

December 2008

The ANZCA Bulletin



**Medical research grants:
ANZCA's \$664,000 funding boost**



Contents

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.

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The ANZCA Bulletin is published four times a year by the Australian and New Zealand College of Anaesthetists. 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. By submitting your letter to us for publication you agree that we may edit the letter for legal, space or other reasons.

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Cover: The Kolling Institute of Medical Research, Royal North Shore Hospital, Sydney.

Photo: Joe Vittorio



Maternity services: Call for quality and safety

ANZCA's response to the federal government review into maternity services in Australia.



Medical research grants: ANZCA's \$664,000 funding boost

18 innovative research projects announced.



Profile: Associate Professor John Fraser

Queensland intensivist on burns research and the artificial heart.

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President's message



Dr Leona Wilson

As we near the end of the year, it is time to look back at some highlights of 2008, what we have achieved, and our ongoing priorities.

The College has had a busy time dealing with governments and their plans for health care in our two countries. In Australia, there has been a plethora of submissions to make ranging from maternity services, the Australia Medical Council's draft Code of Professional Conduct, to a review of higher education. We have now made the first three submissions on national registration and accreditation, and have three more to draw up before Christmas.

While there has been some concern about the lack of effectiveness of input from the profession regarding national registration and accreditation, at a recent consultation with leaders in the medical profession it was apparent that some of our concerns had been listened to. These include the definition of a 'medical specialist', and the transitional arrangements for those already on state specialist registers (Queensland and South Australia), and our support for the Australian Medical Council (AMC) and the Colleges, especially in assessment of International Medical Graduate Specialists (IMGS).

However, the key part of the legislation (Bill B), is due for release next year, and it will contain specific details particularly relating to contentious accreditation proposals. There has been little movement on the proposed role of the Ministerial Council and the potential for political interference. Government officials have argued that as this reference is in the COAG agreement, it cannot be changed. In New Zealand our submission on the Health Practitioners Competence Assurance Act about improving the processes for approval of applications for protection of quality assurance activities have finally borne fruit, with our ANZCA CPD Program, JFICM MOPS Program and ANZTADC bi-national Anaesthesia Incident Reporting System applications being expedited.

Both sides of the Tasman have been reviewing maternity services. Members of the Obstetric SIG have been involved in the preparation of excellent submissions, for which we are very grateful. In this issue of the Bulletin we cover the Australian maternity services review and our call for a national quality safety framework.

Within the College, we have been improving services to our Fellows and Trainees.

The Education Development Unit has taken on a heavy workload, including the review of the FANZCA curriculum, and review of our teacher training. Many of our Fellows and Trainees are involved in these groups, and I am very grateful to them. Submissions are being received from numerous groups and individuals; I would encourage anyone who is interested to make a submission. We continue to offer training to our Fellows who are involved in our work. This includes running clinical teaching courses in most regions, and holding bi-national workshops for examiners, training accreditation accreditors, and members of the IMGS and Trainee Performance Review panels.

The Communications department has introduced a regular e-newsletter which has increased the level and quality of communications to Fellows and trainees. It has also redesigned the Bulletin with a greater emphasis on publicizing the news about anaesthesia, intensive care and pain medicine topics to our Fellows and

Trainees, as well as other groups including government and the media. We are very interested in receiving items from you that may be of interest to others.

We have also recently developed a Trainee Profile which will be available on the College website. This will enable trainees to access all the details that the College holds about them, and amend their contact details on line.

2009 promises to be another busy year. I thank all Fellows for their input and expertise throughout the year. Our feature story on medical research grants in this issue is a great example of the level and quality of participation by Fellows in a vitally important area of the College.

I wish all Fellows, Trainees, College staff and their families and friends my best wishes for Christmas and the coming year.

Dr Leona Wilson
President

National Registration and Accreditation

ANZCA has been active in responding to government requests for input into the proposed system for national registration and accreditation. While the College has indicated its support for national registration we have a number of major concerns regarding accreditation. The critical issue for the College is the extent to which medical education and training standards and accreditation processes remain independent of government and the potential implications for patient safety. The key messages ANZCA has communicated to government include:

- The important role that medical specialist colleges play in pre-vocational and specialist training, our role in specialist education and continuing professional development, ensuring high clinical standards and assessing competencies to protect patient safety.
- That World Health Organisation guidelines make it clear that accreditation processes must be independent of government.
- That ANZCA opposes any changes which would lead to an undermining of accreditation and standards. We strongly oppose the Ministerial Council role in specialist endorsement (the draft Bill includes wide-ranging powers for Boards which have responsibility for seeking Ministerial approval for any new category of specialist).
- Our support for the Australian Medical Council that advises on specialist registration as the independent accreditation body for medical practitioners.

Legislation relating to the framework of the scheme passed the Queensland Parliament on November 13. Further legislation is to be debated in September and December 2009. By mid-2009 medical boards will be established which relate to registration and administrative requirements of the new scheme.

New process for international graduates

ANZCA Council has approved new processes for International Medical Graduates Specialists assessment. The processes have been developed in consultation with the Australian Medical Council (AMC), Medical Boards/Councils and government. The new processes have been posted on the College website. For more details please see page 28 of this issue.

Research grant to improve patient safety

A major cross-institutional research collaboration aimed at reducing the number of patients harmed in Australia has been approved by the National Health and Medical Research Council in the latest round of program grants totalling \$357 million. The focus of the project will be on the roles of teamwork, safe medication use and the application of enhanced information technology to support decision-making. The project will run over five years and includes leading experts including Professor Bill Runciman (University of South Australia).

NSW budget cuts

The New South Wales government recently announced budget cuts. Hospitals in New South Wales will generate an extra \$90 million a year through scrapping hourly-rate payments to some non-staff doctors, requiring them to bill Medicare instead, and by charging doctors fees for the use of hospital facilities. The \$90 million cost-shifting measure will apply to visiting medical officers, currently paid an hourly rate by the state.

Conflict of interest policy

ANZCA Council recently approved a Conflict of Interest policy. The purpose of the policy is to provide guidance on handling potential and actual conflicts of interest involving the College and its activities. The policy has been posted on the ANZCA website.

New organ donation scheme

The Federal Government has established the Australian Organ and Tissue Donation and Transplant Authority which will implement and oversee Australia's new organ donation and transplantation system. The Authority will commence operations early in 2009.

ANZCA e-newsletter

ANZCA continues to receive positive feedback following the introduction of its e-newsletter in July. The newsletter's opening rate exceeds similar e-newsletters or direct mail within the health sector. Future editions will include website reviews. This may be a single website in depth or an overview of multiple websites. Contributions and items are welcome. In the December e-newsletter, we feature an analysis of regional anaesthesia websites. If you are not receiving, or have difficulty accessing, the e-newsletter please contact the communications department at ANZCA.

Medicare National Compliance Program

The new Medicare National Compliance program commences January 1. The program will increase the number of audits from less than 1% to more than 4% annually.

ANZCA Bulletin – The future of anaesthesia

In the March edition of the *ANZCA Bulletin*, we will be exploring the topic 'The Future of Anaesthesia'. If you have any thoughts, suggestions or contributions please forward them to nhenham@anzca.edu.au.

Letters to the editor



Ageing issues

I would like to pass on to the Council my commendation of the *Statement on the Standards Of Practice of a Specialist Anaesthetist – 2008*.

As someone approaching retirement age within the next 10 years, I am pleased to see statements regarding the issues of clinical work, fatigue and age.

Buddy system for anaesthetists

Dr Grant Carr states that he is not sure he will recognise a diminishing standard in his ability as he ages. (*Ageing Issues*, The ANZCA Bulletin Vol 17 Issue 3 Oct 2008).

As I aged, I asked a younger colleague, in both private and public practice, to be

a buddy, as in diving safety. The brief was that an eye and ear would be kept open for indications of a decline in ability and that I should be told.

This gives the younger colleague the authority to broach the subject with the older anaesthetist. It also indicates that the information would not be greeted with the hostility so often seen in this situation.

I would much rather be tapped on the shoulder by a sympathetic colleague than a medical board, coroner or prosecution lawyer. A buddy system would allow open discussion of the problem and its solution long before harm is done or a medical board needs to know.

Dave Fenwick
(Retired Anaesthetist)

Bulletin redesign

Great work. The Bulletin's layout is a thousand times more readable. The content has moved from an official organ, related to documents and procedures, to a very pleasant combination of magazine and journal.

I particularly enjoyed the Research Update and Articles of Interest. It is a great idea to have pertinent summaries, and for experts in an area to provide a reading list. This fills a gap left by journals and meetings.

It's also of great interest to know what the Australian anaesthetic community in particular is up to.

Congratulations!

Peter Howe
Anaesthetist, Royal Children's Hospital,
Melbourne

People & Events



National Health & Medical Research Council conference – Chronic pain and its treatment

From left: Professor Andrew Somogyi, Amal Helou, President of the Pain Society, and Professor Stephan Schug



The National Health & Medical Research Council (NHMRC) conference included a session on chronic pain and its treatment: from molecular to clinical.

The session was held on Thursday, November 20 at the Brisbane Convention Centre and was organised by the Faculty of Pain Medicine (FPM) and The Australian Pain Society.

Professor Andrew Somogyi (Fellow of FPM) and Amal Helou (President of the Pain Society) chaired the session. Professor Maree Smith spoke about the preclinical development of new drugs for pain treatment and Professor Stephan Schug spoke about new clinical developments in pain therapy.



People & Events

Continued

New South Wales Anaesthesia Continuing Education Committee Meeting

The New South Wales (NSW) Anaesthesia Continuing Education Committee hosted its last meeting for the year on November 1–2 at the popular Shoal Bay Resort in the Port Stephens district, an hour north of Newcastle. The weather did not disappoint and delegates and guests were spoilt for choice with bayside leisure activities.

The theme was 'Contemporary Airway Management – Practice Makes Perfect' and addressed a range of current issues including equipment, modern anaesthesia machines and ventilation techniques, drugs and management of airway-related emergencies.



Right: Dr Tamsin Dovell &
Dr Josh Vieusseux

2009 Jobson Symposium Annual Education Programme

28th March, 2009

Kerry Packer Education Centre
Royal Prince Alfred Hospital

**Regional Anaesthesia
'Recent Developments & Outcome'**

2009 Jobson Visiting Professor
Professor Vincent Chan
Department of Anaesthesia
Toronto Western Hospital
University of Toronto – Canada

Please address all enquires to:
Ian Hayes on (02) 9515 8564

Western Australia – Updates in Anaesthesia meeting



On November 1–2, Western Australia (WA) held its annual Country Meeting at the Quay West Resort at Bunker Bay, four hours' drive south of Perth. The annual Updates in Anaesthesia meeting was entitled 'Achieving Dreams and Avoiding Nightmares' and included many interesting sessions. The invited speaker, Dr Peter Hebbard from Victoria, gave an excellent presentation on the use of ultrasound in clinical practice and likely future developments in this area.

The weekend began on the Friday evening with a welcome BBQ and drinks for sponsors, delegates and their families. 106 delegates attended the academic program, while partners and children enjoyed the organised social activities, including a whale-watching tour and a visit to a fauna park. On Saturday evening, buses transported everyone to the nearby Wise Winery for a fantastic dinner.



Clockwise from top: Meeting Convenor Dr Sarah Wyatt with Dr Alison Corbett; Dr Denise Yim and Dr Aileen Donaghy; Dr David Vyse (right) with Organon sponsor Barry Weinmann; Dinner at Wise Winery; WA Chair Dr David Wright with Dr Fiona Sharp; Sandra Box, Regional Coordinator (WA), with health care industry representatives.

ANZCA Council Meeting report

October 2008

Report following the Council Meeting of the Australian and New Zealand College of Anaesthetists held on 18 October 2008

Death of Fellow

Council noted with regret the death of Dr William Clifford Richards (NSW) FFARACS 1972, FANZCA 1992.

Honours and Awards

Prof Bill Runciman (SA) was recently awarded the Sydney Sax Public Health Medal. This medal is awarded to an individual who has made an outstanding contribution in the field of health services policy, organisation, delivery and non-clinical research. It awards outstanding achievement in, and contribution to, the development and improvement of the Australian healthcare system.

Fellowship Affairs

Continuing Professional Development

The number of Fellows utilising the online program has increased in recent months. The process has been aided by the CPD co-ordinator developing a web-based resource to assist Fellows in the use of the online version.

Annual Scientific Meetings

2009 – Dr Genevieve Goulding has been appointed Councillor to the 2009 ASM Regional Organising Committee.

2012 – Council accepted the recommendation from the Fellowship Affairs Committee that the venue for the 2012 ASM be changed from the Gold Coast to Perth.

Health Care Industry Sponsored Educational Materials

As a result of enquiries from the HCI about promoting activities through the College website, a process is to be developed to evaluate educational material that is available to Fellows via the website. It has been agreed that until the process is developed, HCI-sponsored proposals will not be accepted.

Online educational materials for Fellows

A sub-committee has been established to assess the educational material that is made available to Fellows, and the allocation of CPD credits to these activities. It is intended that the sub-committee's work will ensure the

material is relevant to Fellows, educationally sound, and with evidence-based content.

Communications

A comprehensive communications strategy is being developed and will align with the College's overall strategic plan.

The e-newsletter to all Fellows and trainees was reported as having been well received. The design and content of the Bulletin is to be reviewed and will include more feature articles.

International Medical Graduate Specialists (IMGS)

OTS Committee – change of name

In accordance with the accepted nomenclature, the OTS Committee has been renamed the International Medical Graduate Specialists (IMGS) Committee, and the Regulations and other documentation amended accordingly.

Internal Affairs

International Scholarship

Council accepted the recommendation of the International Scholarship Selection Committee to award the 2009 International Scholarship to Dr Lawrence Marikawa Sogoromo from Papua New Guinea. This scholarship was established to provide additional training in Australia or New Zealand to a young anaesthetist who has completed training in their own country's anaesthesia training program to enable them to provide leadership to the specialty of anaesthesia on returning home.

Professional

Approval of Professional Document

Following the normal review process, the following Professional Document was approved by Council:

- PS45 – *Statement on Patients' Rights to Pain Management*

Draft Professional Document: Guidelines for the Safe Administration of Injectable Drugs in Anaesthesia – Prof Alan Merry

This document had been brought to August Council for discussion and has been amended in light of that discussion. It will have a different lead author appointed and will subsequently be circulated to regions for input.

Development of a New ANZCA Policy Document on Guidelines for Accrediting Retrieval Services – A/Prof Kate Leslie and Dr Alastair McGeorge

The Training Accreditation Committee embarked upon a strategic process earlier this year. An area of concern was the supporting documentation for inspection and accreditation of retrieval services. The draft process was approved by TAC on 17 October 2008. The people identified to be part of the 'Expert Group' are Drs Alastair McGeorge, Stuart Henderson, Forbes Bennett and Neil Ballard.

Research

Appointment of a Deputy Chair to the Research Committee

It was considered that the functions of the Research Committee could be more appropriately streamlined with the assistance of a Deputy Chair. Regulation 2.12 has been amended accordingly, and A/Prof Kate Leslie has been appointed to this position.

Training and accreditation

Manning Base Hospital (NSW)

Accreditation for anaesthesia training at Manning Base Hospital NSW will be withdrawn at the commencement of the 2009 Hospital Employment Year.

Revised hospital agreement dated July 2008

Some time ago, the Training and Accreditation Committee developed an agreement between training sites and ANZCA detailing their respective responsibilities. With significant input from Michael Gorton, a document was subsequently developed and approved by TAC and Council. Subsequently, TAC became concerned about the consequences of a training site failing to sign the agreement. Michael Gorton was approached again for advice and suggested that the document be rephrased as a statement rather than an agreement. The process now is that when the final letter of approval is sent to a hospital, a copy of the agreement is attached.

Appointment of Deputy Chair

Dr Margaret Cowling has been appointed Deputy Chair of the TAC.

New Programs Committee

Diving and Hyperbaric Medicine

It was agreed that the Certificate should be consistent with other ANZCA qualifications and that participation in CPD should be required, with no requirement for re-certification. Council agrees that no time limit be placed on the Certificate in Diving and Hyperbaric Medicine.

Dr Leona Wilson
President

A/Prof Kate Leslie
Vice-President

ANZCA calls for quality and safety in maternity services



Dimity Voyatzis (woman in labour), with student midwife Maddie Harrop (standing) and anaesthetist Dr Alicia Dennis (sitting) in birthing room.

IN A WIDE-RANGING 31-PAGE SUBMISSION, ANZCA has called on the Federal Government to ensure that any new models of maternity care emphasise safety through the use of appropriate standards. Responding to a call for submissions by the Minister for Health and Ageing, Nicola Roxon, to inform the development of a Maternity Services Plan for Australia, ANZCA said that a national quality framework is essential to promote consistent standards of practice and a continuous improvement culture: 'The development and implementation of an appropriate quality and safety maternity framework is essential. The framework needs to promote a 'no blame' culture, support the reporting of adverse events and near misses, and use the lessons learnt in a supportive multidisciplinary manner'.

ANZCA also called for maternity services to be regularly audited and reminded the government of the importance of adequate data collection and clinical indicators: 'Maternity services need to be regularly

audited, hence the importance of adequate data collection and clinical indicators. This is vital particularly with the introduction of any change involving alternative workforce models to assess their effectiveness and establish whether or not there have been improvements'. Most importantly, improved health physical infrastructure (including up to date information and communication technology), adequate health workforce requirements, including education and training, was essential to ensure quality services.

ANZCA's submission, which was prepared by John Biviano, Director, Policy, Quality and Accreditation with expert medical advice from Dr Alicia Dennis (Executive Member Obstetric Anaesthesia Special Interest Group and Deputy Head of Anaesthesia, Mercy Hospital), Dr Kym Osborn (Chairman of the Obstetric Anaesthetist SIG and Head of Women's Anaesthetic Department, Women's and Children's Hospital, Adelaide) and Director of Professional Affairs, Professor Barry

Baker. ANZCA Council members were also involved, and there was input from Professor Michael Paech, Chair, Obstetric Anaesthesia, University of Western Australia. ANZCA pointed out the essential role that anaesthetists play as members of the maternity care team. This includes education related to labour analgesia and emergency care, to routing provision of analgesia services with epidural analgesia, and in particular high risk and emergency situations.

'The review provides an important opportunity to consider a holistic approach to maternal care that is woman-centred and, above all, that provides all available options to ensure safety for mother and baby', John Biviano said.

A report based on the consultation is being prepared for the Minister for Health and Ageing by the end of 2008. Following this, the government is expected to announce the details of its maternity services plan during 2009.

A copy of ANZCA's submission can be found at www.anzca.com.au.

Preoperative meeting between midwife Lyndall Bridge (left) and anaesthetist Dr Alicia Dennis (right) regarding morning caesarean birth list.

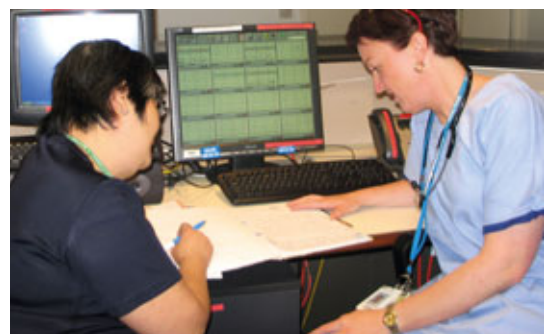


Key points and highlights

- ANZCA supports the development of comprehensive national standards for all maternity services, the reporting of maternal critical events and audit of maternity services.
- The role of the anaesthetist needs to be recognised as an important component of any maternity services plan.
- The ageing of the population presents significant challenges as well as specific issues arising from women choosing to have children later in life (obesity, higher incidence of complications, increased incidence of chronic disease and co-morbidities, IVF).
- A more sustainable approach to the safe provision of anaesthesia services in rural and remote areas (enhanced specialist back up for local practitioners; increased education and training; locum relief and full-time placements, raised awareness of rural practice as career choice).
- Development and implementation of an appropriate quality and safety maternity framework is essential. The framework needs to promote a 'no blame' culture, support the reporting of adverse events and near misses and use the lessons learnt in a multidisciplinary manner.
- Ongoing management of chronic pain associated with delivery through provision of multi-disciplinary pain management services.
- Multidisciplinary team training is urgently required. ANZCA is well placed to offer its expertise and participate in skills training ensuring the highest standards of safety are maintained.
- Evidence based protocols are essential to ensure high standards. The ANZCA/ASA/NZSA Obstetric Anaesthesia Special Interest Group has recently created a series of guidelines based on scientific evidence to meet the needs of anaesthetists in the region.
- Accreditation visits of various public hospitals by ANZCA has revealed a number of common concerns (increased workload of obstetric patients without an increase in specialist or trainee staff establishments; effect of fatigue; lack of team approach in some units resulting in inadequate preoperative assessment and planning of delivery; inadequacy of neonatal resuscitation in the absence of adequate perinatal services).



Dr Kym Osborn, Head of Women's Anaesthetic Department, Women's and Children's Hospital, speaking with a patient.



Birthing suite discussion with duty midwife Phaik Lee Ooi and anaesthetist Dr Alicia Dennis.

Snapshot

267,793 women gave birth to 272,419 babies in Australia in 2005

Births at their highest level since 1971

\$1,672 million spent on maternity services*

Caesarian rate is 30.3%

97.5% of births are in hospital

1936 – 600 maternal deaths per 100,000 live births. 1980 – below 10 per 100,000

Australia is one of the safest countries in the world to give birth or be born

Maternal mortality rates for indigenous women two and a half times as high

Rural women have significantly higher neonatal deaths

Remote women have higher foetal death rates

Source: *Improving Maternity Services in Australia*, Commonwealth Department of Health and Ageing 2008. * denotes 2005 figures.



Postanaesthetic care unit (PACU) after caesarean birth - Abeer (patient) and Khalid (husband) with new baby Al Farran, PACU nurse Andrea Moles.

ANZCA calls for quality and safety in maternity services

Continued

'The Maternity Services Review is the beginning of an exciting and important time in Australia's history especially in the area of obstetric anaesthesia. It is my hope that the Government will now seize the opportunities presented to it. This involves putting in place and monitoring the recommended interventions and most importantly trusting the key stakeholders to work together to improve the health situation for women and their babies in Australia across all demographics.'

Dr Alicia Dennis, FANZCA



Dr Kym Osborn (right) talking to Obstetric Registrar and TMO

I was fortunate enough to have the opportunity to participate in the submission to the Federal Government from ANZCA on the future of Maternity Services in Australia. It was with great hope and enthusiasm that I attended the Maternity Services Review Roundtable at the Department of Health and Ageing in Canberra on the topic of Assessing and Managing High Risk Pregnancies.

Woman-focused care, multiprofessional team training, a national education program, maintenance of standards and safety, and indigenous maternal health were all discussed in a collaborative, constructive and cohesive environment, with a professional facilitator and under the direction of the Commonwealth Chief Nurse and Midwifery Officer, Ms Rosemary Bryant. The individuals

present at the roundtable represented all the key groups that could bring about significant change.

The importance of anaesthetists being an integral part of the multidisciplinary team was emphasised with a focus being on anaesthetists facilitating the safe birthing of women. Highlighted were the facts that we manage both healthy pregnant women by providing analgesia and anaesthesia during vaginal and operative birth, and also critically ill, pregnant women through our advanced, acute resuscitation skills and our knowledge of complicated peripartum situations.

Over subsequent weeks, with the Obstetric Anaesthesia Special Interest Group meeting in Blenheim, New Zealand, many of us continued to discuss key ways forward especially the hope of developing a national government sponsored multiprofessional

regional, rural and remote maternity education initiative incorporating coordinated obstetric emergency management and critical care training.

The Maternity Services Review is the beginning of an exciting and important time in Australia's history especially in the area of obstetric anaesthesia. It is my hope that the Government will now seize the opportunities presented to it. This involves putting in place and monitoring the recommended interventions and most importantly trusting the key stakeholders to work together to improve the health situation for women and their babies in Australia across all demographics.

Dr Alicia Dennis
Deputy Head, Mercy Hospital for Women, Victoria



8am Birthing suite handover round: Multidisciplinary team – obstetrician and obstetric registrar and resident (day shift/night shift), duty midwife, day midwife, anaesthetist and anaesthetic registrar.



‘The multidisciplinary nature of maternity care where midwives act as independent practitioners need not be an issue but it does present a challenge... Most (registrars) quickly develop respect and with it an excellent working relationship with their midwifery colleagues.’

Dr Kym Osborn, FANZCA

From left to right: Dr Kiren Sidhu (O&R Registrar), Dr Kapila Senevirathne (Anaesthetic Registrar), Kirstie Aylett (Delivery Suite Midwifery Shift Coordinator – with back to photographer), Dr Aimee Reilly (O&G Registrar), Dr Anju Agarwal (O&G Registrar), Dr Anthia Rallis (O&G Registrar), Dr Heather Stevens (Anaesthetic Consultant), Dr Kym Osborn (Head of Women’s Anaesthetic Department), Dr Geoff Matthews (Head of Obstetric Department), Dr Kylie Gayford (O&G RMO).

The changes in maternity services in Australia with increases in the birth rate, rates of maternal obesity, maternal age, mothers with chronic disease and co-morbidities, e.g. congenital heart disease and consumer expectations is placing increasing pressure on obstetric anaesthetic services.

The multidisciplinary nature of maternity care where midwives act as independent practitioners need not be an issue but it does present a challenge. In my institution, many anaesthetic registrars initially find this relationship difficult. However, most quickly develop respect and with it an excellent working relationship with their midwifery colleagues.

Can we ensure that maternity services continue to remain safe and in fact improve?

- With any future changes, there needs to be support to facilitate clear pathways for communication between professions.
- In many states there are guidelines relating to maternity care. The Obstetric Anaesthetic Special Interest Group Evidence Based Guidelines Project will assist raising the profile of anaesthetists by providing guidance in specific areas relevant to anaesthesia in maternity services.
- Clinical audit and clinical review need to be supported. Currently the various state-based perinatal outcome data lack information related to anaesthetic services. This needs to be more coordinated with consideration to the inclusion of anaesthetic, maternal morbidity and other related maternal outcomes in the future.

- The state-based Maternal Mortality Committees and the National Advisory Committee on Maternal Mortality need to continue to be supported. The uncertainty regarding future funding of the latter is of concern.

Hopefully this review has assisted in bringing together the various providers of maternity services so that an improved service is developed in the future.

Dr Kym Osborn
Chairman of the Obstetric Anaesthetic SIG and Head of Women’s Anaesthetic Department, Women’s and Children’s Hospital, Adelaide

Funding boost of \$664,000 for medical research

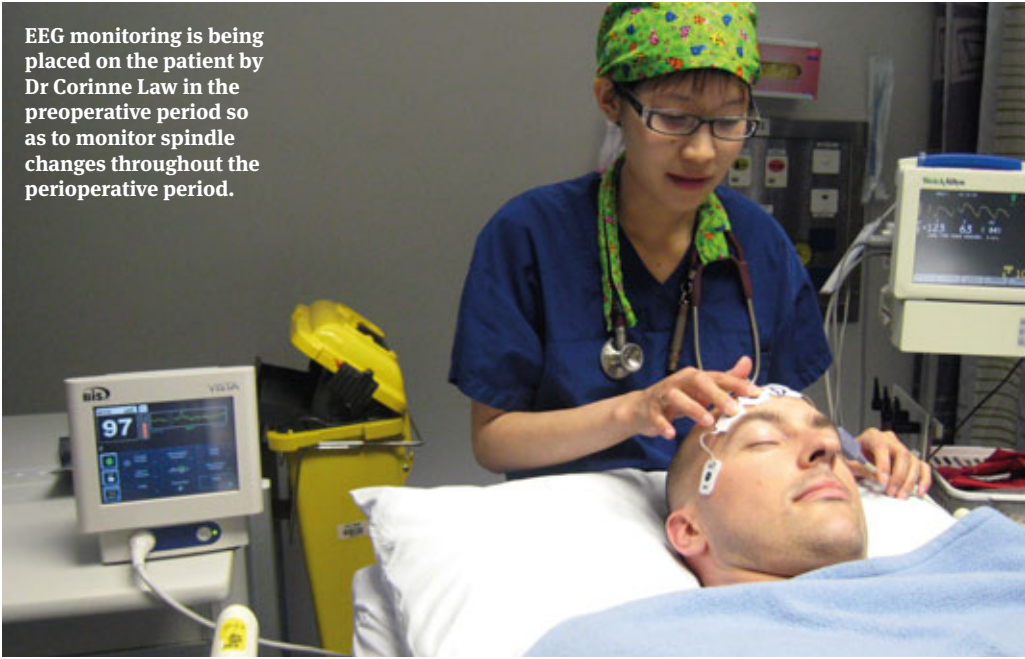
RESEARCH INTO TRAUMATIC HEAD INJURY, shoulder and pelvic pain, improving survival rates following discharge from intensive care, pain relief following prostate surgery, and investigations into how anaesthesia and surgery may affect memory and thinking are just some of the research projects approved by the Australian and New Zealand College of Anaesthetists.

