Zundert, co-convenors of the biannual meeting, welcomed a group of 240 motivated anaesthetists dedicated to improve airway management at the Brisbane Convention Centre from June 10-12.

A successful scientific program was offered to the participants with exceptional international and national speakers, presenting top quality information and answers to the BIG AIRWAY questions. On the last day, participants were invited to take part in a wide range of workshops.

The meeting included welcome drinks and an excellent dinner at Gusta da Gianni restaurant. A large group of industry input showed vast interest and support in our meeting. We would like to thank Cook Medical, Ambu Australia, Teleflex Medical, Smith Medical, Medtronic, Verathon Medical, AbbVie, Vyaire Medical, Karl Storz, Construct Medical, MDA National and Parker Medical.

During the general meeting of the executive committee, Dr Tish Stefanutto stepped down as chair and the group elected Dr Keith Greenland as the new chair and Dr Stefanutto as deputy chair. New ideas for future activities were raised such as regular newsletters, multicentre prospective study similar to NAP4 in the UK, a letter of notification of difficult airways for patients (downloaded from SIG website), upgrading Airway Management SIG website; defining workload of executive office bearers, how to close the gap between executives and Airway Management SIG members and development of resources for teaching.

We hope to see an even larger group of anaesthetists attending our next SIG meeting, two years from now.

Professor André van Zundert

Above from top: Delegates participating in the CICO workshop; Professor Carin Hagberg, Dr Tish Stefanutto, Professor Ellen O'Sullivan and Dr Paul Baker; the CICO workshop.

Delivering obstetric anaesthesia to the bush

The Rural Special Interest Group held its annual meeting from July 7-8 at the Cable Beach Resort in Broome, Western Australia. The meeting marked two milestones with it being the 10th annual meeting and in visiting Western Australia the meeting finalised a full state of states and territories (including New Zealand) that have hosted the meeting. There were some concerns with choosing Broome regarding the distance and costs in travelling from the east coast however these were allayed as the delegate numbers, at 75, were up on the two previous years.

The theme this year was obstetric anaesthesia and we were delighted to welcome back Dr David Elliot and Associate Professor Nolan McDonnell as our keynote speakers. They covered a wide variety of topics ranging from epigenetics and ROTEM for obstetric haemorrhage to analgesia for labour and C-sections along with GA sections and the obese parturient.

The meeting opened with a Welcome to Country and was followed by a talk from Dr Fiona Barron about some of the challenges of communication with Indigenous mothers around Darwin. The session on labour featured Dr Gavin Patullo explaining programmed intermittent bolus for epidurals and GP obstetrician Dr Deb Langford gave us a run down on CTGs. Other speakers included Dr Judy Killen (diabetes), Dr Deb Gardiner (pulmonary embolus), Dr Mick Shaw (pre-eclampsia) and myself along with two colleagues from Armidale discussing our local approach to regional anaesthesia for C-sections.

The workshops program included CPD emergency scenarios with an anaphylaxis workshop run by Dr Nagesh Nanjappa and a major obstetric haemorrhage simulation coordinated by Dr Kenneth Gilpin and Dr Rod Martin at the Broome Hospital with support from local doctors. The final workshop was an ultrasound workshop hosted by Dr David Hoppe, Dr Mike Haines and Dr Gavin Patullo with support from Sonosite who supplied the machines.

The social aspects are an important part of any meeting with delegates able to meet old friends and network. The main social event was drinks overlooking Cable Beach followed by a dinner by the resort pool.

The meeting was a great success and I would like to thank all the speakers for great presentations and also acknowledge the great work done by Kirsty O'Connor and Mairead Jacques from the ANZCA events team who ensured the smooth running of the meeting.

We would like to invite you to join us for the 2018 meeting which will be held on June 15-16, 2018 and will see the Rural SIG return to Uluru in the Northern Territory on what will be the 10th anniversary of the first Rural SIG meeting held there in 2008.

Dr David Rowe

Above from top: Delegates mingling with the exhibitors; Delegates participating in the ultrasound workshop.

New Zealand news

Choosing Wisely launch in NZ

ANZCA's Choosing Wisely recommendations were launched in New Zealand on August 25, after the quarterly meeting of the Council of Medical Colleges, which co-ordinates the Choosing Wisely initiative in New Zealand. The recommendations of four other medical colleges were launched at the same time.

Dr Sally Ure, deputy chair of ANZCA's NZ National Committee, spoke at the launch, saying that the global initiative was an obvious fit with ANZCA's mission "to serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine". She also noted that some of the recommendations dovetailed neatly with this year's ANZCA National Anaesthesia Day promotion theme of "Ageing and anaesthesia".

Dr Dick Ongley, a Christchurch anaesthetist who helped develop the College's recommendations, fronted the media for the New Zealand launch.

ANZCA's recommendations were launched in Australia in March and featured in the March edition of the *ANZCA Bulletin* (pp 34-35).

