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ANZCA BULLETIN

 **ANZCA**
AUSTRALIAN AND NEW ZEALAND
COLLEGE OF ANAESTHETISTS

FPM
FACULTY OF PAIN MEDICINE
ANZCA

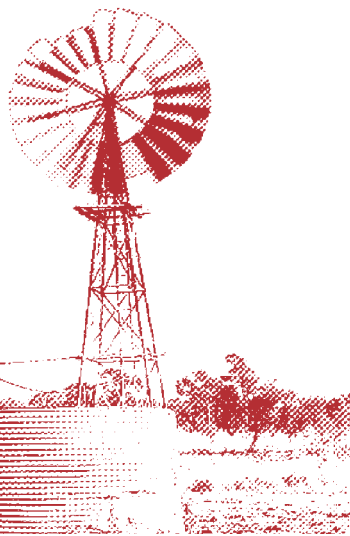
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research: NHMRC
and ANZCA
research grants

Special report:
Health reform
and anaesthesia
in Queensland

Profile: Dr Waleed
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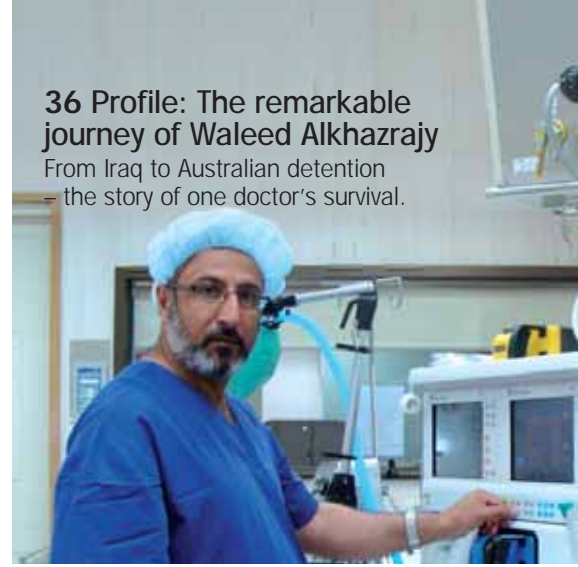
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ANZCA Bulletin

The Australian and New Zealand College of Anaesthetists (ANZCA) is the professional medical body in Australia and New Zealand that conducts education, training and continuing professional development of anaesthetists and pain medicine specialists. ANZCA comprises more than 4500 Fellows across Australia and New Zealand and serves the community by upholding the highest standards of patient safety.

Medical Editor: Dr Michelle Mulligan

Editor: Nigel Henham

Sub-editors: Clea Hincks and Liane Reynolds

Design: Christian Langstone

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Contacts

Head office

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

Faculty of Pain Medicine

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

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Cover: Cerebellum Cross Section Silver, magnified 20 times.

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President's message



As 2010 draws to a close, it is timely to reflect on what our College has achieved this year and what our vision is for 2011. This year we have:

- Commenced the Curriculum Redesign Project.
- Launched the ANZCA Teacher Course: Foundation Level.
- Implemented the online in-training assessment (ITA) process.
- Conducted a comprehensive fellowship survey.
- Presented the views of anaesthetists and pain medicine specialists to government through more than 40 submissions in New Zealand and Australia.
- Launched the Webairs incident monitoring project.
- Increased funding for research grants by 25 per cent to \$838,000.
- Supported the National Pain Summit, resulting in a national pain strategy and a new pain advocacy body called painaustralia.
- Increased the *ANZCA Bulletin's* pagination by 25 per cent with a greater emphasis on news and features.
- Increased media coverage and publicity for ANZCA and FPM substantially.

None of what we have achieved in 2010 would have been possible without the fabulous contributions of so many Fellows and trainees and, of course, our dedicated staff at ANZCA, led by our Chief Executive Officer, Mike Richards and his deputy Carolyn Handley. I would like to thank everyone who has contributed for their hard work and enthusiasm.

Our vision for 2011 – support and engagement of the fellowship

The key focus of our activities for 2011 will be the Fellows. Our goal is to provide strengthened support for the fellowship with a range of important new initiatives, to better facilitate our vision to engage Fellows more fully with the College and the profession across a range of areas. Whereas in the past five years, we have necessarily focused on building core infrastructure and administrative systems and developing capability in the areas of education, training, assessment, communications, policy, strategy and information technology, our vision for 2011 puts the emphasis back on the fellowship.

Our vision for 2011 is like a dividend to Fellows for the resources they have provided through subscriptions and pro-bono activities over the past few years to underpin fundamental structural reforms to the College that were necessary for us to achieve our mission of ensuring continued safe and high quality patient care in our two countries.

Here are the key features for 2011 relating to support for the Fellows and fellowship engagement:

- Create a new Fellowship Affairs department to enhance support for Fellow activity. The new department will bring together the existing activities of continuing professional development (CPD), quality and safety, the Australian and New Zealand Tripartite Anaesthesia Data Committee (ANZTADC) and the Trials Group to give a greater focus to Fellow-related professional activity and provide strengthened support for the key committees. This new department will be headed by a high-level manager who will give fellowship affairs the expertise and attention that they deserve.
- Assist the fellowship to fulfil mandatory CPD requirements. Significant improvements are planned to assist in the ease of access to the CPD program and provide more extensive access to podcasts and other CPD-related educational material. This involves a redesign of the CPD section of the ANZCA website and the creation of mini-sites with greater multimedia functionality. As well, educational material will be captured and disseminated for Fellows' use through podcasts and other media.
- Enhance support to Fellows in their roles as clinical teachers, supervisors of training and regional education officers. In 2011 the College will run an expanded number of clinical teaching training courses, and update the supervisors of training handbook to better support Fellows taking on these important roles.
- Implement the action program arising from the fellowship survey. This will involve a number of new initiatives, ranging from a new Fellows kit to a community awareness campaign.
- Support a research grant proposal for a project studying Fellow engagement with the College. This initiative involves ANZCA providing funding support to a research team (including College Fellows) seeking an Australian research grant to examine the clinician attitudes, experiences, motivators and skills affecting Fellow engagement in College activities and the support they require from management.
- Provide a more user-friendly website by enhancing navigability and ease of use. The extensive website re-design has been continuing through the latter half of 2010 and the final enhancements will be rolled out by the end of the first quarter next year.
- Provide a service to those Fellows who cannot attend the ASM through expanded online multi-media coverage of the event. The coverage of the ASM will be enhanced via the ASM e-newsletter, video interviews, photo galleries, podcasts and increased media attention.

- Provide enhanced Fellow support in the regions by adding to regional staff resources and improving accommodation amenities for regional committees. This involves recruiting a policy officer to the New Zealand office to strengthen its capability in making submissions to government over crucial issues affecting the fellowship in New Zealand; improving the level of support in several regional offices in Australia and increasing the functionality and amenity of regional offices.
- Increase the resource within the ANZCA Library in support of Fellows. The recent fellowship survey confirmed the high regard for the library by Fellows, and the extensive use they make of the facility. To enhance service levels, the library staff resource is being increased by 0.4 full-time equivalent.

Consolidating our support for our trainees

All this activity for the support and engagement of the fellowship does not mean that we have forgotten our trainees! After all, ANZCA is an organisation that exists to train specialist anaesthetists and pain medicine specialists and to support them in their professional lives. Here's what we have planned for 2011 for our trainees:

- A redesigned anaesthesia curriculum that better meets the modern training needs of young doctors. The curriculum redesign project is proceeding apace with the engagement of ANZCA Fellows and staff from the College's education development and training and assessments units. The new curriculum will focus on the need for our specialists to be managers, health advocates, scholars, communicators, collaborators and professionals, as well as expert anaesthetists, and will be implemented in 2012.

- Continued educational support through podcasts and webinars. The e-learning project has been gathering momentum through 2010 and in 2011 we will be providing more focused tutorials and discussions on key topics in the ANZCA curriculum.
- More streamlined record-keeping and provision of advice about training and examinations. Trainee records will be digitised and the processes in Training and Assessments will be reorganised so that trainees will always get a prompt and accurate answer to their queries. Changes we've made to the progression from basic to advanced training will also streamline trainees' admission to the final exam and to fellowship.

It promises to be an exciting year for our College in 2011. I hope that you will engage in these projects and take advantage of the increased support that we hope to offer our Fellows and trainees.

I would like to take this opportunity to wish you all a merry festive season and a relaxing and safe summer break.

Professor Kate Leslie
ANZCA President

How are we going with ENGAGE?

Embrace new training environments.

- Submission to Medicare Australia to secure for anaesthetists a provision for billing for procedures done under specialist supervision.

Negotiate and influence people.

- Submission to the Medical Board of Australia regarding mandation of CPD and the role of medical colleges in monitoring compliance.

Get involved.

- Participation rate of 88 per cent in ANZCA's CPD program.
- The Trials Group annual workshop to scope out new ideas for multi-centre research was attended by 35 anaesthetists and research nurses.

Advocate quality and safety.

- Eight colleges and professional organisations endorsed the latest revision of professional document PS9 (the "sedation" document).

Give your support.

- Dr JB Craig (WA) was appointed the inaugural Governor of the Anaesthesia and Pain Medicine Foundation for his donation of \$100,000 in 1987.

Educate yourself and others.

- Ten educational webinars in 2010 were presented by well-known ANZCA Fellows to 274 participants.

Awards

Dr Leona Wilson ONZM

ANZCA's immediate past president, Dr Leona Wilson, was invested with the insignia of an Officer of the New Zealand Order of Merit (ONZM) by New Zealand's Governor-General, Sir Anand Satyanand in September. She was made an ONZM in the Queen's Birthday Honours List for services to medicine, in particular anaesthesia. Dr Wilson was ANZCA's first New Zealand-based president and its first female president. She completed her two-year term in May this year.

Right: Dr Leona Wilson receiving her ONZM insignia from Governor-General, Sir Anand Satyanand.



Ray Hader Trainee Award for Compassion



Dr Kathryn Hagen from Auckland has been awarded the Ray Hader Award for Compassion. Dr Hader was an ANZCA trainee who died in 1997 from an accidental drug overdose after a long struggle with drug addiction. To mark the 10th anniversary of his death, a friend, Dr Brandon Carp, established an award that promotes a compassionate approach to the welfare of anaesthetists, other colleagues, patients and the community.

Announcing the award, ANZCA President, Professor Kate Leslie, said that Dr Hagen had made a great

contribution to help improve the welfare of trainee anaesthetists. This included organising run reviews of rostered hours and roster improvements at a local hospital level; her work as the Resident Doctors Association representative on the Auckland Vocational Training Committee, researching changes to the run lengths within the Auckland Vocational Scheme; as Chair of the New Zealand ANZCA Trainee Committee coordinating the production of a national handbook for trainees starting their training that is an essential resource for new trainees with information about exams, ANZCA matters and general welfare issues.

"Amongst her colleagues, Kathryn is a trusted, thoughtful, and compassionate friend, who is not only always willing to lend an ear to worries and problems, but also prepared to take action to resolve any issues. Her energy, motivation and diligence is widely admired." Dr Hagen is also a volunteer for the Royal New Zealand Plunket Society – a not-for-profit provider of child health services for children under the age of five. Dr Hagen received \$A2000 which will be used for training or educational purposes and a certificate.

Above left: Dr Brandon Carp with winner of the Ray Hader award, Dr Kathryn Hagen.



Simulation award

Clinical Associate Professor Leonie Watterson received the Simulation Industry of Australia Simulation Achievement Award for her commitment to the development of simulation-based education, training and research in healthcare, "a significant contribution to the development of modelling and simulation science, technology, policy, standards and/or industry in Australia".

ANZCA Fellows awarded \$10.3 million in National Health and Medical Research Council grants



A number of Fellows of ANZCA and FPM were successful in the NHMRC 2011 Project Grant round. They were awarded grants totalling more than \$10.3 million.

Andrew Davidson*, **Rod Hunt**, **Robyn Stargatt**, **Geoffrey Frawley***, **Pollyanna Hardy**. Outcomes from a multi-site randomised controlled trial comparing regional and general anaesthesia for effects on neurodevelopmental outcome and apnoea in infants (\$721,337.60).

Kate Leslie*, **Paul Myles***, **Michael Paech***, **David Story***, **Clara Chow**. POISE-2: A large, international, placebo-controlled, factorial trial to assess the impact of clonidine and aspirin in patients undergoing noncardiac surgery who are at risk of a perioperative cardiovascular event (\$1,136,310.00).

Paul Myles*, **Brendan Silbert***, **David Cooper**, **John McNeil**. Completion of the ATACAS Trial (\$3,328,614.00).

Jack Chen, **Ken Hillman***, **Arthas Flabouris***. The impact of introducing Medical Emergency Team on the reduction of hospital mortality and other adverse events in NSW (\$581,827.00).

Philip Siddall*, **Luke Henderson**. Thalamic neuroplasticity and pain following spinal cord injury (\$289,182.00).

Bala Venkatesh, **John Myburgh***, **Simon Finfer**, **Steven Webb**, **Jeremy Cohen**. A randomised controlled trial of the effect of hydrocortisone on mortality in critically ill patients with septic shock (\$3,270,080.40).

Rick Ledema, **Gwendolyn Gilbert**, **Claire Hooker**, **Matthew O'Sullivan**, **Christine Jorm***. Strengthening frontline clinicians: A multi-method study to reduce MRSA infection and transmission (\$773,401.00).

Andrew Somogyi*. Pharmacogenomics and Opioid Response: beyond the mu-opioid receptor (\$240,000.00).

*Denotes ANZCA or FPM Fellow

For details on the latest round of ANZCA research grants see page 62.

People and events



“Achieving our Best”

We saw some of the best, heard from some of the best, and learnt some of the best and most useful life skills we're ever likely to learn, in one of the best settings – Port Douglas. This year the format was a little different for the combined meeting of the education, simulation, welfare and management special interest groups (SIGs). Our major attraction was the TRIAD consulting group from the USA. This move towards corporate education and communication was a real hit. There were a lot of successful and well attended sessions, including clinician leadership, simulation, medical education and what to do with the “dinosaurs” in your department. Details can be found via the website of the Medical Education SIG. The format and move to non-anaesthetic speakers was a resounding success in terms of feedback. We have listened and you can look forward to exciting speakers and workshops, and maybe TRIAD again, in the future. We look forward to seeing you at Uluru in 2011.

Jodi Graham, Convenor

Above from top left: The Sheraton Mirage, Port Douglas, Queensland; Delegates in session; Dr Rowan Molnar and Dr Jodi Graham; Dr Paul McMahan and John Richardson; Dr Natalie Smith, Associate Professor Sandy Garden and Professor Kate Leslie; Dr Barbara Gaden and Dr Geoff Symonds; Mark Ritchie, Dr Gerry Meijer and Christine Meijer; Associate Professor Daryl Williams and Sheila Heen.



“Updates in Anaesthesia”

The annual WA “Updates in Anaesthesia” meeting was held at Bunker Bay in Dunsborough from October 29 to November 1. The meeting was organised by Dr Liezel Bredenkamp and the Joondalup Health Campus, Department of Anaesthesia and the WA Continuing Medical Education Committee. The theme of the meeting was “EMERGENCY – Stand Back” and covered a great variety of emergencies that the general anaesthetist may come across in his or her career. More information about the meeting can be found on page 92.

Above from top left: Bunker Bay, Western Australia; Dr Prani Shrivastava, Dr Mary Hegarty and Dr David Vyse; Conference delegates in session; Dr Charlotte Jorgensen and Dr Michael Veltman; Barry Weinman, Dr Liezel Bredenkamp and Dr Yasir Al-Tamimi.

People and events continued



FPM Spring Meeting – “Transitions in Pain”

Delegates attending the October FPM Spring Meeting in Newcastle enjoyed an intimate, yet thought-provoking conference. It was interesting to observe much animated discussion occurring not only during the sessions but in lunch and tea breaks. This was stimulated, in part, by the excellent presentations from international and national speakers. Dr Cathy Price from Southampton, UK, challenged our thinking in regard to service redesign based on her trail blazing innovations within the National Health Service. Professor Garry Egger asked us to examine potential lifestyle contributors to glial activation, neural sensitisation and the persistence of pain. Professor Brian Broom brought us back to the individual with pain and their personal story in the midst of the broader system redesign focus.

He challenged us to consider the possibility of “healing” and the need for a protected human-to-human space to facilitate the process.

A debate addressing “Where will pain medicine be in 10 years time?” was a highlight. The international speakers and Professor Egger were joined by Dr Penny Briscoe in a discussion that was both entertaining and informative. Much audience participation followed and multiple answers to the question under debate were offered.

Continuing the exploration of an emerging paradigm in pain medicine, Dr Stephen Leow alerted delegates to the difficulties faced in general practice and Dr Tim Semple gave examples of service redesign from the South Australian experience. Dr Stephanie Oak added her voice to that of Brian Broom in pointing to the power of the individual story and the mind-body connection. Other areas of

interest included an examination of the “genetics of pain” and an update on the new “inflammatory” model of depression that has significant overlap with the neuropathology of pain.

Problem-based learning discussions (PBLDs) and topical sessions were well attended. The Newcastle harbourside restaurants proved popular as did the conference dinner overlooking Newcastle Beach.

Thanks go to all who attended; delegates, healthcare industry representatives, presenters, FPM staff and our local organising committee. My hope is that each person who came was able to take away something of value, be it friendships made or renewed or ideas discussed, all with the potential to contribute in some way to “transitions in pain”.

Dr Chris Hayes, Convenor



Opposite page from left: Obelisk on the hill in Newcastle; Associate Professor Milton Cohen, Professor Ted Shipton, Dr Penny Briscoe and Rory Garrick; delegates at the meeting: Dr Cathy Price; the panel discussion; Dr Stephanie Oak, Dr Graham Rice and Dr David Jones; Dr Graham Rice asks the panel a question; Dr Milton Cohen; Dr Stephanie Oak, Professor Brian Broom and Dr Chris Hayes.

This page from left: Newcastle foreshore; Dr Penny Briscoe and Dr Marc Russo; Dr Paul Wrigley and Dr Jane Trinca; Dr Paul Gray, Professor Julia Fleming and Dr Jane Trinca; Professor Clare Collins; entertainment at the meeting.

People and events continued



The 74th NSW Continuing Education Seminar

The 74th New South Wales Continuing Education Seminar was held from November 20-21 in Port Macquarie. Dr Anne Rasmussen was the local convenor. In her opening remarks she noted it was the first time a NSW continuing medical education meeting had been held at a regional centre more than 250 kilometres away from Sydney. It was pleasing to see the meeting well attended with close to 100 registrants from both Sydney and regional NSW. The theme "Future directions in anaesthesia" was supported by some excellent plenary addresses. Professor Stephen Leeder spoke about the Federal Government's national health reform plan. Professor Mohamed Khadra discussed issues surrounding leadership in medicine and Dr Richard Halliwell looked at the broad topic of "What's next for anaesthesia in Australia?". The plenaries were supported by eight additional lectures, nine workshops and problem-based learning discussions (PBLDs) and a debate between Dr Greg O'Sullivan and Dr Tony Padley on the subject of "Laptops in theatre – are they a byte too far?".

Above from left: Port Macquarie; Dr David Elliott, Professor Stephen Leeder, Professor Mohamed Khadra and Dr Richard Halliwell; the trade area at the seminar; the "Failed intubation" workshop; Dr Tony Padley and Dr Greg O'Sullivan.



President's Christmas drinks

The President's annual Christmas drinks to thank the College's suppliers, sponsors and staff were held at ANZCA house on November 19. ANZCA President, Professor Kate Leslie also presented the Ray Hader Trainee Award for Compassion (see page 4).

Above from left: Dr Kathryn Hagen and ANZCA Chief Executive Officer Mike Richards; Bob Hayball (from insurance brokers Aon), James Hufton (from investment advisors JB Were), Geoff Tory (from the ANZCA finance department) and ANZCA President Kate Leslie; Dr Lindy Roberts, Dr Robert Edeson and Professor Alan Merry; Dr Michelle Mulligan, Professor Michael Davies, Associate Professor David Scott, Mrs Sandy Roessler and Dr Peter Roessler; guests at the President's Christmas drinks: John Biviano (ANZCA Policy, Quality and Accreditation Director) and Dr Frank Moloney.

The Australian health reform plan – implications for regional centres

A medical colleague of mine has a holiday home on Long Island, New York. He constructed a driveway from crushed clam shells. It looks good but is rough on the feet. It resembles the path to health reform: ask President Obama and ask the Honorable Nicola Roxon.

I find it useful to remind myself regularly why we are spending all this fossil fuel on health reform. The answer is that we need better patterns of organisation to cope with an ageing population, more chronic illness, new workforce challenges AND because the system is growing in cost at a rate that we can't sustain. Two things – changing demand and unsustainable growth – are why we need reform.

In April, Mr Rudd altered course for new governance arrangements for healthcare in both hospitals and community. He changed how public healthcare would be funded. He proposed local hospital networks with greater community control, 100 per cent funding for community-based care and an increase in Commonwealth funding of public hospitals, up from 40 per cent to 60 per cent, based on the volume and quality of what they do.

Post-election, the health ministry and health departments have regrouped and taken deep breaths. Mr Rudd's departure left a gaping hold in HMAS Health Reform because he took over its captaincy in his latter days. Serious consequences would have followed save for the continuity provided by Nicola Roxon as Health Minister.

The changes were garnished with money for the states and territories. As well, hundreds of millions of dollars were allocated for buildings for research and regional integrated cancer services as part of the economic stimulus package. Because these led to no telegenic cock-ups, as with the school building and ceiling insulation programs, you would be forgiven for not knowing but there is much good news there.

The recent federal election allowed regional concerns to find a new place on the health reform agenda – up near the top. Matters that the National Rural Health Alliance had been pushing received endorsement, and workforce was recognised as a critical element for the future of regional health. But it is exasperating that we have not yet seized the chance to discuss and decide about



how community and hospital services will work together better in the future.

Regional health service development was endorsed as deserving more capital works and goods. There will be specific “regional priority rounds” of Health and Hospitals Fund and Education Investment Fund infrastructure funding. For other programs – existing primary care infrastructure funding and a range of education programs – the commitment ensures that about one third of funds go to the bush. The one-third commitment is not about equity, but an amount commensurate with the population proportion.

On January 1, NSW will switch from big geographic health areas to a hybrid model of local networks and overarching clusters for its hospitals and their community outreach. Other states are also moving.

Compared with a decade or so ago, health reform is alive and kicking. But as in the US, cost containment has not featured in Australia's health reforms. Australia is in a better financial position than the US, but even here, unsustainable growth rates in healthcare will get us in the end (and you know which end) unless we take efficiency far more seriously. That means getting the right care – enough and not too much – for as many people as possible regardless of where in Australia they live.

Stephen R Leeder AO, Professor of Public Health and Community Medicine, University of Sydney

Professor Leeder is a Director of the Menzies Centre for Health Policy and Chair of the Western Sydney Local Health Network Governing Council.

Informed consent: Communicating with clarity and compassion

Consider this scenario:

You are seeking legal advice from a lawyer, who recommends a course of action. The advice seems reasonable yet you are concerned about the ramifications and the possible risks of the strategy proposed.

Would you accept this expert's advice without question? Alternatively, would you demand to understand the basis of the advice so that you can make a decision that meets with your requirements?

Clearly, some would be content with the first approach. However, others would pursue the second course of action.

This scenario provides a perspective that may be helpful in understanding the needs of our patients when we are fulfilling the role of adviser. Those who wish to take responsibility for their decisions require sufficient understanding of the possible outcomes and consequences. When viewed in this way, informed consent becomes part of a management strategy where the expert, cognisant of all the intricacies, provides advice to those patients who do not appreciate all the nuances, yet wish to retain control and be the decision maker.

Informed consent demands clear communication between healthcare professionals and patients. This underpins good medical practice with particular focus on rapport and trust.

In New Zealand, the Code of Health and Disability Services Consumers' Rights became law in July 1996.¹ It has since been reviewed three times. In July 2008, Australian health ministers endorsed the Australian Charter of Healthcare Rights and recommended its use nationwide.² Both documents emphasise that every individual has the

right to be provided with information that enables him or her to understand health services and treatment options, and participate in decision-making.

Informed consent is a legal requirement and ANZCA's expectations of Fellows in this regard are clearly articulated in the following complementary documents:

- Code of Professional Conduct.
- PS7 Recommendations for the Pre-Anaesthesia Consultation.
- PS26 Guidelines on Consent for Anaesthesia or Sedation.

The above documents provide a general guide, and do not take precedence over legal requirements. If in any doubt, Fellows are advised to consult appropriate management representatives or legal or other advisers.

PS7 identifies informed consent as central to the pre-anaesthesia consultation. The pre-anaesthesia consultation refers "not only to situations pertinent to the administration of general anaesthesia but also includes those related to regional anaesthesia/analgesia and sedation". ANZCA recognises that in emergencies, circumstances may prohibit one from obtaining informed consent as any delay may compromise patient welfare. PS26 acknowledges that "if the situation is so urgent that immediate intervention is necessary to preserve life or prevent serious harm, it may not be possible or sensible to obtain full consent". In such cases, timely follow-up is essential; provision of information and discussion of the treatment undertaken with the patient, or other suitable persons, must ensue as soon as possible.

In 2006 the National Health and Medical Research Council released a publication entitled, *Making Decisions about Tests and Treatments: Principles for Better Communication Between Healthcare Consumers and Healthcare Professionals*. The comprehensive resource acknowledges the many benefits of sound communication between patients and healthcare professionals: "There is evidence that good communication helps to build trusting relationships between consumers and professionals, leads to

greater satisfaction on both sides; helps people to take more responsibility for their own health, and reduces medical errors and mishaps".³

The consumer agenda in the health sector is gaining increasing attention. While some individuals may consequently feel empowered to seek out answers to questions concerning their healthcare, what about those patients of comparatively lower health literacy? PS26 advocates that "information should be provided in a form the patient is likely to understand. This may include the option of presenting information in the printed form or via computer or other electronic means". While audio visual resources may be helpful, they are not a replacement for the required discussion with the patient. The concept of "consent forms" arises frequently however these too only serve as an additional tool. A form may be employed as a checklist, prompting topics for discussion, and can be retained by the patient or carer for future reference. However, it is not a replacement for the necessary verbal exchange. Information provided must be tailored to the particular circumstances and requirements of the patient. A qualified interpreter (not a family member) should be used whenever necessary.

