

THE ANZCA BULLETIN



Surgical Safety Checklist

**Surgical Safety Checklist
launched in Australia
and New Zealand**

What it means

Frequently asked questions

International action

Plus:

HEALTH REFORM

NATIONAL PAIN SUMMIT

**INFECTIOUS DISEASES
AND THE ANAESTHETIST**

**THE FUTURE OF
ANAESTHESIA PART TWO**



The 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, intensive care medicine and pain medicine specialists. ANZCA represents more than 5000 Fellows and trainees across Australia and New Zealand and serves the community by ensuring the highest standards of patient safety.

Editorial

Medical Editor

Dr Michelle Mulligan

Editor

Nigel Henham

Sub-editors

Clea Hincks & Liane Reynolds

Design

Christian Langstone

Submitting letters and material

We encourage the submission of letters, news and feature stories. We prefer letters of no more than 500 words and they must indicate your full name and address and a daytime telephone number.

Advertising inquiries

To advertise in *The ANZCA Bulletin* please contact Marc Wilson, ANZCA advertising sales representative, on 0419 107 143 or email marc@gypsymedia.com.au. An advertising rate card can be found online at www.anzca.edu.au/news/bulletin.

Contacts

Head office

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

Joint Faculty of Intensive Care Medicine

Telephone +61 3 9530 2862
jfcm@anzca.edu.au

Faculty of Pain Medicine

Telephone +61 3 8517 5337
painmed@anzca.edu.au

Copyright

Copyright © 2009 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.

Cover: Royal Adelaide Hospital
Photo: Joe Vittorio

18 Surgical Safety Checklist

Launch of World Health Organization Surgical Safety Checklist and how it affects anaesthetists in Australia and New Zealand.



28 The Future of Anaesthesia part two

Two international perspectives on the future of the specialty.



10 Health reform – the time is right

What has been put forward? What are the implications for the College community? How can ANZCA Fellows and trainees effect change?



40 Infectious diseases and the anaesthetist

A timely reminder on how to minimise infectious exposures.



Contents

- 2 President's message
- 3 News
- 4 People & Events
- 8 Letters to the editor
- 10 Health reform – the time is right
- 12 ANZCA Council Meeting reports
- 15 Awards
- 16 Training non-anaesthetist sedation practitioners – living with PS9
- 18 Surgical Safety Checklist
- 26 Accreditation and re-accreditation: core business for ANZCA
- 28 The Future of Anaesthesia part two
- 34 Anaesthetic Mortality 1985 – 2005: A report covering over 40 million anaesthetics
- 38 Quality & Safety news
- 40 Infectious diseases and the anaesthetist
- 48 Australasian Maternity Outcomes Surveillance System
- 49 New Fellow on Council
- 50 New Fellows Conference
- 52 A Rural Anaesthetist's CPD Experience
- 54 ANZCA curriculum review: your questions answered
- 57 Helping trainees to prepare for their ANZCA Final Examination
- 60 Destination Australia and New Zealand – international medical graduate specialists
- 63 The ANZCA Foundation
- 64 Library update
- 68 ANZCA Trials Group
- 70 Regions
- 75 New Zealand news
- 76 Joint Faculty of Intensive Care Medicine
- 80 In the field: Dr Penny Stewart, ICU in the Alice
- 82 Faculty of Pain Medicine
- 87 Profile: Professor Julia Fleming
- 90 ANZCA's Archives – Foundation Fellows
- 94 Obituary
- 95 Professional documents
- 98 Future meetings

President's message



One of the major aims of our College is 'to determine and maintain professional standards for the practice of anaesthesia, intensive care medicine and pain medicine in Australia and New Zealand' (clause 1.1.3, ANZCA Constitution). In this edition of the *Bulletin* we publish articles related to two major initiatives in standard setting.

Surgical Safety Checklist

The World Health Organization (WHO) checklist has been developed by an international and inter-professional group, which included Alan Merry.

This input has helped ensure that the timing of each of the three checks (time in, time out, sign out) take into account the stage of the proceeding at which sedative and/or anaesthesia drugs are administered to the patient.

Underlying the checklist is the principle that simple strategies, if well developed, can make a great contribution to making patient care safer.

ANZCA, along with RACS, RANZCOG and the New Zealand Nurses Organisation have supported the checklist, and have taken part in its launch in the Australian (Federal) and New Zealand parliaments.

This has enabled us to emphasise the College's role in standard setting, and working with other health professional groups in a collegial manner.

The checklist has been shown to be effective in hospitals and I would urge each of us to work within our hospitals to ensure its effective implementation and use. Taking an active role in the checks will reinforce our role as full members of the peri-operative/peri-procedural team. The involvement of the anaesthetist is essential, and effective use of the checklist will eliminate many of those irritants of anaesthesia life, such as ensuring that the whole team understands the anticipated procedure.

Sedation

As work on the "sedation document" (PS9) proceeds, more and more examples are becoming apparent of sedation being administered to patients in a variety of settings by a variety of health professionals with vastly different levels of training and limited recourse to profession-wide standards of practice.

Kate Leslie and Barry Baker are working with each of the relevant professional groups to develop healthcare wide standards for practice. Their progress was covered in more detail in the latest ANZCA E-Newsletter. Included in these standards are explicit directions about the level of training and qualification of the health professional administering the sedation and monitoring the patient needed for each category of patient and procedure.

The advantage of this approach is that it ensures acceptance of, and support for, the standards generated by all the involved professional groups, and emphasises our role as the experts in this area of practice.

As part of this commitment to ensuring high standards of practice, a training program in sedation for endoscopists has been developed and there is a report on this in this issue of the *Bulletin* (see page 16).

I am very grateful to the many Fellows, trainees and other experts who are involved in the development and maintenance of our standards. Without their efforts, this work would not be possible. The involvement of a wide range of Fellows helps to ensure that the standards developed are practical and able to be used in the "real world".

NZ workforce survey

With the issue of medical workforce a major focus for government and policy makers on both sides of the Tasman, medical colleges have an important role to play in ensuring Australia and New Zealand have a well-trained highly skilled workforce available in the future. Following the successful joint ANZCA/ASA study on the Australian anaesthesia workforce, work has commenced on conducting a similar study in New Zealand. I would encourage all

New Zealand Fellows and trainees to complete the online survey which has been circulated. The data will provide invaluable information assisting in our future planning.

National Pain Summit

ANZCA and the Faculty of Pain Medicine, and other organisations including the Pain Management Research Institute, the Australian Pain Society, and consumer groups such as Chronic Pain Australia, are working together to organise a National Pain Summit which will be held in 2010.

The purpose of the summit will be to elevate chronic pain as a significant issue on Australia's national health agenda. This is another example of where the College is playing a leadership role on an important health issue.

Dr Leona Wilson
President

People & Events



ANZCA's new ACT offices

The opening of ANZCA's new Australian Capital Territory offices was held on June 23 in Deakin, Canberra. Previously, ANZCA had shared offices with the Royal Australasian College of Surgeons.

Dr Stephen Brazenor (Chair of the ACT Regional Committee), Dr Leona Wilson (President, ANZCA) and Mark Cormack (Chief Executive, ACT Health) spoke at the event. Fellows, trainees and various people from the health industry were invited.

From left: Dr Mike Richards (CEO, ANZCA), Dr Stephen Brazenor (Chair of the ACT Regional Committee), Dr Leona Wilson (President, ANZCA) and Mark Cormack (Chief Executive, ACT Health); Dr Prue Martin and Dr Peter Westhofen; Fellows, trainees and staff at the opening; Dr Stephen Brazenor, Dr Grant Devine, Dr Vida Viliunas, Professor Thomas Bruessel, Dr Leona Wilson, Dr Carmel McInerney, Dr Caroline Fahey, Dr Cliff Peady and Vena Murray.





33rd Annual ANZCA/ASA Combined CME Meeting of Queensland

The 33rd Annual ANZCA/ASA Combined CME Meeting of Queensland was held on August 22, 2009 at the Queensland Turf Club in Brisbane.

“The Dabblers’ Occasional Forays into Anaesthesia for Obstetrics, Paediatrics and Trauma” meeting offered 100 anaesthetists a varied program with trends in the areas of obstetrics, paediatrics and trauma discussed.

Guest speakers were Dr Amir Zimmermann and Dr Rhonda Boyle (obstetrics), Dr Neil Paterson and Dr David Anderson (paediatrics), Dr Marc Maguire, Dr Steve Cook and Dr Alexandra Douglas (trauma).

During the day, a presentation was made by Drs Paul Cook and Jim Bradley to Dr Gavan Carroll for his 50-year membership of the Australian Society of Anaesthetists.

The Queensland combined ANZCA/ASA CME committee would like to thank the speakers and facilitators for their work in both preparing for, and participating in, the day.

From left: Dr David Anderson presenting a morning session on paediatrics; health industry displays at the meeting; Dr Genevieve Goulding speaking at the meeting; Dr Paul Cook, Dr Gavan Carroll (receiving his 50-year membership of the Australian Society of Anaesthetists certificate) and Dr Jim Bradley; Dr Gerry Turner and Dr Ken Sleeman; Dr Neil Paterson; Dr Penny Hall and Dr Melissa Goldberg.



People & Events *continued*



Anaesthesia Right Now – A Clinical Update

The 30th annual combined Continuing Medical Education meeting of the Victorian section of the ANZCA Victorian regional committee and the Australian Society of Anaesthetists was held on Saturday, July 25 at the Sofitel Melbourne. The meeting, “Anaesthesia Right Now – A Clinical Update”, was well attended with 244 delegates and 19 healthcare industry exhibitors.

The meeting focused on anaesthesia in diabetes, obesity, the extremes of life (from athletes to major cancers) and a number of important guideline updates. Speakers were drawn from the wider Australian anaesthetic fraternity.

Clockwise from top: ANZCA/ASA Combined CME Meeting July 25, 2009; Dr Rowan Thomas, Associate Professor Kate Leslie, Dr Jenny Carden and Prof Helena Teede; Dr John Moloney discussing the Black Saturday response; Dr Linda Gualano, Dr Debbie Bettenay and Dr Mandy Baric.

New Zealand National Committee hosts function for Health Minister

At the end of July, a number of internal and external meetings in Wellington brought people together from New Zealand and across the Tasman for the ANZCA and JFICM NZ National Committees' meetings. A cocktail function involving the New Zealand Health Minister, Hon. Tony Ryall, was held.

Clockwise from top: Dr Mike Gillham, Chair JFICM NZNC, Dr Brian Lewer, Chair, NZ Anaesthesia Education Committee, Hon. Tony Ryall, Minister of Health, Dr Andrew Warmington, President, NZSA and Dr Geoff Long, National Education Officer, ANZCA NZNC;

Dr Paul Hutchison, MP and Chair, Health Select Committee and Professor Alan Merry, Chair, ANZCA Quality and Safety Committee;

Dr Jonathan Fox, Chair, Council of Medical Colleges, Dr Leona Wilson, President, ANZCA and Peter Glensor, Chair, DHBNZ;

David Dunbar, Registrar, Medical Council of New Zealand, Dr Vanessa Beavis, Chair, ANZCA NZNC, Mike Richards, ANZCA CEO and Debbie Taylor, Ministry of Health.



World Congress of Total Intravenous Anaesthesia

The second World Congress of Total Intravenous Anaesthesia – TCI (TIVA-TCI 2009) was held in Berlin from April 23-25, 2009 with 656 delegates from 65 countries. There were a number of important contributions from the regions where ANZCA is represented by academic and clinical anaesthetists. These included Professors Paul Myles (Monash University), and Kate Leslie (University of Melbourne), Professors Stephan Schug (University of Western Australia), Tony Gin (Chinese University of Hong Kong), Dr Adrian Sultana (University of New South Wales) and TCI researcher and inventor Dr Charles Minto (Sydney University). Papers were also presented by Dr B. Anderson from Otago University (Auckland) and Dr GM Shaw from Canterbury University (Christchurch). Professor Michael Irwin from Hong Kong University gave a total of five presentations. World Siva will be holding a third world congress in 2011. For further information visit www.worldsiva.org

Clockwise from top: Professor Paul Myles and Associate Professor Kate Leslie with other delegates; Professor Stephan Schug and Tony Gin; Dr Adrian Sultana and his wife Pauline.



Letters to the editor



The future of anaesthesia

I am writing in support of Professor Cousins' thoughts expressed in the article "Perioperative and pain medicine" (*ANZCA Bulletin*, June). In particular, I would support the use of "anaesthesiology" and "anaesthesiologist" in preference to "anaesthesia" and "anaesthetist" (the latter being a word I struggle to pronounce myself, let alone the patients and the media). I think that the "ology" words are more likely to be perceived as being associated with "doctors" and "medical practice" as opposed to "technicians" who work for surgeons and, by implication, under the surgeon's direction. Anaesthetist may be more semantically correct as it was the term chosen by our pioneers to describe those who practise our speciality. However, it has left a legacy of confusion and as perception is important in the politics of the real world I think that a change of this nature would aid in our relations with patients, hospitals, other medical staff and also health bureaucracies and governments. I propose that we should call ourselves anaesthesiologists or even specialist anaesthesiologists (to distinguish ourselves from those general practitioners who call themselves anaesthetists) and that we rename our hospital departments as departments of anaesthesiology and Pain Medicine. A similar change could occur with the name of our college.

Dr Guy Buchanan
ACT

Australia's looming anaesthetist shortage

I would like to congratulate Dr Waldron and the workforce group on taking on this daunting task and producing a readable report ("Australia's looming anaesthetist shortage" *ANZCA Bulletin*, March). I was however disappointed at the rather alarmist headline "looming anaesthetist shortage". I was also disappointed at the rather typical subservient unimaginative anaesthetic approach to the problem, i.e. we need to generate more anaesthetists. Are things really as bad as the headline would want us to believe?

In the next 20 years the report forecasts that, even with the projected increase in the overall number of anaesthetists, we are still projected to be 2287 anaesthetists short. This equates to an additional shortfall of 114 anaesthetists every year over the next 20 years. On "eye-ball" analysis this seems a lot. It would be the equivalent of a shortage of seven Cairns departments of anaesthesia every year for the next 20 years, i.e. equivalent to 140 new Cairns Base Hospitals in the next two decades? It seems unlikely that this is the case. Where are all the additional operating theatres coming from to account for this shortage? I believe there is no need to panic. I think other issues within the report could have received more weight e.g. the urban/regional imbalance and why this should be so and remedies to address it.

If anything, rather than vaguely alarmist headlines, I would prefer to see ANZCA positioning itself on issues

such as: national population control, quality control in relation to worthwhile operations, managing surgical and ICU admissions policy, theatre management etc. It is not so much that there is a shortage of anaesthetists it is just that what "we" want to do with them is becoming boundless.

The community, with the College as a voice on these difficult matters, needs to accept that the provision of services is not and does not need to be endless. The College needs to be vocal in bringing reason to the community's expectations and aggressively defending the somewhat clichéd "there was no anaesthetist available" blame phrase to "because unnecessary procedures were being preformed elsewhere" response.

The demand for services will expand to fit the number of anaesthetists. This is akin to building a new inner city bypass – the number of cars on the road will expand to fit the road network.

Employing an anaesthetist to provide anaesthetic services for a patient who does not warrant, or will not benefit from the service provided is not a shortage of an anaesthetist – it is an over-provision of service. On any given day anyone of us could almost certainly reduce the operating list by 25% without any reduction in the community's standard of health. Reducing consumers will decrease demand.

Dr Robert Grace
Anaesthetist
Cairns Base Hospital

Health reform – the time is right

What has been put forward?

What are the implications for
the College community?

How can ANZCA Fellows
and trainees effect change?



As Fellows and trainees would be aware, the Federal Government has an ambitious policy agenda in relation to health reform.

What has been put forward?

What are the implications for the College community?

How can ANZCA Fellows and trainees effect change?

National Health and Hospitals Reform Commission Report

The final report of the National Health and Hospitals Reform Commission (NHHRC) presents a long-term vision for change, with a comprehensive list of 123 objectives. Of particular relevance to anaesthesia, intensive care and pain management are the following:

- “Ensuring timely access and safe care in hospitals” through the separation of planned from emergency treatment services.
- “Delivering better health outcomes for rural and remote communities” and expanding access to specialist outreach services.

- “Working for us: a sustainable health workforce for the future” that includes:

- A new framework for the education and training of all health professionals that is flexible, multi-disciplinary, competency based and with a dedicated funding stream for undergraduate and postgraduate students.
- The establishment of a new National Clinical Education and Training Agency to form partnerships with local universities, vocational education and training organisations and professional colleges to acquire clinical education placements from health service providers.

- “Fostering continuous learning in our health system” with increased emphasis on quality and safety. The Australian Commission for Safety and Quality in Health Care should be established as a permanent, independent national body.

National Primary Health Care Strategy

The National Primary Health Care Strategy has identified four key priority areas for action:

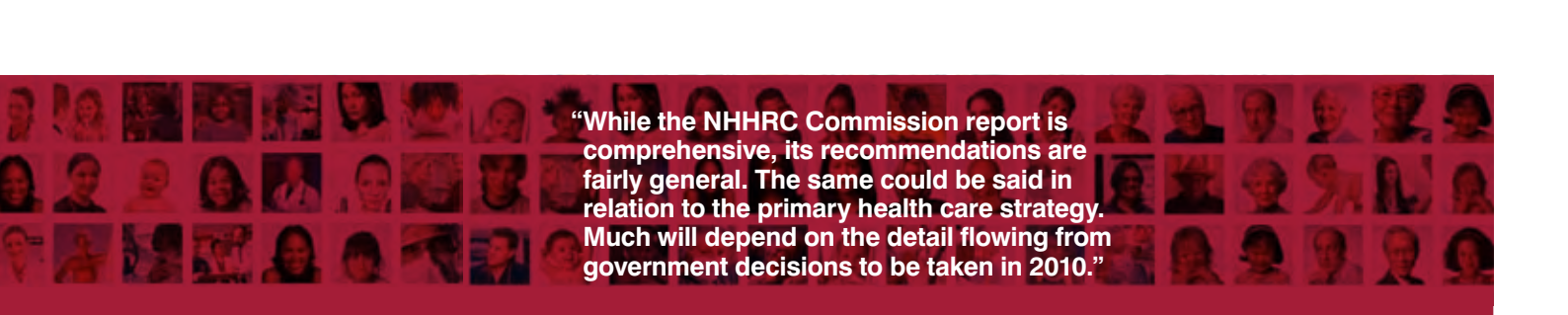
- Improving access and reducing inequity.
- Better management of chronic conditions.
- Increasing the focus on prevention.
- Improving quality, safety, performance and accountability.

National Preventative Health Strategy

The National Preventative Health Strategy, similarly, seeks to address the burden of chronic disease caused by:

- Obesity.
- Tobacco.
- Excessive alcohol consumption.

It identifies seven strategic directions, including early intervention, engaging communities, reducing inequity, and refocusing primary health care towards prevention.



“While the NHHRC Commission report is comprehensive, its recommendations are fairly general. The same could be said in relation to the primary health care strategy. Much will depend on the detail flowing from government decisions to be taken in 2010.”

Comment

The three reports set out key priorities and reform challenges for Australia’s health system. While the NHHRC report is comprehensive, its recommendations are fairly general. The same could be said in relation to the primary health care strategy.

Much will depend on the detail flowing from government decisions to be taken in 2010. ANZCA is closely analysing these reports and will be discussing various aspects of them with government over the coming months.

Each of the three reports contributes to an overarching focus on preventive health initiatives, which ANZCA strongly supports. Effective pain management has a great deal to offer in reducing the burden of chronic disease, particularly in the treatment of acute pain, in its early stages to limit the otherwise likely progression to chronic pain and disability which then contributes markedly to healthcare costs. The establishment of more integrated pain management clinics within hospitals and community health settings could secure the community substantial savings. The proposed National Pain Summit in early 2010 initiated by the Pain Management Research Institute, the Faculty of Pain Medicine, ANZCA, and other organisations will provide a useful mechanism for raising the profile of this area and delivering a workable implementation strategy.

With regard to hospitals, dedicated facilities for elective procedures, separate from emergency departments, will assist in eliminating current blockages in the system. A focus on prevention, pre and post surgery, presents opportunities for clinicians including anaesthetists to support healthy behaviours such as tackling obesity and smoking cessation. An expanded role for anaesthetists in perioperative medicine as advocated recently in the *Bulletin’s* special feature on the future of anaesthesia also deserves serious consideration.

Better networked arrangements for specialist services to support rural and remote centres will ensure improved access for the community and offer

greater diversity of experience for the health professionals concerned. Some ideas include having integrated links between rural areas and main centres with rotations of, say, a month at a time once every two to three years from the main centre to relieve the rural anaesthetists for continuing professional education or holiday relief. This could be facilitated by government support for travel expenses and/or extra staff member is in the main centre to allow systematic rotation of staff. Senior trainees could be encouraged to rotate to rural hospitals for relief and also for their own training. The development of e-learning and e-simulation will also help.

ANZCA has a bi-national networked arrangement that is of high quality and works well. We need to highlight the value of clinical teaching, ensure it is embedded as core business, and that all medical practitioners are trained to teach as they will be needed to train others. The proposed new national clinical education agency poses a risk to medical colleges as providers of postgraduate education. ANZCA needs to engage with the government to ensure the College’s education and training system - which have given Australia and New Zealand a highly trained skilled workforce at minimal cost to the taxpayer- is not placed under threat. Similarly, there is the need to ensure that the high ANZCA clinical and professional standards are maintained.

The Federal Government has indicated that over the next six months it wishes to hear first hand from the medical profession as well as other health professionals and the wider community. The Prime Minister and health minister are currently visiting hospitals across Australia, testing the ideas contained within these reports. The government is always interested in listening to innovative, evidence-informed ideas, particularly those that may help solve political challenges.

While the College has been lodging submissions throughout the review process, there is now an opportunity for anaesthetists, intensivists and pain medicine specialists to be heard directly and reinforce key messages.

Key ANZCA messages

- Ensure adequate numbers of funded medical specialist training positions to enable balanced training rotations and ensure uninterrupted continuation of specialist training
- Support existing postgraduate education provided by medical colleges which provides the community with a highly trained, skilled workforce at minimal cost
- Promote better linkages between major health services and smaller peripheral services, especially between rural and major centres to ensure equity of access to specialist services
- Provide dedicated teaching time for training in public hospitals and ensure it is firmly embedded within job descriptions
- Improve quality assurance programs in hospitals – emphasis on quality and safety initiatives
- Investigate innovative workforce approaches in relation to peri-operative medicine and health prevention to expand the reach of the profession and ensure sustainability into the future.
- Promote integrated public health programs aimed at preventing and managing chronic diseases in line with the prevention agenda and community expectations

Visit www.yourhealth.gov.au for further information on the various reports and details of the consultation schedule. You can also post comments via the website directly.

Please do contact me if you have any suggestions or you have queries concerning any of these reports. The time is right for health reform and we need to be ready to have our say.

John Biviano
Director, Policy, Quality
and Accreditation
ANZCA

ANZCA Council Meeting reports

June 2009

Report following the Council meeting of ANZCA held on June 20, 2009.

Death of Fellows

Council noted with regret the death of the following Fellows:

- Dr Robert Mercer Hart (NSW)
– FFARACS 1961, FANZCA 1992
- Dr Ian Raban McDonald (Qld)
– FFARACS 1956, FANZCA 1992
- Dr Ian Charles McGlew (WA)
– FFARACS 1970, FANZCA 1992

Honours and awards

Dr Graham Sharpe (NZ) was made an Officer of the New Zealand Order of Merit (ONZM) in the recent Queen's birthday honours list.

Education and Training Committee Trainee performance review (TPR)

Council approved a number of amendments to regulation 33 which governs the TPR process (refer appendix 1). The main addition is to Regulation 33.1.5 to allow the TPR team access to the trainee's In-training assessment (ITA) forms as required. In addition, the process will be undertaken through the office of the Director, Training and Assessments, rather than the Chief Executive Officer.

Membership of the Assessments and Workplace-Based Assessments subcommittees

Council reviewed its committee structure and composition in 2008. At this time, the size of the newly created WBA and Assessments subcommittees was restricted to eight members. This was in line with Council's general strategy of reducing the size of its committees.

As the work of the subcommittees has been in progress for over 12 months, it was considered appropriate to review these size restrictions. To enable the subcommittees to include members with suitably diverse expertise and energy to commit to their growing work, their membership has been increased to a maximum of 12.

Assessment Working Groups

The Examinations Management System Implementation Group (EMSIG) has been disbanded following completion of the implementation phase for the examinations management system (EMS).

As a result of a number of issues identified during the EMS implementation, Council supported the establishment of a Planning Group on Assessment Governance (PGAG).

The group comprises:

- Chair of Examinations
- Director of Education
- Director of Training and Assessments with a standing invitation to the Chair of the Education and Training Committee.

The group will:

- Review governance structures and undertake an evidence-based approach to the introduction of revised systems within the FANZCA training program.
- Make recommendations on the best governance approaches to preserve assessment integrity.
- Highlight areas of risk in terms of assessment security.
- Oversee the implementation of revised governance procedures.

International Medical Graduate Specialists (IMGS) Committee IMGS Performance Assessment/Final Examination

The IMGS Committee considered it would be constructive to have a regional committee-nominated Regional Education Officer (REO) type position to whom the IMGS could go for advice with regard to performance assessment and the final examination.

Quality and Safety (Q&S) Committee Mortality Working Group

The triennial report *Safety of Anaesthesia – A review of anaesthesia-related mortality reporting in Australia and New Zealand, 2003-2005* has been completed and is due for publication late July.

ACSQHC: Parenteral Medicines, Fluids and Lines Labelling Project

Prof Alan Merry was appointed as the College representative to this national project, and has since assumed the role of Chair of the working group.

ACHS: Review of EQuIP 4th Edition

Drs Joanna Sutherland and Ian Woodforth have agreed to participate in this review as NSW representatives.

Sourcing representatives for quality and safety activities

In response to a number of requests by the chair of the Q&S Committee for participation in workshops/working groups, and requests to review various documents, consideration is being given to the Q&S Committee accessing the safety officers of the regional/national committees (where they exist). The possibility of re-establishing this role in areas where they do not have such representation is also under review.

Fellowship Affairs Committee (FAC) Restructure and review of membership of FAC

A two-tier committee structure has been approved by Council, which includes the establishment of an advisory group comprising Fellows nominated by the regional/NZ committees. The core committee will deal with regular items of business of FAC, whilst meetings including the advisory group will be engaged in exercises to capture the broad range of views and key visions of Fellows and anaesthesia.

The regional/NZ committees will be contacted in due course for nominees.

Annual Scientific Meetings (ASM) Financial management of ASMs

The following recommendations were accepted by Council:

1. That while overall responsibility for the financial management of the ASM remains with Council, the day-to-day management of the ASM finances lies with ANZCA management.
2. That the role of the regional organising committee (ROC) treasurer be that of the local financial representative and thus financial management be largely undertaken by the Executive Officer, Continuing Professional Development in conjunction with the Director, Finance and Business Administration.
3. That the Director, Finance and Business Administration becomes an ex-officio member of the ROC and be involved in establishing a budget for approval by Council and be available for other meetings when there are financial issues that require high-level input.

4. That the ROC be involved with management in preparing the budget for approval by Council including recommending the level of registration fees. The budget will include all costs associated with the ASM. After the budget has been approved, the ROC will be given regular high-level financial reports.
5. That an amount in the vicinity of 1% (notionally around \$25,000 based on current ASM budgets) be in the budget for discretionary spending by the ROC to make their event distinctive and special.
6. That the ASM be budgeted to make a minimum surplus of 10%.
7. That the budgeted cost of the conference dinner be no more than \$220 per head (indexed).

Complimentary ASM registration of Fellows presenting at the College Ceremony

It has been agreed that from the 2012 ASM, Fellows presenting at the College Ceremony will be charged a fee that is 25% of full registration. This fee will include all social events at the ASM.

2012 ASM - Perth

The dates for the 2010 ASM have been confirmed for May 12-16.

Internal Affairs

Proposal for 13th International Congress of Cardiothoracic and Vascular Anaesthesia 2012

Council supported a proposal to underwrite the above meeting in Auckland as a joint venture with the New Zealand Society of Anaesthetists, the funding split being 60/40 ANZCA/NZSA. As the Australian Society of Anaesthetists has elected not to be a key stakeholder in the meeting, the nature of any involvement by the Cardiothoracic Vascular Perfusion (CVP) SIG is to be discussed.

Proposal for a Special Interest Group (SIG) in Perioperative Medicine

Council supported in principle a request from the Perioperative Medicine Working Group regarding the establishment of a SIG in perioperative medicine. An application and constitution will be put to ANZCA, ASA and NZSA for formal approval, following which, the working group will be disbanded.

Joint Faculty of Intensive Care Medicine (JFICM) separation Continuing Professional Development (CPD) for anaesthetists with Fellow of the College of Intensive Care Medicine (FCICM) who practice intensive care medicine

The College intends to continue offering intensive care medicine sessions that are relevant to its Fellows at its Annual Scientific Meeting. In addition, ANZCA intends to establish a Special Interest Group or other suitable structure for its Fellows who practice, or have an interest in, high-dependency or intensive care medicine.

College of Intensive Care Medicine (CICM) acceptance of the ANZCA primary examination

It has been proposed that a five-year moratorium on change to acceptance of the ANZCA primary towards CICM fellowship be negotiated, under the principle that no trainee should be disadvantaged by the formation of the new CICM.

Cross representation on Council

Council resolved that the CICM president (or nominee) will be invited to join the ANZCA Council as a co-opted observer.

Review of regulation 7 – subscription concessions – following CICM Formation

Council agreed that there is no longer an ideological rationale, or financial imperative, to retain subscription discounts for dual ANZCA/CICM Fellows who practice no anaesthesia, and as such, the 50% concession for dual Fellows was abolished.

It was agreed that there is a sound rationale for continuing concessions to ANZCA Fellows undertaking CICM training, and it was agreed that concession 11 would be expanded to other specialist medical Colleges/faculties.

Reference to ‘intensive care medicine’ has been retained in categories 3 and 7 as intensive care medicine is still within the scope of practice of some ANZCA Fellows. Its reference has been removed from category 10.

The updated regulation 7 is appendix 2 which can be found at www.anzca.edu.au in the news section under Council reports.

Research

ANZCA Foundation

The ANZCA Foundation’s “Purpose, Objective and 10 Research Challenges” has been approved by Council (refer appendix 3).

College Award

ANZCA Council citation

Professor Tess Cramond was awarded a Council citation as a result of a nomination from the Queensland Regional Committee. The award is in recognition of Professor Cramond’s contributions to training and education in anaesthesia and pain medicine over many years in Queensland, and will be presented to her by the chair of the regional committee at a mutually agreeable time.

New Programs Committee

Diving and hyperbaric medicine (DHM)

The College offers a program of training in diving and hyperbaric medicine. After 12 months in training positions the candidates can sit an examination comprising of 10 Short Answer Questions (SAQs) (five in hyperbaric medicine and five in diving medicine), and two times ten minute vivas (one in hyperbaric medicine and one in diving medicine) with two examiners. The examination is held when there are two or more candidates.

At a recent program inspection, the trainees identified the need for example questions to guide their study. In response to this, Council resolved that examples of short answer questions and viva stems should be made available for DHM examination candidates. The examination coordinator, Dr Robert Wong, will oversee the published questions.

Dr Leona Wilson

President

A/Prof Kate Leslie

Vice-President

The appendices to the Council Meeting reports can be found at www.anzca.edu.au in the news section under Council reports.

ANZCA Council Meeting reports

Continued

August 2009

Report following the Council Meeting of the Australian and New Zealand College of Anaesthetists held on 15th August 2009

A half-day Council meeting was held in August to provide time for a strategy planning session in the afternoon.

Death of Fellow

Council noted with regret the death of Dr Jean Oakes (Tas), MFARACS 1952, FFARACS 1961, FANZCA 1992, during a recent visit to London.

Education and Training Committee Deputy Chair

A/Prof David Scott has been appointed to the position of Deputy Chair of the ETC.

ANZCA Training Scholarships

It has been agreed that the application form for these scholarships will be modified to clarify that if the financial circumstances of a recipient improve during the training year for which the scholarship is awarded, they must notify the College. In such cases, the application will be reviewed and the recipient may be requested to relinquish all or part of the scholarship.

Educational Stream at the Annual Scientific Meeting

As part of the re-design of teacher development and support activities, Council supported the provision of an educational stream at each ASM, commencing from 2010. It is proposed that the 2010 ASM educational activities will be confined to the launch of the curriculum review recommendations, along with the commencement of curriculum re-writing activities, and delivery of Clinical Teacher Course modules. Activities from 2011 will be negotiated via the relevant committees. Ongoing evaluation of the program will be undertaken to ensure it evolves in accordance with the educational needs of Fellows and Trainees, and remains aligned with the aims of the ASM and EDU.

Diving and Hyperbaric Medicine Examination

It has been agreed that examples of short answer questions and viva stems will be made available to candidates for the DHM examination.

Fellowship Affairs Committee

Annual Scientific Meetings 2010 ASM – Timing of Annual General Meeting

The AGM in Christchurch will be held at 5pm on Sunday 2nd May.

2012 ASM – Regional Organising Committee

Membership of the ROC for the 2012 ASM in Perth has been approved as follows:

Co-Convenors:	Drs Tanya Farrell and Dave Vyse
Treasurer:	Dr Tanya Farrell
Scientific Convenors:	Prof Michael Paech; & Dr Tom Corcoran
ASM Officer (ex officio):	Dr Richard Waldron
Council Liaison:	Dr Lindy Roberts
Health Care Industry Liaison:	Dr Denise Yim
Social Convenors:	Drs Charlotte Jorgensen and Priya Thalayasingam

Scientific appointments:

FPM:	TBA
Workshop Convenors:	Drs Soo Im Lim and Suzanne Bertrand
PBLD Convenor:	Dr Markus Schmidt
New Fellows Conference:	Drs Irina Kurowski and Angie Lee

2010 New Fellows' Conference

The NFC will be held at the Heritage Hotel, Hanmer Springs, approximately 90 minutes from Christchurch. The theme of the Conference is 'Adventure and Anaesthesia', and Dr Karen Ryan is Convenor.

Closing Date for NFC Applications

It has been agreed that the closing date for applications to the Regional/National Committees for the New Fellows' Conference will be changed from 31 December to 31 October each year. This will allow the Committees two months to meet and submit nominations by 1 January for approval at the February Council meeting.

Internal Affairs

ANZCA Representatives to External Organisations

Dr Nolan McDonnell has been nominated as the ANZCA Representative to the Advisory Committee of the Australian Maternity Outcomes Surveillance System (AMOSS).