Above from top: Dr Sally Ure speaking at the New Zealand launch of ANZCA's Choosing Wisely recommendations; The clinical directors of New Zealand's anaesthesia departments at their annual meeting in Wellington on September 1; Rotorua's geothermal attractions encapsulate the ASM theme of fear and excitement; Dr Tom Fernandez, who is convening ANZCA's third New Zealand Anaesthesia Research Workshop.

Clinical directors share thinking

Clinical directors of New Zealand's anaesthesia departments travelled to Wellington Airport on September 1 for their annual update, facilitated by ANCZCA's NZ National Committee (NZNC) but with an agenda largely of their choice.

NZNC Deputy Chair Dr Sally Ure chaired the day and led the session on College affairs with New Zealand staff contributing and the clinical directors having the opportunity to ask questions.

Group discussions looked at the issue of bullying/ discrimination/sexual harassment, Whanganui Hospital's "Fit for Surgery, Fit for Life" initiative developed by anaesthesia clinical director Dr Marco Meijer, and national standards, chaired by Waikato clinical director Dr Cam Buchanan.

Another session focused on the role of the Health & Disability Commissioner (HDC) with an overview of the legislation and how it relates to anaesthesia providers. Jane King, Associate Commissioner Legal, outlined the procedures and the Commissioner, Anthony Hill, discussed several cases involving anaesthetists.

He reminded the clinical directors that people often complained so not to panic if a complaint was made but they should discuss it upfront promptly and try to resolve it. He said the HDC's focus was consumer-centred. Referring to the issue of whether a doctor might be tempted not to disclose an error if no harm had resulted and they felt they could "get away with it", Mr Hill said he would be profoundly concerned.

Not only was there a strict legal obligation to disclose but doctors should be "big enough, professional enough and responsible enough" to own any errors. The consequences of failing to disclose would be infinitely worse than the original error, he said.

Hotels filling quickly for NZ ASM

With about two months to go before the NZ Anaesthesia Annual Scientific Meeting being held in Rotorua November 8-11, registrations were at the 200-mark with hotels in the city filling quickly.

The ASM is hosted jointly by ANZCA's NZ National Committee and the NZ Society of Anaesthetists.

Scientific convenor Dr Kelly Byrne, and the regional organising committee from Waikato Hospital, led by convenor Dr Kevin Arthur, has put together a varied program exploring the theme "Fear and excitement" with the aim of answering some of the dilemmas that keep anaesthetists awake at night.

Keynote overseas and local speakers will cover conditions that make an anaesthetist's life difficult, anaesthesia for trauma, and hypotension and outcome. Sessions will explore EEG in clinical practice, airway dilemmas, and pre-admission issues including frailty and high-risk patients. Ethics will also be addressed, as will the impact of healthcare and anaesthesia on the environment.

Other sessions will feature stories from the frontline, and dangers in everyday practice. Research and audit will be covered and a Saturday morning session will look at working in the Pacific and Africa.

Another presentation will provide an overview of the first 4000 cases in webAIRS, identifying themes emerging from the data, and concurrent workshops on the Saturday will cover CICO, anaphylaxis, regional anaesthesia and transthoracic echo.

The ANZCA NZ National Committee will hold its annual general meeting for Fellows at 12.30pm on Thursday November 9.

2018 research workshop – mark your diary!

ANZCA's next New Zealand Research Workshop will be held in Auckland on Friday March 23, 2018 – the day before the Auckland City Symposium.

Convenor Dr Tom Fernandez has been able to take advantage of that timing to attract Professor Hilary Grocott, the editor-in-chief of the *Canadian Journal of Anaesthesia*, as guest speaker at the research workshop.

The ANZCA NZ National Committee established the biennial event to provide an opportunity for emerging researchers to network with and learn from New Zealand's leading anaesthesia researchers.

The aim is to provide specialists, trainees and research nurses with a guide on how to become involved with and develop quality research. The day also provides a stepping stone into the area for novices seeking guidance or assistance.

More information will be available from the www.anzca.org.nz website as the 2018 program is developed. In the meantime, inquiries and indications of interest in attending may be directed to Katherine Harris (eventsNZ@anzca.org.nz) at ANZCA's New Zealand office.

Visiting Lectureship nominations due

Nominations for the 2018 NZ Anaesthesia Visiting Lectureship close on September 30, as do expressions of interest in hosting a lecturer next year. More information can be found at www.anaesthesiaeducation.org.nz.

Facilitated by the NZ Anaesthesia Education Committee, the Visiting Lectureship program shares knowledge by enabling outstanding presentations made at larger hospitals to be presented again at smaller regional hospitals. The clinical directors of anaesthesia departments nominate potential lecturers, with that person's approval, from staff members who have given an outstanding presentation at an education session. Those chosen are expected to give their lecture at two regional hospitals.

NZ Anaesthesia Visiting Lectureships for 2017 were awarded to:

- Dr Mike Foss, Waikato, for his talk on "The Complex Pain Patient in the Perioperative Environment", presented at Wairarapa Hospital on May 25 and Hutt Hospital on May 26.
- Dr Cath Purdy, Counties Manukau, for her talk on "Substance Abuse in Anaesthesia", to be presented at Nelson Hospital on December 12.