ANZCA Council recently announced funding of \$664,202 for 2009 for 18 research projects involving anaesthesia, intensive care medicine, pain medicine and perioperative medicine.

The research grants have been allocated to researchers involving Australia, New Zealand and Hong Kong's leading hospitals and universities such as the Peter MacCallum Cancer Centre Melbourne, Royal North Shore Hospital Sydney, Austin Hospital, St Vincent's Hospital Melbourne, Royal Brisbane and Women's Hospital, Royal Women's Hospital Melbourne, North Shore Hospital Auckland, University of Auckland, University of Newcastle, and the Chinese University of Hong Kong. Funds for research are generated via Fellows' subscriptions and donations. 10 per cent of each Fellow's subscription payment goes to fund much-needed research.

'ANZCA has a proud track record in funding important research which has led to significant improvements in terms of patient safety and alleviation of pain and suffering. We received more than 53 applications from around Australia, New Zealand and Hong Kong and we are delighted to support 18 projects which we believe will make an important contribution to medical research worldwide', President of ANZCA, Leona Wilson said.

Professor Alan Merry, Chair of ANZCA's Research Committee, said he was delighted with the list of projects which had received approval: 'These are really exciting research projects. It is a painstaking process involving numerous people across Australia and New Zealand and I would like to acknowledge their great efforts and contribution'.



EEG monitoring is being placed on the patient by Dr Corinne Law in the preoperative period so as to monitor spindle changes throughout the perioperative period.

The following research grants for 2009, recommended by the research committee were awarded by Council at the October Council Meeting.

A phase 2b study to evaluate the safety and efficacy of intravenous paracetamol in reducing body temperature after traumatic brain injury.

Traumatic head injury is an unfortunately common global occurrence. At present there are very few therapies that are known to be effective after a traumatic head injury. Some research has shown that patients who have a raised temperature after non-traumatic forms of head injury have a worse outcome than those who have a normal temperature. This study will investigate whether paracetamol reduces the temperature of the body and reduce the amount of physical and mental disability and death rate by using these interventions.

Dr Manoj Saxena, Prof John Myburgh and Dr John Gowardman (Department of Intensive Care Medicine, St George Hospital, New South Wales)

\$30,000

Validating anaesthesia simulation-based error research (the VASER study).

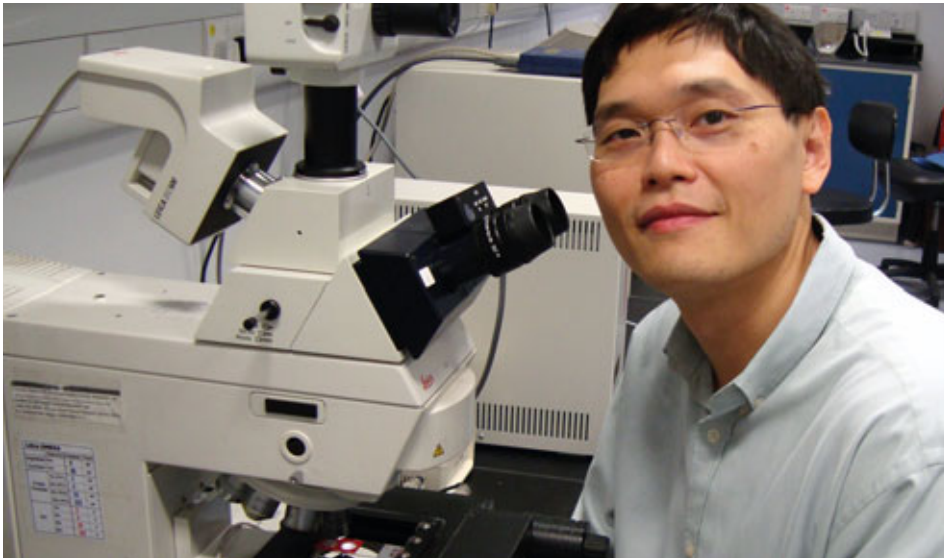
From the perspective of human cost, harm during anaesthesia is unacceptably frequent. However, from the perspective of performing a study to demonstrate the benefit of a new safety initiative, the rate of harm is so low as to require any meaningful study to include a very large number of patients – so many patients in fact, that studies of this type often become prohibitively expensive. High-fidelity or 'immersion' simulation offers an alternative that avoids many of the above problems by using a highly sophisticated manikin, or human-patient simulator, capable of simulating, to great accuracy, the physiological effects of anaesthetic drugs and disease conditions. Our research group has developed a set of scenarios using a high-fidelity human-patient simulator that yields rates of error during simulated anaesthesia, much higher than in the clinical setting (the Error Model).

Prof Alan Merry, A/Prof Jennifer Weller and Dr Brian Robinson (Department of Anaesthesiology, University of Auckland, New Zealand)

\$45,000



Left: Research Committee Chair Prof Alan Merry and Wolfgang Heinrichs (from Mainz) establishing Desflurane in the high fidelity simulator suite in Auckland. There are major difficulties in simulating the use of this agent with real vapour, and this ground breaking work was part of the AEG in 2007 to enhance the clinical relevance and fidelity of this facility for use in work such as the VASER study.



Above: Dr Matthew Chan from the Chinese University of Hong Kong looking for damaged DNA in lymphocyte.

Screening and functional characterisation of mutations that cause malignant hyperthermia.

Malignant Hyperthermia (MH) is a potentially fatal complication of general anaesthesia. We have identified mutations that co-segregate with susceptibility to MH in New Zealand families afflicted with this disorder. We have developed DNA-based tests for MH-susceptibility that can replace the currently used muscle biopsy test for a number of MH families. This has had great benefit for both MH patients and medical practitioners who manage MH patients. Once familial mutations have been identified and functionally characterised, very simple and rapid assays for mutation detection will be developed. We have the ability to design and implement robust family specific assays once mutations have first been identified. This work has the potential to allow DNA-based diagnostic testing for most if not all MH-susceptible families as it will fill a widening gap in our knowledge of the factors causing MH.

Dr Neil Pollock and Dr Kathryn Stowell (Institute of Molecular BioSciences, Massey University, New Zealand)

\$25,000

Genomic stability after nitrous oxide anaesthesia.

There is some emerging evidence to suggest that nitrous oxide anaesthesia may increase the risk of wound infection. However, we do not know why it may predispose patients to infection. In our preliminary study we found that DNA became less stable after nitrous oxide administration. This may impair our defence against bacterial invasion. Our study proposes to correlate the DNA changes with clinical outcome. If we can demonstrate the DNA changes as a contributory factor to postoperative wound infection, this will enable us to define the role of nitrous oxide in anaesthesia and will lead to a change in clinical practice worldwide.

Dr Matthew Chan, Prof Paul Myles, A/Prof Kate Leslie and Prof Tony Gin (Department of Anaesthesia and Intensive Care, The Chinese University of Hong Kong)

\$50,000

Systemic lignocaine shortens length of hospital stay after open radical retropubic prostatectomy: A double-blinded, randomised, placebo-controlled multicentre trial.

Postoperative pain relief for patients undergoing radical prostatectomy (surgical removal of the prostate gland) is provided by either strong painkillers such as intravenous morphine or by the infusion of a local anaesthetic solution. It is not known if a systemic local anaesthetic solution in addition with morphine accelerates postoperative recovery and shortens the duration of hospital stay.

Dr Laurence Weinberg and A/Prof David Story (Department of Anaesthesia, Austin Hospital, Melbourne)

\$25,000

Intraoperative titratability of opioids – Can electroencephalographic (EEG) monitoring help us predict how much to give?

It is known that by measuring the brain's electrical activity using an electroencephalogram (EEG), it is possible to detect changes in a person's level of consciousness. This can be useful in anaesthesia as an indication of how deeply a patient is anaesthetised. Currently it is not possible to determine from this EEG trace how much pain relief medication a patient might require. This study hopes to be able to develop a model relating intraoperative analgesia to EEG nociception which we can test and modify according to the recovery of the patients.

Dr Corinne Law and Prof James Sleigh (Waikato Hospital, New Zealand)

\$50,000

A new strategy to inhibit visceral pain.

Pain in the pelvic region is particularly common in women and is very difficult to treat. This project focuses on a common and debilitating chronic pain caused by bladder inflammation (interstitial cystitis). For most patients with interstitial cystitis there is no

Funding boost of \$664,000 for medical research

Continued

treatment for the pain that they suffer. The results of this study may lead to new ideas for developing therapies to treat pelvic pain.

Prof Michael Cousins and A/Prof Janet Keast (Pain Management Research Institute, Royal North Shore Hospital, Sydney)

\$50,000

Comparison of 2D with real-time 3D transoesophageal echo for assessment of ventricular volumes and mitral valve dimensions.

Transoesophageal echocardiography (TOE) involves imaging the heart with ultrasound via a probe inserted into the oesophagus (food pipe). Until recently echocardiography could only be used to generate 2D images of the heart in real-time (i.e. providing an image of a thin slice of the heart). To obtain diagnostic information, the clinician must look at many of these thin slices and build a mental picture of the true 3D structure of the heart. Recent ultrasound crystal and computing advances have led to the development of the first transoesophageal probe that displays three dimensional images of the heart in motion, in real-time (live 3D). This real-time 3D image display reduces the need to reconstruct anatomy, pathology and function from multiple 2D views. The aim of this study is to compare 2D TOE and real-time 3D TOE with regard to ability to assess heart chamber dimensions, mitral valve dimensions and the precise location of the damage in leaking mitral valves. We plan to study 100 patients who are undergoing surgery to reshape damaged hearts or who have leaking mitral valves. All patients will undergo standard 2D imaging of the heart and the newer 3D imaging to have their cardiac surgery. This will enable us to assess in a systematic way whether 3D TOE provides more accurate information regarding the size of the left ventricle and the shape, size and detailed structure of leaking mitral valves. This is important because if this the case, it may justify the expense involved in upgrading to 3D imaging.

Dr Roman Kluger and Dr Mario Kalpokas (Department of Anaesthesia, St Vincent's Hospital, Melbourne)

\$21,000

Pharmacokinetics of cephalothin, vanomycin and gentamicin used for antimicrobial prophylaxis during elective abdominal aortic aneurysm surgery.

The purpose of surgical prophylactic antibiotic dosing is to ensure adequate drug concentrations are present to inhibit infection during the time that sites are at risk of bacterial contamination. One surgical population at risk from ineffectual antibiotic dosing are patients undergoing semi/elective abdominal aortic aneurysm (AAA) repair surgery. AAA repair surgery often results in large losses of blood and requires administrators of high volumes of intravenous fluids and/or use of vasopressor and inotrope support. Each of these factors can lead to increased clearance of hydrophilic compounds such as the antibiotics typically used for prophylaxis in this population. Increased antibiotic clearance may lead to reduced antibiotic concentrations in serum and in tissue and increase the risk of post-surgical complications. Antibiotic concentrations in tissue are best determined using a technique known as microdialysis. Microdialysis is recognised internationally as the premier method for measuring the concentration of endogenous and exogenous compounds in tissues. Therefore we plan to use microdialysis in tissues of patients undergoing semi/elective AAA repair surgery to develop a more integrated, accurate PK-PD model of antibiotic prophylaxis optimal dosing that should be used in this setting.

Dr Alexandra Douglas, Prof Jeffrey Lipman, Mr Jason Roberts and A/Prof Kersi Taraporewella (Department of Anaesthesia and Intensive Care Medicine, Royal Brisbane and Women's Hospital)

\$45,000

The impact of the intensive care discharge process on patient outcomes.

Patients admitted to intensive care units (ICUs) are often very unwell yet, in Australia and New Zealand, 85% survive to discharge from hospital. However, there are some patients who leave ICU but have to be admitted again because their condition

deteriorates; these patients experience longer hospital stays and some may die before leaving hospital. This study will look at the range of issues present when patients leave ICU and look what happens to them in the wards. The project team aims to implement evidence-base solutions to ensure more ICU patients leave hospital alive and in a shorter duration of time.

A/Prof John Santamaria, Dr David Pilcher, Dr Graeme Duke and Prof D James Cooper (St Vincent's Hospital, Melbourne)

\$25,000

Audit of postoperative complications in Australian and New Zealand hospitals (The REASON study)

Elderly surgical patients suffer remarkably high rates of morbidity and mortality. The ANZCA Perioperative Medicine Committee (POMC) and ANZCA Trials Group plan a large prospective cohort study looking at the rate of complications in elderly surgical patients in Australia and New Zealand. This study uses the methodology of a previous three-hospital trial in Melbourne. Our objectives are to establish the rate of complications in a much broader range of centres and regions, and to establish a collaboration of anaesthetists with an interest in exploring the future of perioperative medicine and in participating in further trials. We plan to recruit about 15 public adult hospitals in Australia and New Zealand. Each centre will recruit about 100 patients over a two month period.

A/Prof David Story, A/Prof Kate Leslie and Prof Paul Myles (Australian and New Zealand Departments of Anaesthesia)

\$30,000

The effects of midazolam on respiratory and cardiovascular control mechanisms during severe arterial hypoxia in the rabbit.

Many commonly used anaesthetic drugs alter respiratory and cardiovascular mechanisms, interfering with the life-preserving homeostatic reflexes. Despite substantial improvements in perioperative monitoring (e.g. pulse oximetry), unrecognized hypoxia (deficiency in the amount of oxygen reaching bodily tissues) remains a threat to the anaesthetised,



**Simulated action at the
Advanced Clinical Skills Centre,
Auckland.**



sedated or recovering patient. There is mounting evidence that physiological responses to hypoxia are modified by low (sub-anaesthetic) concentrations of general anaesthetic agents. Midazolam is a modern intravenous anaesthetic drug used for induction and maintenance of anaesthesia, as well as for conscious sedation in emergency room and endoscopic procedures during which patients continue to breathe spontaneously. Despite research into its effects on cardiorespiratory physiology, the site(s) of action of midazolam in integrated cardiovascular and respiratory control systems are not fully understood. Our study in the rabbit will mimic the clinical situation and allow for better definition of the central and peripheral neural mechanisms of this commonly used sedative and anaesthetic drug.

A/Prof Anthony Quail and Conjoint A/Prof David Cottee (Faculty of Health, The University of Newcastle)

\$25,000

2009 Novice Investigator Grants

A randomised comparison of combined suprascapular and axillary nerve block with interscalene block.

Shoulder surgery can be extremely painful for the first one to three days. Anaesthetists can manage this pain by using local anaesthetic drugs to block the nerves supplying the shoulder. However

the traditional technique, the interscalene block, which involves an injection in the neck can result in complications including spread to other important nerves nearby, which may result in paralysis of the diaphragm, a drooping eye and hoarseness. A new technique has been developed by Dr Darcy Price which places local anaesthetic directly on to the two major nerves supplying the shoulder joint. This study will compare the two techniques including the rate of side effects and complications and patient satisfaction.

Dr Darcy Price (Department of Anaesthesia and Perioperative Medicine, North Shore Hospital, New Zealand)

\$10,000

Ultrasound guided transversus abdominis plane (TAP) block for analgesia after caesarean surgery.

The transversus abdominis plane (TAP) block is a local anaesthetic technique that has been developed in recent years for pain

relief after abdominal surgery. It has been shown to work after caesarean delivery when performed by skilled operators. We aim to test an ultrasound guided approach to this block for pain relief after caesarean section. Women having elective caesarean sections will be randomly allocated to receive an ultrasound guided TAP block with local anaesthetic or placebo in addition to standard pain relief including morphine. We hope to find women who receive the local anaesthetic have better pain relief, need less morphine and have fewer side effects from morphine after caesarean section.

Dr Phillip Cowlshaw and Dr David Belavy (Department of Anaesthesia, Mater Misericordiae Health Services, South Brisbane, Queensland)

\$6,000

The Harry Daly Research Award was awarded to **Professor Michael Cousins** for his project 'A new strategy to inhibit visceral pain'.

The **Schering-Plough Research Award** was awarded to **Professor Matthew Chan** for his project 'Genomic stability after nitrous oxide anaesthesia'.

The **Mundipharma ANZCA Research Fellowship** was awarded to **Dr Corinne Law** for her project 'Intraoperative tiratability of opioids – can electroencephalographic (EEG) monitoring help us predict how much to give?'

The **Pfizer ANZCA Research Fellowship** was awarded to **Dr Laurence Weinberg** for his project 'Systemic lignocaine shortens length of hospital stay after open radial retropubic prostatectomy: A double-blinded, randomised, placebo-controlled multicentre trial'.

The **ANS ANZCA Research Fellowship** was awarded to **Dr Phillip Cowlshaw** for his novice project 'Ultrasound guided transversus abdominis plane (TAP) block for analgesia after caesarean surgery'.

The **Aspect ANZCA Research Fellowship** was awarded to **Professor Stephan Schug** for his project 'Identifying clinical

predictors of long-term pain outcomes among severe physical trauma survivors' (Second year)

The **Medtronic ANZCA Pain Research Fellowship** was awarded to **Dr Darcy Price** for his project 'A randomised comparison of combined suprascapular and axillary nerve block with interscalene block'.

Funding boost of \$664,000 for medical research

Continued

Ultrasound guided transversus abdominis plane block in major gynaecological surgery – a randomised controlled trial.

A large number of women at the Royal Women's Hospital undergo major surgery each year for known or suspected gynaecological cancer. This surgery results in considerable post-operative pain and other serious health consequences. This project aims to demonstrate that pain relief can be improved by using ultrasound to guide the injection of local anaesthetic between the layers of the abdominal wall. The development of small (and relatively affordable) ultrasound machines has allowed anaesthetists to visualise where local anaesthetic is being injected in real time. We believe this allows us to inject local anaesthetic more reliably and safely, resulting in better pain control. The project aims to demonstrate that the technique improves overall pain relief, reduces the amount of other pain killers required (and therefore side effects) and improves patient satisfaction.

Dr James Griffiths (Department of Anaesthesia, Royal Women's Hospital, Melbourne)

\$7,000

Comparison of airway scope and glide scope in patients with cervical spine immobilisation.

The proposed study will compare the performance of the Airway Scope and GlideScope for tracheal intubation in patients with cervical spine immobilisation using MILNS (manual in-line neck stabilisation). The GlideScope is a modification of the standard laryngoscope blade, with a high resolution camera and a light source for illumination embedded within the blade. Endotracheal intubation is performed using a screen image. Its use is well described in the airway management of patients with immobilised cervical spines. The Airway Scope, in contrast, is a novel intubation device: a video laryngoscope with a reusable handle and disposable blade.

Dr Michael Edwards and Dr James Troup (Department of Anaesthesia and Perioperative Medicine, Royal Brisbane and Women's Hospital, Queensland)

\$2,800



Left: Dr Laurence Weinberg in one of the theatres at the Austin Hospital where research into post-operative pain relief is being conducted. See page 17 for research details.

Below: Dr James Griffiths performing and teaching TAP blocks in gynaecology patients at Royal Women's Hospital in Melbourne.



2009 Academic Enhancement Grant

Cognition and anaesthesia.

Previous studies have shown that patients undergoing heart surgery and other forms of surgery may suffer impairments in memory and thinking that extend well beyond the immediate time of surgery. These problems in cognition are known to affect the elderly but the exact cause, duration and other details are poorly understood. This project investigates how many patients five years after initial surgery suffer from difficulties in thinking and memory and whether these patients have deteriorated so much that they have progressed to dementia. It will also examine memory and thinking after a common operation in the elderly, hip replacement surgery. In particular the study will examine the number of small particles that find their way to the brain during the operation. These particles have generally been believed to be innocuous but recent evidence suggests that they may play a part in diminishing brain function. This project will measure these small particles, using a special ultrasound machine when placed over the skull, is able to detect the type and number which travel in the arteries to the brain.

A/Prof Brendan Silbert and A/Prof David Scott (Department of Anaesthesia, St Vincent's Health, Melbourne)

\$90,000

2009 Simulation/Education Grant

The validity of simulation-based training and assessment in anaesthesia.

In addition to sound knowledge and technical skills, effective patient management requires expert communication, teamwork, leadership, situation assessment and decision making, the 'non-technical skills'. Anaesthetists have embraced simulation as a way of improving their expertise in these skills. The anaesthesia simulator can realistically portray an anaesthetised patient, and range of events, including clinical emergencies. It is frequently used for training in crisis management. However, we don't really know if this transfers to real life. Do doctors behave the same way in clinical practice as they do in the simulator? If, following training, we observe good non-technical skills in the simulator, does this imply these behaviours will also be used in the clinical setting? This research project addresses this question of validity of simulation as a method of teaching and assessing anaesthetists' non-technical skills. We aim to videotape anaesthetists in the operating theatre at Auckland Hospital and in the simulation centre at the Auckland University Advanced Clinical Skills Centre, and analyse their behaviours to determine the extent to which behaviour in the simulator is a valid representation of how anaesthetists behave in theatre. This will help identify which elements can validly be taught and assessed using simulation.

A/Prof Jennifer Weller, Prof Alan Merry, Dr Jane Torrie and Dr Robert Frenley (Centre for Medical and Health Sciences Education and Department of Anaesthesiology, Faculty of Medical and Health Sciences, University of Auckland, Auckland City Hospital)

\$34,812

Grant Review Process

Each year ANZCA's Research Committee reviews every grant in great detail to decide which should grants should be supported. This is a major task and depends on the willingness of anaesthetists within our community to contribute to the process. In table 1 we have listed all the people who have reviewed grants this year. Prof Alan

Merry, Chair of the Research Committee said: 'I wish to express very sincere thanks for this valuable and onerous service'.

'Members of the Committee itself read all the grants, select the reviewers, read the reviews, collate the information and act as overall spokesperson for each grant, and attend meetings at which the final decisions are made. They are listed in table 2, and again I would like to thank them on behalf of ANZCA, and on behalf of all those who benefit from this process'.

'The process is rigorous. Members of the Committee are excluded from consideration of any grants for which they have conflicts of interest. Next year we anticipate adding an independent community representative to the committee

to contribute to the impartiality and appropriateness of the process'.

Professor Merry said the major challenge for 2009 would be on maintaining an adequate level of funding in difficult financial times.

'The second challenge (as always) will be the review process. Please remember that contributing to this process is a condition of accepting grants from ANZCA. It is frustrating when people known to have had grants in the past appear to have difficulty finding the time to help. However, these are a minority, and this glass is seven-eighths full'.

ANZCA has moved the deadline for application to April 1 from 2009 to give researchers a little more time.

Table 1: Grant Reviewers

Dr Paul Allen	Dr Jonathan G Hardman	Professor Michael J Paech
Professor Arthur B Baker	Dr William Harrop-Griffiths	Dr Sandra L Peake
Associate Professor Robert Baker	Dr Christopher Hayes	Dr Philip J Peyton
Dr Michael J Barrington	Dr Peter D Hebbard	Dr Ashley N Pollock
Dr Stephen A Bernard	Dr David R Hillman	Dr Mark D Reeves
Professor Duncan W Blake	Dr Kwok M Ho	Dr Richard H Riley
Dr Simon C Body	Dr Malcolm N Hogg	Associate Professor Colin F Royse
Associate Professor Robert J Boots	Dr Andrew W Holt	Dr Robert F Salamonsen
Professor Simon Brookes	Dr Phillip A Holz	Dr William P Saul
Dr Mark R Buckland	Dr Daryl A Jones	Associate Professor Gregory Savage
Dr Anthony R Burrell	Dr Mario Kalpokas	Professor Stephan A Schug
Professor John F Cade	Associate Professor Steven G Katz	Associate Professor David A Scott
Dr Paul Cameron	Dr Robert G Large	Professor Rodney Scott
Dr Douglas Campbell	Dr Thomas Ledowski	Dr Ian M Seppelt
Professor Matthew Chan	Associate Professor Katherine Leslie	Dr Timothy G Short
Dr Louise Cole	Dr David E Lindholm	Dr David A Sidebotham
Professor Peter Colman	Dr Eugene Liu Hern Choon	Associate Professor Scott W Simmons
Dr Tomas B Corcoran	Professor Guy L Ludbrook	Professor James W Sleigh
Professor Michael J Cousins	Associate Professor Ross D MacPherson	Dr David Smart
Dr Dean A Cowie	Dr Colin P Marsland	Dr Gregory Snell
Dr Andrew J Davidson	Dr Colin J McArthur	Dr Paul F Soeding
Dr Andrew R Davies	Dr Ian M McKenzie	Dr Thomas Solano
Professor Michael J Davies	Professor Elspeth McLachlan	Dr Francois H Stapelberg
Dr Mark Davis	Professor Alan F Merry	Associate Professor David A Story
Dr Gordon Doig	Dr Andrew M Mitchell	Dr Neil E Street
Professor Simon R Finfer	Dr Simon J Mitchell	Dr Jennifer J Trinca
Dr Judith Finn	Dr Rowan R Molnar	Associate Professor David V Tuxen
Dr Brendan T Flanagan	Dr Daniel V Mullany	Dr Richard Upton
Dr Julia A Fleming	Professor Johan A Myburgh	Professor Peter V Van Heerden
Associate Professor John F Fraser	Dr Irene Ng	Dr Lars P Wang
Dr Duncan C Galletly	Professor Warwick Dean Ngan Kee	Dr Stephen A Watts
Dr Lenore M George	Dr Alistair Nichol	Dr Laurence Weinberg
Dr Stephen B Gibson	Dr Michael J O'Leary	Dr Trevor Williams
Professor Tony Gin	Dr Neil R Orford	Dr Niall C Wilton
Dr Charles Roger Goucke	Dr Ruari M Orme	
Dr Geoffrey A Gutteridge		
Dr Guy Haller		

Table 2: Research Committee members

Professor Alan Merry, Chair
A/Professor Kate Leslie, Deputy Chair
Professor Andrew Bersten
Dr Chris Hayes
Professor Tony Gin
Professor Paul Myles
Professor Mike Paech
A/Professor Tony Quail
Professor Stephan Schug
A/Professor David Scott
A/Professor Tim Short
A/Professor Phil Siddall
A/Professor Dave Story
Dr Steve Webb
Dr Dan Wheeler

How to support research

If you would like to make a donation to The ANZCA Foundation to assist further research or make a bequest please contact:

Ian Higgins
ANZCA Foundation Director
ANZCA
630 St Kilda Road
Melbourne, Vic 3004
Telephone: +61 3 9093 4900
Email ihiggins@anzca.edu.au

For further information please see page 45 of the ANZCA Bulletin.

The ANZCA Foundation

An initiative of the Australian and New Zealand College of Anaesthetists

Photo taken at the Kolling Institute of Medical Research, Royal North Shore Hospital, a research facility. A number of these new images will be featured in The ANZCA Foundation audio/visual presentation that is currently in development.