Fellows are advised to maintain contemporaneous records. While patient welfare is the key driver for informed consent, it is acknowledged that self-protection is also a consideration, given the increasingly medicolegal context within which healthcare services are delivered. PS26 cautions that while the extent of documentation may be governed by local legislation and practice, it is prudent for the provider to record details of the consent in the patient's notes. This should include "reference to the discussion of relevant material risks and the agreement by the patient to undergo the treatment". A recent review of published reports from the New Zealand Health and Disability Commissioner concluded that communication is one of two key areas of a medical practitioner's role addressed by public complaints, having been identified in 48.7 per cent of the 100 investigations sampled.⁴

Practitioners may elect to delegate the duty of obtaining informed consent however they do so at their own risk. PS26 advocates that “disclosure of information and discussion is best performed by the anaesthetist who will be conducting the treatment”. Ideally, consent should also be obtained by the treating anaesthetist, as he or she may be liable if inadequate consent is obtained by another person on their behalf. Trainees must be supported in this context and patients advised accordingly.

In recent years ANZCA has collaborated with the Australian Society of Anaesthetists to raise awareness of informed financial consent (IFC) among Fellows. Full IFC is defined as occurring when “each and every medical specialty (including the hospital) treating a patient informs the patient of likely costs and out-of-pocket expenses before hospital treatment”.⁵ PS26 asserts that “where appropriate, the financial implications of the proposed treatment should be discussed”. The College’s Code of Professional Conduct also makes reference to IFC. It is recognised that there will be situations or circumstances where such discussion may be impossible or inappropriate. For instance, when an anaesthetist is asked to perform an epidural for labour, the patient is usually in pain and her partner or support person may not be in a state to provide IFC. The focus for everyone is to get the job done. The same issues apply to urgent caesarean sections.

ANZCA is highly committed to improving the level of information being provided to patients in an appropriate and professional manner. We strongly encourage anaesthetists and pain medicine physicians to be mindful of communicating effectively with patients. Fellows wishing to improve their communication skills are encouraged to seek out opportunities through the continuing professional development program.



PS7 and PS26, along with other professional documents are available via ANZCA’s website at: www.anzca.edu.au/resources/professional-documents/. Faculty of Pain Medicine professional documents can be accessed via the FPM website: www.anzca.edu.au/fpm/resources/professional-documents.

The Code of Professional Conduct is available at: <http://www.anzca.edu.au/resources/guidelines/Code-of-Conduct.pdf/view>.

Dr Peter Roessler, Director of Professional Affairs (Professional Documents)

John Biviano, Director Policy, Quality and Accreditation

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On the road in New Zealand



In a punishing schedule of visits, the Chair of ANZCA's New Zealand National Committee (NZNC), Dr Vanessa Beavis, has taken to the road to discuss the work and role of the College with New Zealand's anaesthetic workforce.

The "roadshow" involves 26 meetings in New Zealand's public hospital anaesthesia departments. It started in October, 2010 and will conclude in March 2011. The initiative stems from the NZNC's unanimous vote earlier this year that there should be a countrywide tour of hospitals to help achieve ANZCA's 2010-12 strategy initiative of increasing engagement by, and with, the College's members.

In each presentation, Dr Beavis describes the purpose, functions, structure and financial situation of the College and the role of the NZNC. She also details developments such as the curriculum redesign and the significant changes in assessing trainees, including the extra work this will require from supervisors of training and other supervising consultants.

She describes the type of specialist the changes aim to produce and says that while the previous system was not broken, it was "loose" and improvements were necessary. The new one, she says, will be more robust and defensible, producing greater consistency and a trainee with a better understanding of how they are achieving in the system.

Dr Beavis also speaks about the need for anaesthetists to build a stronger public face and understanding of their role.

"I urge you to recognise that every patient contact is an opportunity to market the profession and what it does," she says. "Introduce yourself as a doctor who is handling the anaesthesia rather than just as an anaesthetist."

A primary objective of the roadshow exercise is to hear from the audience about their issues and concerns. General themes to emerge from the meetings to date include:

- Concern at the amount of work for supervisors involved under the new FANZCA training and assessment requirements.
- Concern that far less qualified alternative providers may be considered while fully medically qualified anaesthetists are required to "jump through more and more hoops", and the need for the College to campaign in this area.
- Issues around international medical graduate specialists (IMGs) and their assessment and the path to fellowship, plus the need to provide some sort of affiliation to the College for those who may be able to gain vocational registration but not a FANZCA because they are still required to work to College rules and should, therefore, have a voice.

- Questions over the incentive for being a Fellow of the College.
- Difficulty of access to some ANZCA resources, particularly the disparity between New Zealand Fellows' access and that for Australian Fellows.
- The need for greater and more formal co-operation between rural and urban hospitals to help solve rural hospital staffing problems (which make them particularly vulnerable to the alternative provider scenario), to improve collegiality generally and to provide more opportunities for anaesthetists in each environment to learn from one another.
- Praise for the recent ANZCA Foundation Teachers Course held in Wellington, with participants saying how valuable they found it and that they were already putting its principles into practice, especially when providing feedback.

Workforce issues, particularly the supply outlook and the prospect of alternative providers, are being discussed in detail at a separate series of meetings under the auspices of a joint ANZCA-NZSA Workforce Subcommittee. However, Dr Beavis does explain the political nature of the issue.

"There is no place for non-medical anaesthesia in this country," she says. "Any help (nurse anaesthetists, physician assistants, etc) must involve delegation, under supervision, and not substitution."



She stresses the need for anaesthetists to undertake research to demonstrate the specialist nature of their work, otherwise they risk being seen only as operating technicians.

The roadshows, co-ordinated by New Zealand's new Communications Manager, Susan Ewart, have required a huge commitment from Dr Beavis, who is also head of anaesthesia at New Zealand's largest hospital, Auckland City Hospital. A full report will be prepared for the NZNC by staff members attending the meetings.

"I urge you to recognise that every patient contact is an opportunity to market the profession and what it does – introduce yourself as a doctor who is handling the anaesthesia rather than just as an anaesthetist."

Roadshow meeting sites



Meetings have already been held in (from left): Auckland, Rotorua, Christchurch and Timaru as well as 16 other centres.



ANAESTHESIA IN QLD

SPECIAL REPORT: HEALTH REFORM AND ANAESTHESIA DEVELOPMENTS IN QUEENSLAND

In previous editions of the *ANZCA Bulletin* Australian and New Zealand Health Ministers have been interviewed regarding some of the key issues facing both countries' health systems and, in particular, anaesthesia and pain medicine specialists and the wider profession. In the September issue of the *ANZCA Bulletin* we commenced a series looking at developments in state jurisdictions beginning with New South Wales. In this issue, we put the spotlight on Queensland, post-Patel, and look at some of the innovations occurring in the Sunshine State.



QUEENSLAND'S HEALTH SYSTEM – CHANGES AND CHALLENGES



SEAN MCMANUS
CHAIR, QUEENSLAND REGIONAL COMMITTEE

Anaesthetists working in Queensland have witnessed many changes over the last 10 years: indeed the Chinese curse “May you live in interesting times” could be applied. In this article, I want to plot the factors existing in Queensland that led to the recent enquiries into the health system and share my views on the responses of the Queensland government and ANZCA to the challenges that face our state.

The geography of the state, the rapid population growth and the structural changes in the public health system combined to create a perfect storm that descended on Bundaberg in the form of the scandal involving surgeon Dr Jayant Patel who was convicted of three counts of manslaughter and one of grievous body harm. In retrospect, we can see that these conditions existed in many hospitals in Queensland and it was Bundaberg's misfortune that it became the focal point. It is no surprise that the public and patients demanded accountability from those responsible for the provision of health services. The results – the Davies and Forster reports from enquiries into the events at Bundaberg and a number of other hospitals – are a salutary lesson for all involved in healthcare. As anaesthetists working in the public hospital engine room where 60 per cent of all services occur, the reports would already have been a useful resource. The fact that the triggering events occurred in the operating theatre make them even more so.

The population of Queensland is concentrated in the south-east corner and then spreads up the coastline for over 2000 kilometres, with multiple

moderately sized towns dotted along the way. Adding inland regional towns such as Toowoomba and Mount Isa, the spread of mid-sized (base) hospitals requiring specialist level medical services exceeds any other Australian state. In many of these hospitals at the time of the Patel affair, the numbers of procedural GPs willing to provide the required services were diminishing as the realities of high insurance costs and minimal backfill for upskilling made it difficult for them to continue.

In addition, Queensland was experiencing a population boom, and as state politicians talked up the number of people moving into the Sunshine State, growth exceeded all infrastructure planning with health no exception. The south-east corner was at the forefront, but regional centres had their share of “seachangers” and “treechangers”. In what seemed like an overnight change, sleepy little holiday spots like Hervey Bay were inundated with retirees looking to see out their years in the Sunshine State. Unfortunately they brought their arthritic hips, bowel polyps, cataracts, and skin lesions with them.

Coincidentally, the public health system in Queensland underwent major structural reform in the mid-nineties. With a focus on efficiency all the individual health administrations were brought in under one management structure – Queensland Health. No doubt efficiencies were achieved, but an unintended consequence was a widening gulf between the administrative and clinical arms of the organisation. The involvement of senior clinical staff in hospital administration gradually diminished as the era of the professional health bureaucrat emerged. The traditional duty of the most senior doctors to undertake administrative duties was reduced and many gladly relinquished them to concentrate on clinical work (their “real job”). The disconnect between Queensland Health and its senior clinical staff was insidious and relentless. Long term staff specialists and VMOs would see multiple managers come and go, various restructures and introductions of innumerable special projects that seemed to absorb funding at an ever-increasing rate, often at the expense of clinical resources. The creation of an “us and them” mentality led to many clinicians regarding Queensland Health as a faceless entity and considering themselves not part of it (despite many working directly for it).

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ANAESTHESIA IN QLD CONTINUED



The shortage of doctors in Queensland, especially in regional areas was acute in the 1990s. Although a worldwide phenomenon, the presence of a single medical school in the state, whose enrolments had not increased in line with workforce demands, was a major issue. A second medical school opened in 2000, but there was significant lag time in producing specialists capable of delivering the required services. Compounding this was the fact that, until recently, virtually all specialist training occurred in Brisbane, so naturally new specialists and their families tended to settle there, making the decision to move to a regional area all the more difficult. Anaesthetists, as the major determinant of theatre capacity, were at the coal face. The media focus on waiting lists, the emergency theatre case workload, the after hours work and the disparity between incomes of public and private anaesthetists meant many departments struggled to attract staff.

In many cases, the shortage was filled by international medical graduate specialists (IMGS) via area of need (AON) provisions. These regulations were designed to allow specialists trained outside Australia to provide services under the supervision of appropriately qualified specialist. Although many were excellent, the standard varied enormously as did the level of supervision they received. In 1990 around 7 per cent of Queensland Health medical staff were overseas trained; that figure is currently around 37 per cent. The lack of established pathways toward gaining fellowship meant many IMGS, already struggling with cultural issues and professionally isolated, found themselves stuck in service provision roles.

The events in Bundaberg and the subsequent reforms have had a profound effect on healthcare in Queensland, particularly on the public side. Queensland Health, the Medical Board of Queensland and various other regulatory bodies were roundly criticised in the reports. The result is a far more stringent adherence to correct process, sometimes exacerbating the delays in getting doctors actually seeing patients.

The replacement of state medical boards by the Medical Board of Australia has brought with it compulsory continuing professional development (CPD). The Health Practitioner Regulation National Law now stipulates that all clinicians have a mandatory duty to report if, in the course of practising their profession, they form a reasonable belief that a registered health practitioner has behaved in a way that constitutes notifiable conduct. Another example of the new paradigm in Queensland is the Health Quality and Complaints Commission (HQCC), a statutory body formed as a watchdog for all health services. The body has substantial resources and powers of investigation. Those clinicians who have been through the investigative process have found it harrowing. One would hope that this new, stricter regulatory environment will reduce the likelihood of future healthcare scandals.

There have been some significant positive outcomes from this process, in particular improvements in the pay and conditions of public hospital staff specialists. Although assisted by political will post-Bundaberg, much work was done behind the scenes negotiating a new agreement with Queensland Health and anaesthetists were actively involved. The Davies and Forster reports both recognised the importance of retaining senior clinical staff and perhaps helped convince Queensland Health as well. The resulting enterprise bargaining agreement, while not universally supported, was a big improvement – especially the recognition of non-clinical time and professional development leave. A staggered series of pay rises made the remuneration competitive with other states and closed the gap on private practice income. The Bundaberg Hospital Department of Anaesthesia is an example of the regeneration that is occurring. The result in other public departments has been similar, with many trainees considering full-time public practice as a long-term career option. The competition for posts has meant that departments are able to be selective in appointing new specialists and to create positive environments for teaching and training. A perusal of the internet posts sees trainees advising each other to work for a year as a provisional Fellow in a department if they want a permanent post.

There has been an enormous amount of work done by ANZCA and its Fellows to improve the situation for IMGS. There is now a formal structured assessment process that groups them into three categories based on the degree of comparability to Fellows of ANZCA. Once classified, IMGS have a much clearer understanding of the requirements for fellowship, with specific supervisors and assessments in place. Specific initiatives for Queensland have been led by associate professors Michael Steyn and Kersi Taraporewella. There are now federally funded positions at major teaching hospitals like the Royal Brisbane and Women's, giving the IMGSs access to the same resources as ANZCA trainees. In addition, former IMGSs have set up the overseas trained specialist anaesthetists network (OTSAN), an organisation designed to assist all IMGSs to start a successful new life in Australia. OTSAN was initially started with a strong bias towards education, as passing the performance assessment (the "exam") is vital. It now helps with other aspects such as immigration requirements, jobs and industrial relations, liaison with national and local structures (e.g. ANZCA, MBA), education (structure, content and technique of the exam) and social networking.

While the events of Bundaberg were tragic, the changes it has brought have benefited many in the health system. To its credit, Queensland Health is attempting to re-engage with senior clinicians. Ironically the proposed federal reforms aim to return some measure of autonomy to the regions, though to what degree remains to be seen. We may well go back to the days of a "hospital board" – everything old is new again.

As we settle into the post-Patel era, what other challenges do anaesthetists face in Queensland? Workforce issues are still at the forefront. Current models predict a shortage of anaesthetists with current training numbers even with zero population growth. The Queensland Regional Committee (QRC) has formally written to the director general of Queensland Health requesting more anaesthetic training posts. We have



From left: Gold Coast Hospital; Cairns Base Hospital.

been advised that there is no funding at this stage. Considering that anaesthetic services are involved in around 60 per cent of all acute hospital services, we are hopeful that funding will be sourced.

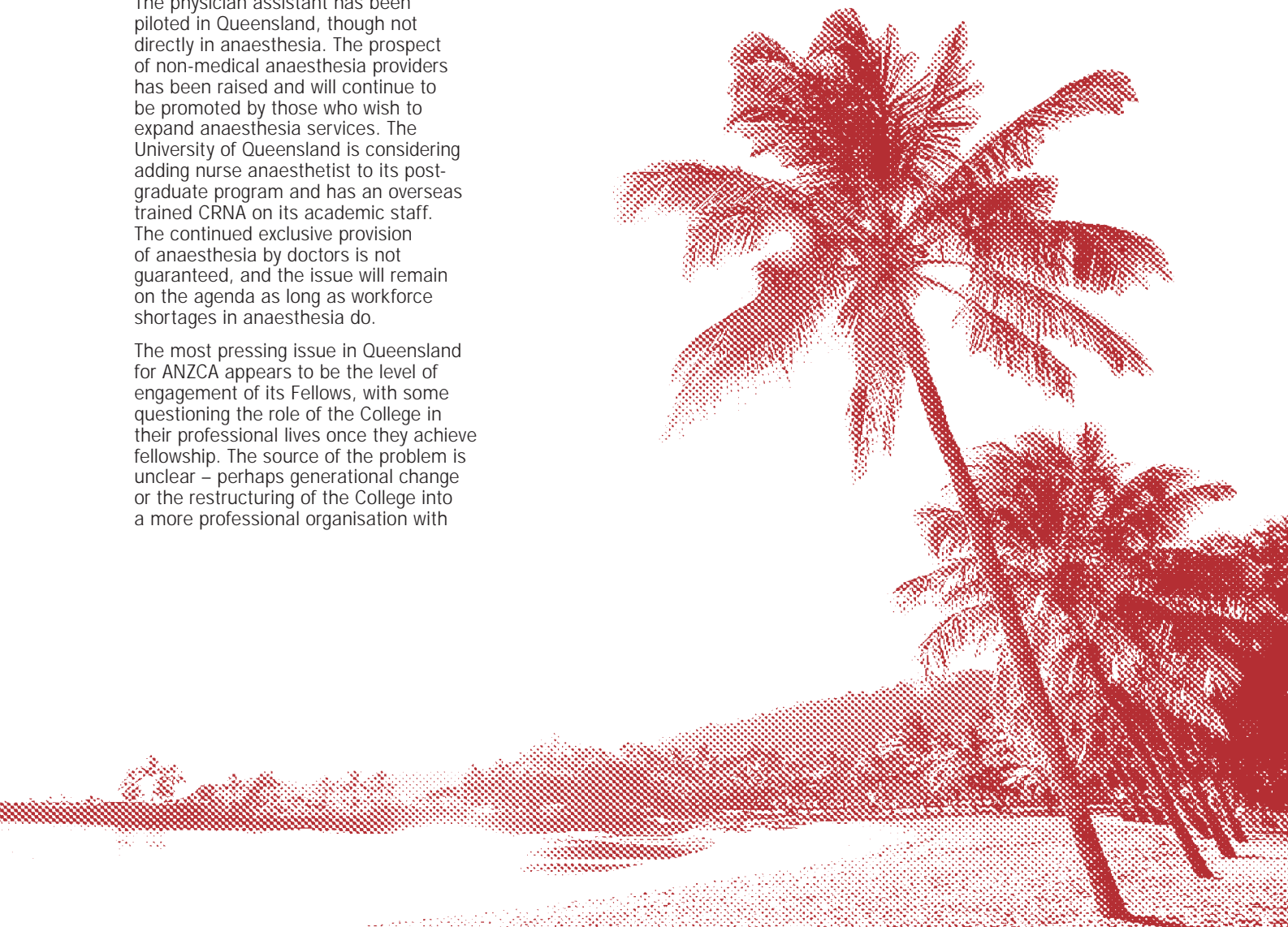
The anaesthetic assistant role is under review in Queensland. Traditionally a nursing duty (registered or enrolled), there is a move toward a more formal accreditation, either by supporting existing anaesthetic nurses to undertake suitable post-graduate courses or having the anaesthetic technician as a distinct professional stream, similar to the ODPs in the UK. The Southbank Institute of Technology has the only Diploma of Paramedical Science (Anaesthesia) in Australia. Technicians are in posts at a few hospitals where they appear to function well, and certainly the recognition of their skills as being specialised has aided morale. Although politically sensitive, the introduction of non-nursing personnel to the hospital workforce may help ease the nursing shortage.

The physician assistant has been piloted in Queensland, though not directly in anaesthesia. The prospect of non-medical anaesthesia providers has been raised and will continue to be promoted by those who wish to expand anaesthesia services. The University of Queensland is considering adding nurse anaesthetist to its post-graduate program and has an overseas trained CRNA on its academic staff. The continued exclusive provision of anaesthesia by doctors is not guaranteed, and the issue will remain on the agenda as long as workforce shortages in anaesthesia do.

The most pressing issue in Queensland for ANZCA appears to be the level of engagement of its Fellows, with some questioning the role of the College in their professional lives once they achieve fellowship. The source of the problem is unclear – perhaps generational change or the restructuring of the College into a more professional organisation with

centralised corporate governance and fund-holding are contributing factors. However, the QRC still has significant roles in education, training, continuing professional development and liaison with our state government on issues of the day. The QRC is dependent on a very small number of Fellows who give up their time to maintain these functions. This year we had 11 nominees for 12 positions on the committee that represents all ANZCA Fellows and trainees in Queensland. The QRC also struggles to find volunteers to conduct hospital inspections and workplace assessments. These activities are time-consuming, but interesting, and are vital to the future of the specialty in our state. I urge you to contribute to them as well as to the QRC's strategic planning process for 2011-15. Please contact me at Sean.McManus@health.qld.gov.au.

“While the events of Bundaberg were tragic, the changes it has brought about have benefited many in the health system. To its credit, Queensland Health is attempting to re-engage with senior clinicians. Ironically, the proposed federal reforms aim to return some measure of autonomy to the regions, though to what degree remains to be seen. We may well go back to the days of a ‘Hospital Board’. Everything old is new again.”



ANAESTHESIA IN QLD CONTINUED

BACK FROM THE BRINK – BUNDABERG REBUILDS POST PATEL



DR MORNE TERBLANCHE
DIRECTOR, DEPARTMENT OF
ANAESTHESIA AND PERIOPERATIVE
SERVICES, BUNDABERG BASE
HOSPITAL, QUEENSLAND

Bundaberg is famous for many things – turtles, rum, ginger beer, Bert Hinkler and unfortunately surgeon Dr Jayant Patel, otherwise known as Dr Death. The Patel saga received international coverage and there was much emotion involved. Even though Patel was recently found guilty on manslaughter charges we have not seen the end of the matter. There is little doubt that Patel practised outside his scope of expertise but what is not clear is the devastating affect it had on the community and hospital staff. Nurses still talk about being victimised in public when wearing their uniform and on an almost daily basis we deal with patients that have “survived” Patel. I say “survived” because often the only contact was at arms length via a registrar.

The effect on the community has been addressed in the media and has become largely a political issue. The effect on the medical establishment has been overlooked. It decimated the senior medical establishment and today only three staff members from the Patel era are still in full-time employment.

I arrived in early 2007 – January 16 to be precise. At that stage the anaesthetic department consisted of a locum director, two permanent staff anaesthetists, one temporary staff specialist and two visiting medical officers (VMOs). Only one staff member had a FANZCA and that was one of the VMOs.

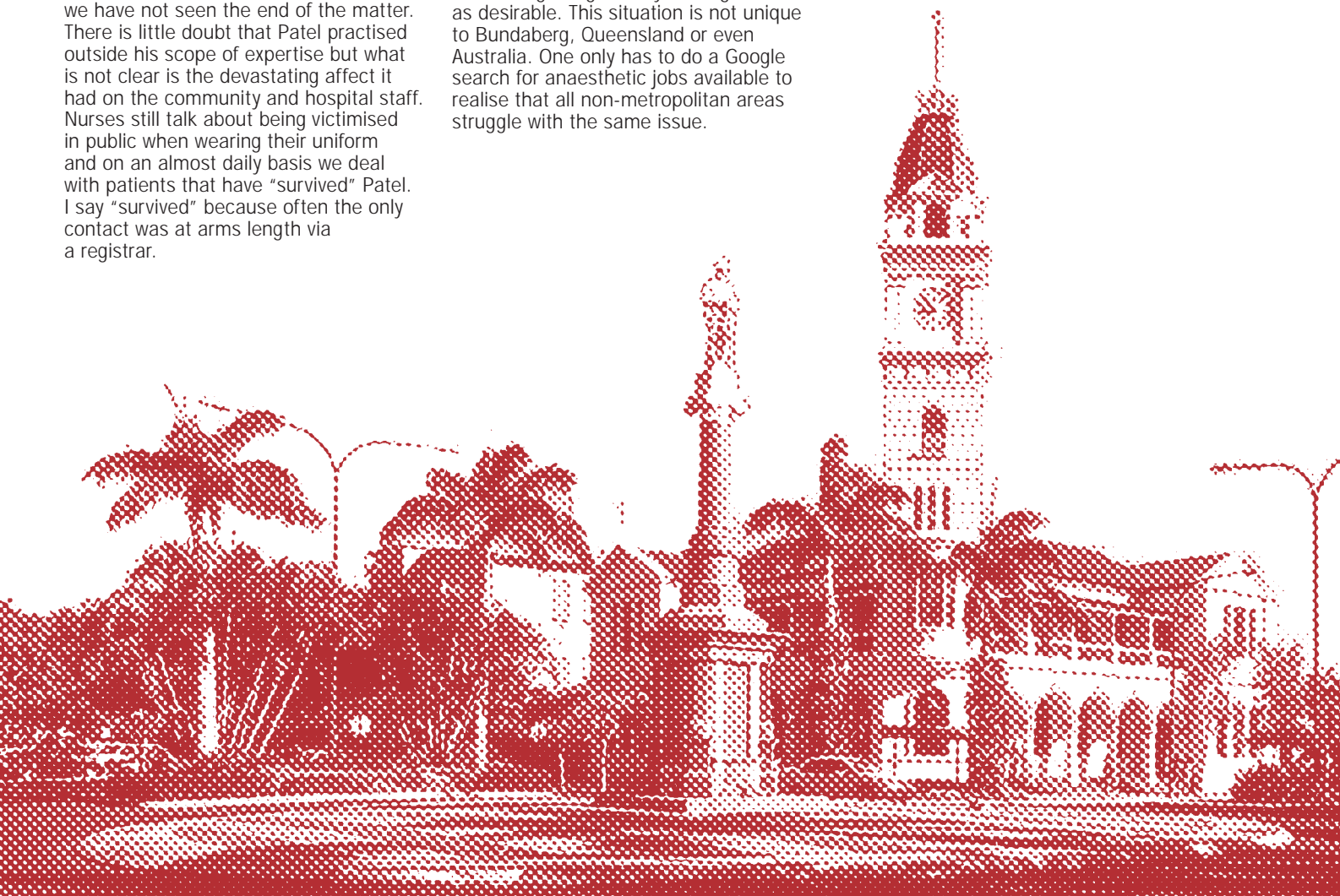
There was a significant drive to attract senior staff from in, and outside, Australia. Today the department consists of a director, deputy director ICU and seven staff specialists. The department now boasts seven FANZCAs and College accreditation for the training of anaesthetic registrars.