Both also presented at the lower North Island regional meeting, held at Palmerston North Hospital on September 1 with attendees including anaesthetists from Taranaki Base, Whanganui, Hawke's Bay Regional, Masterton and Palmerston North Hospitals, as well as pain medicine nurses from Palmerston North and Hawke's Bay. This now well-established meeting, convened each year by Dr Nigel Waters, is an excellent use of the visiting lectureship resource.

Portfolios for trainee committee deputy chairs

The NZ Trainee Committee (NZTC) is working hard to increase the range of experience it gives members as well as increasing engagement with trainees.

At its June 19 teleconference, the committee appointed two deputy chairs with specific portfolios. Dr Lisa Barneto of Wellington has responsibility for internal matters and Dr Leesa Morton, Auckland, is overseeing external matters. The aim is to give a wider range of NZTC members experience in leadership and project management, thus providing better continuity for the committee as a whole.

Advanced trainees – chances to learn

Advanced trainees have two opportunities in November to expand their knowledge – about teaching and about what life is like as a senior medical officer/consultant.

They are now able to take part in the ANZCA Educators Program courses with participation counting towards their scholar role requirements to develop experience and skills in teaching. Some of the program's modules will be taught in a two-day course at Auckland City Hospital on November 23-24. This course will cover planning effective teaching and learning; teaching in the clinical setting; clinical supervision; interactive learning and teaching practical skills.

See www.anzca.edu.au/resources/learning/anzca-educators-program for more information.

The Part Three Course is specifically for advanced trainees soon moving to the consultant role. It provides a wealth of information about where FANZCA can take you, CV and interview skills and more, as well as being an excellent networking opportunity.

The 2017 course, being held at Auckland Airport on Thursday November 30, is proving popular with most places filled by mid-September. Attendance is restricted to 24. See www.anaesthesiasociety.org.nz/education/part-3/ for more information and to register.

Australian news

Western Australia

Updates in Broome

The Updates in Regional Anaesthesia, Country Conference was held at the Cable Beach Resort in Broome from June 16-18, 2017. The keynote presentation was by Professor Peter Hebbard, the Bunny Wilson Lecture presented by Dr Michael Paech and the Sunday morning "GP" anaesthetist presentation presented by Dr David Forster and Dr Yehuda Levy. The workshops included Adductor Canal and Rectus Sheath, which were well attended and we have received positive feedback regarding the quality of the presentations.

The Nerida Dilworth Prize was held during the Saturday, the judges included Professor Peter Hebbard, Dr Nicholas Lightfoot, Dr John Martyr and Dr Lindy Roberts. The prize was awarded to Dr Zaki Ibrahim with a presentation on airway exchange catheters. An ANZCA Council citation was awarded to Dr Michael Paech for his contribution to anaesthesia and was presented by Dr John Martyr.

This was the first time the Country Conference was held in Broome with 95 delegates in attendance, the majority of the delegates surveyed noted that they would like the conference to return to Broome, possibly on a bi-annual basis.

We had full sponsorship from Smiths Medical (Major), GE Healthcare (Major), Willie Creek Pearls (Major), Abbvie, BOQ Specialist, Aspen Pharmacare, Avant, Admedus, Edwards, Health Technology Supplies, MDA National Insurance, MSD, Anaesthetic Practice Management Australia and Sonosite. Willie Creek Pearls provided an excellent presentation on harvesting during the Friday night dinner much to the delight of the delegates.

The conferences for 2018 will be held at Joondalup Resort on April 7 and Bunker Bay from October 26-28.

Above clockwise from top left: Adductor Canal Workshop; Camels on Cable Beach; Delegates speaking with Aspen Pharmacare; Rectus Sheath Workshop; Opening presentations; Dr Mike Paech receiving the citation from Dr John Martyr.

Australian news (continued)

Victoria

Back to the future

The 38th Annual ANZCA/ASA Combined CME Meeting was held on Saturday July 29 at the Sofitel Melbourne on Collins. The theme was "Back to the future" and we had 10 speakers deliver presentations within four sessions. The sessions were "Entering the new era", chaired by Dr Michelle Horne (Convenor, ASA – Education Officer), "Perioperative Medicine toolbox", chaired by Dr Mark Hurley (VRC Chair), "Airways and hypertension", chaired by Dr Jenny King (ASA Chair), and "A team game", chaired by Dr Irene Ng (VRC - CME Officer).

Dr Louise Schaper, CEO, Health Informatics Society of Australia was our guest speaker talking on "Entering a new era of healthcare: The future is already here", and we are thankful for her time and all the speakers for the excellent presentations they delivered. We had very interactive presentations including Dr Catherine Abi-Fares demonstrating a non-invasive Sphenopalatine ganglion block on herself during her talk and Dr David Reiner handing out samples of his perioperative drink.

The overall feedback from the delegates and our HCI sponsors was very positive and the overall meeting was well received.