Photo: Joe Vittorio



ANZCA is grateful to the following people who have made a donation to the College in 2008:

Dr PJ Lawrence	NSW
A/Prof RP Lee	NSW
Dr GK Johnstone	WA
Dr RJ Geytenbeek	QLD
Dr L Mendel	UK
Dr SL Keel	UK
Dr AP Delaney	NSW
Dr GP Mapp	QLD
Dr ME Griggs	VIC
Dr IB Dugan	NSW
Dr I Augsrkalns	SA
Dr DH McConnel	QLD
A/Prof SR Sundaraj	NSW
Dr SK Swallow	TAS
Dr P Liston	NSW
Dr DR Mackenzie	VIC

Dr WV Howard	VIC
Dr ME O'Loughlin	QLD
A/Prof K Leslie	VIC
Dr LJ McBride	NSW
Dr TL Morris	QLD
Dr MC Kilminster	NSW
Dr SS Simpson	QLD
Dr DN Schell	NSW
Dr JM Low	Hong Kong
Dr E Parisod	Switzerland
A/Prof DA Story	VIC
Dr DA Murphy	VIC
Dr MO Schultz	VIC
Dr BA Brockett	QLD
Dr HB Hamzah	WA
Dr SC Towler	WA
Dr M Currie	NSW
Dr SJ Kerr	UK
Dr NP Kavanagh	Ireland

Dr G Thanakrishnan	NSW
Dr JR Lo	UK
Dr RF Salamonsen	VIC
Dr KM Cooke	QLD
Dr PJ Lane	QLD
Dr SA Bernard	VIC
Dr EB Chan	Hong Kong
Dr LK Chu	QLD
Prof RB Holland	NSW
Dr RW Foreman	NSW
Dr JE Harrison	VIC
Dr MS Oliver	ACT
Dr T Tay	NSW
Dr MB Suss	VIC
Mr DF Richardson	VIC
Dr GA Meijer	QLD
Dr MK Saxena	NSW
Mr G Moffatt	VIC

Total: \$31,893

A bequest to The ANZCA Foundation

A bequest to The ANZCA Foundation will greatly enhance ANZCA's ability to undertake important medical research that will significantly improve outcomes for the health of future generations.

You might consider a bequest to The ANZCA Foundation whether as a specific amount of money, a proportion of your estate, the residual of your estate, or other specific property.

Your will and financial planning are intensely personal, and the Foundation respects your privacy. However, if you wish to allocate an amount to the Foundation, or to honour or commemorate a named individual, the staff at the Foundation are readily available to discuss it with you and provide assistance. All discussions will, of course, be confidential.

We strongly recommend that you seek professional advice regarding your will. A solicitor will help you make a clear, concise will, which is easily located and causes no misunderstanding.

Testimonials from Fellows who have made a notified bequest to The ANZCA Foundation

'The launch of The ANZCA Foundation Bequest Program has encouraged me to make a notified bequest to the Foundation. I hope that many others will also make such a commitment so that ANZCA can continue to undertake crucial medical research.'

Leona Wilson

'We have decided to make a bequest to the ANZCA Foundation because all Australians will need an anaesthetic at some time for surgery, childbirth, trauma or other health conditions. Also, one in five working-age and one in three older people will need effective pain management. However, the fields of anaesthesia and pain management do not receive an appropriate level of government research funding. The ANZCA Foundation is the only body that focuses on these two areas that are vital to all of us.'

Michael and Michele Cousins

'I want to give future anaesthetists the opportunity to pursue their research goals because I know how fulfilling a career in research is and how much it can help patient care. Please join me in making a bequest to The ANZCA Foundation.'

Kate Leslie

For all enquiries please contact:

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Fitness to practise

The New Fellows Conference is an opportunity for Fellows with an interest in leadership and College affairs to discuss issues and opportunities with other new Fellows and senior members of Council in the week prior to the ANZCA ASM.

The ANZCA New Fellows Conference was held earlier this year at the Tuscany Wine Estate in the Hunter Valley. Twenty-four delegates attended including ANZCA Councillor-in-Residence A/Prof Kate Leslie, elected New Fellows Conference representative from 2007 Dr Natalie Smith, and the 2009 convenor, Dr Chris Jackson. There were representatives from across Australia, New Zealand, Fiji, Hong Kong and Malaysia. In addition to the conference goal of providing an opportunity for professional discussions and networking between Fellows in anaesthesia, pain medicine and intensive care, this year's specific theme was 'Fitness to Practise : Achieving Career Longevity'.

Through a series of seminars, debates and small group discussions we considered the meaning of 'fitness to practise' within the context of issues such as:

- Alternate career paths, and workforce issues such as part-time and interrupted practise (i.e. how does the new generational mindset impact on individuals' fitness to practise?).
- How will the ageing workforce impact on individuals' fitness to practise, and when should one retire from active clinical duties?
- Who is responsible for our competency, and how do we monitor ourselves when there are no benchmarks available to compare ourselves to?
- What is effective peer review?
- How do we manage under-performing colleagues? And how do we distinguish medical error from incompetence?

Fitness to practise

This term refers to our own fitness to practise clinical medicine, both in terms of physical and mental health, as well as our obligations to remain competent and develop as professionals.

We debated the relevance of the Hippocratic Oath as a code of conduct for modern physicians, and concluded that it is out-dated. Of more relevance today is the Physician Charter, written by the American Board of Internal Medicine (ABIM), American College of Physicians (ACP) and the European Federation of Internal Medicine (EFIM) in 2002. It lays out three fundamental principles related

to the primacy of patient welfare, to patient autonomy, and to social justice. These fundamental principles are the foundation to the ten commitments (or set of professional responsibilities) that are proposed to guide ethical behaviour:

1. Commitment to professional competence.
2. Commitment to honesty with patients.
3. Commitment to patient confidentiality.
4. Commitment to maintaining appropriate relations with patients.
5. Commitment to improving quality of care.
6. Commitment to improving access to care.
7. Commitment to just distribution of finite resources.
8. Commitment to scientific knowledge.
9. Commitment to maintaining trust by managing conflicts of interest.
10. Commitment to professional responsibilities.

Of most relevance to the conference theme of 'fitness to practise' are:

1. Commitment to professional competence.

Physicians must be committed to lifelong learning and be responsible for maintaining the medical knowledge and clinical and team skills necessary for the provision of quality care. More broadly, the profession as a whole must strive to see that all of its members are competent and must ensure that appropriate mechanisms are available for physicians to accomplish this goal.

2. Commitment to improving quality of care.

Physicians must be dedicated to continuous improvement in the quality of health care. This commitment entails not only maintaining clinical competence but also working collaboratively with other professionals to reduce medical error, increase patient safety, minimise overuse of health care resources, and optimise the outcomes of care. Physicians must actively participate in the development of better measures of quality of care and the application of quality measures to assess routinely the performance of all individuals, institutions, and systems responsible for health care delivery. Physicians, both individually and through their professional associations, must take responsibility for assisting in the creation and

'Generations X and Y value balance in life, variety in their job, and a change in roles. Their lives are likely to be a mosaic of different roles and careers and we need to accept this change is here to stay.'

implementation of mechanisms designed to encourage continuous improvement in the quality of care.

3. Commitment to professional responsibilities.

As members of a profession, physicians are expected to work collaboratively to maximise patient care, be respectful of one another, and participate in the processes of self-regulation, including remediation and discipline of members who have failed to meet professional standards. The profession should also define and organise the educational and standard-setting process for current and future members. Physicians have both individual and collective obligations to participate in these processes. These obligations include engaging in internal assessment and accepting external scrutiny of all aspects of their professional performance.

These professional responsibilities align closely with the duties and responsibilities of a doctor registered with the Medical Council of New Zealand, and of course with the ANZCA Code of Professional Conduct, and professional document PS16 (Statement on the standards of practise of a specialist anaesthetist – 2001).

Generational Issues

We considered fitness to practise within the context of the generational changes in our workforce discussing characteristics of different generations of doctors, in particular the impact on practise of the 'generational mindset' of Generation Y.

While it is generally accepted that there are benefits to achieving 'work-life balance', Generation Y seem to expect this balance from the start of their career. They do not feel the need to earn it – they demand it.

Generations X and Y value balance in

'The consensus was that there should not be a mandatory age for retirement, but that there should be an opportunity for those who wish to retire early, or decrease on-call commitments, to do so. It is accepted that there is an increasing risk of incapacitation and poor performance as we age, but we cannot generalise about the way in which advancing age affects individual performance and clinical practice.'

Attendees at New Fellows Conference



life, variety in their job, and a change in roles. Their lives are likely to be a mosaic of different roles and careers, and we need to accept this change is here to stay. This generational mindset, in combination with the increasing feminisation of the medical workforce, has led to an increase in part-time clinical practise.

There was a robust and entertaining debate held with the proposition that 'part-time work means part-time commitment'.

We discussed how much clinical work in any one field is enough to stay competent. Although there was no consensus opinion, this did highlight the need for ongoing monitoring of one's own competence, and the benefits of peer review and continuing professional development for maintenance of safe clinical practise.

At the other end of the spectrum, we considered those nearing the end of their career pathway.

The consensus was that there should not be a mandatory age for retirement, but that there should be opportunity for those who wish to retire early, or decrease on-call commitments, to do so. It is accepted that there is an increasing risk of incapacitation and poor performance as we age, but we cannot generalise about the way in which advancing age affects individual performance and clinical practice. There is no evidence for poorer patient outcomes with anaesthetists aged over 65.

Older anaesthetists also bring to their job a great many benefits, including a wealth of experience, corporate memory, gravitas and status, and skills in management, teaching and research.

In considering fitness to practise, any anaesthetist needs to consider their physical health, mental health, and clinical

competence. Common sense dictates which physical incapacities are likely to render an anaesthetist incapable of practise. There should be a commitment by the anaesthetist to regular health checks and screening – perhaps our medical regulatory boards should mandate this?

Mental health is extremely important, and stress, burnout and clinical depression are well recognised problems. As a profession we need to support those nearing the end of their careers to manage stress.

Retirement should be planned for throughout one's career, and be viewed as a 'process' rather than an 'event'. We need a 'mindful engagement' with life and those with whom we share it.

Competency

We concluded that assessment of competence and professional development must apply throughout one's career.

There are considerable difficulties in both defining and measuring our performance as anaesthetists. When we are assessing competence, what outcome measures are important and how should we obtain the data? What methods does ANZCA have to suggest to its Fellows? Those of us who keep personal logbooks may have statistics on our own complication rates, but what meaningful information does this give us without benchmarking?

One suggestion arising from the debate on retirement was that courses such as EMAC, EMST/ATLS and ACLS (and perhaps Airway Workshops) should be compulsory at least every five years after Fellowship. This would enforce ongoing external (i.e. by ANZCA) and self-assessment of competence throughout one's career. This would, of course, require a large increase in infrastructure to provide equipment and instructors, however we concluded that this would be an appropriate goal to work toward.

Discussion centred around the types of peer review that we are familiar with, ranging from the informal 'tea room chat', to mentorship, 360 degree assessment, morbidity and mortality meetings, regular audit of clinical indicators, to formal critical incident debriefing and the ANZCA Practise Peer Review (PPR).

We discussed advantages and disadvantages of each type of approach,

and agreed that effective peer review should involve directed and specific feedback in a non-confrontational manner, with constructive suggestions for moving toward an appropriate change in practise.

Many of us were unaware of the PPR and its value as an independent means of assessment of our own performance.

Managing the poor performer

We discussed characteristics of 'poor performers' (both trainees and specialist colleagues):

- Lack of knowledge and skills.
- Poor communication skills.
- Poor physical or mental health.
- Lack of insight.
- Tendency to blame others.

We also explored concepts of human error theory, and the ways in which individual factors (as above) interact with organisational and management factors, work environment, team dynamics and patient factors to contribute to adverse events.

Taking the opportunity for early intervention increases the likelihood of a successful outcome when dealing with an individual with poor performance. Feedback needs to be non-judgemental, directed and specific. Clear expectations need to be set, and the individual needs to be supported to achieve these expectations. Again the importance of work-life balance and support outside the workplace was emphasised. Supporting poorly performing trainees was highlighted as being one of the most stressful components of the job for those of us who are Supervisors of Training. The strategies presented in the Clinical Training Course for SoTs are useful.

Dr Sally Ure

Consultant Anaesthetist
and Supervisor of Training,
Wellington Hospital

The 2009 New Fellows Conference ('Keeping Doctors Well') will be held at Port Douglas 29 April – 1 May. Written applications are invited and should be forwarded to regional committees, New Zealand National Committee or Faculty of Pain Medicine by 5 January 2009.

Anaesthesia – A unique field of medical practice

‘The practice of anaesthetists is dynamically complex: potent drugs are administered, technical procedures employed, and intricate mechanical equipment utilised in an environment characterised by intense time pressure. The characteristics of the practice of anaesthesia differ from those encountered in many medical fields and the nature of the work of anaesthetists has remained outside the mainstream of research into medical practice.’

Ref: Klemola U-M, Norros L. *Analysis of the clinical behaviour of anaesthetists: recognition of uncertainty as a basis for practice.* Med Edu 31(6): Nov 1997; 449-456

What is an anaesthetist? How do you explain exactly what it is that we do? Yes, occasionally we sit in the corner and read a newspaper – but even then we are still in full control, watching and noting everything that happens. What exactly is it that makes us so special?

I think that there are many ways in which anaesthesia is a unique field of medical practice. Some of these are obvious, some less so. Some are shared to some degree by a few other specialties. Many of these aspects are not even recognised by other medical specialists unless we point them out. Here are some of the reasons that make our specialty unique:

1. We are totally responsible for all aspects of patients’ immediate well-being at a particular point in time. All details of patient care, from mortality to preventing minor morbidity, in every body system, integrating knowledge of past history, current status and future well-being, both in the short and intermediate term, are our responsibility. A good anaesthetist will, out of necessity, appreciate the big picture, the minute detail, and everything in between. Most other specialties focus on a particular aspect of patient care in a much less acute time frame.

2. We do this while working under incredible time pressure. This is imposed from outside, by hospital systems and theatre managers and surgeons, as well

as by ourselves in our striving for rapid turnover of unmanageable lists in order to be able to go home while it is still light. Can any of us say that time pressure does not affect our work practices?

3. A good anaesthetic is a boring anaesthetic; that is, nothing particularly dramatic happens. When we are good we are invisible, unnoticed, taken for granted, even considered unimportant. We make a difficult and dangerous job look easy. Most doctors do not strive to engender this impression in their patients!

4. We choose, prescribe, prepare, administer, observe and monitor drugs ourselves, first hand, in very quick succession. This naturally leaves us open to error in such a complicated field, and it is a tribute to our safety mentality that so few serious drug errors do occur.

5. We use all 5 senses (well, 4 anyway) in our routine work. How often do we explain to our students that we are actually looking, listening, feeling and even smelling, all at the same time? And at various different sites within the theatre (e.g. looking at the patient, listening to the monitor and the surgeon and the suction bottle, feeling the bag move while smelling the volatile agent). How many other specialists can do multiple things at once?

6. Our general knowledge must encompass all of medicine and all of surgery as well as our own specialist field, as a patient can present with any medical condition for any type of surgery at any time. And while we are so knowledgeable about others, no-one else really understands or appreciates what is involved with our own specialty. For example, we recognise what is involved with a difficult aneurysm repair or bowel resection, but how many surgeons do you know who really understand the problems posed to us by the difficult airway or the morbidly obese?

7. We are the ghostbusters in medicine, the bottom line. When anyone, in any field, is faced with an acutely ill patient that they can’t manage, what do they do? They call us. Intensivists get this a bit from the ward (and some of these are also anaesthetists), but we can get it from the emergency room, even the ICU, and from within theatre itself.

8. We have a very particular relationship with our registrars. Most specialists see their registrars on the occasional ward round, clinic, or theatre list, but we are one on one, often 100% of the time, with ours. Most specialties have a pyramidal structure; one consultant on the top with an expanding team of juniors underneath, and the more junior the trainee, the less likely they are to physically spend time with the consultant. We are the opposite – each registrar has a ‘team’ of consultants with whom they work, and the more junior they are, the more likely they are to be physically with their consultant for the entire working day.

I recently caught some of the gastroenterologists in my hospital wondering if they would meet the teaching requirements for professorship at the local university – the requirement was spending two half days a month with ‘their’ medical students. They eventually decided that they could probably manage this – if they asked their registrars to spend this time with the students.

9. Our registrars have a unique traineeship in many ways. They are known to have a potentially high level of stress, with the attendant risks of depression and suicide. The now well-known stressors include – having multiple bosses (up to 20 or more) with countless different ways of delivering an anaesthetic, pressure to ‘get it right’ 100% of time, having differing levels of responsibility with different bosses, coping with clinically urgent situations in crisis mode, learning a wide range of knowledge and technical skills, surviving busy night shifts with many different ‘masters’ e.g. midwives, nurses, theatre manager, surgeons, as well as having ready access to drugs of addiction.

10. We seem to have an image problem. We must be one of the very few medical specialties that are often not seen as doctors by the public (indeed, I can’t think of any others). We also somehow often seem to receive a low level of respect from many other medical specialists, whereas we are usually happy and expected to pay them this courtesy.

11. I think that this is partly because we sometimes accept standards of practice that others wouldn’t. How often are we expected

Anaesthesia – A unique field of medical practice

Continued

to just get on with the current situation rather than spend five minutes organising our workplace environment to suit us? For example, some of my colleagues put in central lines hunched up under drapes after routine surgery has already started, or start an anaesthetic with the machine in an inaccessible position. Anaesthetic nurses often just hand us equipment or drugs that we ask for and we're expected to do the rest. How many surgeons would be happy to be given equipment in a package that they had to open themselves, or start an operation with the patient in a position that makes it difficult for them to do their job – so why do we do this?

12. The immediate nature of our work is not shared by many other doctors. We must be highly trained for crisis situations. When everyone else panics, we must be cool, calm and collected. Surgeons are permitted to panic (as we will save the patient). A+E and ICU doctors do also need this skill – but they can call the anaesthetist if they're really in trouble (see point 7 above!).

13. Team work. We usually function as a fairly quiet part of a team but must step up to become an assertive team leader when required. Many other specialists seem to have trouble with simultaneously occupying both of these positions.

14. We have a long history of audit, M+M, self reflection, emphasis on patient safety, and simulation – far more than any other field of medical practice. We emphasise how dangerous our work is or can be, and talk explicitly about the risk-benefit ratio in what we do – perhaps oncologists are our closest relatives here.

I'm sure that there are many other factors that make us unique in our profession. Please let me know your thoughts and let's compile an even longer list!

Dr Natalie Smith is a staff specialist at Wollongong Hospital, New South Wales. She is the Supervisor of Training and Deputy REO for NSW. She has long been convinced that anaesthetists are very special people and has been frustrated as to why she has to keep explaining this to others. Tired of expounding her pet topic to any and every hapless student, resident, and registrar who comes her way, she wants to stimulate a wider discussion on the subject.

International Medical Graduate Specialist assessment

ANZCA Council has approved new processes for International Medical Graduate Specialist (IMGS) Assessment (both for Area of Need (AoN) and specialist recognition/Fellowship) to commence on January 1, 2009.

The new processes have been developed in consultation with the Australian Medical Council (AMC), the Medical Boards/Councils and Government.

While the Area of Need (AoN) processes are relevant only to Australia, the IMGS Assessment process covers both Australia and New Zealand.

The main changes to the processes include the following:

- Anaesthetists supported in AoN positions will not have to reapply to the AMC for IMGS Assessment.
- The IMGS assessment interview panels will classify IMGS into the following categories:
 - Advanced Standing Towards Substantial Comparability (SC)
 - Partially Comparable (PC)
 - Not Comparable (NC).
- Applicants with Advanced Standing Towards Substantial Comparability may be eligible to proceed to Fellowship without examination, after having completed 12 months clinical anaesthesia in Australia or New Zealand and successfully completing a comprehensive Workplace Based Assessment (WBA). The WBA will be undertaken on-site by a member of the ANZCA IMGS Committee and a representative nominated by the relevant ANZCA Regional Committee and conducted over a full day.
- Applicants considered at interview to be Partially Comparable will be required to undertake up to 24 months clinical practice assessment, successfully complete the IMGS Performance Assessment or Final Examination (their choice), after which they must successfully complete a WBA.
- IMGS who have been supported in AoN positions will need to progress to IMGS interview within three months of commencement of duties.

- All AoN applicants will continue to be required to successfully complete an on-site assessment by a Fellow nominated by the relevant Regional Committee.

- IMGS and AoN applicants interviewed after 1 January 2009 will be required to undertake the new processes. All IMGS currently undertaking requirements previously advised to the interview panels in Australia and New Zealand will be eligible to complete the requirements under the old processes until the five-year time limit is reached.

The new process documents have been published on the College website at: www.anzca.edu.au/imgs-aon/three-areas-of-assessment. Regulation 23 that governs the IMGS assessment process has also been amended and is available at: www.anzca.edu.au/resources/regulations/regulation-23.html.

ANZCA mandates CPD

Introduction

The decision to mandate participation in a 'formal CPD program' for all active ANZCA Fellows was taken by Council in October 2007, effective from January 2009. The President's Message in the October Bulletin included the statement that 'The new ANZCA CPD program allows Fellows to design their own CPD requirements from a range of sources in order to fulfil their professional obligations'.

It is recognised that some Fellows may prefer another CPD program to ANZCA's, because of the nature of their practice. An article in the March 2008 Bulletin stated that the objective of the CPD program was 'to provide a framework through which Fellows can maintain and improve their knowledge, skills and attitudes, and develop professional and personal attributes required through their career'.

Background

CPD of some sort has existed in Australia and New Zealand since at least 1901, when Edward Embley, who practised anaesthesia in Melbourne, inaugurated teaching in anaesthetics at the University of Melbourne and the Royal Melbourne Hospital and read a major paper at the International Congress of Medicine in London. Working as a pharmacist to support his medical training, he carried out laboratory and animal research (mostly at nights and weekends) into the mechanism of sudden death in chloroform anaesthesia. These papers were an example of clinical and laboratory research which contributed to the death of chloroform¹.

In 1929, Geoffrey Kaye from Melbourne read a major paper on a review of deaths during anaesthesia².

CME dominated both ASA meetings from 1934, when attendance often involved a sea voyage to attend, and Faculty of Anaesthetists meetings from 1952. MOPS began in 1995 and CPD in 2008.

Overseas trends – Canada

ANZCA MOPS was modelled on the program of the Royal College of Physicians & Surgeons of Canada, itself modified from that of RANZCOG. There have been many changes over the years.

Maintenance of Certification (MOC) has been compulsory in Canada only since 2008. That program is distinct from those designed to confirm competence or continuing fitness to practice, as is ANZCA CPD. The Canadian framework is broadly similar to ours, although each of their six sections is structured differently, and 'credit' scoring varies. The MOC cycle is five years, with a minimum number of credits per year. Failure to comply over a five-year period results in withdrawal of Fellowship. A list of Fellows and their MOC status is published on the web. There is random audit of 3% of Fellows each year³.

Written for a Canadian audience, Gutkin provides insights into the international trend to mandatory CPD and revalidation⁴.

In the United Kingdom, the terms often now used are Revalidation, Relicensing, Registration and Recertification. Professor Dodds summarises what he believes is the future for doctors there, scheduled for 2010⁵.

For individuals, recertification will include department accreditation, participation in CPD and individual professional performance review. This will be retrospective from 2005, so specialists have been gathering data since then. Relicensing will include personal appraisal based on the GMC 'Good Medical Practice' as the standard, and multisource feedback.

After many delays, it is clear that increased surveillance of individual practice is well underway, but not yet finalised. Licensing, not just registration, will be required for all doctors in clinical practice.

In the United States of America Recertification is the term now used, with standards set by the American Boards⁶. The key to compliance is to be involved in regular Maintenance and Enhancement of Competency (MAEC). Requirements include CME, Self Assessment Examinations, proof of an unrestricted license, and no 'conviction of a felony'. It has an eight-year cycle, with annual components.

Australasian Trends

The name 'CPD' has largely replaced 'MOPS'. 'Credentialling' is a well established term in both Australia and New Zealand. More than 60% of local Colleges mandate their programs, and none have examinations. Cycles vary from 1 – 5 years.

The Future

The future in Australia and New Zealand is unclear, and will probably remain common in principle but different in detail. In Australia, it seems clear that national registration and accreditation will include an increased number of mandated requirements. In CPD, the system may be more like the Canadian model than others. New Zealand's current requirements may be those of the future. Inclusion of some form of assessment to the Australian or New Zealand 'Good Medical Practice' guidelines (as in the UK) or to some form of ethical guidelines (as in the USA) seems likely. There is no doubt that 'the future' will start in 2010.

References

- Embley, E.H. *The causation of death during the administration of chloroform*. B. Med J 1902; 1: 817-821, 885-893, 951-961.
- Kaye, G. *Pathological findings in deaths during anaesthesia*. Med J Aust 1930; 1: 66-83
- RCPSC Maintenance of Certification Program <http://www.rcpsc.medical.org/opd/index.php>
- Gutkin, C. *Mandatory Continuing Professional Development* Can Fam Physician 2007; 53(8): 1396
- Dodds, P.C. *Revalidation: Where are we now?* RCOA Bulletin 2008; 2433-2437 <http://www.rcoa.ac.uk/index.asp?SectionID=3>
- American Boards of Physician Specialties *Standards for Recertification* – <http://www.abpsga.org/certification/anaesthesiology/recertification.html>

Prof Garry Phillips
CPD Committee Member

CPD – Obtaining a Statement of Participation

The ANZCA CPD program is now a three-year program and one of the benefits of the new program is that you can print out your own Statement of Participation whenever you need it. Your Statement of Participation can be printed via the online portfolio. This has also been set up for offline portfolio users.

However, if you are semi retired and not practising as often, you can submit your CPD activity for the year either online or via the CPD Unit for an Annual Statement of Participation.

Online portfolio participants

In the CPD online portfolio, select the left hand link 'Annual CPD Review' which will take you to the summary page which outlines your CPD program and the total of credits per category. At the end of the summary there will be a link 'Print your Statement of Participation'. This will appear once you have started your CPD plan and entered some activities.

A Statement of Participation will then be displayed stating that you are participating in the ANZCA CPD program and following will be a summary of the credits already entered into your portfolio for your information.

Offline portfolio participants

If you are participating via the hardcopy CPD portfolio you can login online and complete the following steps:

- Select the link 'Add Offline Submissions' on the left-hand menu
- Enter your total credits for all categories then 'Submit'
- A summary page will appear with the link 'Print your Statement'.
- Select this link and you can then print your Statement of Participation.

If you are unable to access a computer you can request from the CPD Unit an Offline Annual Summary Form which can be emailed, faxed or posted to you for completion.

The CPD Unit is able to assist if you need any further assistance.

Contact Teresa Brandau-Stranks,
CPD Coordinator

Email: cpd@anzca.edu.au

Phone: +61 3 9510 6299.

Obstetric Anaesthesia: Scientific Evidence Project

The ready availability of up-to-date peer-reviewed information is an essential element of modern clinical practice. In February 2007 the Obstetric Anaesthesia Special Interest Group commenced the task of establishing such a knowledge base with the broad purpose of creating an information resource on key clinical topic areas in obstetric anaesthesia based on best-available evidence specifically tailored to the needs of our region. It was envisaged that such a knowledge base could have the capacity to not only facilitate the maintenance of high standards of clinical care by anaesthetists but also help disseminate scientific evidence to consumers and to other health professionals and policy makers. With the full support of the three parent organisations, a steering group was established and with the direct contribution of numerous clinicians and academics across our region the concept became a reality following an official launch at a scientific meeting of the Obstetric Anaesthesia Special Interest Group at Blenheim New Zealand in October 2008.

In principle, it was intended that the finished product should incorporate the following elements:

1. a readily accessible electronic format,
2. the option of a print version to be created by the end-user,
3. the opportunity for the clinician end-user to link the knowledge base to quality assurance activities,
4. a governance structure which could ensure that the content remains up-to-date and the entity is sustainable.