Even before the Patel saga the hospital had difficulty in attracting Australian-trained doctors. Outposts like Bundaberg are generally not regarded as desirable. This situation is not unique to Bundaberg, Queensland or even Australia. One only has to do a Google search for anaesthetic jobs available to realise that all non-metropolitan areas struggle with the same issue.

Our entire specialist establishment now has worked in large metropolitan areas overseas. All acknowledge that in their respective countries they would never have considered working in a regional centre, yet most are now of the firm opinion that they cannot see themselves going back to the big smoke.

Our staff made life-changing decisions in moving to Australia. Ending up in a regional centre was a given as they had to work in an area of need. For them this turned out to be a blessing in disguise. How do we make the Aussies see the light? Is it a case of build it and they will come?

I think a bit of luck was involved in our evolution. Four years ago the then-Director of Anaesthetics, a locum and an overseas trainee himself, realised after many futile attempts, that attracting Australians to the region was virtually impossible. Bundaberg was, and still is, considered professional suicide. Why go and work in an institution that is, from all reports, failing and doing more harm than good?





Permanent staff was the answer and the overseas market the only option. Even though there was some exposure of the Patel saga overseas it was not exactly front page news. So we needed to take Patel out of the equation. Tell people that there is a job available in a seaside town in sunny Queensland with loads of opportunities for development. You have the chance to be involved in something big, a new redevelopment, come and put your stamp on it. Great schools and even better beaches with a very attractive pay package, what do you have to lose? If it was real estate you would have called it a "renovator" with potential. Who could say no?

I couldn't. It wasn't until I arrived that I appreciated what an impact Patel had on the community and staff. But by then it was too late. I couldn't exactly pack my bags and go back to South Africa.

There was a tangible uneasiness in theatre. I was viewed with some suspicion by the nurses and who could blame them? All the doctors have left and the only ones standing were the nurses and they were there to protect their patients against a repeat performance. Every action and decision was scrutinised and where doubt existed it was escalated to management.

The fact that a director of medical services' lifespan in Bundaberg was about the same as a tail gunner in WWII didn't exactly help to improve things. The two anaesthetists that were left from the Patel era were still recovering from shell shock. It was so all consuming that working towards a FANZCA was a distant memory. It was all about survival and going back to the basics of self preservation. We are talking about first class anaesthetists here who became collateral damage and had to explain themselves in court. Who knows how long it will take for all wounds to heal?

Stability among senior staff was non-existent. Locums came and went. We did get lucky with locums every now and then, and when we did we held on to them for as long as we could. Once nurses developed trust in your ability they started asking when you were leaving. That was just the way it was. Bundaberg was an entry point to somewhere else.

To improve the situation it was realised that you need a critical mass of people of a certain quality and ability that were going to hang around for a bit. This is where ANZCA and the Statewide Anaesthetic and Peri operative NETWORK (SWAPNET) played major roles.

All our anaesthetists including myself hail from somewhere offshore. We had little to no idea of the intricacies of managing an anaesthetic service in regional Australia. We had our suspicions that it may not be much different to other places in the world but how do you know for sure? You ask, is the short answer. And we did. The network members not only provided information or reinforced what we already knew but, more importantly, made us realise that we were not alone and that most of our issues were not unique.

From these discussions we came to realise that ANZCA could be an ally in making the department more attractive to locals. Attracting Australian doctors is of vital importance in establishing a stable, viable department.

ANZCA accreditation would provide the following:

1. An unlimited flow of junior doctors.

In the past, all junior doctors were recruited from overseas. There are huge financial implications in doing business this way but more importantly there are cultural, linguistic and training difficulties. Also, from the point a doctor accepts a position until they arrive takes three to six months, which makes the department reliant on locums. With ANZCA accreditation we would be allocated four registrars from Queensland on an annual basis. As an added bonus most of these doctors would be Australian trained.

What better way of exposing Australian doctors to the possibilities a rural centre has to offer, than by employing them? We are entering our second year of training and already we are reaping the benefits and for the first time ever we have more job applications than jobs. For the first time in many years the department is employing Australians. These may only be first-year registrars but they are part of the future of this department. Maybe the next director will be one of them!

2. An opportunity for academic development for senior staff.

What can be more important than a registrar keeping the consultant honest? The guidelines set out by ANZCA provided us with an excellent framework for the development of not only a training program but a whole department. It was almost like a user manual for the establishment of a department and I mean establish because just having a few anaesthetists around doesn't make a department. Senior staff now have a much more structured approach in their own education as they form an active part of registrar training.

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"We need to support our colleagues and treat them with the respect they deserve. They are a valuable resource and it is important that every effort is made to assist them in integrating not only in the health care system but society. Stability is more important than nationality and stability is essential for improvement."



ANAESTHESIA IN QLD CONTINUED

Clinical governance falls under this banner. Audits, morbidity and mortality meetings and chart reviews now form part of the education process. Each registrar with the help of a consultant is involved in a project. Because this is all integrated in the training program, quality control is of a higher standard than ever before. The consultants took on these roles with enthusiasm and I am convinced it contributes to job satisfaction.

3. General support. One of the biggest advantages in having an assessment for accreditation is that it lends support to the department in resource allocation. In our department we had difficulty in allocating funds for an up-to-date ultrasound machine. To attract staff you have to offer up to date equipment and facilities if you want to compete with bigger centres. An ultrasound machine would mean an additional training instrument, professional development for consultants and improved patient safety. The College supported this view and made a recommendation to executive. With this additional support money was allocated and we now boast a brand new state-of-the-art ultrasound machine.

ICU AND THE ANAESTHETIST

Bundaberg, as with other smaller units, has an intensive care unit (ICU) that is staffed and managed by the anaesthetic department. Many anaesthetists feel uneasy with this marriage and it is not exactly an attractive offer for most people. With various levels of experience and interest in ICU it was an issue that had to be addressed.

With the help of Queensland tele-health services and the Royal Brisbane Hospital ICU, Bundaberg introduced tele-health in ICU. It has gone through various stages of development with continuous improvement. With mobile tele-health technology the ICU team is now able to do a business round daily at the bedside with an intensivist from Brisbane. It was so successful that staff were finally comfortable with the principle of a close unit. In the past 12 months the admission rate has increased by 10 per cent and retrievals have decreased by 30 per cent, with no change in mortality. I was fortunate enough to present this very successful initiative at the recent Critical Care AGM in Melbourne as an invited speaker and it was well received.

Ultimately, success in Bundaberg is the sum total of many factors. The most important factor is staff, the right people in the right place at the right time. You will have noticed that I didn't mention international medical graduate specialists (IMGs) and the politics surrounding the issue. It is a powder keg but recent changes in the assessment process are a step in the right direction. There is no denying that the Australian health system will depend on IMGs for the foreseeable future.

We need to support our colleagues and treat them with the respect they deserve. They are a valuable resource and it is important that every effort is made to assist them in integrating not only in the healthcare system but society. Stability is more important than nationality and stability is essential for improvement.

Right: Townsville Hospital.



The Bundaberg anaesthetic department is going from strength to strength and the surgical departments are now playing catch up. We have established an acute pain service and are working towards a more holistic chronic pain service. The next big project is getting accreditation for basic ICU training.

Success depends on creating a pleasant stable environment and exposing Australian trainees to the opportunities places like Bundaberg has to offer so that hopefully one day, they will come back with their families. Bundaberg and rural Australia should sell the whole package to potential employees. Maybe we should get a real estate agent to do our advertising campaign; they do it so much better.

"The fact that a Director of Medical Services' lifespan in Bundaberg was about the same as a tail gunner in WWII didn't exactly help to improve things. The two anaesthetists that were left from the Patel era were still recovering from shell shock. It was so all consuming that working towards a FANZCA was a distant memory. It was all about survival and going back to the basics of self preservation."





**STATE-OF-THE-ART ANAESTHETIC TECHNOLOGY IN QUEENSLAND
AUTOMATED ANAESTHETIC RECORD KEEPING (AARK) PROJECT**



DR JOHN ARCHDEACON
CLINICAL CONSULTANT,
AARK PROJECT

BACKGROUND

The AARK project was initiated to deliver an integrated statewide anaesthetic record keeping solution. It is implementing a standardised solution for Queensland Health that supports having an electronic patient record available in the perioperative environment.

AARK is part of the Queensland Government's \$243 million investment in eHealth. It was initiated by the StateWide Anaesthesia and Perioperative Network (SWAPNet) in Queensland, which recognised that before we can improve the quality of anaesthesia in Queensland we first need to be able to compare techniques and outcomes.

The introduction of AARK has already significantly improved data entry times for clinicians – from an average of 30 minutes down to eight minutes for long surgical cases. This means clinicians have more time to spend with their patients.

CAIRNS BASE HOSPITAL

The AARK system has been developed almost entirely with the input of anaesthetists and post-anaesthetic care unit (PACU) nurses. Cairns Base Hospital's Department of Anaesthesia was the first to roll out the system as

part of the hospital's redevelopment in 1999. Over the next four years, the anaesthetic department provided guidance regarding the content and function of the developing product.

Cairns has been using the AARK system in the induction rooms, theatres and recovery beds of its operating suite since 2003 and has seized every opportunity to demonstrate its benefits to visiting anaesthetists and administrators. Registrars who have been using the program in Cairns have been reluctant to move to other hospitals where AARK is not available.

STATE-OF-THE-ART TECHNOLOGY FOR QUEENSLANDERS

AARK has now been embraced by 12 Queensland Health hospitals and has reduced the time spent on retrieving a patient's previous anaesthetic information. Patients undergoing surgery are now receiving an enhanced quality of care thanks to the state-of-the-art system which allows patient information to be automatically captured from monitoring devices.

Clinicians are also seeing improvements in the consistency of data recording, clarity and access to patient information, meaning better care for Queenslanders. Acceptance of the system by both nurses and doctors has been enthusiastic at all locations, and the intuitive nature of the system sees new users working confidently within days of first exposure. Freeing the clinician from the continuous need to document patient vitals gives time for more considered care.

Prompts for the easy ordering of post-operative protocols for managing pain and nausea result in very high adoption and the simple presence of a record that shows each clinician in fine detail how their patient has fared improves quality of care.

BRINGING TOGETHER CLINICAL EXPERTISE AND INNOVATION

The AARK project has brought together the expertise and funding to prepare hospitals and their staff for implementation, to install the hardware, educate the users, and to solve the technical issues inherent in rolling out a complex system to geographically dispersed hospitals.

The system is centrally funded and maintained, ensuring that a current and consistent version will be present in all locations across the state – particularly important for a mobile workforce of registrars and nurses. User support is provided through an online self-service helpdesk. The development and integrity of the project is guided by groups of clinical product champions and co-custodians Associate Professor Michael Steyn and Dr John Archdeacon (the project's clinical consultant).

CLINICAL SUPPORT THROUGH ANALYSIS AND REPORTING

The AARK system includes a clinical analysis and reporting module (CARM) which:

- Allows analysis of outcomes relevant to anaesthesia, such as pain and nausea scores in recovery with reference to analgesics and antiemetic prophylaxis given in theatre.
- Reports items of interest to the College, such as levels of supervision of trainees relative to patient ASA status and time of day, and provides detailed log books and administrative reports.

WHERE TO FROM HERE

Ongoing development of the AARK system is planned to include computer-assisted decision making and prompts such as prophylactic antibiotics in relevant cases. This will make it easy for clinicians to follow best practice protocols throughout the state and encourages quality improvement.

The AARK system will continue to be implemented at nominated facilities with anaesthetic departments across Queensland.

“The introduction of AARK has already significantly improved data entry times for clinicians – from an average of 30 minutes down to eight minutes for long surgical cases. This means clinicians have more time to spend with their patients.”

ANAESTHESIA IN QLD CONTINUED



CONTINUING MEDICAL EDUCATION



DR GENEVIEVE GOULDING
CHAIR, COMBINED ANZCA/ASA
CME COMMITTEE

The Queensland combined ANZCA/ASA CME committee oversees a number of CME activities for the state, both for Fellows and trainees.

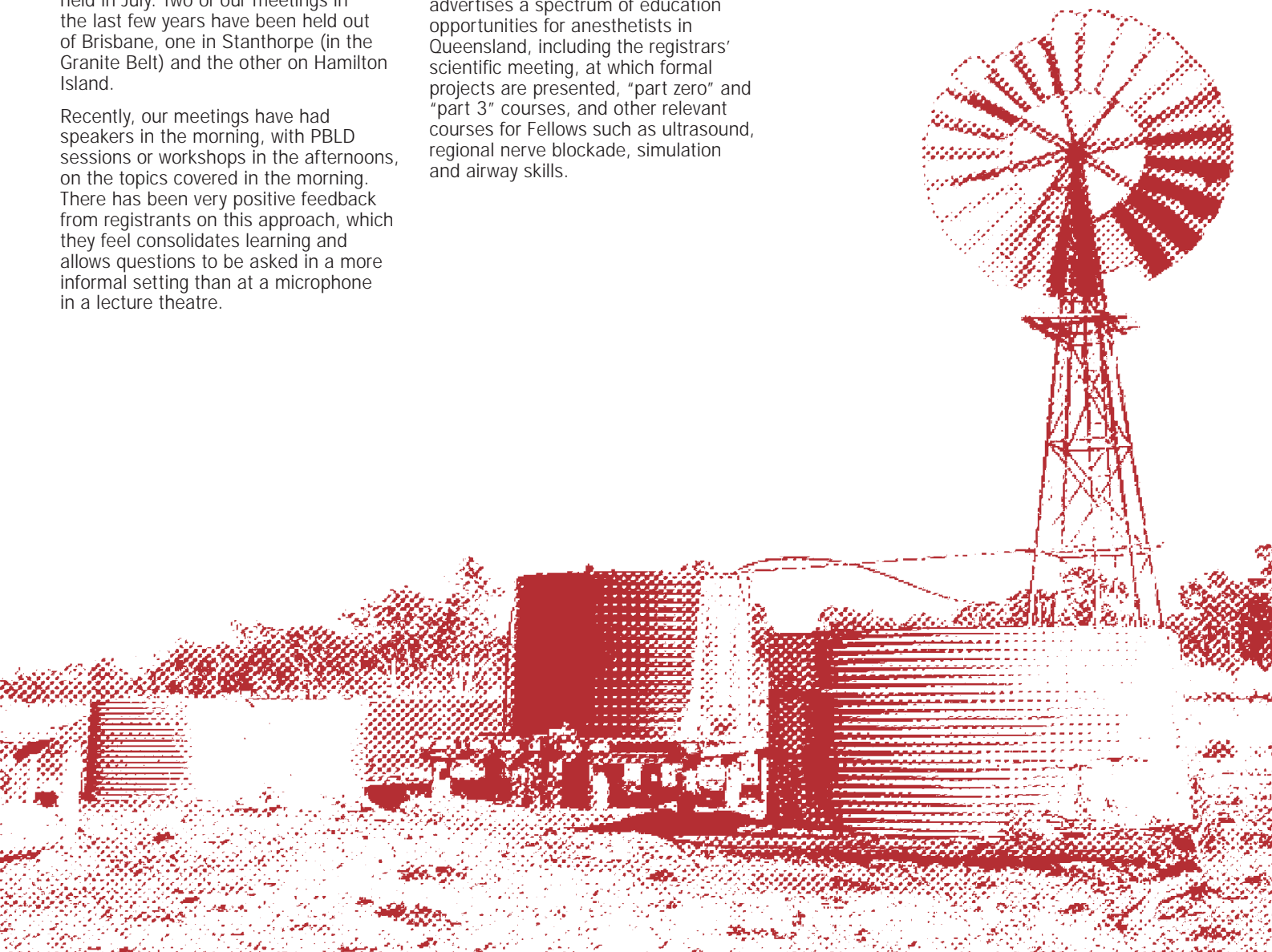
Traditionally, our annual meeting is held in July. Two of our meetings in the last few years have been held out of Brisbane, one in Stanthorpe (in the Granite Belt) and the other on Hamilton Island.

Recently, our meetings have had speakers in the morning, with PBLD sessions or workshops in the afternoons, on the topics covered in the morning. There has been very positive feedback from registrants on this approach, which they feel consolidates learning and allows questions to be asked in a more informal setting than at a microphone in a lecture theatre.

In the past few years, the committee has provided a series of evening lectures (three per year), in an attempt to provide interaction between private and public anaesthetists as well as encouraging anaesthetists to engage in CME outside their own departments. Topics are varied and talks from non-anaesthetists are encouraged. Recent speakers include Michael Gorton, the College solicitor (mandatory reporting), Dr Judy Killen from Wagga (perioperative management of diabetics on the new long-acting insulins and insulin pumps), and Dr Mark Appleyard, a local gastroenterologist (advances in interventional gastroenterology, including a discussion of the workforce impact of the National Bowel Cancer screening program and sedation (and colonoscopy) by non-anaesthetists).

It remains a challenge to provide CME activities for such a vast state and to engage anaesthetists to participate. The committee has a newsletter that advertises a spectrum of education opportunities for anaesthetists in Queensland, including the registrars' scientific meeting, at which formal projects are presented, "part zero" and "part 3" courses, and other relevant courses for Fellows such as ultrasound, regional nerve blockade, simulation and airway skills.

"In the last few years, the Committee has provided a series of evening lectures (three per year), in an attempt to provide interaction between private and public anaesthetists as well as encouraging anaesthetists to engage in CME outside their own departments."





From left: Royal Brisbane and Women's Hospital; The Wesley Hospital.

FORMAL PROJECTS



KERSTIN WYSSUSEK
SENIOR STAFF SPECIALIST
PRINCESS ALEXANDRA HOSPITAL
BRISBANE QLD

In 2010 I was elected as a new member of the Queensland Regional Committee (QRC). As the position of the Formal Project Officer (FPO) was vacant a longstanding member of the QRC recommended me for this position. Although I carry a heavy clinical and teaching load, I felt quite comfortable taking on this particular job. To manage some 35 formal projects annually is not only demanding but also educational and creates opportunities. With a masters degree (MSc) and a PhD, I have sufficient academic background to be able to advise and guide trainees through the formal project process.

After having studied all the relevant ANZCA documents, including TE 11: Policy on the Formal Project – 2009, I identified the challenges and developed a plan. This involved formalising the formal project assessment process in Queensland and finding people who could assist me. I took advantage

of the broad knowledge of a former QRC formal project officer (FPO) who is a colleague in my department. The Queensland Trainee Coordinator and the Manager of the QRC supported me with their professionalism and established processes.

My first action as the new Queensland FPO was to introduce myself to all Queensland supervisors of training, Module 11 supervisors and all QRC members, encouraging everyone to support trainees in the completion of their research project.

All communication between the trainee and the FPO is via the Queensland Trainee Coordinator on the QRC. We have standardised email responses and forms to simplify our work.

I report at each meeting about the progress and finalised formal projects. I have been invited to present at the part zero course for Queensland trainees and I will be pointing out the significance of a scientific project and expectations about quality.

I would like trainees to understand that their research project will be assessed by a Formal Project Assessment Committee. The FPO nominates two formal project reviewers. Both reviewers assess the project, complete Form FPC and return them to the FPO advising whether the formal project is to be accepted or revised. This process takes time and is largely dependent on the reviewer's availability. I strongly advise trainees to find a supervisor for their project. This could be a Module 11 supervisor, a consultant with a research interest or any FANZCA.

Once a year, the QRC publishes titles of completed projects in the regional news in the *ANZCA Bulletin*. This enables trainees to at least get an idea about approved research projects. We believe that the time between primary exam and starting to learn for the final exam is the best time to approach the formal project. In the near future, every Queensland anaesthetic trainee, who has passed the primary exam, will receive a letter from the QRC reminding them to start working on their formal project.

Thanks to the help of several members of the QRC I have adjusted to my new role quickly and it has given me a great opportunity to engage in ANZCA's activities.

"I strongly advise trainees to find a supervisor for their project. This could be a Module 11 supervisor, a consultant with a research interest or any FANZCA."

A YEAR IN MANHATTAN

In the process of organising his overseas fellowship in anaesthesia, Dr Tim Hall spoke to Dr Andrew Cameron. Andrew spent a year working as a Regional Fellow at the Hospital for Special Surgery (HSS) on the Upper East Side of Manhattan, New York City, from August 2007 to August 2008. The New Zealand Trainee Committee (of which Dr Hall is a member) thought it would be helpful to share Dr Cameron's insights with other trainees.





Dr Tim Hall: Why did you choose to go to HSS?

Dr Andrew Cameron: I was lucky to hear a regionalist by the name of Nigel Sharrock (who works at the HSS) speak at a scientific meeting. He is a well-known academic who has studied the influence of anaesthetic technique on outcomes for orthopaedic patients, including endpoints as diverse as deep vein thrombosis prevention and cement fixation of joint prostheses. I was impressed by the way he had an approach to the patient which was not restricted to what happens in the operating theatre, but instead focused on the whole hospital administration. The job was in regional anaesthesia which I enjoy, and also my brother happens to live in New York. I thought it would be a “different” kind of experience, and I wanted to live in New York City. So I sent in my curriculum vitae online and they replied.

When did you start organising the job?

I sent my curriculum vitae in 2006, while I was doing a Provisional Fellow job at Auckland City Hospital. They emailed back and were really supportive; they’re quite positive about taking international Fellows. I guess I began my inquiries about two years in advance.

What about the United States Medical Licensing Examinations (USMLE)?

Yes, I had to sit them. The whole process took about 12 months. I sat the Step 1 and the theory component of the Step 2 in Auckland. I then went to Houston to sit the practical component of Step 2. A few months later I went to San Francisco to sit Step 3. This was not compulsory but it meant that I qualified for a much better visa. The exams themselves were very fair; the “basic science” (Step 1) was the hardest. I could only manage two weeks’ study leave, but that was enough. Sitting the exams showed the HSS guys that I was serious about coming and it seemed to help my job application. The exams are expensive and the added cost of flights and hotels made it really expensive. I used my continuing education budget to pay for some of it, but a lot of it was out of my pocket.

Then?

After sitting my first USMLE exam I had an interview in December 2006. To get a job at a big US centre like HSS, it’s pretty essential to attend an interview. So I emailed them and arranged a visit. I had to meet individually with the members of the fellowship committee. It was a bit overwhelming but they were very encouraging. There was another international graduate interviewing at the same time.

How much did it cost to sit the USMLE and do the visit?

All up, probably about \$NZ20,000 (\$A15,500).

So what did a typical day look like at HSS?

I lived next door to the hospital in hospital-provided accommodation. I’d get to work shortly after 6am to set up my operating room. There were a couple of anaesthetic techs, but their job was to service equipment and restock rooms and they were covering a couple of dozen theatres across three floors. We did our own machine checks and set up all our own equipment. If I was doing a big spine case I would have to run through all my own art lines and central venous lines etc.

Almost every day there was an academic meeting at 7am. Then the cases would start at 8am. The attending (consultant) would often bring in breakfast for us; we were certainly never hungry.

What were your typical cases?

HSS only does elective orthopaedic surgery. There was a fast turnover and high throughput. Pretty much every case (except the spines) was done under regional anaesthesia with sedation. The hospital works on a private hospital model, so an attending would supervise me putting in the blocks. I would stay with the patient throughout the case. Sometimes the attending would be supervising two rooms. Fellows were guaranteed to finish at 6pm, although theatres often ran late into the evening.

(continued next page)

Above from top: Dr Tim Hall and Dr Andrew Cameron; Dr Nigel Sharrock teaches a Fellow how to perform a lumbar plexus block; The Hospital for Special Surgery in New York.

A YEAR IN MANHATTAN CONTINUED

"I think in Australasia we sometimes practice "anaesthesia-by-anecdote"; in New York they were very research-led."

That's a 12-hour day! Did you work hard?

Yes – much harder than I was used to. It was a solid 12-hour day most days, with Fellows given a lunch break by the attending. We did four days a week clinical work in the hospital and then one day per week doing research. I also did one 24-hour shift every month covering the extended recovery area/intensive care unit. We would look after fairly complex post-surgical patients, including ventilated ones. We also had to answer pain calls and arrest calls for the wards.

HSS is a high-profile hospital – did you get to anaesthetise any high profile people?

Yes! I even made it into the sports magazines. *Muscular Development and Fitness* published a photo of me putting a spinal into an elite body-builder. I met a lot of top-level sportspeople, as well as a couple of TV personalities; because of patient confidentiality I obviously can't say more.

Your job title was "Regional Fellow" – does this mean that every patient got blocks for their orthopaedic surgery?

HSS is a huge proponent of regional anaesthesia. Almost every operation is done under regional and sedation; even some of the shoulder joint replacements. Paediatric and spine surgery patients were the only ones who routinely had a general anaesthetic. I turned up wanting to do ultrasound guided blocks (and of course I did hundreds) but the fellowship went much further than that; I was taught parasthesia, landmark and nerve stimulator guided techniques as well, by guys with decades of experience. The teaching and volume of clinical experience were phenomenal. We were allowed to choose our areas of special interest. I focused on spines and shoulder surgery.

Did you get any leave?

I got four weeks' annual leave and two weeks' academic conference leave. I was also given two weeks' special leave to do some volunteer work. I'd expressed an interest in anaesthesia in developing countries, so I was invited to join an HSS group which was working in the Philippines. That experience was one

of the highlights. I've done some more work in developing countries since then.

Did you get any chance to travel?