Dr Michael Cooper has been appointed College representative to the RACS International Aid Symposium.

Research

ANZCA (Monash University) Research Fellow

Naming rights have been granted to Prof Paul Myles to use the title ANZCA (Monash University) Research Fellow for the research fellow position at the Alfred Hospital. Use of the title will be limited to a period of three years, with annual review by the ANZCA Trials Group Executive. There will be a requirement for re-application at the end of this three-year term.

The incumbent will be required to undertake research based in Australia and New Zealand, to assist with the promotion of research consistent with the objectives of the ANZCA Trials Group, Research Committee, and Foundation, and to present research outcomes at a suitable ANZCA scientific meeting.

A policy on ANZCA Research Fellows, consistent with the principles and obligations referred to above, is to be formalised through the ANZCA Trials Group Executive.

National Pain Summit 2010

Council has agreed to provide administrative and financial support of up to \$85,000 for the summit to be held in Canberra in March next year.

Dr Leona Wilson
President

A/Prof Kate Leslie
Vice-President

Queen's Birthday honour for Dr Graham Sharpe



Dr Graham Sharpe, FANZCA, was appointed as an Officer of the New Zealand Order of Merit (ONZM) in the Queen's Birthday honours on June 1 for his services to anaesthesia. Dr Sharpe has contributed extensively to obstetric and paediatric anaesthesia in New Zealand for more than 25 years. Dr Sharpe is the immediate past president of the New Zealand Society of Anaesthetists and works at both Wellington Hospital and in private practice.

New Zealand Society of Anaesthetists president, Dr Andrew Warmington, said Dr Sharpe "understands the value of teamwork and the importance of good communication among his peers and with women and babies under his care. I hope this honour is, in some small way, recognition for all the hours of out-of-hours and on-call work that go into delivering good and compassionate patient care."

Training non-anaesthetist sedation practitioners – living with PS9

Introduction

Gastrointestinal endoscopy is one of the most commonly performed medical procedures in Australia and New Zealand, and the number of procedures is growing rapidly. Much of the sedation for endoscopy is administered by anaesthetists, but when access to anaesthetists is limited, other medical practitioners are called upon to provide sedation. In this article, we will discuss recent initiatives by the College to improve the quality of endoscopy sedation and ensure safe practice wherever endoscopy is performed.

Background

Access to specialist anaesthesia services for endoscopy patients in NSW public hospitals has been a longstanding problem. The issue was highlighted by the Greater Metropolitan Clinical Taskforce (GMCT) in 2006 and a working party was established which included representation from the NSW Regional Committee of ANZCA. The working party agreed that the “gold standard” for endoscopy sedation was an anaesthetist-based service, and that propofol-based sedation resulted in improved patient comfort, safety and efficiency. It was also acknowledged that some gastroenterologists and surgeons on the working party had considerable experience in endoscopy sedation, including the use of propofol, and that endoscopist-administered propofol-based sedation was common in the US and Europe.

At the same time, ANZCA, the Gastroenterological Society of Australia (GESA) and the Royal Australasian College of Surgeons (RACS) (the “tripartite group”) were collaborating in a review of ANZCA Professional Document PS9: “*Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical or Surgical Procedures*”. The revised document was promulgated in February 2008. The document recognises the reality that practitioners with diverse qualifications and training are administering a variety of medications, including propofol, to facilitate endoscopy. The document limits the use of propofol by non-anaesthetist medical practitioners to ASA 1-3 patients



who are suitable for conscious sedation. The document requires non-anaesthetist medical practitioners who wish to administer sedation to acquire airway and resuscitation skills and to undertake training in sedation.

The Sedation Training Working Group

After the revised PS9 was promulgated, the core representatives of the GMCT-based working party and the tripartite group formed a working group to investigate the training requirements for non-anaesthetists who wished to provide sedation (including the use of propofol). This working group was chaired by Professor Barry Baker (ANZCA Director of Professional Affairs) and included Associate Professor Kate Leslie (ANZCA Vice President), Drs Joanna Sutherland and Tracey Tay (ANZCA NSW Regional Committee members) and representatives from GESA and RACS.

The working group decided to concentrate its initial efforts on those endoscopists who had administered sedation to at least 1000 patients (so-called “grandfathers”). Over a series of meetings and after review of the available literature for such training processes, the working group agreed on the course curriculum, identified available training resources, described appropriate practical experience and supervision, and devised a method of “sign-off” for these practitioners. Curriculum criteria that were identified as essential included: patient assessment (particularly when to

refer to an anaesthetist), pharmacology (particularly the sedation continuum), monitoring (including sedation depth), management of complications, advanced life support (including airway and ventilation skills), recovery and discharge criteria, and quality assurance. PS9 was used to underpin all curriculum objectives. The working group was supported in this endeavour by the governing bodies of each member of the tripartite group and the GMCT who provided administrative assistance and a seeding grant.

The sedation course for “grandfathers”

The inaugural two-day pilot course was held at the Hunter New England Simulation and Skills Centre (HNESSC) in May 2009, under the direction of Dr Cate McIntosh. Nine experienced gastroenterologists from six metropolitan Sydney teaching hospitals attended the course. The course included background reading relating to basic pharmacology, airway management, oxygen therapy, pulse oximetry and advanced life support, and two days of intensive problem-based learning and “hands-on” training in a simulated environment. On day two, the gastroenterologists were joined by their nursing colleagues to participate in immersive simulation-based team training, which focused on the management of the complications of sedation (as specified in PS9). The feedback from the course was overwhelmingly positive: the participating gastroenterologists believed



that such simulation-based training for sedation should be a core part of gastroenterology training in the future.

Post-course oversight and sign-off

After completion of the pilot course, the “grandfather” gastroenterologists agreed to participate in a process of oversight by the departments of anaesthesia within their own hospitals. A mini-CEX assessment tool was developed, based on PS9, allowing for assessment by more than one observer, and on a number of occasions. By August 2009, at least four of the “grandfather” gastroenterologists had commenced the final process of oversight, leading to assessment and sign-off.

The future

A second training course at the HNESSC is scheduled for September 2009, and eight gastroenterologists have enrolled. It is anticipated that there will be ongoing demand for similar courses in NSW, for trainees in gastroenterology and possibly surgery. ANZCA Council will shortly review the governance arrangement for curriculum development and delivery, clinical practice oversight and supervision, assessment and continuing professional development criteria for

sedation practitioners. Other implications of PS9 are yet to be addressed, particularly the need to train non-medical personnel who are assisting in the provision and monitoring of sedation.

ANZCA Council is aware of other areas where non-anaesthetist medical practitioners are administering sedation and Council delegates are in discussion with other groups with the aim of setting a uniform standard for safe and high quality sedation for all patients. It is anticipated that PS9 will ultimately underpin all sedation practice, and that anaesthetists, through ANZCA, will provide leadership through training and oversight for this activity.

Dr Joanna Sutherland
Coffs Harbour Health Campus

Dr Cate McIntosh
John Hunter Hospital,
Newcastle

1. ANZCA Professional Document PS9: Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical or Surgical Procedures: www.anzca.edu.au/resources/professional-documents/professional-standards/ps9.html

From left: Day 1 – course participants involved in problem-based learning discussion based on sedation complications; Course participant Dr Cameron Bell with Dr Cate McIntosh; ACLS – “hands on” team training.

Surgical Safety Checklist



World Health Organization

Surgical Safety Checklist launched in Australia and New Zealand

What it means

Frequently asked questions

International action

SIGN IN

- PATIENT HAS CONFIRMED
 - IDENTITY
 - SITE
 - PROCEDURE
 - CONSENT

- SITE MARKED/NOT APPLICABLE

- ANAESTHESIA SAFETY CHECK COMPLETED

- PULSE OXIMETER ON PATIENT AND FUNCTIONING

DOES PATIENT HAVE A :

KNOWN ALLERGY?

- NO
- YES

DIFFICULT AIRWAY/ASPIRATION RISK?

- NO
- YES, AND EQUIPMENT/ASSISTANCE AVAILABLE

RISK OF >500ML BLOOD LOSS (7ML/KG IN CHILDREN)?

- NO
- YES, AND ADEQUATE INTRAVENOUS ACCESS AND FLUIDS PLANNED

PROSTHESIS/SPECIAL EQUIPMENT:

IF PROSTHESIS (OR SPECIAL EQUIPMENT) IS TO BE USED IN THEATRE, HAS IT BEEN CHECKED AND CONFIRMED?

- YES
- NOT APPLICABLE

TIME OUT

- CONFIRM ALL TEAM MEMBERS HAVE INTRODUCED THEMSELVES BY NAME AND ROLE

- SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE VERBALLY CONFIRM
 - PATIENT
 - SITE
 - PROCEDURE

ANTICIPATED CRITICAL EVENTS

- SURGEONS REVIEWS: WHAT ARE THE CRITICAL OR UNEXPECTED STEPS, OPERATIVE DURATION, ANTICIPATED BLOOD LOSS?

- ANAESTHESIA TEAM REVIEWS: ARE THERE ANY PATIENT-SPECIFIC CONCERNS?

- NURSING TEAM REVIEWS: HAS STERILITY (INCLUDING INDICATOR OR RESULTS) BEEN CONFIRMED? ARE THERE EQUIPMENT ISSUES OR ANY CONCERNS?

HAS ANTIBIOTIC PROPHYLAXIS BEEN GIVEN WITHIN THE LAST 60 MINUTES?

- YES
- NOT APPLICABLE

HAS THROMBOPROPHYLAXIS BEEN ORDERED?

- YES
- NOT REQUIRED

IS ESSENTIAL IMAGING DISPLAYED?

- YES
- NOT APPLICABLE

SIGN OUT

NURSE VERBALLY CONFIRMS WITH THE TEAM:

- THE NAME OF THE PROCEDURE RECORDED
- THAT INSTRUMENT, SPONGE, NEEDLE AND OTHER COUNTS ARE CORRECT

- HOW THE SPECIMEN IS LABELLED (INCLUDING PATIENT NAME)

- WHETHER THERE ARE ANY EQUIPMENT PROBLEMS TO BE ADDRESSED

- SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE REVIEW THE KEY CONCERNS FOR RECOVERY AND MANAGEMENT OF THIS PATIENT

✓ Governments and health groups support safety initiative

The World Health Organization's (WHO) Surgical Safety Checklist was launched in Australia and New Zealand during August. In Australia, the launch was held at Parliament House, Canberra on August 19 involving the Federal Minister of Health, Nicola Roxon and was well attended by representatives of anaesthesia, surgery, perioperative nursing, obstetrics and gynaecology, the Australian Commission on Safety and Quality in Healthcare, and others. In New Zealand, the checklist was launched in New Zealand's Parliament by the Minister of Health, Tony Ryall, on August 27 and was supported by medical groups including anaesthetists, surgeons, obstetricians, ophthalmologists, gastroenterologists, and organisations including the Ministry of Health and the Health and Disability Commission.

Australia



From top: Professor Alan Merry and Federal Health Minister, Nicola Roxon; President of RACS Professor Ian Gough with Nicola Roxon and former Australian Medical Association President Dr Mukesh Haikerwal; Robyn Lawson, ACORN, James Harrison IFPN, and members of ANZCA's Quality and Safety Committee, Dr Margie Cowling and Dr Pat Mackay.

New Zealand



From top: Ian Civil, RACS, Tony Ryall, the Minister of Health, and Professor Alan Merry, Chair ANZCA Quality and Safety Committee; Dr Vanessa Beavis, New Zealand National Committee and Dr Malcolm Futter, Wellington Hospital; Bronwen Evans, NZ Association of General Surgeons; Christine Jackson, NZ College of Midwives; Cameron McIver, NZ Medical Association; Leigh Anderson, and Ali Fraser, Perioperative Nurses College of the NZ Nurse Organisation.

✓ Ministerial speeches in Australia and New Zealand (edited extracts)



“Initiatives like this surgical checklist will no doubt add to the quality of care patients receive in our hospitals.”
Nicola Roxon

Australia

The Lancet in 2004 observed that: “The greatest opportunity to improve outcomes for patients over the next quarter century would probably come not from discovering new treatments but from learning how to deliver existing effective therapies...”

Effective and potentially life saving – the Surgical Safety Checklist is a safeguard that will improve the quality of care for Australian patients. The checklist will provide clinicians with a standardised series of questions to minimise “adverse events”. Minimising avoidable injury and death will reduce the human cost of hospital errors and have a major impact on not just the financial cost of readmissions and longer hospital stays...

The Rudd Government is road testing the findings of the National Health and Hospitals Reform Commission. The report observes that the number of avoidable adverse events occurring each year in Australia was “equivalent to 13 jumbo jets crashing and killing all 350 passengers on board”.

This is an astounding finding. Australia has more than 700 public hospitals admitting 4.7 million patients each year – including around 900,000 surgical procedures. So the scope to avoid injury and patient deaths – that is to reduce the human costs to real people with real lives and real families – is potentially huge.

What it does tell us is that there are systems improvements that can be put in place which would not only improve the health and safety of patients, but also make immense savings to the cost of the health system.

Initiatives like this surgical checklist will no doubt add to the quality of care patients receive in our hospitals.

The checklist, adapted for Australian conditions, demonstrates that there are systems improvements that cannot just produce better patient outcomes, but quite literally save lives. Systemic improvements, including the widespread use of the checklist, will mean that Australians can have increased confidence in the health system and the quality of their care.

Hon. Nicola Roxon MP
Minister for Health and Ageing
Australia



“Doctors and nurses suffer perpetual information overload – it is increasingly harder for one person to remember everything, or for a large team to be sure they have everything covered in a high stakes situation such as surgery.” Tony Ryall

New Zealand

In health we are very good at setting up systems when something has gone wrong and to investigate the causes. What we're not so good at yet is spending the time to avoid making the mistakes in the first place...

Doctors and nurses suffer perpetual information overload – it is increasingly harder for one person to remember everything, or for a large team to be sure they have everything covered in a high stakes situation such as surgery.

The Ministerial Review Report suggests that in New Zealand there are substantial human and financial costs associated with medical error. Most patients receive good care most of the time. However, the report estimates 44,000 people admitted to hospital suffer an unintended injury caused in the management of their conditions, rather than the underlying disease – this is a similar rate to other countries. If we can improve quality and safety even 20% of this it will significantly improve the lives of those patients...The checklist has a strong focus on teamwork and communication in the operating room, because increased teamwork in surgery has been linked to improved surgical outcomes and significantly reduced rates of adverse events. But the main role of the checklist is simply to ensure thoroughness and consistency – that all necessary steps are completed, all the time... It is such a simple improvement, yet it has such a significant effect, providing better outcomes, and less time in hospital for patients at effectively no cost to the health systems involved. I strongly encourage all clinicians with the support of their managers and Colleges to adopt the Surgical Safety Checklist in their hospitals.

Hon. Tony Ryall MP
Minister of Health
New Zealand



Checklist will save lives

Professor Alan Merry ONZM

The World Health Organization Surgical Safety Checklist was initiated in response to two things. First, recognition of the previously underestimated importance of surgery to the overall health of any nation, and therefore of the world. Second, concern over the ongoing problem of iatrogenic harm particularly in surgery.

It is simply unacceptable that patients continue to be harmed by the procedures designed to help them, and although these events are infrequent, the volume of surgery is high, so the problem is very important.

It took less than half a day for the clinical experts on patient safety assembled at the WHO headquarters in Geneva to identify teamwork as the pivotal issue for safer surgery. Adequate access to skilled surgeons is, of course, essential for safe surgery, but properly trained and skilled anaesthetists are also essential and so are skilled peri-operative nurses. Furthermore, these clinicians actually need to talk to each other.

And they need to adopt the established tools of process engineering to bring the reliability of the operating room to the six-sigma standard of safety expected of other high-stakes organisations in the 21st century. It is therefore hugely gratifying that the this checklist has the support of all the key clinicians – surgeons, anaesthetists and nurses. It also has the endorsement of important organisations whose role it is to support clinicians in their pursuit of patient safety, such as the Quality Improvement Committee in New Zealand and the Australian Commission on Safety and Quality.

The checklist extends previous initiatives, such as “timeout” by its three-phase approach and by its emphasis on communication and teamwork, so it was appropriate that its launch included all those who will be important in its implementation. It was developed through an extensive process of evidence-based inter-professional collaboration by the WHO as part of the Second Global Challenge, under the auspices of the World Alliance for Patient Safety. In a pilot study across eight centres internationally, its implementation significantly and substantially improved compliance with a number of basic safety processes and reduced iatrogenic harm, resulting in a lowering of mortality and morbidity.¹ A number of important pre-anaesthetic checks have been established by organisations such as ANZCA for many years. The checklist simply consolidates, reinforces and formalises these procedures. It is a very simple clinical tool that will

have an enormous impact on how medical teams prevent mishaps and their associated complications. More importantly, it will save lives. The checklist has been modified for use in Australia and New Zealand in a collaborative process that included ANZCA. These modifications, in fact, are limited to three additional checks, relevant to practice in this part of the world. It should now be adopted by all hospitals everywhere.

Benefit from the checklist will only occur if all members of the operating team make the effort to use it appropriately. This implies stopping briefly in the processes of surgery and anaesthesia to go through the relevant checks together. If the time is not right, because of pressure to care for a patient, the right thing to do is to ask if the person administering the list can wait, and then do it as soon as one is sensibly able. Errors and omissions in the process of perioperative care need to be identified before patients are anaesthetised, not after. Thus success will depend on the engagement of all concerned. There may be some practitioners who think either that these checks are not necessary for them, only for others. There may also be some who think the list is primarily for surgeons, not for anaesthetists.

In fact, bad mistakes may be uncommon, but they can happen to anyone and occasionally these are serious. The checklist had substantial input from anaesthetists into its development and at each stage explicitly deals with risks of direct relevance to anaesthetists, as well as to others. Finally, all of us are responsible for safety, even if the issue is primarily within the domains of surgery or nursing.

Implementation of the checklist provides an opportunity for leadership from anaesthetists. We have an enviable reputation for leading the patient safety movement. We should set the example and make sure this checklist is used to reduce avoidable patient harm to an absolute minimum.

Professor Alan Merry ONZM

Head of Department of Anaesthesiology
Faculty of Medical and Health Sciences
University of Auckland
Chairman, ANZCA Quality
and Safety Committee

Professor Merry was Principal Investigator at Auckland City Hospital for the World Health Organization study.

1. Haynes AB, Weiser TG, Berry WR, et al. A surgical safety checklist to reduce morbidity and mortality in a global population. *New England Journal of Medicine*. 2009;360(5):491-9.

“It is a very simple clinical tool that will have an enormous impact on how medical teams prevent mishaps and their associated complications. More importantly, it will save lives.”

Snapshot

- Internationally, an estimated 234 million operations are performed annually.
- The World Health Organization’s global study involved almost 8000 patients at eight sites around the world including Auckland, Toronto, New Dehli, Manila and London.
- The study found that death rates for surgical patients was 1.5% before the checklist was introduced and fell to 0.8% after its introduction
- Inpatient complications fell from 11% of cases to 7% after.
- The results were published in *The New England Journal of Medicine* in January this year.
- The Checklist takes place in three phases: before induction of anaesthesia; before the first incision; and before the patient is taken from the operating theatre.
- Takes two minutes to complete and involves no additional expense to the hospital or patient.
- To date, more than 300 professional societies, health organisations, ministries, and NGOs have endorsed the concept of the Safe Surgery Saves Lives Program.



Still images from the World Health Organization website video showing the checklist in action.

✓ Implementation – frequently asked questions

Q: Don't hospitals already use checklists?

A: Many hospitals already do have checklists in place, but their consistent use is dismayingly variable. Many developed settings perform a "Time Out" where the team confirms the patient identity, procedure, and site of operation. Teams are using this time to perform and expand briefing, but this has never been elaborated to the extent that the Safe Surgery Saves Lives project has done.

Q: My hospital is quite large with many operating rooms. How can I implement a checklist in this environment?

A: The key to successful implementation is to start small. Start with a single operating room on one day and see how it works. This will guide you to strategies for altering the checklist to your needs, as well as identify potential barriers to adaptation.

Q: My team often stays together for the whole day. Must we introduce ourselves before every surgery?

A: The most critical time for introductions is at the beginning of the operative day. There is no need to repeat introductions if they have already been made. However, if new members join a room, they should introduce themselves as should every member of the team present. Even if everyone knows each other, introductions are important as they serve to reinforce team communication.

Q: Who should be in charge of running the checklist?

A: Although every member of the operating team – surgeons, anaesthetists, nurses, technicians, and other operating room personnel – is involved in its execution, a single person should be responsible for leading the discussion of all components of the checklist and is essential to its success. This will often be a circulating nurse, but it can be any clinician or healthcare professional participating in the operation. This individual can and should prevent the team from progressing to the next phase of the operation until each step is satisfactorily addressed.

Q: We are already busy in the operating room. Isn't this just one more task using up valuable time?

A: Once the checklist has become familiar to the operating teams, it requires very little extra time to perform. Most of the steps are incorporated into existing workflow and the remainder will add only one or two minutes to the OR time. However, the checklist can also save time ensuring better coordination between the teams, minimising slowdowns for tasks like retrieval or additional equipment.

Source: World Health Organization 2009.
For further information: www.who.int/en



✓ International perspective



“For some the introduction of the checklist will be liberating, others will find it constraining, irritating or even embarrassing. Whatever our individual feelings, as senior clinicians we need to lead it and accept that we need to adapt some of our own individual concepts to this uniform approach.”

The following is an edited extract of an article by two British anaesthetists that appeared the August 2009 edition of Anaesthesia News.

The way we practise anaesthesia varies considerably.

As individual anaesthetists we are different in terms of personality and behaviour and have all developed habits through experience that we believe keep our patients safe.

One of the authors routinely performs an audible “ABC” check prior to transfer to theatre. This resulted from two cases of anaphylaxis that presented on transfer to the operating table.

Another colleague religiously checks the bag of fluid that the ODP has set up following experience of a fatal mishap. Some colleagues swear by precise combinations of drugs, others do not.

New trainees to the specialty are often confused by the different approaches to anaesthesia, believing, for example, that the precise choice of atracurium or rocuronium insisted on by two different seniors is a major issue, whereas in reality it is not. Surgeons are the same.

Each of us has adapted a way of working that fits our personality and our approach to patients. All of us feel that

our way of doing things is best, but we should concede that despite this, we are all vulnerable to error.

Some parts of our practice have been tightly regulated, such as the AAGBI “Anaesthesia machine check” and drug labelling, but up till now, regulation has featured relatively little in the details of our day-to-day practice.

In contrast, theatre nursing care has developed using systems and is much more constrained by rules, with few of the freedoms that medical clinicians can adopt. There are some benefits to this approach. As an example, final counts are performed routinely in every operation and have reduced the incidence of retained swabs and instruments dramatically. Antithrombotic measures, which are more of a medical responsibility, do not enjoy this thoroughness.

Our hospital practice has become increasingly pressurised. Patients arrive on the day of surgery, lists change order at the last minute as beds and equipment are located, and lists and teams move location to ensure maximum theatre efficiency. The luxury of working consistently with the same team, with the easy familiarity and comfort of your collected wisdom and practices, is becoming less common.

In anaesthesia care, factors crucial for patient safety include checking the anaesthesia equipment before use, prediction of airway problems and appropriate preparation for major haemorrhage.

In surgery, it is obviously essential to check that the correct operation is to be performed as well as discuss issues of concern with the rest of the team. Allergies must be confirmed preoperatively.

The checklist also considers human factors by ensuring that everyone in theatre has been introduced to each other. Quite why this is not routine already is interesting, as in any social situation we introduce ourselves to each other. However in theatre, the hierarchy that exists prevents some team members from contributing in a meaningful way, as they are not acknowledged as having an identity or role by the leaders. No sports captain would play a match without knowing everyone in the team - and they are only playing a game!

We believe that a standard approach to operating theatre safety such as the WHO checklist makes sense. We need to adopt a culture in our operating theatres to ensure that the patient remains at the centre.

The checklist takes little time, can be performed consistently in every operating theatre by every team, and everyone knows what is expected of them, from consultant to trainee. Local adaptation is encouraged and should allow us to express our individual personalities and safety behaviours.

For some, the introduction of the checklist will be liberating, others will find it constraining, irritating or even embarrassing. Whatever our individual feelings, as senior clinicians we need to lead it and accept that we need to adapt some of our own individual concepts to this uniform approach.

We must not abrogate leadership to trainees and nurses, or the resulting complacency will render the intervention meaningless. Paradoxically, since the checklist is simple and not expensive, it may be underestimated in its potential. However, a recent publication in the *New England Journal of Medicine* demonstrated reduced rates of complication, re-operations and mortality in eight pilot sites in different economic settings from around the world.

Is the WHO Checklist easy to introduce? No, not at all. What are the barriers? Ourselves. Change is difficult and teams need to understand why they are using the checklist. Simply putting a poster on the wall or mandating multiple ticks on a sheet of paper will not change culture.

Form a working group with representative anaesthetists, surgeons, theatre and ward nurses, theatre manager, ODPs and trainees. Start in one theatre with some enthusiasts and trial the checklist with one team.

Modify the checklist to suit your practice – it should not interfere with the normal flow of work in theatre. Resist the temptation to add too much to the checklist – “ticket, money, passport” is the final check you need to do to catch your flight – anything else gets unnecessarily complex.

Involve the theatre practice educators. They are the natural link to the wards, and the checklist often highlights issues that are occurring “upstream” on the wards – final ward checks not completed, surgical site marking not being performed.

Allow the checklist to become embedded in practice in one theatre: the subsequent rollout to other theatres becomes much easier.

Listen to concerns – individuals will often have good feedback and ideas. In Great Ormond Street Hospital we realised that the checklist would not work for us without a team brief at the start of the list to plan the day.

Identify resistance to the introduction of the checklist by taking part. Nurses will help maintain the change in practice, but they need support and will find it difficult to drive the change. This is a team responsibility. Recognise that a consultant who holds an unrelated conversation whilst the checks are being made is sending out a very negative message about safety.

Measure the impact of the checklist to inform your clinical governance group. A basic requirement is to be able to demonstrate that the checklist was used. More powerful is an audit of ‘glitches’ that occur – anything that delays the list, or omissions picked up by the checklist. If possible, measure your critical incident and surgical site infection rate before and after introduction of the checklist – often easier said than done. The Patient Safety First Campaign has some useful advice (www.patientsafetyfirst.nhs.uk/).

We believe the checklist should be led by the senior members of the team in theatre – usually the consultant surgeon and anaesthetist. In Exeter these checks are performed as a series of questions and answers between the surgeon and anaesthetist – “Could you confirm what operation you are doing?” – “I confirm, I am doing a left nephrectomy...” Beware of complacency resulting in the checklist becoming a tick box exercise that has to be completed, rather than a tool for patient safety.

Isabeau Walker

Consultant Anaesthetist, Great Ormond Street Hospital

Iain Wilson

Consultant Anaesthetist, Exeter

Source: Anaesthesia News, No 265 August 2009. Reproduced with permission.

“Is the WHO Checklist easy to introduce? No, not at all. What are the barriers? Ourselves. Change is difficult and teams need to understand why they are using the Checklist. Simply putting a poster on the wall or mandating multiple ticks on a sheet of paper will not change culture.”

Accreditation and re-accreditation: core business for ANZCA

by Associate Professor Kate Leslie
Chair, ANZCA Training Accreditation Committee



Bundaberg Hospital – latest site to be accredited for training

The Department of Anaesthesia at the Bundaberg Hospital is the latest site to be accredited for ANZCA training and will be incorporated into the Queensland anaesthesia rotational training scheme from 2010.

Dr Morne Treblanche, Director of Anaesthesia, leads an enthusiastic team of specialists who cover a busy and varied workload that includes general and sub-specialty surgery, trauma, obstetrics, intensive care, and acute and chronic pain services.

When they visited Bundaberg in June 2009, Dr Mark Gibbs, Dr Richard Willis and Associate Professor Kate Leslie were impressed with the commitment of the department and management to providing high quality training and education.

Supervisor of Training, Dr Julia Groves, is gearing up orientation and primary examination teaching programs for trainees, and through the hospital's videoconferencing facilities, trainees and specialists can participate in the College's distance education activities.

Rural hospitals are a vital part of ANZCA's rotational training schemes and the College is keen to assist more rural hospitals in gaining approval for anaesthesia training.

Training department accreditation

Accreditation and re-accreditation of training facilities is core business for the College. Our mission is to ensure that high-quality training environments are available for ANZCA trainees and that specialists are properly supported in their clinical, teaching and administrative roles.

Governance and management

The process is governed by the Training Accreditation Committee (TAC):

- Associate Professor Kate Leslie (Chair)
- Dr Lindy Roberts (Chair, Education and Training Committee)
- Dr Stuart Henderson (Director of Professional Affairs, Assessor)
- Dr Jeremy Brammer (ANZCA Trainee Committee Representative)
- Mrs Susan Sherson (Community Representative)
- Dr Kerry Brandis (Councillor)
- Dr Frank Moloney (Councillor)
- Dr Richard Waldron (Councillor)
- Dr Mark Gibbs (Fellow)
- Dr Alastair McGeorge (Fellow)

TAC meets three times a year at ANZCA House in Melbourne, and additionally by teleconference to consider urgent matters. Our main job is to consider accreditation visit reports and compliance letters, but we are also conducting a series of strategic projects looking at accrediting retrieval services, training in the private and rural sectors and improving accreditation processes.

TAC liaises with the accreditation units of the Faculty of Pain Medicine and the Joint Faculty of Intensive Care Medicine, as well as the ANZCA Education and Training Committee, and ultimately reports to ANZCA Council.

Accreditation is managed through the Policy and Accreditation unit of the College. Janet Devlin, Accreditation Administrative Officer, has ably handled the day-to-day running of accreditation for more than 10 years. With more than 150 training sites, each re-accredited on a seven-yearly cycle, it's a big job! Janet liaises with hospitals about up-coming inspections, coordinates the inspection teams, distributes and collects all the documentation, and then assists the TAC chair with correspondence and minutes. Janet also skilfully fields numerous enquiries from departments and trainees about accreditation.

The inspection process

Following approval of the annual inspection timetable, departments are contacted to schedule a date for the inspection. We try to select a date when the maximum number of specialists and trainees will be present.

The department then completes an on-line datasheet that includes details of the staffing and workload of the hospital, the hospital's compliance with the College's professional documents, and the educational programs provided. Trainees are invited to complete a four-week workload survey that summarises the in- and out-of-hours workload and the level of supervision. They also complete an anonymous on-line survey that captures their opinions about the workload, supervision, teaching and exam preparation provided at the hospital. Along with the report from the previous inspection, these documents are forwarded to the inspectors prior to the visit.

ANZCA's accreditation inspectors undergo training in interviewing and TAC processes at one of our annual training days. The groups of inspectors includes current and retired Councillors, senior Fellows and representatives of the Australian regional committees, the New Zealand National Committee and the regional training committees of Hong Kong, Singapore and Malaysia.

Like many other Fellows who assist the College, all our inspectors work on a *pro bono* basis. They enjoy inspections because it's a chance to meet a wide range of Fellows and trainees, to have a detailed look at the way other departments are run and to survey the inside of Qantas Clubs far and wide (just kidding – the travelling is not a highlight!).

On the day of the inspection, the team initially meets with the director of anaesthesia to introduce the process, review the paperwork and identify any areas of concern, with the emphasis on helping the department to achieve its goals. We then meet with hospital management to get an overview of the issues facing the hospital and to advocate on behalf of the department of anaesthesia.

We schedule an hour to talk with the trainees, and then meet with the supervisor(s) of training and the senior staff. A lot of time is spent inspecting the operating theatres, other anaesthetising



locations and Departmental offices. At the end of the day, we meet again with the director of anaesthesia and management to discuss our preliminary recommendations. We try to group visits to hospitals within a rotation so that we get an overall picture of the scheme.

After the visit, the team submits its report to the TAC, which considers the report in detail and corresponds with the hospital. Training sites are not finally accredited until all the recommendations are met or substantial progress has been made. A routine inspection process usually takes about 12 months from scheduling to completion and results in approval for a seven-year period.

Departments and hospitals with difficulties

From time to time, departments, specialists, trainees or regional/national committees contact the College with concerns about an approved training department. Typically, these concerns relate to specialist staffing, supervision or workload. In many instances, dedicated Fellows are struggling to provide training and clinical service

in an inadequately supported and/or rapidly changing environment. The Chair of TAC initially liaises with representatives from the regional/national committee to investigate the report at a local level, but if the issues cannot be resolved, an out-of-sequence inspection is arranged. At these visits, extra time is spent interviewing trainees and specialists about their concerns, and advocating on behalf of the department with management. While there is always the prospect that accreditation could be lost, in most instances, TAC is able to work with these Departments to re-establish a high-quality training environment.

In circumstances where a department is facing difficulties, TAC ensures that recommendations about accreditation are made in a timely fashion so that trainees already working at the hospital or appointed to the hospital for the subsequent training year are given certainty and not disadvantaged.

Members of TAC and the inspection teams view their role as supporting departments in the provision of high-quality care and training. We are

always looking for ways to improve the accreditation process (for example, it has only recently become an on-line process) and would happily receive suggestions.

For more information on ANZCA's accreditation processes, please visit the accreditation pages at www.anzca.edu.au or contact Janet Devlin on 8517 5325 or email jdevlin@anzca.edu.au.

By Associate Professor Kate Leslie
TAC Chair
Department of Anaesthesia and Pain Management
Royal Melbourne Hospital

Above from left: Associate Professor Kate Leslie (Chair, TAC), Dr Julia Groves (SOT), Dr Morne Treblanche (Director of Anaesthesia), Dr Mark Gibbs (Member, TAC) and Dr Richard Willis (ANZCA Director of Professional Affairs) inspecting the Department of Anaesthesia at Bundaberg Hospital.

Far left: The entrance to the Emergency Department at Bundaberg Hospital.

THE FUTURE OF ANAESTHESIA PART 2

In the June edition of the *Bulletin*, ANZCA looked at the future of anaesthesia and what lies ahead for the specialty as a vital component of modern medicine in Australia and New Zealand. In the second of a two-part series we publish two international perspectives.

The Pursuit of Excellence

Ronald D Miller, MD

Professor and Chairman of Anesthesia and Perioperative Care, University of California

This is an edited extract of the 47th Annual Rovenstine Lecture by Ronald D. Miller, M.D. Professor and Chairman of Anesthesia and Perioperative Care and Professor of Cellular and Molecular Pharmacology, University of California San Francisco, presented at the Annual Meeting of the American Society of Anesthesiologists, October 18-22, 2008.