The specific practical features that have been developed include:

1. a web-based format generally accessible to any user of the internet,
2. a web-page structure which includes:
 - a. an electronic scientific evidence document with hypertext flexibility,
 - b. a PDF version of this document,
 - c. access to the cited references through the ANZCA library accessible to clinicians through their usual password access,
3. a user feedback link to promote development cognisant of the needs of clinicians and consumers.

The steering group and contributors believe they have created a resource that is both current and relevant and which will continue to evolve over time to continuously improve quality and safety in obstetric anaesthesia.

To view Obstetric Anaesthesia: Scientific Evidence, please visit the ANZCA website www.anzca.edu.au and click on 'resources' and 'publications' or visit www.anzca.edu.au/fellows/sig/obstetric-anaesthesia-sig/obstetric-anaesthesia-scientific-evidence

Associate Professor Scott Simmons

On behalf of the Working Party

Examination dates 2009

Primary Examination

	Venue	First Sitting	Second Sitting
Closing Date		15 December 2008	1 June 2009
Written	All Major Centres	2 March 2009	27 July 2009
Oral	Melbourne Hong Kong	27, 28, 29 April 2009	14 – 16 September 2009 18 September 2009

Final Examination

	Venue	First Sitting	Second Sitting
Closing Date		13 February 2009	3 July 2009
Written & Medical Clinical	Adelaide, Brisbane, Melbourne, Perth, Sydney, Auckland and Hong Kong	3 & 4 April 2009	28 & 29 August 2009
Oral	Melbourne Sydney	29 & 30 May 2009	30 & 31 October 2009

2009 Examination Fees

Primary examination fee – \$3,485

The examination fee is to be remitted in Australian dollars by bank draft, personal cheque (Australia only), or by credit card directly to College headquarters by the examination closing date together with completed Application to Present for Primary Examination.

Final/IMGS examination fee – \$4,060

The examination fee is to be remitted in Australian dollars by bank draft, personal cheque (Australia only), or by credit card directly to College headquarters by the examination closing date together with completed Application to Present for Final or IMGS Examination.

Late Applications or Late Documentation Will **Not** Be Accepted After an Examination Closing Date

Closing date – Primary

Applicants applying to present for the Primary Examination, who have not already registered with the College, should register as an ANZCA trainee at least two weeks before the closing date for examination applications. This is to ensure that any problems in documentation can be clarified before the relevant examination closing date.

Please note that because of numbers involved, it has become necessary for the College not to accept any applications to present for a College Examination after the closing date for that examination. This ruling must also apply to documentation in support of the application.

Written section venues

The following are the available venues for the written section of the Primary Examination: Australia (Adelaide, Brisbane, Cairns, Canberra, Darwin, Hobart, Launceston, Melbourne, Newcastle, Perth, Sydney and Townsville), New Zealand (Auckland, Christchurch, Dunedin, Hamilton and Wellington), Asia (Hong Kong, Kuala Lumpur and Singapore).

Closing date – Final/IMGS

Applicants applying to present for the Final Examination, must have fulfilled and documented all eligibility requirements as specified under Regulation 15, or do so by the date of the written section (including 24 months clinical anaesthesia) by the date on which the written section of the examination commences (Regulation 14.6.2).

Please note that because of number of applications involved it has become necessary for the College not to accept any applications to present for a College Examination after the closing date for that examination. This ruling must also apply to documentation in support of the application. Please take postage delays into consideration when sending applications near to the closing date. Registration of mail appears to substantially increase the time it takes for mail to arrive at the College. Overseas candidates should allow extra time for applications to arrive by the closing date.

Written and medical clinical sections venues

In 2009, the written and medical clinical sections will be held only in Adelaide, Brisbane, Melbourne, Perth, Sydney, Auckland and Hong Kong.

Contact:

Final/IMGS Examinations:
finalexam@anzca.edu.au

Primary Examination:
primaryexam@anzca.edu.au

July/September 2008 Primary Exam

A total of one hundred and forty six (146) candidates successfully completed the Primary Fellowship Examination at this presentation and are listed below:

Anisa Aisha Binti Abu Baker	MLY
Nada Najib Shihab Alrawi	VIC
Gerard Stuart Ariotti	QLD
Colin Stewart Barnes	NZ
Willem Basson	QLD
David Bednarczuk	SA
Anton Willis Gerard Booth	QLD
Adrian Boyn	NSW
Shona Mary Bright	TAS
Silke Brinkmann	WA
Gabrielle Louise Bullock	NSW
Heather Maree Butler	VIC
Lau Shiu Kwan Candice	HKG
Michael John Challis	TAS
Paul Cheng Loon Chan	VIC
Michelle Sue-Lin Chia	VIC
Yeoh Chih Nie	MLY
Andrew Lyn Hamilton Childs	NZ
Samuel Cho	NSW
Katrina Alexandra Clarey	NSW
Peter John Clarke	VIC
Andrew James Cluer	SA
Craig John Coghlan	QLD
Bryan Michael Cook	QLD
Richard Grant Cooper	NZ
Carlton Costello	NSW
Faith Perez Crichton	SA
Timothy James Hannam Crichton	SA
Nicholas Patrick Crimmins	QLD
Michael Philip Curtin	QLD
Jai Nair LePoer Darvall	VIC
Benjamin Martin Darveniza	QLD
Thambiliyagoda Dissanayake	VIC
David Andrew Donnelly	NSW
Brendon Karl Dunlop	WA
Alastair Patrick D'Vaz	NSW
Melinda Colleen Ford	ACT
Jonathan Fraser	SA
Yvette Gainey	WA
Matthew Lee Geall	SA

Tiffany Sheryn Glass	NZ
Alison May Graham	VIC
Tu Cam Ha	NSW
Sheila Hart	NZ
Mario Salvador Henriquez	NSW
Maryam Hezar	NSW
Cheng Ho Yi	HKG
Timothy Oscar Holliday	NSW
See Hooi Geok	MLY
Rosa Meng-Chen Hou	NSW
Andrew Yanqi Huang	NSW
Koh Huey Ling	QLD
Syed Obaidul Huq	NSW
Alastair James Ineson	NZ
Caroline Anne Jackson	NSW
Nathan Clifford James	WA
Navroop Singh Johal	VIC
James Edward Johnson	QLD
Leung Ka Lam	HKG
Leung Ka Ming	HKG
Keshavan Kanesalingam	NSW
Christopher Lawrence Kay	VIC
Cheah Keen Hoe	MLY
Siaw Ping Kho	NSW
Rowena Lee Knoesen	NZ
Joseph Ming Kwan Koh	NZ
Aditya Kousik	NSW
Lisa Ku	VIC
Raj Kumar	QLD
Michael Law	NSW
Frederick Luang Dart Lee	NSW
Chee Teik Lee	VIC
David Tak Wai Leung	NSW
Rebecca Anne Lewicki	SA
Tey John Boon Lim	SGP
Herman Lim	VIC
Lai Lo Man	HKG
Kirryn Amanda Lowe	NSW
Scott Chern Yaw Ma	SA
Andrew John Magness	VIC
Nancy Malek	NSW
Andrew John Marriott	SGP
Andrew John Paul Martin	NZ

Daniel Richard Mattingley	NZ
Symon McCallum	QLD
Lee Min-Qi	SA
Behin Moser	QLD
Kristine Anne Moser	TAS
Jessica Caroline Mouat	NZ
Gisele Marie Louise Mouret	NSW
Glen Andrew Mulholland	NZ
Hui Mun Tsong	MLY
Subhashini Nadarajah	NZ
Amardeep Singh Nanuan	VIC
Ruta Nerlekar	VIC
Rebecca Jane Owen	VIC
Anand Jog Pudipeddi	NSW
Tang Pui Yan	HKG
Catherine Lisa Purdy	NZ
Anand Ajith Rajan	NSW
Thimali Rajapaksa	NZ
Fiona Mary Reardon	NSW
Nicholas Rosoman	QLD
Paul Andrew Ross	NSW
Twain David Russell	WA
Allanah Catherine Scott	NZ
Kalmin Thaminda Senaratne	QLD
Nicole-Maree Margaret Sheridan	QLD
Navdeep Singh Sidhu	NZ
Kurugalage Siriwardana	NZ
Steven Chi-Ming Siu	NSW
Michael Soares	WA
Simon Phillip Spiers	NSW
Jonathan Paul Stacey	NZ
David John Stewart	QLD
Iain Campbell Stewart	NSW
Koh Su May	VIC
Timothy Suharto	NSW
Paul James Suter	QLD
Eric Jiong-Chang Eric Tai	WA
Wong Tak Yee	HKG
Stanley Tay	VIC
Andrew Deane Taylor	QLD
Joseph Charles Luke Taylor	NZ
Alexandra Taylor	VIC
Andrew Gethyn Thomas	SA

July/September 2008 Primary Exam

Continued

Cindy Thomas Joseph	MLY
David Tragen	QLD
Yee Wah Tse	HKG
Wan Tsz Pann Winnie	HKG
James Jonathan Tuckett	NZ
Catherine Mary Vaughan	WA
Brooke Jean Vickerman	QLD
Bevan James Vickery	NZ
Christopher David Walker	NZ
Emma Lucinda Walters	QLD
Andrew James Warnock	NZ
Charles Christopher Morel Warren	NSW
Alison Williams	WA
Yau Wing Sze	HKG
Wong Yee Lap Eric	HKG
Wong Yoke Mooi	MLY
Robin David Young	NZ
Yasmin Vivian Celeste Zarebski	NSW
Lan Lan Zhang	SA
Helen Zois	NSW

Renton Prize

The Court of Examiners recommended that the Renton Prize for the half year ended 31 December 2008 be awarded to:

Dr. Stanley Tay	VIC
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Merit Certificates

Merit Certificates were awarded to:

Dr Timothy James Byrne	VIC
Dr Jai Nair LePoer Darvall	VIC
Dr Navroop Singh Johal	VIC
Dr Lloyd Antony Roberts	VIC
Dr Rachel Ruff	NSW
Dr Bevan James Vickery	NZ
Dr Alison Williams	WA
Dr Tang Pui Yan	HKG

Final Fellowship Examination (Anaesthesia)

August/October 2008

The Medical Clinical and Written Sections of the examination were held in Adelaide, Auckland, Brisbane, Hong Kong, Melbourne, Perth and Sydney.

The Anaesthesia Vivas were held in Sydney at the AJC Convention Centre – Randwick.

The Court of Examiners was as follows:

Chairman	Dr P Gibson
Deputy Chair	Dr M Priestley
Examiners	
Dr V S Beavis	Dr G E Moloney
Dr C S Butler	Dr Morris
Dr D J Castanelli	Dr P R McCall
Dr C R Chilvers	Dr J M McDonald
Dr C J Cokis	Dr Douglas McEwan
Dr T G Costello	Professor M J Paech
Dr M H Cowling	Dr P Peres
Dr P T Farrell	Dr P G Ragg
Dr M Gray	Dr C Sims
Dr K B Greenland	A/Prof M W Skinner
Dr K N Gunn	Dr T S Tan
Dr R M Halliwell	Dr D R Tremewen
Dr C M Johnson	Dr V Viliunas
Dr M A Joseph	Dr R J Waldron
Dr A M Kaplan	Dr L S Weber
Dr R Kluger	Dr M D Westmore
Dr M Y Lai	Dr M Y Wong
Dr V G Laursen	Dr B H Yong
Dr S C Maclaurin	

140 Candidates presented for Medical Clinical and Written sections of the examination and 135 were invited to attend the Anaesthesia Vivas. A total of 112 successfully completed the Final Examination.

Jeremy Duncan Trenorden Abbott	QLD
Wan Ling Leong	NSW
Ikhwan Naser Abdul Rahim	QLD
Win Nie Lim	NSW
Bruce Adendorff	NSW
Mylene J. Lorenzo	NSW
Jonathan William James Albrett	NZ
Wai Leng Lum	NSW
Jacob Ananthuruthil Paul	QLD
Marc Christopher Hugo Maguire	QLD
Cassandra Andrews	VIC
Cameron Mark Main	SA
Uate Qalo Babbitu	SA
Nicholas Webster Marks	NZ
Emma Elizabeth Anne Bean	NSW
Raymond Mervyn John Martin	QLD
Hossam Wissa Nakhla Beshara	NSW
Kirsten McCullough	SA
Barbara Beuthe	WA
Petra Fey Muriel Millar	QLD
Bhandarker Bhavesh Dineshbhai	QLD
Andrew John Mitchell	QLD
Emma Jane Blair	NZ
Sacha Ivan Muller-Botti	NSW
Phoebe Jeanette Brodie	NSW
Shailesh Murty	SA
Allan James Brown	NZ
Raymond Nassar	NSW
Matthew Bryant	QLD
Audrey Siet-Ting Ng	WA
Peter Carlin	SA
Mau-Hing Ann Ngui	WA
Adrian Chin	QLD
Melanie Louise Olsen	SA
Michael Kok Foong Choo	VIC
Philip Matthew Owen	NSW
Michael John Collins	VIC
Clinton George Paine	NZ



Members of the Court

Richard Antony Connell	VIC	Nathan James Kershaw	NZ
Gene Anthony Palmer	WA	Su Sien Thon	NZ
Astley Mark Cottrell	QLD	Rajeev Kishen	WA
Warren Anthony Pavay	WA	Minh The Tran	NSW
Geoffrey Stephen Crawford	QLD	Simon Koh	NSW
Ross Graham Peake	ACT	Andrew Edwin Tse	NZ
Brendan Matthew Doherty	QLD	Juliana Nai Jia Kok	QLD
Katherine Joy Perry	NZ	Johannes Marthinus De-Wet Van Riet	NZ
Neil Michael Dooney	SA	Harikrishnan Kothandan	SA
Ingrid Petrasovicova	VIC	Radha Vivekananthan	VIC
James du Preez Drew	NZ	Kulasinghe B S L Kulasinghe	QLD
Vivi Pham	NSW	Andy Yi-Yang Wang	NSW
Kate Elizabeth Drummond	SA	Jeyanthi Kunadhasan	VIC
Murali Rajaratnam	QLD	Stephen Keith Whiting	NZ
Ivana Erac-McKenzie	VIC	Nani Indriati Kuswanto	VIC
Rana Munawar Ahmed	SA	Jerrey Wikarsa	NSW
Morne Vernon Fortuin	VIC	Jason Suk Hyun Kwon	QLD
Paul Andrew Richards	SA	Emily Claire Wilcox	NSW
Craig D French	QLD	Sarah Louise Latham	ACT
Elizabeth Ranjana Richards	QLD	Roger Tzekin Wong	TAS
Anil Singh Gill	VIC	Corinne Jacqueline Law	NZ
Erandhi Nirupama Samaraweera	NZ	Janette Carolyn Wright	VIC
Kieran James Guy	QLD	Long Ha Le	ACT
Mark Andrew Sandy	VIC	Aihua Wu	VIC
Amelia Kate Harricks	NSW	Gene Sit Yee Lee	NSW
Kishore Kumar Sanghi	NSW	Hildegard Kerstin Wyssusek	QLD
Lisen Emma Hockings	WA	Emelyn Mei-Lin Lee	WA
Damian Michael Simpson	VIC	Yu Chor Hoaw	NSW
Jeffrey David Hoskins	NSW	Lee Shu Ying	SGP
Vikramjit Singh	NZ	Stefan Matthias Ziege	QLD
Sanaa M Ali Ismail	NSW		
Peter Smith	NSW		
Jonathan Peter Jarratt	NZ		
Louisa Marie Smith	QLD		
Dumindu Sanjeewa Jayasinghe	QLD		
John Robert Smithells	NZ		
Manika Jegathesan	VIC		
Geneva Simone Sportsman	NSW		
Alan Stephen Kakos	VIC		
Venkatesan Thiruvenkatarajan	SA		
Sharada Baig Kamireddipalli	TAS		
Michael James Thomas	NZ		
Daniel Kennedy	WA		
Kerry Louise Thompson	VIC		



Retiring examiners: Dr Patrick Farrell, Dr Peter Perez, Dr Peter Gibson



Dr Michele Joseph and Dr Peter Gibson

The Court of Examiners recommended that the Renton Prize for the half year ended 31 December 2008 be awarded to:

Dr Stanley Tay	VIC
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Merit Certificates were awarded to:

Nathan James Kershaw	NZ
Petra Fey Muriel Millar	QLD
Clinton George Paine	NZ
Damian Michael Simpson	VIC

Final Fellowship Examination (Anaesthesia)

Continued

Geographical distribution

Area	Numbers Presenting	Numbers Approved
Hong Kong	1	0
Malaysia	1	0
New South Wales	32	25
New Zealand	19	18
Queensland	28	24
Singapore	2	1
South Australia	15	12
Tasmania	4	2
Victoria	23	18
Northern Territory	2	0
Western Australia	10	9
Australian Capital Territory	3	3
Total	140	112

Analysis of number of attempts

Number of Attempts	Numbers Presenting	Numbers Approved
1	111	93
2	19	12
3	6	4
4	3	2
8	1	1
Total	140	112

Training and Examinations

Distribution:

College Council
Chair, Examinations

Panel of Examiners
Regional/National Committee Chairmen

Supervisors of Training
Regional/National Education Officers

IMGS Performance Assessment

October 2008

The written section of the examination was held in Adelaide, Auckland, Brisbane, Hong Kong, Melbourne, Perth and Sydney.

The Medical/Clinical Vivas were held at the following venues:

Region	Venue
Adelaide	Repatriation General Hospital Surgical Centre (Ward 7)
Auckland	Outpatients Department Level 6 Support Building Auckland City Hospital
Brisbane	Princess Alexandra Hospital Pre-Admissions Clinic
Hong Kong	Li Ka Shing Specialist Outpatient Clinic (North Wing) Prince of Wales Hospital
Melbourne	Out Patients Department Royal Melbourne Hospital Parkville
Perth	Royal Perth Hospital Goderich Outpatients Clinic
Sydney	University Clinics Level 2 Westmead Hospital

Twenty two (22) candidates presented for the International Medical Graduate Specialist Performance Assessment held in August/October 2008 in Sydney and the following nine (9) Candidates were successful.

Dr Abraham Lynn	NSW
Dr Bosnjak Goran	QLD
Dr Gibson Graeme	TAS
Dr Groves Julia	QLD
Dr Heck Martin	QLD
Dr Jeyadoss Jellsingh	SA
Dr Schapiro David	QLD
Dr Steiner Reinhard	SA
Dr Tecszy Monika	ACT

41% of candidates passed the IMGS Performance Assessment. The pass rates in each section of the IMGS Performance Assessment were as follows:

Section	IMGS pass rate	Final exam pass rate
Short Answer Questions	23%	45%
Medical Clinical Vivas	55%	65%
Anaesthesia Vivas	45%	80%

Twenty six (26) IMGS candidates presented for the *Final Fellowship Examination* held in August/October 2008 and the following seventeen (17) were successful.

Dr Bruce Adendorff	NSW
Dr Anamthuruthil-Paul Jacob	QLD
Dr Beshara Hossam	NSW
Dr Beuthe Barbara	WA
Dr Bhandarker Bhavesh	QLD
Dr French Craig	QLD
Dr Kamireddipalli Baig Sharada	TAS
Dr Kothandan Harikrishnan	SA
Dr Kulasinghe Kulasinghe	QLD
Dr Lorenzo Mylene	NSW
Dr Muller Botti Sacha	NSW
Dr Murty Shailesh	SA
Dr Petrasovicova Ingrid	VIC
Dr Thiruvenkatarajan Venkatesan	SA
Dr Wu Aihua	VIC
Dr Wysusek Hildegard	QLD
Dr Ziege Stefan	QLD

The IMGS Certificate of Excellence was not awarded.

Research

ANZCA Trials Group Update

The ANZCA Trials Group has been central in establishing and strengthening ties with numerous Australian and New Zealand sites, particularly with the rollout of its latest research endeavour – the REASON Audit.

The Trials Group aims to improve the evidence base of anaesthesia, intensive care, pain medicine, and the emerging field of perioperative medicine, by developing and conducting high-quality, multicentre, randomised-controlled trials and related research.

Research Update

REASON Audit – Research into Elderly Patient Anaesthesia and Surgery Outcome Numbers

This audit reviews postoperative complications in high-risk patients undergoing surgery in Australian and NZ hospitals. Twenty-two centres (across Australia & NZ) have expressed interest and 14 are currently contributing to the audit with over 1500 data sets submitted to date. The audit is expected to be concluded in early 2009 and results are planned to be announced at the ANZCA ASM in Cairns.

The Reason Audit Chief Investigator, Associate Professor David Story, was the recipient of a 2009 ANZCA Research Grant.

Finally, the Reason Audit Investigators would like to thank all contributors to this audit for all their hard work and persistence in this research. We are happy to provide sites with their individual data and assist with analysis.

ENIGMA II Trial – Nitrous Oxide Anaesthesia and Cardiac Morbidity after Major Surgery

The ENIGMA-II trial is progressing smoothly. Currently twenty-three sites are recruiting patients and a further eleven are expected to come online soon (including six in Europe). The trial is exceeding the expected number of patients with over 1200 recruited to date. The ENIGMA-II 1-year follow-up study is about to commence

For more information, please visit www.enigma2.org.au or admin@enigma2.org.au.

The ATACAS Trial – Aspirin and Tranexamic Acid for Coronary Artery Surgery Trial

The ATACAS Trial will be the largest study yet conducted to ascertain the benefits and risks of aspirin and antifibrinolytic therapy in coronary artery surgery. Sixteen sites have recruited 475 patients, and an additional 10 sites (in the UK, Canada, India and Malaysia) are undergoing ethics approval. Furthermore, a number of sites have commenced the collection of saliva samples as part of the iPEGASUS (international PERioperative Genetics And Safety oUtcomes Study) sub-study. The ATACAS 1 year follow-up study is also about to commence.

For more information, please visit www.atacas.org.au or contact admin@atacas.org.au.

If you are interested in contributing to any Trials Group Multi-Centre Research, please contact Stephanie Poustie, Research Coordinator, ANZCA Trials Group via email spoustie@anzca.edu.au or phone: +61 3 8517 5326.

Pilot Research Grants for 2009

The ANZCA Trials Group invites applications from Fellows of ANZCA, JFICM and FPM for pilot research grants for projects related to anaesthesia, intensive care, pain and perioperative 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. The Trials Group will award up to five Grants at A\$5,000 with infrastructure support from the Trials Group Research Coordinator.

To be eligible for a pilot research grant, applicants should send a description of the proposed research project, a copy of their curriculum vitae and a covering letter indicating that they are seeking endorsement from the Trials Group and wish to apply for a pilot research grant. Applications will be adjudicated by the Trials Group Executive.

Please visit www.anzca.edu.au/resources/research/anzca-trials-group/pilot-grant-scheme.html

Or contact Stephanie Poustie, Research Coordinator, ANZCA Trials Group at spoustie@anzca.edu.au or +61 3 8517 5326.

Next issue...

Survey research: some useful information on how to conduct survey research, and what the Trials Group does and does not provide for College Fellows and Trainees' formal projects. In the meantime, here is a reference for a publication from the Trials Group on survey research:

Surveys: An Introductory Guide to Survey Research in Anaesthesia

D. Jones*, D. Story†, O. Clavisi‡,
R. Jones§, P. Peyton**

Anaesth Intensive Care 2006; 34: 245-253

Drug errors in perioperative practice

Errors in drug administration are of major concern in the health industry in Australia and New Zealand. However, many hospital quality-assurance programs ignore or have no data on anaesthesia-related drug errors although it has become a major issue in perioperative medical care and there is a significant increase in such reports. This is due to a number of factors already discussed in the Bulletin.¹

In earlier reports the main issue was substitution of a relaxant for a sedative drug, frequently resulting in awareness. As a result, the red-barrel syringe was instituted to be used for relaxant drugs only, as instituted by Prof John Russell and the Australian Patient Safety Foundation (APSF). Even this measure is not foolproof

as evidenced in two reports where fentanyl or midazolam was administered from a red-barrel syringe, resulting in inadequate relaxation and difficulty in endotracheal intubation.

However, with the vast increase in drugs employed during anaesthesia and the wide introduction of post-operative pain management, many different drug errors have been reported to the Victorian Consultative Council on Anaesthetic Mortality and Morbidity (VCCAMM) over the past eight years and some of these are itemised in the accompanying table. It is noteworthy that a significant number of these errors resulted in unplanned admission to an Intensive Care Unit for periods varying from 12 to 64 hours.

Drug Intended	Drug Administered	Outcome
Cephalozin	Bolus vancomycin	Hypotension (ICU)
Thiopentone	Cephalozin	Difficult intubation
Cephalozin	Thiopentone	Unplanned anaesthesia
Morphine	Ephedrine	Significant hypertension
Dexamethazone	Ephedrine	Significant hypertension (ICU)
Metaraminol	Phentolamine	Prolonged hypotension (ICU)
Ephedrine	Naloxone	nil
Protamine	Metaraminol	hypertension
Epidural bupivacaine top-up	Epidural morphine 10 mg	Prolonged respiratory depression (ICU)
Epidural bupivacaine	Epidural metaraminol	nil
Epidural bupivacaine	Potassium Chloride	Severe hypertension (ICU)
MS Contin 30mg	Oxycontin 120 mg	Respiratory depression (ICU)
IV fluids	Ketamine	Hypotension (ICU)
Slow infusion magnesium sulphate	Prolonged rapid infusion	Respiratory depression (ICU) Hypotension
Suxamethonium	Air	Unmodified fitting during ECT
Preoperative sodium citrate	Major overdose	Alkalosis ICU
Spinal bupivacaine	N Saline	Elective CS converted to GA
Spinal bupivacaine	Heparin	Nil
Heparin	Midazolam	Bypass op. rapidly corrected

Patricia Mackay
Emeritus Consultant
VCCAMM
Victoria

Reference

1. ANZCA Bulletin, December 2006, Volume 15 Issue #4, page 26, Mackay, P

Recommended reading: Epidural Anaesthesia

At a time when many of us are reviewing our use of epidural anaesthesia because of concern about complications and doubts about the benefits, a recent paper from *The Lancet* provides a useful contribution to the debate about the risk-benefit profile of this technique.

Epidural anaesthesia and survival after intermediate-to-high risk non-cardiac surgery: a population-based cohort study. The Lancet, Volume 372, Issue 9638, 16 August 2008-22 August 2008, Pages 562-569. Duminda N Wijeyesundera, W Scott Beattie, Peter C Austin, Janet E Hux, Andreas Laupacis.

Acknowledging that the definitive randomised controlled trial can probably never be done for logistical reasons, the authors used administrative health care data bases and propensity score matching to produce a matched pairs cohort with over 44,000 in each group. Their results show only a small improvement in 30 day survival of questionable significance but confirm the safety of the procedure. Interestingly the requirement for spinal decompression laminectomy was the same in both groups at 0.02%.

There is an accompanying editorial commentary by Drs Michael Barrington and David Scott from Melbourne's St Vincent's Hospital in which they endorse the improved analgesia offered by the epidural technique as sufficient indication for its use.

Do we need to justify epidural analgesia beyond pain relief? The Lancet, Volume 372, Issue 9638, 16 August 2008-22 August 2008, Pages 514-516. Michael J Barrington, David A Scott.

This is a really interesting 'Quality and Safety' issue and this paper and accompanying commentary provides some significant food for thought.

Because it was in *The Lancet* many Fellows may not have seen it, although it received a lot of coverage in both medical and the lay media. It can be readily accessed through the College/ Library website.

Patrick J Hughes
Victoria

Recommended reading: History out of the ether

History out of the ether: a review by John Carmody of NSW, of the publication by Stephanie J Snow: *Blessed Days of Anaesthesia: How anaesthetics changed the world*. Nature /Vol 456/6 November 2008, p38

Note: John Carmody is a medical scientist at the University of Sydney, Australia.