Domestically, my wife and I travelled to Las Vegas, the Grand Canyon and New Orleans. We went also to the Dominican Republic, and a conference in Cancun (Mexico), but money was fairly tight. The cost of living in New York was very high, and I was there with my wife who was not working. The hospital helped out with subsidised accommodation, and the occasional extra paid list on weekends, but we still needed to use some savings.

So did the year actually cost you money? How much?

Yes, I would say we spent about 40,000NZD [31,000AUD] over and above my pay. Because of that I spent some time locuming both before and after my fellowship. I'd recommend this to anyone from our part of the world who is considering a US fellowship.

Did you do research?

Yes, I did research on blocks for shoulder surgery which has been presented as a poster at the ASRA Annual Scientific meeting. We're still working on the published version.



Was doing research worthwhile as part of a fellowship?

Absolutely. I think in Australasia we sometimes practice “anaesthesia-by-anecdote”; in New York they were very research-led. It was a really good experience for me to see just how much effort is involved in organising and performing a randomised controlled trial. They really did achieve excellence via research, and they provide a lot of resources to support trainee research.

Was it a good place for people to go with family?

Yes and no. My wife and I weren’t married at that point, so she had no visa, couldn’t work and had to rely on travel insurance for her health cover. It was fun for a while but I know that she missed working.

It’s more straightforward if you’re married; health insurance is included for family members and a visa is fairly easy to arrange (I think). Larger apartments are available for those with kids. Having said that, I think New York would be a tough place to be with a young family.

What were the three best things about your Fellowship?

1. Working with the doctors at HSS who were the arguably the best in the world at what they did, but were incredibly humble and down-to-earth.
2. Living in Manhattan!
3. Seeing research-led anaesthesia in action.

And the three worst things?

1. Being poor!
2. The strain on my family – for example, my wife living in New York without a job and without much to occupy her.
3. The transition back home – from such an exciting place where I was practicing very specialised and cutting-edge anaesthesia to New Zealand where I found it difficult to find work that catered to my new-found interests/skills.

Do you think it helped you get a consultant job?

Yes and no. It was obviously very good experience. But the New Zealand job market can be tough. I am lucky enough to now be working at Middlemore Hospital where I do a lot of orthopaedics (so I am essentially working in my sub-specialty area). I am fortunate as there are not many places in New Zealand where I could spend as much time doing such a specific type of anaesthesia.

Would you do it again?

Absolutely. Professionally and personally, it was one of the best things I ever did.

Are you happy to be contacted by people keen to go to New York?

Yes. I am also happy to chat to people just about fellowships in the US in general, including the USMLE process. I want to encourage people to consider it. I can be contacted by email on andy.cameron@me.com

The remarkable journey of Waleed Alkhazrajy

Fifteen years ago, Dr Waleed Alkhazrajy fled Iraq, arriving in Australia on a wooden fishing boat. He spent 11 months in detention and then picked fruit in Western Australia before passing the exam to practice medicine with the second-highest mark in the country. He spoke to Clea Hincks.

It was when he was ordered to cut off the ears of army deserters or brand their foreheads with a cross that young doctor Waleed Alkhazrajy knew he had to leave Iraq.

That was May 1995 and he had been in the army for 18 months when the edict from the Saddam Hussein-led regime declared its brutal means of stemming the growing exodus of disillusioned conscripted soldiers from its army fighting the Kurds in the north and Shiite rebels in the south.

As soon as the decree came through, Dr Alkhazrajy left his unit and was able to briefly reunite with his family before fleeing hundreds of kilometres from his Baghdad home to Jordan, using a false passport (most tertiary qualified Iraqis were banned from leaving the country under the Hussein regime) and paying bribes as he went. He knew that if he was captured, he would suffer the same consequences as the other army deserters – or worse, be executed for opposing the regime.

“I left behind my mum, my dad, my brother and my sister,” he said.

“I couldn’t even say goodbye because I was so drained and didn’t know where I was going. I didn’t know if I was going to see them again or not and I didn’t want to say goodbye because I didn’t want them to remember that moment – and I didn’t want to remember it either.

“So I just left without turning my head to say goodbye or to kiss them goodbye and I remember hearing my mum weeping in the background.”

His decision to leave had major consequences. “My dad was taken to the security offices and questioned and beaten and detained for quite some time. This is what they do there – if you’re still around in the area they want you to give yourself up.”



Knowing what his father went through still weighs heavily. “It’s now coming back to me and it’s just a bit too much because you start to remember it again. It’s very hard,” Dr Alkhazrajy said.

Sadly, Dr Alkhazrajy never again saw his father who died before he could join his son in Adelaide where he is now a successful anaesthetist who has recently established a new anaesthetic private service.

But for Dr Alkhazrajy, escaping Iraq was something in which he felt he had no choice. He said carrying out the orders to punish deserters in such a cruel way would have morally contradicted everything he stood for.

“The thing is, you become a doctor to help people to heal not to inflict suffering, regardless of what’s happening,” he said.

Dr Alkhazrajy spent about a year in Jordan before he was able to locate the right people who could arrange for him to be smuggled out of the country.

“You meet a lot of people. One sends you to the other and it’s a long process. You just have to be collected and determined and exercise as much caution as you can. But caution is just a word in that world – it’s nothing to do with action.”

Dr Alkhazrajy was funded by his family, who he communicated with via trusted intermediaries, to live in Jordan. They also gave him the \$US15,000 needed to pay the smugglers to get him to Australia.

It was an anxious time – there would have been dire consequences for his family had they been caught helping him, not to mention almost certain death for himself. But he couldn’t stay in Jordan where he was stateless and paperless, thus unable to work or access the health system.

“You could be killed on the street and nobody would know,” he said.

Dr Alkhazrajy had no choice in the country he would be sent to – that decision was at the mercy of the smugglers and what they could arrange at any given time – and he knew very little about Australia.

In September 1996 Dr Alkhazrajy finally left Jordan, putting his life in the hands of the smugglers for the next two-and-a-half weeks. Using another false passport he flew to Malaysia then to Indonesia and from there he travelled to Timor, a trip of more than 10,000 kilometres.

There he formed part of a group from Iraq of six doctors, a dentist (the wife of one of the doctors), and a 19-year-old



man avoiding conscription. They were told to board a minibus and were driven around for five hours to lose anyone who might be following them.

“We kept wandering in that little minibus from 4 o’clock until 9 o’clock up mountains and through jungles and seeing different things which was good because I got to know the other people that were going to be with me,” he said.

It was pitch dark when the group finally disembarked. They made their way down a steep cliff to the beach with only a small torch lighting their way.

Once on the beach, the smugglers (who could only communicate with the group through sign language) indicated that the group must cut their pants off at the knees and leave all belongings behind. For Dr Alkhazrajy this meant spare clothes, photographs and about \$US1500. Most upsetting, though, he had to leave behind the watch given to him by his family when he graduated from medical school.

“We walked out into the water until we found two small vessels and we were told to get on them and they took us out into the middle of the sea,” said Dr Alkhazrajy, who estimated the trip to the bigger boat took half an hour.

The group was joined by about 18 other refugees – and a hen. It was apparently deemed bad luck to have an

odd number of females (the dentist was the only woman in the group) aboard a boat, hence the chicken – who served a useful purpose at the end of the trip when they were hungry!

It was an emotional time as they reached the small wooden fishing boat that would take them to Australia.

“I really can’t describe it because it’s a mixture of everything,” he said. “You think of a fruit salad and that is delicious but this is, I think, the fear salad. You are a bit of scared, have a bit of apprehension, you have a bit of going to the unknown and you have a bit of anticipation.

“I guess you also have a bit of hope and you don’t know if that hope is true or not – and that’s another fear. And then there’s the fear of the water I guess – especially for a person like me who doesn’t know how to swim at all. That adds to it.

“But you’re also saying ‘Okay, what’s the other option?’ You don’t have any other option. The decision has to be made on the spot and this is your best bet for your life.”

As morning dawned after two nights at sea (mercifully the crossing was calm) the group – hungry, dehydrated and tired – could finally see Ashmore Reef in the distance.

“My dad was taken to the security offices and questioned and beaten and detained for quite some time.”

“We arrived there and that’s where things became a bit brighter,” he said. “It was the first rise of the sun and we found ourselves facing this small island.”

The first Australians the group saw were conservationists on a large white boat who approached the asylum seekers, concerned that they might disturb birds on the island.

“We thought ‘if you care about birds you will care about us,’” Dr Alkhazrajy said. The group was told that the navy would be arriving the next day – and was then asked “what are you doing for food?”

(continued next page)

Above left: Dr Waleed Alkhazrajy at work in Adelaide; Iwan group, Hatra, UNESCO World Heritage Site, Iraq, Middle East.

The remarkable journey of Waleed Alkhazrajy continued



The conservationists made a meal using the chicken and a bag of rice that they had been unable to cook on the old wooden boat – a welcome change from the “horrible” bread the group was given during the crossing and tinned sardines.

“So that was a good meal after a few days of not eating much. It was wonderful but we didn’t want to eat too much because we couldn’t go to the toilet, so that was a problem,” Dr Alkhazrajy said.

The next day the conservationists caught a large fish and cooked it with vegetables and rice for the group. “We were very well looked after by these people whom we were all grateful to,” he said. “It was a very good welcome.”

Eventually the navy arrived with the Federal Police and the boat was towed to Darwin.

“It was one of the best days of my life once I boarded the navy ship,” Dr Alkhazrajy said. “That night I had the best sleep of my life because I knew I was safe. There was still a lot of unknowns but it was a relief to have reached that point.”

The asylum seekers were strip searched and then able to shower and given new clothes. After two nights

in Darwin they were transported to a detention centre in Port Hedland where for the first month they were only allowed out of their cells for two hours a day, an hour in the morning and an hour in the evening.

“When we first arrived we were happy because we were there and this happiness was so overwhelming it minimised the feeling of being incarcerated in that detention centre,” he said. “We were locked in these rooms but the happiness was very soothing in this time.”

Eventually the group was released into the main compound of the detention centre. “The feeling you have is of hope and that you are safe and secure and that there would be some outcome. At the same time you are angry and you feel that you haven’t done anything wrong. It’s all been imposed on you – you didn’t have any other choice.”

After six months, the small Iraqi group was refused asylum but their cases were referred to the Refugee Review Tribunal and after four months the decision was overturned.

“It is political but that’s how it is – you have to treat it as it is,” Dr Alkhazrajy said. “All eight of us were

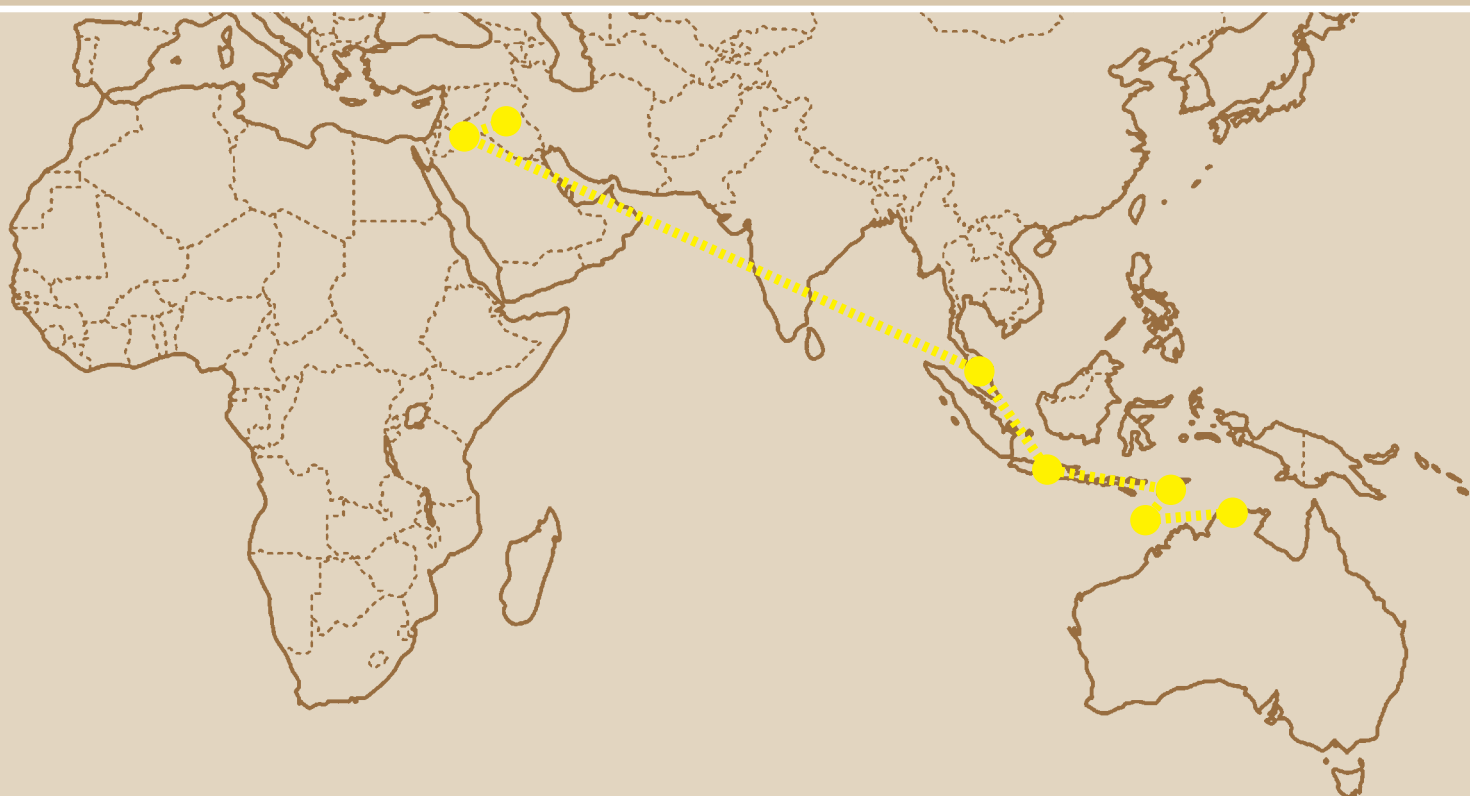
accepted. We were rejected in bulk and accepted in bulk, which shows it was a political decision because they didn’t assess us case by case – and that was one of our defences.”

In August 1997, Dr Alkhazrajy was taken to Perth by bus. He had earned a little money cooking and cleaning in the detention centre but needing more, he moved to Donnybrook in Western Australia where he picked fruit while studying for the Australian Medical Council exams that would allow him to practise in Australia.

A year later, he passed with 82 per cent – the second-highest mark in Australia amongst a group of candidates that included many for whom English is their first language.

Dr Alkhazrajy never had problems with communication – English is the second language for Iraqis but medical degrees are done in English – even patient records are kept in English. During his appeal to immigration authorities he chose not to use interpreters who he felt could be damaging to his case.

In 1999, Dr Alkhazrajy started work at Frankston Hospital in the emergency department as a resident medical officer.



Within a month, he was upgraded to a registrar.

Frankston Hospital anaesthetist Dr Helen Kolawole, who at the time ran a program for overseas-trained doctors sitting the council's clinical examination, said Dr Alkhazrajy would attend every course, regardless of what shift he had been working.

"He stood out as someone who was extraordinarily determined," she said. "He was prepared to do whatever it took to get through."

After enjoying his rotations in theatre he decided to apply to join the anaesthesia training program and was accepted in Adelaide where he finished his training in 2006.

"I like that you are providing the best care for the patient and I like that it's one at a time," he said of anaesthesia. "You spend all your effort for this patient at this time and then you look after them afterwards. The high standards of anaesthesia here are appealing too."

Dr Alkhazrajy is now an active member of the Australian Society of Anaesthetists (ASA) and is on several committees. Last year he was the scientific convener for the ASA's national scientific congress in Darwin.

As a trainee he helped form a trainee committee of the ASA which he eventually chaired for three years. He was responsible for the ASA's first trainee handbook, now in its seventh edition.

"My motivation is first of all a feeling of wanting to give back to the profession that gave me so much and took me on board, looked after me and trained me," he said

Regardless of his standing in the anaesthesia community Dr Alkhazrajy, who is also the president of the Islamic Society of South Australia, said he sometimes experienced intolerance when people did not take the time to explain how and why things are done differently in Australia.

Dr Alkhazrajy said he would be keen to eventually return to Iraq to help run courses and training programs to lift standards there. Doctors seeking extra education and training outside Iraq were often refused visas by nations fearing they would stay and seek asylum.

Dr Alkhazrajy's brother and sister, who are both dentists, now live in Adelaide with their families. His sister completed her degree in Australia in just 18 months and his brother teaches at the

"You could be killed on the street and nobody would know."

dental school in Adelaide. His sister-in-law is a vet working at the Institution of Medical and Veterinary Science and his brother-in-law is an accountant with his own business. His mother lives with him and his wife Nicole and his daughters Sara, 6, and Aisha, 4.

And what became of the other seven from the original group of eight from Iraq that arrived on the wooden boat in 1996? One is a cardiologist and another is a surgeon in Sydney, one is a GP in Melbourne and two are GPs in Perth. The dentist is also practising in Perth and the young man escaping the army now has a booming travel agency there.

Above from left: Dr Waleed Alkhazrajy with his medical degree; with students at the University of Baghdad; Map denoting Dr Alkhazrajy's journey from Iraq → Jordan → Malaysia → Indonesia → Timor → Ashmore Reef → Darwin.

Continuing Professional Development

CPD Tips

The following is the second in a series of articles appearing in the *ANZCA Bulletin* directing Fellows, especially those practicing in rural areas, to convenient places to collect continuing professional development (CPD) credits. The aim of this article is to outline resources available to collect CPD credits from category 2 activities. As a reminder, Category 2 activities are defined below:

Category 2 level 1 – passive activities

These are self-directed activities in reading and learning through print, audiovisual and web media. Topics may cover any of the attributes of a specialist anaesthetist.

One credit per hour, maximum 10 credits.

Activities may include:

- Reading journals and books.
- Learning from educational audio and video tapes.
- Learning from computer programs and Internet.

Category 2 level 2 – interactive activities

These are self-directed and self-initiated activities that are planned, developed and undertaken individually. Topics may cover any of the attributes of a specialist anaesthetist.

Two credits per hour, no maximum cap.

Activities may include:

- Developing a CPD plan (at the start of program).
- Learning projects.
- Hospital attachment for at least one day.
- Approved courses, for example, towards a relevant qualification.

As the interactive activities can vary vastly according to the different

interests of Fellows, I will focus on passive activities and highlight three fantastic resources that are based overseas but relevant and appropriate for local CPD credits.

Continuing Education in Anaesthesia, Critical Care and Pain

This is an excellent resource for Fellows wishing to ensure that their practice remains current. The description and purpose of the resource is as follows: “*Continuing Education in Anaesthesia, Critical Care & Pain*, is a joint venture of the BJA and the Royal College of Anaesthetists in collaboration with the Intensive Care Society and Pain Society.

The purpose of *Continuing Education in Anaesthesia, Critical Care & Pain* is the publication of material to support the continuous medical education and professional development of specialists in anaesthesia, critical care medicine and pain management.”

This is a fantastic resource for all Fellows whose practice is broad and for those looking to acquire new skills. Some examples of the topics from the latest issue are:

- Paravertebral block.
- Deep hypothermic circulatory arrest.
- Anaesthesia for children with neuromuscular disease.
- Rigid indirect laryngoscopy and optical stylets.
- Anaesthesia for paediatric urology.
- Chronic pain and prescription opioid misuse.

This journal is available, free of charge, to all Fellows who have access to the library on the College website. It also includes multiple-choice questions that can be printed out and answered to assist with the documentation of CPD credits.

Anaesthesia and Intensive Care Medicine

For those of us who have been out practising for some time and wish to revise, *Anaesthesia and Intensive Care Medicine* may be a better resource. It describes itself as “an invaluable source of up-to-date information, with the curriculum of both the primary and final FRCA examinations covered over a three-year cycle. Published monthly this ever-updating text book will be an invaluable source for both trainee and experienced anaesthetists.”

This is conveniently timed for our new CPD program, which has

a triennium timetable as well. You can document revision of the entire curriculum on every triennium CPD report.

Some examples of recent topics in the latest journal are:

- Cleaning, disinfecting and sterilisation of equipment.
- Fires and explosions.
- Electrical hazards: Cause and prevention.
- Surgical diathermy.
- Risk associated with anaesthesia.
- Ventilatory support in the intensive care unit.
- Management of the airway in intensive care.
- Community-acquired pneumonia.
- Asthma and chronic obstructive pulmonary disease in the intensive care unit.
- Acute lung injury.
- Management of the poisoned patient

This journal is also available, free of charge, to all Fellows who have access to the library on the College website. They include multiple choice questions as well which can be printed out and answered to assist with the documentation of CPD credits.

Anesthesiology and Pain Management CME and Medical News

This resource is available at clevelandclinicmeded.com. It is a North American based CME program available on the internet.

The topics are broad and very comprehensive. Besides covering all the sub-specialties in anaesthesia, it covers:

- Pre-anaesthesia training.
- Ambulatory anaesthesia.
- Post anaesthesia care unit.
- Monitoring.
- Equipment.
- Anaesthesia and Co-existing disease.
- Pharmacology.

This resource is not free and not all the content may be easily adapted to local practice, however there is a wealth of information available.

The above three resources would more than cover all your Category 2 CPD needs if required, and I would encourage everyone to utilise them.

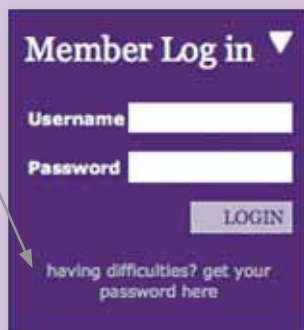
Dr Vincent Sperando FANZCA
New South Wales

ANZCA Library

The ANZCA Library is a resource-rich service that is available to all Fellows and trainees free of charge. The library contains the latest information on anaesthesia and pain medicine both in Australia and internationally. Library resources are easy to access either directly by calling ANZCA Librarian, Laura Foley on +61 3 8517 5305 or by going online and following the quick links below. Also, don't forget to check ANZCA's regular E-Newsletter that is published every six weeks for the latest titles, articles, research and other resources.

www.anzca.edu.au

- Enter ANZCA ID in the username field.
- If you cannot remember your password, or have not yet registered, click on the "having difficulties?" link.



- Follow the relevant instructions.
- The IT unit will automatically respond.
- The library website is located under "Resources" at the top of the page, or "Quick Links" at the bottom of the homepage.



RESOURCES
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Final Exam Preparation Resource
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CPD activity approval update

The ANZCA CPD program framework involves group learning and self-learning and practice assessment, and education development activities.

The intention is that the program be self-directed, in recognition of the fact that the CPD needs of individual Fellows vary significantly. CPD points allocation for any particular educational event is best done by the individual attending, based on self-assessment and reflection, within the context of personal learning requirements.

The practice of a third party establishing CPD credibility is unnecessary, and runs counter to the principle of self-assessment and reflection. As such, the ANZCA CPD department will no longer be prospectively accrediting individual events for CPD points allocation. The individual participant will be responsible for allocating CPD points, based on their own learning requirements and the personal benefit gained from attending the event. The CPD Framework of Activities Table (see www.anzca.edu.au or the ANZCA CPD booklet) can be used for guidance. The terms, "accredited by ANZCA" or "approved by ANZCA", will no longer be applied.

It is expected that those events which have already been accredited by ANZCA for CPD points allocation will continue to advertise. This in no way implies that these events are of a higher quality than those events which do not advertise ANZCA accreditation. Nor should it in any way imply ANZCA endorsement of those products being discussed.

ANZCA CPD staff are still available to assist Fellows if required. Participants are reminded to retain evidence of attendance.

Dr Rodney Mitchell
Chair, CPD Committee

ANZCA Curriculum Redesign Project



The ANZCA Training Program is in the process of being redesigned, following recommendations from a comprehensive review.

The ANZCA Curriculum Redesign Project will undertake the necessary development and authoring processes to produce a revised and improved ANZCA Training Program. The redesign will ensure that anaesthetic training remains contemporary in both clinical content and educational method.

More than 40 ANZCA Fellows are working on the redesign of ANZCA Training. The Curriculum Redesign

Steering Group (CRSG) is overseeing all aspects of the redesign process, including development of a new structure for the programme. There are ten Curriculum Authoring Groups (CAGs), each creating revised content for the training program in specific topic areas. To ensure effective and efficient implementation of the revised ANZCA Training Program, the Curriculum Project Advisory Group (CPAG) will develop operational and administrative systems to support the new training program, and retirement of the current program.

For more information on the ANZCA Curriculum Redesign Project:

- Visit the College website: www.anzca.edu.au/edu/projects/curriculum-redesign
- Contact the Education Development Unit:
E: education@anzca.edu.au
T: +61 3 8517 5361

Above: Fellows participate in a curriculum authoring workshop held at ANZCA House in October 2010.

Library update

Images and videos

Images and videos are great tools for education, training and research. The ANZCA Library has collated a number of image and video databases, including a new resource from the National Library of Medicine, *Images*.

Other databases include:

- Access Anesthesiology.
- Wellcome Library.
- The Visible Body.
- Images from the History of Medicine.
- Winking Skull.com.

Copyright, licensing and intellectual property must always be considered but many of these resources allow use with due acknowledgement.

These links and other research tools can all be found on the ANZCA website: www.anzca.edu.au/resources/library/research-tools.html.

Health and safety alerts – ECRI Institute notices

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

Recent publications include:

- Nonpunitive Peer Review: Emphasizing Learning.
- Anesthesia Patient Safety Foundation commissions ECRI Institute to produce safety training video on operating room fires: http://www.apsf.org/resources_video.php.
- Operating Room Device Alerts, October 2010.
- Health Devices, September 2010.
- Warming Cabinets – ORRM Executive Summary.
- Health Devices, October 2010 – Ensuring Effective Endoscope Reprocessing; Elastomeric Pain Pumps.