During the most recent 10 years, the rate of change in anesthesiology has far exceeded that of the previous 25 years. We have had extremely rapid change in several aspects of our daily professional lives, including hospital admission policies (eg, patients being admitted the morning of surgery), reduced resident work hours, increasingly large amounts of outcome data, and a changing role of the surgeon, the implications of which surprised us, especially me, and many others. During that time, our specialty did achieve excellence in operating room anesthesia. We, and the ASA as an organisation, should be congratulated. However, anesthesiologists, including myself, were concerned that as a profession we were not ready for the future.

As a result, the ASA leadership formed the ASA Taskforce for Defining Anesthesia Paradigms in 2025, which I was honoured to chair. The taskforce was charged with reviewing the inevitable change and new opportunities within our specialty, discussing concerns regarding the status quo, commitment to relying on the

profession rather than a consulting firm for assessing the future, and exploring the idea of proactive inquiry versus defensiveness and inaction. Exploring these areas via the taskforce was inspirational and challenging to many of us. We interviewed many leaders in American medicine and regarding the increasing dominance of perioperative medicine and the need to increasingly review the entire perioperative process as one integrated unit, including emphasis on critical care medicine. One prediction by those we interviewed was that anesthesia would not step up to the plate; the prediction was that, for financial reasons, anesthesiologists would not be leaders in perioperative medicine. Another prediction was that an increasing number of beds would be dedicated to perioperative medicine and critical care. That process has evolved more rapidly than even our taskforce anticipated, as indicated by the increased number of perioperative directors.

Has anesthesia stepped up to the plate? Has there been debate? One indicator that addresses the first question is the number of advertisements in the journals I read. By rough count, there has been a severalfold increase in the number of perioperative director advertisements in the United States since that taskforce report. This is not a precise analysis, but the dramatic increase in advertisements indicates the increasing importance of the perioperative concept. Furthermore, most of the appointed perioperative directors

are anesthesiologists. We, as a specialty, did indeed step up to the plate. Another significant outcome of the taskforce is that it increased the attention level to anesthesiology's future. Our future is widely discussed and debated, especially by our leaders. I have heard Mark J. Lema, MD, PhD (Chairman of Anesthesiology, Critical Care and Pain Medicine, Roswell Park Institute, Buffalo, New York), discuss many issues, especially our finances. Patricia Kapur wrote an article titled "The Future of Anesthesia Practice" in the summer 2008 *Bulletin* of the California Society of Anesthesiologists. I could name many others. With so many people probing our future, the chance that our specialty's future is secure is much more likely. It is impossible to know what the impact of our taskforce's report had on our specialty's response, but with considerable bias, you can easily imagine my opinion.

Strategies and questions

Can we use the same strategy as used with the ASA taskforce for addressing our current and future challenges? Does the pursuit of excellence have any boundaries as far as our specialty is concerned? The pursuit of excellence demands our attention both inside and outside the boundaries of our specialty, as exemplified previously by Snow, Bonica, Bendixen, and others. Furthermore, our specialty has a continued parade of challenges or opportunities to address. For example, what if robots become increasingly important for surgery and possibly anesthesia?

What if the delivery of anesthesia becomes completely automated, especially with regard to drug administration and its monitors? An example is “Dr McSleepy” from McGill University. You can “Google” it if you want more information. Its effectiveness remains to be determined. If so, how will that influence our future?

What if acute pain management is dominated by self-administered devices by nonintravenous routes? How will that influence our future? What if a “dedicated procedure centre” dominated by hospitalists becomes common? These centres have been described and will insert central and arterial lines. How will this influence our future? I repeat the previous statement: To achieve excellence, we must examine both inside and outside our boundaries.

There are many more examples and possible future developments that could be listed. However, the fundamental question is, how do we respond to these questions and still pursue excellence? Do we need a specific process to address these developments?

Do we respond prospectively or react retrospectively? One approach would be to devise some type of organised survey and collection device and then have some learned group analyse the previously mentioned questions’ potential place in anesthesia when they become a reality. In my opinion, retrospective reactions usually are made in an atmosphere not conducive to the pursuit of excellence.

Even with my passion for predicting the future, I could not have possibly imagined the impact of surgical resident work hours and reimbursement schemes on the practice of care (or the lack thereof). These added responsibilities are generally desired by our specialty, but has that helped us plan for the future—or has it bound us down and made us less creative? I am encouraged that our specialty has stepped up to the plate in such a thoughtful and meaningful manner with regard to perioperative medicine, but I remain concerned about preoperative evaluation. In my opinion, preoperative evaluation needs to be performed by anesthesiologists or closely supervised by us. In the pursuit of excellence of every aspect of our specialty, I am concerned about the increasing trend to relinquish our responsibility of preoperative evaluation to other providers.

The importance of research

As indicated previously, the need for our specialty to be creative and in control of its intellectual content demands emphasis on research. The ASA has been acutely aware that our share of academic research funding has been inappropriately small when considering the importance of

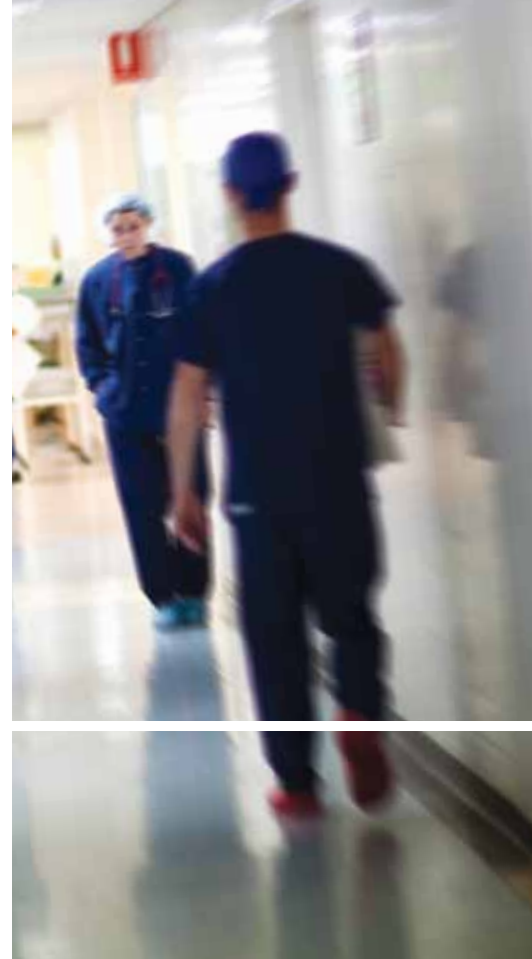
our specialty in American medicine. The ASA has placed added emphasis in research by celebrating it in a variety of ways, including increased funding to the Foundation for Anesthesia Education and Research and the establishment of the Severinghaus Lecture in Translational Science.

Along these lines, there is no doubt that anesthesiology research has increasingly penetrated and influenced basic science and other clinical disciplines via their journals—congratulations to those anesthesiologists. Despite the currently poor economy, I, perhaps, hopefully not alone, believe that some interesting opportunities may be on the horizon.

These following points illustrated in an article by Kaiser in which Keith Yamamoto is quoted in *Science* clearly indicate that the National Institutes of Health (NIH) is trying to make the application process easier and is placing greater emphasis on “impact” rather than “methods”. Focus more on anticipated impact of the research. Focus less on methods and other details.

Schwinn and Balsler, in 2006, and Reves, in his 2006 Rovenstine Lecture, analysed the “root causes” for low research productivity, including failure to attract research-oriented trainees. They proposed structural changes to provide “systems, problem-based analysis, etc,” including scholarships, increased research time during anesthesia residencies, mandatory research in all subspecialty fellowship programs, and changes in academic compensation plans to reward research. These proposals and actions are wonderful. After their inspiring recommendations, some questions naturally followed. Subsequently, Alex Evers and I wrote an editorial in April 2007. In effect, Evers and I asked whether the remedies proposed by Reves and by Schwinn and Balsler would be sufficient to invigorate anesthesiology research.

We came to the conclusion that these are steps in the right direction, but more is needed. What is needed is top research talent. Why do physicians start research careers? The answer is that they dream that they will solve a major medical problem important to society overall. Physician–scientists are attracted to fields such as medicine and pediatrics because they dream of curing major healthcare problems such as cancer and Alzheimer disease. So the question is, if I were to ask all of you anesthesiologists what pressing clinical problems for the specialty of anesthesiology need research for a solution, what would I hear? I believe that an inconsistent and quite diverse answer, which would not be sufficiently concise for the pursuit of excellence, would follow. We need to know what these problems are. Evers and I presume



“In my opinion, preoperative evaluation needs to be performed by anesthesiologists or closely supervised by us. In the pursuit of excellence of every aspect of our specialty, I am concerned about the increasing trend to relinquish our responsibility of preoperative evaluation to other providers.”

that grant deficiency is our specialty’s manifestation of a more profound problem, but is merely a symptom of our intellectual lack of a clear mission.

I apologise for being a bit harsh with this statement: Although our specialty should be and is proud of our significant contributions to patient safety, it is inappropriate to content ourselves with the fact that few patients experience intraoperative death due solely to anesthetic mishap. For example, we need to take ownership of the substantial perioperative morbidity and mortality. There are many unrecognised problems in perioperative medicine, such as postoperative renal failure, systemic inflammatory response syndrome, and cognitive dysfunction, to name a few. Some of our anesthesia colleagues are moving into these areas, but we need more—a national commitment. We must identify, publicise, and embrace the problems that need to be solved. Compelling and solvable problems will attract the best and brightest to our field.

THE FUTURE OF ANAESTHESIA PART 2 CONTINUED

“Although our specialty should be and is proud of our significant contributions to patient safety, it is inappropriate to content ourselves with the fact that few patients experience intraoperative death due solely to anesthetic mishap. For example, we need to take ownership of the substantial perioperative morbidity and mortality.”

The taskforce model

Let us now talk about tactics. Floyd Bloom suggests envisioning scientific life in the year 2050 in his article “Thinking Ahead”. Three of Bloom’s recommendations relevant to my discussion are as follows:

Organise various groups to hypothesise what science will be in the year 2050. Yes, some findings are unanticipated and thrilling. If you envision what is over the edge of the horizon, perhaps we can invent the tools needed to get there. With these recommendations in mind, my first tactic is to develop a long-range vision.

It is difficult to precisely chart the future of American medicine, generally, and our specialty, specifically; however, we must try. In the process of trying, our visual acuity will be increased, and, therefore, we will be more likely to detect opportunities or subtle changes that allow us to respond in a thoughtful and thorough manner. I also have always been incredibly impressed with the value of consulting with individuals outside our specialty for advice. It really hit home to me how valuable this outside advice was when chairing the ASA taskforce for Defining Anesthesia Paradigms in the Year 2025. With that general background, I would offer a reconstitution of the taskforce design to try to assess our future, specifically with the formation of new and different tasks. With considerable bias, I believe that the original taskforce for Defining Anesthesia Paradigms in the Year 2025 had considerable merit; however, with a newer taskforce, we most certainly can take advantage of those strategies that happened to work. In my opinion, it was especially valuable to talk with people outside of our specialty, including politicians, economists, industrialists and other specialties.

Developing the following three ongoing and futuristic taskforces is important for helping to shape the future of our specialty:

- The future of anesthesiology and perioperative medicine.
- Analysis of the role and place of all new technology and pharmacology.
- An international think tank to define the outstanding questions our specialty needs to answer.

I have commented on my role on the paradigms in 2025 taskforce, and the first

taskforce noted above should continue and broaden this important topic. A second, and equally important, new taskforce should analyse the role and place of all of our technologic and pharmacologic additions. The ASA certainly helps members to adopt and integrate new technology and pharmacology into our practices. Can they do more? As indicated in some of my previous points, how will these changes change the practice of anesthesia? Will these changes even influence the type of personnel or coverage that we provide for general anesthesia? We should know. We should do it in a manner that allows us to act proactively rather than reactively. The proactive approach, obviously, opens the opportunity for our specialty and its leadership to influence the future use of this technology and pharmacology. There are some examples in the ASA and our specialty in which we have successfully done that. Most certainly, the Foundation for Anesthesia Education and Research and the Anesthesia Patient Safety Foundation have been terrific in some of these areas. However, I would recommend that we do that on a broad and consistent basis via a specific task force.

The third task force, perhaps structured as an international think tank, is desperately needed. The purpose of this task force would be to define the outstanding questions that our specialty needs to address as far as research is concerned. This would include not only basic science research, but also clinical research and translational research. I would submit that, as with the future of anesthesia taskforce, multiple sources of information should be sought, including industry and biotech companies. I can most assuredly tell you that a couple of my comments are based on my knowledge of what some biotechnology and pharmacologic firms are doing. I also believe that this taskforce must go beyond the boundaries of the United States. It is clear that many places in Europe, Asia, and Australia have been very active in creative investigation. We need to devise a technique by which an international consensus could be developed in a creative manner as to what the big, important questions are. I think it would be invigorating and productive, and perhaps could even influence funding overall for our specialty. One of the additional challenges would be the

manner in which we, as anesthesiologists, should influence the many subspecialty areas (eg, neuroanesthesia). That is a challenge in its own right.

Of prime importance is that these new taskforces or think tanks need to think big and dream. Whether there is a more productive strategy for addressing these important and ongoing issues remains for others to determine. I humbly suggest a taskforce approach. Perhaps there are better ways, but the importance of long-term and consistent attention to these three topics is crucial.

Pursuing excellence today

In conclusion, our specialty has not always been dedicated to the pursuit of excellence. The degree of this dedication comes and goes depending on finances, political leadership and academic leadership. I would argue that the pursuit of excellence should always be the number one agenda item for all anesthesiologists, but especially for our training programs and specialty overall. It is true that the attention to detail, the attention to finances, and the attention to politics are crucially important and occupy our minds on a daily basis. In the background, however, our vision needs to be acute and sensitive to pick up every opportunity to facilitate our specialty’s achieving the pursuit of excellence. I believe that even as you walk through the exhibits, if you are looking for new ideas for the pursuit of excellence, you are more likely to see them if they are in front of you, if you have that idea in your mind, rather than if you do not. Of course, we need to extend our attention to the pursuit of excellence well beyond the exhibits.

We should make it a practice in all committees and our daily practice to ask ourselves, “Have we tried to pursue excellence today?” If we do, our chances of achieving excellence are much more likely. To paraphrase Oscar Wilde, we are all trying to find our way, but some of us are looking at the stars. Thanks to all of you for joining me in looking at the stars during this plea for the pursuit of excellence.

Ronald D Miller, MD

Professor and Chairman of Anesthesia and Perioperative Care, University of California.

Anesthesiology 2009, 110:714-20 – The American Society of Anesthesiologists. Reproduced with permission.

Anaesthesia, the flexible specialty

Dr CD Hanning,
Consultant in Sleep Medicine,
University Hospital of Leicester

Medicine has always been regarded as one of the most flexible of the professions, giving opportunities for introverts and extroverts, the thinker and the doer. It embraces those who like talking to patients (psychiatrists?) and those who don't (pathologists?) as well as those demonstrating practical skills (surgeons and anaesthetists?) and those of a more cerebral bent (physicians?). There are even those who have taken their medical training and moved into other fields such as comedy, writing or politics (Harry Hill, Jonathan Miller and Liam Fox?). Caricatures are easy, but serve to demonstrate the ability of medicine to provide a satisfying career for a wide range of personalities and inclinations.

I wonder if anaesthesia might be considered the most flexible of all the specialties in medicine by encompassing almost as wide a range of opportunities as does medicine itself? The core of anaesthesia as a specialty remains the care of patients undergoing surgery. While essentially a practical, hands-on skill, it nevertheless encompasses sufficient intellectual challenge to satisfy. Rewards are immediate for those who need their emotional feedback quickly. There is communication with patients but it is short, focused and circumscribed. I have great sympathy with this mixture. In my experience, there is nothing to beat the satisfaction of achieving a smooth, pain-free, perfectly timed arousal from anaesthesia. I have watched with awe as the better trainees manage it, case after case, and wonder if I was ever that good.

There is no doubting that many of you reading this piece will pass your entire careers very happily administering anaesthetics and will derive great satisfaction from so doing. I do not seek to belittle those who choose such a pathway, indeed I have the greatest admiration for those whose technical expertise far exceeds my own, but I am impressed by the proportion of those entering anaesthesia who seek to move into a branch of the specialty which does not involve the actual "passing of gas". Pain management, both acute and chronic, critical care, and my own particular interest in sleep medicine are the principal examples. Obstetric anaesthesia typically does not fall conveniently into either category, being a mixture of acute pain relief and operative work. My prejudice

is that obstetric practice should be regarded as part of what may be termed "mainstream anaesthesia", although a perversion which can and should be beaten out of trainees at an early stage.

In the course of my career, I have moved from an academic pathway, principally involved in critical care medicine, to an NHS post with a special interest in sleep medicine. Pharmaceutical research brought me into close contact with the worlds of acute and chronic pain management. At no time in my career have I undertaken more than four theatre sessions per week. In my defence, I did renounce obstetric anaesthesia, and all its works, at an early stage in my career. This may not qualify me to speak with sufficient authority on the art and practice of anaesthesia but it does give me a broad overview of our specialty.

In the early days of the specialty, relatively few consultants strayed from the operating theatre, but today the proportion is probably well over half. In my own Trust, the University Hospitals of Leicester, 57% (50/87) have at least one clinical session in a "para-anaesthetic specialty". The question is begged, why do such a large proportion of consultants seek to spend at least some of their clinical time not administering anaesthesia? Is it just that anaesthesia in the 21st century no longer represents a challenge? Can it be that it's so safe and predictable that it's boring and insufficient of an intellectual challenge? Is it the environment, working constantly with surgeons and being subject to their whims? The advent of minimally invasive surgery may be of great patient benefit, but it has reduced the ambient light level of the operating theatre and has increased the average operation duration. Are we simply suffering from year-round seasonal affective disorder, bored to tears and desiring only to escape? Administering anaesthesia can be a lonely task: do we just long for a bit more human contact? Those, like myself, who have worked in Europe with anaesthetic nurses will recognise how their presence makes the day more pleasant, providing not just someone to monitor the boring, stable bit in the middle of the case, but also someone with whom one can have a professional discussion.

Thankfully, anaesthesia, as a specialty, does offer a wide range of options to those, who for one reason or another, may wish



"The question is begged, why do such a large proportion of consultants seek to spend at least some of their clinical time not administering anaesthesia? Is it just that anaesthesia in the 21st century no longer represents a challenge? Can it be that it's so safe and predictable that it's boring and insufficient of an intellectual challenge?"

to move away from the mainstream. Acute pain management extends anaesthesia care out of the operating theatre and into the wards. Touching, as it usually seems to, on other aspects of perioperative care such as fluid balance and nutrition, it permits the exercise of "physicianly" skills, and contributes to our claim to be physicians of the perioperative period. Follow-up usually extends over several days giving the intellectual and emotional rewards of longer patient contact.

Critical care medicine is probably the sub-specialty with the greatest component of acute medicine, taken further by the outreach teams who seek to take the lessons of critical care to the emergency departments and general wards. As with acute pain management, follow-up extends over days or weeks. It is noteworthy that critical care research and practice are beginning to look beyond the time spent on the ICU and HDU to the

THE FUTURE OF ANAESTHESIA PART 2 CONTINUED

ward, and even to the return home. Does this represent not only a desire to ensure that the effort put into a patient's initial recovery is not wasted, but also a wish to participate in the emotional rewards that come from longer-term follow up?

Chronic pain management generally takes a much bigger step away from the arts and skills of the operating theatre. True, many practitioners restrict themselves to the practical aspects of nerve blocks and applied analgesic pharmacology, but many branch out into the psychological aspects, acupuncture and, even, complementary therapies. What drives those who start out as mainstream anaesthetists to move into an area of medicine seemingly so different? Is it just the urge to fill a niche in patient care unfilled by other specialties, or is it the attraction of exercising different skills and the rewards of longer-term patient contact? How much of it is driven by a desire to escape the confines of the operating theatre?

My own specialty of sleep medicine probably represents the greatest departure from mainstream anaesthesia. Some of you may be wondering about the justification for including it. The bulk of sleep medicine is the management of obstructive sleep apnoea. What specialty has most understanding of the upper airway and how to keep it open? Which specialty first used and best understands nasal CPAP? If that specialty is also familiar with different states of consciousness and the drugs that alter it, then they can be regarded as having a legitimate claim to involvement in sleep medicine.

Perhaps a description of what drove me to follow this career pathway would be instructive. My physiology degree drew me into anaesthesia and intensive care, with a particular interest in all things respiratory.

A part in the development of inductance plethysmography, a non-invasive method of monitoring respiration resulted in an interest in respiration, after surgery. Patients sleep after surgery and it was necessary to find out more. The stage was set for a meeting with a young man with severe obstructive sleep apnoea (OSA) who had been completely misdiagnosed by his paediatrician. The discovery of this vast field of medicine, which seemed to have been almost entirely ignored by the rest of the profession, was a real eye-opener and the spur to develop clinical sleep services. The rest is history. Much of it was the fascination of the physiology and the filling of a patient need which no one else seemed to want but it was also the emotional rewards of long-term follow up, for some of my CPAP patients are now approaching their 20th year on treatments. There are few things in medicine more rewarding than to see a patient with severe OSA a couple of days after starting nasal CPAP, and their delight in restored wakefulness and improved mental function.

I do not regret for one second, my decision to seek a career in anaesthesia – the breadth of opportunities and the flexibility have made it a very rewarding choice. In my view, anaesthesia is the most flexible of medical specialties.

What do you think?

Dr CD Hanning

Consultant in Sleep Medicine,
University Hospital of Leicester

*Bulletin of the Royal College of
Anaesthetists, May 2009 Issue 55.
Reproduced with permission.*

“Acute pain management extends anaesthesia care out of the operating theatre and into the wards. Touching, as it usually seems to, on other aspects of perioperative care such as fluid balance and nutrition, it permits the exercise of ‘physicianly’ skills, and contributes to our claim to be physicians of the perioperative period.”



Anaesthetic Mortality in Australia and New Zealand 1985 – 2005: A report covering over 40 million anaesthetics

Dr Neville Gibbs, FANZCA

Introduction

The publication of the most recent safety of anaesthesia report by ANZCA extends the period of national anaesthetic mortality reporting in Australia to 21 years. The data obtained over this time provides the most comprehensive and extensive information about anaesthetic mortality available from any source. There have now been seven consecutive triennial reports, each covering over five million anaesthetics¹⁻⁷. The cumulative total of the number of anaesthetics from which the data is drawn is conservatively well over 40 million. The first two reports (1985-1987, 1988-1990) were published by the Australian National Health and Medical Research Council (NHMRC). Subsequent reports have been published by ANZCA, the latest being for 2003-2005. Scrutiny of these reports presents a unique opportunity to examine changes and trends in anaesthesia-related mortality in Australia and New Zealand over this period. However, there are several caveats in the interpretation of these reports, and in making comparison between reports. The aim of the current paper is firstly to outline these caveats, and then to summarise the changes in anaesthesia-related mortality with which we can be confident between 1985 and 2005.

Caveats

Definition and classification of anaesthesia-related death

An anaesthesia-related death is one in which some aspect of anaesthesia

delivery or its related management causes or contributes to the death. This could be due to an adverse response to an anaesthetic drug, or an error in its administration from a variety of causes. If the adverse response or error would not normally cause death, but proves lethal in the presence of other physiological disturbances, anaesthesia is considered a contributory factor. The same applies to a "failure to rescue" from a surgical or other complication. In contrast, if the adverse response or error is lethal in its own right, anaesthesia is considered the sole cause. The same would apply to any "failure to rescue" from an anaesthetic complication. In general, an "error", whether human or system, would be considered preventable, while an "adverse response" may or may not be preventable.

While the classification of anaesthesia-related mortality was consistent across all seven reports (based on the classification of Edwards et al, 1956⁸), all classifications of anaesthesia mortality are subjective to some extent. This is unavoidable, because while "death" is objective, determining the extent to which anaesthesia factors are involved always requires an "opinion".

The Edwards et al Classification

Category 1

Where it is *reasonably certain* that the death was caused by the anaesthetic agent or technique of administration or in other ways coming *directly under the province* of the anaesthetist. (Italics by N. Gibbs).

Category 2

Similar cases in which there is *some element of doubt* as to whether the agent or technique was *entirely* responsible for the fatal result. (Italics by N. Gibbs).

Category 3

Cases in which both the anaesthetic and the surgical technique contributed to the fatal result.

The remaining categories are not anaesthesia-related e.g. Category 4, death due to surgical factors; Category 5, inevitable death; Category 6, coincidental death.

There was a minor modification introduced by the NHMRC Mortality Working Party in 1991. At this time, a sub-classification "G" was added for those cases in which no correctable factor could be identified.

Category 1

Where it is *reasonably certain* that death was caused by the anaesthetic or other factors under the anaesthetist's control. (Italics by N. Gibbs).

Category 2

Where there is *some doubt* whether death was *entirely* attributable to the anaesthetic or other factors under the anaesthetist's control. (Italics by N. Gibbs).

Category 3

Where death was caused by both anaesthetic and surgical factors.

From the 1997-1999 triennium onwards, a sub-classification "H" was introduced for those cases in which the medical condition of the patient was considered a significant factor.

Identification of anaesthesia-related deaths

The method of identifying anaesthesia-related deaths has been relatively consistent within each state over the seven reports, but the methods have varied between states. The different methodologies for identifying and classifying anaesthesia-related deaths are outlined in each of the reports.

- In New South Wales (NSW), the Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) receives notification from the state coroner of all deaths occurring under, as a result of, or within 24 hours of anaesthesia. Reports are then requested from the anaesthetists concerned. While providing a report is voluntary, there has been a consistently high (>90%) compliance.
- In Victoria, the Victorian Consultative Council on Anaesthetic Morbidity and Mortality (VCCAMM) receives reports directly from anaesthetists. This reporting is voluntary. There is no specified time limit between the anaesthesia and the death. Information is obtained also from the coroner's office. Since 2001, there has also been mandatory reporting of mortality and major morbidity (sentinel events) to the Department of Human Services. The Council has a key role in reviewing those cases involving anaesthesia and perioperative care.

- In **Queensland**, the Committee to Enquire into Perioperative Deaths received reports directly from anaesthetists. This reporting was also voluntary. The coroner's office also reported deaths in which anaesthesia or surgery may have contributed. The Queensland committee ceased functioning effectively in 2005, with loss of access to data for the 2003-2005 period.
- In **South Australia (SA)**, the Anaesthetic Mortality Committee received reports of deaths within 24 hours of an anaesthetic (or later if death was likely to have occurred as a result of anaesthesia) directly from anaesthetists. Reports were also received indirectly from teaching hospitals. All reports were voluntary. In 1987, the committee was replaced by the Perioperative Mortality Committee, but this did not function until 1991. The SA committee ceased functioning effectively in 2003.
- In **Western Australia (WA)**, the anaesthetic mortality committee receives reports of deaths within 48 hours of an anaesthetic directly from anaesthetists. These reports are mandatory under a state health act.
- **Tasmania** had no anaesthesia mortality committee before 2005, but there was an arrangement by which anaesthetists in Tasmania could voluntarily report deaths to SCIDUA in NSW.
- Similarly, anaesthetists in the **Northern Territory** could report deaths to the SA Perioperative Mortality Committee.
- There have been no formal arrangements by which anaesthetists in the **Australian Capital Territory** could report anaesthesia mortality.
- In **New Zealand** reporting has been in abeyance since the late 1980s. A new Perioperative Mortality Committee is anticipated in the near future.

Note that for the reasons explained above, for the 2003-2005 triennium, data were obtained only from NSW, Victoria, and WA. Nevertheless, these three states cover about two-thirds of Australia's population, and therefore provide a reasonable indication of anaesthetic mortality in Australia for this period. It is important

that every effort is made to achieve reporting from all Australian states and territories, and from New Zealand.

A major issue in identifying all anaesthesia-related deaths is the identification of deaths in which no anaesthetist is involved, such as may occur during sedation for endoscopic or other procedures. It is likely that the majority of these cases are missed, because there are no formal mechanisms for reporting these deaths, other than through coroners' offices. Similarly, deaths in which anaesthetic drugs are used during resuscitation or airway control in emergency departments or intensive care units are likely to be missed.

Despite the different methods of identifying deaths between states, in all cases the same classification was used, and in all cases the classification was the consensus opinion of a committee with wide representation, using de-identified information.

Determination of the total number of anaesthetics

The method of determining the total number of anaesthetics has varied between reports. This is important, because the accuracy of the "anaesthesia-related mortality rate" depends not only on the accuracy of the numerator (number of anaesthesia-related deaths), but also on the denominator (total number of anaesthetics administered) over the same time period. For the 1985-1987 report, the NHMRC working party estimated that there were approximately 5.47 million anaesthetics given over the triennium. This estimation was derived from Australian Health Insurance Commission and State Health Authority data, but was recognised as incomplete. The working party noted that their estimate was approximately equivalent to about 10% of the Australian population having one anaesthetic per year. For the 1988-1990 report, the Working Party used this number (10% of the Australian population) to estimate the total number of anaesthetics administered.

For the 1991-1993 report, the number of anaesthetics administered per annum was an approximation based on the total number of separations from hospitals in

the states and territories involved (based on ICD-9 codes for July 1993 to June 1994) less separations involving "diagnostic or non-surgical procedures", or where there was "no procedure or procedure was not stated". This information was obtained from the Australian Institute of Health and Welfare (AIHW)⁹. The total number of anaesthetics for the triennium was this annual number multiplied by three. A similar methodology was used for the 1994-1996 report and the 1997-1999 report, based on separations from July 1995 to June 1996, and July 1997 to June 1998 respectively. The deficiencies of this methodology were recognised in each report, foreshadowing a change to a method based on anaesthesia rather than surgical codes when possible.

For the 2000-2002 report, the number of anaesthetics was based for the first time on anaesthetic rather than surgical codes. Coding of anaesthetics was introduced into Australian Hospitals in 2000 (ICD-10). Data for the year July 2001 to June 2002 were obtained from the AIHW and multiplied by three for the triennium. The accuracy of this methodology depends on the accuracy of coding at a hospital level, but is more direct than estimates based on surgical procedures. A similar methodology was used for the 2003-2005 report, using data for the three states involved from July 2004 to June 2005.

It can be seen that the method of determining the "total number of anaesthetics" was not consistent across the reports (Table 1). The total number of anaesthetics for the 1991-1993, 1994-1996, and in particular the 1997-1999 triennia were very high, and in retrospect were likely to have been an over-estimate. Alternatively, the current method using anaesthesia codes is an underestimate. Therefore, caution should be taken when comparing anaesthesia-related mortality rates across the reports. In general, it would be preferable to use an underestimate than an overestimate, because it would be less likely to provide a false impression of safety.

Table 1. Estimate of number of anaesthetics and mean population during the triennium from those states and territories contributing data

Triennium	Anaesthetics (million)	Method of Estimation of Number of Anaesthetics	Mean Population (million)
1985-1987	5.47	Health Insurance Commission and State Health Data	16.01
1988-1990	5.11*	~10% of population (pa)	16.12*
1991-1993	7.89	Hospital surgical separations	17.49
1994-1996	8.49	Hospital surgical separations	17.56
1997-1999	10.32	Hospital surgical separations	18.90
2000-2002	7.74	Anaesthetic codes	19.41
2003-2005	5.41**	Anaesthetic codes	13.68**

*Excludes SA

**NSW, Victoria, and Western Australia only (total population for Australia 20.11)

Interpretation of patient, procedural, risk, and other factors in anaesthesia-related deaths

Data collected in relation to each anaesthesia-related death includes patient characteristics such as age, gender and American Society of Anesthesiologists (ASA) Physical Status¹⁰. Data also includes surgical procedure, type of hospital in which the procedure was performed (eg. public or private) and location of death (eg. operating theatre, intensive care unit, etc). The grade of anaesthetist is also indicated (eg. specialist, trainee, etc). Finally, the causal or contributory factors are also classified (pre-operative, anaesthesia technique, drugs, management, post-operative, and organisational). While these data are included in the triennial reports, there is no denominator available. Therefore, the data cannot be interpreted fully. In particular, it may not be appropriate to compare these data between reports because the denominator may have changed (eg. an increase in the age or risk profile of patients undergoing surgery or a change in the number of urgent procedures or other factors).

Changes in anaesthesia-related mortality

Anaesthesia-related mortality rate per anaesthetic administered

The anaesthesia-related mortality rate per number of anaesthetics administered has ranged from a high of 1:36,000 for the 1985-1987 triennium to a low of 1:79,500 for the 1997-1999 triennium (Table 2). However, as explained earlier, caution should be taken when comparing these rates, due to the different methodologies in estimating the total number of anaesthetics. The two most recent rates of 1:56,000 and 1:53,400 are probably the most accurate, but all methods have some uncertainty.

Anaesthesia-related mortality rate based on population

In contrast to the estimates of total number of anaesthetics administered, the population data provided by the Australian Bureau of Statistics¹¹ are likely to be very accurate. The anaesthesia-related mortality rate based on population has changed little between reports, ranging from as low as 1.8 per million population per annum to as high as 2.77 (Table 2). This is encouraging information, because it is likely that the total number of anaesthetics per million population per annum has increased over the 21 years, and it is also likely that the risk profile of both patients and procedures has increased over this time. If these assumptions are correct, then anaesthesia safety has improved substantially over this time.

Anaesthesia-related mortality rate vs anaesthesia-caused mortality rate

The anaesthesia-related mortality rate includes deaths classified as category 1, 2 or 3. Anaesthesia-caused mortality is a subset of anaesthesia-related mortality, pertaining only to category 1 deaths (in which it was 'reasonably certain that death was caused by the anaesthetic or other factors under the anaesthetist's control'). Category 1 deaths can also be considered as those deaths in which anaesthesia is the "primary cause".

The percentage of category 1 deaths has decreased consistently from 50% in the 1985-1987 report, to 21% in the 2003-2005 report (Table 2). We can be more confident about this decrease, because it is based on percentages within each report, rather than absolute numbers or estimates. Moreover, of all the categories of anaesthesia-related death, category 1 deaths are the most likely to be identified. Such deaths are likely to have a high profile, and are more likely to be reported to anaesthesia mortality committees or state coroners. If we consider the anaesthesia-caused deaths in relation to the total number of anaesthetics, then the rate has decreased from about 1:74,000 for the 1985-1987 report, to about 1:250,000 for the 2003-2005 report.