Patricia Mackay
Victoria

PICC lines re-visited

Yet another warning from the Therapeutic Goods Administration (TGA) has been issued regarding PICC lines following an incident involving a five-year-old child in Queensland. This brings the total number of TGA warnings regarding these devices and the risks of embolisation of cut wires to four since November 2002.

Fellows were reminded of the risks associated with trimming PICC lines in a 2007 ANZCA Bulletin¹ (also, see ANZCA website, Quality and Safety, Articles and Publications, Archive, *Unravelling and Embolisation of Guide-wires with PICC Lines – March 2007*) and we will be interested in the outcome of the TGA's current investigation and definitive action into a further seven reports of similar adverse events.

These devices are potentially very dangerous and the guide wires should NOT be cut.

Philip Ragg
Victoria

Reference

1. ANZCA Bulletin, March 2007, Volume 16, Issue # 1, page 27, Ragg, P

Desflurane Hepatotoxicity

There has been a recent case report of a patient suffering drug-induced liver injury (DILI) after exposure to Desflurane where other likely causes had been excluded. A literature review revealed several published reports of Desflurane drug-induced liver injury. Desflurane is metabolised in the liver to trifluoroacetylated proteins as are Halothane and Isoflurane. Sevoflurane does not have this metabolite but does have other metabolites such as Compound A that have been shown to be potentially toxic. Anderson et al¹ have demonstrated autoantigen-induced IgG antibodies to Desflurane in three patients who suffered DILI, 'suggesting that allergic and autoimmune mechanisms have critical roles in the development of desflurane DILI'. It is appropriate to remember that drug-induced liver injury is still a potential cause of post-operative liver failure.

Terry Loughnan
Victoria

Reference

1. Anderson JS, Rose NR, Martin JL, Eger EI, Njoku DB. Desflurane hepatitis associated with hapten and autoantigen-specific IgG4 antibodies Anesth Analg. 2007 Jun;104(6):1452-3



John Fraser: Burns research and the artificial heart

Dr John Fraser holding an artificial heart



WHILE ASSOCIATE PROFESSOR JOHN FRASER is an intensivist at the Prince Charles Hospital in Brisbane and recognised as one of the pre-eminent researchers into critical care gaining substantial international recognition for his PhD work – he has also acted alongside the likes of Dame Helen Mirren, David Tennant and Daniel Craig, the new James Bond.

Professor Fraser's internationally acclaimed PhD work on post-burn scarring (Scar Wars), together with Professor Roy Kimble (a fellow Scotsman, but sadly, John notes, a Rangers' fan), looked at the process of how a fetus heals a burn without producing a scar, but a baby heals a burn with a scar.

'The fetus and the baby obviously have the same genes but one must be switched on or switched off to effect scarring. We formed the Royal Children's Hospital Burns Research Group (RCH-BRG) and tested this by inducing a small thickness injury in a sheep fetus, placed it back in the uterus under anaesthesia and it recovered with no scar. After birth, the lamb healed the same burn with a scar,' Professor Fraser said.

'Working with scientists from the University of Queensland, we found a specific protein is produced in the fetal stage. Having isolated the protein we have now patented it and the hope is that the protein can be produced in large amounts.

'If trials are successful, our hope is that it will reduce scar formation, particularly in children, where a scar is a much more severe problem, due to the rate of their constitutive growth versus slow scar growth. Less scarring will allow the child to have a more normal development, less re-operations and less time away from family and school. Roy has a fantastic team of dedicated scientists and I am certain they will continue this work until they find success.'

Professor Fraser's interest in burn research was inspired by Professor John Kinsella in Glasgow and Brisbane's own Professor Bala Venkatesh.

'I was lucky enough to be Venkatesh's trainee when I arrived in Brisbane. I was a little like the Sorcerer's apprentice – trying my best, but getting most things wrong. The work ethic and originality in the research process of both Venkatesh and John Morgan

'It is one of the great strengths of the [Critical Care Research] Group – we can have engineers, medics, surgeons, perfusionists, all working on the same device and bringing their individual skills to the table.'



was the stimulus for me taking three years out to focus on my research,' he said.

After finishing his period with the RCH-BRG, Professor Fraser returned to The Prince Charles Hospital and established the multi-disciplinary Critical Care Research Group (CCRG).

'There was really no group where trainees and novices could bring their research ideas. The Group was established to allow multi-disciplinary research to grow around the critically ill patient,' he said.

The Group has a diverse range of studies and received National Health and Medical Research Council (NHMRC) grant success last year for assessment of regional ventilation using hyperpolarized helium MRI and electrical impedance tomography (with Andreas Schibler), quantifying the effects of brain death on organ function pre- and post-transplantation, as well as assessing effects of balloon pumps on cerebral function, new methods of assessing cardiac output while developing BiVACOR – a totally implantable artificial heart.

'Dr Daniel Timms developed the concept for the biventricular assist during his PhD and came across to the CCRG to continue development and run the animal studies. It is one of the great strengths of the Group – we can have engineers, medics, surgeons, perfusionists all working on the same device and bringing their individual skills to the table,' Professor Fraser said.

'Daniel and the team have now established multiple international collaborations to progress its development in Asia and Europe, culminating in the interest for active collaboration from a leading cardiovascular centre in Germany, the Heart and Diabetes Centre in Bad Oeynhausen.

'In Brisbane, we built a mock circulation loop funded by an ANZCA simulation grant. We use this for teaching but also have been able to run the pump on the loop which allows us to optimise the electromagnetic impeller and flow from both left and right ventricle. We have completed nine acute live studies and the results were very encouraging. We are now looking to find funding for the chronic studies, which will be very expensive, but essential before human studies', he said.

'It is a key area of research to both

anaesthetists and intensivists, as heart disease is the developed world's biggest killer and the shortage of donor hearts has accelerated the development of mechanical alternatives.

'Currently there are a number of devices designed to help the right or left side of the heart, but there's no implantable latest generation biventricular device. There are a couple of big and bulky pneumatic devices, including a French one announced last week, but they are unlikely to be a solution for the majority of patients. It is unlikely that the number of donor hearts will ever meet the demand of the burgeoning epidemic of heart failure, so artificial hearts need to become more advanced, as I think we will see more of them implanted as time goes on.

'The BiVACOR has two chambers and the blood is pumped by the spinning action of a centrally located impeller. The impeller is hydro dynamically suspended and rotated at 2000 RPM controlled by a bank of electromagnets with no touching parts. Eventually, the power source will be located internally, diminishing the risk of line infection.'

The majority of the Critical Care Research Group's work is done out of hours and Professor Fraser juggles this with his full time clinical work and family life.

He grew up in Glasgow and acted with the Scottish and National Youth Theatre while he was also studying medicine full time. The highlight of his acting career was when he was part of the first British acting group to be invited to Russia in 1989 to perform the previously banned T S Eliot's 'Murder in the Cathedral' at the Moscow Arts Theatre, where Stanislavsky and Chekhov have worked together.

Professor Fraser acted in films with Helen Mirren, and alongside Dan Craig (the new James Bond) for several years in London's West End as well as at the Edinburgh Festival and beyond.

'My son asks if I hadn't decided to do research work with sheep, would I, in fact, have been elected the new James Bond. I answered that there had never been a squat talkative Glaswegian in the role, so probably!,' he said.

Professor Fraser was heavily involved in music and led a ten-piece rock band as a



John Coggan – a Queensland farmer who is lucky to be alive

About four years ago, John Coggan was short of breath after chasing some cattle and he ended up in hospital for months before being diagnosed with a rare heart condition. He had surgery many times before he received a transplant heart.

John Coggan says Professor Fraser saved his life. John spent months at the Prince Charles Hospital in Brisbane and had two artificial heart pumps fitted. His wife was frequently told he was about to die. His chest was opened more than a dozen times and eventually the doctors had to leave it open, as he received more than 600 units of blood and products.

John was overwhelmed the day he was told a donor heart was available.

Professor Fraser is anxious to point out that a successful transplant is due to many doctors, surgeons, nurses and scientists – all working together.

The Coggans were keen to help raise much-needed funds for the Critical Care Research Group at the Prince Charles Hospital. This year they tackled the Guinness World Record for wheat planting and planted more than 500 hectares in 24 hours to beat the record. Professor Fraser was very grateful for the money raised (more than \$75,000).

John Fraser: Burns research and the artificial heart

Continued

registrar, which has resulted in a traditional spot of impromptu karaoke at the annual ANZICS meeting.

After finishing his PhD, Professor Fraser returned to Prince Charles Hospital to work alongside his mentor, Professor John McCarthy.

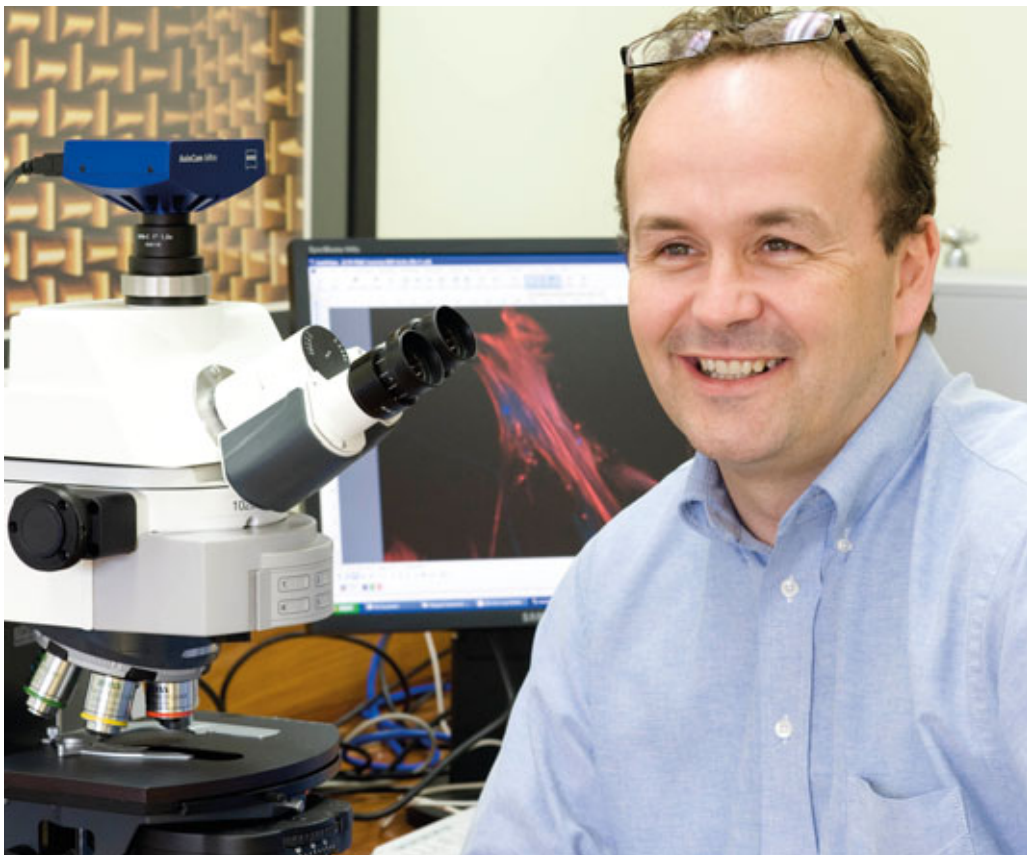
'John was a truly inspirational leader and the epitome of a Renaissance Man. He excelled as an artist, sportsman and anything he took an interest in. He was a bit of a rebel, and reminded me that the important thing was to do what was right by the patient, regardless how tired one was, or what the vogue was at that time. He understood people and taught us to do the same. John was also brave and skilled enough to ask patients (near death) about what they wanted at that stage,' Professor Fraser said.

'Sadly, John died a couple of weeks ago, but I think cardiac surgery basically stopped in Brisbane that day, as most of the intensivists, cardiac anaesthetists and cardiac surgeons were all in Gympie reminiscing on his brilliance and humanity.'

Associate Professor Fraser graduated as a Fellow of the Joint Faculty of Intensive Care Medicine (JFICM) in 2001 after receiving fellowships from the Royal College of Anaesthetists, its Irish equivalent, and one from the Royal College of Physicians in the UK prior to this. His enjoyment of intensive care is due to the integration of acute physiology and requirement of working together with many teams to achieve the best outcomes.

'In a way, it's what I enjoy about research. The great researchers I have worked with – Venkatesh, Morgan, Kimble, etc – have always been passionate about their work, despite all the hassles attracting funding and unpaid extra work,' he said.

'Unfortunately, the Australian government spends more money on sport than investing money in research. There are many people who are doing great things in Brisbane and all across the country, but there's no funding available. There's always a risk of losing the team and the research we've been working on due to a lack of funding.'



When asked why he does research, he thinks for some time before answering.

'I think it is the hope that we can solve the unknown – so much of our time is spent not knowing exactly the right thing to do with critically ill patients. That's what drives me, and am sure it's what has driven the great people I have learned under – the hope that we can make a difference for one person, then maybe a hundred, then maybe a thousand.'

'My son asks if I hadn't decide to do research work with sheep, would I, in fact, have been elected the new James Bond. I answered that there had never been a squat talkative Glaswegian in the role, so probably!'

Trainee forum – pain management

As part of anaesthesia training, trainees are required to have experience in pain management. Yet how effective and accessible is pain training? Are trainees receiving sufficient exposure to pain clinics and centres? Three trainees from Queensland, Western Australia and Victoria recently discussed issues ranging from rotation and the level of supervision to the challenges of working in a pain clinic.

Dr Emile Kurukchi has recently completed his training at hospitals in Townsville and Cairns in north Queensland and is currently based at Cairns Base Hospital.

Dr Rebecca Martin is an ATY2 in the Western Australian training rotation and is currently working at Sir Charles Gairdner Hospital in Perth.

Dr David Ip has spent rotations in many Melbourne hospitals and is currently at The Austin Hospital.

Were there any difficulties getting access to pain experience as part of your training and were there any issues regarding completing the objectives of module 10?

Emile Kurukchi (Queensland): For acute pain services there was ample opportunity to get good experience and I found it very valuable. At times when registrars or consultants were on leave, we were left to do the pain round by ourselves. Although we were comfortable with this, I think it takes away some of the teaching opportunities that are available. From a chronic pain point of view, getting experience was a little bit hard. My training was in Townsville, which is a small regional centre. We had one specialist who did chronic pain and he happened to be the department director, so he would often be away at meetings or at committees. We only had a one-day-a-week chronic pain clinic, so sometimes you went a while without doing it. But we often had a visiting specialist for three days and that was good. Rather than three months of solely chronic pain, it was one day a week for six months and sometimes you were in clinic by yourself and not entirely sure what to do.

Rebecca Martin (Western Australia): I agree with Emile that with acute pain there's ample opportunity to get exposure from day one. In most hospitals I've worked in, it's a fairly top heavy acute pain service, in that you almost always have a dedicated pain nurse and a consultant-led round during the week which is great for teaching. In a way we're spoilt with our level of consultant input through our training. After hours we're then expected to deal with a lot of problems by ourselves, which we do, although everyone is comfortable with ringing people if there are any major

problems. I got to do a term of two days a week of chronic pain and the rest of the week in theatre. At Sir Charles Gairdner, there is a large chronic pain service with a multi-disciplinary clinic that takes one anaesthetic registrar full-time for three months. Recently they've introduced two 2-day-a-week rotations, so someone does Monday and Tuesday and someone else does Wednesday and Thursday. I did two days a week, which I found really good because as long as the clinic's busy enough, you can actually get enough exposure just doing a couple of days.

David Ip (Victoria): I agree with Rebecca and Emile. During the last four years, I've worked at six different hospitals and they all have different structures in terms of how the pain service was run and organised. I think the access to experience really depends on the resource level at the hospital and whether there was an anaesthetist at the hospital who had an interest in chronic pain. I'm at the Austin at the moment and they have a well-run acute pain service and small chronic pain clinic. Registrars in their fourth year undergo a 10-week rotation through it. They get the exposure to chronic pain inpatients and outpatients and related pain procedures. So the ability to complete the module was pretty easy.

What are the pros and cons of different types of rotation to pain clinics?

DI: I think after almost three months of being a full-time pain registrar, going back to anaesthesia was a little bit different. It was interesting, as I'd almost forgotten how to give an anaesthetic for a sick patient or a complex case.

RM: Some people feel it's good for their development as an anaesthetist to have experienced chronic pain but their real interest is giving anaesthesia so it appeals to them to do a part-week program. They may not get the fuller version and they might miss out on some of the continuity and experience issues but, logistically, it's a way to get twice as many trainees through these clinics rather than giving just a few people full-time exposure.

EK: I think the way Rebecca has gone through her chronic pain training is

probably more desirable than one day a week. I felt that with one day a week, it takes you the morning to get into it and, by the end of the day, it's another week until you do it again, while two days a week gives you a bigger chunk without being out of theatres. The point of getting more trainees through is very important.

How did you feel about the type and amount of supervision you received?

RM: It's difficult, because most acute pain is fairly routine and it's only occasionally that you get something very difficult when you actually do need the consultant's support. I found you get consultant level supervision a lot of the time when you probably don't need it and maybe we could be encouraged to take on more. I've been at some places where you're desperately still trying to see all those pain patients you've been asked to see as the afternoon progresses and you're still trying to run theatre or manage labour ward. You sometimes feel the pain patients are not really getting enough attention. It depends on the priority given to pain in each department and that varies between hospitals.

DI: It very much depends on the makeup of the department and whether they have an interest in pain or not. In some departments, there is nobody that has an interest in pain. The only constant is that there is a pain nurse. Often the pain nurse is the back bone of the service.

EK: Certainly in both the regional hospitals in north Queensland, Cairns and Townsville, we've had a well-formed acute pain service that has an acute nurse. I think while a consultant-led round is very important, sometimes the only way you really learn how to deal with things is when you're forced to think about things and manage them yourself, otherwise it's far too easy just to agree with the suggestions of someone who's more experienced. But as opposed to chronic pain, I feel that acute pain is a vital extension to the anaesthetics we give in theatre, because it's really important that the patient gets to recover pain free.

RM: There's a sub-specialisation happening across the whole of medicine

though. This is a problem not just with pain because if we consult for virtually everything then all doctors are becoming more sub-specialised and not being willing to even try and manage something outside of their own speciality. Basic pain management should be core knowledge for all doctors and just charting straightforward things like paracetamol should not be something that needs an acute pain service. All doctors should be able to manage basic pain.

What are some of the challenges of looking after patients with chronic pain and how experience in a pain clinic may have helped?

EK: I was terrible at managing patients' analgesia, both intra-operatively and post-operatively if they were a chronic pain patient before I had done the chronic pain clinic. Often many chronic pain patients have had operations in the past and will tell you what worked and how it was given. Some patients are challenging and they expect things to be difficult but I think they're reassured by the idea that you understand that it's going to be difficult and reassure them that you're going to work towards keeping things as controlled as possible.

RM: Chronic pain patients are extremely difficult because often, through no fault of their own, they have a condition which the medical profession can't fix. That's when the chronic pain experience comes in because there are always options, even if it's just changing or retrying things.

DI: I think the experience has been actually vital. It's where you learn that a change of focus is needed for managing chronic pain patients. It's not trying to cure or greatly reduce pain, it's trying to learn to live with it, to develop coping strategies and to continue to function despite it.

What types of patients are you treating and how successful are the treatments and what advances have been made in relation to chronic pain?

EK: Chronic pain patients are customised to dealing with health professionals so it can be a real challenge taking control of the patient as a junior. Often they have a lot more experience in dealing and bargaining



Dr David Ip



Dr Rebecca Martin



Dr Emile Kurukchi

with whoever is taking care of them. At times, I found it intimidating. I suppose the other difference is that, in acute pain services, simple interventions often make a big difference quickly, whereas chronic pain patient interventions often have subtle results which take time to become evident. The goals are different as well; in acute pain, the goal is controlling or eliminating pain, while in chronic pain that's often not possible and the goal is more about improving quality of life for function.

RM: Pain medicine is an exciting area to be in because the level of evidence required for some of the treatments that we institute in these patients is often not there, compared to what might be expected in another branch of medicine. So sometimes we're almost doing experimental things and patients are willing to accept new things that you suggest. I think also we play a great role in rationalising the care of these

patients. Sometimes they're seeing many different doctors trying to fix the problem. They might be seeing a rheumatologist and a neurosurgeon, as well as an orthoped and they also see their GP regularly but nobody is coordinating. Sometimes it can be of great benefit just to see them regularly and rationalise their care.

DI: Playing the role of a general practitioner in coordinating specialist care is a very time-consuming role, not best handled by a pain specialist from a resource point of view. I think the major referral centre in Victoria has a waiting list up to 12 months for patients. It also tends to be always under-funded. The relatively small pain clinic at the Austin is very tight on resources and therefore selective in terms of its patient referral base. Unfortunately it has to knock back some referrals. There is a great shortage in Victoria of chronic pain resources. I'm not sure if that is similar

Trainee forum – pain management

Continued

across Australia. It's a very sub-specialised area and it's not an area that a lot of people are getting into.

RM: I agree. We have, at least at the moment, a waiting list of 12 to 18 months to get a new patient referral to the clinic. Part of the problem is that it does take a long time to sort the patient out. The appointment times are prolonged. As far as resource allocation goes, I think that if they put more money into people like us or the chronic pain doctors, more money would be saved over the long-term. I have seen a few patients that are seeing a lot of different services they clearly don't need.

How has exposure to pain clinic work influenced your future career choices?

RM: In my training, I always had a vague interest in doing the pain fellowship. I'm glad that I got a chance to do some clinic time and some procedural time. I'm still thinking that it's a likely possibility in my future to do the fellowship. I know people who have come back after years of consultant practice to do a fellow year and do the exam and then gone on to be a pain specialist.

DI: As with all sorts of areas of medicine, often we're influenced by mentors or people who we see are doing a fantastic job and who are inspirational. I think that often plays a large part in what areas of medicine we specialise in or get interested in. So it's not necessarily the exposure to pain clinics but rather the teaching and consultants we work with that may influence career choices.

EK: Rotations are definitely an important way of getting people exposed to sub-specialities. I don't think anyone would ever consider doing a fellowship without getting some experience in it. However, if I was interested in training as a pain specialist, I would have to move to Brisbane and certainly for someone with a family, I don't see that being part of my future at this stage.

How have you found the overall training and do you have any suggestions for improvement?

EK: The training experience is different to every trainee because they have different expectations and requirements. I had worked as a general practitioner for four years before starting anaesthesia, so starting pain clinics and working with other health professionals was part of my background. From a professional point of view, I feel I got what I needed from both my

acute and chronic pain training. I certainly enjoyed doing the acute pain round. While I don't see myself doing chronic pain in the future, I have certainly gained very good experience to help me in my day-to-day work as an anaesthetist. I've also conducted my training outside of major metropolitan centres.

DI: I think in terms of my overall training, I think I've been exposed to a breadth of both acute and pain problems. I think some trainees go through ANZCA training without actually having been exposed to a chronic pain centre or even sort of exposed to procedures associated with chronic pain. If it was mandatory then it would make it a lot harder for a few to achieve the module but it may be able to familiarise more trainees to the area.

RM: I think introducing the module system definitely changed exposure to chronic pain in training. I think it was pretty easy to get through your ANZCA training prior to the official pain module without much exposure to chronic pain. I think it's good to try and get some exposure to both evolving and new developments in acute pain and chronic pain. We're trying to be well-rounded anaesthetists and I think a well-rounded anaesthetist has had exposure to both. Overall, I feel my training has been pretty good in giving me an understanding of both acute and chronic pain.

Update on training for sedation in gastrointestinal endoscopic procedures

Recently, the Australian and New Zealand College of Anaesthetists (ANZCA), the Gastroenterological Society of Australia (GESA) and the Royal Australasian College of Surgeons (RACS) jointly issued an updated policy on sedation (ANZCA Professional Document PS 9 *Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical or Surgical Procedures*). In the ideal world, all procedural sedation would be administered by anaesthetists. However, given our current workforce situation, medical practitioners who are non-anaesthetists administer a significant proportion of procedural sedation in public hospitals.

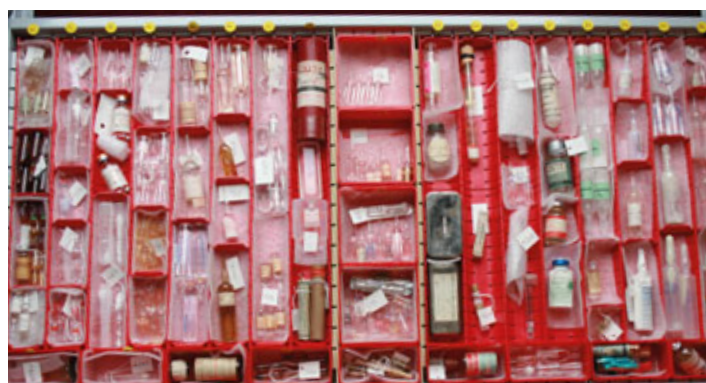
The revised Guidelines outline the training and credentialing that should occur before non-anaesthetists administer sedation. In the first instance, the tripartite group agreed that a course should be established which addresses the issue of credentialing experienced medical practitioners (i.e. those who have had at least three years of practice in administering procedural sedation) who wish to be credentialed. This course can then be modified for medical practitioners with little or no experience in administering sedation.

A small committee has been established with representatives from all three organisations. This committee is in the very early stages of developing a course for such a credentialing process. It is envisaged that the course will include problem-based examples to establish the background theoretical approach for sedation administration, a series of simulation examples to establish practical and team aspects for the management of procedural sedation, a visit to an approved clinic where sedation is administered to observe other practitioners, and finally an assessment of the medical practitioner's own sedation practice in his/her normal clinical environment.

Any suggestions or comments towards this process would be welcomed by the committee, and should be sent to Professor Barry Baker bbaker@usyd.edu.au who is chairing this small committee on behalf of the parent organisations.

Geoffrey Kaye Museum – completion of hazards project

Below, clockwise from top left:
Full bottles of anaesthetic agents;
Decanted bottles in lockable
drawer, 2008; Ampoules; Sharps.



The Museum is pleased to announce that issues relating to ANZCA's holdings of dangerous goods and hazardous substances in the Geoffrey Kaye Museum of Anaesthetic History collection have been resolved. This important area of the College is now compliant with occupational health & safety legislation and museum best practice standards.

The logistics, processes and safety concerns associated with this project were a first not only for ANZCA but for most museum and heritage areas holding such substances. The uniqueness of the project sparked an interest in College staff, volunteers and consultants who were invited to assist in the operations.

Work commenced in May this year when consultants advised the College on how best to approach this unique project. Over three weeks in June, Drs Westhorpe and Ball assisted in this chapter of the greater cataloguing project by identifying the dangerous [flammable and explosive anaesthetic agents] and hazardous [drugs and sharps] objects determining whether

the objects met the Museum Collection Policy requirements. Based on these decisions, objects were disposed, donated or re-packed and stored appropriately for the long-term.

Anaesthetic agents stored in bottles were decanted and their vessels kept as historical markers of anaesthetic development. The decanting and disposal of de-accessioned objects were carried out by approved contractors in compliance with OH&S legislation.

The hazardous objects [drugs and sharps/needles] were also sorted and culled, photographed and re-packed for long-term storage. All procedures throughout the movement, identification, sorting, re-packing and storing stages were carried out following strict OH&S and Museum guidelines. Processes and decisions were documented and information updated in the museum management database.

This project would not have been completed so efficiently without the invaluable support and guidance provided

by Dr Rod Westhorpe, Dr Christine Ball (Honorary Curators), Carolyn Handley (Director, Corporate) and Jenny Lethbridge (HR Consultant).

The museum will now work towards completing the final chapter of the cataloguing project, related to the anaesthetic equipment, machinery and instruments. Our objective is to provide an ongoing exhibitions program that is engaging through more interactive displays, showcasing the diversity and international significance of the collection and the associated stories as captured in the recently recorded oral histories.