Chairing meetings

The ANZCA Library has recently acquired *The Australian Guide to Chairing Meetings*, recommended for new and not-so-new committee members.

1. Parliamentary procedure.
2. Importance of standing orders.
3. The agenda.
4. Motions and amendments.
5. Closing the discussion.
6. Specimen meetings.
7. Specimen standing orders and rules of debate.
8. Committees.
9. Inaugural meetings.
10. Conferences.
11. Shareholders' meetings.

New research in anaesthesia and pain medicine

Log-in to the ANZCA Library website to access these journals articles.

Clinical Guidelines

Perioperative protocol.
Institute for Clinical Systems Improvement (ICSI). 2009 Sep. 100 p. <http://guideline.gov/content.aspx?f=rss&id=15538>

Inhaled Nitric Oxide in Preterm Infants.
Structured Abstract. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/clinic/tp/inoinftp.htm>

Evidence-based patient safety advisory: malignant hyperthermia.
Gurunluoglu R, Swanson JA, Haeck PC, ASPS Patient Safety Committee. Plastic and Reconstructive Surgery. 124(4 Suppl):68S-81S, 2009. <http://guideline.gov/content.aspx?f=rss&id=15235>

Positive end-expiratory pressure (PEEP) during anaesthesia for the prevention of mortality and postoperative pulmonary complications.

Imberger G, et al. Cochrane Database of Systematic Reviews, Iss. 9. Art. No.: CD007922, 2010.

Clinical Practice Guidelines from Scandinavian Society of Anaesthesiology and Intensive Care Medicine
Acta Anaesthesiologica Scandinavica Virtual Issue 2010

- Scandinavian clinical practice guidelines on the diagnosis, management and follow-up of anaphylaxis during anaesthesia.
- Scandinavian clinical practice guidelines for therapeutic hypothermia and post-resuscitation care after cardiac arrest.
- Pre-hospital airway management: guidelines from a task force from the Scandinavian Society for Anaesthesiology and Intensive Care Medicine.
- Pre-operative fasting guidelines: an update.
http://onlinelibrary.wiley.com.ezproxy.anzca.edu.au/journal/10.1111/%28ISSN%291399-6576/homepage/virtual_issue__clinical_practice_guidelines.htm

Research articles

Complications and mortality in older surgical patients in Australia and New Zealand (the REASON study): a multicentre, prospective, observational study
Story DA, et al. *Anaesthesia*. 65(10):1022–1030, 2010.

Efficacy and safety of melatonin as an anxiolytic and analgesic in the perioperative period: a qualitative systematic review of randomized trials.
Yousaf F, et al. *Anesthesiology*. 113(4):968-76, 2010.

The First National Pain Medicine Summit—Final Summary Report
Lippe PM, et al. *Pain Medicine*. 11(10):1447–1468, 2010.

Sugammadex for reversal of neuromuscular block after rapid sequence intubation: a systematic review and economic assessment
Chambers, D, et al. *British Journal of Anaesthesia*. 105(5): 568-575, 2010.

From the front lines: a qualitative study of anesthesiologists' work and professional values
Wong, A. *Canadian Journal of Anesthesia / Journal canadien d'anesthésie*. Epub October 20, 2010.

Regional anaesthesia and antithrombotic agents: recommendations of the European Society of Anaesthesiology
Gogarten, W., et al. *European Journal of Anaesthesiology*. 27(12):999-1015, 2010.

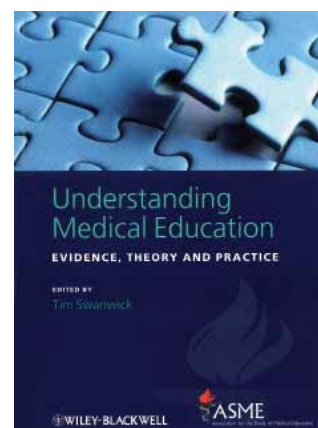
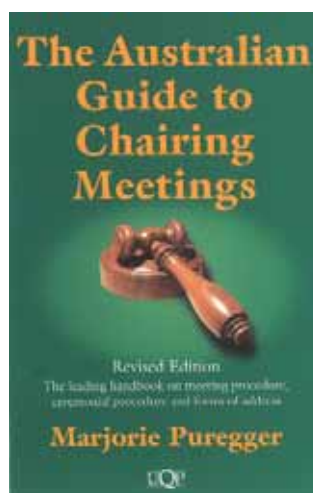
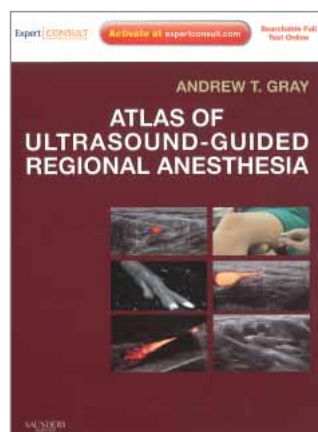
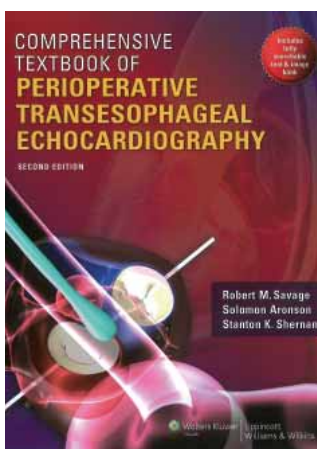
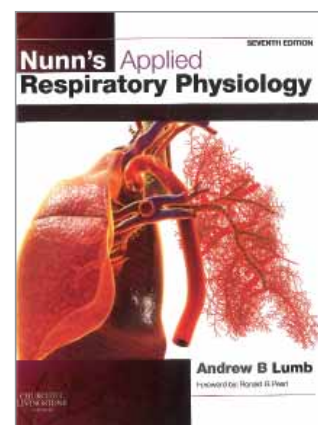
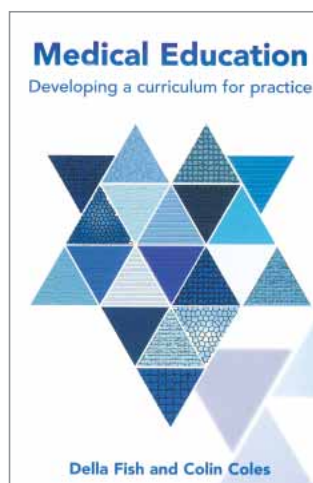
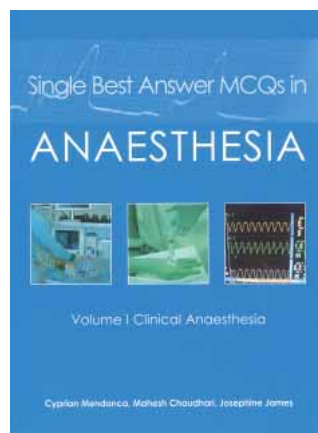
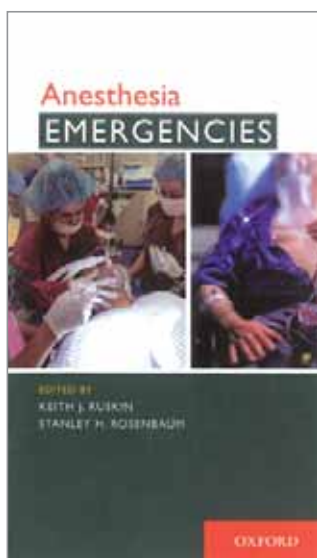
New titles

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

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

Melbourne-based members are encouraged to visit the ANZCA Library to collect requested books. Items will be sent to other library users within Australia. When requesting an item from the catalogue, please remember to include your name, ID number and postal address to ensure prompt delivery.

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



Other new titles include:

Annual refresher course lectures and (60th. : 2009 Oct. 17-21 : New Orleans, Louisiana): Presented October 17-21, 2009; during the Annual Meeting of the; American Society of Anesthesiologists

Practice-based teaching: a guide for general practitioners / Hays, Richard. -- 2nd ed -- Melbourne: Eruditions Publishing, 2006.

Practice guidelines for spinal diagnostic and treatment procedures / Bogduk, Nikolai [ed]. / Standards Committee of the International Spine Intervention Society. -- San Francisco, CA. *Kindly donated by Dr Geoffrey Speldewinde.*

Contact the library

Librarian: Laura Foley
www.anzca.edu.au/resources/library
Phone: +61 3 8517 5305
Fax: +61 3 8517 5381
Email: library@anzca.edu.au

Educational resources

Did you know that the Australian and New Zealand College of Anaesthetists (ANZCA) has educational resources available to assist your learning?

ANZCA is committed to providing the highest quality, contemporary anaesthetic education. The College offers a number of resources to support learning and these are freely available using your ANZCA ID and password.



ANZCA Library

The ANZCA Library can help you with:

- Over 200 online journals.
- Online textbooks.
- Hardcopy books sent to your door.
- Medical databases for literature searching.
- Tools for keeping up to date.
- Requesting articles not held online.
- Research support.

Login to the website: www.anzca.edu.au/resources/library or

Go to “Quick links” at the bottom on the ANZCA homepage: www.anzca.edu.au

For more information email: library@anzca.edu.au



Podcasts

A series of video and audio podcasts are available to download or web-stream from the ANZCA website. Current podcast topics have been developed to assist trainees in their preparation for the ANZCA examinations.

Podcast titles include:

- Anaesthesia for ear, nose and throat surgery.
- Basic principles of neuroanaesthesia.
- Anaesthesia for eye surgery.
- AICDs and pacemakers.

Further podcast titles and general information about ANZCA’s educational podcasts are available from www.anzca.edu.au/edu/e-learn

or

Go to “Quick links” at the bottom on the ANZCA homepage: www.anzca.edu.au

For more information email: education@anzca.edu.au



Webinars

Interactive webinars, presented by ANZCA Fellows, have recently been introduced for trainees.

This contemporary teaching tool provides trainees studying for ANZCA examinations an opportunity to communicate with content experts in real time.

Webinars can benefit trainees in several ways and typical features include:

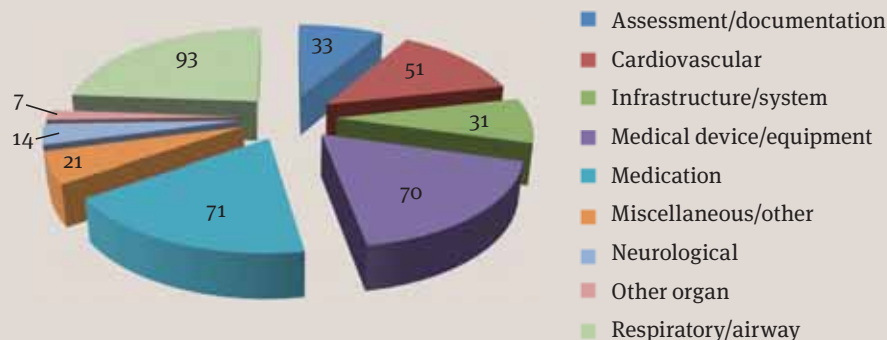
- Slide show presentations.
- On the spot multiple choice questions and short answer questions.
- The ability to share experiences with other trainees located in other regions.

To view upcoming webinar events and to register your interest in participating please visit ANZCA’s e-Learning Library: www.anzca.edu.au/edu/e-learn

For more information email: education@anzca.edu.au

Quality and safety

ANZTADC update



Main Categories – total events 391

The Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) have been collecting incidents using a Web-based Anaesthetic Incident Recording System called WebAIRS since September 2009. On November 19, when this update was written, a total of 391 incidents had been recorded. The breakdown of the main categories is shown in the interim report above.

Sub-category report for main category – assessment/documentation

Sub Category	Count
Clin. assesmt (inadequate/incorrect)	13
Risk. assesmt (inadequate/incorrect)	9
Docmt. (missing or illegible)	5
Operating list incorrect	2
Other	4
Total	33

The table above shows the interim results returned when a drill down analysis is performed on the main category “Assessment/documentation”. Incidents in this main category have comprised 8.4 per cent of incidents recorded so far. We are now more reliant on these documents, as pre-operative assessments are commonly performed by practitioners other than the anaesthetist for the procedure. As we base our clinical decisions on these documents, this is an area which has the potential to lead to medical error. On reviewing individual reports it was clear that the majority of the incidents recorded may have had serious consequences if the errors had not been detected. In the case of the two incorrect operating lists, one would have led to the wrong procedure being performed and the other would have led to an omitted procedure, had they not been detected in both cases by the attending anaesthetist.

Registration of sites

87 sites have commenced the registration process since the broadcast email was sent out in early October 2010. In some cases organisations may be having difficulty with the documentation process for registration especially the ethics requirements. ANZTADC has recently developed a new ethics form which may simplify the process. It is planned to mail this out in early December to those sites who have registered their organisations. If any Fellows need assistance with ethics or the ANZTADC memorandum of understanding document, especially those working in smaller institutions, please contact me via ANZCA.

If you haven’t yet registered and would like to register your organisation please do so via the link <http://www.anzca.edu.au/anzca1/structure/committees/anztadc.html> or alternatively via the homepages of the Australian Society of Anaesthetists (ASA) or New Zealand Society of Anaesthetists (NZSA). The ANZTADC program is provided at no cost to fellows of ANZCA, members of the ASA or NZSA.

We wish to thank all of the registered sites for taking part in the ANZTADC project and for the useful feedback.

Adjunct Professor Martin Culwick

Medical Director ANZTADC
The Australian and New Zealand Tripartite Anaesthetic Data Committee is a joint endeavour and jointly funded by ANZCA, the ASA and the NZSA.



Anaphylaxis to chlorhexidine – tip of the iceberg?

Anaphylaxis under anaesthesia is a rare but often dramatic event that anaesthetists may be forced to diagnose and treat. Many of us are aware that historically the commonest cause of anaesthetic associated anaphylaxis is neuromuscular blockers. This continues to be the experience of our anaesthetic allergy clinic at Royal North Shore Hospital in Sydney, however new trends are emerging that are suggesting that anaesthetic anaphylaxis from other causes may no longer follow established patterns.

An example of this is chlorhexidine, which is increasingly used as an antiseptic prior to a wide variety of procedures, including surgical procedures, insertion of lines, neural blockade techniques, urinary catheters (as a prep and also in the gel lubricant). It may also be impregnated into central lines in some cases.

While apparently rare a decade ago, chlorhexidine anaphylaxis has been seen more commonly recently. Over the past few years, several cases have been confirmed by testing at our clinic. The increase in diagnosis is probably due to

an increase in usage of the antiseptic and also better diagnosis (skin testing and recently RAST testing looking for antibodies). The absolute numbers of cases are too small to estimate incidence, particularly as the number of exposed patients cannot be estimated. I expect that chlorhexidine's rise to prominence as an antigen will continue.

In some cases the lack of intravenous drugs administered near to the time of anaphylaxis led to confusion regarding the diagnosis and treatment of the anaphylactic event, or delay in diagnosis when the patient is referred to a testing clinic with a list of drugs administered but without mention of the use of chlorhexidine in some form (such as during urethral catheterisation). So it is important for anaesthetists to be vigilant for the signs of anaphylaxis associated with anaesthesia, and to remember chlorhexidine is a potential and rising cause. If you suspect a patient of yours has had a reaction, it is your medicolegal responsibility to ensure that they are referred to your local anaesthetic allergy testing centre.

Dr Michael Rose
VMO Anaesthetist
Anaesthetic Allergy Clinic
Royal North Shore Hospital, Sydney

ECRI Safety Alerts

1. ARROW- Various intravascular kits and spinal/epidural catheters or needles.
The outer tray packaging may be cracked thus compromising sterility. In Australia Arrow local sales representatives should be contacted to identify lot numbers affected.
2. Baxter-3-way Large Bore Stopcocks may leak if the handle on the above is turned past the stop. This may result in interruption of the administration of critical therapy and Baxter has received reports of adverse outcomes.

The product numbers concerned are: IC8471, 2C6201, 2C6202, 2N5600, 3C0021, 3C0090, 3C0180, 3C0098, 3C0114, 3C0174, 3C0175.

For further information contact the local Baxter representative.

Dr Patricia Mackay OAM
Communication/Liaison Portfolio
Manager, ANZCA Quality and Safety
Committee



Anaesthesia safety well represented on NZ Health Quality and Safety Commission

The New Zealand Government has created the independent Health Quality & Safety Commission. An interim board was established to allow this work to get under way, and the commission will be formally established as a Crown entity in legislation by the end of the year. The commission is responsible for assisting providers across the health and disability sector (public and private) to improve service safety and quality, and therefore outcomes, for all who use these services in New Zealand.

Chairman of the interim board is ANZCA Council member Professor Alan Merry of Auckland, who discussed the recently released 2009/2010 report of serious and sentinel events across the country's district health boards (DHBs)

A sentinel event is defined as an event that results in, or has the potential to result in, serious lasting disability or death, not related to the natural course of the patient's illness or underlying condition. Those reported also included an element of preventability. Although the New Zealand media focused on the number and nature of the events enumerated in the report, Professor Merry said the figures in fact showed New Zealand hospitals had a very safe healthcare system with a continuing focus on patient safety and there were minimal reports involving anaesthetists.

DHBs treated and discharged almost a million people in the 2009/2010 year. "Of these, 374 people were involved in a serious or sentinel event that was actually or potentially preventable," he said. "Of those people, 127 died during admission or shortly afterwards, though not necessarily as a result of the event. Half of these deaths occurred through suicide."

Professor Merry said it was important that healthcare personnel learnt from the events and reduced their likelihood in the future.

Falls (34 per cent), clinical management problems (33 per cent) and suicides (17 per cent) were the three most commonly reported serious and sentinel events for 2009/2010, as they were for the previous year. The report showed an increase in reported events, which Professor Merry said was anticipated, illustrating improved reporting processes in hospitals and a greater awareness of health and safety processes. International experience with event reporting shows that the process of increasing awareness often results in a rise in the number of events reported.

It is encouraging that many DHBs and private hospitals are introducing specific programs and changes to make real improvements in patient safety and while New Zealand has an excellent health system by international standards and the vast majority of patients are treated safely and effectively, a small number of preventable incidents occur.

Professor Merry emphasised that learning from these incidents is essential if we are to continually improve the safety and quality of care provided by our hospital services.

The report *Making our Hospitals Safer: Serious and Sentinel Events 2009/2010, the DHB Summary of Serious and Sentinel Events 2009/2010*, and the media release is available at www.hqsc.govt.nz.

Airway crisis in the recovery room

This is the first in a series of airway-related emergencies that illustrate the complexities and diversity of patients that have challenged anaesthetists and their colleagues. We present patients with adverse outcomes and discuss the impact of these events on departmental procedures and clinical training and practice.

Case Report

A 39-year-old woman was scheduled for drainage of a dental abscess. She was well until three days earlier when she complained of a sore tooth and sore throat. The following morning she visited her GP and was prescribed amoxicillin and Panadeine Forte. She had difficulty swallowing the medications and she attended a dentist one day later. At this time her mouth opening was reduced and swelling of the submandibular area was noted. Another GP review was undertaken and metronidazole and procaine penicillin were given. The patient returned home to bed but after midnight an ambulance was called for transfer of the patient to a regional hospital. A dental abscess was confirmed and she was transferred to a tertiary centre. Surgery was scheduled for 8.15am Saturday morning.

On arrival in the operating suite a senior registrar in anaesthesia found that the patient had well-defined bilateral submandibular swelling with 2 cm mouth opening. Her voice was slightly hoarse. The trachea was easily palpated and midline. The nares were prepared with Co-Phenylcaine spray and preoxygenation was commenced. Propofol was infused at a rate to maintain spontaneous ventilation. Gentle bag-mask ventilation was performed and a nasal airway was inserted and connected to the anaesthesia circuit. Sevoflurane was commenced and spontaneous ventilation was maintained while fiberoptic bronchoscopy was performed. The vocal cords were noted to be



swollen but the laryngeal inlet was patent. Following application of 4 per cent lignocaine spray a 6.5 mmID nasotracheal tube was passed over the bronchoscope.

Drainage of the dental abscess and tooth extraction were done and morphine 5 mg, benzyl penicillin and metronidazole were given. The use of dexamethasone was considered with the surgeon and deliberately not given in the setting of infection. A large pocket of pus was evacuated and the surgeon commented that there was not much tracking in the tissues. The left submandibular triangle was swollen and four surgical drains were placed. Following surgery the airway was inspected again via direct laryngoscopy by the surgeon and anaesthetist and there was consensus that there was minor swelling that was unlikely to cause a problem following extubation. For safety, it was planned that the patient be transferred to a high-dependency unit (HDU) following recovery but as there was no bed available, a plan was made for a prolonged recovery stay until an HDU bed was vacated (estimated time of two hours). Anaesthesia was discontinued and the patient was awakened, the trachea was extubated and the patient was placed in a sitting position.

On arrival in the recovery room the patient was awake, breathing comfortably and able to communicate with some hoarseness, but no stridor. The patient cooperated with regular suctioning of her oral cavity as required while breathing oxygen. Morphine was administered for analgesia and

nebulised adrenaline was prescribed to reduce swelling. Two hours later, the patient, still in the recovery room, became agitated due to difficulty breathing and anaesthetic review was requested. The patient appeared tired but otherwise in good condition with SpO₂ levels ranging 95-97 per cent. The nebulised adrenaline was commenced and soon afterwards the patient developed stridor and became distressed, and was seen to be using accessory muscles while sitting upright. An emergency was declared and the anaesthetist and anaesthesia technician attended and decided to reintubate the trachea. Quick preparations were made for a difficult intubation including retrieval of the difficult airway trolley and the fiberoptic scope. As the patient was laid flat in preparation, she completely lost her airway due to upper airway obstruction and bag-mask ventilation was attempted, unsuccessfully. Increasing abdominal distension was seen. Propofol and suxamethonium were given but there was still unsuccessful bag mask ventilation so laryngoscopy was immediately performed but no identifiable structures were seen due to extreme swelling. A gum-elastic bougie was inserted into a giving space in the very swollen airway and a tracheal tube was passed over the bougie. Some chest movement was detected with ventilation and it was thought that breath sounds could be heard. Propofol 50 mg was given and the ICU was contacted.

(continued next page)

Airway crisis in the recovery room continued

The heart rate began to decrease and the patient's saturation of approximately 50 per cent did not improve. Breath sounds were rechecked and considered to be present. Atropine was given and cardiac massage commenced and capnography was requested but not present in the recovery room. The capnography machine arrived and was switched on but took too long to warm up so was unable to be utilised. The ECG showed bradycardia and the SpO₂ showed values of 50 or lower. The fiberoptic bronchoscope was requested to check the tube position but unfortunately the light source had caught fire and it was unusable. As no airway check could be made the tube had to be considered incorrectly placed despite the apparent breath sounds, and it was removed leaving a bougie in place in case reintubation was required. The anaesthetist decided to proceed to surgical airway A Portex Mini-Trach cricothyroidotomy set was produced but the parts were too complex to assemble quickly so a needle cricothyroidotomy with a 14G cannula was attempted but unsuccessful. The ICU registrar arrived around this time but had no experience with Mini-Trach sets either. A consultant anaesthetist arrived and laryngoscopy with a long blade was attempted but the light bulb failed. Blind insertion of a bougie was being attempted when a consultant intensive care physician arrived. He suggested insertion of a laryngeal mask airway which was placed and ventilation was achieved. He then performed an urgent scalpel cricothyroidotomy which resulted in CO₂ detection. The ECG rhythm developed into a supraventricular tachycardia and chest compressions were ceased. A femoral central venous catheter was inserted and the patient was returned to the operating theatre for a formal tracheostomy. The patient was then transferred to the ICU for ongoing care. Three days later the patient died and a post-mortem examination was performed. The anaesthesia and nursing personnel involved took part in a multidisciplinary debriefing session and were offered professional counselling.

Post-mortem examination

The post-mortem examination showed the body of an adult, medium build,

with evidence of infection of the soft tissues of the top of the neck with a sinus track of infection extending through the left mandible to the apex of the root of the left third molar tooth. There was a submandibular abscess with purulent material extending into the mylohyoid and left digastric muscles and extension laterally to the hyoid bone and thyroid cartilage. There was mucosal oedema of the larynx, extending from the back of the tongue to the upper part of the trachea. There were three neck incisions including a crico-thyroidotomy. There was pulmonary congestion and oedema with bilateral pleural effusions. There was diffuse brain swelling consistent with hypoxic brain injury.

The inquest

An inquest was held two years later and the coroner determined that the death arose by misadventure. The coroner suggested that it was not acceptable for a patient to die in a tertiary hospital from the effects of airway compromise. Several recommendations were made for patients who have had infection and surgery in the vicinity of their airways including continuous O₂ saturations monitoring, availability of expired CO₂ monitoring and placing patients in a unit with immediate access to surgical intervention if it becomes necessary.

Anaesthesia department response

Following the airway crisis but prior to the inquest, the department of anaesthesia instituted major changes to the availability and range of airway equipment and mandated training for all clinical staff.

1. All "standard" airway trolleys at every anaesthetising location were upgraded to include a wide range of routine and emergency airway equipment. In addition to the standard array of face masks, oral, nasal and laryngeal mask airways; trans-tracheal catheter and cricothyroidotomy and jet ventilation T-piece sets were added and stored in clear plastic aprons suspended on the sides of all airway trolleys.
2. "Difficult" airway trolleys were developed from old anaesthesia machines and cylinders of oxygen and Heliox were attached. A Manu-

Jet jet ventilator was attached and prepared for immediate use. Portable battery-operated fiberoptic bronchoscopes and a wide range of laryngoscope blades and intubating laryngeal masks were also added. These difficult airway trolleys were positioned in the vicinity of the defibrillator crash carts in the surgical preparation areas and recovery rooms.