The ANZCA 25th anniversary was also acknowledged including a cake with drinks at the end of the meeting in celebration.

Dr Michelle Horne,
Convenor, ASA – Education Officer

Victorian Quality Assurance Meeting

The first Victorian Regional Committee Quality Assurance meeting for the year was held on Saturday May 27. The theme for the meeting was "airway complications". Our speakers presented a general overview of airway related complications as well as case presentations on CICO and laryngeal trauma. This was followed by small group discussions of interesting cases and a summary session. The cases generated good discussion which led to some salient take home messages.

Queensland

Primary practice viva evenings

The Queensland Regional Office ran two successful primary practice viva evenings in August and September.

Course Convenor Dr Edward Pilling wrote to past volunteer examiners: "One word of note, most mock examiners come to the viva evening with pre-prepared vivas and answers, often based on their own primary exam experience. If you don't have a pre-prepared viva or if your primary exam was some time ago, then please don't let it put you off taking part! I have some spare vivas which I can provide and if you let me know beforehand this will give you time to familiarise yourself with the questions. I can be contacted at ed.pilling@gmail.com."

If you wish to prepare your own viva, then the primary syllabus and a guide to the examination can be found on the ANZCA website. According to ANZCA: "Broadly, the curriculum for the primary is applied physiology, pharmacology, anatomy, measurement, equipment, quality and safety. Learning outcomes relating to maternal and paediatric physiology and pharmacology are also assessed in the primary examination." (Source: www.anzca.edu.au/training/examinations/primary-exam). Recent exam reports can be found here: www.anzca.edu.au/training/examinations/primary-examination-reports.

In the real exam, candidates have three viva stations of 20 minutes, two minutes for perusal of an opening question, two examiners per station and two five-minute topics per examiner. The time allocated for our viva night is 12 minutes per viva and six minutes for feedback/change over. This means that in the practice you should have time to examine on two topics, just like examiners in the real thing. Candidates rotate around examiners and so one prepared viva per examiner is normally sufficient."

Above: Candidates and examiners practice their viva skills at the ANZCA Queensland Regional Office.

South Australia and Northern Territory

Faculty Dean visit

The Faculty Dean, Dr Chris Hayes, visited South Australian members in June. He gave an informative session highlighting the FPM Committee structure, updates to the Faculty and the 2018-2022 strategic planning review. Members were asked to give feedback to be considered by the Faculty when reviewing the strategic plan which included issues relating to interventional pain medicine, medicinal marijuana, providing a six-month pain diploma, liaison, Medicare and EPPOC.

While in Adelaide, the Dean visited the Royal Adelaide Hospital and Flinders Medical Centre pain units.

ANZCA president visits

Professor David A Scott attended the August ANZCA SA/NT Regional Committee meeting for his annual visit. Ms Jo-Anne Chapman, General Manager, Policy, Safety & Quality and Ms Jo Mason, Program Director, Specialist Training Program (STP) were also in attendance to provide an update on the STP and International Rural Training Program.

Above: Dr Chris Hayes and SA FPM members; Dr Bruce Rounsefell, Chair of SA FPM Regional Committee and Dr Chris Hayes, the Faculty Dean.

Above right: Thomas Grosser-Kennedy, Luke Arthur, Mitchell Petersen Tym, Christopher Harry, Laura Fisher, Thomas Maycock, Michaela Malek, Daniel Stone, Thomas Goddard.

Part Zero Course

The mid-year Part Zero Course was conducted by the SA/NT Trainee Committee on July 29. Nine of 11 new trainees who were accepted on to the South Australian and Northern Territory Rotational Anaesthetic Training Scheme (SANTRATS) attended the informative session. Several topics were covered including rotational issues, TPS & WBAs, Part 1 and Part 2 tutorials, GASACT and welfare. A new topic was introduced on "alternative pathways" and how to complete anaesthetic training if unable to stay on the rotation.

How the unconscious controls our behaviour... for better or for worse

Dr Michael Goldblatt (opposite) presented "How the unconscious controls our behaviour... for better or for worse" at the second CME meeting of 2017, held at the historic Lion Hotel in North Adelaide in June.

Dr Goldblatt, who works half time as a staff specialist at Flinders Medical Centre and half time in private practice with Stace Anaesthetic Services, was awarded a Diploma of Clinical Hypnosis in 2012 after training with some of the world's leading hypnotherapists.

Dr Goldblatt's presentation highlighted how we meet people all the time who behave in ways that defy logic. Why would any rational adult continue to smoke? Why are some patients who are covered in tattoos and piercings, absolutely terrified of the smallest of cannulas?

Outstanding feedback was received from delegates who attended the presentation and who enjoyed the opportunity to speak to Dr Goldblatt and to learn more about new research in the fields of cognitive and social psychology.

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

Australian news (continued)

Tasmania

Above from top: View from The Dunes, Barnbougle; CICO workshop, from left, Dr Michael Lumsden-Steel, Clinical Associate Professor Marcus Skinner, Dr Daniel McGlone and Dr Pravin Dahal; Celebrating ANZCA's 25th anniversary with original ANZCA Council members from left, Dr Stewart Bath and Dr Mike Hodgson.