Percentage of cases with 'no correctable factor'

The percentage of anaesthesia-related deaths where no correctable factor was identified increased from 4% for the 1991-1993 triennium to 33% for the 2003-2005 triennium (Table 2). Again, we can be more confident about this increase, because it is based on percentages, rather than absolute numbers or estimates. In these cases, no error was identified. This implies that the death was due to an adverse response to anaesthesia that was not preventable with our current state of knowledge. It is difficult to determine whether this represents a true increase, or whether the increase is relative to a decrease in the number of deaths in which a correctable factor was identified. The latter is more likely, because anaesthetic agents and techniques have not changed appreciably over this period, while monitoring, training, and education have all improved. Another possibility is the increasing acceptance of higher risk patients for anaesthesia and surgery. This is supported by the substantial increase in the number of cases in which the medical condition of the patient is considered a significant factor in the death (Table 3).

Table 2. Anaesthesia-related mortality in Australia 1985-2005

	1985-87	1988-90	1991-93	1994-96	1997-99	2000-02	2003-05
Anaesthesia-Related* Mortality per million population pa	2.77	1.8	2.67	2.56	2.29	2.35	2.73
Anaesthesia-Related* Mortality per anaesthetic	1:36,000	1:55,000	1:68,000	1:63,000	1:79,500	1:56,000	1:53,400
Category 1 (%)	50	35	39	41	36	31	21
Age >60y (%)	66	68	74	86	92	92	75
ASA PS 3-5 (%)	58	60	74	90	85	81	84
Non-elective (%)			61	67	65	66	50
Teaching Hospital (%)			52	55	53	50	58
Specialist (%)	69	71	73	72	73	77	84
No Correctable Factor (%)			4	13	9	20	33

*Anaesthesia-Related = Categories 1, 2 and 3 of Edwards et al Classification⁸. Remaining data are percentages of Anaesthesia-Related. Category 1 = Anaesthesia-Caused. ASA PS = American Society of Anesthesiologists Physical Status¹⁰.

Risk factors

Two easily identifiable patient risk factors are patient age and ASA physical status. Most of the deaths (74-92%) occurred in patients over 60 years of age, and 74-90% of patients were ASA physical status 3-5. The most common surgical categories were orthopaedics, abdominal, cardiothoracic, vascular, endoscopy, urology and ENT (ear, nose and throat). These were relatively consistent across the reports. About 50-66% of the deaths were associated with non-elective (urgent or emergent) procedures. More than 50% of the deaths occurred in metropolitan teaching hospitals. The percentage of deaths in which the anaesthetist was not a specialist anaesthetist fell from 31% for the 1985-1987 report, to 16% for the 2003-2005 report. Unfortunately, it is not possible to fully interpret the influence of these factors, due to the absence of the relevant denominators.

Causal or contributory factors

The classification of causal or contributory factors has been relatively consistent since 1991. On average, there have been about 2.2 causal or contributory factors implicated in each anaesthesia-related death (although this number has fallen for the last triennium) (Table 3). The causal and contributory factors are spread across the range of potential factors. The obvious recent changes are the increase in the percentage of cases in which no correctable factor was identified, and in the number of cases in which the medical condition of the patient was considered a factor.

Table 3. Causal or contributory factors

	1991-93	1994-96	1997-99	2000-02	2003-05
Number of deaths	116	130	135	137	112*
Number of factors per death (mean)	2.2	2.2	2.1	2.4	1.6
Preoperative (%)	47	39	40	42	27
Intraoperative					
Technique (%)	39	54	70	40	36
Drugs (%)	45	50	39	45	32
Management (%)	38	26	20	45	22
Postoperative (%)	30	15	23	43	15
Organisational (%)	18	37	21	25	24
No correctable factor: G (%)	4	13	9	20	33
Patient condition a factor: H (%)			13	27	58

Preoperative includes assessment and pre-operative management (including optimisation and resuscitation); Technique includes airway management, ventilation, and choice of technique; Drugs include choice, dose, adverse reactions, and reversal; Management includes monitoring, equipment, and response to crises; Postoperative includes monitoring, management, and supervision; Organisational includes adequacy of experience and assistance, level of supervision, and planning.*NSW, Victoria, and WA only.

Discussion

The seven triennial anaesthesia mortality reports provide an extensive source of information on anaesthesia-related mortality in Australia between 1985 and 2005. While there are some caveats relating to various aspects of the data, it is unlikely that more accurate information is available from any other source or covers as large a number of anaesthetics. The data shows that anaesthesia-related mortality has decreased in Australia from about 1:36,000 anaesthetics from 1985-1987, to about 1:54,000 from 2003-2005. This is about a 50% reduction. This is despite a likely increase in the age of the surgical population, in the level of risk of patients, and in the complexity of surgical procedures performed. It is likely that the list of "factors under the control of the anaesthetist" have also expanded over this time. More impressive still has been the reduction in anaesthesia-caused mortality (category 1 deaths, anaesthesia as a primary cause) from about 1:74,000 anaesthetics from 1985-1987, to about 1:250,000 anaesthetics from 2003-2005. In addition, the percentage of deaths in which a correctable factor can be identified has fallen from 96% from 1985-1987, to about 66% from 2003-2005, and the medical condition of the patient is being recognised as a factor in a larger percentage of deaths.

Overall, the information contained in the seven reports is very encouraging. Anaesthesia-related mortality in Australia is extremely low in absolute terms, and appears to be either stable or decreasing. Patients, anaesthetists, health care managers, and health departments can be reassured by this data. However, they should not be satisfied. Several aspects of anaesthesia-related mortality are sobering. Firstly, in about two thirds of cases, a correctable factor can still be identified. In other words, some system or human error related to anaesthesia contributes to the death. This means that it should be possible to further reduce anaesthesia-related mortality by improved training, education, facilities, or resources. The remaining one third of cases present an even greater challenge. In these deaths, no correctable factor can currently be identified. This means that in a small subset of cases, the contribution of anaesthesia to death cannot be prevented with our current state of knowledge. Therefore, in order to prevent *all* causes of anaesthesia-related mortality, further research and development, as well as further education and resources, are required.

Dr Neville Gibbs, FANZCA
Editor, *Safety of Anaesthesia*
Chair, Anaesthetic Mortality Committee
of Western Australia

Anaesthetic Mortality In Australia and New Zealand 1985 – 2005: A report covering over 40 million anaesthetics

Continued

References

1. National Health and Medical Research Council. Report of Anaesthetic Related Mortality in Australia 1985 – 1987.
2. National Health and Medical Research Council. Report on Deaths Associated with Anaesthesia 1988 – 1990.
3. Australian and New Zealand College of Anaesthetists: Anaesthesia Related Mortality in Australia 1991 – 1993. Editor: B F Horan.
4. Australian and New Zealand College of Anaesthetists: Anaesthesia Related Mortality in Australia 1994 – 1996. Editor: N J Davis.
5. Australian and New Zealand College of Anaesthetists: Safety of Anaesthesia in Australia 1997 – 1999. Editor: P Mackay.
6. Australian and New Zealand College of Anaesthetists: Safety of Anaesthesia in Australia 2000 – 2002. Editor: N Gibbs. Assistant Editor: C Borton.
7. Australian and New Zealand College of Anaesthetists: Safety of Anaesthesia in Australia 2003 – 2005. Editor: N Gibbs.
8. Edwards G, Morton HJV, Wylie WD. Deaths associated with anaesthesia. A report on 1000 cases. *Anaesthesia* 1956;11:194-220.
9. Australian Institute of Health and Welfare (AIHW) www.aihw.gov.au
10. American Society of Anesthesiologists Physical Status (www.asahq.org/clinical/physicalstatus.htm)
11. Australian Bureau of Statistics. www.abs.gov.au



Quality and Safety Committee member profile

My role on the Quality and Safety Committee is to provide feedback on the Clinical Indicators used by the Australian Council of Healthcare Standards (ACHS). ACHS is an independent body that accredits hospitals; it is not the only accreditation organisation in Australia but it is the one most used. Collecting clinical indicator (CI) data is part of a raft of conditions that need to be met for accreditation.

As some of you may be aware Professor Paul Myles and I have been part of a working party that has recently reviewed the CIs for anaesthesia. A new, smaller set of CIs will be used from 2010.

After leaving ANZCA Council earlier this year I was very pleased to be invited to stay on the Quality and Safety Committee as I have always had an interest in this area. In fact my focus during my involvement with ANZCA over the last 15 years has been promoting high quality anaesthetic care.

In June this year, I became the Anaesthesia craft group representative on the South Australian branch council of the AMA. Being involved with health reform in this broader medical context is quite fascinating and also very rewarding.

I have been a specialist anaesthetist for over 20 years and worked in both private and public practice. For the last 10 years I have been at Flinders Medical Centre, a tertiary hospital in Adelaide, as a full-time staff specialist. I enjoy working in the public system as I like the camaraderie and also the case mix. In addition, public practice has offered me the flexibility that I need to contribute in these other areas.

The Quality and Safety Committee has already produced some great initiatives, and I look forward to continuing to participate in its endeavour to improve patient care.

Dr Margie Cowling
South Australia



Human error: a new approach?

The Cole Commission into the tragic sinking of HMAS Sydney off the coast of Western Australia during World War II has established that inexplicable actions by the very experienced captain led to the disaster. Of interest (and also applicable to anaesthetists) is a review article written by Daniel M Wegner from the Department of Psychology at Harvard University entitled “How to Think, Say, or Do Precisely the Worst Thing for Any Occasion.”¹

It is argued that ironic processes of mental control keep us watchful for errors thus avoiding the worst in most situations but that this same process increases the likelihood of such errors when we attempt to exert control under situations of stress, time pressure or distraction. This is clearly of relevance to the practice of anaesthesia.

It would appear that the return of undesirable suppressed thoughts or actions can in most instances be overcome when effective control strategies are employed to minimise mental load when mental control is needed. How this could apply to anaesthetists managing a crisis is doubtful. However, frequently errors are committed in a non critical situation where training in mental control may be advantageous.

The article makes interesting reading.

Dr Patricia Mackay
Victoria

Reference:

1. Daniel M Wegner: *Science*; 3 July 2009 Vol 325. www.sciencemag.org

Victorian Consultative Council on Anaesthetic Mortality and Morbidity (VCCAMM)



1. Annual reports for the years 2006 and 2007, containing important information on anaesthesia-related morbidity as well as mortality are available on the VCCAMM website www.health.vic.gov.au/vccamm/ under “VCCAMM Reports”, “Major Reports”.
2. Also on the website (under “Warnings and Alerts”) and endorsed by VCCAMM are two editorials by Associate Professor Terry Loughnan. One relates to the use of intralipid rescue for local anaesthetic toxicity and the need for availability of the agent for all patients undergoing major regional anaesthesia who may be at risk. The second editorial concerns the myocardial complications of clozapine with the need for ongoing cardiac monitoring and careful evaluation prior to anaesthesia.

3. Additionally on the website is “Alert: Risk of airway obstruction from retained swabs and throat packs”. Following reports of retained throat packs, the VCCAMM, over many years, has issued warnings about the necessity for all packs, swabs and pledgets to be included in the theatre count. Sadly this has not been adopted universally with the result that life-threatening situations of potential airway obstruction from retained packs continue to be reported. In a number of instances, the retained pack has not been identified until 16 to 48 hours after the patient has returned to the ward. Anaesthetists have an obligation to ensure that theatre protocols include, as a routine, a full count of all packs used by surgeons and anaesthetists.

Dr Patricia Mackay
Victoria

Infectious diseases and the anaesthetist

By Dr Jenny Stevens, Dr Archie Darbar and Dr Kim Weng

Needle handling and standard precautions are important issues but often neglected. Anaesthetists are also at high risk of infectious exposures to H1N1 due to the procedures we perform. This article serves as a reminder that simple procedures such as washing hands, wearing gloves and careful needle handling are effective and can minimise infectious exposures and complications.

Dr Archie Darbar is an infectious disease consultant at Royal North Shore Hospital. Dr Jenny Stevens is an anaesthetist also specialising in pain medicine at St Vincent's Hospital, and Dr Kim Weng is a ATY3 final year anaesthetic registrar in St Vincent's Hospital.

St Vincent's Hospital in Darlinghurst is in an area with a high number of intravenous drug users, HIV/HCV patients, and high-risk populations.

A senior anaesthetic registrar was called to the emergency department to insert a central line in a patient who had an abscess requiring intravenous antibiotics and who was known to be an intravenous drug user. As the registrar withdrew the 23-gauge finder needle from the patient, the needle flipped over and stuck into his finger. The patient was known to have chronic hepatitis C infection. As a result, the anaesthetic registrar endured psychological distress, delayed his attempts to have children, and had follow-up for a year before he was confident that he was clear of the disease.

Those with similar experiences describe them as frightening. Charles¹ in 2003 reported 1450 occupational exposures over 111 months at six major metropolitan hospitals in Melbourne. Of the exposures 60% were due to needle stick injuries.

Immunisation: the first step

What obligations does the hospital have to you regarding immunisation and what are your obligations?

Some hospitals require evidence of immunisation when you sign a contract but apart from that they have no obligation to chase you for immunisation reminders or records. They are only obliged to have a vaccination policy, keep staff vaccination records and provide information about vaccine-preventable diseases.

Exposure Prone Procedures (EPPs)²

These are invasive procedures involving contacts between health care workers and sharp surgical instruments or sharp tissues in body cavities including the mouth. These include procedures that are at risk of transmitting blood-borne viruses from infected healthcare workers to patients.

In general, procedures performed by anaesthetists are not considered as exposure-prone procedures as they are defined by the risk to the patient, not the risk to the healthcare worker.

Anaesthetists who do not perform EPPs are not required to be tested for blood-borne viruses due to the very low risk of occupational transmission if standard precautions are applied. They are also not required to reveal their infection status to patients.

According to Australian health department policy, all healthcare workers including anaesthetists who perform EPPs must be tested to ascertain their HIV, Hepatitis B virus (HBV), and Hepatitis C virus (HCV) status annually³. After significant occupational exposure or high-risk non-occupational exposures, status should also be checked. Anaesthetists who perform EPPs and who are already infected are responsible for informing their employer of their infectious status and should not perform EPPs if they are either HIV antibody positive, HBeAg positive, HBV DNA positive, or HCV PCR positive. It should be noted that this is controversial and it would be difficult to get adequate data on actual practice due to confidentiality requirements.



Area health services are required to have occupational rehabilitation to manage employees with infectious diseases for redeployment or find alternate duties or employment. They are not obliged to offer assistance with rehabilitation to independent visiting medical officers.

Although not obliged to unless performing EPPs, anaesthetists are encouraged to participate in a vaccination program as recommended by ANZCA⁴ and the Department of Health and Ageing. Vaccinations for all healthcare workers involved in patient care or handling of human tissues should include⁵⁶:

- Hepatitis B
- Influenza
- Pertussis
- Measles
- Mumps
- Rubella
- Varicella

If anaesthetists work in high-risk areas for hepatitis A, for example a remote indigenous community, then the hepatitis A vaccine is also recommended.

In addition, BCG should be given to those with a high risk of exposure, especially to drug-resistant tuberculosis. This will primarily apply to those travelling and spending significant time in areas where TB is endemic (for example doing aid work in a developing country).



“This article serves as a reminder that simple procedures such as washing hands, wearing gloves and careful needle handling are effective and can minimise infectious exposures and complications.”

EPPs define a risk to the patient and say nothing about the risk of transmission from patient to health care worker. Numerous studies have shown anaesthetists have exposure to blood not only from percutaneous routes but through mucosal blood during intubation, on equipment such as endotracheal tubes or laryngoscope blades and suction catheters; audits have revealed that anaesthetic personnel did not consistently wear gloves⁷ to lessen potential exposure risk. Prospective studies have shown that anaesthetic personnel sustain percutaneous injury with needles in 0.13% - 0.4% of operative procedures⁸. The rate of needlestick of anaesthetic residents was 2.5 injuries/resident year⁹. Comparison was made to orthopaedic residents (5.6), general surgical residents (5.5), obstetric residents (4.5) and residents in internal medicine (0.75).

The nature of percutaneous injuries suffered by anaesthetic personnel is significant. Green¹⁰ reporting data from the Exposure Prevention Information Network (EPINet) surveillance program recorded an 87% rate of hollow bore needle stick injuries which carry a higher risk than suture needles. Of these, 78% were after use of the device suggesting that these were largely preventable. In another study¹¹ he concluded that 30% of percutaneous exposures were high risk.

Standard and transmission-based precautions. What is the difference?

Standard (universal) Precautions¹²

Standard Precautions are the range of measures that will protect you from blood-borne diseases. They should be applied to all patients, and include the safe handling of sharps, cough etiquette and respiratory hygiene, and protective barriers: gloves, mask and eye protection. The Department of Health and Ageing recommends Standard Precautions for all patients whenever patient contact is made.

Most exposures to blood-borne diseases result from failure to follow recommended procedures for the safe handling and disposal of contaminated sharps or from not wearing protective equipment. Anaesthetists are responsible for the management of any sharps they use.

Transmission-Based Precautions

Transmission-Based Precautions are for patients suspected of being infected with a specific pathogen, so that additional control measures are required to prevent transmission. These precautions are designed to prevent respiratory disease transmission. The most common pathogens that anaesthetists may be exposed to are tuberculosis, varicella and respiratory viruses including influenza.

Droplets versus aerosols

Influenza and most respiratory viruses are spread by droplets. Droplets are (>5 micron) particles that are expelled from an infectious person in a predictable pattern and fall within a radius of approximately one metre. The droplet makes contact with mucous membranes of nose, mouth or conjunctivae of susceptible persons. When inhaled, they tend to land in the upper respiratory tract. Standard masks and contact precautions within a two metre radius (arbitrary) of the patient are sufficient. Other diseases with droplet transmission include *pneumococcal pneumonia*, *streptococcal pharyngitis*, pertussis and parvovirus B19.

Airborne diseases are spread by aerosols, which are small airborne particles (< 5 microns and often as small as 1.5 microns) suspended in air. These pathogens are widely dispersed by air currents, travel randomly and may be inhaled by a susceptible host in the same room or in an area with shared air circulation. This can often be many metres away from the site of dispersion. Aerosols are not stopped by a poorly fitting surgical mask. Diseases transmitted in this way include *Neisseria meningitidis*, measles, *Mycobacterium tuberculosis* and SARS. Special ventilation requirements include single room with negative airflow, numerous (6-12) air exchanges with external environment and HEPA filtration required to accommodate these patients to prevent nosocomial transmission of infection. Respiratory protection is provided by an N-95 mask fitted tightly over the nose with a particulate filter to trap tiny aerosolised particles.

Infectious Diseases and the Anaesthetist

Continued

Droplets (or aerosols) are generated during talking, coughing or sneezing and during procedures such as intubation or bronchoscopy. In addition to wearing masks correctly, contact precautions are also recommended for interactions and procedures on patients suspected of having this group of illnesses due to possibility of self inoculation of respiratory secretions from surrounding surfaces.

What to do if you are exposed

Immediate post-exposure management³

- Wash the exposure site with soap and water. Rinse eyes and mouth with water if affected. Remove clothing and shower if contaminated.
- Assess the risk, including significance of the injury, the status of the source and the healthcare workers affected.
- Obtain consent for baseline tests, pre and post-test counselling must be provided to both affected healthcare workers and the source patient.
- Consult an infectious diseases specialist, who should be provided by the hospital to all.
- Use appropriate prophylaxis if necessary.
- Produce detailed documentations of the events.
- Organise follow-up for further testing, treatment, expert consultation, counselling and compensation.
- Confidentiality must be maintained at all time.

Rapid assessment is advised to ensure early administration of prophylaxis.

Risk assessment if an exposure occurs to a blood-borne disease

The significance of the injury depends on the extent of the injury, the item that caused the injury, and the body fluids and volume involved. If the injury involves percutaneous exposure, mucous membrane exposure such as eyes or mouth, or non-intact skin exposure to infectious fluids, the injury is considered significant.

The source patient should have baseline tests to confirm the HIV, HBV, and HCV status after informed consent and counselling. If the patient refuses testing or is unable to be tested, the relative risk of the patient being infected must be evaluated from epidemiological information.

Implications of exposure

In the case of significant exposure, the anaesthetist should have baseline testing for HIV, HBV, and HCV. During the period of testing and confirmation of disease status, anaesthetists should not donate blood, should protect sexual partners by using condoms, seek advice regarding pregnancy or breastfeeding and modify work practices involving exposure prone procedures.

Psychological issues

It can be an extremely anxious time for anyone having a significant exposure to an infectious disease. Given the low rate of seroconversion after occupational injury, often anxiety itself causes the greatest impact on the healthcare worker. Many exposed healthcare workers would take precautions to prevent transmission of diseases such as altering their lifestyle, delaying having children or abstaining from sexual activity, which may exacerbate depression and the sense of social isolation.

What to really lose sleep over

Source	Estimated prevalence in Australia	Risks after occupational exposure
HIV	16,692 people in 2007 ¹⁴	0.3%
HBV – HbsAg (+) only HBeAg (+)	90,000-160,000 people in 2005 ⁶	1-6% 22-31%
HCV +ve HCV PCR -ve	264,000 people in 2005	10% 1.9%

Hepatitis B (HBV)

Hepatitis B is the most infectious of the blood-borne diseases.

The risk of transmission to a non-immune healthcare workers following needle stick injury is 1-6% for an HBeAg negative source and 22-40% for an HBeAg positive or HBV DNA positive source. There is a 40-50% risk of developing acute hepatitis in adult infection. Chronic active hepatitis occurs in more than 25% of carriers, and up to 25% die prematurely of cirrhosis or hepatocellular carcinoma¹⁵.

However it is the only blood borne virus for which vaccination is available. HBsAg titre should be obtained one to two months after completion of the vaccination course to confirm immunity, as a significant proportion of hepatitis B vaccinees will be non-responders after primary vaccination. Some people will be persistent non-responders and they should be informed that they are not protected and should minimise exposures.

For healthcare workers with impaired immunity, for example those with either HIV infection or renal failure, a booster may be required. This depends on the level of anti-HBs. If you are not immunocompromised then a booster is probably not required even if your level of anti-HBs is low¹⁶.

Following significant exposure, the person exposed should have anti-HBs level and HBsAg tests immediately if not previously vaccinated against hepatitis B. If anti-HBs is negative, a single dose of hepatitis B immunoglobulin 400 IU needs to be administered within 72 hours of exposure. Also hepatitis B vaccine should be provided as soon as possible, within seven days of exposure as recommended. Two further doses of

vaccine need to be given at one and six months after the first dose. Post-exposure prophylaxis is not necessary for health care workers already fully immunised.

Bottom line: it is a bad disease and infectious but do not lose sleep – get immunised.

Hepatitis C (HCV)

Anaesthetists are at risk of contracting the hepatitis C virus from penetrating injuries with contaminated sharps. After exposure from a HCV-positive patient, the rate of seroconversion is estimated at 10%, and if the source is negative for HCV PCR, the risk is approximately 1.8%. At least 85% of people infected with hepatitis C and not identified early will develop chronic hepatitis, and without therapy 20% of people will progress to cirrhosis and 3% to hepatocellular carcinoma. Previous exposure does not result in immunity and re-infection can still occur if repeatedly exposed¹⁷.

There is no immunisation or post-exposure prophylaxis proven to be effective against hepatitis C at present. However, treatment of acute hepatitis C with interferon alfa-2b prevented chronic infection in 43 out of 44 patients in one study¹⁸.

Bottom line: no vaccination is available, there is moderate chance of seroconversion, especially with high viral load. Expect many sleepless nights and high emotional impact if you do seroconvert but early treatment should ensure that you are cleared of the virus.

Human Immunodeficiency Virus (HIV)

The risk of acquiring HIV after an occupational exposure to HIV-infected blood is **low**. It was reported that the average risk of HIV transmission is approximately 0.3% after a percutaneous exposure to HIV-infected blood. HIV seroconversion is generally documented within four weeks from exposure.

Australia remains a low-prevalence country for HIV¹⁹. However, it is important to consider local epidemiology in dealing with patients although application of universal precautions should help prevent occupational exposures.

After significant exposures, an experienced infectious disease physician should be consulted to initiate post-exposure prophylaxis (PEP) depending

on the type of exposure. PEP is preferably commenced within 1-2 hours following exposure but it is still effective until 72 hours post exposure²⁰. PEP should be continued for four weeks. No double blind randomised trials examining the efficacy of PEP are likely to be completed, hence recommendations about PEP are based on a retrospective case control trial²¹ of zidovudine prophylaxis which demonstrated an 81% reduction in likelihood of infection if prophylaxis was used.

The choice of a number of agents is dependent on the risk assessment of injury and the known viral load status or resistance profile of the source of the virus to antiviral therapy. Two antiretroviral drugs are normally used for most PEP, and a third drug is only used for exposures that have an increased risk of HIV transmission. However, PEP is not 100% effective in preventing HIV seroconversion if the inoculum is large, if there is a delay in the initiation of PEP, if transmission is of a resistant virus, or there is an incomplete course of PEP due to side effects.

Bottom line: the risk of seroconversion is low and post-exposure prophylaxis will reduce your risk further if you can tolerate it, but it is not 100% effective and the disease and treatment are both bad things to have. Most people do not complete a four-week course of antiviral therapy due to toxicity or the realisation of low risk.

Tuberculosis (TB)

In Australia, the incidence is low; about 1000 cases of TB are notified to health authorities each year. Of these, 85% of cases occur in people born overseas, particularly in Asia, southern and eastern European countries, the Pacific Islands, and north and sub-Saharan Africa. Rates of TB are also high in Aboriginal and Torres Strait Islander people and in Papua New Guineans living in some parts of Australia. Active TB is also associated with diseases such as HIV²².

Healthcare workers with impaired immunity, particularly those with HIV, should avoid exposure to infected patients, as there is a potential to develop fatal disseminated TB.

There is a BCG vaccine available.

“At least 85% of people infected with Hepatitis C and not identified early will develop chronic hepatitis, and without therapy 20% of people will progress to cirrhosis and 3% to hepatocellular carcinoma.”

Protective efficacy is only estimated at around 50%, and this varies due to differences in vaccine strains, local prevalence of *mycobacteria*, and host factors such as age at vaccination and nutritional status. Given the low incidence of TB in Australia and variable efficacy, BCG is only suggested for healthcare workers in areas where there is a higher immigrant population from those countries with a high prevalence, especially of drug-resistant strains. The World Health Organisation (WHO) does not recommend repeat vaccinations.

Transmission-Based Precautions for airborne diseases should be applied when in contact with patients with infective TB. Both the infected patient and all people in contact with the source should wear an “N-95 mask”, which has 99.5% efficiency against particles in the 0.3-0.5 micron range.

Anaesthetists should keep in mind the variable protective efficacy of BCG and use all necessary protective equipment particularly in areas of high prevalence. It is important to promptly identify symptoms or signs of active TB, which are:

- Persistent cough.
- Haemoptysis, weight loss, fever, and night sweats.
- Chest x-ray changes consistent with pulmonary TB.

Infectious Diseases and the Anaesthetist

Continued

Bottom line: you are most likely to have concerns with TB if there is a patient who is identified as having pulmonary tuberculosis after you have performed laryngoscopy, bronchoscopy or suctioning of the airway. In this situation you probably did not wear the appropriate mask and are identified as at risk on contact tracing. Being immunised may protect you; otherwise prophylaxis and/or treatment are effective.

Pandemic (H1N1) Influenza 2009²³

WHO declared outbreaks of the novel Pandemic (H1N1) Influenza 2009 virus infection in April 2009, and raised its level of pandemic alert to level 6 in June²⁴.

Pandemic (H1N1) Influenza 2009 is a highly transmissible virus between humans and there is no immunity to this infection because of the new genetic form. In most cases, the disease is mild but it can be severe in some at-risk groups (the immuno suppressed including pregnant women, the obese, those with chronic medical conditions including lung disease, and indigenous groups). Anaesthetists should apply Transmission-Based Precautions (droplet and contact) in suspected cases. Guidelines recommend cessation of nebulised therapy and restriction of aerosol generating procedures to prevent nosocomial transmission.

Anaesthetists who have been exposed to a confirmed case without using appropriate protective equipment, should excuse themselves from work if flu-like symptoms develop and seek medical advice. Pandemic (H1N1) Influenza 2009 is susceptible to the neuraminidase inhibitor oseltamivir (Tamiflu) which has been released from the national stockpile for use by occupationally exposed HCWs²⁵. There will be a procedure within each individual institution to access supply. Therapy should be commenced within 48 hours (preferably < 36 hrs) from symptom onset. NSW Health Guidelines suggest healthcare workers should stay away from employment for 72 hours from commencement of antiviral medication or until symptoms resolve. Oseltamivir may not be as effective against seasonal influenza due to the development of resistance. Reports of Pandemic (H1N1)

Influenza 2009 being resistant to oseltamivir are increasing. A vaccine has been trialed and will be released for the clinical use later this year.

Summary

It cannot be emphasised enough the importance of standard precautions and safe needle practices to minimise the risks of percutaneous injuries. All anaesthetists should comply with the guidelines and have their immunisations up to date.

These are the primary strategies against transmission of blood-borne diseases. It is important to know anti-HBsAb levels if previously vaccinated; if vaccination has not occurred then this should be attended to immediately. Vaccination status with regards to measles, mumps, rubella, varicella, BCG and pertussis should be known. Knowledge about *meningococcal*, *pneumococcal* and *Haemophilus influenzae type b* vaccines is important for immune compromised healthcare workers. Additional precautions for respiratory disease should depend on whether the disease is primarily of droplet or aerosol-borne transmission.

Anaesthetists need to be extra cautious when in contact populations with a high prevalence of infectious disease such as intravenous drug users, prisoners and immigrants from high disease prevalent countries. After significant exposures, risk assessment with an infectious disease specialist is essential in order to initiate post-exposure prophylaxis early to reduce the risk of seroconversion. Follow-up and counselling may help to reduce the psychological impact associated with exposures.

Dr Jenny Stevens

St Vincent's Hospital, Darlinghurst

Dr Archie Darbar

Royal North Shore Hospital

Dr Kim Weng

St Vincent's Hospital, Darlinghurst

References:

1. Charles PGP, Angus PW, Sasadeusz JJ, Grayson ML, et al. Management of healthcare workers after occupational exposure to hepatitis C virus. *MJA* 2003; 179: 153-157
2. Australian Department of Health Policy PD2007_036. Infection Control Policy. 23-May-2007
3. Australian Department of Health Policy PD2005_162. HIV, Hepatitis B or Hepatitis C – Health Care Workers Infected. 25-Jan-2005
4. Australian and New Zealand College of Anaesthetists. Guidelines on Infection Control in Anaesthesia. Professional Standards PS28 2005
5. The Australian Immunisation Handbook 9th Edition 2008. page 104-6
6. Recommendations of the Advisory Committee on Immunization Practices (ACIP) and the hospital Infection Control Practices Advisory Committee (HIPAC). *MMWR* 1997; 46(RR-18): 1-42
7. Popejoy SL and Fry DE. Blood Contact and exposure in the Operating Room. *Surg Gynaecol Obstet* 1991; 17: 4803.
8. Harrison CA, Roger DW and Rosen D Blood contamination of anaesthetic and related staff. *Anaesthesia* 1990; 45: 831-3
9. Heald AE and Ransohoff DF. Needlestick injuries among resident physicians. *J Gen Intern Med* 1990; 5: 389-93.
10. Greene ES, Berry AJ, Arnold WP et al. Percutaneous injuries in anaesthesia personnel. *Anaesth Analg* 1996; 83: 273-8.
11. Greene ES, Berry AJ, Jagger J, et al. Multicenter study of contaminated percutaneous injuries in anaesthesia personnel. *Anesthesiology* 1998; 89: 1362-72
12. Siegel JD, Rhinehart E, Jackson M, Chiarello L, the Healthcare Infection Control Practices Advisory Committee. 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Centers for Disease Control and Prevention page 66-73
13. Australia Department of Health Policy PD2005_311. HIV, Hepatitis B and Hepatitis C – Management of Health Care Workers Potentially Exposed. 27-Jan-2005
14. National Centre in HIV Epidemiology and Clinical Research 2008. HIV/AIDS, Viral Hepatitis and Sexually Transmissible Infections in Australia; Annual Surveillance Report

15. Dore G, Wallace J, Locarnini S, Desmond P, Gane E, Crawford D, et al. Hepatitis B in Australia: Responding to a Diverse Epidemic.
16. Watson B, West DJ, Chilkatowski A et al. Persistence of Immunologic memory for 13 years in Recipients of a Recombinant Hepatitis B Vaccine. *Vaccine* 2001; 19: 3164-8.
17. Hepatitis C Virus Projections Working Group: Estimates and Projections of the Hepatitis C Virus Epidemic in Australia 2006
18. Jaeckel E, Cornberg M, Wedemeyer H et al. Treatment of Acute Hepatitis C with Interferon Alfa-2b. *NEJM* 2001; 345; 20: 1452
19. Guy RJ, McDonald AM, Bartlett MJ, Murray JC, et al. HIV diagnoses in Australia: diverging epidemics within a low-prevalence country. *MJA* 2007; 187: 437-440
20. Young T, Arens FJ, Kennedy GE, Laurie JW, Rutherford G, et al. Antiretroviral post-exposure prophylaxis (PEP) for occupational HIV exposure (REVIEW). The Cochrane Collaboration. *The Cochrane Library* 2009, Issue 2
21. Cardo DM, Culver DH, Ciesielski CA, et al. A case-control study of HIV seroconversion in health care workers after percutaneous exposure. Centers for Disease Control and Prevention Needlestick Surveillance Group. *N Engl J Med* 1997 Nov 20;337(21):1485-90
22. Victorian Government Department of Human Services. Management, Control and Prevention of Tuberculosis: Guidelines for Health Care Providers (2002-2005). August 2002
23. Australian Government, Department of Health and Ageing, Australian Health Management Plan for Pandemic Influenza, version 2.0 8 July 2009
24. Statement by WHO Director-General Dr Margaret Chan, *World now at the start of 2009 influenza pandemic*, 11 June 2009 http://www.who.int/mediacentre/news/statements/2009/h1n1_pandemic_phase6_20090611/en/index.html
25. Cheng AC, Dwyer DE, Thomas A et al. ASID / TSANZ guidelines: treatment and prevention of H1N1 influenza 09 (Human swine influenza) with antiviral agents. *MJA* 2009; 191: 1-8

Gumnuts and joeys – delivering anaesthesia in the bush



The Rural Special Interest Group held its second conference at the Crowne Plaza Resort in the Hunter Valley from July 23-25, 2009. This year's meeting had a theme of obstetric anaesthesia and included obstetricians and GP anaesthetists on the list of speakers. The program was designed to update rural specialist and GP anaesthetists in routine obstetric anaesthesia as well as the emergencies.