Completion of the cataloguing project will support more rigorous exhibition, tour, research, loan, education and promotional programs that will reflect favourably on the College as a whole by extending public awareness of anaesthesia to a greater, more diverse and inclusive audience.

Maria Drossos
Museum Collection Officer

Revolutionising anaesthesia in Mongolia

ANAESTHESIA in Mongolia is 40 to 50 years behind Australian standards and two ANZCA Fellows, on behalf of the Australian Society of Anaesthetists (ASA) and World Federation Society of Anaesthetists (WFSA), have been returning to the politically and geographically isolated country to try and close the gap.

Dr David Pescod and Dr Amanda Baric from the Northern Hospital in Melbourne, have been running annual seminars translated from English into Mongolian and visiting hospitals since Dr Pescod's first visit in 2000. Dr Baric became involved in 2006 and together they have run seminars on obstetrics, and anaesthesia and perioperative medicine. In June this year they held a seminar on pain management. They now have also incorporated problem-based learning discussions and practical workshops into their visits.

'The seminars have proved to be very popular and have grown in the last three years from around 30 to over 100 participants last year. There are currently 140 practising anaesthetists in Mongolia but only 70 practice in the capital of Ulaanbaatar because there is still a traditional nomadic culture and half of the population live in the country,' Dr Pescod said.

On Dr Pescod's first visit to Mongolia in 2000, no analgesia was being used and patients were simply being paralysed, given halothane (the anaesthetists were taught this was an analgesic) and taken into surgery. They were then taken back to the ward, often still partly paralysed, and given an antihistamine as an analgesic.

'We've managed to introduce analgesia, the concept of a recovery and we've taught them to reverse paralysis,' Dr Baric said.

There are many obstacles. Due to the language barrier (Mongolian is a very difficult language to learn), it is very difficult to ascertain what the anaesthetists have been taught.

The only anaesthetic training the doctors received was under the Russians about 40 or 50 years ago and even this may have been considered inadequate at the time. There has been limited education since this original training. Continuing maintenance of standards for anaesthetists suffers from vast distances, the pressure of clinical



work and a virtual absence of continuing postgraduate education.

The health system in Mongolia is unique because the Russians built hospitals for every working group in every city and town. During the 1990s, there were over 400 hospitals with a total of 18,000 beds, yet there was a population of less than two million people. This socialist system, called the 'semashko' system of health care, meant that during the 1940s, hundreds of nurses were trained in weeks, doctors in months and all the anaesthetists were self-educated.

'We came to Mongolia with our own assumptions and it quickly became evident that they were doing many things which were based on teaching practices that were wrong,' Dr Baric said.

'For example, during a discussion after the obstetrics seminar, someone asked what dosage of suxamethonium to give mid-way through a spinal caesarean in an awake patient to relax the uterus. We didn't know that we needed to teach them not to paralyse awake patients because it's something that we just wouldn't do. Another example is the use of intra-arterial

antibiotics in severe infections, Dr Pescod said.

'Not speaking Mongolian and not having extensive time in the country means it's hard to pinpoint such misconceptions,' Dr Baric said.

Two or three years ago, a Mongolian anaesthetist took Dr Pescod aside and apologised to him.

'He said that for the first several years the anaesthetists hadn't practised anything we'd taught them. Finally, during that year, they started to put what they'd learnt into practice and saw a reduction in the death rate,' Dr Pescod said.

'From that point we developed a level of trust and this has been the most satisfying part of our work. After 40 years of their own training, they had to adjust to us coming in and saying gently that they shouldn't do things a certain way. It's very difficult to un-teach practices but they've realised anaesthetic mortality has improved.'

Mongolian anaesthetists earn \$100 (US) a month and rent is \$40 (US) a month. Anaesthetic training in Mongolia is quite short and based on an apprentice-style



Images this page, clockwise from top right: A spinal operation at the obstetric hospital in Mongolia; Dr L Ganbold, president of the Mongolian Society of Anaesthetists, and Dr Pescod sign a memorandum of understanding; a Mongolian drover in the countryside; Mongolian children participating in abareback horse race.



traineeship, ranging from six to 18 months. Just last year, it was reduced back to six months due to a shortage of anaesthetists.

'In six months, anaesthetic trainees would probably do only 20 general anaesthetics and that's their only experience on top of a five-year medical degree. They then go on to work in the isolated country with minimal resources and also become the next educators for the new group of anaesthetists who then learn even less,' Dr Baric said.

Since 2000, Dr Baric and Dr Pescod have developed and adapted their teaching techniques using the limited resources available.

'We are now focusing on setting up and rebuilding the Mongolian anaesthetic training program from scratch to help sort out the various problems. In return, the Mongolian Government has now committed to leaving anaesthetic training at 18 months,' Dr Pescod said.

'We are going to base the new training program on the successful Fiji School of Medicine anaesthetic training developed in the late 1990s by Australian anaesthetists

from the Overseas Development and Education Committee of the ASA.'

The new training program, which is supported by the ASA and Interplast, will be modular based, using an anaesthetic textbook, website (www.developinganaesthesia.org) and CD based resources written by Dr Pescod. A resource centre with computers, desks, a printer and a wage for an educator will also be provided. It is hoped the new program will commence in October 2009.

'We want the Mongolians to eventually own the training program. We are setting it up so they can continue it without relying on external help. However, we have made a commitment to continue to provide post-graduate training seminars,' Dr Baric said.

'We've been very fortunate that some of the younger Mongolian anaesthetists attended the World Federation Society of Anaesthetists' one-year training program in Thailand. With this extra training, they will become the educators of our training program. We now have a core group of enthusiastic and English-speaking anaesthetists to drive the program.'

'A senior anaesthetist has also been appointed as an advisor to the Minister of Health in Mongolia which will be useful. There are six people from the Department of Anaesthesia at the Northern Hospital who help us write modules, seminars and donate equipment and time,' Dr Pescod said.

Various drug companies have been generous and, in addition to the ASA, Dr Baric and Dr Pescod have started to receive a limited amount of sponsorship and small donations for the training program. They believe a lot can be achieved with minimal financial outlay.

'The Maternal and Paediatric Research Centre in Mongolia does 4,000 deliveries a year and has a 30 per cent rate of severe pre-eclampsia but there was no blood pressure monitor, no ECG and no saturation monitor, so we donated a cardiocap monitor and oximeters,' Dr Pescod said.

'Maternal Hospital number Three in Mongolia performs 2,000 deliveries a year and 400 caesareans using one spinal needle, one laryngoscope and one tube. We donated some of each.'

Dr Baric and Dr Pescod's Mongolian seminars will be run annually for the foreseeable future and they are looking for volunteers to assist them. Next year's seminar will take place in June and focuses on airway management. An obstetric clinical teaching week will run concurrently with the seminar.

To assist with the Mongolian training program, to make a donation or for further information, please contact Dr Pescod at David.Pescod@nh.org.au or Dr Baric at Amanda.Baric@nh.org.au

Dr Pescod is also involved with Interplast Australia – a not for profit organisation that takes tax deductible donations on behalf of the Mongolian project.

Library update

Get on top of it!

Make your New Year's Resolution to get the most out of your ANZCA membership and check out the Library website.



The ANZCA Library offers:

- Online journals specialising in anaesthesia, pain management and intensive care medicine
- Medical databases which link to full text articles when available
- Catalogue of books available to all Australian-based ANZCA members
- Tips for keeping up-to-date including an RSS feed of new resources in the library
- Research tools
- Patient information
- Article requests
- Assistance with any information needs, whether it be literature searching, creating guidelines, understanding evidence based medicine, or using reference managers.

All active ANZCA members can access the Library's online resources using their College ID number and a password generated from the website.

We are always looking at ways of improving our services and resources. Simply call or email the library staff with your queries and suggestions on +61 3 8517 5305.

ANZCA special book collections

After a long process, the ANZCA library has collected and catalogued three large collections of historical books. With an increased interest from the membership in anaesthesia history, library users can now easily search the ANZCA Library catalogue for particular items or browse the following collections:

The Gwen Wilson Collection holds about 70 items donated to ANZCA by Dr Gwen Wilson on a unique range of topics, reflecting Dr Wilson's interests and research.

The Geoffrey Kaye Collection contains over 100 items, some published over 100 years ago, which were part of Dr Geoffrey Kaye's private collection.

A General Historical Collection collates over 270 older publications from a wide variety of sources, including many early editions of core anaesthesia texts.

New tool

E-learning Anaesthetic Machines Module / MHRA

The safe and effective delivery of general anaesthesia has become an essential part of modern health care. The anaesthetic machines used vary from one manufacturer to another and yet incorporate many common generic features. This educational package looks briefly at the history of the anaesthetic machine and then covers the basic principles involved in the safe use of anaesthetic machines. It has been designed to complement the training already provided by other professional bodies and the manufacturers.

Available online at: www.mhra.gov.uk/ConferencesLearningCentre/LearningCentre/Anaestheticmachines/index.htm

Notice to New Zealand Fellows and trainees

A core collection of anaesthetic textbooks is available for loan from the New Zealand office of the College. Please check the library catalogue via the ANZCA Library website.

Contact details for the New Zealand office are as follows:

New Zealand National Committee (ANZCA)
PO Box 7451
Wellington South
New Zealand
Phone +64 4 385 8556
Fax +64 4 385 3950
Email anzca@anzca.org.nz

New titles

1. **Airway management in emergencies** / Kovacs, G; Law, J Adam. – New York: McGraw-Hill, 2008
2. **Atlas of common pain syndromes** / Waldman, Steven D. – 2nd ed – Philadelphia, Pennsylvania: Saunders Elsevier, 2008. (Book; CD-ROM)
3. **Manual of simulation in healthcare** – New York: Oxford University Press, 2008.
4. **Obstetric anaesthesia** / Clyburn, Paul [ed]; Collis, Rachel [ed]; Harries, Sarah [ed]; Davies, Stuart [ed]. – New York: Oxford University Press, 2008
5. **Peripheral nerve blocks: a color atlas** / Chelly, Jacques E [ed]. – 3rd ed – Philadelphia ; Sydney: Lippincott Williams and Wilkins, 2009. (Book) 617,964 PER
6. **Physics, pharmacology and physiology for anaesthetists: Key concepts for the FRCA** / Cross, Matthew; Plunkett, Emma. – Cambridge: Cambridge University Press, 2008. (Book) 617,96076 CRO
7. **A Practical Approach to Obstetric Anaesthesia** / Bucklin, Brenda A [ed]; Gambling, David R [ed]; Wlody, David J [ed]. – Philadelphia, PA: Lippincott Williams & Wilkins, 2009. (Book) 617,9682 PRA

International news and resources

8. Requirements for transfusion

laboratory practice: First edition 2008 / National Pathology Accreditation Advisory Council; NPAAC. – 1st ed – Canberra: Australian Government Department of Health and Ageing, 2008. (Book; Guideline) 615.650028 REQ

Most popular books for 2008

1. Yao and Artusio's anesthesiology : problem-oriented patient management (2008).
2. The clinical anaesthesia viva book (2002).
3. Anaesthetic equipment.
4. Clinical teaching: a guide to teaching practical anaesthesia (2003).
5. Cardiopulmonary bypass: principles and practice (2008).
6. Crisis management in anaesthesiology (1994).
7. Management of the difficult and failed airway (2008).
8. Nunn's applied respiratory physiology (2005).
9. Principles of physiology for the anaesthetist (2008).
10. Benumof's airway management: principles and practice (2007).
11. Pharmacology for anaesthesia and intensive care (2003).

Contact the library

Web www.anzca.edu.au/resources/library

Phone +61 3 8517 5305

Fax +61 3 8517 5381

Email library@anzca.edu.au

The 'Discovery' of Ether Anesthesia and Its 'Re-Discovery' by Hollywood / JAMA. 2008; 300(18):2188-2190.

By Howard Markel, MD, PhD

View introduction at: jama.ama-assn.org/cgi/content/extract/300/18/2188?ct

A code of practice for the diagnosis and confirmation of death / Academy of Medical Royal Colleges

Guidelines for doctors and health professionals on this sensitive topic of diagnosing and confirming death.

Available online at: www.aomrc.org.uk/aomrc/admin/reports/docs/DofD-final.pdf

Infection control in anaesthesia / Association of Anaesthetists of Great Britain and Ireland

Updated guideline – 11 November 2008

www.library.nhs.uk/theatres/ViewResource.aspx?resID=121926&tabID=288

Spinal cord stimulation for chronic pain of neuropathic or ischaemic origin / NICE Guidance

This technology appraisal includes practice guidelines, a patient-oriented leaflet, and background information.

Summary: Spinal cord stimulation is recommended as a possible treatment for adults with chronic pain of neuropathic origin if they:

- continue to experience chronic pain (measuring at least 50 mm on a 0–100 mm visual analogue scale) for at least 6 months despite standard treatments, and
- have had a successful trial of spinal cord stimulation as part of an assessment by a specialist team

Available online at: www.nice.org.uk/guidance/index.jsp?action=byID&o=12082

New Report on Lessons from AHRQ-Funded Bar-Coded Medication Administration Projects

The AHRQ National Resource Center has released a new report in its health IT decision maker brief series with an interesting proposal on bar-coding medication for safety in their administration.

Available online at: healthit.ahrq.gov/images/augo8bcmadmbrief/bar_coded.html

Preoperative evaluation / Institute for Clinical Systems Improvement

Major recommendations of this guideline cover:

1. Decision to Perform Elective Procedure
2. High-Risk Procedure?
3. Preoperative Basic Health Assessment
4. Abnormal Findings Pertinent to Preoperative Evaluation?
5. Further Evaluation Performed and Evaluated for Surgical/Anesthesia Risk
6. High-Risk Patient?
7. Management of Stable Comorbidities
8. Communicate Results and Instructions to Facility and Patient
9. Immediate Pre-Procedure Assessment

Available online at: www.guideline.gov/summary/summary.aspx?view_id=1&doc_id=12973

Prevention of hypotension during regional anaesthesia for caesarean section – Effective use of vasopressors

Editorial by Dr Girish Sadhu, Topic Advisor for the Specialist Library for Surgery, Theatres and Anaesthesia

Available online at: www.library.nhs.uk/Theatres/ViewResource.aspx?resID=288767

Independent Practice / Association of Anaesthetists of Great Britain and Ireland

Guidance for health professionals involved in private practice in the UK

Available online at: www.aagbi.org/publications/guidelines/docs/independent_practice_o8.pdf

Bridion (sugammadex)

A new drug for reversing muscle relaxation after a general anaesthetic has been released in Europe. The US FDA have not approved it due to rare allergic reactions.

Description available online: www.bridion.com/HCP/

International news and resources

Continued

Antithrombin III in critically ill patients: systematic review with meta-analysis and trial sequential analysis. / *BMJ* 2007; 335: 1248-51

By Afshari, A., et al – Winner of the European Society of Anaesthesiology Draeger Prize for Intensive Care Medicine 2008.

Conclusion: Antithrombin III cannot be recommended for critically ill patients based on the available evidence.

Available online at: www.bmj.com/cgi/content/full/bmj.39398.682500.25v1

Surgical News, Vol. 9, No. 8, Sept 2008 / The Royal Australasian College of Surgeons

Includes articles on:

- The ANZ Journal of Surgery
- Bullying: a workplace ailment
- Leaping into the CHASM: Collaborating Hospitals Audit of Surgical Mortality

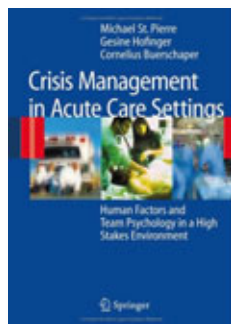
Available online at: www.surgeons.org/Content/NavigationMenu/CollegeResources/Publications/SurgicalNews/volognoo8.pdf

Guideline for the use of general anaesthesia (GA) in paediatric dentistry / Royal College of Surgeons of England – Faculty of Dental Surgery

It is important to ensure that children and adolescents receive safe and effective pain control during dental procedures. These guidelines address the appropriate use of general anaesthesia (GA) in paediatric dentistry and emphasise the importance of comprehensive treatment planning to ensure a satisfactory standard of oral health after a dental GA.

Available online at: www.rcseng.ac.uk/fds/clinical_guidelines/documents/Guideline%20for%20the%20use%20of%20GA%20in%20Paediatric%20Dentistry%20May%202008%20Final.pdf

Book review



Crisis management in acute care settings: Human factors and team psychology in a high stakes environment.

Michael St Pierre, Gesine Hofinger, Cornelius Buerschaper
Springer 2008

ISBN: 978-3-540-71061-5

Providing safe patient care in emergency medicine has always been one of the greatest challenges of healthcare. Anaesthetists are regularly faced with clinical problems that may be sudden, unexpected and life-threatening, and that demand thoughtful as well as swift decisions. Time pressure, diagnostic uncertainty, stress, high stakes, team-work and organisational structure issues can all contribute to a difficult crisis-management environment.

This excellent book addresses these concerns. It does not discuss the medical aspects of crises. It focuses on people and how they work in an emergency setting. It applies theories of human error, decision-making, and behaviour to the wide range of skills and actions that are essential to good crisis management.

This is not a book for the faint-hearted. Although it could be used as an introductory text, the reader with some background understanding and appreciation of the issues will gain more from it than a novice. This is the book to turn to when one has read the usual non-technical skills and error management literature and wonders ‘what next?’

The book is divided into four main sections: Basic principles of error, complexity and human behaviour, Individual factors, The team, and

The organisation. Each section contains several chapters, which follow the same format. Each chapter begins with a clinical case study from an acute care specialty (anaesthesia, ICU, and emergency medicine are the main foci) which illustrates the main discussion point. The topic is then explored in detail, with an appropriate amount of theory and reference. Great care has been taken to make this as clinically relevant as possible throughout. Each chapter finishes with a summary of the important points, and in two of the sections they also contain ‘tips for daily practice’ – a list of helpful clinical suggestions. Not all of these will apply to every reader, but I have found the majority to be relevant for both my own clinical work as well as for teaching purposes.

The authors are German – one anaesthetist and two presumed psychologists, although their backgrounds are not explicitly described. There are some awkward moments of translation but these do not interfere with either the flow or the context of the text. The modular nature of the book means that each chapter is complete in itself. The book can be read from one chapter to the next, or as individual chapters selected to meet a particular need. Basic concepts are explained once in detail and then cross-referenced. The highlights for me were the case scenarios at the beginning and the summaries at the end of each chapter.

This is not a book for everyone. It will be highly treasured by those seeking an in-depth analysis of ‘human factors’ and how they relate to our particular specialty. It deserves a place in every general medical library, and in enlightened anaesthetic departments. One can only assume that there must be a plethora of similar books for other high stakes environments such as aviation – a volume that is specific for our own particular high stakes situation is a very welcome addition.

Dr Natalie Smith is a staff specialist at Wollongong Hospital, New South Wales



Clockwise from top left: Dr Mary Lawson, Dr Simon Morphet, Dr Lia Freestone, Dr Stephen Swallow, Dr Michael Lorimer and Dr Jenny Lain.



Tasmania

The Combined ANZCA/ASA Scientific Meeting will now be held from Friday 20 – Sunday 22 February 2009 at the Hobart Function and Conference Centre, Elizabeth St Pier, Hobart. The title of the meeting is ‘What’s up Doc?: Anaesthetic implications of new techniques and procedures’.

A registrar’s workshop will be held on the Friday afternoon, followed by welcome drinks at Hadleys Hotel. A clinical teaching workshop will also be held concurrently on the Sunday morning. Talks scheduled during the meeting include bariatric surgery, cardiology update, endovascular surgery updates and gastrointestinal developments. Dinner on the Saturday evening will be at Mure’s Upper Deck on the waterfront.

For further information, please contact the Tasmanian Office on +61 3 6223 8848

Report on Clinical Teaching Workshop Royal Hobart Hospital 11 November 08

A Clinical Teaching Workshop with Dr Mary Lawson was held in the Anaesthetic Department at the Royal Hobart Hospital on 11 November 2008. The half-day workshop addressed the challenge of assisting trainees with difficulty. It was attended by a large core of the anaesthetic teaching staff including Supervisors of Training, module supervisors and interested clinical teachers.

The workshop included a presentation

from Dr Lawson outlining some of the many tools, resources and processes available in the field. This was followed by a robust interactive session which gave participants the opportunity to discuss trainees in their experience and ways to better help them. In particular, there was a focus on recognising a trainee with a problem and delineating the various causative and contributing elements before considering strategies to help.

This was the first practical workshop addressing teaching issues in Tasmania for some time. It was enthusiastically received by all who attended and felt they benefited from the session. The balance of information provision with active participation coordinated by a capable educator made for useful and pleasant afternoon.

There was positive feedback about the event and we look forward to further workshops and targeted professional development in the future.

Finally, thank you to those involved in organising the session and to the participants for their enthusiastic contribution. In particular, thank you to Dr Mary Lawson for her time, effort and expertise. It was a very rewarding afternoon.

Dr Lia Freestone
Supervisor of Training
Royal Hobart Hospital

Victoria

Victoria continues to run some very interesting Continuing Medical Education meetings for Fellows and trainees. Recent excellent presentations included Associate Professor David Scott, Councillor of the College and Deputy Director of Anaesthesia at St Vincent’s Hospital (‘Updates in Acute Pain Management’) and Dr Michael O’Reilly, Executive Vice-President for Medical Affairs for Masimo Corporation (‘The Radical 7 Pulse Oximeter’). This follows Associate Professor Michael Irwin from the University of Hong Kong giving a presentation on perioperative fluid management and Dr John Moloney, the Alfred Hospital (‘Blood Matters’).

Events planned for the first half of 2009 include:

February 16–20: Final full time course (ANZCA House)

February 23: Final anatomy course (ANZCA House)

February 27: Orientation in anaesthesia (ANZCA House)

July 25: ASA/ANZCA Combined CME Meeting (Sofitel, Melbourne)

September 25: Annual Anaesthetic Registrars’ Scientific Meeting

The July event will cover diabetes, obesity, anaesthesia in extreme circumstances and a number of important guideline updates. The ARSM will be held later in 2009 to enable registrars to focus on their academic endeavours prior to participating in the ARSM.

Further details on Victoria’s Regional Committee’s activities can be found on the College website www.anzca.edu.au

Regions

Continued

New South Wales

Below: ANZCA NSW staff & healthcare representatives



The NSW Anaesthesia Continuing Education Committee hosted its last seminar for 2008 on November 1–2. This year we returned to the popular Shoal Bay Resort in the Port Stephens district one hour north of Newcastle. The weather didn't disappoint our delegates and guests who were spoilt for choice with bayside leisure activities.

The theme 'Contemporary Airway Management – Practice Makes Perfect' addressed a range of current issues including equipment (videolaryngoscopes, LMAs), modern anaesthesia machines and ventilation techniques, drugs and management of airway related emergencies. Cath Downs repeated her practical session on CPD that had been well received at our August meeting.

Our new format was very popular with the delegates, consisting largely of small group concurrent sessions, providing a good choice of small group practical workshops and case based learning activities. On Saturday afternoon, Stephen Lightfoot and Greg Knoblanche entertained and enthralled us in a stimulating debate: 'We Should Not Reuse Airway Equipment' which loosened us all up for a wine tasting hosted by the Hunter Valley based winemaker Brokenwood. After a lovely BBQ dinner the previous night we had a good turnout on Sunday morning for a question



Dr Richard Semenov

and answer session moderated by Leona Wilson with our NSW college counsellors as panellists, Frank Maloney, Michelle Mulligan and Nicole Phillips. We were also fortunate to have the newly appointed President of the ASA, Liz Feeney join us for the meeting.

Queensland

ANZCA/ASA Combined CME Committee of Queensland 12th Annual Registrars' Meeting

When: 28 February 2009

Time: Commencing at 8.30am

Where: West End Corporate Park
Ground Floor, River Tower
20 Pidgeon Close
West End Queensland

The Annual 'Tess Cramond Prize' will be awarded and presented for the best formal project presentation at this meeting.

For further information contact Linda Cuffe Queensland Events Co-ordinator on qldevents@anzca.edu.au

ANZCA Queensland Trainee Committee Part Zero Course 'Zero to Hero' will be held on February 7, 2009. The meeting is open to all new anaesthetic trainees and will cover the College and the ASA and information on the Queensland Anaesthetic Rotational Training Scheme. There is no fee for registration.

In 2009 the Queensland Regional Committee has changed the format of courses on offer to trainees. For further information and registration forms please go the Queensland website www.qld.anzca.edu.au.



Western Australia



Sunset at Wise Winery

On the weekend of November 1–2, Western Australia held its annual Country Meeting at the Quay West Resort Bunker Bay which is about four hours drive south of Perth. The weekend began on the Friday evening with a welcome BBQ and drinks for sponsors, delegates and their families. The evening was held on the terrace overlooking Bunker Bay.

On Saturday morning, the academic program began for the 106 delegates, while partners and children enjoyed the organised social activities which included a whale watching tour, visit to a fauna park, tennis or for those who wished to relax a visit to the resort spa. On Saturday evening, buses transported delegates, sponsors and partners to the nearby Wise Winery for a fantastic dinner and great wine.

The annual Updates in Anaesthesia meeting was entitled 'Achieving Dreams and Avoiding Nightmares'. The first session dealt with 'Avoiding Nightmares-Case Selection for non-tertiary referral centres'. The session included presentations from Drs Greg Lumsden, David Hillman, Alison Corbett and Amanda Smith who discussed the appropriate placement for surgery on patients with obesity, obstructive sleep apnoea, as well as paediatric and obstetric cases.

Session 2 was entitled 'Achieving your dreams – Gadgets for the Girls and Toys for the Boys'. Dr Claire McTernan critically appraised some new airway gadgets; Dr Jay Bruce spoke about the depth of anaesthesia monitoring; Dr Michael Ward made the case for use of cardiac output monitoring intraoperatively. The invited speaker, Dr Peter Hebbard from Victoria, gave an excellent presentation on the use of ultrasound in clinical practice and likely

**Speaker Dr Michael Ward with
Session chair Dr Sai Fong**



future developments in this area. A series of workshops on ultrasound-guided nerve blocks and intravenous access were held on Saturday afternoon organised by Dr Jay White. Dr Peter Hebbard was able to share his expertise in the practical skills of TAP blocks.

The Sunday morning session included presentations on dealing with nightmares. Dr Gavin Coppinger talked about disaster planning; Dr Fiona Sharp presented on the management of diving disasters; Dr Steve Philpot drew on his experiences as a doctor at Royal Darwin Hospital in the days after the Bali bombings and Dr Alan Millard gave an innovative presentation about dealing with a death on the table. Following morning tea, Dr David Butler presented the case for the affirmative and Dr Peter Hebbard gave the case for the negative in a lively debate entitled 'To epidural or not to epidural for laparotomies'.

Thanks must go to the invited speaker, Dr Peter Hebbard, the sponsors, presenters and the Organising Committee from Fremantle Hospital, especially the Academic Convenor, Dr Sarah Wyatt, who put together a well received Scientific Program and an enjoyable weekend in the South West of Western Australia.

Right: SA/NT photos from top: Theo Tsaconas and Dr David Nemeth; Drs Dick Willis, Guy Christie-Taylor, Julia Coldrey and Professor Paul Myles; Drs Neil Dooney, Matthew Newman and Ray Cheng; Drs Linda Partridge, Mathew Grill and Andrew Beinssen.

South Australia/ Northern Territory

The SA/NT Combined ANZCA/ASA CME Committee held their annual weekend meeting on 1 November 2008 at the Sebel Playford Hotel, Adelaide. The topic, 'Keeping it above the Clavicle' proved popular with delegates. The invited speakers, Professor Paul Myles and Dr Chris Acott, gave insightful presentations and were ably supported by local speakers.