Barnbougle – a great location for a one-day winter meeting

Sunshine greeted delegates and speakers at this year's Tasmanian Combined Annual Winter Meeting. Barnbougle was at its winter best, with more than 45 delegates and speakers enjoying the stunning views from The Dunes conference facilities.

Those attending had the opportunity to experience all things "air" with this year's theme of InnO2vate. Speakers Dr Sasanka Dhara, Clinical Associate Professor Marcus Skinner and Dr Karl Gadd started the day on the latest in airway equipment, techniques and recent research findings. Concurrent Airway CICO workshops were held in the morning and provided delegates with the opportunity to gain hands-on learning of FONA techniques and porcine tracheas. Participants greatly valued the small group workstations.

Dr Paul Lee-Archer travelled from Lady Cilento Children's Hospital in Brisbane, to share his research knowledge of dexmedetomidine in children and paediatric THRIVE. Ms Lanthe Boden, senior physiotherapist and UMelb PhD candidate shared her research on the highly efficacious prehab for prevention of pneumonia in abdominal surgery. Dr Elizabeth Winson shared her expertise on extracorporeal life support.

Dr Benoj Varghese from the Royal Hobart's ICU presented an update on tracheostomies and Dr Josie Larby from Launceston General's respiratory department provided some interesting bronchoscopy cases.

Following a delicious lunch overlooking the north east coast, Dr Colin Chilvers (Chair of the Tasmanian Regional Committee), led a session celebrating the ANZCA 25th anniversary and acknowledging the vital contribution of original council members Dr Stewart Bath (from ACT) and Dr Michael Hodgson (from Hobart). A celebratory chocolate cake followed this presentation for afternoon tea, with Dr Bath and Dr Hodgson cutting the cake with everyone acknowledging this important milestone for the College.

Pre-dinner drinks were enjoyed at Lost Farm where everyone had an opportunity to relax, network and admire the sunset over the water with the fantastic views of Bass Straight. Delegates, friends and family enjoyed the three-course dinner, which topped off another successful winter meeting.

The co-convenors of the meeting, Dr Dane Blackford and Dr Lokesh Anand thought the day and social events went very well and greatly appreciated the speakers and workshop faculty who contributed to the success of the meeting.

Dr Colin Chilvers congratulated the convenors and the organising committee for a great meeting and thought that the location and facilities were among the best this meeting has had so far. Dr Chilvers further explained that being such a great venue, consideration is already being given to holding next year's winter meeting again at Barnbougle.

Above: Southwest Tasmanian mountains above the cloud layer by Dr Roger Wong.

Outside the comfort zone: A clinical anaesthesia update

Have you ever felt that shiver of fear?

That nugget of uncertainty?

The spectre of consequence?

Have you experienced anaesthesia outside the comfort zone?

Modern anaesthesia is a wonderful thing. It is constantly growing and rapidly changing. Sick, complex and unusual patients are surviving, even thriving. They may live near you. They may turn up on your list. They need capable care. We may all be called upon to anaesthetise people with complex conditions for surgery in our own hospitals.

The Tasmanian combined Annual Scientific Meeting (ASM) 2018 is a clinical update in anaesthesia. It is an opportunity to share, refresh and expand our knowledge. The program is focused on new and emerging fields of anaesthesia and those uncommon clinical conditions that are becoming more common. In 2018 we are extremely fortunate to have some excellent interstate and local speakers including Dr Lachlan Miles (anaesthesia for post-transplant patients), Associate Professor Phillip Ragg (adults with congenital heart disease) and Dr Rani Chahal (onco-anaesthesia).

The meeting will also provide ample opportunities to meet ANZCA CPD requirements and BLS mandatory training requirements with more details to come.

The Tasmanian Regional Committee for ANZCA and the ASA invite you to the Tasmanian ASM 2018 on Saturday March 3, 2018. A cocktail function will be held after the meeting at the Atrium in the Henry-Jones Hotel. A trainee day precedes the ASM on Friday March 2, 2018. Registrations are expected to open in mid- to late-October 2017.

The meeting is held in beautiful Hobart, the smallest, but in our opinion the best capital city. From the waterfront to Mount Wellington Hobart is packed with natural beauty and attractions including Salamanca, MONA, everything from gentle bushwalking to hair-raising mountain biking and oodles of great restaurants and vineyards. We look forward to seeing you there.

Dr Lia Freestone
Convenor, Tasmanian combined Annual Scientific Meeting 2018

Australian Capital Territory

Above from top: Dr Andrew Deacon, Professor Ian Kerridge and Dr Jennifer Hartley; A full house of Fellows and trainees to listen to Professor Kerridge.

An evening with Professor Ian Kerridge

More than 50 local Fellows and trainees attended an evening presentation in Canberra on Thursday June 1 with the theme of peri-operative decision making in the modern era. Professor Ian Kerridge delivered two very topical presentations: "Evidence based medicine – the worst (and only) kind of evidence we have" and "Saying no to futile surgery".