The meeting started with a Neonatal Resuscitation workshop, kindly run by Dr Paul Craven (neonatologist) and Denise Kinross (CNC) from the John Hunter Hospital in Newcastle. The interactive workshop mixed excellent discussion with hands on use of equipment and was extremely well received by all participants.

The opening session, chaired by John Male, focussed on labour ward analgesia with Rod Martin presenting some original work looking at the reasons behind the differing rates of labour epidurals between rural and metropolitan centres. This was followed by David Rowe who spoke about modernising rural epidurals by promoting the use of PCEA's. The final speaker for the session was David Elliott who highlighted some of the pros and cons of using Remifentanyl PCA's on the labour ward.

The second session of the afternoon, chaired by Craig Mitchell, moved into the operating theatre with Patrick Maloney giving us an insight into why obstetricians will decide a patient needs a C-Section complimented by two talks from Makarla Stead outlining best practise for both regional anaesthesia and general anaesthesia for C-Sections. Nolan McDonnell then tried to cram his PhD thesis into a 20 minute guide to post C-Section analgesia.

Day two moved into the realms of obstetric emergencies with the first session, chaired by David Rowe, covering pre-eclampsia from the obstetrician's perspective, provided by Rahul Sen, and the anaesthetist's perspective from Stephen Gatt. The session was rounded off by David Elliott giving us a refresher on the failed intubation drill. The second session of the day, chaired by Nolan McDonnell moved onto obstetric haemorrhage and Patrick Maloney and Craig Mitchell showed us how an obstetrician and anaesthetist need to work in harmony during this particular emergency. The day finished with Deb Gardiner and a bag of chocolate, keeping the audience alert and involved as she discussed the pregnant patient undergoing non obstetric surgery.

Day three shifted focus to maternal co-morbid disease with the first session, chaired by Deb Gardiner, including two talks by Sergio Diez on cardiac disease in pregnancy and liver disease of pregnancy interspersed by Rahul Sen talking about thromboprophylaxis in pregnancy and Judith Killen giving us a run down of the diabetic parturient. The final session of the meeting gave the delegates a chance to debate how and where to manage the growing numbers of obese mothers. Stephen Gatt covered the management issues before Scott Finlay gave us a GP anaesthetist's view of the reality of caring for these women in geographically isolated communities.

The social aspects of the conference made the most of the beautiful Hunter Valley. Golf was on hand and a few tried the championship course around the hotel whilst others enjoyed an escorted tour of a few wineries on the Friday afternoon.

I would like to thank the organising committee which included Deb Gardiner and Craig Mitchell who helped develop the program, and Marta Dzedzicki at ANZCA who converted our program and choice of venue into a very high quality conference.

The success of the first two Rural SIG meetings has led the executive to host an annual Rural SIG conference with initial planning well under way for the 2010 meeting to be held in Hamilton Island in July with a theme based on general anaesthesia in the bush. Check the website for further details.

Any Fellows who would like to join the organising committee or have an original paper they would like to present are welcome to contact the Rural SIG via the SIG Coordinator, Kate Briggs on +61 3 9510 6299. I look forward to seeing you all again in 2010!

Dr David Rowe
Convener

AMOSS (Australasian Maternity Outcomes Surveillance System)

by Dr Nolan McDonnell



On June 24, 2009 I was privileged to attend the launch of AMOSS (Australasian Maternity Outcomes Surveillance System) by the Hon. Nicola Roxon (Federal Minister for Health) at Parliament House in Canberra. I attended the launch in the capacity of the ANZCA representative for the project as well as one of the investigators who has been involved with the development of AMOSS since its inception. AMOSS is an exciting project that has been designed to investigate, in real time and with rapid feedback, severe and rare obstetric morbidity in Australia and New Zealand, and then to assist in translating the findings into policy development, clinical guidelines and education and training to improve the safety and quality of maternity care in Australia and New Zealand. It has received considerable NHMRC funding, initially as a five-year project grant.

AMOSS has been modelled on its successful UK equivalent, the UKOSS, which was established in 2005 and has already produced valuable information on peripartum hysterectomy, eclampsia, amniotic fluid embolism and antenatal pulmonary embolism. It relies on the reporting by individual hospitals of any disorders under investigation. Each participating hospital in the AMOSS network will have a multidisciplinary network of people with an interest in maternity care. Information on the cases will be entered as non identifiable data onto a secure, web based system (www.amoss.com.au, www.amoss.co.nz) with

monthly reminders about the disorders under investigation being sent to all participating hospitals.

We have initially selected five conditions associated with pregnancy (antenatal pulmonary embolism, amniotic fluid embolism, extreme morbid obesity, eclampsia and placenta accreta) and one intervention (peripartum hysterectomy) as the focus for the first year of research. It is planned that each condition studied will initially run for one year, except for amniotic fluid embolism which will be an ongoing project. After the initial one-year introductory period we hope to be able to expand the conditions studied and make the infrastructure available to investigators wishing to examine other obstetric complications. This raises a number of exciting potential research opportunities in obstetric anaesthesia, especially in relation to obstetric airway management, complications of neuraxial anaesthesia and critical illness in pregnancy.

AMOSS is a collaborative project on a grand scale, with buy in from all the major specialty and midwifery colleges as well as the other major interest groups. Both Australia and New Zealand are in desperate need of a system to monitor severe maternal morbidity. For AMOSS to be successful it needs your help. With more than 280 hospitals providing obstetric care throughout Australia and New Zealand we are seeking interested people in both the public and private sectors to assist as local AMOSS co-ordinators (ideally as part of a team of interested midwives

and obstetricians) and for anaesthetists and intensivists to have their "ears to the ground", listening out for cases which are currently being studied by AMOSS. As the conditions being studied are rare, the workload for most people will be very light, but the negative reporting of conditions is just as vital as the actual case ascertainment. AMOSS has dedicated project managers who will take care of most of the issues in regards to ethical and executive approval at each site.

At the time of writing we have 90 hospitals recruited, and hope to reach 180 by the beginning of 2010 when AMOSS should be fully up and running. Our aim is to have at least one interested anaesthetist from all units that provide obstetric care throughout Australasia (and especially those working in the private sector) involved in the project. Participation as an AMOSS co-ordinator is also a great way to earn ANZCA CPD points*.

If you are interested in being part of AMOSS, either as a local site co-ordinator or if you have a condition that you would like to study using the AMOSS infrastructure, then please do not hesitate to contact me via email, Nolan.McDonnell@health.wa.gov.au or the AMOSS project team, amoss@unsw.edu.au.

Dr Nolan McDonnell

Staff Specialist
Department of Anaesthesia and Pain
Medicine King Edward Memorial Hospital
for Women, Subiaco, Western Australia.

*Participation as a local AMOSS co-ordinator has been approved for ANZCA CPD points: Approval number 1528 (Research/Survey: Category 3 / Level 1: 2 Credits per hour). Accreditation does not represent endorsement or approval by ANZCA of the activity.

The state and territory representatives for AMOSS at the launch at Parliament House in Canberra, from left: Rachael Lockley (NT), Professor Alec Welsh (NSW), Professor David Ellwood (ACT), Dr Nolan McDonnell (WA), Professor Jeremy Oats (VIC), Associate Professor Leonie Callaway (QLD), and Associate Professor Bipin Gupta (TAS).

New Fellow on Council



More than half-way through my two years on ANZCA Council, I have been offered an opportunity to reflect on my time on Council as the New Fellow Councillor.

To be eligible for the role, the New Fellow on Council must begin the term within three years of attaining Fellowship. I am the second new Fellow to have been privileged to contribute to Council affairs. It is a position that was created to provide to Council a perspective of recent graduates of the FANZCA training program. It also allows a New Fellow to gain valuable insight into the workings of the College Council and its various committees.

The Council “year” begins with the new Council meeting at the end of the ANZCA Annual Scientific Meeting in May. I remember well the first meeting I attended – what seemed like only a few hours after the end of the Sydney ASM Gala Event at Luna Park! At this meeting the membership of the various

committees of Council is established for the following 12 months. As my interests lie in education and training I joined the Education and Training Committee, and was also a member of the Fellowship Affairs Committee. Council meetings are held in Melbourne on a Saturday every two months, while the Committees meet in the days prior.

The Education and Training Committee is a busy committee that oversees all facets of the training program. The College is in the process of a review of the curriculum. I now have a much greater understanding of the challenges involved in providing such an excellent training program.

The Fellowship Affairs Committee covers issues surrounding the fellowship such as the ASM, communication and continuing professional development. It has been most rewarding to be involved during a period of change.

As a Councillor I have also had the opportunity to participate in hospital accreditation visits. It is a privilege to be able to review departments of anaesthesia. During the visits I have been involved in I have come away with a greater understanding of both the strengths and weaknesses of my own department and practice and how I can improve things.

Councillors are made ex-officio members of their state regional committees and I became involved with the NSW Regional Committee. This has been very beneficial in gaining a greater understanding of local issues. The regional committees are a vitally important conduit between Council and each state’s Fellows, as well as providing a voice to Council about issues that may be region specific. While encouraging new Fellows to consider nominating for a position on College Council I would also like to encourage greater involvement in regional committees.

My time on Council to date has been incredibly rewarding. I have a much greater understanding of the practice of anaesthesia as a profession and the

role that fellows can have in ensuring our training program produces the best anaesthetists we possibly can. I have gained knowledge and skills that I can bring to my department and to my region. I feel that I can better support and educate trainees on a daily basis. I have worked with an amazing group of dedicated anaesthetists and College staff and can only feel that the future of our profession is safe in their hands.

In return, I think that the new Fellow does provide a valuable and unique perspective. I don’t feel that I was just an observer. I had a voice and my opinion was respected.

I hope that all New Fellows will consider the valuable role that they can play in the future of our profession – be it at a local, regional or Council level.

Dr Nicole Phillips
New Fellow Councillor

New Fellows Conference 2010

**April 28-30, 2010,
Hanmer Springs,
Christchurch,
New Zealand**

The New Fellows Conference (NFC) is held in conjunction with the annual ANZCA scientific meeting and is available to Fellows within eight years of achieving FANZCA. The college sponsors the conference and selects delegates to represent the various regions. The style of the NFC tends to be interactive, with presentations and workshops relating to the conference theme. The 2010 NFC promises to be a uniquely Kiwi experience complete with inspiring environment, invigorating weather, a range of challenges both physical and intellectual and the opportunity for a little luxury...

The Heritage Hotel at Hanmer Springs Alpine Village will be the conference base. Lying 90 minutes North of Christchurch, Hanmer is a popular year round destination and is located on the Alpine Scenic Route. As its name suggests, Hanmer is an alpine setting with an adjacent ski-field, adventure activities, mountain-biking and walking trails and a well-developed natural hot-springs and spa complex. There will be opportunity each day to take advantage of walking tracks and hot springs.

The 2010 conference theme is “Anaesthesia and Adventure” (broadly defined). The Concise Oxford English Dictionary defines adventure as: “an unusual, exciting or daring experience or excitement arising from this” with origins in the Latin *adventurus: about to happen and advenire to arrive*.

Proposed sessions within this broad theme are:

1. Now you’ve arrived, where to from here? (Career planning and options)
2. Juggling commitments and choices. (Including a workshop with Kiwi adventurer and entrepreneur Mark Inglis)
3. The Hanmer Challenge (Combined physical and problem-solving challenges).
4. Giving something back (Contributing to your department, the specialty, the wider world...)

Delegates will be asked to prepare a brief (5 – 10 minute) presentation related to the conference theme. These will be included within sessions to highlight points and provoke discussion.

The involvement of Mark Inglis provides a point of difference to the activities. Mark is a well known and high achieving adventurer, athlete, scientist, businessman and philanthropist. He will run “The Choice” workshop on Day

2 and deliver a keynote speech that evening. This will set the scene for the penultimate session on Day 3: “Giving Something Back”. We hope to hold a concluding session with lunch and debrief at Pegasus Bay Winery en route to Christchurch, to merge seamlessly into the main conference.

General objectives of the New Fellows Conference include the sharing of ideas and experiences and furthering insight into aspects of the College role. Specific aims of this conference are broadening awareness of career options and development, balancing these and perhaps most importantly, identifying and encouraging ways in which we can contribute in the wider context.

New Fellows are encouraged to attend next year’s conference by contacting their regional or national committee by October 30.

We anticipate a great few days of stimulating discussion and entertaining activities, all in the beautiful, tranquil alpine village of Hanmer Springs.

Dr Karen Ryan,
Convener

An insider's perspective

Details of the beautiful location and engaging program aside, there are some features of the New Fellows Conference that make it stand out as an experience amongst professional educational activities. The limited group size helps the interactive format to flourish: small enough to know everyone by name, large enough to bring diversity to discussion. The program presenters were no longer distant experts behind a lectern but accessible and interested participants themselves. Each was given several slots in the program enabling them to explore different ideas or build on a particular theme. Small group debates with topics such as 'That Happiness is the natural human state', provided entertaining and thoughtful diversion.

Personal highlights included the opportunity to meet anaesthetists from around the country and overseas. It was remarkable to reflect on the fact that members of a group with such diverse heritage, experience, personal and professional interests should find a place in a fellowship such as ANZCA. Sharing with them a program that, on the face of it, had little to do with anaesthesia but everything to do with anaesthetists was a rewarding exercise. I would encourage new Fellows to consider attending coming conferences for a similarly enriching (or perhaps just relaxing) experience. That we were able to do it with views of the Queensland coastline was just a lucky bonus!

Dr David Bramley
2009 NFC Representative
Western Health Service, Victoria



A rural anaesthetist's CPD experience

By Dr Frank Moloney
Chair, ANZCA CPD Committee



In 1997 I was called to Melbourne to partake in a “think tank” on the development of a Continuing Professional Development (CPD), then called “MOPS”, program for ANZCA.

I suppose I was there representing rural anaesthetists. I knew it was not my typing and IT skills that gave me a seat at the table for this opportunity!

Professor Teik Oh, FANZCA FJFICM, was driving the establishment of the MOPS process with the full support of the ANZCA Council. I couldn't help wondering, as a relatively isolated rural practitioner, how could I reach the expectations of the program? I also questioned how I could prove that I had attended local teaching sessions and mortality and morbidity meetings and why there was this intrusion into my work after 18 years of safe practice.

I explained during this think tank that it was far more difficult for rural anaesthetists to comply, for two reasons: greater cost because of travel and accommodation expenses, and the difficulty in covering your workload by your colleagues when you are away.

As a rural group having just gained our first registrar the year before, we limped into the MOPS program by beefing up our teaching program and review of practice. Every now and again one of us was randomly audited (5% of participants annually) but there was no fallout from this. Q & A points were the target, so records of our mortality and morbidity meetings were kept. I had no idea that as MOPS changed to CPD in the future I would be busily engaged in the planning and implementation process.

On joining the ANZCA Council in 2005 I was asked by former President Wally Thompson to be the MOPS Officer, as the person I was replacing had held that title. I readily agreed as I was now familiar with the MOPS Program and I thought there wouldn't be much work attached. It didn't take long for me to realise this assumption was way off the mark.

I was suddenly the adopting father of Teik Oh's new brainchild – the CPD Program. MOPS was undergoing serious transformation. ANZCA Council, for what I see now for many valid reasons, was upgrading MOPS to CPD and I was the “herder of the cats”.

The changes came for two main reasons. ANZCA was convinced that national registration was imminent and government was analysing each college CPD program with the intention of imposing its own program if there was a perception that existing programs were inadequate. New Zealand had recently introduced practice audits in an attempt to detect underperforming practitioners (one country, one jurisdiction).

Our new CPD was also based on programs in other developed countries. It appears complex, but it is fair and professionally assisted by staff at ANZCA House. We were clear that our CPD was not for detecting the underperformers but for improving performance and we repeatedly explained that it was not our way or the highway. ANZCA would accept any CPD program, structuring them into four categories; Group Learning, Self-Learning, Practice Assessment and Education Development Activities. It was a three-year program but for New Zealand and NSW, annual certificates of participation were available. We always supported and encouraged online participation.



CPD was introduced in 2008 and was mandated in 2009, again consistent with other countries and programs.

We have received hate mail, false accusations and there have been misunderstandings but on the positive side there has been encouragement and letters of support. The DPAs and the CPD Committee have demonstrated participation at multiple meetings and our patient College staff including Juliette Mullumby, Teresa Brandau-Stranks and Sara Habib constantly offered calm advice regarding online and offline participation of the program.

The common pathways for covering category points are:

1. Teaching, meetings, conferences and workshops.
2. Reading journals, books, hospital attachments and preparing your CPD Plan.
3. Mortality and morbidity meetings, case conferencing, clinical audits and hands on skills workshops.
4. Non compulsory category, teaching, research and examining.

As I reflect on these experiences, I remember that even this activity can gain me CPD credits. I am in sync with my CPD Plan which was a three year plan constructed to ease out of after hours activity (done) and to retire gracefully and safely (a work in progress!).

ANZCA staff can provide assistance and answer any questions on the CPD Program. The CPD Coordinator, **Sara Habib** can be contacted on +61 3 9510 6299 or by emailing cpd@anzca.edu.au.

Dr Frank Moloney
Chair, ANZCA CPD Committee
Director of Anaesthesia
Orange Base Hospital

“I couldn’t help wondering, as a relatively isolated rural practitioner, how could I reach the expectations of the program? I also questioned how I could prove that I had attended local teaching sessions and mortality and morbidity meetings and why there was this intrusion into my work after 18 years of safe practice.”

ANZCA curriculum review: your questions answered

By Mary Lawson, Director of Education
and Claire Byrne, Education Research and Evaluation Officer

A review of the current ANZCA Training Program has been planned since its introduction in 2004, when it was nicknamed the 'New FANZCA'. As planned, the ANZCA Curriculum Review Project was initiated in late 2008 to coincide with the first cohort of trainees completing the full training program. A Curriculum Review Working Group (CRWG) – comprising Fellows, trainees and staff – has been appointed to provide oversight and guidance for the duration of the review.

In this article we will address some important questions about the Curriculum Review Project and provide you with an update on progress made and outline a plan for redevelopment of the ANZCA Training Program.

What is being reviewed?

The aim of the curriculum review is to enhance educational quality in three key areas of the ANZCA Training Program:

- The teaching, learning and assessment methods used.
- The processes undertaken to manage and enhance the quality of the curriculum.
- The operational matters associated with the curriculum.

This framework has provided the structure for the entire review process.

Why do it?

There are a number of major issues facing the medical systems in which anaesthetists work and train which ANZCA will need to contend with successfully in the near future. In particular, we will need to be prepared for the increased number of junior doctors seeking a place in vocational training from 2012, due to the increased number of medical student places offered by both the Australian and New Zealand medical schools in recent times. Similarly, we will need to be able to respond effectively to government calls for us to expand our range of training settings further; into the private sector and rural areas, for example.

We also need to maintain a contemporary clinical and educational focus to the ANZCA Training Program. This will mean that we are incorporating the best available evidence to support the content of the program and also the processes by which it is taught, learned and assessed.

Why should you be involved?

To ensure the ANZCA Training Program remains contemporary in nature, and is also equipped to manage the upcoming changes to our medical systems, we need to ensure any changes stem from a clear mandate from our members (both Fellows and trainees). To produce a set of recommendations that are both comprehensive and relevant to anaesthesia practice in ANZCA nations/regions, we need to ensure input from a wide and representative sample of our College body:

- **Current trainees and Teaching/Supervising Fellows:**
For all of you who are actively involved in the ANZCA Training Program at the moment, we particularly value your first-hand experience with the existing training program.
- **Non-teaching Fellows:**
For those of you either not actively involved with our training program, or working in settings which have not traditionally included trainees (e.g. private practice, VMOs etc.), we particularly value your suggestions to help us provide a feasible expansion into such settings.
- **Other Fellows:**
For those of you who were involved with the training program in the past (e.g. retired Fellows) we particularly value the insights from your previous experience, including the many changes and advances to the practice of anaesthesia in recent times.

How can you be involved?

Two underpinning principles of the ANZCA Curriculum Review Project have been *transparency* and *consultation*. To ensure *transparency*, there has been a range of updates included in each of the College publications since the project inception. Additionally, all aspects of the project have been regularly posted on the ANZCA website at: www.anzca.edu.au/edu/projects/curriculum-review

Two major stages of consultation in the ANZCA curriculum review were planned: a very broad submissions process and a survey of all ANZCA Fellows and trainees.

Stage 1 Consultation – The ANZCA Curriculum Review Submissions:

This first stage of consultation was completed in January 2009 and took the form of an open submissions process. Submissions could be made by any group or individual having an interest in the ANZCA Training Program and / or ANZCA Teacher development and support initiatives. In addition, a wide range of internal and external stakeholders were specifically invited to provide their views and thoughts in a structured format.

The 132 submissions received from groups and individuals (both internal and external to ANZCA) have been published on the ANZCA website at: www.anzca.edu.au/edu/projects/curriculum-review/submissions/. They make interesting and thought-provoking reading and represent a very broad spectrum of opinion and experience.

ANZCA curriculum submissions process: areas for comment.

1. Comments were invited on the current ANZCA Training Program as follows:

- Strengths and weaknesses of the current ANZCA Training Program
- The teaching, learning and assessment methods, in particular:
 - Program content
 - Learning materials
 - Teaching and learning methods
 - Assessment tools
 - Alignment of teaching, learning and assessment
- The processes undertaken to manage and enhance the quality of the program, in particular:
 - Initiatives to evaluate and improve the program
 - ANZCA teacher training, development and support initiatives
 - Trainee support and guidance initiatives
- The operational matters associated with the curriculum, in particular:
 - Selection of trainees
 - Curriculum organisation and administration

2. Comments were invited on the desired outcomes of ANZCA training using the following 'CanMEDS' framework:

- The anaesthetist as medical expert
- The anaesthetist as communicator
- The anaesthetist as collaborator
- The anaesthetist as manager
- The anaesthetist as health advocate
- The anaesthetist as scholar
- The anaesthetist as professional

3. Participants were invited to submit innovative ideas for the ANZCA Training Program

4. Comments were also solicited on Innovative ideas for the ANZCA Clinical Teacher Development and Support Program

5. Other comments



Shape the future ANZCA Training Program!

Complete the ANZCA Curriculum Review Survey online at:
www.anzca.websurvey.net.au.

Participation prizes: Encourage your peers to complete the survey too! On reaching a final response rate of 40% a complementary registration to the ANZCA 2010 Annual Scientific Meeting will be drawn. One prize each for a Fellow and a trainee will be on offer.

CPD approval: The survey is approved for the ANZCA CPD program (approval number 1577). Category 3/Level 1: 2 credits per hour.

Stage 2 Consultation – The ANZCA Curriculum Review Survey:

The second stage of curriculum consultation is designed to determine consensus on a variety of issues identified during the submissions process. You could think about the submissions process as an investigation of all of the issues, barriers and suggestions involved in providing a high quality educational preparation for contemporary anaesthesia. Having identified the issues we need to engage the whole population of ANZCA Fellows and trainees in determining agreed and prioritised ways forward.

The survey has been designed using a combination of:

- a thematic analysis of the curriculum review submissions;
- principles of the ANZCA Curriculum Review Working Group (CRWG);
- assessment principles developed by the ANZCA Assessment Sub-committee (ASC);
- known evidence-based educational principles; and
- input from related College committees, working groups and administrative units.

Fellows and trainees will each receive a hard copy of the survey in the mail in early October 2009. It is also available in on-line format and can be completed online at: www.anzca.websurvey.net.au. Further information is available from the ANZCA Education Development Unit (e: education@anzca.edu.au or t: +61 3 8517 5361). A prize will be offered should the final response rate meet the target of 40%

for Fellows and trainees. CPD points can be claimed for completion of the survey.

What else is happening?

In preparing to implement a revised curriculum, there are a number of critical steps along the way. The changes that are recommended will need to be carefully planned, piloted and implemented at an appropriate pace. We can predict some of the areas that are likely to require attention and have already engaged in activities which are, collectively, focused on building both the quality and capacity required to introduce a new educational program. The types of activity include some of the following:

- **Improving our teaching, learning and assessment:** A range of projects is being coordinated for this purpose. These will help to underpin a revised curriculum.
- **Improving our teacher training and support:** We are also reviewing and redeveloping the range, content and format of how we prepare and support our clinical teachers.
- **Building our capacity to provide online resources:** Examples of this work include the education podcasts being developed and “webinars” that support them. Type “Education Podcasts” into the ANZCA search engine on the website or follow the “Quick Links” from the homepage to review this project. Also, read the article about the launch of a web-based resource for trainees preparing to sit the Final Exam in this edition of the *Bulletin* (see page 57).

ANZCA curriculum review: your questions answered

Continued

These are just some of the ways that we are preparing for the revision to the ANZCA Training Program. All these projects are focussed on enabling the College to provide high quality education for an increased number of ANZCA trainees into the future.

What is all the talk of a “revised curriculum framework”?

Another major piece of work being undertaken at the moment is a redevelopment of the ANZCA Curriculum Framework. You may, quite understandably, wonder what purpose is fulfilled by a curriculum framework. In brief, a curriculum framework provides an agreed and organised set of learning outcomes which define the scope of content to be learned and what needs to be taught and assessed. Recognising that there is a need for focused development of teaching, learning and assessment resources for the ANZCA Training Program, the ANZCA CRWG have decided to select an existing framework which can be adapted to the specific ANZCA context.

Within international medical education a plethora of such frameworks have been designed and implemented. One of the most well recognised and objectively researched is the CanMEDS Curriculum Framework. Originally designed to be inclusive of all medical specialties, the CanMEDS Framework lends itself to easy adaptation.

The revised ANZCA Curriculum Framework will aim to explicitly define all aspects of contemporary Australasian anaesthetic practice. From this definition we can ensure our training program provides a comprehensive and thorough preparation for practice in this context.

Where to from here?

The forthcoming survey results will be used to develop a set of recommendations which will be submitted to ANZCA Council for approval. On approval these will be used as the basis for a process of redesigning and rewriting of the ANZCA Training Program. The recommendations will be announced at the 2010 ASM in Christchurch, New Zealand, and this will coincide with the start of an intense period of rewriting. There will be opportunities for Fellows and trainees to be involved in this process. To create a well-balanced curriculum will require the input of a wide range of experts and generalists alike.

What are the next major challenges?

Curriculum review is always a difficult process. This is particularly the case when a complex program of professional practice is involved. Clinical practice is rapidly evolving and it is difficult to ensure that we have a course in place that will mirror such a rapid and multi-faceted process of change. There are many lobbyists who wish to see their own area of expertise or special interest protected or promoted within the curriculum. Discipline “turf wars” are common and we need to find ways to accommodate a variety of distinct views whilst maintaining and improving the overall quality and integrity of the whole program.

Maintaining a high level of engagement from the Fellowship and trainee body is a means to maintain a balanced approach to curriculum review and redevelopment and we will endeavour to ensure that the current level of consultation and involvement continues into the future.

Please take the opportunity to participate in shaping the future of the ANZCA Training Program by completing the Curriculum Review Survey. Achieving a high response rate to this survey will enable a set of recommendations to be made that will guide us in a practical and well-balanced way through this period of change towards the future ANZCA Training Program.

Proposed curriculum activity timeline (September 2009 – January 2010)

September 2009:

- Survey launched later this month
Fellows and trainees: Be sure to read your emails for links to the online survey – the easiest way to have your say.

October 2009:

- Survey closes at the end of this month
Fellows and trainees: Encourage your colleagues to complete the survey; don't forget, a prize will be on offer if we reach a 40% response rate! CPD points are available for completion of the survey.

November 2009:

- CRWG to meet later this month to interpret the survey results and draft recommendations.

December 2009 – January 2010:

- Writing of the final report from the Curriculum Review Project will be undertaken.

February 2010:

- Final report of the Curriculum Review Project submitted to the College Council through the Education and Training Committee.

May 2010:

- Dissemination of the Curriculum Review Project recommendations;
- Launch of the ANZCA Curriculum Redevelopment Project; and
- Launch of the new ANZCA teachers' Program.

Fellows and Trainees: Come to the ANZCA ASM in Christchurch (New Zealand) this month to be involved!

June – December 2010:

- Curriculum Redevelopment Project.

January 2011:

- Advertising of the future ANZCA Training Program;
- Intensive ANZCA teacher training and orientation; and
- Continuation of the Curriculum Redevelopment Project.

January 2012:

- Implementation of the future ANZCA Training Program.

Coincides with a significant increase in medical graduates seeking vocational training.

Helping trainees to prepare for their ANZCA Final Examination: Launch of a web-based education resource

A web-based education resource has been launched on the ANZCA website. Its purpose is to help trainees prepare for the *process* (rather than the *content*) of the Final Examination. The resource may also be useful to ANZCA teachers who are supporting trainees with their preparation and for current or potential examiners to orientate them to some of the exam processes.

Dr Alex Konstantatos initiated the project to develop the Final Exam Preparation Resource (FEPR). He sought assistance from College educators, colleagues who have had experience as examiners as well as recently successful candidates and those who experienced difficulties with the exam. The final product is a compilation of what was considered most helpful as a guide to those who were preparing for the ANZCA Final Examination.

All trainees, including those working at rural and remote rotations, can make use of the FEPR. All that is required is a computer with internet access and a College login and password. Access is available at: www.anzca.edu.au/edu/projects/distance-education/fepor. A direct link is also included under the "Quick Links" banner on the ANZCA homepage.

Trainees can access the topics that are of most relevance to them by referring to the most appropriate area of the resource. Each area has several sections within it covering a topic in more detail. For example, the section on simulated vivas has several examples of vivas in video format which deal with common errors of technique in the viva setting.

An advantage of having the FEPR in an online format is the ease with which it can be modified to incorporate new information or update existing information as is necessary. Trainees and supervisors of training are encouraged to view and use the resource and to provide feedback by completing the short online evaluation integrated into the resource.

The Final Exam Preparation Resource (FEPR) was the idea of Dr Alex Konstantatos (right), an ANZCA Fellow from the Alfred Hospital in Victoria. Alex has a special interest in education and experience in helping prepare candidates for exams. He is also an examiner for the College's Primary Examination. He was asked to provide some insights into his experience developing the resource.

What is the resource and how do you imagine that trainees will make use of it?

The FEPR is really a set of resources all collated in one online environment. It contains information about the administration of the final exam and tips and suggestions for how to study for it and common pitfalls to avoid.

It was designed to support trainees at all stages of preparation for the final exam. Some examples of how they could use the resource would include:

- **Early exam preparation:** To find out about the composition and administration of the exam or ways to structure general study in areas of note making, fact retention and summary preparation.
- **Later stages of preparation:** To develop specific techniques of preparing for the short answer questions, multiple choice questions, and for the medical and anaesthetic vivas.

What lessons did you learn from producing the Final Exam Preparation Resource?

I learnt that we (as educators) have been wrong in assuming that trainees have knowledge of how to study. It doesn't mean that someone who has passed complex medical exams has an effective and efficient approach to their study – it may be that they have a good memory and sometimes a bit of luck. Good study techniques ensure that trainees will achieve their full potential in the exam setting and ensure that they don't have to be chained to the desk studying all the time.



What would you do differently if you were starting the project again?

If I were to start the project again I would think more about the format in which I was going to present my resource before beginning the script. There were many things I learnt along the way such as how to phrase the message in as effective a way as possible given the situation. For example, a setting where there was a viva and I wanted to convey a message about a particular error in viva technique.

Do you have any ideas for other educational projects?

I have two ideas that I would like to consider for my next sabbatical in two years time. The first is an education resource for the Primary Exam, something which is, theoretically, simpler as I am a Primary Examiner. The second is a resource for examiners which explores more effective styles of preparing and asking questions in the setting of vivas.

What gave you the greatest sense of satisfaction and enjoyment with the project?

My greatest satisfaction was to see the finished product which I think looks very polished and professional. I can only hope that people will find it helpful.

Above right: Dr Alex Konstantatos and Susan Batur.

The Helping trainees to prepare for their ANZCA Final Examination: Launch of a web-based education resource

Continued

Susan Batur, Education Project Officer at ANZCA worked closely with Dr Konstantatos on the Final Examination Resource. We spoke to her about the project.

What was the main lesson learned from helping with the production?

It was great to work closely with Dr Konstantatos on this project. I really enjoyed the collaboration and team working aspects. I don't think I'd realised just how many different people are needed to create a resource such as this. The project really brought home to me the importance of effective teamwork as so many different skills were needed. Dr Konstantatos composed the narration and we had assistance from IT and education staff, an external video production team and, of course, crucial feedback from trainees, Fellows, College office bearers and the Final Exam Committee.

What for you was the greatest challenge?

I think that with all aspects of assessments, we have to be really careful about the accuracy of content and this meant a considerable amount of checking and editing had to take place. The editing and checking for consistency between the different sources of information was complex. I also learned the importance of creating resources that won't go out-of-date as soon as one College regulation changes and so that was something that had to be carefully monitored too. I hope that this means that the FEPR will remain contemporary and helpful for some time to come.

What has been the greatest source of satisfaction and enjoyment for you working on the project?

The feedback has been terrific. It's great to have been involved in a project where the product is so clearly useful. In particular I have received lots of positive

feedback from Supervisors of Training who are able to tell their trainees about the resource when they are preparing for their exam.

Can you describe a major contribution that you made to the project?

I took a lead in developing the online evaluation form for the resource. Every time a Fellow or trainee uses it we are asking them to evaluate its use and relevance and provide suggestions for improvement. Doing this online is an important step for the College – it would seem odd to develop an online resource and then to send out a paper survey to evaluate it!

See the 'Quick link' to the Final Exam Preparation Resource from the ANZCA Homepage <http://www.anzca.edu.au>

The screenshot shows the homepage of the 'The Final Exam Preparation Resource'. At the top, there is a navigation menu with links for 'Evaluation', 'Resources', 'Credits', and 'Disclaimer'. Below this is an 'Index' section with five main categories: 'Introduction', 'Components of the Final Examination', 'Preparing for the Final Examination', 'Simulated Anaesthesia Vivas', and 'An Examiner's Perspective'. Each category has a list of sub-topics. The 'Introduction' category includes 'Introductory Overview'. The 'Components of the Final Examination' category includes 'The Written Papers', 'The Medical Vivas', and 'The Anaesthesia Vivas'. The 'Preparing for the Final Examination' category includes 'Introductory aspects including the syllabus', 'What references should I use?', 'Preparing notes and summaries', 'Revising material', 'Group study', 'The Multiple Choice Questions', 'The Short Answer Questions', 'The Medical Vivas', 'The Anaesthesia Vivas', and 'Investigations'. The 'Simulated Anaesthesia Vivas' category includes 'Example 1: Handling a general question', 'Example 2: Handling a specific question', 'Example 3: Dealing with an emergency', 'Example 4: Providing full descriptions', 'Example 5: Trying to predict the direction too much', 'Example 6: Too Frightened To Move On', 'Example 7: Arguing and backtracking', and 'Example 8: A complete 15 minute viva'. The 'An Examiner's Perspective' category includes 'Interview With Examiner'.