3. Capnography equipment is always operational in recovery areas.
4. Discussions between the Intensive Care Unit and the department have resulted in liberalising of ICU entry criteria for patients who have had surgery and/or infection of the upper airway.
5. Creation of a skills training room. Mandatory training for all anaesthesia staff on insertion of a trans-tracheal catheter into a plastic model of a trachea and operation of jet ventilation devices and subsequent development of a teaching program for trans-tracheal needle and scalpel cricothyroidotomy techniques.
6. Strengthen adherence to a "management of the aftermath" protocol with intense support for all anaesthesia, technical and nursing staff involved.

Conclusion

An airway catastrophe following surgical treatment of a dental abscess was devastating for all those involved. The psychological distress was reinforced by a coronial system that lags behind the clinical event by several years. None-the-less, this event was an opportunity for a clinical department to re-evaluate the approach to airway emergencies such that staff preparedness and equipment to manage such crises are optimised. Not all patients with acute airway obstruction can be saved with expert care but anaesthetists should set a high standard of preparedness.

Dr Richard Riley

Anaesthetist, Royal Perth Hospital; Clinical Associate Professor of Anaesthesia, University of Western Australia

Obstetric emergencies – courses and training



Anaesthetists are often called to help during obstetric emergencies. Our help may range from siting intravenous access to advanced life support after cardiac arrest. Usually we will not be the first on the scene, and it is imperative that those present at the beginning of an emergency, whether they are midwives or junior obstetric staff, have the skills to begin resuscitation. As specialist anaesthetists our role is not only to help at the scene, but to provide education for our colleagues in the maternity sector to enable them to start resuscitation in those first few minutes.

The Confidential Enquiry into Maternal and Child Health 2003 - 2005 report¹ found that 64 per cent of direct deaths were associated with substandard care, with examples including: poor or non-existent team work, inappropriate or too-short consultations by telephone, failure to share relevant information and poor interpersonal skills. The King's Fund is a charity that seeks to understand how the health system in England can be improved. Using that insight they help to shape policy, transform services and bring about behaviour change. They state: "Teams that work together should also train together, with regular training taking place on the labour ward rather than on 'away days'"².

The Australian Government is undertaking a Maternity Services Review and the Australian department of health would like maternity services to have multiprofessional training in managing obstetric emergencies. "An aim of [interprofessional] learning is to develop skills, knowledge and attitudes

that can be used in interprofessional decision making and problem solving. A valuable example of interprofessional learning is joint maternity and neonatal emergency training. [This] can help build trust and establish collaborative working relationships."³ The New Zealand Ministry of Health recommends that all staff involved in the care of pregnant women should undertake regular training in the management of obstetric emergencies.⁴

As anaesthetists who work in obstetrics, we need to continue our professional development in the field of obstetric emergencies. There are a number of courses available throughout Australasia. Some are designed for midwives, others for obstetric teams, some for trainees in obstetrics and anaesthesia and some for specialists. Instructor training is itself invaluable to those of us who work with anaesthesia trainees.

Two particular courses from the UK are now taught in Australasia: MOET (Managing Obstetric Emergencies and Trauma) and PROMPT (PRactical Obstetric Multi-Professional Training). Some groups in Australia have adapted the PROMPT course to suit local needs.

MOET has been running for more than 12 years in the UK, and the first course was held in Australia in 2009 and New Zealand in 2010. The course was designed by and for specialist obstetricians and anaesthetists to improve knowledge and skills for dealing with difficult, serious and life-threatening conditions. It aims to equip participants with the confidence and

ability to manage serious obstetric and anaesthetic complications in pregnant women.

MOET promotes a systematic and structured approach to all emergencies. It includes basic and advanced maternal resuscitation, based on the principle that adequate resuscitation of the mother is paramount. While aimed principally for obstetricians and anaesthetists at the level of consultant or senior registrar, midwives attend as observers and participate as assistants in the scenarios, as in real life. The course manual, which is a stand-alone teaching text, is an invaluable resource to anyone working or teaching in maternity.

MOET is run under the auspices of the Advanced Life Support Group (ALSG), based in Manchester. MOET courses in Australia are organised by APLS (Advanced Paediatric Life Support) Australia, while anaesthesia staff in Wellington Hospital are supported by the National Patient Simulator. The course runs for two-and-a-half days and covers resuscitation and trauma (first day), obstetrics (second day) and examinations (final half-day). It is a comprehensive package of didactic teaching, scenarios, skills drills, small group workshops, demonstrations and moulages (scenarios) to teach and reinforce knowledge and skills. There is continuous assessment of skills during the course, as well as a multichoice exam and scenario test on the final day.⁵

The MOET course builds on core skills and knowledge expected of a senior clinician. It is more advanced



than the PROMPT course, however the two courses are complementary. PROMPT has more emphasis on communication, teamwork and emergency management systems within individual maternity units, but does not attain the peak levels of achievement for individuals.

PROMPT is a multiprofessional training course which covers the management of a range of obstetric emergency situations. It is designed to ensure all practitioners are aware of how the emergency maternity systems work in their location.⁶ PROMPT was developed in Bristol more than five years ago. Registrars, obstetric specialists, midwives of various grades and anaesthetists come together to train in clinical emergencies. The emphasis is on teamwork, learning about leadership, improving communication and situational awareness during the management of an emergency on delivery suite. Realistic emergency drills using delivery rooms on their own delivery suite with actors (usually midwife educators) and realistic props are used to give hands on experience and practice in decision-making. Participants must draw up drugs, obtain emergency equipment and set up infusions of blood and fluids.⁷

Key elements are that doctors and midwives train together on their own delivery unit, and that there is emphasis on communication and teamwork. There are interactive lectures with time for discussion and opportunities to draw from the participants' own clinical experience. The ultimate goals

of training are to improve clinical outcomes and to reduce adverse patient incidents. PROMPT is run in the local facility over one day so that disruption to staffing is limited.

There are many local versions of PROMPT (see table). These include IN-TIME⁸ (Western Australia), VicPROMPT (Victoria) and FOREMOST⁹ (South Australia). Queensland has similar courses. Several other courses have been developed for maternity clinicians.

Victoria has the Pregnancy Care and Maternity Emergency Education Program¹⁰ that delivers multidisciplinary, team-based training. It builds on the existing knowledge of maternity clinicians to further develop their confidence and competence. It consists of workshops and scenarios where teams respond to a maternity emergency followed by debrief. Midwifery and medical colleagues work together, improving understanding and communication. In addition, there is development of a site-specific review and action list, which is particularly valuable for small rural centres. The education team comes to the local centre to plan the workshop beforehand so that it is tailored to suit individual health services.

New South Wales has the FONT¹¹ project (Fetal Welfare, Obstetric Emergency, Neonatal Resuscitation Training) developed by NSW Health. For anaesthetists there is Emergencies in the Obstetric Patients run at the Sydney Medical Simulation Centre based at Royal North Shore Hospital. It covers anaesthesia emergencies in

obstetric patients, especially for rural anaesthetists and anaesthesia trainees.¹²

There are a large range of courses available to us. Each of us involved in obstetric services should attend or instruct at these courses to continue to improve perinatal and maternal care. Which course will you attend in 2011?

Dr Elaine Langton

(on behalf of the obstetric anaesthesia special interest group)
Clinical Leader Obstetric Anaesthesia
Wellington Hospital

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Obstetric emergencies – courses and training continued

Australia and New Zealand

MOET – Managing Obstetric Emergencies and Trauma

Who is it for? Specialist obstetricians, Specialist anaesthetists, senior registrars, GP obstetricians, GP anaesthetists, Emergency specialists, midwives as “observers”.

What is covered: BLS and ALS in pregnancy, neonatal resuscitation, trauma in pregnancy, obstetric emergencies –haemorrhage, preeclampsia, eclampsia, vaginal breech delivery, shoulder dystocia, instrumental delivery, symphiotomy, uterine inversion, face presentation, headache and confusion, abdominal pain in pregnancy, managing women who decline transfusion, triage.

Venue: Melbourne, Sydney, Wellington (National Simulation Centre).

Cost: \$2200 per candidate for three days.

How often? three to four per year

Special values: Designed by and for specialist anaesthetists and specialist obstetricians, resulting in a high level of learning for the individual. Teaches a systematic approach to any emergency

Contact: Dr Rahul Sen, Specialist Obstetrician, Royal Hospital for Women, Sydney, rahulsen@doctors.org.uk; Dr Douglas Mein, Specialist Anaesthetist, Wellington Hospital douglas.mein@ccdhb.org.nz

New Zealand

PROMPT – Practical Obstetric Multi-Professional Training

Who is it for? The whole maternity team – midwives, associate midwife managers, obstetric RMOs, anaesthetic RMOs.

What is covered: BLS and ALS in pregnancy, obstetric emergencies –haemorrhage, preeclampsia, eclampsia, vaginal breech delivery, shoulder dystocia, instrumental delivery, teamwork, leadership, communication, situational awareness, local emergency practices.

Venue: Auckland, Tauranga, Wellington, and other centres – participants’ own delivery suite

Cost: Varies, depending on the venue. Runs for a full day.

How often? As often as needed for every staff member to attend once in two years.

Special values: Candidates work in their own delivery suite with their own multidisciplinary team. Builds teamwork and teaches the local emergency guidelines.

Contact: Dr Martin Sowter, Specialist Obstetrician, Auckland Hospital martinsowter@xtra.co.nz

Victoria

VicPROMPT – Practical Obstetric Multi-Professional Training

Who is it for? The whole maternity team – midwives, associate midwife managers, obstetric RMOs, anaesthetic RMOs.

What is covered: BLS and ALS in pregnancy, obstetric emergencies –haemorrhage, preeclampsia, eclampsia, vaginal breech delivery, shoulder dystocia, instrumental delivery, teamwork, leadership, communication, situational awareness, local emergency practices.

Venue: Participants’ own delivery suite.

Cost: Varies, depending on the venue. Runs for a full day.

Special values: The locally developed Victoria version of PROMPT. Candidates work in their own delivery suite with their own multidisciplinary team. Builds teamwork and teaches the local emergency guidelines.

Victoria

PCMEEP - Pregnancy Care and Maternity Emergency Education Program

Who is it for? Medical and midwifery teams in primary, secondary and tertiary maternity services.

What is covered: Neonatal resuscitation, obstetric emergencies –haemorrhage, breech and shoulder dystocia, hypertensive crisis, eclampsia, uterine hyperstimulation, cord prolapse or maternal collapse; crisis resource management, maternal morbidity and mortality, clinical risk management.

Venue: Team’s own venue, facilitated by a team consisting of clinical midwife consultants, obstetricians and simulated patients.

Special values: Evidence-informed multidisciplinary education in the team’s own environment. Opportunity to discuss recent cases and to review local resources

Contact: maternityservices@dhs.vic.gov.au

Western Australia

IN-TIME – Inter-disciplinary Teamwork In Managing Emergencies

Who is it for? Anyone involved in the care of obstetric patients - a mix of midwives, obstetric residents, registrars and consultants, anaesthetic consultants and trainees and GP obstetricians.

What is covered? Multi disciplinary teamwork, BLS and ALS, perimortem section, PPH, preeclampsia, eclampsia, cord prolapse, breech delivery, shoulder dystocia.

Venue: most are held at King Edward Memorial Hospital, Perth, but some courses at other units a few times a year.

Cost: Runs for a full day. Free to staff.

How often? About every 6-8 weeks.

Special values: Inter-professional course centred on the value of teamwork.

Contact: Dr Nolan McDonnell, Specialist Anaesthetist, King Edward Memorial Hospital for Women
nolan.mcdonnell@health.wa.gov.au

South Australia

FOREMOST – Flinders obstetric resuscitation emergency management operational skills teamwork training

Who is it for? All grades of obstetricians (from non procedural GPs through to consultants as well as medical students), anaesthetists (GP to consultant) and midwives (students through to DON).

What is covered? Multi disciplinary teamwork, BLS and perimortem section, PPH, preeclampsia, eclampsia, cord prolapse, uterine inversion, breech delivery, instrumental delivery, shoulder dystocia.

Venue: Participants' hospital.

Cost: \$800 per candidate for eight hours.

How often? At least 13 times per year.

Special values: Teamwork, in situ training, flexible enough to accommodate local needs from country GP obstetrics to level 6 teaching hospital.

Contact: Dr Steve Scroggs, Director Clinical Services, Flinders Reproductive Medicine,
Steven.Scroggs@health.sa.gov.au

New South Wales

Anaesthetic emergencies in the obstetric patient

Who is it for? All anaesthetists, but in practice anaesthesia registrars and only occasionally consultant anaesthetists.

What is covered? Assessment of maternal risk, planning anaesthesia management, pain during regional block, maternal haemorrhage, total spinal, preeclampsia and eclampsia, amniotic fluid embolism, cardiac arrest, crisis resource management.

Venue: Sydney Medical Simulation Centre based at Royal North Shore Hospital.

Cost: Runs for one day and costs \$395.

How often? Twice a year with an extra course midyear targeted at rural GP anaesthetists.

Special values: High tech “bells and whistles” of a dedicated simulation centre.

Contact: smsc@nscchhs.health.nsw.gov.au
or www.scssc.usyd.edu.au

New South Wales

FONT – Fetal welfare, obstetric emergency, neonatal resuscitation training

Who is it for? Everyone involved in maternity care: providers of maternity services, all maternity service clinicians including obstetricians, trainees and midwives.

What is covered? Preeclampsia, eclampsia, antepartum haemorrhage, cord prolapse, management of breech presentation, postpartum haemorrhage, maternal resuscitation, shoulder dystocia, neonatal resuscitation, premature labour.

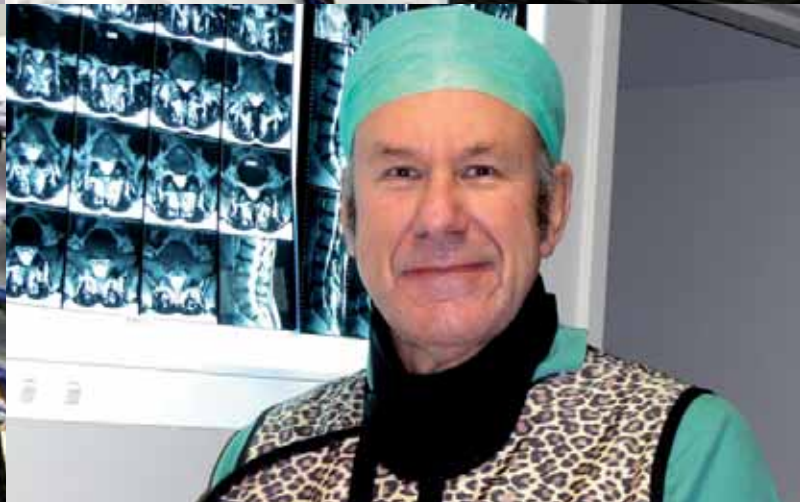
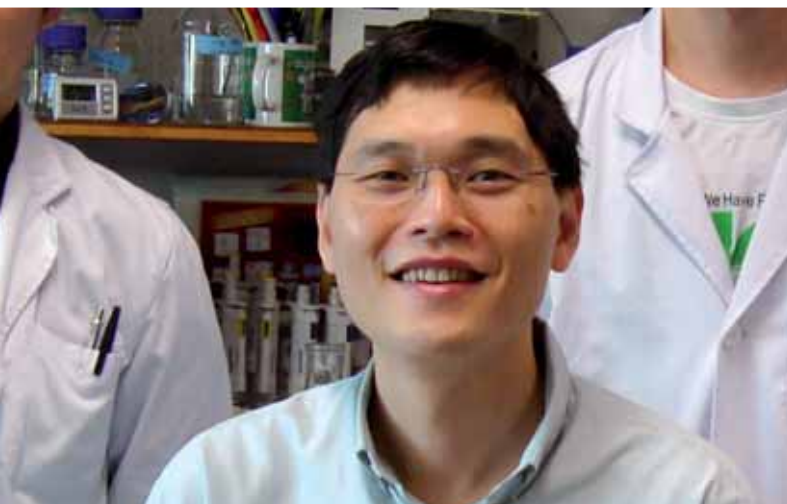
Venue: Each Area Health Service.

How often? Everyone involved in maternity should attend once in three years.

Special values: Endorsed by NSW Health to ensure a consistent statewide approach to educational provision.

Contact: hcooke@perinatal.usyd.edu.au or
www.ciap.health.nsw.gov.au/specialties/K2MS/font.html

ANZCA announces funding boost to medical research



ANZCA Council recently announced funding of \$664,677 for 15 research projects, including a Scholarship Grant for a PhD student, to commence in 2011. One continuing project was also supported. These important research initiatives will be carried out in leading hospitals and universities in Australia, New Zealand and Hong Kong and will continue to make an important contribution to medical research and patient safety, not only in these countries, but worldwide.

Research award recommendations

The **Harry Daly Research Award** was awarded to **Associate Professor Jennifer Weller** for her project “The effectiveness of video-based training to improve teamwork behaviours in acute care: a randomised controlled trial”.

The **Mundipharma ANZCA Research Fellowship** was awarded to **Professor David Hillman** for his project “Airway collapsibility during sedation and anaesthesia in patients with and without obstructive sleep apnoea”.

The **Pfizer ANZCA Research Fellowship** was awarded to **Professor Matthew Chan** for his project “Genetic determinants of persistent pain after surgery”.

The **St Jude Medical ANZCA Research Fellowship** was awarded to **Dr Philip Finch** for his project “Mechanism of adrenergic hyperalgesia in the partial sciatic nerve ligation model of neuropathic pain”.

Clockwise from top left: Professor Matthew Chan; Professor David Hillman; Dr Philip Finch; Associate Professor Jennifer Weller.

Project Grants

Outcomes from a randomised controlled trial comparing regional and general anaesthesia for effects on neurodevelopmental outcome in infants

Many studies have now demonstrated that animals exposed to common anaesthetics have increased levels of neuronal apoptosis and abnormal neurobehavioural outcomes. The aim of this international randomised controlled trial is to determine whether regional and general anaesthesia given to infants undergoing inguinal hernia repair result in equivalent neurodevelopmental outcomes. Neurodevelopmental assessments of the infants will occur at two and five years with standard neuropsychological tools.

Associate Professor Andrew Davidson, Dr Rod Hunt, Dr Geoffrey Frawley, Ms Pollyanna Hardy, Royal Children's Hospital, Melbourne; Dr Robyn Stargatt, La Trobe University, Australia.

\$60,000

Airway collapsibility during sedation and anaesthesia in patients with and without obstructive sleep apnoea

The investigators are interested in understanding the reasons why some individuals have upper airways that obstruct more readily during anaesthesia (and sleep) than others and how vulnerability to obstruction varies with the level of sedation. In this research project they propose to make direct measurements of the propensity for an individual's airway to collapse during sedation and anaesthesia. They are interested in developing a simple measure of upper airway collapsibility readily applicable to the clinical environment. It is possible that such a measurement could allow identification of individuals at particular risk of upper airway collapse perioperatively and beyond allowing monitoring and precautions to prevent airway collapse to be instituted proactively. Given the relationship between airway collapsibility during sleep and anaesthesia this measure could help identify patients at risk of obstructive sleep apnoea, a common, disabling and under-diagnosed condition.

Professor David Hillman, Dr Peter Platt, Sir Charles Gairdner Hospital, Professor Peter Eastwood, Dr Jennifer Walsh, West Australian Sleep Disorders Research Institute, Australia.

\$60,000

The effectiveness of video-based training to improve teamwork behaviours in acute care: a randomised controlled trial

The importance of effective teamwork behaviours is now well established in management of anaesthetic crises and improved teamwork has been linked with reduction in error and improved patient outcomes. A number of such behaviours have been identified including establishing a leader, task coordination, assessment of team capabilities and shared situational assessment. Strategies to share situation assessment include a recap or review of the situation, sometimes referred to as a "call out" by the leader.

Simulation-based training is frequently used to teach teamwork behaviours, but is resource-intensive and not widely accessible. Modelling of appropriate behaviours using video may be an effective alternative. The hypothesis of this project is that an educational intervention using videos to model a specified behavior of "call out" will improve sharing of information among team members, improve team performance and improve management of a simulated critical event. This will be a randomised blinded controlled trial with recruited anaesthetists randomly allocated into two groups: intervention and control.

This study is at the cutting edge of studies investigating the interventions to improve team performance in anaesthetic emergencies. The results of this study will determine if video-based technology can be used to supplement or replace requirements for attendance at simulation-based courses in order to improve crises management behaviours.

Associate Professor Jenny Weller, Dr Jane Torrie, Dr Boaz Shulruf, University of Auckland; Dr Robert Frengley, Waikato Hospital; Associate Professor Sandy Garden, Associate Professor Brian Robinson, Wellington Hospital, New Zealand.

\$50,000

Genetic determinants of persistent pain after surgery

The primary goal of this project is to identify the genetic contributions of persistent pain, 12 months after major abdominal surgery. Professor Chan will work with a team of experienced pain physicians and researchers in molecular biology to look for a gene that may cause persistent pain after surgery. In a group of patients undergoing major surgery, blood and salivary DNA samples will be collected to see if these genetic variants are associated with persistent pain after surgery. If heritable susceptibility can be demonstrated, a DNA sample before surgery will provide the earliest possible opportunity to identify the patient at risk of chronic pain. The ultimate goal is to provide early potential preventative therapies, regular follow-up and prompt interventions so that chronic postoperative pain can be avoided.

Professor Matthew Chan, the Chinese University of Hong Kong, Prince of Wales Hospital, Dr Alex Konstantatos, Alfred Hospital, Melbourne.

\$30,000

Investigating the applications of anaesthetist-performed transthoracic echocardiography in anaesthesia

Transthoracic echocardiography (TTE) and training in its use is becoming increasingly available and utilised by anaesthetists for rapid assessment of patients' heart function prior to, during and after anaesthesia and surgery which assists in directing specific treatment. Non-cardiologist-performed TTE has been repeatedly demonstrated to be feasible and influential in decision-making in patients in critical care. The investigators will clarify the influence of how useful TTE can be when performed by the anaesthetist in guiding important management decisions about the anaesthetic care of patients. The research program aims to study the effects of anaesthetist-performed TTE on diagnosis and decision-making prior to elective and emergency surgery and a third study to determine whether TTE affects patient outcome in fractured neck of femur surgery patients. The research is part of a PhD candidature for Dr David Canty.

Dr David Canty, Professor Colin Royse, University of Melbourne and University of Tasmania, Australia.

\$140,000 over three years

ANZCA announces funding boost to medical research continued

The effect of exogenous glucagon-like peptide-1 (GLP-1) on glucose absorption in critically ill patients

Patients admitted to the intensive care unit (ICU), or having major surgery, frequently have abnormally high blood glucose concentrations. This is commonly called “stress-induced diabetes” and can occur despite the patient previously not having diabetes. It usually resolves when the patient recovers. This problem is normally treated with an intravenous infusion of insulin. However, insulin can cause dangerously low blood glucose concentrations. The researchers have been investigating a safer alternative to insulin for glucose control in critically ill patients. It involves the administration of another hormone called glucagon-like peptide-1 also known as GLP-1. It has been shown that intravenous GLP-1 infusion safely and effectively reduces blood glucose levels in critically ill patients but in one of our studies it also appeared to reduce glucose absorption. This would be an unwanted side effect as it may jeopardise the nutrition of our patients. In this study, the reduction in glucose absorption will be temporary so will not have any significant clinical effects on the patients. This study will examine the effect of short term GLP-1 administration on glucose absorption in critically ill patients. If nutrient absorption is unaffected by GLP-1, it will support further research into the use of this novel therapy for longer term glucose control.

Dr Marianne Chapman, Dr Adam Deane, Royal Adelaide Hospital, South Australia.

\$29,561

Lymphocyte sub-populations and innate immunity in the perioperative period – the effect of antiemetic doses of dexamethasone

The focus of this investigation is to examine the effect of a single dose of dexamethasone on postoperative lymphocyte and immune function in healthy female surgical patients, deemed to be at high risk of postoperative nausea and vomiting (PONV). PONV remains a significant problem in modern day anaesthesia practice. It is unpleasant for the patient and increases the complexity of their care. Dexamethasone is particularly effective in preventing PONV up to 24 hours and perhaps even longer following anaesthesia. Dexamethasone is also, however, an immunosuppressive glucocorticoid. This powerful immune suppression can predispose to the development of life-threatening infections. The dose that is used in anaesthesia is however very low and may not be sufficient to cause the degree of immune suppression necessary to result in these infections. No study to date has specifically examined this potentially serious complication. It is critical to establish the safety of dexamethasone, a widely used drug, in this respect. The investigators propose to perform the current trial in a group of patients who would normally be given dexamethasone. They will examine the effect of the drug on key components of the immune response; lymphocyte subsets and precursors, and chemokines/cytokines which control inflammation. The demonstration of such an effect would lead impetus to a much larger-scale examination of the association of dexamethasone with long-term postoperative infective complications.

Associate Professor Tomas Corcoran, Professor Martyn French, Royal Perth Hospital; Professor Michael Paech, King Edward Memorial Hospital for Women, Western Australia.

\$53,419

Mechanism of adrenergic hyperalgesia in the partial sciatic nerve ligation model of neuropathic pain

Neuropathic pain is a difficult and costly health care problem. It is a common condition that is frequently misdiagnosed and difficult to treat because the primary factors that drive the disease are not understood. The investigators believe that the sympathetic nervous system, which is not associated with pain under normal conditions, plays an important role and aim to show how these nerves are involved and how the pathway may be blocked, thereby identifying new treatment strategies.

One explanation for the involvement of the sympathetic nervous system in neuropathic pain is that an abnormal connection develops between sympathetic nerves, which normally regulate the fight-or-flight response and other automatic bodily responses, and the pain processing system. The investigators research findings support the idea that sympathetic nerves contribute to pain after peripheral nerve injury. Noradrenaline is one of the major chemical messengers of the sympathetic nervous system. It transmits messages by acting on specialised receptors on nerves and blood vessels (adrenergic receptors). This research has shown that pain-signalling nerves contain a subclass of excitatory adrenergic receptors, and that the density of these receptors increases greatly after peripheral nerve injury. This could explain why events that increase activity in sympathetic nerves also increase pain and distress in people with painful peripheral nerve injuries.