Professor Kerridge is one of Australia's leading bioethicists and has an international reputation for his research in bioethics, public health ethics, clinical ethics and the philosophy of medicine. He is a Staff Haematologist/Bone Marrow Transplant Physician at Royal North Shore Hospital (Sydney) and Professor of Bioethics and Medicine at the Centre for Values, Ethics and the Law in Medicine (VELiM) at the University of Sydney.

The evening included canapes, beverages and dinner and provided a great opportunity for our colleagues to catch up socially whilst also attending a very informative evening. A very special thanks to Dr Andrew Deacon and Dr Jennifer Hartley for their efforts in organising Dr Kerridge to present in Canberra.

Australian news (continued)

New South Wales

Farewell to Dr Sarah Green

ANZCA's prominence as a specialty college is dependent on the input, support and engagement of its Fellows. Across Australia, passionate, intelligent and enthusiastic Fellows volunteer their time to contribute to myriad roles that maintain our College's vision and mission, and the regional committees play a pivotal role in this.

Sarah Green, NSW Regional Committee Deputy Chair and Safety & Quality Officer embodied all that is good about being a FANZCA – insightful, thoughtful, engaging and committed to ensuring the best outcomes for her patients and her profession. She will be sorely missed by the NSW regional committee, but we wish her well in her involvement with the ANZCA CPD Program, managing her clinical commitments and a teenager navigating the HSC. Good luck Sarah.

Above: Dr John Leyden, Chair NSW Regional Committee and Dr Sarah Green, Deputy Chair NSW Regional Committee/ NSW Safety and Quality Officer.

Obituary

Dr Lynley Faith Hewett 1941-2017

Prostitutes and prisoners were among those cared for by Lynley Hewett, the former in her prevocational work as a GP locum in the red light district of Perth, the latter in her time as a consultant at Fremantle Hospital, but in the spirit of her strong Christian faith and commitment to the Hippocratic Oath, all were treated with the utmost dignity, respecting each of them as a human being, just like any other, in need of care.

Born in Kuala Lumpur, then at a few weeks of age rapidly evacuated to Western Australia as the Japanese army marched down the Malayan Peninsular, Lynley grew up in Albany and then Perth, excelling at school. She graduated MB BS from the University of Western Australia, where she was the women's fencing champion and stroked the women's rowing team to success. She was then intern at Fremantle Hospital.

Three months into her internship Lynley was not paid one week, and on querying this with the administration, the hospital had asked that she repay money to them – the issue being they had paid her at 17 pounds per week (the male wage) rather than the 11 pounds per week that female doctors were paid, not realising that Lynley was a woman's name! All her male colleagues having their Friday fish and chips with her left the lunch table without a word, and returned 20 minutes later having secured equal pay for Lynley. Lynley would not have me tell this story from a feminist point of view, but this clearly demonstrated the high esteem with which Lynley was held by her colleagues after only 12 weeks as a doctor, and in which she would continue to be held for the next 52 years, throughout her working life and into retirement.

Like many before and countless since, Lynley headed to the United Kingdom where she worked in London and Oxford, passing her fellowship examinations on the first attempts. Professor Barry Baker was also at the Radcliffe at that time, and recalled that Lynley was a superb anaesthetist, but was particularly appreciated by her bosses as being an Australian straight talker. You knew where you stood with her, and this they very much admired.

Lynley very much excelled at straight talking. On one occasion a male patient asked Lynley why she as a lady had a cricketer's box, and why she was holding this above his face. Lynley replied that this was not a cricketer's box, but a Schimmlebush mask, and that he would be going off to sleep, very quickly.

At the 1999 ANZCA Annual Scientific Meeting in Adelaide, Lynley was chatting with Barry Baker in their academic regalia, when a drunk walking by asked "Who the f*** are you?", to which Barry Baker replied "Henry VIII and wife", and quick as a flash Lynley retorted "Number six – I still have my head attached". The drunk went silent, while all those around were in fits of laughter. As Lynley commented, it was marvellous to have collegial friendships that extended over decades.

On her return Lynley worked initially as an intensive care physician as well as an anaesthtetist, and worked at almost all the major teaching hospitals, and at many private hospitals in Perth, and in her career visited many country hospitals as well.

Lynley valued her anaesthesia college fellowships, and appreciated much more than most what the real meaning of fellowship was. Not only was she an incredibly talented clinician, but she served her profession in so many ways on committees. When voluntary reporting of anaesthesia critical incidents was introduced to private hospitals, she was the first to report her own incidents. However despite her admissions of fallibility as an anaesthetist, I suspect there were so very few.

Her fellowship also provided her with a fellowship gown, which she said was a necessity to take with you to all anaesthesia conferences. Why, you may ask as I did? Because in Lynley's words "One has found it very useful as a dressing gown when one has had to evacuate one's hotel because of a fire in the middle of the night." We can only wonder!