Destination Australia and New Zealand – international medical graduate specialists

International medical graduate specialists have been part of the Australasian medical workforce for decades, and anaesthesia is no exception.

Some have come for an exotic working holiday, travel and adventure, some for love, some for further training, especially in intensive care and pain medicine, and a few have come for religious or political freedom.

Whatever the reason, many decide to stay. Often the pathway to ANZCA Fellowship has been extremely difficult, involving many years of study and personal and family sacrifice.

Australasian anaesthesia has been enriched by our international medical graduate specialists. Many have worked and continue to work in far flung regions where local graduates are notable by their absence. Our international medical graduate specialists bring skills and diversity to our workplaces. Many are making significant contributions in research, quality assurance, teaching and College activities.

In this and subsequent issues of the *ANZCA Bulletin*, we will share some of our international medical graduate specialists' stories.

At the Royal Brisbane and Women's Hospital, there are nine international medical graduate specialists among its staff specialists.

Dr Genevieve Goulding
Councillor,
Chair IMGS Committee

If you are an IMGS with an interesting story or are working in an unusual or challenging area, please write to the *Bulletin* and share it with us.



Lucie Voldanova

Dominique Hopkins

Lucie Voldanova trained and worked in Italy. In 2003 she arrived with her husband in Australia and worked in a small, beautiful town in remote Queensland with the intention of staying for only six months. She says: "But soon we both started to like the country and enjoyed the working environment and conditions and therefore I decided to go through the IMGS process. I obtained my ANZCA Fellowship in 2006. My special interest is locoregional anaesthesia and obstetrics. Once I passed the fellowship examination, I was actively involved with educational activities of Overseas Trained Specialist Anaesthetists' Network (OTSAN), whose mission is to assist and guide colleagues from different backgrounds and isolated areas of Australia."

Dominique Hopkins was born and raised in France. She studied biochemistry and medicine in South Africa, then specialised in anaesthesia and was in private practice there until she moved to Australia. Her interests include regional anaesthesia, acute pain and research.



Michael Steyn is Scottish trained in both general practice and anaesthesia, specialising in burns and plastics for adults and children. He moved to Brisbane in 2003 and obtained the FANZCA. He is the Director of the Department of Anaesthesia and is also on the ANZCA IMGS Committee. Michael contributes regularly to OTSAN meetings.



Carina Koorts

Kate Hames

Rajesh Brijball

Helmut Schoengen

Peter Goodyear

Kerstin Wyssusek

Carina Koorts completed MMed and FCA(SA) examinations during 2002 in Pretoria, South Africa. She spent two years at PFY at Monash Medical Centre in Melbourne in 2003 – 2004. She was awarded FANZCA in 2004 after examination in that year. Employed at the Royal Brisbane, she is aiming to achieve and maintain a broad skill base, and contribute to activities in tertiary training hospital.

Kate Hames graduated from the University of Queensland Medical School in 1992. She went to the UK in 1994 and was awarded the FRCA in 1999. She completed her training in 2003 and returned with her husband and children in 2004. She entered the then OTS (now IMGS) process and obtained the FANZCA in 2005 after successfully completing the exam. Kate now has significant teaching and training responsibilities at the Royal Brisbane and Women’s Hospital.

Rajesh Brijball came to Australia at the end of October 2005 and attained his FANZCA the following year. He is a senior specialist anaesthetist at the Royal Brisbane and Women’s Hospital. He also holds an adjunct academic position of senior lecturer with the School of Medicine, University of Queensland. He is also an assistant professor with the Faculty of Medicine, Bond University. He is an examiner of the final fellowship ANZCA examination and the president of OTSAN.

Helmut Schoengen trained in Germany and came to Newcastle, Australia in 2001 for a working holiday. He has German, European and Australian anaesthetic fellowship, a PhD in anaesthetics and a specialist degree in health informatics and in diving medicine. “I enjoy the challenge of the broad range of clinical work at the Royal Brisbane and Women’s Hospital and the Royal Children’s Hospital and participating in teaching local anaesthetic trainees.” He is a founding member of OTSAN and is committed to teaching and supporting IMG specialist anaesthetists.

Peter Goodyear trained in the UK and moved to the Royal Brisbane Hospital as an Area of Need specialist and passed through the OTS process. He is the supervisor of the Acute Pain Service, and his interests are in vascular and thoracic anaesthesia. He is in charge of intern anaesthetic teaching and involved in medical student ALS training, and teaching acute pain to medical students and interns.

Kerstin Wyssusek was educated and trained in Germany, where she obtained a Masters Degree and PhD. She gained German fellowship in 1995 and Australian fellowship in 2008. Her special interest is in quality and safety and education, as in up-skilling IMG anaesthetists. She is chair of the educational group within OTSAN and was a convener at the 11th and 12th OTSAN educational meetings.

Library update

Health and safety alerts - ECRI Institute notices



The ANZCA Library subscribes to ECRI publications on operating room risk management and health device alerts and information. Check this space regularly for updates on the latest information produced by ECRI.

Recent notices include:

- Update on informed consent
- Mandating malpractice insurance coverage for practitioners
- Disruptive practitioner behavior
- Off-label use of drugs and devices
- Ergonomics
- Alerts for anesthesia units.
- Fostering collaboration between clinical engineering and IT
- Hazard Report: Karl Storz Fluid Management System May Not Warn against Fluid Overload
- A guide to computer-aided surgery
- Preventing line and cable misconnections

New resources

The ANZCA Library is pleased to announce the addition of two new major resources.

Access Anesthesiology is a portal to information on pain management, critical care, and perioperative medicine, and provides access to nine popular textbooks, guidelines, procedures, videos, calculators and self-assessment tools.



AUSDI – Australian Drug Information for the healthcare professional



Generic drug monographs for drugs in Australia. A major update, scheduled for September, will include more product information, image searching and a mobile version.

Special offer to ANZCA members

Emergencies in Anaesthesia edited by Keith Allman, Andrew McIndoe, Iain Wilson.

Oxford University Press would like to extend an offer of a 20% discount to ANZCA members of the new title *Emergencies in Anaesthesia*. Contact the library for an order form.



Search engine round-up

Google vs Yahoo vs Bing

Can't tell the difference between Google, Yahoo and Microsoft's new Bing? Blind Search allows you to search all three search engines, removes the branding, and arranges the results in columns. You don't know which search engine results are which until you vote on the best column of results. Hint: Google isn't always the best.
<http://blindsearch.fejus.com>

WolframAlpha

WolframAlpha is a new search engine that uses mathematical equations to produce more meaningful search results. Examples of how WolframAlpha can be used for medical searching: <http://www26.wolframalpha.com/examples/HealthAndMedicine.html>
<http://www86.wolframalpha.com/>

Rollyo

Do you find that you are regularly searching the same websites for information? Rollyo lets you roll all those websites into one and search across them in a single action.

"Create search engines using the sources you trust"
<http://rollyo.com/>

New research in anaesthesia, pain medicine and intensive care medicine

A number of articles on postoperative problems

Current Opinion in Critical Care. 2009 Aug; 15 (4).

Available online via the ANZCA Journal list: <http://www.anzca.edu.au/resources/library/online-journals.html>

Sedation and Analgesia in the ICU Pharmacology, Protocolization, and Clinical Consequences.

Edited by P. Pandharipande, E.W. Ely

Critical Care Clinics Volume 25, Issue 3, Pages 431-636 (July 2009)

Available in hardcopy from the ANZCA Library

Managing Patients with Chronic Non-Terminal Pain

Clinical Care Guidelines

<http://www.med.umich.edu/iinfo/fhp/practiceguides/pain.html>

Single dose oral etoricoxib for acute postoperative pain in adults

Clarke R, Derry S, Moore RA, et al.

Cochrane Database Systematic Reviews. 2009 Apr 15;(2)

Single dose oral etoricoxib produces high levels of good quality pain relief after surgery. The 120mg dose is as effective as, or better than, other commonly used analgesics.

<http://mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004309/frame.html>



A systematic review of randomized controlled trials that evaluate strategies to avoid epidural vein cannulation during obstetric epidural catheter placement. Jill M. Mhyre, et al. *Anesth Analg* 2009; 108:1232-1242

The risk of intravascular placement of a lumbar epidural catheter in pregnancy may be reduced with the lateral patient position, fluid predistension, a single orifice catheter, a wire-embedded polyurethane epidural catheter and limiting the depth of catheter insertion to 6cm or less. In general, low manuscript quality weakens the strength of these conclusions.

Available online via the ANZCA Journal list: <http://www.anzca.edu.au/resources/library/online-journals.html>

Postoperative neurocognitive dysfunction in elderly patients after xenon versus propofol anesthesia for major noncardiac surgery: a double-blinded randomized controlled pilot study. Hocker J, Stapelfeldt C, Leiendecker J, et al. *Anesthesiology*. 2009 May;110(5):1068-76.

Postoperative impairment of neurocognitive function was observed in a substantial proportion of elderly patients even 30 days after treatment. Xenon-based anesthesia was not associated with decreased incidence of POCD in comparison to propofol.

Available online via the ANZCA Journal list: <http://www.anzca.edu.au/resources/library/online-journals.html>

Reversal of profound neuromuscular block by sugammadex administered three minutes after rocuronium: a comparison with spontaneous recovery from succinylcholine. Lee C, Jahr JS, Candiotti KA, et al. *Anesthesiology*. 2009 May;110(5):1020-5.

Reversal of profound high-dose rocuronium-induced neuromuscular block (1.2mg/kg) with 16mg/kg sugammadex was significantly faster than spontaneous recovery from 1mg/kg succinylcholine.

Available online via the ANZCA Journal list: <http://www.anzca.edu.au/resources/library/online-journals.html>

Pharmacological Management of Persistent Pain in Older Persons

American Geriatrics Society Clinical Practice Guideline

The guideline recommends that acetaminophen be considered as initial and ongoing pharmacotherapy of patients with mild to moderate musculoskeletal pain, but – in a significant departure from the 2002 guideline – recommends that nonselective NSAIDs and COX-2 selective inhibitors be considered rarely, with caution, in highly selected individuals.

http://www.americangeriatrics.org/education/pharm_management.shtml

Regional block versus general anaesthesia for caesarean section and neonatal outcomes: a population-based study

Charles S Algert, et al. *BMC Medicine* 2009, 7:20 (29 April 2009)

The infants most affected by general anaesthesia were those already compromised in utero, as evidenced by foetal distress. The increased rate of adverse neonatal outcomes should be weighed up when general anaesthesia is under consideration.

<http://www.biomedcentral.com/1741-7015/7/20/abstract>

Diagnostic hysteroscopy under general anaesthesia Royal College of Obstetricians and Gynaecologists

Updated guideline provides advice for clinicians in obtaining the consent of a woman undergoing diagnostic hysteroscopy under general anaesthesia.

<http://www.rcog.org.uk/files/rcog-corp/uploaded-files/Consent1DiagnosticHysteroscopy2008.pdf>

Call for book reviewers

ANZCA members are encouraged to contact the ANZCA Library or ANZCA Communications Department if they are interested in submitting a new book review. ANZCA Library can notify reviewers when a new book on their speciality has been added to the collection and can lend the book to interested members.

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

ANZCA members are entitled to borrow a maximum of five books at one time from the College Library. Loans are for three weeks and can be renewed on request. Members can also reserve items that are out on loan.

Melbourne-based members are encouraged to visit the ANZCA Library to collect requested books. Items will be sent to other library users within Australia.

A core collection of the anaesthetic syllabus textbooks is available for loan from the New Zealand office of the College. A list of New Zealand books can be accessed by selecting "New Zealand" from the "location" drop-down box of the catalogue.

When requesting an item from the catalogue, please always remember to include your name, ID number and postal address to ensure prompt delivery.

New titles May – August 09

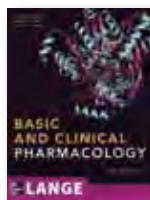
The anaesthesia science viva book: Clinical science as applied to anaesthesia, intensive therapy and chronic pain : A guide to the oral question Bricker, Simon. – 2nd ed – Cambridge: Cambridge University Press, 2009.



The Australian and New Zealand intensive care and anaesthesia primary exam: a complete annotated syllabus, including references to Australian military medical history, canonical literature and numerous mnemonics Faunce, Thomas Alured. – 9th ed – Canberra, A.C.T.: Thomas Alured Faunce, 2006.



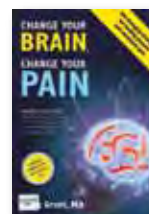
Basic and clinical pharmacology Katzung, Bertram G [ed]. – 11th ed – New York: McGraw-Hill, 2009.



Breathing matters: a New Zealand guide Bartley, Jim; Clifton-Smith, Tania. – Auckland, New Zealand: Random House New Zealand, 2006.



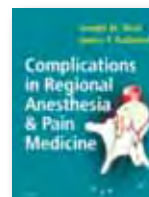
Change your brain, change your pain Grant, Mark. – Wyong, NSW: Mark Grant, 2009.



Chestnut's obstetric anaesthesia : principles and practice Chestnut, David H [ed]. – 4th ed – Philadelphia, PA: Mosby Elsevier, 2009.



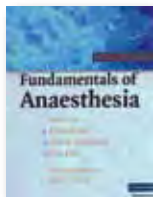
Complications in regional anaesthesia and pain medicine Neal, Joseph M [ed]; Rathnell, James P [ed]. – 1st ed – Philadelphia, PA: Saunders Elsevier, 2007.



Core curriculum for professional education in pain Charlton, J Edmund [ed]. International Association for the Study of Pain. Committee on Education. – 3rd ed – Seattle: IASP Press, 2005.



Fundamentals of anaesthesia Smith, Tim [ed]; Pinnock, Colin [ed]; Lin, Ted [ed]. – 3rd ed – Cambridge: Cambridge University Press, 2009.



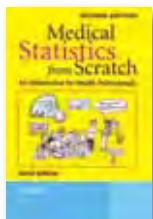
Handbook of pain assessment Turk, D C [ed]; Melzack, Ronald [ed]. – 2nd ed – New York: The Guilford Press, 2001.



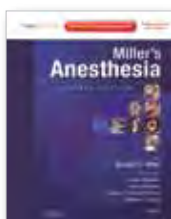
Healing headaches: a New Zealand guide Bartley, Jim. – Auckland, New Zealand: Random House New Zealand, 2007.



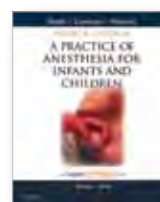
Medical statistics from scratch: an introduction for health professionals Bowers, David. – 2nd ed – Chichester, England: John Wiley & Sons, Ltd, 2008.



Miller's anesthesia Miller, Ronald D [ed]. – 7th ed – Philadelphia, PA: Elsevier Churchill Livingstone, 2009. REFERENCE ONLY – NOT FOR LOAN.



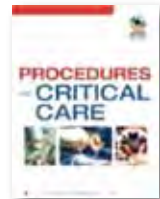
A practice of anesthesia for infants and children Cotè, Charles J [ed]; Lerman, Jerrold [ed]; Todres, I David [ed]. – 4th ed – Philadelphia: Saunders Elsevier, 2009.



Paediatric anaesthesia Doyle, Edward [ed]. – Oxford: Oxford University Press, 2007.



Procedures in critical care Hanson, C. William. – 1st ed – New York: McGraw-Hill Medical, 2009. E-book.



Pain management for older adults: a self-help guide Hadjistavropoulos, Thomas [ed]; Hadjistavropoulos, Heather D [ed]. – Seattle: IASP Press, 2008.



Contact the Library

www.anzca.edu.au/resources/library

Phone: +61 3 8517 5305

Fax: +61 3 8517 5381

Email: library@anzca.edu.au

ANZCA Trials Group

Research into Elderly Patient Anaesthesia and Surgery Outcome Numbers - the REASON Audit.

The REASON Audit is a collaboration between the ANZCA Perioperative Medicine Committee (POMC) Working Group and the ANZCA Trials Group. The audit examined complications and mortality in older patients. The REASON audit followed on from a study by McNicol et al.¹ who investigated patients aged over 70 years or more who stayed at least one night after non-cardiac surgery in a cluster of three Melbourne teaching hospitals (Austin Hospital, Royal Melbourne Hospital and Alfred Hospital).

The audit involved 21 hospitals across Australia and New Zealand collecting data on over 3000 patients. The data from this cohort will be combined with data from the patients in the McNicol paper producing a total cohort of more than 4000 patients.

The REASON Audit team would like to thank all participating sites' investigators and research staff for their hard work in collecting the data. All sites have now received their collated, individual data while the overall analysis is underway.

In addition the audit collaborators would like to acknowledge the generous grant of \$30,000 from the ANZCA 2008 Research Grants Awards. This Grant money will allow us to make a small contribution to each site as well as covering the statistical advice costs.

REASON Audit Lead Investigators; Associate Professor David Story, Associate Professor Kate Leslie, Professor Paul Myles. Associate Investigators; Dr Vanessa Beavis, Dr Su-Jen Yap, Dr Ross Kerridge, Mr Michael Fink.

The participating hospitals were in Victoria (St Vincents, Western General), NSW (Westmead, Prince of Wales, John Hunter, Coffs Harbour, Lismore, Wollongong, Dubbo), Queensland (Cairns, Princess Alexandra, Redcliffe, Royal Brisbane and Women's), Tasmania (North West Regional, Royal Hobart), SA (Flinders), WA (Royal Perth), NT (Royal Darwin), and NZ (Auckland City, Middlemore and Maunka).

1. McNicol L, Story DA, Leslie K, Myles PS, Fink M, Shelton AC, Clavisi O, Poustie SJ: Postoperative complications and mortality in older patients having non-cardiac surgery at three Melbourne teaching hospitals. *Med J Aust* 2007; 186: 447-52.

Pilot Grants Scheme: a reminder to Fellows

The ANZCA Trials Group Pilot Grant Scheme is a fast-track program introduced to assist College Fellows in the development of high quality research projects. Each year the Trials Group allocates \$25,000 (\$5000 per project) in support of preliminary pilot-phase testing of trials or preliminary surveys that have the potential to successfully acquire NHMRC funding and develop the research into a larger study.

The ANZCA Trials Group invites applications from Fellows of ANZCA, JFICM and or FPM to apply for pilot research grants for projects related to anaesthesia, perioperative medicine, or pain medicine.

The aim of the grant is to assist researchers in the following areas: pilot-phase testing of trials; collection of baseline data using surveys; or establishing a network of investigators. Pilot grants should not be confused with novice grants, and are open to all Fellows throughout the year.

More information can be found at: www.anzca.edu.au/resources/research/anzca-trials-group/pilot-grant-scheme.html

Changes to survey research requirements

Survey research facilitated by the Trials Group is under review with the aim of improving the scientific and overall quality of survey research. Changes have been made to the process of application for trainees who wish to do a survey for their formal project. Trainees are required to submit their application to the Trials Group BEFORE they obtain their formal project officer and HREC approval. More information can be found at: www.anzca.edu.au/resources/research/anzca-trials-group/fellows-and-trainees/fellow-and-trainee-surveys.html.

All prospective survey researchers who wish to have their surveys distributed by ANZCA are reminded that to enhance their response rate, an ANZCA Fellow needs to be included as an investigator in all applications. For further information contact Stephanie Poustie, the Trials Group Coordinator: spoustie@anzca.edu.au or trialsgroup@anzca.edu.au.



Links to Monash University

The ANZCA Trials Group has moved to its new co-location in the School of Public Health and Preventive Medicine, Monash University, Alfred Campus (above).

While the Trials Group will continue to have an ongoing and strong presence at the College, the move to an academic environment will foster collaborations with other research groups and better enable the development of new research under the banner of the ANZCA Trials Group.

The Trials Group will still be accessible to Fellows and trainees, and will continue to provide support for survey research and administration of the Pilot Grants Scheme.

For further information contact Stephanie Poustie, the Trials Group Coordinator: spoustie@anzca.edu.au or trialsgroup@anzca.edu.au.

Future Directions for Anaesthesia Research: strategic and overview meeting October 9, 2009

The ANZCA Trials Group is holding a meeting on Friday, October 9 to overview its achievements to date, and develop future strategies for successful endeavors in multicentre anaesthesia, post-operative and pain medicine research in Australia. Other objectives include reviewing progress to date of existing multicentre research trials; evaluate the role and success of pilot studies (and ANZCA funding); consider proposals for new trials; plan their implementation and funding; identify, mentor and support new young investigators; plan an annual (or bi-annual) Trials Group meeting, including location, format; and consider collaborations with other Australian and overseas Trials Groups.

There is an open invitation to interested and emerging researchers who are encouraged to attend. For further information contact Stephanie Poustie, the Trials Group Coordinator: spoustie@anzca.edu.au or trialsgroup@anzca.edu.au.

Regions

New South Wales



Oxygen and the anaesthetist

The main topic of discussion at the NSW winter meeting on August 8 was “Oxygen and the Anaesthetist”. More than 220 delegates attended the meeting. A non-anaesthetist gave an overview of oxygen from the beginning of time, which was thoroughly enjoyed by those who attended.

The changed format of concurrent workshops, PBLDs and talks was effective and once again allowed delegates to choose the way their CME was structured. This will be continued in future CME meetings.



FPM NSW inaugural CME dinner meeting

The FPM NSW Regional Committee held its inaugural CME dinner meeting in Crows Nest on August 27. It was well attended with 29 delegates, which would in effect comprise about a third of the NSW Pain Fellows. We were well supported by many of the big names in pain medicine and this augers well for the regional committee in the future.

The meeting commenced with a short talk on “Supporting the opioid prescription policy” by Carolyn Winkler, the Director of Quality use of Medicines from Mundipharma which highlights the need to monitor opioid prescriptions and support responsible use of opioids. As interim Chairman, Dr KE Khor then gave a brief introduction of the committee, identified our role and work in the service of pain medicine in NSW and highlighted some of our ongoing tasks at hand such as organising CMEs, promoting the profile of pain medicine and facilitating recruitment of trainees in pain medicine in NSW. Dr Paul Wrigley also updated delegates on training for exams for trainees as well as the upcoming CMGT. Dr Martine Holford and Associate Professor Milton Cohen then presented a case discussion of an addicted “patient from hell” with multiple challenges that really test the medical system. There was much discussion, many arguments, debates, comments and pronouncements that really livened up the presentation. We all felt that we had learned a lot and aim to convene a meeting on the interface of pain and addiction medicine in the next CME meeting.

Special thanks to our sponsor for the evening Mundipharma, Annette



Strauss and her team in the regional office for administrative support, Martine Holford with assistance from Clive Sun for convening the meeting as well as to all who have attended to support the initiatives of the FPM NSW Regional Committee. It was a very successful meeting.

Above from left: Dr David Gorman and Associate Professor Milton Cohen; Associate Professor Raj Sundaraj and Dr Stephen Gibson.

NSW Anaesthetic Continuing Education Committee

The NSW Anaesthetic Continuing Education Committee is pleased to present another full day of anatomy demonstrations using specimens especially dissected for anatomy relevant to nerve blocks on Saturday, November 28. Topics to be demonstrated include, head and neck blocks, larynx, upper and lower limb regions, inguinal region, vertebral column, root of neck, intercostal nerve and eye blocks. There is a strict limit on the number of registrants (50), so please enrol early. To register please visit NSW Regional website by following the link – www.nsw.anzca.edu.au/events.



Queensland



ANZCA – Clinical Teaching Course Workshop

The CTC Workshop “Teaching in small groups” was held at the ANZCA Queensland Office on July 24, 2009. Felicity Hutton and Dr Genevieve Goulding facilitated the course.

Pictured right (back row from left): Dr Usha Gurunathan, Dr Robyn Price, Dr Julia Groves, Dr Amanda Harvey, Dr Mark Young, Dr Diana Webster. Front row from left: Dr Louisa Smith, Dr Sharon Maconachie, Dr Genevieve Goulding, Education, Training and Development Manager Felicity Hutton, and Dr Rebecca Ruberry.



Maren Strachan

ANZCA Queensland Regional Committee AGM

The Queensland Regional Committee held its Annual General Meeting in the Queensland Regional Offices on July 22, 2009. The report of the Chairman and the Regional Education Officer was presented to the meeting. Members also had the opportunity to discuss other issues currently of concern in Queensland including membership involvement in the work of the regions. The guest speaker was Ms Maren Strachan (above). Maren holds a BA in Speech, Theater and Communications from St Olaf College in Minnesota and a MA in Occupational Therapy from St Catherine’s University Minneapolis. Maren has worked in the US, New Zealand and Australia, as well as having been a Peace Corps Volunteer in the Central African Republic. Maren spoke on “Pain Management from a Different Perspective” exploring the meaning of “pain” in its wider interpretations and what impact it can have on our lives and decisions.



Professor Michael R Chester

Faculty of Pain Medicine – CME Dinner

Attendees at the Faculty of Pain Medicine CME Dinner Meeting held on Tuesday, August 11 at the ANZCA Queensland Office heard Professor Michael R Chester (above) from the UK speak on “Overcoming obstacles to patient centred service delivery: the UK National Refractory Angina Centre experience 1996-2009”. Professor Chester is the Director of the National Refractory Angina Centre, Consultant Cardiologist Royal Liverpool and Broadgreen University Hospital Trust and Professor of Rehabilitation and Preventive Health Education, Liverpool Hope University. An informative presentation with valuable discussion and question time followed.

Faculty of Pain Medicine welcomes Professor Julia Fleming

The Faculty of Pain Medicine Queensland Regional Committee hosted a welcome dinner at the Queensland Club on July 30 for Professor Julia Fleming. Professor Fleming has been appointed as Director of the Professor Tess Cramond Multidisciplinary Pain Centre at the Royal Brisbane Women’s Hospital following the retirement of Professor Tess Cramond after 42 years of dedicated service to patients with persistent pain. The dinner was attended by 19 Fellows including Professor Fleming. A profile of Professor Fleming appears on page 87 of the *Bulletin*.

Australian Capital Territory



The opening of ANZCA’s new ACT offices was held in late June in Deakin, Canberra. Dr Stephen Brazenor (Chair of the ACT Regional Committee), Dr Leona Wilson (President, ANZCA) and Mr Mark Cormack (Chief Executive, ACT Health) spoke at the event (see page 4). Fellows, trainees and various people from the health industry were invited.

Alison Inglis recently joined ANZCA as the ACT regional coordinator, after completing a hand over with Vena Murray.

Regions

Continued

Victoria



Dr Forbes McGain

The ANZCA Victorian Regional Committee and the Victorian section of the ASA will hold a Continuing Medical Education meeting on Wednesday, October 14. The presenter will be Dr Forbes McGain (above), FANZCA, FJFICM, talking about “Peri-Operative Inotropic Support And The Giftasup Guidelines: Whose Guidelines?” Refreshments will be served in the ANZCA House foyer from 6.15-7pm and the presentation will run from 7-8.30pm in the auditorium. To RSVP contact Daphne Erler before Monday, October 12 via email vic@anzca.edu.au or call +61 3 8517 5313.

A Quality Assurance Meeting will be held on Saturday, October 10 from 2-5.30pm. The convenors will be Michael Boquest and Rod Tayler. The meeting will be held at ANZCA House, 630 St Kilda Road, Melbourne. The registration cost is \$77. To RSVP contact Daphne Erler before Friday, October 2 via email vic@anzca.edu.au or call +61 3 8517 5313. Visit www.vic.anzca.edu.au/events for further information.

Tasmania



The combined ASA/ANZCA education committee organised a successful ultrasound workshop for 20 participants in July. Invited speaker Dr Peter Hebbard lectured and facilitated a station on TAP blocks. Other stations included vascular access, interscalene and supraclavicular blocks, lower limb blocks and a hands-on phantom/chicken station. The feedback from attendees has been positive.

An education day was organised for the Tasmanian anaesthetic trainees on Saturday, August 8 in Hobart. Seventeen registrars attended, with people travelling from Burnie and Launceston. The topic of the training day was “anaesthetic emergencies”. It ties in with the theme of the future ANZCA/ASA Scientific Meeting in Hobart in February next year.

The program began with an interesting speech by Dr Michael Lorimer. He spoke about vigilance, anaesthetic emergencies and mortality and knowing when to call for help or even bail out. Dr Sasanka Dhara and Dr Sav Totonidis ran problem-based learning discussions including a “Can’t intubate can’t ventilate” scenario, with the opportunity to practice the insertion of a jet ventilation catheter.

Dr Lorimer ran through “Unexplained Hypoxia” cases, and Dr David Brown took us through “Circulatory Collapse”, with a discussion on anaphylaxis to consider as part of a differential. Dr Malcolm Anderson tested our resuscitation skills both theoretically and practically (and for the most part, the mannequin survived). To finish, Dr Shona Bright provided a short discussion on what to do in the event of a catastrophe or death. From there the discussion extended to an explanation of external supports available such as the ASA and GASACT. We ended with the opportunity for registrars to voice any concerns they had about their training and education to Chris Wilde, Chairman of Tasmania’s Trainee Committee.

The day would not have been possible without sponsorship by Abbott.

Planning is well under way for the February 20-21, 2010 Annual Meeting titled “A Disaster of a Conference” on anaesthetic emergencies.

A further GASACT/ANZCA Trainees meeting is planned for late 2009.

South Australia/ Northern Territory



The third Royal Adelaide Hospital Primary Sciences course was held at Palmer Place in August this year. Nine candidates attended the course, to assist them in preparation for their respective primary examinations (below).



Western Australia



Clinical Teaching Course workshop

The most recent Clinical Teaching Course workshop was delivered by Education, Training and Development Manager Felicity Hutton in Perth on June 5. The workshop focused on “Developing strategies for effective clinical supervision” and Supervisors of Training, Module Supervisors and those involved in teaching ANZCA trainees were invited to attend from ANZCA, FPM or JFICM. Dr Lindy Roberts co-facilitated the workshop and we thank her for her willingness to share personal supervision strategies, her enthusiasm and positive input.

The full-day workshop was extremely well received and all attendees actively participated in a range of activities.

WA 2009 Winter Scientific Meeting

The Annual Autumn Scientific Meeting was held on Saturday, June 13 at the Perth Convention and Entertainment Centre. The theme of the meeting was “The Heart of the Matter”. The meeting was well supported with more than 130 anaesthetists and 16 trade representatives attending. For the first time concurrent sessions were held throughout the day.

Dr Serge Kaplanian, a consultant anaesthetist from Princess Margaret Hospital, gave the “Nerida Dilworth Lecture” entitled “Anaesthesia for Adults with Congenital Heart Disease presenting for Non-Cardiac Surgery”. His presentation of such a broad and complex topic was greatly appreciated.

The first of our concurrent sessions began prior to morning tea. Dr Soo-Im Lim presented a lecture on Anaesthesia for Children with Muscle Disease followed by Dr Craig Sims who spoke on the “Off-Label Use of Drugs in Children”. Dr Mark Schneider gave a PBLD presentation on “Coronary Stents, Clopidogrel and Non-Cardiac Surgery – A juggling act?” and Dr Andrew Gardner discussed patients with cardiac failure requiring a laparotomy”.

The afternoon concurrent sessions included presentations from cardiologists. Dr Rukshen Weerasooriya spoke on how to manage cardiac electrical implanted devices during anaesthesia and Associate Professor David Playford spoke about



diastolic heart failure. Dr Tomas Corcoran, the Director of Research at the Department of Anaesthesia and Pain Medicine at Royal Perth Hospital also gave a presentation on the practical use of inotropes for anaesthesia. Dr Ian Forsyth, covered paediatric-based anaesthesia scenarios. This was followed by a paediatric case based panel discussion chaired by Dr Ric Bergesio which included panel members Drs Bruce Hullett, Paul Swan, Neil Chambers and Priya Thalayasingam.

The 2009 Nerida Dilworth Prize which is given to a registrar in Anaesthesia in Western Australia, who contributes significantly to the ASA and/or ANZCA, was awarded to Dr Aneeta Sinha.

The day concluded with a chance to catch up with colleagues at an informal sun downer.

Thank you to the presenters, session chairs, sponsors and especially the co-convenors, Dr Prani Shrivastava and Dr Alison Corbett who worked very hard to make the day a success.

From top: Clinical teaching workshop delivered by Felicity Hutton, Education, Training and Development Manager (front row left) and Dr Lindy Roberts, ANZCA Councillor and co-facilitator (back row, fourth from left); Dr Nerida Dilworth and WSM 09 Nerida Dilworth Prize winner, Dr Aneeta Sinha; Dr Craig Sims, Dr Serge Kaplanian, Dr Prani Shrivastava and Dr Alison Corbett.





NZ Anaesthesia ASM 2009, Rotorua, November 4-7, 2009

This conference promises to be an event not to be missed. It will appeal to those in the anaesthesia community wishing to combine a strong scientific program together with an attractive outdoor destination, at a pleasant seasonal time in New Zealand. Each year the scientific program continues to excel and there are opportunities to hear and interact with speakers who are experts in their field. Leading international and national speakers, Professor Peter Marhofer from Vienna, Professor Hans Joachim Priebe from Freiburg, Dr Ivan Joubert from Cape Town, and Dr John Barnard from Hamilton, the NZSA Visiting Speaker for 2009, will cover a myriad of topics from “trauma anaesthesia Vienna style”, “cricoid pressure: benefit or harm”, to “ventilation strategies”, to name a few. For the full program please go to www.sixhats.co.nz/nza09

New Zealand health workforce

Over the last eighteen months, the New Zealand National Committee has responded to requests from a number of Government agencies about New Zealand workforce and training matters. ANZCA and other colleges have commented about the apparent duplication of these requests. The Minister of Health has acknowledged this and in a recent letter to NZNC has announced that a clinical

training board is to be established to provide a national view of future health and disability training and workforce needs. The Chair of the ANZCA New Zealand National Committee met with the Minister of Health and the Director General of Health in September as part of a Council of Medical Colleges delegation to discuss workforce and other issues.

Physician assistants

The Medical Council of New Zealand is consulting on “Regulation and training of physician assistants”. The Council has been exploring the use, training and regulation of medical assistants. In general, the role of a medical assistant can be summarised as someone who assists a doctor. Their role can involve diagnosis, provision of treatment and prescribing. Unlike nurse practitioners they do not practise independently, but are dependent on a doctor’s oversight. Medical assistants appear under a range of different titles, including physician assistants, medical care practitioner, clinical assistants, physician extenders and mid-level practitioners.