Regions

Continued



New Zealand

CTC workshop

The New Zealand Office held a successful CTC workshop on assessments on 10 October 2008. Dr Craig Noonan facilitated the first of two workshops to be held in the New Zealand office during October.

The second was a larger clinical teachers' course workshop – 'Developing Strategies for Effective Clinical Supervision' – and was held on 31 October. Sixteen supervisors from numerous parts of New Zealand and the National Education Officer, Dr Paul Smeele, participated. Thanks to Fiona McCook, the ANZCA Education Training and Development Manager, for her time and effort in facilitating this event.

Heather Ann Moodie

Executive Officer, New Zealand



Left to right, Dr Stephen Pearce (Whangarei), Dr Tim Wright (Dunedin) (obscured), Dr Jennifer Woods (Christchurch), Dr Andrew Usher (Wellington), Dr Rob Carpenter (Waikato), Dr Elaine Langton (Wellington), Fiona McCook, Dr Colin Marsland (Wellington), Dr Miriam Canham (Wellington),

Dr Maria Au-Young (Palmerston North), Dr Paul Smeele (Christchurch), Dr Sally Ure (Wellington), Dr Kirsty Jordon (Wellington), Dr Pierre Botha (Tauranga), Dr Charlie Brown (Taranaki), Dr David Williams (Waikato) and obscured Dr Mandy Perrin (Rotorua) and Dr Alan Crowther (Waikato).

JFICM New Zealand National Committee meeting

The committee met on November 17 and considered a number of issues including:

- New Zealand Medical Training Board (MTB) consultation documents
- Workforce data for MTB and the District Health Boards New Zealand Health Workforce Information Projections Project
- Health Practitioners Competence Assurance Act 2003 review
- Draft New Zealand Ambulance Service Strategy
- New Zealand Incident Management System – Draft policy for the Management of Healthcare Incidents
- Medical Council of New Zealand's consultation: 1. Proposed new registration pathway for telepathology and teleradiology across international boundaries; 2. Draft guidelines for managing disruptive behaviour.

Top of page:

JFICM NZNC meeting. Left to right: Dr Shawn Sturland (New Fellow rep), Dr Peter Dzendrowskyj, Dr Seton Henderson, Karen Hearfield (JFICM Administrative Officer), Dr Mike Gillham (Chair), Dr Gerard McHugh (ANZCA NZNC rep), Dr Peter Hicks (ANZICS rep), Dr Claudia Schneider and Dr Ross Freebairn (JFICM Board). Apologies: Dr Tony Williams, Dr Peter Roberts (RACP rep), Dr Janet Liang (ANZICS rep) and Dr Rob Bevan (Trainees' rep).



Left to right, Supervisors or Module Supervisors of Training: Drs Craig Birch (Middlemore Hospital), Adele Wilson (Taranaki Base Hospital), Jennifer Woods

(Christchurch Hospital), Pierre Botha (Tauranga Hospital), Tim Wright (Dunedin Hospital); CTC facilitator, Craig Noonan (Melbourne).

Division of Rural Hospital Medicine meeting

On November 18, 2008 the ANZCA NZNC Chair, Dr Vanessa Beavis, Deputy Chair, Dr Vaughan Laurenson and Heather Ann Moodie, Executive Officer, NZ met with the Chair of the Division of Rural Hospital Medicine (DRHM), Dr Garry Nixon and other DRHM members to discuss the logistics of introducing the JCCA training and MOPS programs to New Zealand.

The DRHM is a division of the Royal New Zealand College of General Practitioners. DRHM has recently gained vocational registration status with the Medical Council, which has now provided the opportunity to initiate the plans to introduce the 12 months JCCA training for Fellows of DRHM in New Zealand.

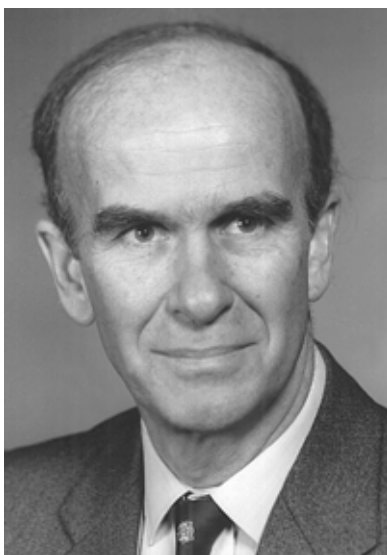
Dr Michael John Hind Hodgson

Michael Hodgson was the second President of the Australian and New Zealand College of Anaesthetists. He succeeded Peter Livingstone and was in turn followed by Michael Davies. Michael Hodgson was also the first Tasmanian to hold this post or that of Dean of Faculty.

Michael Hodgson was born 25 May 1941 at East Scores Nursing Home, St Andrews, Scotland. He was the second of four children born to Samuel Hind Hodgson and Maisie Hodgson, nee Waddell. The name Hind was Michael's father's mother's maiden name and his father adopted and introduced the tradition of including it into the names of subsequent male family members. Michael commenced his schooling in Kent (UK) and then in 1947 the family of six boarded the SS Esperance Bay and sailed to Australia where they settled in Tasmania. It was here that Michael undertook his schooling at Moonah Primary, Princes St State School and Hobart Technical School, finishing in 1958.

At that time it was not possible to do a medical degree in Tasmania, so Michael went to the University of Queensland where he completed his undergraduate medical degree. The University of Tasmania did not offer a medical course until 1965, and up to that time, Tasmanians wanting to do medicine went to mainland universities. Adelaide took two Tasmanians who had completed a science degree and the others went to Brisbane, Melbourne or Sydney although later on Monash University in Victoria became the more common destination until the opening of the medical school in Hobart.

Internship was completed at Brisbane General Hospital in 1965 and second year at Cairns Base Hospital in 1966. Whilst in Queensland, Michael married Margaret Frances Skinner and there they had their two children, Steven and Katrina. Thereafter Michael returned to Hobart and took up the post of anaesthetic registrar at the Royal Hobart Hospital from 1967-1969. Anaesthetic registrars were first appointed to Royal Hobart Hospital in the mid-fifties. From Hobart, Michael travelled to Edinburgh where he held the post of anaesthetic registrar at the Royal Infirmary Edinburgh from 1970-1971, during which time he sat and passed his English fellowship exam.



Upon return to Australia, he sat and passed the Australian Fellowship and then held posts as a staff anaesthetist at Royal Hobart Hospital, subsequently Director of Department and thereafter a VMO. During these years, Michael held posts on the Tasmanian Regional Committee as Education Officer and as Chairman. He was subsequently elected to Board of Faculty where he acted as Assessor, Chair of the Hospital's Accreditation Group, Chair of the executive, Vice Dean and Dean.

There were many issues of significance that occurred during Michael's time on the Board, although the one that will perhaps be the best remembered was the separation of the Faculty from the Royal Australian College of Surgeons and the establishment of the Australian and New Zealand College of Anaesthetists. This event led to a series of innovations that are still felt today. These include the purchase of Ulimaroa on St Kilda Rd to be the headquarters of the new College, and approval of the College Coat of Arms and Crest. There was continual work towards the development of a Faculty of Intensive Care and a Faculty of Pain Medicine as well as the adoption of the template for Special Interest Groups to be formed that is now so much a part of College educational processes.

Other major issues that arose were discussions on the assessment of overseas trained doctors, and council giving in principle support for mandatory annual

training assessment of trainees and in principle support that appropriate subspecialty experiences be a mandatory requirement for training in anaesthetics. There was also agreement given to publish Gwen Wilson's great work on the early history of anaesthesia in Australia 'One Grand Chain', agreement to commission portraits of College Presidents and acceptance of training curriculum in anaesthesia for rural general practice. And finally the agreement on a certificate participation in a program of Maintenance of Professional Standards (MOPS).

I will leave the final word to Michael Hodgson after recording my indebtedness to him for his assistance in preparation of this essay. When asked to add anything that he felt wanted to be included he wrote 'I believe that the work by the Faculty/ College in developing position statements has improved the status and reputation of anaesthetists and the quality and safety of anaesthetics.'

I would like to record my great appreciation of the contribution to this monograph provided by Dr Hodgson.

Assoc Prof T E Loughnan

Dean's Message



As I sit here writing this message for the December issue of the Bulletin, well ahead of time, I have much reason to ponder the vagaries of the publication process. There is enough uncertainty in the world that anything stated below could well be redundant by the end of the year – as stock markets fluctuate wildly and the words ‘sub-prime crisis’ and ‘credit crunch’ are on every newsreader’s lips, not to mention ‘Freddie’ and ‘Fannie’. However, let me perhaps start with what is hopefully a certainty and wish you all a happy holiday season, losses on the stock market notwithstanding.

An historic year

As Fellows and Trainees are by now all aware, this has been a busy and historic year for the Joint Faculty. Following the overwhelming vote in favour of the formation of a new College of Intensive Care Medicine at the AGM in May 2008, there has been steady and excellent progress in negotiations with the RACP and with ANZCA towards this goal. The ANZCA Council, under the leadership of Dr. Leona Wilson and the RACP Board, under Prof. Geoffrey Metz, have provided every assistance and guidance along the path to independence. It has been a privilege to work with both towards our common goal of an independent body.

Name of the new College

The name chosen for the new college by the Board, the College of Intensive Care Medicine of Australia and New Zealand, or CICM(ANZ), provoked some lively discussion amongst Fellows. As background, this name was decided on by the Board of JFICM because:

- A name for the new entity was required urgently in order to be able to register a company. The new company would then be the body to which assets and intellectual property etc may be transferred, as the JFICM itself has no legal standing in this regard.
- It was important to secure a name that hopefully most Fellows would be happy with, and indeed some of the names proposed by Fellows in discussion since have already been registered by other bodies and so were unavailable for use by the new College.

There was also comment about adding ‘of Australia and New Zealand’ to the name of the new College, with both pro- and

antagonists, and the effect this would have on the post-nominal letters. Any Fellow of the JFICM would realise that the current post-nominal letters, properly, are FJFICM, ANZCA&RACP. However, common usage sees us using only FJFICM. Similarly Fellows of the new College would be able to use FCICM(ANZ) or FCICM. From the above it should be obvious that some considerable thought was given to the matter of the name of the new College by the board of JFICM and the choice of name was not peremptory, in the sense of being dictatorial, but was peremptory in the sense of being authoritative and decisive, given the timeline and the parameters. A poll has since been taken from Fellows and Trainees regarding this matter to canvass wider input. The most popular name and post-nominals from the poll were *The College of Intensive Care Medicine* and *FCICM* respectively. It seems the Board’s decision was not that far wide of the mark after all! If only the matter of the name of the College were the most complicated part of the separation process...

Resignation of Dr Megan Robertson

It is with regret that the Board received the resignation of Dr. Megan Robertson. Megan has been an extremely hard-working member of the Board for several years. She has served the Fellowship and trainees in various capacities since she gained Fellowship (e.g as supervisor of training). It is only with the assistance and hard work of people like Megan that the JFICM is able to run efficiently and well. As I look around the board table, I often reflect that the people there are doing at least two and often more jobs, with several of them unpaid. They are all talented clinicians, but this is seen only as the baseline. Added to this are the tasks in research, teaching and administration that all are involved in to some extent. In this respect, the board reflects what goes on in the general Fellowship with regard to work practices. Then comes the voluntary service to Fellows and trainees that many Fellows play in roles such as supervisors of training, regional committee members, board members, examiners and as teachers of trainees, our future specialists. I don’t really wish to compare our profession and specialty with any other profession, particularly with regard to the spirit of altruism and volunteerism we enjoy, but suffice to say

many of my lawyer friends are unable to comprehend the concept of putting in hours of work for no personal financial gain! I counter with the remark that there are not many jobs where one is fascinated and uplifted by the experience every day.

JFICM administration

The JFICM office staff has been working very hard this year, under the able and steady leadership of the Executive Officer, Phil Hart. Phil has settled into his role extremely well and he and his team provide excellent support to the Board in providing service for trainees and Fellows. The workload continues to grow, with increasing numbers presenting for the examinations (52 candidates undertook the oral and clinical components of the last Fellowship examination). The JFICM primary examination also continues to grow, providing a pathway for trainees wishing to train exclusively in intensive care medicine.

ANZICS, RACP, ANZCA, ACEM

Relationships with ANZICS are very good, to the extent that JFICM is exploring possible options with ANZICS regarding the sharing of accommodation once the new College is established. Ideally a new ‘Intensive Care House’ would tenant CICM, ANZICS, the Intensive Care Foundation and ACCN. This would allow sharing of facilities such as IT providers, boardroom space, receptionist etc. The Board was also pleased to endorse the latest ANZICS document on brain death and organ donation – a document all Fellows can be proud of.

Close contact, on the educational front, continues with ANZCA, the RACP and the Australasian College of Emergency Medicine to streamline the process for trainees undertaking dual specialist training. It is planned that this process will continue once the new College is established. It remains a guiding principle that no current trainee will be disadvantaged by the establishment of the new College.

Finally, I’d like to sincerely thank the JFICM office staff and the Board for all their support during 2008. I wish you, and all our trainees and Fellows a happy, safe and peaceful 2009.

Professor PV van Heerden
Dean

JFICM Board News

Examinations

P V van Heerden
Dean

J Myburgh
Vice Dean and Treasurer

R Freebairn
Censor

R Lee
*Immediate Past Dean, Chairman, Hospital
Accreditation Committee*

P Morley
Education Officer

C Corke
Assistant Education Officer

B Lister
*Chair, Paediatric Examination Committee,
Communications Officer and Journal Officer*

B Venkatesh
*Chairman, Examinations Committee
and Chairman, Fellowship
Examination Committee*

G Joynt
*MOPS Officer, and International
Liaison Officer*

M O'Fathartaigh
*Co-opted Representative, South Australia
and Rural Focus Officer*

A Beswick
*Co-opted Representative, Tasmania and
ASM Officer*

N Blackwell/N Orford
New Fellow Representative

Maintenance of Professional Standards (MOPS)

A reminder to all Fellows, your MOPS diaries for 2008 are due at the end of February 2009. To ensure you receive your Statement of Participation, please complete your online diary or send in your paper diary by 28 February 2009. If you have any questions please contact Lisa Davidson at the JFICM office, ldavidson@anzca.edu.au or +61 3 9530 5861.

New Fellows conference

In May this year the JFICM held its inaugural New Fellows' Conference. The Conference was a great success with all participants providing positive feedback on the topics covered by all speakers. The Conference will once again run in 2009 in Brisbane, just prior to the JFICM ASM from 27-28 May. An invitation to all eligible Joint Faculty Fellows will be sent out shortly. Please check the JFICM website in the next few weeks for further details.

Intensive Care Exam Dates for 2009

First General Fellowship Examination

Written section: April 3

Oral Section: May 28 & 29, in Brisbane

Second General Fellowship Examination

Written Section: August 28

Oral Section: October 22 & 23, in Sydney

First Primary Examination

Written Section: March 2

Oral Section: May 1, in Melbourne

Second Primary Examination

Written Section: 28 September

Oral Section: November 13, in Melbourne

Paediatric Fellowship Examination

Written Section: August 28

Oral Section: October 19, in Brisbane

JFICM Examiners Workshop

The annual Joint Faculty of Intensive Care Medicine Fellowship Examiners Workshop will be held on the February 18-19, 2009. The purpose of the workshop is to familiarise recently appointed examiners in the examination process, although all examiners on the Fellowship Panel are invited to attend. Topics such as designing short answer questions and the reliability of marking will be explored.



Paediatric and General Fellowship Oral Exams

It was as case of all hands on deck the week of October 13-17 in Melbourne. Four candidates sat the oral section of the Paediatric Fellowship exam on the Tuesday, followed by 52 candidates presenting for the oral section of the General Fellowship exam (clinical hot cases on Thursday, vivas on Friday).

The hot cases for the Paediatric exam were held at the Royal Children's Hospital, while the hot cases for the General Fellowship were spread across three hospitals, the Royal Melbourne, St Vincent's and the Monash Medical Centre. The vivas were all held at the Sebel Hotel.

In total, 35 examiners attended (nine for the Paediatric exam, 26 for the General Fellowship) as well as all of the JFICM staff and a further eight Fellows as observers. The exams were followed by very pleasant dinner, looking out over Albert Park Lake at The Point restaurant.

A high percentage of candidates passed the exam including all four Paediatric candidates and 42 out of 52 General Fellowship candidates. Congratulations to everyone who was successful at the exams, and thank you to all the Fellows and Staff who contributed to making the event such a success, especially Dr Bruce Lister (Chairman of the Paediatric Examination Committee), Professor Bala Venkatesh (Chairman of the General Fellowship Examination Committee) and Carola Schmidt (Admin Officer, Exams). A big thank you must also go to the staff at the hospitals involved, who generously gave up their time to ensure that the clinical component of the exams ran smoothly.

The next General Fellowship examinations will be held in Brisbane in May 2009.

Examinations

Continued



Primary Exam – examiners and successful candidates



Successful Candidates – October General Fellowship Exam



General Fellowship Examiners

Primary Oral Exams

The Joint Faculty of Intensive Care has only recently begun holding our own Primary Examinations, as most of our trainees have in the past come to study Intensive Care Medicine having already completed a primary exam in another field (commonly, anaesthetics, emergency medicine or internal medicine).

This year, on November 6, the third cohort of candidates to sit the JFICM Primary completed the oral component at ANZCA House in Melbourne. All three candidates were successful.

Dean's Message

We know that chronic pain is common, with the Australian incidence being approximately 20%, rising to 50% in the older population. For patients with cancer and HIV/AIDS, the incidence can be over 70%. Patients, even with what were previously considered terminal events, are living longer, so many in our community suffer with ongoing pain.

The Access Economics report from 2007, as well as outlining the high price of pain for Australia, (the total cost was estimated at over \$A34 billion), highlighted, using the Von Korff chronic pain grade scale, that 27% of those who reported chronic pain reported high levels of pain disability with moderate to severe limitation of their life due to the pain. This represents 5% of the Australian population!

For many years, we have encouraged our students to believe their patients when they report pain, and in 2004 Michael Cousins' in the Editorial in *Pain* commented 'failure to treat pain appropriately is substandard medicine with adverse outcomes, is unethical and is susceptible to both legal and professional action'. The Editorial produced the concept of 'Pain relief: a universal human right!'

In the mid-eighties initially Portenoy and Foley² and then others proposed that opioids do have a role to help patients manage their chronic pain. Since 1986, the prescription of opioids has risen exponentially. In Australia, the use of morphine tablets and capsules has increased forty-fold and oxycodone capsules, tablets and suppositories has risen approximately four-fold since 1990.³

If this medication was being used appropriately to manage patients with chronic pain and cancer pain and it was shown to improve their functioning and quality of life, we could be justifiably proud of the steps that Australian doctors have taken. However, of concern are the reports⁴ that the medically prescribed painkiller, oxycontin, has overtaken heroin as the most popular drug in the Kings Cross injecting room, evidence of an emerging booming black market.



Dr Penelope Briscoe

It is reported that patients gain prescriptions for oxycontin from doctors (at \$5 a prescription if they are on a health care card) and can then sell the tablets for up to \$50 each.

Opioid diversion is not just limited to patients with chronic pain. There are now reports of patients with cancer pain (who are living a lot longer) also on-selling their prescription medication which has been prescribed to them in good faith by their medical practitioner. Unfortunately, as the number of patients on opioid prescriptions increases, it will not be possible to properly monitor this.

A number of states still have their S8 prescription scrutinised by the Drugs of Dependence Unit (currently in South Australia this involves over 30,000 prescriptions a month)⁵ but in larger states like New South Wales, where the resources are not available to do this thoroughly, they have made the decision not to do it at all. In fact, New South Wales has gone one step further in that you only need an authority if you, as a doctor, deem that your patient is 'dependent' or on injectable medication.

We, as practitioners, have been trained to believe our patients and take them at face value. We are now going to need to be adept in looking for signs that the patient is misusing, abusing or diverting the medication that we've prescribed.

To this end, the Faculty and the Royal Australasian College of Physicians, particularly members from the Chapter

of Addiction Medicine, worked together to produce a report 'Prescription Opioid Policy: Improving Management of Chronic Non-Malignant Pain and Prevention of Problems Associated with Prescription Opioid Use'. This document is now in the final stages and will be released in the near future and I thank Associate Professor Milton Cohen for all his work.

As many patients referred to pain clinics are already on opioids, it will be our role as pain physicians to assess whether or not we believe they have improved the patient's function and quality of life and, if there is no good evidence of this, then recommend a weaning programme while instituting more appropriate multi-disciplinary management of their pain including judicious use of adjuvant medication, encouraging appropriate physical therapy and recommending cognitive behaviour pain management programs to allow our patients to manage their pain more appropriately themselves.

The decision to continue to prescribe or to wean opiates in complex, difficult or suspect patients may need to be done in a multi-disciplinary setting with input from the Addiction Medicine specialists. The balance we need to strive for is between supplying efficient, cheap, readily accessible pain-medications to those patients who do benefit, without them fearing consequences from this medication, versus us recognising those who won't be helped, or could even be harmed and thus preventing the risk of misuse by a few.

Dr Penelope Briscoe
Dean

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3. Working Group: RACP 2008 'Prescription Opioid Policy: Improving Management of Chronic Non-Malignant Pain and Prevention of Problems Associated with Prescription Opioid Use' – in press.
4. Fife-Yeomans J: 'You pay for junkie drug rort' *The Daily Telegraph*: October 2008.
5. Colin Brown: DDU SA Dept of Health – Personal communication.

News

Victorian Government reviews pain management services

As reported in the FPM Council report, the Victorian Department of Health and Community Services is undertaking a review of chronic pain services. Manpower issues including benchmarking and appropriate funding arrangements will be covered in the report which is due in 2009.

Establishment of Interim FPM NSW Regional Committee

The Faculty is pleased to report that, at a recent meeting of NSW Fellows, it was unanimously agreed to form an interim FPM NSW Regional Committee. The interim committee comprises:

Chair:	Dr K E Khor ANZCA
Deputy Chair:	Dr Martine Holford ANZCA
Secretary:	Dr Guy Bashford AFRM
Treasurer:	Dr Charles Brooker ANZCA
Members:	Dr Paul Wrigley ANZCA
	Dr Clive Sun AFRM
	Dr Lewis Holford ANZCA
	Dr Marc Russo ANZCA

PS45 update

Fellows should be aware that Professional Document PS45: *Statement on Patients' Right to Pain Management and Associated Responsibilities* has been updated. It is available in full on the website: www.anzca.edu.au/resources/professional-documents/professional-standards/ps45.html

National Pain Summit

The Pain Management Research Institute in partnership with the MBF Foundation is planning a National Pain Summit to be held at Parliament House in Canberra in 2009. Pain specialists from the Faculty are involved with the steering committee. Further information will be provided in future editions of the ANZCA e-newsletter, Synapse, and the ANZCA Bulletin.

Clinical Pain Management 2nd Edition: Acute Pain

FPM and ANZCA Fellows, Drs Pam Macintyre and Suellen Walker are co-editors of the *Acute Pain* volume in this 4-volume set of books; a comprehensive set of textbooks for trainee and practicing specialists in pain management and related areas, presenting readers with all they need to know to provide a successful pain management service. A number of other Faculty Fellows wrote chapters; Australia and New Zealand are exceedingly well represented on a per capita basis. For more details on this series: www.clinicalpainmanagement.co.uk/index.html

Continuing Professional Development

The ANZCA/FPM CPD Program is now a three-year program. A benefit of the new program is the ability to print out your own Statement of Participation whenever you need it via the online portfolio. This has also been set up for offline portfolio users. Semi retired Fellows participating in the one year program can submit their CPD activity for the year either online or via the CPD Office for an Annual Statement of Participation.

AIC Editorial Board Citation Award

Professor Tess Cramond has been recognised by the Australian Society of Anaesthetists for her contributions to anaesthesia and intensive care. Citations were presented to past Editorial Board members in recognition of their contributions to the success of the journal, *Anaesthesia and Intensive Care*.

International meetings

Two interesting Meetings take place in early 2009 in Hawaii and New York. The 25th Meeting of the American Academy of Pain Medicine takes place January 28–31, 2009. The World Institute of Pain 5th Congress is scheduled for March 16–19 in New York. Please visit the ANZCA web site for details.

Annual Scientific Meeting – Cairns

The ASM 2009 Meeting in Cairns May 2–6 includes a Faculty Refresher Course Day. The theme is 'Unravelling the Chaos in Pain'. The FPM ASM Visitor, Dr Andrew Rice (UK), will participate in the RACS meeting in Brisbane and will visit Adelaide following the Faculty's Refresher Course and ASM Meeting. Dr Steven Passik (US) has accepted the invitation as the FPM Queensland Visitor.

Admission to Fellowship of the Faculty of Pain Medicine

By training and examination:

Patrick Joseph Coleman
Kwang Hui Tay
Teik Guan Tay
David Allen
Evangelos Tziavrangos

Faculty of Pain Medicine Dean's Prize and Best Free Paper Award

Fellows and Trainees are reminded of the Faculty Dean's Prize, for the Fellow/Trainee judged to have presented the most original Pain Medicine/Pain research paper, of sufficient standard, at the free papers session of the FPM ASM.

Eligibility is limited to trainees of the Faculty of Pain Medicine or trainees of the five participating professional bodies of the FPM, or Fellows of FPM within eight (8) years of admission to their original Fellowship at the date of the meeting. The prize takes the form of a certificate and a grant of \$1,000 for educational or research purposes. The prize will be awarded at the FPM Annual General Meeting.

If you wish to be considered for this prize, you should mark your abstract submission accordingly. The deadline for submission of abstracts is 6 February 2009. See the ASM website for further details: www.anzca2009asm.com/abstract.html

The Faculty Free Papers session is open to all registrants. For those not eligible for the Dean's Prize, a Best Free Paper award, in the form of a certificate, will be made.

Pain Medicine Workforce in Australia

State	Population per Specialist FPM	Accredited Funded Trainee Positions	FPM Active Fellows per state	Accredited Units for Training	Population
Victoria	157,733	4	33	5	5,205,216
NSW	102,822	6.5	67	9	6,889,072
QLD	126,729	4	33	1	4,182,062
SA	72,023	3	22	2	1,584,513
WA	91,556	2	23	2	2,105,783
TAS	70,477	1	7	1	493,341
ACT	339,865				339,865
NT (nil)					214,975
(Total)			186		

While creating a submission to the Victorian Department of Human Services 'Review of Chronic Pain Management Services', Helen Morris (Faculty Executive Officer) and I prepared some interesting figures regarding the Faculty of Pain Medicine workforce.

We also discovered that in Victoria medical workforce planning does not have Pain Medicine as a listed specialty, even though we were recognised by the Australian Medical Council in 2005. Therefore planning for service delivery and specialist training was unlikely to be supported with other recognised specialties taking precedence. We were also asked to give a benchmark for specialist services per head of population, again difficult as Australia has been a world leader in the establishment of the specialty, and no benchmark has been set.

Our lack of Pain Medicine Specialty training in Victoria is evident, however,

and the figures make interesting reading, supporting the lack of resources in Victoria. In future it will be valuable to do a more in-depth survey looking at what percentage of time Fellows practice in Pain Medicine, public and private work, research, training and administration activities of our Fellows.

In the meantime, a small group of Victorian Fellows are lobbying to have this shortfall recognised, in an effort to increase training in Victoria. Our colleagues in other states may like to work along similar lines, while the Faculty raise this at a national level, too.

Carolyn Arnold
Director
Caulfield Pain Management and Research Centre
Melbourne

Examinations

**2008 Court of Examiners and Observer,
Dr Michel Dubois of the American
Board of Pain Medicine.**



**Dr Ray Garrick with Merit Award recipient,
Dr Richard Sullivan.**



Successful candidates for 2008.

The 2008 Faculty of Pain Medicine Examination was held at St Vincent's Hospital, Sydney. Fourteen of the twenty candidates were successful. The Barbara Walker Prize for Excellence in the Pain Medicine Examination was awarded to Dr Charles Kim and a Merit Award went to Dr Richard Sullivan. Both award winners are from Victoria.