On a serious note her concept of fellowship also extended to helping and assisting Fellows when they were struggling, most of this caring work being conducted out of the eyes of public view.

Speaking to her colleagues there were so many descriptions of her in the field of medicine – clinically brilliant, incredibly intelligent, formidable, great sense of humour. But the one description that stands out most, and I think that she would be most chuffed about, would be that so many described her as a compassionate doctor. Compassionate to her patients and their families, to her colleagues, and to her operating theatre staff members.

Outside medicine among other things, she was a City of Subiaco councillor, on the State Metropolitan Redevelopment Authority, held a pilot's license and a yachtmaster's certificate, sculpted, rode a mule to the bottom of the Grand Canyon in a snow storm, and was a passionate Fremantle Dockers supporter. Unfortunately for successive coaches, she managed to obtain their email addresses and would weekly offer her opinion regarding the performance of both the players and the coach!

In an interview from a University of Western Australia publication shortly before her death, Lynley wrote:

"I have retired from anaesthesia but I loved every minute of medicine and was greatly honoured to be in that profession of trust and to be part of the advances we caused in anaesthesia since 1964. I enjoy retirement and adore both my dog and my God. At the end of my life I have more letters after my name than I have in my name which must say something about me but I do not know what!"

Lynley died after an acute episode relating to a chronic illness. She is survived by her family, and missed by her friends and colleagues.

Dr Andrew Gardner, FANZCA
Sir Charles Gairdner Hospital, Nedlands WA

Dr Andrew Paul John Couch 1988-2017

Dr Andrew "Andy" Couch was born on ANZAC Day 1988 with his twin brother Greg, and passed away peacefully in his sleep on May 8, 2017, aged 29.

He was a big brother to Jess and son to Paul and Gemma. From an early age, Andy was known to be the cheeky one and a troublemaker. Over the years, his playful personality, which gained him the title of the joker of the family, also developed into a gentle, selfless side, which made him unforgettable to the many people who got to meet him, know him and love him.

Andy completed his primary school education at Prouille school in Wahroonga, and attended secondary school at St Aloysius College at Milsons Point, before completing a gap year in Lancashire, UK, where he made many lifelong friends. He then completed his undergraduate medical degree with distinction at the University of Newcastle, during which he also went on exchange to the University of Oslo.

In 2013, he began his junior medical years at Westmead Hospital, where he initially wanted to be known only as "Andrew" (because it sounded more proper ... however, that was short lived!)

From the beginning of his career, Andy was drawn to critical care, and in his critical care senior resident medical officer year, he began volunteering his weekends to the RaceSafe medical team, which provided him with many stories of adventures. Andy found his calling as an anaesthesia registrar, starting at Blacktown Hospital in 2016 and then at Westmead Hospital in 2017.

As a member of many different teams during his time on the ward, his charismatic personality ensured that everybody that he worked with loved him (his presence at the ward banquets provided by nursing staff was testament to that!) Beyond his charismatic and joking personality, Andy's love for his job coupled with his caring and considerate nature was always present in the way he interacted with his patients, where he would often be seen to make them laugh and be at ease.

Andy was academically gifted and never ceased learning or trying to improve himself. During his years of medical practice, Andy was awarded first prize for the registrar presentation at the ANZCA Continuing Medical Education Conference in 2016, first prize in pharmacology for the masters of medicine degree at the University of Sydney and successfully completed the ANZCA Primary Examination in April 2017.

Studying for the primary exam is a mentally and physically challenging marathon but Andy never let it affect his positivity or his determination. Andy's study group and colleagues will forever remember his hand written graphs and colour-coded notes that he paraded around with him for a year, as well as his passion for the Krebs cycle and the propofol TCI graph. He was not only a motivating force for his peers, telling everyone "you've got this" as the exam dates loomed, but he was also a fantastic teacher, being voted the favourite tutor of 2016 to first year medical students at the University of Western Sydney.

Despite his dedication to his career, work-life balance remained a priority for Andy. His family were the most important part of his life, and he would always make time for those nearest and dearest to him. He pursued his passion for travel, visiting places far and wide including south-east Asia, Europe and South America.

Words can never truly describe how amazing Andy was as a person and as a doctor. At work, he was always very focused, calm and organised. He always stepped up and took charge when it was needed and he always had a systematic approach to problems. He had a great sense of humour, always bringing a positive energy with him and he also knew how to push everyone's buttons! Most importantly he was generous, selfless, fiercely loyal and forever irreplaceable.

In his short life, Andy lived and loved life more than many of us dream to achieve. For those of us who knew Andy, we can truly say that we have tried to approach every day with the passion and gusto that Andy would have afforded it.

The loss of the passionate, loving and charismatic Andy acts as a constant reminder to pursue what matters most to us in our lives.

He was remembered in a beautiful funeral at Holy Name Catholic Church, Wahroonga to a congregation of 850 people, which was testament to the number of people Andy had impacted during his life. He is sadly missed by Gemma and Paul, Jess and Greg, and his wide network of family and friends.