This project will investigate this concept in an animal model of neuropathic pain. This approach will allow the investigators not only to control the location and extent of the nerve injury, but also to examine the physiological basis of neuropathic pain in far greater detail than would be possible in human studies.

Dr Philip Finch, Professor Peter Drummond, Dr Julia Inglis, Murdoch University, Western Australia.

\$59,588



Physico-chemical compatibility of intravenous paracetamol (Perfalgan) with commonly used analgesic drugs

There is no data available regarding the compatibility of IV paracetamol and some commonly used analgesic agents. Patients who are having intravenous infusions of these analgesic agents who are prescribed IV paracetamol therefore must have these infusions ceased or a separate line inserted. Paediatric patients in whom intravenous access can be more problematic can suffer the most due to the cessation of these analgesic infusions.

The aim of this study is to establish physio-chemical compatibility and stability data for intravenous paracetamol (Perfalgan®) and commonly used concentrations of intravenous analgesic agents. Duration of stability of drug combinations will also be assessed. By demonstrating compatibility of these drugs, postoperative paediatric pain control will be improved.

Dr Edmond O'Loughlin, Fremantle Hospital, Western Australia

\$10,624

A genome-wide association study on the genetics of anaesthetic awareness

Awareness is a rare but distressing complication of general anaesthesia. Typically patients recover consciousness and then tell their anaesthetist that they heard sounds or conversations or felt the operation during a time when they were supposed to be unconscious. Patients frequently report feeling afraid and helpless during the episode and may suffer from psychological problems as a result.

In this study, it is planned to identify 100 patients who suffered awareness during apparently adequate general anaesthesia by advertising in the lay media and around our hospitals. These patients will then be interviewed and a saliva sample taken. The DNA in the saliva will be extracted and will be compared to the population norms. It is hoped that the investigators will identify specific areas of the genome that are different in patients who suffer from awareness and can elucidate whether a person's genetic make-up makes them susceptible to anaesthetic awareness.

Professor Jamie Sleigh, Waikato Hospital, New Zealand; Professor Kate Leslie, Royal Melbourne Hospital; Associate Professor Andrew Davidson, Associate Professor David Amor, Royal Children's Hospital, Victoria.

\$60,000

SUSTAIN for PAIN research trial. Subcostal UltraSound guided Transversus Abdominis plane INFusions for Pain relief of Abdominal INCisions

SUSTAIN for PAIN is a collaborative research study between Western Health, the Royal Melbourne Hospital, the Royal Women's Hospital, Barwon Health and Northeast Health, Wangaratta. The trial will examine Transversus Abdominis Plane ropivacaine infusions following abdominal surgery. Patients will be recruited into two groups. The first group will receive standard care, including all usual postoperative analgesia. The second group will receive standard care, but also a TAP ropivacaine infusion for 48 hours. The study will look for a reduction in the amount of morphine required in the second group as a marker of improved pain relief. Other secondary endpoints include the incidence and severity of morphine side-effects, the ability of the patient to perform everyday tasks and their self-reported level of pain.

Dr Elizabeth Hessian, Western Health; Dr Myles Conroy, Barwon Health; Dr James Griffith, Royal Women's Hospital; Dr Peter Hebbard, Wangaratta Hospital; Dr Irene Ng, Professor Kate Leslie, Royal Melbourne Hospital, Victoria.

\$12,178

Above from left: Dr Susan Lord; Dr Edmond O'Loughlin.

ANZCA announces funding boost to medical research continued

A randomised double-blind placebo-controlled trial of the efficacy of Remifentanyl for procedural pain in neonates

Newborn babies with conditions such as prematurity, birth defects or infections may require prolonged hospitalisation and multiple painful procedures essential to their medical care and survival. It is vital to reduce the pain they experience, not only for humanitarian reasons, but also because pain may have long-term effects on the newborn's still-developing nervous system.

In particular, many require insertion of PICC lines to maintain long-term vascular access for medications and nutrition. This procedure is challenging and causes moderate to severe pain in newborns. Currently there is no satisfactory pain relieving treatment for this procedure. Comfort measures, sucrose and breast milk reduce pain during minor procedures, but are inadequate for this more painful one. Local anaesthetic creams on their own do not significantly reduce the pain, and skin irritation and toxicity prevent their use in premature babies. Morphine provides better relief, but takes an hour to work and causes decreased breathing for up to 12 hours afterwards, leading to unnecessary mechanical ventilation. Preliminary evidence suggests that remifentanyl, an ultra-short-acting morphine-like drug, may provide pain relief without prolonged breathing suppression afterwards.

This randomised controlled study will evaluate the benefit of remifentanyl for pain relief during PICC line insertion in neonates. All babies will receive current standard care (age-appropriate use of sucrose and local anaesthetic cream). In addition, each baby will receive either remifentanyl infusion or dextrose (a placebo) infusion. Babies' faces will be video-taped and their pain scores, vital signs and physical status will be compared during and after their procedure.

Dr Susan Lord, Dr Ian Wright, John Hunter Children's Hospital, Newcastle, Australia.

\$41,540

Does adjunctive therapy with minocycline improve pain in burns patients when initiated on admission to hospital? A prospective randomised controlled trial

Both short and long term pain management continues to be an issue in the treatment of burns patients. Often these patients require high doses of opioid pain relief and other medications to prevent and treat pain. These medications are often required for a number of months following discharge from hospital. Opioid medications can be associated with a number of side-effects and are often difficult to reduce as a degree of unavoidable addiction develops.

Minocycline, an antibiotic with a proven safety record, has recently been shown to reduce pain in animal studies and also reduce the requirement for long-term use of opioid medications and opioid related side-effects, as well as reduce the risk of development and maintenance of abnormal nerve-related pain.

At present there is no human data in the form of quality studies examining the use of minocycline added to usual pain management therapies in burns patients. The proposed study involves the administration of minocycline to patients suffering burns injuries who are likely to be experiencing severe prolonged pain and comparing it to a placebo to determine both short and long term pain outcomes, as well as the necessity for use of high dose opioids and other pain relief medications. In order to ensure patient comfort, pain management in both the minocycline and placebo participants will be controlled using standard pain management regimes.

Dr David Lindholm, The Alfred hospital, Melbourne, Australia

\$21,019

Does gabapentin reduce itch in children with acute severe burns? A prospective randomised double-blinded controlled study

Many children with burn injuries experience itchiness as a result of the burn itself, or the healing process. This can be quite severe and can affect healing if scratching causes damage to the skin or skin grafts. At the Children's Hospital at Westmead, the treatment of itch involves a number of different drug therapies. Gabapentin has been used for this purpose, but there has been no good quality research showing exactly how effective it is.

The project will involve treating children with either gabapentin or a placebo and collecting information about the level of pain, itch and sedation experienced by the child. All other treatment will be given as normal. The duration of treatment is four weeks and the investigators will be in regular contact with the families to monitor for any possible side effects. At the conclusion of the study period, we will look for any differences in the number of children experiencing significant itchiness in the gabapentin group compared to the placebo group.

In conducting this research, it is hoped to be able to improve understanding of how effective gabapentin is in the treatment of burns-related itchiness, with the overall goal to improve the standard of care for all children suffering from burns.

Dr Andrew Weatherall, Dr Wanda Yung, Children's Hospital at Westmead, Australia.

\$27,430



Ultrasound transmission gel: an assessment of neurotoxicity

Regional anaesthetic techniques, known as nerve blocks, are used to improve pain relief after surgery and in chronic pain medicine. The techniques involve injecting local anaesthetic around nerves to anaesthetise areas of the body. Ultrasound imaging can be used to guide the needle with greater accuracy resulting in better and safer pain relief for patients after surgery.

Ultrasound transmission gel is used to improve image quality when performing ultrasound techniques. Some gel can be carried by the needle to the nerve during the process of needle insertion. There are no published human or animal studies looking at whether the gel causes any nerve damage. The investigator aims to determine if ultrasound gel causes damage to nerves using a placebo controlled trial in an animal model. Ultrasound gel will be injected around nerves using micro-ultrasound techniques similar to those applied in clinical nerve blocks. Neuropathologists will then examine the nerves looking for changes consistent with nerve damage.

This study will be the first assessment of neurotoxicity associated with a widely used ultrasound gel. The results will have direct clinical implications for human safety during anaesthesia and interventional pain medicine.

Dr David Belavy, Royal Brisbane and Women's Hospital, Queensland.

\$19,318

Simulation/ education grants

The impact of assessment on life and learning

Assessment is a powerful driver of learning behaviour and successful learners develop strategies to maximise their chances of passing examinations which may or may not be the most effective way of acquiring the knowledge, skills and attitudes required of a specialist anaesthetist. Furthermore, assessments have a significant impact on quality of life and there have been some reports of high incidence of burnout in trainees in other disciplines related to the stress of examinations.

The overall question for this educational research is, how does the FANZCA assessment regime promote or hinder effective approaches to learning by anaesthesia trainees, impact on their quality of life and facilitate the journey from novice to professional?

The results of this study will generate new information in an under-researched area with the intention to inform the development of assessment policies in postgraduate specialist training in anaesthesia. The ultimate aim of this study is to develop assessment regimes that increase the effectiveness of postgraduate training, support trainees and promote effective strategies for life-long learning.

Associate Professor Jenny Weller, Dr Marcus Henning, Dr Boaz Shulruf, Dr Rain Lamdin, University of Auckland, New Zealand; Professor Brian Jolly, Monash University, Australia.

\$22,800

Reflective practice in anaesthesia trainees

The use of critical self-reflection has been quite widely explored in various healthcare disciplines. However, the ability of post-graduate specialty trainees in anaesthesia to demonstrate effective self-reflection has not been previously investigated. It is an essential skill in the development of professional practice and a necessary pre-requisite for life-long learning. This study will measure the baseline level of self-reflection skills in anaesthesia trainees and develop a teaching package to improve these skills. The efficacy of the intervention will be tested in a randomised controlled manner and issues related to feasibility will be explored. If the outcome is positive, such a teaching package could potentially be offered to all anaesthesia trainees in the future.

Dr Natalie Smith, Wollongong Hospital, New South Wales.

\$7,750

Above from left: Dr David Belavy, Dr David Lindholm, Professor Jamie Sleigh.

ANZCA announces funding boost to medical research continued

Academic Enhancement Grant

Innovations in perioperative physiology, monitoring and care

This grant application includes an overall program of 18 anaesthesia research studies. The initial project – a randomised, blinded multicentre, non-inferiority study of Plasmalyte and Hartmann’s solution in patients undergoing liver resection incorporates several Austin strengths: intravenous fluids, acid-base clinical chemistry and liver surgery. In this multicentre study with Monash Medical Centre and Peter MacCallum Cancer Centre the investigators will compare Hartmann’s solution, the intravenous fluid most often used during surgery, with Plasmalyte, a far less used alternative. Although both have been available for many years, they have rarely been formally compared. The investigators believe that after liver surgery, blood acidity will be similar using either Hartmann’s or Plasmalyte, but that Plasmalyte will not affect blood lactate levels; an important marker of recovery after liver surgery and in other clinical conditions. If correct, these findings would help anaesthetists and critical care doctors choose fluids for sicker patients and for resuscitation. Other studies in the broader program include postoperative outcome, cardiopulmonary and clinical chemistry monitoring, pain relief, and environmental aspects of anaesthesia. This initial project and the broader overall research program will make important contributions to many aspects of perioperative patient care.

Associate Professor David Story, Associate Professor Philip Peyton, Associate Professor Larry Mc Nicol, Austin Health, Victoria.

\$90,000



Lennard Travers Professorship

ANZCA congratulates Associate Professor Andrew Davidson for the award of the quadrennial Lennard Travers Professorship for 2011. This prestigious award is open to Fellows of the College in Australia, New Zealand, Hong Kong, Malaysia or Singapore to work in an area of his/her choosing towards the advancement of knowledge in a nominated area of anaesthesia in those countries. The tenure of the professorship is one year and Andrew will hold the courtesy title “Lennard Travers Professor of Anaesthesia”.

Andrew is a senior staff anaesthetist at the Royal Children’s Hospital in Melbourne. He is head of the Clinical Research Development Office and head of the Anaesthesia Research Group at the Murdoch Children’s Research Institute in Melbourne. He is also an associate professor in the Department of Paediatrics at the University of Melbourne.

He is an associate editor for the journal *Anesthesiology* and section editor for *Pediatric Anesthesia*. He is Chair of Paediatric Anaesthetists for the New Zealand and Australia Research Committee and is a member of the ANZCA Clinical Trials Group.

In the last five years, Andrew has delivered invited lectures at 27 international and eight national scientific meetings; held 17 research grants from national and international funding bodies and holds two NHMRC project grants. He has published six book chapters and 34 peer-reviewed articles. He supervises three PhD students and has supervised a number of masters, BScHons and advanced medical science students.

The Lennard Travers Professorship emolument will assist Andrew in pursuing his study comparing two fluids for IV fluid maintenance in children in a randomised clinical trial. This trial will help promote the role of anaesthesia in the perioperative management of children.

Andrew will deliver the Australasian Visitor’s Lecture at the College Annual Scientific Meeting in Perth in 2012 as part of the Lennard Travers Professorship.

Grant review process

Thank you to all reviewers listed below who agreed to review a grant, and in some cases two, for your invaluable contribution to the grant review process. The ANZCA Research Committee is extremely grateful for your assistance.

Each year, the ANZCA Research Committee read the grants, select three reviewers for each grant on the basis of their expertise and relevance to the project, read the reviews, collate the information and act as overall spokespeople for each grant and make a final recommendation to Council. The grant review process is rigorous and transparent. Conflicts of interest are recorded and members of the committee are excluded from consideration of any grants for which they have a conflict.

Research Committee members are:

Professor Alan Merry, Chair
Associate Professor David Scott, Deputy Chair
Dr Andrew Davies
Professor Tony Gin
Dr Chris Hayes
Professor Paul Myles
Professor Michael Paech
Associate Professor Tony Quail
Professor Stephan Schug
Associate Professor Tim Short
Associate Professor Philip Siddall
Associate Professor David Story
Professor Bala Venkatesh
Dr Angela Watt, Community representative
Associate Professor Jennifer Weller
Dr Dan Wheeler
Mr Ian Higgins, Director, Anaesthesia and Pain Medicine Foundation (by invitation)

Grant reviewers for the 2011 grant round

Associate Professor Brian Anderson
Dr Michael Barrington
Dr Guy Bashford
Dr Malcolm Battin
Professor Duncan Blake
Associate Professor Frank Bloomfield
Dr Simon Body
Dr Robert Callister
Professor McDonald Christie
Associate Professor David Cottee
Professor Jeff Cutfield
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Professor Michael Hensley
Dr Andrew Hilton
Dr Graham Hocking
Dr Malcolm Hogg
Dr Jay Horvat
Professor Michael Irwin
Professor Gareth Jones
Associate Professor Ross Kennedy
Dr Michal Kluger
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Associate Professor Ross Macpherson
Dr Stuart Marshall
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Professor Catriona McLean
Dr Jeff Mogil
Dr John Morgan
Dr Richard Morris
Dr Sandra Peake
Dr Philip Peyton
Dr Mark Priestley
Dr Richard Riley
Professor Colin Royse
Associate Professor Carlos Scheinkestel
Professor Stephan Schug
Dr Andrew Shaw
Dr David Sidebotham
Professor James Sleight
Professor Maree Smith
Professor Andrew Somogyi
Associate Professor David Story
Dr Suellen Walker
Dr Stephen Watts
Professor Johanna Westbrook
Dr Dan Wheeler
Professor Fiona Wood
Dr Paul Wrigley

Strategic directions research workshop

One of the key aims of the ANZCA Trials Group is to develop new multi-centre trials to solve important problems in anaesthesia, perioperative medicine and pain medicine. To this end, the Trials Group held its 2nd Annual Strategic Directions Research Workshop on October 1, 2010 at the College's headquarters in Melbourne. The workshop was attended by members of the ANZCA Trials Group Executive, researchers who are already collaborating in the group's multi-centre trials and Fellows who are interested in contributing in the future. The 35 participants attended at their own expense and for the first time anaesthesia research nurses were also invited. The workshop was led by Associate Professor David Story (Chair, Trials Group Executive) and was co-ordinated by Stephanie Poustie (Trials Group Research Co-ordinator).

The workshop included presentations on the progress of proposals that were presented in 2009. They included the following: Professor Kate Leslie on POISE 2; Dr Elizabeth Hessian on TAP blocks in abdominal surgery; Professor Matthew Chan on persistent pain after surgery; Dr David Canty on echocardiography in fractured NOF surgery; Dr Tomas

Corcoran on the uses and side effects of dexamethasone in surgery; Professor Paul Myles on ATACAS and ENIGMA II; and Associate Professor David Story on the REASON audit.

Dr Elizabeth Hessian, Professor Matthew Chan, Dr David Canty and Dr Tomas Corcoran are all recipients of 2011 ANZCA Research Grant Awards for their research. Associate Professor David Story was a recipient in 2009 for the REASON audit, while Professor Kate Leslie and colleagues won a 2011 NHMRC grant of \$1,136,310 for the POISE-2 Study. Professor Paul Myles secured additional NHMRC funding for the ATACAS study of \$3,328,000. Congratulations to all.

In addition to the day's program, the Executive Officer of Australian and New Zealand Intensive Care Society (ANZICS) Clinical Trials Group, Rhiannon Elliot gave an informative talk on the ANZICS business case for the employment of research coordinators in ICUs. This topic is an area of further interest and collaboration between the trials groups of ANZICS and ANZCA.

This year six new proposals were presented. Topics included:

- Anaesthesia techniques in ECT.
- Regional or GA in endovascular aneurysm repair.
- Fluid therapy regime in major surgery.
- Therapies in post CABG bleeding.
- TA use in burns surgery.
- Cognitive function post surgery.

Subsequently, the proposed trials will be ranked in order of priority, detailed protocols will be developed and high level funding will be sought. The success of these workshops means that planning for 2011 will involve a regional location over an entire weekend.

The workshop proved to a very exciting and productive day for everyone. It was a great opportunity for old collaborators to meet up in person and for new collaborations to be fostered. The future of research by ANZCA Fellows looks bright. Any interested Fellows are encouraged to contact the Trials Group Research Co-ordinator, Stephanie Poustie, via email: spoustie@anzca.edu.au.

**Attendees at ANZCA Trials Group
Strategic Directions Research
Workshop**

- Dr David Bramley (Vic)
- Renee Barham (Vic)
- Sarah Baulch (Vic)
- Professor Thomas Bruessel (ACT)
- Dr David Canty (Tas)
- Professor Matthew Chan (Hong Kong)
- Associate Professor Tomas Corcoran (WA)
- Vanessa Cuthbert (Vic)
- Dr Andrew Davidson (Vic)
- Dr Robert Elliot (Vic)
- Dr Simon Gower (Vic)
- Bernadette Gravina (Vic)
- Dr Richard Halliwell (NSW)
- Dr Elizabeth Hessian (Vic)
- Dr Ross Kerridge (NSW)
- Professor Kate Leslie (Vic)
- Dr Peter Lillie (SA)
- Davina McAllister (NZ)
- Professor Paul Myles (Vic)
- Dr Philip Peyton (Vic)
- Stephanie Poustie (Vic)
- Sue Olliff (NZ)
- Dr Edmond O'Loughlin (WA)
- Dr Cameron Osborne (Vic)
- Marg Quayle (Vic)
- Dr Mark Reeves (Tas)
- Professor Stephan Schug (WA)
- Dr Brendan Silbert (Vic)
- Sophia Sidiropoulos (Vic)
- Dr Palvannan Sivalingam (Qld)
- Associate Professor David Story (Vic)
- Georgie Thompson (Vic)
- Dr Stuart Walker (NZ)



Above clockwise from left: Professor Paul Myles, Associate Professor Tomas Corcoran, Dr David Bramley; Dr Georgie Thompson, Vanessa Cuthbert, Dr Simon Gower, Bernadette Gravina, Dr Cameron Osborne; Participants at the workshop: Professor Kate Leslie, Associate Professor David Story, Associate Professor Andrew Davidson; Rhiannon Elliot, Associate Professor David Story.

The Anaesthesia and Pain Medicine Foundation

The foundation's inaugural governor

In late October the ANZCA Vice President, Dr Lindy Roberts, presented the inaugural Governor of the Foundation, Dr JB Craig with a certificate to mark this important appointment. The presentation was held at the new ANZCA offices in Perth and was attended by family and colleagues of Dr Craig and the Western Australian office staff.

In 1987 Dr Craig donated \$100,000 to the College to support research by Fellows, especially Western Australians and particularly in the area of pain medicine. The JB Craig Award is administered by the foundation and the research committee and is awarded from the interest on the corpus when suitable applications have been approved for funding.



The foundation is grateful to the following people and organisations who have supported our programs in 2010:

The Patrons Program

Governor

Dr JB Craig (WA)

Life Patrons

Dr William Howard (Vic)
Associate Professor John Rigg (WA)

Patrons

On Call Locums (NSW)
Dr Richard Vaughan (WA)
Dr George Boffa and Mrs Laura Boffa (NSW)
Dr Bernard Cook (NSW)
Dr John Gray (Vic)
Dr Tim Allen (SA)
Mr Gordon Moffatt (Vic)
Professor Kate Leslie (Vic)
Professor Tess Cramond (Qld)
Dr Ying Hung Mok (HK)
Dr John Harrison (Vic)
Dr Guoming Liu (Vic)
Dr Arthur Penberthy (Vic)
Dr Walter Thompson (WA)
Associate Professor Richard Walsh (NSW)

The John Snow Society

Dr Leona Wilson (NZ)
Professor Kate Leslie (Vic)
Professor Michael Cousins and Mrs Michelle Cousins (NSW)
Dr Elaine Kluver (Qld)

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Dr Cedric Hoskins and Mrs Doreen Hoskins (NZ)
Mr Ian Higgins (Vic)

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Malaysia

Professor GS Ong

To make a bequest, become a patron and for all other inquiries please contact the foundation office.

ANZCA House
630 St Kilda Road
Melbourne VIC 3004
Tel: +61 3 9510 6299
Fax: +61 3 9510 6786
Email: scollins@anzca.edu.au

Inaugural GASACT Trainee Congress – Melbourne 2010



The year 2010 marked the 10th annual meeting of the Group of Australian Society of Anaesthetists Clinical Trainees (GASACT) committee. It also marked, importantly, the inaugural trainee congress in Melbourne, offering trainee-focused lectures, workshops and social functions to coincide with the Australian Society of Anaesthetist's (ASA) national scientific congress (NSC).

The opening day of the congress saw invited trainee representatives from ANZCA, and sister Societies in New Zealand, the United Kingdom and Canada join the GASACT committee in their meeting to discuss issues of relevance to trainees. While the Association of Anaesthetists of Great Britain and Ireland (AAGBI) have had its Group of Anaesthetists in Training (GAT) since 1967, the GASACT group had its origins in 2000. New Zealand lags further behind this with such a trainee group yet to be formed. The committee meeting provided a useful forum in which to share insight and perspective amongst a diverse group of trainees.

The "Super Sunday" of the congress consisted of exclusive trainee workshops on echocardiography ("Echo 101") and teaching ("Tune into teaching"). The rapidity with which these sold out was a reflection of their popularity and usefulness. Trainees were then able to attend a trainee luncheon, which coupled good food with good conversation as trainees had



the opportunity to rub shoulders with distinguished invited anaesthetists. The afternoon consisted of a series of interesting lectures based around the theme "skills and technology in alternate realities". These ranged from remote and veterinary anaesthesia, to practical skills which aid the doctor-patient interaction. The day was concluded with the "Melbourne meander" – an on-foot tour of the city culminating in a cocktail party at one of the city's swanky bars.

The efforts of the GASACT team and NSC organising committee in forming an inaugural trainee congress are to be highly commended. To add trainee specific events to the wealth of educational material already on offer at the NSC made the event extremely beneficial and even more worthwhile. Trainees are the future of the College and the Societies so any increase in participation by them at such events can only be heralded as a positive move for our specialty. Hopefully such trainee-focused events will continue to become an increasingly common feature in College and society meetings in both

Australia and New Zealand leading to increased trainee participation in continuing medical education and non-clinical anaesthesia.

The 2011 GASACT trainee congress will coincide with the 70th ASA National Scientific Congress to be held in Sydney in September. Given the infamous competition between the two cities, all bets are on for the organising committee aiming to top the Melbourne experience. With the standard of the inaugural trainee congress, they will have their work cut out for them.

Dr Thomas Fernandez
NZSA Trainee Representative
Anaesthetic Trainee,
Auckland City Hospital

From top: The Melbourne Exhibition centre, site of the 2010 ASA NSC and inaugural GASACT trainee congress; The 2010 GASACT committee with invited international trainee representatives.

Edelweiss: A speech at the Final Fellowship Examination presentation



The following is an edited version of a speech given by the Chair of Examiners Dr Mark Priestley to successful final Exam candidates at a function at Randwick Racecourse in Sydney on October 23.

Congratulations everyone for passing the final exam of the Australian and New Zealand College of Anaesthetists. It's my favourite part of the day, as I'm sure it is for you and I know it is for the examiners. As a panel of examiners we take great pride in the standard we set to succeed in this examination, and it's a great joy to see so many of you achieve that standard, reflecting your efforts and those of your training programs. We realise that for most of you it has been a tough road, in fact so tough that the analogy is often made that the preparation for this exam is like climbing a long steep hill, so arduous you jettison unnecessary trappings, like a social life, and so tough you can't see the summit, let alone beyond it, so that questions about what you'll do with your life after the exam are fobbed off as irrelevant until you've achieved this goal. Well, you're here now, and while your emotions might be a cloudy mixture of exhilaration, relief, exhaustion and perhaps a little alcohol, I want you to pause and reflect on exactly what it is you have achieved today, and point out a few things on the other side of the hill that might interest you.