The Council is interested in views on how New Zealand should make use of medical assistants, and whether any form of regulation and/or training for medical assistants should be introduced. The Council is seeking comment on its paper which can be downloaded from the MCNZ website at <http://www.mcnz.org.nz/NewsandIssues/tabid/55/Default.aspx>.

The closing date is October 2, 2009.

ANZCA/NZSA workforce report 2009

The College is in the process of gathering information for the ANZCA/NZSA 2009 New Zealand Anaesthesia Workforce report.

A workforce survey is being conducted in September as part of a broader study to measure the supply and demand of anaesthesia services in New Zealand and to identify the factors that potentially affect the future supply of those services.

Obtaining a high participation rate is critical to the accurate determination of model parameters, and by extension the results of the survey. It will help us to understand the variations in background, working conditions and allocations of time of the anaesthesia workforce.

NZNC office bearers

At the New Zealand National Committee (NZNC) meeting in July, the internal office bearers’ elections were held and the following appointments were confirmed for the 2009/2010 year:

Dr Vanessa Beavis, Chair;

Dr Paul Smeele, Deputy Chair;

Dr Gerard McHugh, Hon Secretary and Hon Treasurer;

Dr Geoff Long, National Education Officer;

Dr Arthur Rudman, Formal Projects Officer;

Dr Gary Hopgood, Deputy Formal Projects Officer;

Dr Vaughan Laurenson, Chair New Zealand Panel for Vocational Registration.



This is the penultimate contribution by a Dean of the Joint Faculty of Intensive Care Medicine to the *Bulletin*. I shall save my farewells and “thank yous” to the final contribution in December. However, I beg your indulgence if this missive has a slightly philosophical bent to it.

Being a part of ANZCA

As we approach independence as a new College of Intensive Care Medicine (CICM) it is very interesting to note the ongoing development and evolution of the organisations around us that operate under the ANZCA banner. There is, of course, the Australian and New Zealand College of Anaesthetists itself, which has all the hallmarks of a mature learned college. It has a talented Council and a very professional staff. Its processes and procedures are highly evolved. Long gone are the days of operating as a secretariat. There are now directors of divisions, staffed appropriately, to look after the various college functions – all for the benefit of trainees and fellows. ANZCA is in the process of developing strategic plans for its future roles. This is what the new CICM aspires to and hopefully, in time, will achieve.

At the same time there is the Faculty of Pain Medicine (FPM), which is developing very well and spreading its wings under the protective mantle of ANZCA. This is the position JFICM was some time ago and I am somewhat envious of the exciting time the Board and Fellows of the FPM have ahead of them as their specialty grows and matures. The specialty of anaesthesia can be rightly proud of the development of these two subspecialties, intensive care medicine and pain medicine, from within its ranks. I look forward to seeing the new directions ANZCA plans to move in with the development of new strategic plans for the future.

Stepping up to the mark

The other big development since my last column in the *Bulletin* has been the effect of the H1N1 influenza pandemic on intensive care services in Australia and New Zealand. Intensive care physicians can be very proud of their response to this crisis. The aspects of the pandemic which bear comment are the fact that this has had a huge impact on hospitals and, in particular, intensive care services. As at the end of August 2009 approximately 716 H1N1 patients have been treated in intensive care units in Australia and 136 in New Zealand. The relative numbers for New Zealand (patients per population, with fewer per capita available intensive care beds) are indeed frightening. Also, unlike a disaster (bomb blast, train wreck etc), where the effect, although substantial, is transient, this impost on intensive care beds has been sustained for weeks on end, with only early signs of respite now. Of interest, this is essentially a new disease in that the presentation and natural history of the illness is evolving as we watch it. So, unfortunately we have come to realise that the “traditional” influenza victims (the elderly and infirm) are not the only ones at risk. Young pregnant women and the obese (but otherwise well) seem to be at risk too. Good data is being collected about the demographics and outcome of the pandemic – hopefully we’ll be able to learn a lesson for the next time.

The pandemic has also resulted in many policy statements from departments of health and other bureaucratic bodies about the conduct of health care professionals in an environment of limited resources and how to perform ethical triage. Clearly these departments are unaware that these skills are required on a daily basis by intensive care physicians undertaking normal practice. Patients in acute hospitals are sicker and older and the community expectations of what can be achieved by medicine are growing. Our colleagues in the hospital appear less interested in acute care and less informed about what intensive care medicine can offer. One result of this is that intensive care physicians are often at the cutting edge of where the hard decisions are being made about end of life issues and triage. It’s a pity that it takes a pandemic for others to recognise this.

CICM

All the processes to enable commencement of operations of CICM in January 2010 are being put in place. A budget for the first year of operations will be presented to the Board of CICM shortly. Invitations for Foundation Fellowship of CICM have been sent out and the take-up has been gratifyingly swift. The CICM symbols, coat of arms and motto, are being finalised with good input from Fellows at the AGM and, more recently, via the website. This will allow new FCICM diplomas to be printed soon and the majority of Foundation Fellows can expect to receive them by the end of 2009.

In the meantime all JFICM processes have been running smoothly, with the next set of fellowship examinations just around the corner.

Professor PV van Heerden

Dean, JFICM
President, CICM

Influenza A/H1N1

Dr Ian Seppelt, Department of Intensive Care Medicine, Nepean Hospital, NSW for the ANZIC Influenza Investigators.

A novel triple recombinant H1N1 influenza A virus emerged in North America in April and has rapidly spread around the world, becoming the World Health Organisation's first declared pandemic for the 21st century. This has had a significant effect on intensive care services in Australia and New Zealand and there are many lessons we can draw which will be of benefit to colleagues in the northern hemisphere as they move into autumn and winter.

The first message is that we coped. At its peak in July the influenza A pandemic accounted for about 25% of intensive care bed occupancy. It certainly put a significant strain on intensive care resources, but never got to the point of a "disaster" where needs overwhelmed the resources available. Staff got sick, but were more likely to catch the 'flu from their children at home than from patients at work. In that regard the H1N1 influenza is not SARS, or any other highly infectious disease which puts intensive care staff at immediate risk of death. We can speculate about what we would have done had the critical illness caseload been ten times, or even twice, what it was. The information we can offer will be extremely important as other countries, particularly more resource limited countries, plan their responses.

Despite comments from some critics that this is no different to seasonal influenza, the H1N1 influenza has certainly led to a new intensive care syndrome. We have been seeing young patients, many without any comorbidities, who have presented



"A novel triple recombinant H1N1 influenza A virus emerged in North America in April and has rapidly spread around the world, becoming the World Health Organisation's first declared pandemic for the 21st century."

with a life threatening pneumonitis. Characteristically this syndrome has included profound hypoxaemia with high PEEP dependency but preserved lung compliance, which distinguishes it from ARDS of other aetiologies. A significant number have required Extracorporeal Membrane Oxygenation (ECMO), and this pandemic has led to a rapid expansion of ECMO capabilities in many cities. Patients have not been the elderly who are prone to seasonal 'flu, but young and middle-aged adults, and obesity and pregnancy have featured as particular risk factors. Despite the severity of illness the overall mortality has been low, perhaps reflecting the fact that the patients have been previously well adults with good reserves.

With the onset of the pandemic came the unique opportunity to describe the epidemiology of this illness across an entire population in two countries. As testing of patients in the community ceased and efforts to quarantine were abandoned, our intensive care units became the only indicator of both the spread and the response to the disease.

We have seen successive phases, starting in New Zealand, spreading through Victoria and New South Wales and now involving Queensland, northern Australia and Western Australia. With excellent cooperation and goodwill from all intensive care units, we have managed to establish the ANZIC Influenza Registry, which now has data from almost every patient who has required intensive care admission for influenza in Australia and New Zealand since June 1. An initial analysis of the registry data is under way. We should be very proud of this. There is nowhere else in the world that has such intensive care data for entire populations – and it is a credit to all contributors who provided the data on short notice and minimal funding.

The registry will continue into 2010 and perhaps beyond, and units should continue to enter any confirmed cases of influenza A. This information will be important as the H1N1 vaccine is distributed, as we will be able to track both uptake and effectiveness based on the number of new cases going in to winter 2010.

Examinations

The year 2009 marks the 30th anniversary of the Intensive Care Fellowship Examination and the numbers presenting continue to grow.

The second General Fellowship Examination this year has a total of 68 candidates, with the written section held on Friday, August 28 in Adelaide, Brisbane, Hobart, Hong Kong, Melbourne, Perth, Sydney and Townsville. An additional six candidates sat the Paediatric Fellowship Examination (written section).

The Paediatric Fellowship oral section will be held at the Westmead Children's Hospital with the hot cases, viva section and results presentation to all take place on Tuesday, October 20. Later that week, the hot case section for the General Fellowship will be held at the Royal Prince Alfred, Prince of Wales and St George Hospitals on Thursday, October 22, with the viva section and results presentation to be held at the Novotel at Brighton Le Sands on Friday, October 23.

In recognition of the 30th Anniversary of the Intensive Care Fellowship

Examination, the Joint Faculty and the General Fellowship Examination Committee are holding a celebration dinner on Thursday, October 22, to coincide with the October exam.

Finally, the JFICM Primary Examination has attracted eleven applicants with the written section to be held on Monday, September 28 in Adelaide, Brisbane, Melbourne and Sydney. The viva section and results presentation will be held at ANZCA House in Melbourne on Friday, November 13, 2009.

College of Intensive Care Medicine update

Preparations for transition to the new College of Intensive Care Medicine are proceeding smoothly. The CICM Board of Directors (the current JFICM Board) now meets on a regular basis. The Constitution of the College has been formally adopted and draft regulations, based largely on the current JFICM regulations, were presented to the June board meeting and with minor revision should be finalised by the next meeting.

All JFICM staff will transfer their employment to the new College at the end of the year, which will allow the business and processes of the College to continue with minimal disruption. The process of setting up computer systems (finance system, member database, etc) is under way as is the preparation and design of the new College website. In the meantime, a temporary website for the new College has been constructed at www.cicm.org.au

Foundation Fellowship

All Fellows of the joint faculty will be welcomed as Foundation Fellows of the College of Intensive Care Medicine. A letter was sent out in early August inviting all Fellows to apply and a very rapid and gratifying response has been received from many. Foundation Fellows will receive a new diploma from the College and will be entitled to use the post-nominals FCICM.

The Board considered at length several options for raising funds to give the new College some degree of financial security and to establish an asset base which may one day lead to us acquiring a permanent home. It was eventually decided that charging an entry fee of \$1000 to Foundation Fellows would be the most equitable way to proceed. Therefore, Fellows have been asked to pay this sum with their application for Foundation Fellowship. Any further contributions in addition to this amount will be very welcome, and will help to ensure the financial viability of the College for the future.

Accommodation

The College will move out of its offices in ANZCA House at the end of the year. Suitable office space in the inner suburban vicinity of Melbourne is being sought, with a view to taking a three-year lease. At that time we may be in a position to consider a more permanent arrangement.

Coat of Arms

A lot of work has been done on the design of a Coat of Arms for the College, which will adorn the College diploma and also the College stationery. The proposed design for the Coat of Arms was presented to the Fellowship at the ASM and received a generally positive reception. A competition for suggestions of a motto to accompany the Coat of Arms was also held recently. More than 80 responses were received. The majority of them suggested some kind of Latin phrase, usually trying to express the combination of learning, sound judgement and caring that is implicit to intensive care medicine. The Board is considering the entries and will shortly make a final choice.

Support for Regional Committees

The administrative support for the JFICM Regional Committees (and the NZ National Committee) is provided by ANZCA staff in the regional offices. Although this does not amount to a lot of hours in some of the regions, particularly those with a small number of Fellows, it would be very difficult to replace this support with a new structure. Discussions are under way with the ANZCA management to try and maintain the arrangements for the next 12 or even 24 months. This would be on a commercial basis, with the new College paying ANZCA for staff time. Board member Amod Karnik has been given the task of liaising with the regional chairmen to ascertain their needs over this interim period.

Dr Penny Stewart: ICU in the Alice



How do most of us see Australia? Once away from the coast, the imagery that springs most immediately to mind tends to be of sunburnt country, kangaroos, Aboriginal people, and sport (in particular, AFL football). Well, if you want to be somewhere that fulfils every preconceived idea of the Australian interior, Alice Springs is the place to be. However, Alice surprises all who visit her.

Alice Springs is an unusual place. It is beautiful and has a natural environment that you cannot ignore; the red dust gets under your skin and somehow changes you. It is a place of contradictions. It is a small town, but because there is such a large transient population you are always meeting new people. It is isolated, but has flights each day to every state capital. It is in the psyche of just about all Australians, and yet very few people really understand what the desert is. It is a cultural mixing pot with people coming together with art music and outdoor life. There is a festival most weeks in winter, my two favourites are the Beanie festival and the wearable arts.

For me Alice is the heart of Australia; and the Aboriginal people are Australia's conscience. For Australia to be strong it needs to recognise and value Aboriginal culture within mainstream Australian culture, allowing Aboriginal understandings to come into play with our own assumptions about ways to live in this country. I have no idea how that might happen, but I do know that Aboriginal culture has much to offer us in rethinking some of the more troubled and problematic consequences of mainstream western life.

The important premise of Aboriginal culture is to adapt to the environment, making minimal impact upon it; a position very different from the Western culture of changing the environment to fulfil our needs.

I will share with you some typical experiences in Alice's intensive care unit. We are a four to six bedded ICU with an HDU of four beds attached to it. Our patient base is 70% Aboriginal with an average APACHE of 18 and age of 42 years. Chronic disease is rife, with the highest rate of rheumatic heart disease, bronchiectasis and end stage renal failure in the Western world. We also have high rates of hypothyroidism, HTLV1 (but luckily virtually no HIV); strongyloides, amyloidosis (secondary to chronic infection), diabetes, heart disease and terrible lipid profiles. That is not to mention the social problems of alcoholism, illiteracy, depression and petrol sniffing. However, on the positive side we look after the most physiologically tough people I have ever met. They also have a great sense of humour. These qualities make working with them rewarding in unexpected ways.

Aboriginal culture is about the environment and family so everything we do must be adapted for this. There are at least 14 main Aboriginal tribal groups from the centre with as many languages. Most Aboriginal people speak at least five languages, but often English is their fifth language and it may be limited or non-existent. This group of people call themselves the desert MOB. All have either Aboriginal or English names to match the

environment or to describe their place in Aboriginal society. Some of my favourites are Fly, Possum and Motorcar. Less appropriately, some just have the name of the station owner their family worked for.

The day in ICU begins with the night registrar recounting the tales of the night. Often one of the new patients will be completely covered in a blanket with a big eye peering out watching how everyone interacts and deciding whether it is safe to emerge. The registrar will usually say that they have been unable to get a history from the patient; trust has not yet been established and sharing information only happens with trust. An old lady is introduced who has no English and no relative who has come in with her. However the registrars excitedly inform me that they have worked out who she is, as she had paint on her fingers. They looked up the catalogue of painters and matched her to her photograph in the artists' list, then confirmed her identity by showing the patient some reproductions of her work. The old lady had proudly acknowledged the paintings as hers, so we have a name and, importantly, a medical record and contact details. In other cases, without such clues, we would wait for the Aboriginal liaison MOB to come, as one of them would be able to identify her.

The Aboriginal liaison MOB is a group of dedicated people and talented linguists that help with all the cultural broking issues. The Aboriginal liaison MOB are central to understanding family dynamics, issues, contexts and translating. They make it possible for the patients to stay in hospital



“For Australia to be strong it needs to recognise and value Aboriginal culture within mainstream Australian culture, allowing Aboriginal understandings to come into play with our own assumptions about ways to live in this country.”

to receive the therapy that they desperately need. This group of under-recognised heroes competently take care of issues such as making sure the person’s children are safe and being looked after, their money problems sorted and their family informed of what is happening. They are part of the most efficient form of bush telegraph. Sometimes only one family member will have a phone but that person is always found and contacted. Alternatively, visits to the town camps where some family members live, are made. The liaison MOB also help sort out safe accommodation for family members that come in from out bush, and are wary of going into a town camp (this is the term for Aboriginal owned land in town) where they know despite the camp being termed a “dry camp” there are still too many drunks around.

Morning ward rounds have the same elements as any ICU; a problem list, an examination and a plan. Once trust has been established, patients often give us vital hints as to what should happen. These should not be ignored as our patients are very observant. This is the only ICU that I have worked in where patients have held their own endotracheal tubes for turns and where the remote control and TV are more important for treatment tolerance than propofol and fentanyl, especially on Friday and Saturday nights during the AFL season. Negotiating is not always an advantage; I spent 30 minutes of anguish, waiting for half time in the Collingwood, Geelong preliminary final, eager to insert a chest drain for a pneumothorax, with impending tamponade. Being a Yuendumu

man and thus a Collingwood supporter (same colours), he was not going to miss a moment of the match and gave me permission to interfere only during half time.

The day may be interrupted by matters of commerce. Relatives will bring in a painting to sell to get the money for petrol for the rest of the family MOB to come to town. As a result, I have walls covered in beautiful artwork and more canvases rolled up in my cupboard than I will ever be able to hang. My family back in Sydney have also had their homes transformed by wonderful artworks. If you want to work in Alice it is advisable to have access to plenty of wall space.

Communication is always a challenge given that there are so many different languages, and a lot of modern medical diseases have no aboriginal name. Aboriginal people have a keen desire to understand why they are sick and what is needed to make them better. Use of visual aids such as x-rays helps explain the disease and its progress. Finding the right way to communicate within each situation is one of the most satisfying challenges, as once understanding is achieved it transforms the relationship between the hospital and entire family. It plays an essential role in establishing trust. The process of building trust is further strengthened by acknowledging various belief systems. Aboriginal people have many spiritual beliefs about sickness and families will often bring in Ngangkari’s (traditional Aboriginal doctors), who heal both body and spirit. Families and the ICU

encourage both types of medicine together. With such different understanding of how diseases arise and how you cure them one needs to be careful of what one says. Once, after I had spoken at length to a family about how sick their relative was and what we were doing, I remarked that we needed to cross our fingers and hope it all worked. Two hours later I came back to find the family in deep conference about this crossing of the fingers: how do you do it? In what way? And for how long?

The hospital staff in Alice are great. We have enthusiastic nursing staff and junior medical officers who I like and admire. Like the patients, they have a great sense of humour and are dedicated. With the mix of long term staff and short term rotating staff from St Vincent’s, Royal Adelaide Hospital and Royal Prince Alfred, the tea room is filled with conversations and controversy as we all grapple with policies that change with each new election, that regulate the way in which the desert MOB, and indeed all Aboriginals, live.

Work in Alice is often demanding, usually challenging, but never boring or futile. The work is so full of all aspects of life and I have got more out of the work than I had ever expected. That is why I love being an intensivist in Alice.

Above from left: Dr Penny Stewart and partner Bob Taylor; A patient in the Intensive Care Unit; Alice Springs Hospital; The Alice Springs landscape; Alice Springs Intensive Care Unit logo.

Dean's Message



This has been a year where Pain Medicine has been thrown into the spotlight in so many ways, both good and bad.

At the start of 2008 we were shocked by the death of Heath Ledger, a young, charismatic Australian actor, who was found home alone. Following his death, hundreds of allegations and accusations filled the media. The final toxicology report commented that "Mr Heath Ledger died as a result of acute intoxication by the combined effects of oxycodone, hydrocodone, diazepam, temazepam, alprazolam and doxylamine. We have concluded that the manner of death is an accident, resulting from the abuse of prescription medications."

Three benzodiazepines, two opioids and a sedative medication in a young man with no known pain problems. Recently this has been thrown into the spotlight again with the death of Michael Jackson.

Concerns had been expressed about Michael Jackson's abuse of medication over a number of years. He did not drink alcohol and was outspoken against illegal drugs; however, he abused prescription drugs. Apparently he used numerous aliases to receive prescriptions and was known to use pethidine, alprazolam, hydrocodone, hydromorphone, oxycontin as well as a couple of anti-depressant medications, but the alleged cause of his death is in fact the use of intravenous propofol.

Figures out of the US show that prescription painkillers are the new drug of choice, overtaking marijuana and cocaine, and opioid painkillers now cause more overdose deaths in the US than cocaine and heroin combined. The US Federal Drug Enforcement Administration reports that seven million Americans are abusing prescription drugs; more than the number abusing cocaine, heroin, hallucinogens, ecstasy and inhalants combined.

The pendulum has swung from 1986 when Portnoy and Foley first proposed that opioids could be used safely to treat non-cancer pain. Australia is not immune;

reports in a Sydney newspaper last year reported that oxycodone (nicknamed hillbilly heroin) is the drug of choice in the injecting room in Kings Cross. The Australian reports show that addicts are coming from a higher social economic background and in the US they are described as being often white, employed, stable people in steady relationships but dependant on prescription drugs.

This year the RACP has released a prescription opioid policy with input from Milton Cohen from our Faculty, calling for a review of how opiates are prescribed and dispensed and Dr Alex Wodak, Director of Alcohol and Drug Services at St Vincent's Hospital, Sydney, has warned that Australia is experiencing a similar rate of oxycodone and morphine prescriptions to the US and may soon follow the trend in overdose deaths.

The pressure on the doctors looking after people such as Michael Jackson and Heath Ledger and to provide them with what they require must be immense. We are taught to treat people and yet patients are obviously claiming prescriptions from multiple practitioners (and in some cases, like Heath Ledger, across multiple continents) therefore we have to have a high degree of diligence and suspicion.

Steve Passik, at the ASM, "shocked" our anaesthetic colleagues when talking about this issue and going on to talk about the "likeability" of certain opioids. He commented that oxycodone (in a study conducted amongst university students) was the most "liked" opiate and the university students described it as having amphetamine like effects. Drugs such as oxycodone may be more of an issue in vulnerable patients. We know that 15% of our population have problems with alcohol abuse and up to 10% have problems with illicit drug abuse.

Addiction is a genetic disorder, so how can we pick those patients "at risk" to addiction. Some patients appear psychologically or genetically vulnerable, or more at risk with certain "risky" medication? In NSW from 1985-1994, it was noted that medical practitioners abusing opioids most commonly used pethidine (84%).

So we "naïve doctors", who have been trained all our lives to believe our patients and accept that "pain is what the patient says hurts" and trained to take things at face value are now being asked to become suspicious, questioning and in fact sceptical if we are asked for prescriptions for opioids or benzodiazepines.

The RACP document is one step towards raising the awareness. Jurisdictions around Australia are handling this problem differently. In Western Australia they have just released a number of documents including opioid contracts for doctors to use with their patients. In South Australia we have presented a number of resources for general practitioners outlining the problems with opioid and benzodiazepine misuse. We know that benzodiazepines impair driving; we have concerns about high dose opiates and any short acting medications as all of these could impair ability to drive and so our practise needs to change.

We also need to recognise that the majority of our patients are using the medication as prescribed, so how do we pick those that may not?

Cancer patients are living longer and are now "morphing" into chronic pain patients and also have the same risk of abuse and diversion. We all have anecdotal stories about cancer patients who we are prescribing for "in good faith" only to find that they are supplementing their income by on-selling what we provide. Where does the responsibility stop? We are now aware that there are indications that Michael Jackson's doctor will be charged. It is something that we, as doctors, need to recognise may happen to us if our patients misuse what we have provided in good faith.

As I said earlier, the pendulum has swung from opioid phobia in the early eighties through to believing the patient and giving them what they require, and now the pendulum needs to swing back to the middle again and hopefully that can occur. It would be terrible if we could not give appropriate medication to the patients who need it, we just somehow need to be able to recognise those that will abuse.

Steve Passik said at the ASM in May "If the opioid pendulum is to land in the middle rather than swing back all the way to extreme under prescribing, each patient must be individually screened for their potential for abuse".

His four "A's" of pain treatment are to look for evidence of:

- Analgesia (pain relief)
- Activities of daily living (increased)
- Adverse effects (side effects)
- Aberrant drug taking (addiction related outcomes)

It is much easier to organise an appointment for 30 seconds to renew a prescription. It will take well over 30 minutes to explain why the patient needs to change behaviour.

Dr Penelope Briscoe
Dean

Royal Australasian College of Surgeons Annual Scientific Congress 2009

The pain medicine program continues to develop as a section of interest at the Annual Scientific Congress of the Royal Australasian College of Surgeons. This has been mainly due to the strong support that the ASC Convenor Dr Campbell Miles has given to this section.

This was the sixth consecutive inclusion of pain in the scientific program. The pain papers extended over May 7-8 at the Brisbane Convention Centre. The section was integrated with the neurosurgical program and the medico legal program. The Foundation's guests for 2009 were Professor Andrew Rice from Chelsea and Westminster Hospital in London and the Medtronic guest lecturer was Professor Michael Turner, neurosurgeon from Philadelphia.

Andrew Rice presented a plenary lecture on pathophysiology of nerve injury while Michael Turner spoke on techniques for avoiding complications in the surgery for neurostimulation.

The meeting was also fortunate to have Richard Mannion, a neurosurgeon from Cambridge, who had worked with Clifford Wolfe. He also contributed to the program.

The Faculty was represented by the Dean, Penny Briscoe, Brendan Moore and Mark Tadros as well as the surgical Fellows. Sessions addressed topics including cranio facial pain; peripheral nerve injury; pain and the osteoporotic spine; pain and AMA 6 Guidelines and neuromodulation.

Sessions attracted up to 70 fellows. The convenor for this section was Leigh Atkinson. For the ASC in Perth 2010 David Holthouse will be the convenor. For the RACS ASC in 2011 Andrew Zacest has already begun work on the program.

The College of Surgeons appreciated the opportunity to have the ANZCA Foundation Guest attend this meeting.

Australian and New Zealand Pain Society Combined ASM

The Australian Pain Society and the New Zealand Pain Society will join forces in March 2010 and hold a combined Annual Scientific Conference on the Gold Coast in the week immediately before Easter. The conference is titled "The Impact of Pain".

An impressive list of speakers includes:

- **Professor Irene Tracey**, Director of the Oxford Centre for Functional Magnetic Resonance Imaging of the Brain (fMRI) at Oxford University,
- **Professor Francis Keefe**, Director of the Pain Prevention and Treatment Research Program at Duke University Medical Centre and Professor of Psychology and Neuroscience at Duke University
- **Professor Troels Jensen**, Professor of Experimental and Clinical Pain Research at Aarhus University and a consultant neurologist and director of Danish Pain Research Centre in Denmark.

In addition to an extensive three-day program the conference will also offer a number of pre conference workshops on Sunday March 28 including:

- **Interventional Pain Management Workshop – Pain Management in the acute care setting**
- **Back to Basics Training Day**
- **Psychologist workshop**

As well as the International Neuromodulation Society Conference and a Consumer forum.

For more information visit the conference website at www.dconferences.com.au/apnsnzps or contact DC Conferences on (61) 2 9954 4400.

Draft of Acute Pain Management: Scientific Evidence

In 2005, the Australian and New Zealand College of Anaesthetists (ANZCA) and the Faculty of Pain Medicine (FPM) published the second edition of *Acute Pain Management: Scientific Evidence*.

As it is a National Health and Medical Research Council (NHMRC) requirement that such documents should be revised as further evidence accumulates, and as there has been a continuing and large increase in the quantity and quality of information available about acute pain management, it was seen as timely to reassess the available evidence. ANZCA and the FPM therefore again took responsibility for revising and updating the document – this third edition.

A working party was convened to coordinate and oversee the development process and a number of Fellows have again been involved either as contributors or members of a multidisciplinary review panel.

The aim of the document is, as with the first two editions, to combine a review of the best available evidence for acute pain management with current clinical and expert practice, rather than to formulate specific clinical practice recommendations. Accordingly, the document aims to summarise the substantial amount of evidence currently available for the management of acute pain in a concise and easily readable form to assist the practising clinician. New and updated content has been incorporated with the content of the second edition.

A draft of this revision (the 3rd edition) was available for public consultation at www.acutepain.org.au for a period of one month beginning August 10, 2009. Following this and on the basis of comments received, another draft will be prepared for presentation to the NHMRC in December 2009. We hope to publish early in 2010.

Dr Penelope Briscoe
Dean

Dr Pam Macintyre
Chair on behalf of the APM:SE Working Group



National Pain Summit

The National Pain Summit is a vitally important healthcare policy initiative which aims to elevate awareness of the prevalence and economic cost of persistent pain to the community and address this issue through the development of a National Pain Strategy. A key aspect will be a focus on strategies in acute pain management that aim to reduce the risk of progression from acute to persistent pain.

The National Pain Strategy will be aligned with Federal Government's proposals for health reform and will aim to deliver major benefits to consumers, by making more effective, cost-effective and accessible healthcare solutions available to all Australians.

The proposal for the summit arose from the recommendations of the *Access Economics Report 2007: The high price of pain - the economic impact of persistent pain in Australia* that was produced in collaboration with MBF Foundation using Pain Management Research Institute epidemiological data and other research. The MBF Foundation (MBFF) has provided the initial funding to begin the process of organising the summit. The following objectives have been agreed by the working groups:

- To contribute to leadership in the development, planning and implementation of persistent pain management research, education and best practice clinical services using a whole of population approach.

- To bring together experts in the field of persistent pain management, primary healthcare providers, consumers and key government and private sector stakeholders, to achieve a comprehensive understanding of what is required to manage and minimise the impact and extent of persistent pain in the Australian community – in health, social, human, financial and economic terms.
- To achieve agreement for a national strategy for implementation of the model of best practice treatment of persistent pain and new standards for treatment of pain patients.
- To develop an effective National Pain Strategy to make best practice pain management accessible to all Australians through harnessing the expertise of all stakeholders including health professionals, private sector partners, industry, relevant NFP organisations, consumer groups, non-government payers (including general, non-health insurers) and state and federal governments.

The summit involves five stages which are integral to the development of a National Pain Strategy:

1. Preparation stage

This involves three parallel working groups who are each responsible for key elements of the strategy. A preliminary leaders' meeting was convened at ANZCA House on June 5. The groups comprise consumer representatives, pain and other relevant medical specialists and primary health care providers from all relevant disciplines. Their initial output resulted in a strategic framework for consideration and further development at a Leaders Meeting. They will make recommendations in relation to the role of primary care, evidence for best practice pain management and optimum model for delivery of services. (This stage has already commenced).

2. Leaders Meeting on September 17

This involved a core stakeholder group of around 50 participants. It included members of the working groups and other representatives of the primary stakeholder group who considered the recommendations of the working groups and agreed on the strategic framework for the National Pain Strategy.

3. Development of draft strategy

An experienced health policy consultant will be engaged to draft a National Pain Strategy document based on the outcome of the leaders meeting.

4. National Pain Summit

The draft National Pain Strategy will be presented to a meeting of around 100 representatives of all stakeholder groups, for consultation and validation to ensure an effective, comprehensive and transparent consultation process.

5. Post Summit action

It is proposed that the National Pain Strategy endorsed by the summit will be carried forward to government jointly by the Faculty of Pain Medicine/ANZCA, the Australian Pain Society and the consumer body, Chronic Pain Australia.

Recommendations for a National Pain Strategy will be closely aligned with the recommendations of the National Health and Hospitals Reform Commission Interim Report, the recommendations of the National Primary Health Care Strategy Committee, the National Preventative Health Strategy Taskforce and the National Health Priority Action Council, especially in relation to managing chronic disease in Australia.

Fellowship training and examination dates for 2009

Examination dates

November 25-27, 2009
Royal North Shore Hospital, Sydney, NSW.

Closing date for registration:

October 9, 2009.

Admission to Fellowship of the Faculty of Pain Medicine

By training and examination:

Dr Michael Peter Carroll	NSW
Dr Robert Malcolm Thomas	QLD
Dr John Yang	NSW
Dr Yeo Swan Thong Vincent	SINGAPORE

Policy on supervision of clinical experience for vocational trainees in pain medicine

1. Introduction

Supervision of clinical experience allows vocational trainees in pain Medicine to have a good quality learning experience as they progress towards independent practice. Supervision of clinical work during training is a vital part of developing professional competence, and can guide training. The level and form of supervision provided varies as a trainee gains experience and expertise during the training program.

2. Supervisors

- 2.1. Supervisors of Training must be appropriately qualified, holding FFPMANZCA or other qualifications approved by the Faculty of Pain Medicine.
- 2.2. Medical staff other than the Supervisor of Training may provide day-to-day or after hours supervision.

3. Level of Supervision

The level of supervision will vary for a given trainee. It will be more intensive in the initial period of training. Supervision should be available at all times.

- 3.1. Level 1: Supervisor working directly and in close proximity with a Trainee.
- 3.2. Level 2: Supervisor within same location in the hospital, and available for assistance and face-to-face consultation within minutes, and immediately by telephone.
- 3.3. Level 3: Supervisor present elsewhere in hospital, and available for consultation and assistance within 15 minutes, and immediately by telephone.
- 3.4. Level 4: Supervisor not in hospital but contactable and, if necessary, available within a reasonable travelling time (less than 60 minutes). This level of supervision applies to out-of-hours cases. Telephone consultation must be available at all times.

4. Supervisors of Training time for trainees

In large pain units with more than two trainees, an allocation of one session per week to Supervisors of Training is necessary to meet their responsibilities. This session can occur fortnightly in smaller pain units with up to two Trainees.

5. General principles

Whenever the Trainee is on duty, there must be a clear line of responsibility from the patient, through the junior medical staff to the trainee, and to the consultant responsible for the patient's care. Should the consultant usually responsible for the clinical care of a particular patient not be available, the trainee should have access to a similarly qualified consultant who is prepared to act in a locum capacity.

During the structured year of training, the supervisor should focus on knowledge, attitudes and skills required for:

- Interviewing
- Specific Pain History
- Physical Examination
- Mental state examination
- Formulation of Cases
- Presentation
- Interventions
 - clinical
 - procedural
- Case management
- Multidisciplinary team participation and management
- Educating and Training of others
- Correspondence
- Administration

6. Interventional supervision

The trainee should observe supervisors conducting diagnostic and therapeutic interventions. It may be appropriate for the trainee to practice in a simulated environment and a number of closely supervised repeats may be desirable for some trainees and for some skills. Supervisors should observe a trainee conducting similar interventions until such stage, that the trainee can continue these activities independently, confidently and at a competent level.

7. Feedback

In addition, periods are to be set aside specifically for the purpose of supervision of the training issues that are not directly occupied with providing clinical care. Trainees should be encouraged to discuss their progress on a regular basis (not less than 30 minutes per fortnight) with their Supervisor of Training during these face-to-face sessions.