In Andy's memory, a fund has been established through ANZCA Research Foundation, the "Dr Andrew Couch Memorial Fund".

Dr Yisha Cao, Westmead Hospital
Dr Sarah Turner, Westmead Hospital

Dr Eric Oswald Goonetilleke 1923-2017

It was a chance meeting with an Australian High Commissioner to Singapore in the late 1960s whom he had treated as a patient that sparked Dr Eric Goonetilleke's interest in moving to Melbourne with his family to start the next phase of his medical career.

By the end of the 1960s his life in Singapore was going well. He was married with two children and was well respected in his profession. It seemed as if he was heading towards a comfortable life there but, in 1970 he accepted an offer from Dr Robin Smallwood, the then director of anaesthesia at Melbourne's Austin Hospital and former dean of the Faculty of Anaesthesia, to move the family to Melbourne. Eric would be working with Dr Smallwood as deputy director of anaesthesia.

Back then the exchange rate was three and a half Singapore dollars to one Australian dollar so his savings didn't amount to much. He was nearing 50 but had decided to start a new phase of life in what was then a strange, cold country. He had decided that his family's future was more important and embarked on the next phase of a rewarding medical career that had initially been interrupted by the outbreak of World War II and the Japanese occupation of Singapore.

Eric was born in Singapore in 1923. He completed his schooling at the prestigious Raffles Institution in Singapore and it was here that he met fellow student Lee Kuan Yew who later became the nation state's founding father and long-serving prime minister.

Not long after Eric began his medical training in 1942 World War II intervened. The medical school was forced to close so Eric completed an accounting degree until he could resume his medical studies after the war ended.

Eric met his wife of 62 years, Rita, over a hot chocolate at a Singapore hospital in the early 1950s. As a trainee nurse Rita was required to prepare hot chocolates for the medical students. Eric was smitten. They formed a brave and formidable coalition.

As a junior doctor he was stationed in several towns in Malaya before starting his anaesthesia training in Singapore. Eric was generous with his time and skills to those in need. This was at a time where accessing basic medical care in Malaya was difficult and expensive.

In 1960 Eric travelled to the UK so he could receive advanced specialist training as an anaesthetist. He worked in Liverpool at the Alder Hey Children's Hospital and completed higher degrees in the Faculty of Anaesthetists at the Royal College of Surgeons in England (FFARCS Eng) and the Royal College of Surgeons in Ireland (FFARCSI). As an anaesthesia trainee from the British Colonies, he was invited to a Buckingham Palace tea party where he met the Queen.

He returned to Singapore and worked for the government as one of only three anaesthetists in the country. He had already established a reputation as a compassionate and caring doctor who worked long hours. In the mid-1960s Eric spent time at The Alfred hospital in Melbourne where he completed additional training in anaesthesia for open heart surgery which was then in its infancy.

He then returned to Singapore for a few years before moving to Melbourne in 1970 for the Austin Hospital position.

Eric was awarded the FFARACS in 1975 (later FANZCA 1993) and remained at the Austin until 1977 when he left to enter private practice. He became a founding member of the Dandenong Anaesthesia Group where he continued to work until his retirement at 72 years.

Eric Hilton Goonetilleke, a lawyer in Canberra, recalled how his father had a diverse range of interests. He was particularly passionate about cars, dogs, music and his religion as a Seventh Day Adventist.

"He loved cars and driving. One of the things that he had to bring over from Singapore when we came over was his Austin A40. At the time I thought it was terribly embarrassing. But it was one of a kind. He didn't worry about driving fast or long distances, even though we lived in Balwyn. For much of his working life he would drive to Dandenong, sometimes coming home for lunch! However, I still remember the time when he drove the whole family to Sydney and back for a weekend."

Eric was a self-taught musician and visitors to the family home would often find him sitting at the piano or his electric keyboard with one of the family's beloved pet dogs nearby.

Religion was important to Eric and he regularly read and studied the Bible, and played gospel music. Eric Hilton noted that his father welcomed visits from Mormons and Jehovah's Witnesses so he could debate the finer points of scripture with them. His favourite verse was psalm 23 of which there was a reading at his funeral on April 27 at the Seventh Day Adventist Church in North Fitzroy.

Eric Hilton and his sister Patricia Goonetilleke, FANZCA, have fond memories of their father and described him as modest and a life-long friend to many.

Patricia followed her father into anaesthesia and was appointed director of anaesthesia and perioperative medicine at the Royal Brisbane and Women's Hospital (1999-2005). She chaired the Anaesthesia Advisory Committee at Epworth Hospital in Richmond (2005- 2008), is a member of the Elesmere Anaesthetic Services, and a visiting medical officer at the Mercy Hospital for Women in Heidelberg.

Eric died on April 20, 2017 aged 93 years. He is survived by his wife Rita, children Eric Hilton and Patricia, and grandchildren Hamish James, Megan Belle and Amy Bridget.

This obituary was compiled with the assistance of the Goonetilleke family.