**Chair of Examinations, Dr Ray Garrick congratulates
Barbara Walker Prize Winner, Dr Charles Kim.**

Report from the Board Meeting held on 20 October 2008

The Board convened a Governance Workshop on the morning of 20 October with a facilitator from the Australian Institute of Company Directors. This was a useful exercise, identifying areas for streamlining and improvement of governance processes. Usual Board business was conducted in the afternoon.

Relationships Portfolio

Physician representation on the Board

To reflect the recent reorganisation of the Royal Australian College of Physicians and the fact that the predominant physician group in the FPM is rehabilitation medicine, the Board is looking at how appropriately to represent all the stakeholders.

Liaison with ANZCA

Dr Leona Wilson, President ANZCA, attended for part of the October Board Meeting. Areas of discussion included improving communications, Faculty representation on ANZCA Committees, opportunities for consultation and collaboration. Acute Pain and Module 10 were highlighted as areas that ANZCA and the Faculty could work more closely to mutual benefit.

Trainee Affairs Portfolio

International Medical Graduates

The Board discussed proposed changes to ANZCA International Medical Graduate Specialist Assessment Processes which would impact on award of FPM Fellowship for Faculty trainees with an overseas qualification. Further advice has been sought from the College IMGs Committee.

Practising and Teaching of Acute Pain Management

Following discussion during the 2009 FPM Spring Meeting at Ayers Rock of the variability in training and exposure to Pain Medicine across Australasia, the Board supported efforts to standardise exposure, improve education to all practitioners involved in patient care and development of a generic program for regional CME

Meetings with a focus on this topic. Submissions will also be made to ANZCA's curriculum review.

Training Unit Accreditation

Review of Chronic Pain Management Services

There had been a meeting between representatives of the Faculty and of ASPEX Consulting, who are undertaking a review of chronic pain services in Victoria on behalf of the DHS. Important issues to come out of the meeting were:

- Manpower issues – Per population Victoria is behind other states. Advice was sought on a benchmark figure, however, as a new speciality there is currently no benchmark. Governments seem unaware of Pain Medicine as a specialty with manpower issues that need addressing.
- Desirable level of a pain facility – Whether this constituted adequate or graded services with centres of excellence. The Dean had raised her South Australian experience and ASPEX have now asked to visit.
- Lack of recurrent funding - The differing funding and reporting models had been highlighted with no commonality between them and no review of population demand etc.
- A report will be available from the DHS when further progress has been made.

An article will be published in the Bulletin and Synapse as there will be resonance in other states. Queensland has also had a review and both investigations will be coordinated through the Faculty.

Examination

Twenty two trainees attended the Pre-Examination short course in Adelaide. Twenty candidates have registered to sit the 2008 Examination at St Vincent's Hospital Sydney on 26-28 November 2008. Observers will be: Dr Michel Dubois, Chief Examiner for the ABPM, Dr Mark Tadros, New Fellow observer and new Examiners, Drs Diarmuid McCoy and Paul Gray.

Fellowship Affairs Portfolio

Fellowship

Two new Fellows were admitted by training and examination which takes the number of Fellows to 256.

Regional Committees

A meeting of NSW Fellows was held in November to discuss formation of a NSW Regional Committee. Dr K E Khor was elected interim Chair and Dr Martine Holford as Deputy Chair.

The Board strongly encourages Fellows in other regions to consider formation of a committee.

Profile of Pain Medicine

The Board will commence work on a strategy for the next three years to continue to raise the profile of Pain Medicine amongst specialists including the broader challenges of attracting people to the speciality.

The Pain Management Research Institute in partnership with the MBF Foundation is planning a National Pain Summit to be held at Parliament House in Canberra in 2009. Pain specialists from the Faculty are involved with the steering committee.

Research

Standardised Outcome Measures in Persistent Pain

An agreement is currently being negotiated between two centres for a pilot core outcomes database project. Other centres will be invited to join this demonstration project but would be required use the established dataset and to fund themselves. Further details will be published in Synapse in due course.

Professional

Recognition of Pain Medicine as a Speciality – New Zealand

Dr Stuart Henderson, ANZCA Director of Professional Affairs, will assist the Faculty to complete this application as a matter of urgency.

AMC Good Medical Practice: Code of Conduct

The Faculty provided input to this document and opportunities for public

comment were held around the country throughout October and November.
<http://goodmedicalpractice.org.au>

Continuing Education & Quality Assurance

Quality and Safety

The issue of significant morbidity and mortality that occurs on occasion following a lack of effective acute pain medicine treatment had been raised at a breakfast meeting during the 2008 Spring Meeting at Ayers Rock. The Board considered what influence the Faculty might have in terms of preventing this type of event. A range of initiatives will be explored including liaison with ANZCA's Quality and Safety Committee and developing common threads in the hospital accreditation processes between the College and Faculty with regard to Acute Pain Services.

Scientific Meetings

- *ASM 2009*

The FPM ASM Visitor, Professor Andrew Rice (UK), will attend the RACS Meeting in Brisbane and visit Adelaide following the Faculty's Refresher Course and Annual

Scientific Meeting. The Refresher Course Program 'Unravelling the Chaos of Pain' is complete and a registration brochure will be available on line in December and hard copies will be circulated in January with the ASM Registration brochure.

Dr Brendan Moore agreed to represent the Faculty at the New Fellows' Conference on 29 April – 1 May. The closing date for applications from New Fellows to attend is 2 January 2009.

- *Spring Meeting 2009*

The date and venue was confirmed as 16-18 October at the Sofitel Melbourne. To forward the momentum started at the Ayers Rock meeting, the meeting will again be held in conjunction with the Acute Pain SIG of ANZCA/ASA/NZSA and will have a theme of 'Dealing with the Difficult Patient'. To further strengthen ties between the groups, the possibility of holding combined meetings every second year to coincide with IASP meeting years will be further explored. The Scientific Meeting Officer will develop a long term policy for the Spring Meeting Program.

- *ASM 2010 – Christchurch*
Visitors were confirmed as Dr Jeffrey Mogil (FPM ASM Visitor) and Dr Richard Rosenquist (FPM New Zealand Visitor).
- *AAPM meeting Hawaii January 2009*
Fellows are encouraged to attend this meeting. For more details: www.painmed.org/annual_mtg/index.html
- *Participating Colleges Meetings – 2009*
The RACS ASC in Brisbane 5-9 May will include a 2 day Pain program. The Faculty's ASM Visitor, Professor Andrew Rice (UK) will participate and will speak on 'Neuropathic Pain and Nerve Injury'. The Medtronic Visitor, Dr Michael Turner (USA), a neurosurgeon, will speak on 'Surgical Experiences with Neurostimulation'. Several Faculty Fellows are also speaking.

Resources Portfolio

Finance

The Board will meet by teleconference on 3 December to ratify the 2009 Budget and subscription and fee structure.

Pain Fellowship at The Royal Brisbane & Women's Hospital

Dr Sarah Aturia was a trainee at the Royal Brisbane and Women's Hospital last year. The following article, which appeared in the October edition of Anaesthesia News (Newsletter of the Association of Anaesthetists of Great Britain and Island), reviews the Faculty of Pain Medicine's training program.

My interest in Pain Medicine developed during senior house officer training and was further reinforced by one-week sessions as a registrar. Research findings, particularly central changes and functional imaging, increased my curiosity in this rapidly-growing and exciting field. I ultimately plan to pursue this career and wished to extend my experience. I found Brisbane suitable for both my academic and family requirements.

A lengthy job and visa application process resulted in a one-year Pain Fellowship at the Multidisciplinary Pain Centre (MPC), Royal Brisbane and Women's Hospital (RBWH), Queensland. It is a tertiary referral teaching hospital and is affiliated with the University of Queensland and Institute of Medical Research. The MPC was opened by its current Director, Professor Tess Cramond in 1967. It was the second pain clinic established in Australia and recently celebrated its 40th anniversary.

The Multidisciplinary Pain Centre (MPC)

In 2003, the MPC moved to a custom-built unit located adjacent to the Professor Stuart Pegg Adult Burns Unit. The facilities include eight dedicated inpatient beds to which patients are admitted under Pain Medicine consultants; offices, outpatient consultation rooms, a procedure room with dedicated image intensifier, recovery area, patient education area, interview room and staff room.

The MPC provides a state-wide service for patients with persistent pain of malignant or non-malignant origin who are referred by a medical practitioner. The population of Queensland is 4.2 million and its area is more than six times that of the United Kingdom. It provides a consultation service for other units within the hospital including the burns unit and works in close liaison with the acute pain management service which functions separately. There is a 24-hour consultation advisory service for referring doctors and domiciliary nurses.

The staff of the Multidisciplinary Pain Centre includes specialists in pain medicine from several disciplines, nursing staff for the ward, the outpatient clinics and the procedure room, two psychologists, two physiotherapists and two occupational therapists. There is a clinical/research



Dr Sarah Aturia

coordinator for the Allied Health Staff. There are ten pain medicine specialists, two of whom are full-time, and come from the following backgrounds:

Anaesthetics	6
Psychiatry	2
Rehabilitation medicine	1
Addiction medicine	1

The MPC conducts two pain management programs – a two-week inpatient program for patients with medicalco-morbidities or whose medication warrants stabilisation, and an outpatient program on one day a week for eight weeks. The eight dedicated beds are used predominantly for patients on the inpatient program and for cancer patients requiring advanced interventional techniques.

Every Monday, four new patients are admitted and assessed by the house officer, psychiatrist, psychologist, occupational therapist and nursing staff prior to discussion with the consultant for implementation of the management programme. The two-week period of admission can be utilised when appropriate to rationalise drug use in patients on high dose opioids. Patient assessment and discussion with the GP regarding the appropriateness (or not) of this medication is commenced prior to the admission.

Multidisciplinary meetings are held every Wednesday morning. Strategies

recommended are documented very clearly in the discharge summaries to the patients' GPs. Multidisciplinary telephone case conferences are conducted for challenging cases to outline the patient's management plan and to ensure clear transfer of information.

Throughout the programme, patients attend classes with scheduled activities. They are encouraged to learn new coping strategies and to accept responsibility for the management of their pain. There is a strong emphasis on education, non-pharmacological management strategies, physiotherapy and hydrotherapy and participation in a management plan developed in association with the consultant under whom the patient is admitted.

Cancer pain referrals are received from either within the RBWH or from GPs across Queensland. The service offered includes advice on rationalisation of medication and interventions, culminating in admission of challenging cases to the MPC.

The Pain Fellowship

The one-year Pain Fellowship necessitates working in an accredited unit, undertaking satisfactory in-training assessments, sitting the Faculty of Pain Medicine (FPM) examination and writing a case report. Prior to acceptance for the Fellowship, it is necessary to obtain approval that previous training and experience in Pain Medicine meets the required standard.

There is a structured training program, including provision for the fellows to sit in with the psychiatrist for consultations. Working closely with the psychiatrist during patient assessment is a valuable opportunity to achieve a better understanding of the relationship between mood, personalities/personality disorders and pain.

While I was there, the MPC had two Fellows instead of the usual four, which meant more exposure to a wide range of patients and a corresponding increase in work. The Fellow on-call receives the initial referrals from other hospital units and departments and responds to call for advice from GPs all over Queensland. He/she also supervises the day-to-day duties of the house officer, whose entire role

is the care of the MPC inpatients. Weekend calls are non-residential, involving a ward round in the morning and an occasional telephone call seeking advice.

The Fellows who are not on-call are involved in procedure lists and clinics. There are opportunities to attend amputee and radiation oncology clinics, nerve conduction studies and a local private hospital. To maintain general skills, the anaesthetists who comprise the majority of the Fellows participate on the anaesthetic on-call roster which in my case was twice a fortnight.

Every Wednesday is an education day that begins with a CME presentation by one of the team members, closely followed by the Multidisciplinary meeting at which the management plans for new patients (week 1) and the discharge plans for other patients (week 2) are developed after input from all team members. These are recorded in detail in the hospital charts. Teleconferences with referring doctors form an important part of the unit meeting, helping doctors in rural areas overcome the tyranny of distance. All members of the multidisciplinary team contribute. The Fellows and consultants spend the rest of the morning discussing a pre-listed topic based on the FPM curriculum. This demands extensive reading of up-to-date evidence-based literature. Discussing past questions makes the challenging examination appear only slightly more manageable. The consultants in Brisbane are supportive of the exam preparations, with viva practice close to the exam. One of the consultants is a FPM examiner and one has been an examiner for ANZCA and FPM.

The Examination

And what of the examination itself? It is conducted in a different State each year – when I sat it, I travelled to Geelong, Victoria. It consists of:

- 10 out of 15 short answer questions
- an hour-long case with the patient examined in the presence of examiners followed by a 30-minute presentation of the history, physical examination and results of investigations
- three case scenarios and an investigation station
- three physical pain examination stations and one communication skills station.

The three-day examination period is physically, mentally and psychologically exhausting! The highlight of course, is on the final day when the list of lucky numbers is pasted on the board at 16.30 hrs!

Catching up

Having put the exams aside, the last few months were spent catching up on travel and sight seeing. Queensland is a vast state with many interesting places to behold. There is a wide range of activities every weekend and, particularly for children, the list is endless. There are world-class beaches that are very accessible – located on the Sunshine Coast to the north and the Gold Coast to the south. The coastal frontiers are particularly popular with surfers. A trip further north leads you to the breathtaking sight and experience of the Great Barrier Reef which is a ‘must see’.

The support I received on arrival was tremendous, the MPC assisting in every way possible to ensure that I settled into the programme. One of the particularly memorable highlights was a bouquet of flowers with best wishes for the exam on arrival to my hotel room.

The MPC training program, plus a typical Aussie Christmas spent with a very hospitable family and the entire Queensland experience, made the whole year worthwhile. Highly recommended!

Dr Sarah Akol Aturia
SpR Anaesthetics
Oxford Radcliffe Hospitals NHS Trust

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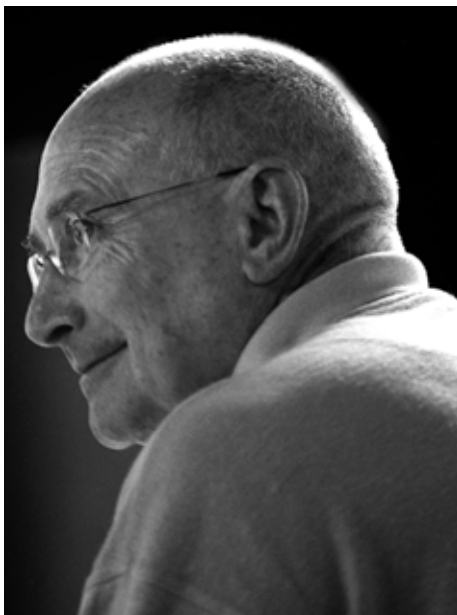
Dr John B McCarthy

1948 – 2008

Dr John Bernard McCarthy was born in Gympie in 1948 and lived on the family farm at Widgee, where his family had been pioneers in shaping that land. He attended the Christian Brothers School in Gympie and excelled academically, as well as in cricket and rugby league. He was awarded a scholarship to the University of Queensland to study medicine. During his elective as a medical student in the 1960s, he travelled to Cuba, where he was thrilled by the ideals espoused by Che Guevara and Fidel Castro, both of whom he met. He assisted in the development of the Communist manifesto for Bolivia, and came to the attention of the American secret services on several occasions.

After graduating from university, he worked in hospitals in Brisbane and Sydney. While working in Sydney he met and began a lifelong friendship with the late Fred Hollows, embracing the opportunity to work with Professor Hollows and travelling with him to many outreach clinics in the quest to improve the health status and conditions of the aboriginal and Torres Strait islander people. On returning to Brisbane, he commenced anaesthetic training at the Royal Brisbane Hospital. His strong socialist leanings almost cut short his career in Intensive Care before it began, such was the prevalent political thinking in Queensland medicine in the 1970s! Managing to oppose his removal from the training scheme (due to his card-carrying membership of the Socialist party) he became the first person in Queensland to pass the examination required to obtain the Diploma in Intensive Care of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons. He worked as a specialist in anaesthesia and intensive care at the Royal Brisbane Hospital and then at Nambour hospital.

In 1990, he came to The Prince Charles Hospital as the Director of Intensive Care Services and held this position until 2003. John was the last of the great all-rounders – in medicine if not cricket. He was simultaneously the director of Adult and Paediatric Intensive Care Services, the Emergency Department and when the lung transplant service expired, he managed all the post-operative lung transplant patients until the service was re-established, while taking up the mantle of Director of junior doctors training.



He was never too busy to see a patient, whether day or night. His presence was announced by a warm, booming laugh that arrived long before the man himself. The sight of his yellow ute (frequently with some caged chickens on the tray) was a heartwarming sight for many doctors when things were getting a bit too tricky. He was generally surrounded by a number of medical specialists seeking his advice on all matter of subjects – from case selection, to management of difficult patients, to the likely cricket score at the weekend. John was a born adventurer. One such adventure was inspired by a couple of young cystic fibrosis sufferers, who were bored through prolonged hospital admission, and were becoming non-compliant. John picked them up at 5am, and showed them how to do ‘circle work’ in his ute in a nearby paddock. The same morning the Health Minister attended the hospital and asked the tired boys did they like the hospital, and why. Their explanation that this was the only hospital where they were allowed to do circle work left both the Minister and journalists slightly perplexed.

He managed to achieve, not only through his own brilliant intellect but by attracting a following of devoted and loyal staff with his charisma, work ethic and genuine concern for people – staff and patients. He would be found cooking eggs at 2am if a patient

asked for them and John felt it important in the recovery process. In leading from the front, his nursing staff, trainees and other members of the team were always aware that the patient came first. As a teacher, he described himself as ‘heretical’ but with his humane style, empowered all staff to discover their potential to do their best. His ability to communicate and cross through social boundaries is probably best explained by assessing those who came together to pay their last respects at his funeral in Gympie. The entourage who travelled up to his funeral included a world-renowned American transplant surgeon, who freely admitted John had taught him how to manage a sick patient, as well as a long-time kitchen worker at Prince Charles, who regaled us with stories of John’s cunning in the Hospital Union movement in the ‘90s.

John’s overwhelmingly busy schedule always managed to include his passion – a game of cricket on a Saturday afternoon. A registrar would ring with a particular clinical problem and they would often receive the reply, ‘But I’m on a hat trick!’ or ‘But I’m 49 not out!’ John was able to judge the better trainees as the ones who knew when the change of innings was likely to occur.

John was a pioneer in many areas. He recognised at a very early stage the importance of contribution to the Australia New Zealand Intensive Care Society database and the use of data to expand intensive care services and ultimately improve patient care at the Prince Charles Hospital. He recognised the valuable contribution every staff member made in the Intensive Care Unit. He recognised the value of early mobilisation and the importance of psychological wellbeing in a patient’s recovery from critical illness. It was not uncommon for John to organise a trip for an 18-year-old patient to the shopping centre, or a lung transplant patient to travel home – both fully ventilated. In most occasions, these ‘difficult’ patients would recover more quickly than the staff who took them on their trips!

John had an extremely strong sense of social justice and treated everyone, rich or poor, the same way he would like

to be treated himself. His socialist Irish roots ensured that he campaigned for the oppressed and those too down trodden to defend themselves – indigenous rights, local union matters and aspects of social justice permeated John's life. As an all-rounder, John had a vast number of interests: through his illness over the last several years, he focused on his innate artistic abilities, and had two sell-out art shows. Again, during his illness, where many would look back on their achievements, John rebuilt the family home and farm at Widgee where he bred his beloved Appaloosa horses and exotic birds, while learning to make goat's cheese from his pet goat. His love of sport, particularly cricket, necessitated a 'can do' attitude, and epidural injections of steroids were called on at least once to ensure his bowling didn't suffer. His voracious appetite for knowledge was legendary and John was widely read, in literature, politics and the arts. Trying to keep up with his truly all-encompassing soliloquies could prove tiring even to the most gifted student.

John's greatest love was his wife, Kerry, and his family. He was enormously proud of the achievements of his children – Brigid, Bernadette, Matthew, Leo and Cecilia.

He left The Prince Charles Hospital in 2003 to work at Selangor and Noosa Hospital where he set up their Intensive Care Units. His final illness was diagnosed in 2006 and his life-expectancy at that stage was less than six months. However, as befits a man of John's vitality, he survived for over two years, working until the last couple of months, after which he returned to the farm, to plumb the new toilet, re-roof the house (with no neutrophils apparently) and continue to paint his beloved Widgee property from the wrap-around veranda looking over the creek, cows, geese and assorted wildlife.

In 2007, the Intensive Care Unit in the new Emergency Block, was named after him – The John B McCarthy Intensive Care Unit. John died on 1 November 2008. He will be sorely missed and the numerous people he has trained and mentored will attempt to continue in his footsteps.

Dr Dan Mullany, Dr Marc Ziegenfuss, Dr John Fraser, Sue Bullock and Kerry McCarthy
Photo: Jeremy Hayllar

'To laugh often and much; to win the respect of intelligent people and the affection of children; to earn the appreciation of honest critics and endure the betrayal of false friends; to appreciate beauty; to find the best in others; to leave the world a bit better, whether by a healthy child, a garden patch or a redeemed social condition; to know even one life has breathed easier because you have lived. This is to have succeeded.'

This quote by Ralph Waldo Emerson (1803 – 1882) was on Dr John B McCarthy's office door.

Dr John Martin Rutherford Bruner

1925 – 2008



Dr John (Jack) Martin Rutherford Bruner was born in Philadelphia, Pennsylvania where his father Martin was a successful dentist. The family roots were in rural Kansas, and Martin must have retained a liking for the land, because he acquired a small cattle property on which Jack was required to attend the livestock, as well as other tasks which convinced him that a professional career was to be preferred.

Hence in 1943, he enrolled in Harvard Medical School – but there was a catch. Along with all eligible males in the United States at that time, he had to register for the draft, and did so, choosing the Navy. This resulted in a combination of part-time Navy routines with Medical School courses until April 1945, when Jack and his pre-med colleagues were yanked out of medical school and sent to Newport, Rhode Island for a crash course to become a medical corpsman.

The ‘logic’ behind this arrangement was that the forthcoming invasion of the Japanese Home islands was expected to result in 50% Marine Corps casualties, based on the experience of Okinawa. The avoidance of that bloodbath as a result of dropping atom bombs on Hiroshima and Nagasaki convinced Jack that President Truman had made the right decision, a belief from which he never wavered in spite of many revisionist claims by people who had never been at risk.

By autumn 1945, therefore, the war was over, and the Navy sent Jack back to medical school, but he was not free of obligation, as we will see. Graduating from Harvard in 1949, Jack spent two years of internship in Pennsylvania Hospital, and was a Haematology registrar in the following year when the Navy swooped and drafted him onto a Destroyer Escort (DE), a purpose-built vessel with the sole function of detecting and destroying submarines. They were cheap to build, struggled to make a top speed of 17 knots, but this was just adequate to deal with the submarines of those times.

Meanwhile, in July 1950, Jack had married Barbara Temple, the glamorous daughter of a Massachusetts family. The young couple were impecunious, to say the least, since interns at Pennsylvania H were expected to work for no pay, nor was his

registrar stipend any better. At least when the navy reclaimed him, matters improved somewhat, at the cost of his absence on sea duty. But when that was over, something else had to be found, because by then a daughter had arrived, and Barbara was pregnant again.

This led to the next phase of Jack Bruner’s medical career – eight years of family practice (1954–1962) in Groton, Massachusetts, a township the existence of which had previously been unknown to the Bruners. It also introduced the family to the ‘Bennett House’ at 4 (later 17) School Street, which was to remain a part of their lives for the next half century.

Although Jack liked family practice and loved his patients, he felt the era of specialisation approaching, and made a courageous decision to accept the drop in income which would result from entering a training program in anaesthesia for which he had developed an aptitude, to the extent that he had been appointed Chief of Anesthesia at Groton and Associate chief at Ayer Community Hospitals. Jack realised that without formal qualifications, these appointments led nowhere, so he became a resident in anaesthesia at Peter Bent Brigham Hospital, under the tutelage of the formidable Leroy Vandam. Two years later he was Board Certified, and commenced his career as a specialist, joining a firm of anaesthesiologists based at Mount Auburn Hospital, where he worked with Dwight Harken in open heart surgery, and began his life-long interest in the physics of arterial blood pressure in which he became a world authority.

From boyhood, Jack had been interested in electricity, and had constructed his own audio apparatus (‘not from a kit’, as he insisted). This naturally led to involvement in medical electronics, then just beginning to pervade hospital practice, not only in the Operating Room, but also in Units dealing with critical illness including burns.

Bruner’s expertise in this area inspired authorities at the Mass General to head hunt him, which he initially resisted, but eventually succumbed to, becoming a member of staff at MGH and Associate Professor at Harvard Medical School. It was in those years that he was observed and admired by several Australians who

had sought experience at MGH, including Michael Davies, later president of ANZCA who said that Bruner was the best clinical anaesthetist he had ever seen.

All of which led to his invitation as Visiting Speaker at the General Scientific Meeting of the Faculty of Anaesthetists, RACS in 1985. Jack and Barbara were charming guests, who gave full value to their hosts both academically and socially. So it was no surprise that they were invited back in 1991 to celebrate the first anniversary of the John Hunter Hospital in Newcastle, where once again Jack gave several of his most entertaining and instructive presentations.

By 1992, Bruner felt that it was time to forego the daily 32-mile commute from Groton to Boston and back, a journey which had become much longer and more fraught than when he had begun making it 25 years earlier. So he retired from clinical practice, but was by no means idle.

The community of Groton has reasons to be more than grateful for his skilful and wise management of their electricity supply as commissioner, a role he retained until his death. He and Barbara were generous supporters of Groton’s outstanding Indian Hill Musical Society’s academy, proudly established and maintained without a cent of government money.

Somehow also found time to acquire a pilot’s licence!

At Easter in 2008 he was diagnosed with pancreatic cancer, and rapidly declined until his death in May. In September a memorial celebration of his life was held in Groton, attended by many of his friends and accompanied by the Black Eagle Jazz Band – exactly the way Jack would have wanted.

Jack is survived by his wife of 58 years, Barbara; sons John and Bradford and daughter Temple. There are six grandchildren.

Ross Holland, October 2008



Professional documents

Following the normal review process by Council, the following Professional Document has recently been approved:

PS45 – *Statement on Patients' Rights to Pain Management and associated responsibilities*

Please note that the above document has been published in full on ANZCA's website – www.anzca.edu.au.

Australian and New Zealand College of Anaesthetists

ABN 82 055 042 852

Professional documents

P = Professional

T = Technical

EX = Examinations

PS = Professional standards

TE = Training and Educational

TE1	(2008)	<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>Formal Project Guidelines (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 and associated responsibilities*
 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*
 PS48 (2003) *Statement on Clinical Principles for Procedural Sedation*
 PS49 (2008) *Guidelines on the Health of Specialists and Trainees*
 PS50 (2004) *Recommendations on Practice Re-entry for a Specialist Anaesthetist*

August 2008

Professional documents

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Australian and New Zealand College of Anaesthetists

and

Joint Faculty of Intensive Care Medicine

ABN 82 055 042 852

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-5 (1995) *Withdrawn*
 IC-6 (2002) *The Role of Supervisors of Training in Intensive Care Medicine*
 IC-7 (2006) *Secretarial Services to Intensive Care Units*
 IC-8 (2000) *Quality Assurance*
 IC-9 (2002) *Statement on the Ethical Practice of Intensive Care Medicine*
 IC-10 (2003) *Minimum Standards for Transport of the Critically Ill*
 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*
 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*

September 08

Australian and New Zealand College of Anaesthetists

and

Faculty of Pain Medicine

ABN 82 055 042 852

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>

Professional documents

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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>

September 08