8. In-training assessment

In-training assessments (ITAs) will be carried out at quarterly intervals. The last ITA will be summative.

Professor Julia Fleming



Professor Julia Fleming has recently been appointed Director of the Professor Tess Cramond Multidisciplinary Pain Centre at the Royal Brisbane Women's Hospital. We spoke to Professor Fleming about her work.

Like a number of anaesthetists of her era, Professor Fleming believes that dealing with complex pain issues is part of being an anaesthetist. "During my anaesthetic training, interventional care was common, new concepts and technologies for pain management, including epidural opioids and PCA devices were under development, and both acute and chronic pain service delivery was being formalised internationally," she said. "We became interested in complex pain from an early stage, and established interventional clinics to manage patients with ischaemic leg pain, reflex sympathetic dystrophy, neuropathic and cancer pain. However, we subsequently realised that assistance from other disciplines was needed, leading to establishment of stand-alone multidisciplinary units."

After completing preclinical and clinical research projects in Australia and the US, including areas as diverse as visual neuroanatomy (Psychology Department, Princeton University, NJ), impact of local anaesthetics on the developing foetus and of HFO on the newborn (Monash University Centre for Early Human Development), cocaine addiction and evaluation of non-invasive cardiovascular monitoring devices (Yale University, US), Professor Fleming developed an interest in spinal cord injury and the impact of pain on autonomic

hyperreflexia while at Austin Hospital. This inspired her to complete a PhD under Professor Colin Goodchild at Monash University in the 1990s focused on the molecular biology (receptor subtypes), and pharmacological modulation, of inhibitory GABAA receptors in spinal cord, ultimately in models of neuropathic pain. During this time she developed a keen interest in the impact of glial activation on these inhibitory systems, an area of future potential research. She completed her PhD write-up while spending a subsequent research year and completing a Diploma of Pain Management with Professor Michael Cousins within the Pain Management and Research Centre at Royal North Shore Hospital.

During her PhD years, there was worldwide resurgence of research into the neurobiology of pain. An enormous amount of scientific data was produced. "A decade later it was realised that the translation of basic research into the clinical arena was actually really difficult. Many clinical successes involved utilising medications without any clear understanding of how they worked. Compounds identified to work in animal models failed in humans. There now needs to be far more focus on translational research, on exploring the genetic basis for pain, on clinical assessment of fundamental mechanisms of pain and on quality assurance in pain medicine. Why do some people get pain and others don't? Why is there such variability in responses to medications for different types of pain? What are the outcomes of what we do, and how can we improve. We need to conduct more comprehensive neurophysiological assessments of complex pain patients to more fully understand underlying mechanisms and results of treatment."

Professor Fleming finds working in pain medicine rewarding. "You are able to develop longer term clinical relationships (than in anaesthesia), be involved in forward-planning and evaluate treatments you've introduced," she said. "I enjoy dealing with some of the multidisciplinary aspects of pain assessment and the fact that they're a complex group of patients to manage. You often have major successes and patients really appreciate what you've done for them. We can make a difference."

Professor Fleming thinks that it's very

important that pain medicine specialists become mentors for educational and quality assurance work in pain in the broader medical community. She adds that the medical profession must plan for the future. "Why have we got all these pain problems? Probably because we didn't intervene early enough and, because there are so few pain medicine specialists, we're often dealing with issues too late. I think education and collaboration with other clinicians is really imperative and that's where I think pain medicine is going in the next decade. I really welcome that the Faculty now is admitting those who have primary roles in acute pain management, and general practitioners into training positions.

"We need to collaborate closely with our referral base within hospitals and in primary care, and promote education about fundamental principles of good pain management to these groups, to ensure that pain is optimally managed at all stages, and preferably as early as possible to minimise chronicity. One difficulty in pain medicine is getting access to medical students as there is intense competition amongst clinicians for their training time".

"Another issue is that most of those coming into higher training as pain medicine specialists have just completed their primary fellowships, and to take time out from a primary speciality such as anaesthesia, a very technical speciality, leads to a risk of deskilling. This, and limited career opportunities in pain medicine in the public sector, leads to many Fellows "being lost" back into their primary speciality. However, we must acknowledge that we are then seeding expertise back into the primary specialties, which should be of benefit to pain medicine and to training in the primary disciplines in the longer term. This also would apply not only to anaesthetists, but to other specialists, such as rehabilitation medicine and palliative medicine, where a more extensive knowledge of complex pain issues can only lead to improvements in patient care. In pain medicine, we need to be careful that we're not seen to be competitive, but that we're complementary to care. In addition to focusing on increasing our own numbers, we need to be aware that we are likely to ultimately reap benefits from those we train who go back to their own disciplines."

Report from the Board meeting held on August 17, 2009

Faculty Board

The Faculty Board met on August 17. A half-day strategic workshop will be convened in conjunction with the October Board Meeting.

Relationships portfolio

Liaison with pain societies

A teleconference meeting of the FPM, the APS and NZPS was convened on June 5 to maintain communication with regard to future meetings and other opportunities for collaboration including the National Pain Summit and the Global Day Against Pain. Musculoskeletal pain is the next Global Day against Pain topic and the three organisations will collaborate on a poster and fact sheet.

Opportunities for developing joint professional documents and government submissions to improve communications and speak with a unified voice will be explored. FPM regional committees are being encouraged to co-opt APS representatives.

Liaison with medical colleges

Royal Australasian College of Surgeons Annual Scientific Congress 2009

With the strong support of the RACS ASC Convenor, Dr Campbell Miles, the Pain Medicine program continues to develop as a section of interest at the ASC of the Royal Australasian College of Surgeons. This year's was the sixth consecutive inclusion of pain in the scientific program. Associate Professor Leigh Atkinson was the convenor for this section.

Pain Medicine sections have been confirmed for both the 2010 ASC (Perth) and 2011 ASC (Adelaide) and work has commenced on these programs.

Corporate affairs

New Zealand application for specialty recognition

Following input from Dr Steuart Henderson, ANZCA Director of Professional Affairs, the application for specialty recognition in New Zealand has now been submitted. This is a two-stage process which is anticipated to take approximately 18 months.

Regional Committees

Queensland

Queensland members of the Faculty of Pain Medicine welcomed Professor Julia Fleming to Brisbane. Julia Fleming has

been appointed to the Department of Anaesthetics and Pain Medicine at the Royal Brisbane Hospital succeeding Professor Tess Cramond.

NSW

The FPM NSW Regional Committee held a Continuing Medical Education dinner meeting on Thursday, August 27. A session on "Issues of pain management in NSW – specialists, trainees and patients" was presented by Dr K E Khor (NSW Regional Committee Chair), Dr Martine Holford and Dr Paul Wrigley.

Fellowship Affairs Portfolio

New admissions

Dr Michael Carroll FAFRM (RACP) (NSW), Dr Robert Thomas FANZCA (QLD), Dr John Yang FANZCA (NSW) and Dr Yeo Swan Thong Vincent (MMed, SINGAPORE) were admitted to Fellowship by training and examination.

Professional

Acute Pain Management: Scientific Evidence 3rd Edition

A draft of this revision (the 3rd edition) was made available for public consultation at www.acutepain.org.au for a period of one month beginning August 10, 2009. Following this and on the basis of comments received, another draft will be prepared for presentation to the NHMRC in December 2009. It is hoped that publication will be early in 2010. Further information can be found in this edition of the *Bulletin*.

Submissions

Victorian Workforce Redesign Toolkit

The Faculty contributed to a response to a request by the Victorian Department of Human Services to comment on broader workforce models, particularly in relation to perioperative medicine and management of pain.

National Transport Commission

The Faculty responded to a request by the National Transport Commission to comment on a review of the medical standards that apply for driver licensing purposes (commercial and private vehicle drivers); and for mandatory health assessments for rail safety workers. Specifically, advice was sought in relation to the impact of pain medications (in particular opioids) for drivers of commercial vehicles and for rail safety workers, including how such impacts might be assessed and

managed. Thanks go to Dr KE Khor and Dr Mark Tadros for their input. Information about the review and public consultation can be found on the NTC website at: www.ntc.gov.au/viewpage.aspx?AreaId=35&DocumentID=1863

Good Medical Practice: A Code of Conduct for Doctors in Australia

The Australian Medical Council has released the final version of Good Medical Practice: A Code of Conduct for Doctors in Australia, which was developed on behalf of the state and territory medical boards. You can access the code at www.goodmedicalpractice.org.au

The Faculty participated in the consultation process that shaped the development of the code, which the AMC believes sets out the principles that characterise good medical practice and makes explicit the standards of ethical and professional conduct expected of doctors by their professional peers and the community.

The Medical Council of New Zealand code can be found at: www.mcnz.org.nz/portals/o/guidance/goodmedpractice.pdf

National Drugs and Poisons Schedule Committee

The Dean recently made a submission on behalf of the Faculty to the National Drugs and Poison Schedule Committee's Record of Reasons for June 2009. This report has just been released and can be accessed at the following webpage: www.tga.gov.au/ndpsc/record/rr200906.htm

Please see item 11.3 regarding the Committee's consideration of the scheduling of OTC codeine.

National Pain Summit

A preliminary leaders' meeting was convened at ANZCA House on June 5. A wide range of stakeholders from the healthcare sector and the community were represented either in person or by teleconference. The Facilitator for the leaders' meeting to be held on September 17, Norman Swan, briefed the group by teleconference on the objectives of the leaders meeting and the work required from each of the groups in the lead up to this.

Following a request for FPM/ANZCA support for this project from Professor Michael Cousins, the College has agreed on a budget to support organisation of

the National Pain Summit, including communication, project management, venue and administrative support.

Further information on the National Pain Summit can be found in this edition of the *Bulletin*.

Continuing Education and Quality Assurance

Scientific Meetings

2009 Spring Meeting

Registrations for the Faculty's third Spring Meeting "Duelling with Pain" at the Sofitel on Collins in Melbourne from October 16-18 have commenced. The program will address the challenges in managing the spectrum of complex acute, chronic and cancer pain problems. The sponsorship budget has already been met and promotional efforts have been increased to raise awareness of this event.

2010 ASM – Christchurch

Plans are well advanced for the Refresher Course Day and ASM Program including Dr Jeffrey Mogil (Canada) as the FPM ASM Visitor and Dr Richard Rosenquist (USA) as the FPM New Zealand Visitor. The programs for both the Refresher Course Day and ASM are now available on the website. Registration brochures will be circulated toward the end of 2009.

2010 Spring Meeting

Dr Chris Hayes will convene this meeting in Newcastle and an organising committee has been established. The theme will be "Transitions in Pain" with prominence given to the "Models of Care" sub-theme.

2011 ASM – Hong Kong

Dr P P Chen has been confirmed as the FPM Convenor for the 2011 Meeting in Hong Kong. Professor Leigh Atkinson will be the deputy convenor. Professor Catherine Bushnell (Harold Griffith Professor of Anesthesia and Professor in Dentistry and Neurology at McGill University) and Professor JS Han (Beijing Medical University) have agreed to be the Faculty keynote speakers at this meeting.

Trainee affairs portfolio

Examination

The 2009 examination will take place from November 25-27, 2009 at the Royal North Shore Hospital, NSW and the closing date for registration is October 9, 2009.

The Pre-Examination Short Course program at the Royal Adelaide Hospital will be held on September 9-11 and will run over 2½ days and will include a Long Case.

Examination committee

Dr Ben Marosszkey and Dr Lindy Roberts have resigned from the examination panel and Associate Professor Milton Cohen has resigned from Examinations Committee. The Faculty would like to thank these Fellows for their contributions.

Two new examiners have been appointed to the panel, Dr Wilbur Chan and Dr Owen Williamson. Professor Michael Cousins and Professor Pam Macintyre have been reinstated as examiners.

There are 27 on the examination panel – 15 ANZCA, 3 RACP, 2 RACS, 2 RANZCP, 4 AFRM and 1 CARCSI.

Education Committee

The Board has approved the Policy on Supervision of Clinical Experience for Vocational Trainees in Pain Medicine.

The document set out the levels of supervision and the general principles of when a trainee is on duty. This policy has been published in this edition of the *Bulletin*.

Supervisors of Training

The Faculty is holding a Supervisor of Training workshop at the ANZCA NSW Regional Office on Friday, October 30. The morning program will include a teleconference with the Assessor, Dr Frank New, who will give a brief report on case reports and answer any questions SoTs might have. The afternoon will involve a structured workshop, facilitated by Felicity Hutton (ANZCA Education Manager) with the theme of "Managing the Difficult Trainee". All FPM Supervisors of Training are being encouraged to attend this workshop which has been tailored to the needs of Pain Medicine SoTs.

Training Unit Accreditation

Recent Reviews

The Alfred Health Pain Services was re-accredited for a year and the Prince of Wales Hospital and Singapore General Hospital were re-accredited for pain medicine training for two years.

2010 Strengthening Medical Specialist Training Program

It has recently been confirmed that pain medicine has been placed on priority listing B under the Victorian Government's 2010 Strengthening Medical Specialist Training Program, along with geriatrics, pathology and psychiatry. This program provides annual incentive funding in targeted specialties for up to three years to assist health services to increase the number of accredited specialist training positions.

The program aims to provide flexible funding options to support growth in specialist training positions in specialties where there are identified shortages. It provides for incremental growth in training capacity in the public health system in preparation for the increased number of medical trainees seeking specialist training positions in 2013/4 onwards. It is expected that after three years of incentive funding for newly created positions, health services will provide ongoing funding for the position.

The program focuses on supporting those disciplines facing significant workforce pressures and ensuring that Victoria's future medical workforce receives the right training in the right environment. It is exciting news and excellent progress that Pain Medicine has been recognised as an area of need. The Faculty will be encouraging unit directors within their hospitals to consider applications through this program. Additional information is available from: www.health.vic.gov.au/___data/assets/pdf_file/0011/356951/2010-Information-Sheet.pdf

Resources portfolio

2010 budget

Preparations have commenced for the Faculty's 2010 budget bid.

ANZCA's Archives – Foundation Fellows



This is the second in a series of articles on Foundation Fellows of the Faculty of Anaesthetists, Royal Australasian College of Surgeons.

Reginald Lewis 1912 – 1997: Tasmania's Foundation Fellow

Reginald Lewis was the first specialist anaesthetist in Tasmania and worked as a visiting medical officer at the Royal Hobart Hospital and in private practice in Hobart from 1948 until 1990.

His extensive case notes open a window into the world of an Australian practitioner and Foundation Fellow at the time of the inauguration of the Faculty of Anaesthetists, Royal Australasian College of Surgeons in August 1952.

Dr Lewis obtained his MBBS at Melbourne in 1936 and began work as a resident medical officer at Launceston General Hospital in 1937. The following year he was involved in a celebrated case - and possibly made medical history - when he administered a major anaesthetic, using a D M Austox machine, to a woman requiring continuous iron-lung respiration for the delivery of her baby boy.

Dr Lewis subsequently obtained his Diploma in Anaesthetics at Sydney

University in 1947 and commenced private practice in Hobart. As Dr Gwen Wilson observed, he was among the new generation of anaesthetists in Australia who would swell the ranks of the Australian Society of Anaesthetists and become founders of the Faculty of Anaesthetists, Royal Australasian College of Surgeons (1).

In his obituary article published in the November 1997 edition of the *ANZCA Bulletin*, Dr Michael Hodgson wrote:

“the contribution Reg made to anaesthesia was not through presenting papers at meetings, nor through publishing in journals, but through his teaching of the principles of good sound anaesthetic practice.” (2)

In 2008 Dr Alan Bond remembered Dr Lewis as...

“quiet, self-effacing and intensely private ...he offered an outstanding example to those of us who chose to sneak a look at the way he worked. He was neat, methodical and completely unflappable and, I believe, much admired by the surgeons he worked with. He also had a wry sense of humour in which laconic observations were usually accompanied by a rather enigmatic smile which lit his whole face. He was by no means a great innovator. On the contrary, he set store by what he knew and felt familiar with. Indeed, I once heard one of his senior colleagues quote an adage he felt epitomised Reg: ‘Be not the first by whom the new is tried. Nor yet the last to lay the old aside.’ To summarise Reg in a nutshell two words leap to my mind – quiet competence.” (3)

Fraser Faithfull
ANZCA Archives

A near loss

Reg Lewis was meticulous, some would say obsessive, in recording details of the anaesthetics to be administered in a “May and Baker” diary and later transcribed into a day book.

Recorded were the patients' details, the surgeon, the operation performed, the anaesthetic given and any significant features or events. He started these records when he commenced practicing in Hobart in 1947 until his last anaesthetic in January 1990.

When Reg died, his wife asked me to explore his study and advise what to do with anything of significance I might find. There were the usual books and journals, hand-written lecture notes when he was a student at the University of Melbourne and sundry other items.

I felt the anaesthetic records were of special significance because they spanned a long professional career and would be a mine of information for researchers and I suggested forwarding them to College Archives for safe keeping. Mrs Lewis asked if I would do this and I contacted the late Joan Sheales (ANZCA Registrar). In the meantime I put them in the boot of my car while I made the necessary arrangements to transfer them to Melbourne.

Some little time later my car was broken into and small items were stolen. I didn't look in the boot. Imagine my alarm one Saturday when I got a phone call from Mrs Lewis asking me whether I had sent the records to the College. I indicated I had contacted the College and they were in my car until I made the necessary arrangements to transfer them.

Mrs Lewis said she had been contacted by the police who said that they had found them in a stolen car some kilometres from my home.

These records are priceless. They are in the College Archives and available for research.

Dr Michael Hodgson
Former ANZCA President 1992 – 1993

**Above: Dr Reginald Lewis and
Dr Michael Hodgson.**

**Right: Details of D M Austox apparatus
(Geoffrey Kaye Museum of Anaesthetic
History Collection).**



A day in the life

Wednesday August 27, 1952 was Reg Lewis' first full day of anaesthetic work after the inauguration of the Faculty of Anaesthetists, Royal Australasian College of Surgeons two days earlier. On that day he gave six anaesthetics, for:

1. Exploration of shoulder in a 37-year-old.
2. Removal of six toenails.
3. Hysterectomy in a 60+ year-old.
4. 3 1/2-year-old for Ts and As
5. 6-year-old for Ts and As
6. 13-year-old for Ts and As

Perusal of Reg Lewis' diary notes for August 27 illustrates the difficulty of interpreting personal acronyms of some 57 years ago. It is clear that his first anaesthetic was induced at 0900 and the last at 1745.

The shoulder surgery patient's notes included the observation "very drowsy from toxæmia and sedation at Royal" and it was noted that the hysterectomy patient had "advanced Parkinson's disease – on hyoscine – large pupils – no other premed". There is frequent reference in the records to "IV, "ether", "ether blower", "pharyngeal airway", "atropine", "oxygen" and "nitrous oxide".

It is known that by 1952 in Australia, volatile agents in common use apart from ether included cyclopropane and

trichlorethylene; that thiopentone was in widespread use, as were curare and gallamine; that decamethonium had arrived by 1949, and suxamethonium by 1952.

Laryngoscopes, endotracheal tubes, means of inflating the lungs and suction were all widely available, as was a variety of anaesthetic equipment. However, blow-over ether, with or without added oxygen, the Boyle-Davis gag and a variety of airways were also still used (4).

But the true genius of Hobart was the ability of its anaesthetists to provide anaesthesia for the first case of phaeochromocytoma removal reported in the Australian literature, published in the *Medical Journal of Australia* in 1954 (5). Included in this article is the following:

"As it was anticipated that resuscitation would be required, detailed preparations were made beforehand. One medical officer was delegated to take blood pressure and pulse readings, these being recorded by a slater. Another medical officer was in charge of the intravenous infusions, and had a ready supply of nor-adrenaline, 'Piperoxane', hexamethonium bromide, serum, blood and saline. A third medical officer coordinated the work of the surgeon, the anaesthetist and the two medical officers previously mentioned. It was felt that these detailed arrangements

were necessary for a successful outcome.... at one stage the patient's condition caused some alarm, and the surgeon was requested to stop for a short time....at nine hours after operation it was found that nor-adrenaline given at a rate of 50 drops per minute (concentration eight milligrammes per litre) maintained his blood pressure...during the next thirty-six hours the rate of flow of nor-adrenaline was gradually reduced, and at forty-six hours after operation the infusion was stopped."

So not only careful planning and effective anaesthesia, but also prolonged recovery/intensive care in the days when facilities for these were not available and depended on the leadership of the anaesthetists, no doubt supported by equally dedicated nursing staff.

Professor Garry Phillips

Former ANZCA President 1996 – 1998

ANZCA's Archives Foundation Fellows

Continued

Anaesthetic Deaths

More than 50 years ago, around the time of the establishment of the Faculty, Reg Lewis drafted notes about anaesthetic deaths and listed measures by which such tragedies might be prevented.

1. Pre-anaesthetic assessment.
2. Sedation to minimise fear and in hospital at least overnight.
3. Use the method in which you possess the most experience and confidence, no matter how simple that may be.
4. Toxic and frail and elderly patients require a minimal amount of anaesthetic.
5. Beware the case of intestinal obstruction, it will usually vomit during induction.
6. Beware of the unattended child in the case that has had parents hanging around with food and drink.
7. Never allow adrenalin with halogenated hydrocarbons – chloroform, trilene, ethyl chloride, avertin.

8. Maintain unobstructed airway – noisy resps indicate partial obstruction, but complete obstruction is silent.
9. Frequently feel the pulse – irregularities or EP.
10. Supplement with oxygen in all poor risk cases.
11. Never administer an anaesthetic unless you possess a laryngoscope, cuffed endotracheal tubes, adaptors and bag for inflating the lungs with oxygen, a length of fine rubber tubing with glass connectors for air suction and an efficient working sucker, and above all know how to use them.
12. Never give a combustible anaesthetic in the presence of a source for ignition, especially diathermy.
13. Adequate resuscitative measures during and after the operation.

Dr Michael Hodgson

Former ANZCA President 1996–1998

References

1. Wilson, G. et al, One Grand Chain – The History of Anaesthesia in Australia 1846-1962, Volume 2 1934 – 1962, ANZCA, Melbourne, 2004, p. 148
2. ANZCA Bulletin, November 1997, p. 55.
3. Correspondence from Dr Alan Bond to ANZCA Archivist, October 2008.
4. Wilson, G. op cit, pp. 425-462
5. Lewis R.G., Knight L.W., “Report of a case of Phaeochromocytoma cured by surgical removal” Med J Aust 1954: 978-981

We would like to acknowledge Jill Humphreys' help with transcription in the third segment, “A day in the life”.

Case Records of Dr Lewis held in ANZCA Archives:

- Thirty-five pocket diaries covering 1939, 1948 to 1981 (except 1959). There is a second diary for 1968. Notes in the annual pocket diaries may have been transferred to the larger case book volumes.
- Fourteen large case books covering January 1948 to January 1990.
- A set of receipt books covering 1948 to 1958 (one volume) and 1967 to 1972 (4 volumes).

Dr Ian Charles McGlew

MBBS, FRCA, FANZCA

1938-2009



Dr Ian Charles McGlew was born in Perth on October 9, 1938. He spent his early years on the family farm in Beverley, and went to Guildford Grammar School as a boarder in grade 6, at the same time as his brother Andrew started in the class above. Ian was good at sport and was in the first 18 football team and in the athletics team. Many times he related how he ran against Herb Elliott in the interschool sports.

Ian matriculated in 1955, and started medicine in 1956. His year was the last one to have to go out of WA for part of the course. He went to Adelaide for second and third years during which time he stayed at St Mark's College. He returned to WA at the end of 1958 to for years four, five and six at the new medical school of WA. During this time he played first grade rugby for Royal Perth Hospital. The team was composed mainly of doctors and medical students. He worked at Fremantle Hospital for two years, had three months in Port Hedland and then went to England. He worked at Southend, drawn there by the presence of J Alfred Lee, and then moved to St George's Hospital in London. He sat and passed the FFARCS in July 1966 (this later became FRCA).

Ian and Liz were married in London on the day England won the World Cup soccer final. They went to Falun in Sweden for six months before returning to Western Australia where Ian took up the post of staff anaesthetist at Sir Charles Gairdner Hospital. After a year in that post he joined a private practice group, and stayed on the visiting staff of Sir Charles Gairdner for the next 25 years, during which time he gave sterling service to the Department of Anaesthesia and to the hospital. He was a very competent, careful and caring anaesthetist and was held in the highest regard. Colleagues also enjoyed working with him because he was such a likeable person. He sat and passed the FFARACS in 1970, and became a Fellow of ANZCA in 1992.

Ian was active in medical and anaesthetic affairs. He was on the WA branch council of the AMA, and did a term as treasurer.

He served on the WA state committee of the Australian Society of Anaesthetists from 1972, and was chairman in 1976-1977. He then went on to the WA Regional Committee of the Faculty of Anaesthetists as it was then known, and was chairman from 1981 to 1984. He then spent seven years as an examiner for the Final Fellowship. He retired from anaesthetic practice at the end of 2005.

Ian was a great family man and good handyman, especially carpentry. Liz and Ian spent most of their spare time in the 1990s at Denmark, where Ian developed a vineyard, Yanwirra, from scratch, and ended up with a fine property. He laboured tirelessly in the vineyard but also renovated the house building a big deck by himself.

He was interested in, and followed, many sports. He was a member of the WACA, the Western Force, and the Fremantle Dockers. He loved his golf

and was a member of Lake Karrinyup Golf Club. He had joined The Weld Club in 1960, and was a member for almost 50 years, serving on the wine committee for five years and for two years was chairman.

Ian bounced back several times from operations but this last time, sadly, he deteriorated quite rapidly and died on June 17, aged 71. Ian always looked very much younger than his age and this was so right up to the end.

Ian is survived by his wife Liz, four children, Sandy, Holly, Blair and Rohan, and seven grandchildren. The enormous crowd at Ian's funeral was no surprise. He will be sorely missed by many.

Dr Neville Davis AM
FANZCA
July 2009

Professional documents

Australian and New Zealand College of Anaesthetists

Professional documents

P = Professional

T = Technical

EX = Examinations

PS = Professional standards

TE = Training and Educational

TE1	(2005)	<i>Recommendations for Hospitals Seeking College Approval for Vocational Training in Anaesthesia</i>
TE2	(2006)	<i>Policy on Vocational Training Modules and Module Supervision (interim review)</i>
TE3	(2006)	<i>Policy on Supervision of Clinical Experience for Vocational Trainees in Anaesthesia</i>
TE4	(2003)	<i>Policy on Duties of Regional Education Officers in Anaesthesia</i>
TE5	(2003)	<i>Policy for Supervisors of Training in Anaesthesia</i>
TE6	(2006)	<i>Guidelines on the Duties of an Anaesthetist</i>
TE7	(2005)	<i>Guidelines for Secretarial and Support Services to Departments of Anaesthesia</i>
TE8	(2003)	<i>Guidelines for the Learning Portfolio for Trainees in Anaesthesia</i>
TE9	(2005)	<i>Guidelines on Quality Assurance in Anaesthesia</i>
TE10	(2003)	<i>Recommendations for Vocational Training Programs</i>
TE11	(2008)	<i>Policy on the Formal Project (interim review)</i>
TE13	(2003)	<i>Guidelines for the Provisional Fellowship Program</i>
TE14	(2007)	<i>Policy for the In-Training Assessment of Trainees in Anaesthesia</i>
TE17	(2003)	<i>Policy on Advisors of Candidates for Anaesthesia Training</i>
TE18	(2005)	<i>Guidelines for Assisting Trainees with Difficulties</i>
EX1	(2006)	<i>Policy on Examination Candidates Suffering from Illness, Accident or Disability</i>
T1	(2008)	<i>Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations (interim review)</i>
T3	(2008)	<i>Minimum Safety Requirements for Anaesthetic Machines for Clinical Practice</i>
PS1	(2002)	<i>Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia</i>
PS2	(2006)	<i>Statement on Credentialling and Defining the Scope of Clinical Practice in Anaesthesia</i>
PS3	(2003)	<i>Guidelines for the Management of Major Regional Analgesia</i>
PS4	(2006)	<i>Recommendations for the Post-Anaesthesia Recovery Room</i>
PS6	(2006)	<i>The Anaesthesia Record. Recommendations on the Recording of an Episode of Anaesthesia Care</i>
PS7	(2008)	<i>Recommendations on the Pre-Anaesthesia Consultation</i>
PS8	(2008)	<i>Guidelines on the Assistant for the Anaesthetist</i>
PS9	(2008)	<i>Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical or Surgical Procedures</i>

Professional documents

Continued

- PS10 (2004) *Handover of Responsibility During an Anaesthetic*
 PS12 (2007) *Statement on Smoking as Related to the Perioperative Period*
 PS15 (2006) *Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery*
 PS16 (2008) *Statement on the Standards of Practice of a Specialist Anaesthetist*
 PS18 (2008) *Recommendations on Monitoring During Anaesthesia*
 PS19 (2006) *Recommendations on Monitored Care by an Anaesthetist*
 PS20 (2006) *Recommendations on Responsibilities of the Anaesthetist in the Post-Anaesthesia Period*
 PS21 (2003) *Guidelines on Conscious Sedation for Dental Procedures*
 PS26 (2005) *Guidelines on Consent for Anaesthesia or Sedation*
 PS27 (2004) *Guidelines for Fellows who Practice Major Extracorporeal Perfusion*
 PS28 (2005) *Guidelines on Infection Control in Anaesthesia*
 PS29 (2008) *Statement on Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities (reissue)*
 PS31 (2003) *Recommendations on Checking Anaesthesia Delivery Systems*
 PS37 (2004) *Regional Anaesthesia and Allied Health Practitioners*
 PS38 (2004) *Statement Relating to the Relief of Pain and Suffering and End of Life Decisions*
 PS39 (2003) *Minimum Standards for Intrahospital Transport of Critically Ill Patients*
 PS40 (2005) *Guidelines for the Relationship Between Fellows and the Healthcare Industry*
 PS41 (2007) *Guidelines on Acute Pain Management*
 PS42 (2006) *Recommendations for Staffing of Departments of Anaesthesia*
 PS43 (2007) *Statement on Fatigue and the Anaesthetist*
 PS44 (2006) *Guidelines to Fellows Acting on Appointments Committees for Senior Staff in Anaesthesia*
 PS45 (2008) *Statement on Patients' Rights to Pain Management*
 PS46 (2004) *Recommendations for Training and Practice of Diagnostic Perioperative Transoesophageal Echocardiography in Adults*
 PS47 (2008) *Guidelines for Hospitals Seeking College Approval of Posts for Vocational Training in Diving and Hyperbaric Medicine*
 PS49 (2008) *Guidelines on the Health of Specialists and Trainees*
 PS50 (2004) *Recommendations on Practice Re-entry for a Specialist Anaesthetist*
 PS51 (2009) *Guidelines for the Safe Administration of Injectable Drugs in Anaesthesia*

Australian and New Zealand College of Anaesthetists

and

Joint Faculty of Intensive Care Medicine

Professional documents

- IC-1 (2003) *Minimum Standards for Intensive Care Units*
 IC-2 (2005) *Intensive Care Specialist Practice in Hospitals Accredited for Training in Intensive Care Medicine*
 IC-3 (2008) *Guidelines for Intensive Care Units seeking Accreditation for Training in Intensive Care Medicine*
 IC-4 (2006) *The Supervision of Vocational Trainees in Intensive Care*
 IC-6 (2002) *The Role of Supervisors of Training in Intensive Care Medicine*
 IC-7 (2006) *Administrative Services to Intensive Care Units*
 IC-8 (2008) *Quality Assurance*
 IC-9 (2002) *Statement on the Ethical Practice of Intensive Care Medicine*
 IC-10 (2003) *Minimum Standards for Transport of Critically Ill Patients*
 IC-11 (2003) *Guidelines for the In-Training Assessment of Trainees in Intensive Care Medicine*
 IC-12 (2001) *Examination Candidates Suffering from Illness, Accident or Disability*
 IC-13 (2008) *Recommendations on Standards for High Dependency Units Seeking Accreditation for Training in Intensive Care Medicine*
 IC-14 (2004) *Statement on Withholding and Withdrawing Treatment*
 IC-15 (2004) *Recommendations of Practice Re-entry for an Intensive Care Specialist*

Australian and New Zealand College of Anaesthetists

and

Faculty of Pain Medicine

Professional documents

PM2	(2005)	<i>Guidelines for Units Offering Training in Multidisciplinary Pain Medicine</i>
PM3	(2002)	<i>Lumbar Epidural Administration of Corticosteroids</i>
PM4	(2005)	<i>Guidelines for Patient Assessment and Implantation of Intrathecal Catheters, Ports and Pumps for Intrathecal Therapy</i>
PM5	(2006)	<i>Policy for Supervisors of Training in Pain Medicine</i>
PM6	(2007)	<i>Guidelines for Longterm Intrathecal Infusions (Analgesics/Adjuvants/Antispasmodics)</i>
PS3	(2003)	<i>Guidelines for the Management of Major Regional Analgesia</i>
PS38	(2004)	<i>Statement Relating to the Relief of Pain and Suffering and End of Life Decisions</i>
PS39	(2003)	<i>Minimum Standards for Intrahospital Transport of Critically Ill Patients</i>
PS40	(2005)	<i>Guidelines for the Relationship Between Fellows and the Healthcare Industry</i>
PS41	(2007)	<i>Guidelines on Acute Pain Management</i>
PS45	(2008)	<i>Statement on Patients' Rights to Pain Management and Associated Responsibilities</i>
PS49	(2008)	<i>Guidelines on the Health of Specialists and Trainees</i>

College Professional Documents adopted by the Faculty:

PS4	(2006)	<i>Recommendations for the Post-Anaesthesia Recovery Room (Adopted February 2001)</i>
PS7	(2008)	<i>Recommendations for the Pre-Anaesthesia Consultation (Adopted November 2003)</i>
PS8	(2008)	<i>Guidelines on the Assistant for the Anaesthetist (Adopted November 2003)</i>
PS9	(2008)	<i>Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical or Surgical Procedures (Adopted 2008)</i>
PS10	(2004)	<i>The Handover of Responsibility During an Anaesthetic (Adopted February 2001)</i>
PS15	(2006)	<i>Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery (Adopted February 2001)</i>
PS18	(2008)	<i>Recommendations on Monitoring During Anaesthesia (Adopted February 2001)</i>
PS20	(2006)	<i>Recommendations on Responsibilities of the Anaesthetist in the Post-Anaesthesia Period (Adopted February 2001)</i>
PS31	(2003)	<i>Recommendations on Checking Anaesthesia Delivery Systems (Adopted July 2003)</i>
T1	(2008)	<i>Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and other Anaesthetising Locations (Adopted May 2006)</i>