Firstly, I want you to look back down the hill, spare a thought for those that did not make it this time, and acknowledge and thank the people that helped you get to the top. Some may be family and friends here tonight who have made their own sacrifices for your achievement, and some will be supervisors of training, colleagues and mentors who are just as proud of your success as we are and deserve your thanks when you see them next.

Next, I want you to reflect on exactly what it is you have achieved here today. Assuming you meet the

other requirements of training you will receive the qualifications of a specialist anaesthetist, but it is the knowledge and skills you have acquired on the way up that will be of most use to you on the other side of the mountain. The qualification, FANZCA, world-recognised for quality, is permanent, but the skills and knowledge accumulated are not.

It's as if the qualification is a badge you can sew on your backpack and take everywhere, but the skills and knowledge are like herbs and flowers you've picked up on the way that survive only at high altitude, and it's the herbs and flowers you'll be using to heal people, because that's what you'll be doing, healing people. Healing the pain of labour or post surgery, rendering your patients unaware so that surgeons can heal, or simply relieving the worry and anxiety they feel before they have surgery, or before their children have surgery. To say your job will be a community service would be an understatement and the people glad of your achievement today include all those patients, yet unknown, whose suffering will be relieved while they are under your care.

So when you look out on the horizon over the other side of the hill, in whichever direction you choose – (obstetrics or paediatrics, private or public, urban or rural) you will see paths that go up even more hills and paths that seem to travel gently and easily down to the sea. Just remember that while the easy paths may seem to be where your happiness lies, true happiness at work – whether you're a professor of anaesthesia or you own a café – lies in being good at what you do. Keeping the knowledge and skills you have acquired that make you good at what you do will require you to remain constantly at high altitude, and that will require you to stay in the hills, climbing a little each day. Or, if you allow yourself to descend the valleys, knowing that you will have to set yourself new goals for new hills.

The good news is that what you accumulate after a while is not just knowledge but wisdom, and with that and the compassion and empathy you get from recognising your work as a healing vocation, you'll be just fine at what you do.

What path to take? I hope some of you will choose education or research because if you can improve the quality of many anaesthetists you can improve the lives of many thousands more patients. But for a start, when you graduate, I urge you to come to an annual scientific meeting. Apart from wearing a fetching frock like mine and shaking hands

with the president, you can attend a ceremony that formally welcomes you into the fellowship, you'll get to witness about 200 of your colleagues giving up their time and energy for free so that you can become a better anaesthetist, and you'll meet colleagues from all over Australasia, some of whom may become good friends for life. Above all you'll see what it means to be a member of a College rather than a company, and you'll learn that the rewards of being in a fellowship come not from what you earn, but what you contribute.

The one other thing I'd like to add is this: Don't be afraid to be passionate about your job.

The trend these days is so much to focus on lifestyle and work-life balance and I'm a strong proponent for that, but don't be afraid to seek out the most enjoyable and interesting aspects of your work and foster the passion that can develop. You don't necessarily have to work long hours to do that. We're very privileged as medical specialists to have the luxury of that, but one of the most enjoyable aspects of my involvement with this examination (apart from the warm glow I get knowing I'm not a candidate ... and I learn a lot!) is to witness and share an extraordinary passion for the job. The sheer collective desire to achieve the best possible outcome is palpable every time I come here. To find the most appropriate balance between being as fair as possible to both candidates and the community requires hard work, and despite the fact that that hard work is voluntary, these examiners do it with more zeal and commitment than their paid jobs because they're passionate about it and they love it. As role models for what I'm trying to describe they are wonderful, but they're not the only ones. We have great role models for workers with passion in anaesthesia research, overseas medical aid, council administration and the many, many teachers and supervisors of training, among others.

You should be able to look at these role models and realise it's OK to love your job.

With that I would like to invite you, your family and friends to celebrate the occasion with the Court of Examiners and myself.

**Dr Mark Priestley, FANZCA Chair,
Final Exam Subcommittee**

Successful candidates

Primary fellowship examination

The written section of the examination was held in all capital cities in Australia, Cairns, Launceston, Newcastle, Townsville, Auckland, Christchurch, Dunedin, Hamilton, Hong Kong, Kuala Lumpur, Singapore and Wellington on July 26. The viva examination was held at the Australian Institute of Management in Melbourne from September 13-15. A total of 266 candidates successfully completed the primary fellowship examination at this presentation and are listed below.

Australian Capital Territory

Michael Richard Mark Adams
Candida Francesca Marane
Will Matthiesson
David Richard Neale
Claire-Mary Jeanette Thomsett
Rajesh Babu S

New South Wales

Karina Simone Berzins
Robert Bishop
Felicity Anne Bowen
Sarah Rebecca Bowman
Benjamin Gareth Brown
Michelle Jane Castro
Andrew John Chapman
Shona Chung
Antony Douglas Clyde
Robert Henk Crocket
Sarah Renee Crosby
Riyad Adul Aziz Dawood
David Dao
Amy Louisa Dickson
Ryan Downey
Paul Drakeford
Phoebe Epstein
Edward Kayesh Fairley
Gregory Alan Foster
David Ziggy Fyfe
Dennis Gokcay
Hui Joo Heng
Ji Young Ciel Heo
Adam Mark Hill
David Huntington
Liyana Patabendige Maheshi
Vasundara Jayaweera
Dhivya Kailasapathy
Monika Kenig
Hee-Sun Kim
Alex Kroll
Michelle Ming Yee Kwok
Katherine Lanigan
Kar Man Lee
Phillip Kwan-Giet Lee
Lei Lei
Yin Yin Leow
Yuting Lu

Claire Louise Goldsbrough
Patrick Antony Mamo
Eugene Andre Mansour
Nicholas Peter Maytom
Philip Sidney McGrath
Donald Andrew McLachlan
Robert Charles McMonnies
Helen McPhee
Jacqueline McPhee
Giles Miller
Callum Hsing Ming Moi
Jonathan Douglas Minton
Hoi Yee Mok
Xuan-Phuong Nguyen
Francisco Eduardo Martinez Orellana
Daniel Thomas Orr
Alastair Donald Paterson
Florian Gustav Paturi
Don Franciskuge Jeewaka Perera
Khoi Nguyen Pham
Benjamin Piper
Arathi Ajith Rajan
Vinay Rao
Chetan Reddy
Jennifer Reilly
James Lennox Rickcord
Joshua Frank Rijsdijk
Timothy David Robertson
Nathan Peter Royan
Robert John Scott
Alyssa Joan Scurrah
Akshat Sehgal
Kavitha Shetty
Clare Margaret Shiner
Stephen Jonathan Smith
Timothy James Southwood
Lisa May Lin Stanton
Ngaroma Tirita Steele
Elizabeth Mei-Ying Symons
Chloe Louisa Tetlow
Eng Tiong
Hawn Trinh
Brendan Paul Troy
Timothy Joseph Weston
Francis James White
Dammage Hasith Vipashavith
Wickramaratne
Jie Chuan Wu
James Zi Feng Xian
Tao Yuen Alan Yam
Stanley L Yu
Wei-Jie Zhuo

Northern Territory

Gwendolyn-Mary Stewart
Claudia Elsie Tom

Queensland

Zeyad Aljeboori
Ohnmar Kyawt Kyawt Aung
Saya Aziz
Babitha Kudakandira Basappa
John Michael Beck
Nicola Vincenzo Giorgio Cannizzaro
Eleanor Charlotte Castle
Rebecca Elizabeth Christensen

Stephen Richard Daglish
Joshua Surian Daly
Sandra Marie Derry
Diwakara M K
Suran Dhanapala
Tawona Dhlakama
Peter Christian Elepfandt
Annabelle Victoria M Harrocks
Luke Jonathon Heywood
Madeline Hoy
Peter Iu
Dwane Lachlan Jackson
Amit Kapoor
Peter Christian Larsen
Shannon Aileen Laycock
Daniele Lazzari
Bernadette Louise Lupton
Jonathan Hui Hwong Lau
Victor Khi Leong Lee
Wai Leong Liew
Josephine Maria
Emma Therese Moloney
Patrick James Nelmes
Edney Richardson
Liam Michael Ring
Daniel James Robertson
Sadhish Kumar S
Stephen Schreiber
Kristopher Jon Skeggs
Holly Jayne McCabe Smith
Linda Mei-Yi Sung
Ryan Tsu-Kit Tan
Tobias Paul Trinks
Catherine Eileen Trill
Lenore Frances Van Der Merwe

South Australia

Edward Erle Coxon
Suzanne Louise Cartwright
Lok Yin Evelyn Cheng
Ravindra Vincent Cooray
Oliver Jebaretnam David
Kate Douglas
Katarzyna Grela
Nathan Trent Judd
Palash Kar
Ravi Farhan Khan
Shu Ying Lai
Philippa Louise Lane
Paul John Secombe
Swati Sethi
Martin Tyson

Tasmania

Carsten Aase
David Robert Alcock
Alan Choon Kiang Ch'ng
Shaun Daniel O'Brien
Michael Charles Lumsden-Steel

Victoria

Samantha Jane Bigg
Charles James Bitcon
Emma Joanne Boden
Christelle Botha
Lauren Maree Bourke
Gregory Michael Bulman
Dean Bunbury
Simon Woon-Hui Chong
Jennifer Jiaping Fu
Mark Joseph Heynes

Grace Huei-Hsin Huang
Gurdeesh Kaur
Sang Yee Lee
Dennis Wai Chung Lee
Maurice Peter Le Guen
David Ji Yan Long
Neil Andrew MacDonald
Sarah Kate Magarey
Lachlan Fraser Miles
Dale Fergus Murphy
Jacquelyn Peta Nash
Rachel Lee-Yin Ng
Iraj Nik Pey
Jade Radnor
Samuel Hong Chang Sha
Elizabeth Anne Shaw
Sharanjeet Kaur Sidhu
Lalitha Sivagnanam
Chez William Smith
Polly Spencer
Hugh Edward Taylor
Nerida Frances Telec
David Justin Tsang
Alister Boon Tsin Ooi
Jacob Benjamin Wawryk
Bethany Patricia White

Western Australia

Candy Skye Edwards
Natasha Kamala Epari
Christopher Michael Gibson
Karina Gotjamamos
David Edward Bridgman
Bree Adele Maciejewski
Nazeen B Tajudeen

New Zealand

Jalal S Alsaad
David John Anderson
Tristan Robert Bennett
Jennifer Margaret Best
Tong Wei Chung
Andrew John Colls
Roana Donohue
Michael Edward Foss
Julia Margaret Foley
Romilla Mary Franks
Victoria Yien Freeman
George Ripley Gorringer
Samuel Morrow Grummitt
Ganesh Hanumanthu
Marissa Candace Henderson
Nicola Jane Holdgate
Nicola Gail Hooper
Kathryn Jane Law
Ravi Shankar Manda
Kanchana Manickam
Logan Gregory Marriott
Titaina Danielle Palacz
Rachel Ann Sara
John Paul Scarlett
Ross Dominic Scott-Weekly
Bibhuti Thakar
Olivia Jane Thomas
Richard Michael Walsh
Katherine Zoe Wills
Jennifer Anne Wright
Paul Grant Young

Hong Kong

Chan Wai Naam Wales

Chong Ka Hei

Fong Ching Man

Hong Yip

Kam Yuen Ip

Lai Tsun Yin

Lee Pui Yew Steffie

Lee Sze Wai Karen

Lee Tsz Man

Lee Wing Lai

Leung Janice Ho Ting

Li Tin Yuk Amy

Lo Kar Yan Joyce

Pang Ka Man Carmen

Shiu Ying Fung

Wai Rebecca Pak Kei

Wong Man Kin

Wong Sau Ching Stanley

Wong Silky

Malaysia

Divya Ann Abraham

Brian Mun Wei Hue

Leena Kumari a/p Nagappan

Shaktivel A/L G Palanivel

Sukcharanjit Singh A/L

Bakshi Singh

Phang Ye Yun

Singapore

Abej Matthew Varughese

Mathews

Ang Bun Hui

Ashokka B

Choo Wee-Sen

Khoo Xian Li Deborah

Koo Boon Chan

United States of America

Jane Hui Ling Chan

Renton Prize

Lachlan Fraser Miles (Vic)

Merit certificates*Pharmacology*

Sarah Renee Crosby (NSW)

Fong Ching Man (HK)

Luke Jonathon Heywood (Qld)

Wong Man Kin (HK)

Alister Boon Tsin Ooi (Vic)

Samuel Hong Chang Sha (Vic)

Wai Rebecca Pak Kei (HK)

Physiology

Fong Ching Man (HK)

Luke Jonathon Heywood (Qld)

Samuel Hong Chang Sha (Vic)

Gwendolyn-Mary Stewart (NT)

Wai Rebecca Pak Kei (HK)

Final fellowship examination

The medical clinical and written sections of the examination were held in Adelaide, Brisbane, Melbourne, Perth, Sydney, Auckland and Hong Kong on August 27 and 28. The anaesthesia vivas were held in Sydney at Randwick Racecourse on October 22 and 23. A total of 139 candidates presented for the medical clinical and written sections of the examination of which 130 were invited to the anaesthesia vivas. A total of 98 successfully completed the final fellowship examination and are listed below.

Australian Capital Territory

Melinda Colleen Ford

Jill Dominique Francine Luc

Van Acker

Vaughn Oerder

New South Wales

Sandra Chieh Hsiang Cheng

Simon Lindsay Cook

David Andrew Donnelly

Andrew John Donohue

Alastair Patrick D'Vaz

Robert Gadzicki

Christopher Gorringer

Louise Vera Hails

Tom Matthew Hall

Claudia Higgs

Andrew Yanqi Huang

Ross Andrew Keen

John Anthony Kerdic

Sarah Hadi Khatib

Chao-Hsien Ko

Naofie Catherine Lavin

Nina Loughman

Lindy Talia Lowenstein

Suresh Vennoor Madhavan

Manoj Indraka Mallikahewa

Ann Marie McCallum

Pedram Mohammadi

Paul Andrew Ross

Tony Kai-Yuan Shih

Peter Yat Chi Tam

Charles Christopher Morel

Warren

Alison Williams

Melissa Ann Yee

Joanne Yeo

Lilian Eva Yuan

Helen Zois

Queensland

Daniel Stephen Bartlett

Robert J Boeke

Christian Bonney

Nicholas Patrick Crimmins

Michael Phillip Curtin

Craig Anthony Daniel

Craig Laurence Fraser

Sudhir Kumar

Robert David Miskeljin

Premala Nadarajah

Anand Parameswaran

Jason Mark Pincus

Srinivas Rachakonda

Jayakumar Rangaswami

Lalitha Lakshmy Rameshbabu

Juluri Hanumantha Rao

Timothy Theodore Scholz

Paul Ferguson Scott

Sarika Sharma

Scott Anthony Smith

David Tragen

South Australia

Jason Peter Koerber

Zoe Louise Lagana

Christie Joy Lang

Joanne Louise Moore

Andrew Robert Wallace

Lan Lan Zhang

Tasmania

Katrina Webster

Victoria

Devarakonda Rajesh Babu

Megan Elizabeth Fletcher

Jacobus Geertsema

Catherine Van Der Herten

Shanon Lee Jarvis

Navroop Singh Johal

Atlas Ching-Hong Ko

Melissa Wendy Faith McDougall

Rebecca Jane Owen

Slava Poel

Western Australia

Edward Michael Debenham

Brendon Karl Dunlop

Dana Halmagiu

Sarojini Jagadish

Michael Law

Rajani Kanth Potula

Eric Jiong-Chang Tai

Chaitanya Tak

Anthea Asirvadam William

New Zealand

Stacey Marie Byers

Tin Lun Chiu

Sheila Hart

Kwok Fui Hor

Rowena Lee Knoesen

Glenn Andrew Mulholland

Christopher James Poynter

Florian Matthias Pracher

Thimali Rajapaksa

Louise Mary Speedy

Jonathan Paul Stacey

Joyce Yan Tai

Malaysia

Sajidah Ilyas Mohammad Ilyas

Hui Mun Tsong

Hong Kong

Carmen Ka Man Chan

Man Hiu Kwan Jannifer

Singapore

Tan Yin Kiat Glenn

Cecil Gray Prize

Sheila Hart (NZ)

Merit certificates

Charles Warren (NSW)

Edward Debenham (WA)

Ross Keen (NSW)

Joanne Yeo (NSW)

Jacobus Geertsema (Vic)

Twenty-five candidates presented for the International Medical Graduate Specialist Performance Assessment held in August/October 2010 and the following 12 were successful:

Dr Robert Boeke (Qld)

Dr Christian Bonney (Qld)

Dr Dana Halmagiu (WA)

Dr Sudhir Kumar (Qld)

Dr Manoj Mallikahewa (NSW)

Dr Vaughn Oerder (Vic)

Dr Rajani Potula (WA)

Dr Srinivas Rachakonda (Qld)

Dr Jayakumar Rangaswami (Qld)

Dr Juluri Rao (Qld)

Dr Sarika Sharma (Qld)

Dr Catherine Van Der Herten (Vic)

Eight IMGS candidates presented for the final fellowship examination held in August and October 2010 and the following five candidates were successful:

Dr Rajesh B Devarakonda (Vic)

Dr Robert Gadzicki (NSW)

Dr Sarojini Jagadish (WA)

Dr Suresh Vennoor Madhavan (NSW)

Dr Chaitanya Tak (WA)

Examination fees – your questions answered

A matter of particular interest to trainees is the exam fees the College charges for candidates, especially the level that is set by management and approved by Council. The College is ever mindful of the impact of exam fees on trainees, and Council and management are concerned to ensure that the fee levels are always as reasonable and appropriate as possible. This article gives information as to the level of exam fees in 2011, and provides an account of why they have been set at that level.

At its meeting on November 20, 2010, the College Council approved the budget for 2011, which included marginal increases to College subscriptions and fees. Generally, the fee increase was set at 4.8 per cent, which – allowing for an inflation forecast for 2011 of 3 per cent – represents an increase in real terms of 1.8 per cent. The examination fee for the primary and final examinations were approved to increase at the same level. ANZCA is in the mid-range of other specialist medical colleges in the level of exam fees that it charges trainees.

ANZCA has a long tradition of delivering services wherever possible at minimal costs for both its trainees and Fellows. For a period of six years between the calendar years 1999 up to and including 2005, there were *no increases* in exam fees, not even to take account of increases in CPI – which meant that the value of the fee in real terms was declining. During that time, any increase in the costs associated with the exams was absorbed by ANZCA, which was only made possible by the performance of the College's investment portfolio.

Until recently, ANZCA budgeted to rely on investment income to supplement College operations. However, because of significant falls in the value of the investment portfolio (a drop of about one third in value in the period 2008-2009, which reflected equity market trends, generally), this was no longer sustainable. Since 2009, operating *expenditures* have been budgeted to be funded from operating income, thus avoiding the reliance on the unpredictable performance of investments.

Importantly, the College's investment portfolio is not only used as a reserve in extraordinary times (such as the global financial crisis) but is also the source of funding for research grants, various scholarships and professorships, linked with the foundation as well as to provide funds for periodic capital costs. As such, a corpus of the portfolio must be retained to allow such activities to continue.

As a not-for-profit organisation, ANZCA does not make a profit and, in fact, the College budgets only for a very small contingent surplus, so increases in fees – such as exam fees – are the same as increases in costs, generally. It should be noted that exam fee increases in the past five years have been set at *exactly* the same level as increases in the annual subscription fees for Fellows.

A question often asked is: "Do examination fees match the costs incurred in running the exams?" It is difficult to provide an accurate overall cost related solely to conducting examinations because ANZCA's budgets and financial reports are framed around the income and expenditures of the College's organisational units rather than activity programs, as such. Furthermore, the cost of examinations may have an impact on a number of units within the College. Therefore, any calculation of the cost of running exams would have to take account of direct costs as well as indirect costs. Direct costs include such things such as:

- Hiring of venues (including catering, security and office equipment). The requirement to hire venues in centres outside Victoria – rather than examine at ANZCA House, as was the case historically – has been made necessary by the great increase in candidate numbers. The cost of venue hire has added significantly to the overall expense of examinations.
- Staff costs (at venues including invigilators, support for examiners, transport and accommodation for College staff).
- Examiner costs (the examiners work on a *pro bono* basis, however allocations must be made to cover all air and ground travel, accommodation, catering and meal allowances).
- Costs associated with patients for the medical viva component. The medical vivas have been separated from the orals in the last three years and are now held throughout the regions.
- Printing costs for exam papers, etc.
- Postage of exam papers (to be marked by examiners).
- IT (the exam candidate lists, examiner rosters, MCQ and SAQ, as well as the results) are held on a newly developed Exams Management System and analysed so that candidate results can be published as soon as possible.

There are also direct costs associated with running the Training and Assessments unit, which include:

- Staff costs for the examinations unit (includes communications between examiners as well as candidates). This also involves confirming availability of examiners, rostering of examiners, and having spare examiners on hand in case of last-minute withdrawals. They also have significant interaction with exam candidates who need to be grouped, be assigned numbers, and receive correspondence, etc.



- Conferencing costs for the examination committees (face-to-face meeting, which may involve travel, accommodation as well as teleconferencing).
- Examiners' training and question writing workshops (held in Melbourne).
- Verification of documents (ITAs, module completion) to ensure eligibility of candidates to sit exams. This was done by the assessor on a *pro bono* basis until three years ago, when the number of candidates became too onerous. This has since been done by a (clinician) Director of Professional Affairs (Assessor), but even now the volume of work has necessitated the appointment of a second DPA (Deputy Assessor).
- IT exams software support and development. Again, for many years, this development was done on a *pro bono* basis by Fellows; it is now being taken over "in house" by the College's IT unit.

In addition, there are indirect overhead costs associated with the contributions of finance, IT and HR to the running of the examinations unit and the exams themselves.

In recent years, ANZCA has worked hard to strengthen the content and relevance of the anaesthesia training program so that it remains at the forefront of postgraduate medical education in Australia and New Zealand. This has included significant investment in curriculum redevelopment and improvements in the content and way training is delivered, online infrastructure, increased support to trainees and supervisors, improved communications, policy and advocacy.

This has been particularly important as the demand to sit the examination continues to grow and the external environment changes, as it has done over the past five years. In 2011 we

expect 755 candidates to sit the primary examination at 21 venues around Australia, New Zealand, Hong Kong, Singapore and Malaysia. This represents an increase of 65 per cent compared with 2005. Also in 2011, we anticipate that 307 candidates will present for the final examination – an increase of 35 per cent over 2005.

In summary, the cost of the primary or final examination is not just the exam itself, but also involves year-round activity throughout the College. Nonetheless, Council and management are always concerned to ensure that examination fees remain reasonable and defensible.

(Dr) Mike Richards FAIM, FAICD
Chief Executive Officer

New Zealand news



New Zealand National Committee

ANZCA President Professor Kate Leslie attended the November 26 meeting of the New Zealand National Committee (NZNC). Some of the key issues discussed included:

- The new in-training assessment (ITA) process and workplace-based assessment procedures.
- The need for ANZCA to develop and lobby for its position regarding alternative providers.
- Other workforce issues, including new career planning requirements, the workforce service reviews, and supply and demand projections.
- IMGS changes and the path to Fellowship for IMGS.
- A demonstration of an Auckland District Health Board software initiative for recording trainee progress that can be utilised to plan rosters to ensure trainees can meet their requirements, and how it might fit with ANZCA's new ITA requirements.
- Rural hospital medicine developments and issues.
- The role of the doctor in the 21st century (see below).
- Key themes emerging from the roadshow (see page 18).

Above from left: Back row, from left: Drs Malcolm Stuart, Vaughan Laurenson, Stuart Henderson, Nigel Robertson, Geoff Long, Joe Sherriff; Second back row: Drs Kerry Gunn and Indu Kapoor; Middle row: Drs Gerard McHugh, Jennifer Woods, Sheila Hart, Kieran Davis, Sabine Pecher; Front row: Drs Leona Wilson and Vanessa Beavis, and Professor Kate Leslie.

ICCVA/NZ ASM 2012



New Zealand's 2012 Anaesthesia Annual Scientific Meeting will be held in conjunction with the 13th International Congress of Cardiothoracic and Vascular Anesthesia (ICCVA) Meeting in Auckland. A team from its organising committee attended the 12th ICCVA meeting in Beijing from September 21-24 to promote the Auckland event to this year's participants. They included organising committee co-convenors Dr Marian Hussey and Dr Ivan Bergman; Dr Stephen Laurent, healthcare industry liaison on the organising committee; Professor Alan Merry, scientific convener for the 13th ICCVA; and Heather Ann Moodie, Executive Officer for ANZCA NZ and a member of the 2012 organising committee.

During the week in Beijing, they had a stand promoting the Auckland event, attended various meetings to discuss it and gave presentations about the conference. Contacts were also made with exhibitors. The team was also able to observe and take lessons from the organisation of the Beijing meeting, that will help shape the format of the 2012 meeting.

See <http://www.iccva2012.com/> for further information and to register interest in the 2012 meeting, "What becomes of the broken hearted? Outcomes and how to change them".

Above from left: Manning the stand at Beijing; Dr Marian Hussey, Dr Ivan Bergman, ANZCA NZ's Executive Officer Heather Ann Moodie and Dr Stephen Laurent.

Physician assistants

With a trial of physician assistants (PAs) under way in New Zealand's Middlemore Hospital in South Auckland, ANZCA and the NZSA were invited to have a joint representative attend an October 1 meeting in Adelaide to discuss the role and future of PAs in Australian healthcare. Dr Andrew Reid (North Shore Hospital) attended on behalf of ANZCA/NZSA.

Presentations from the South Australian Government, Health Workforce Australia (HWA), anaesthetists, surgeons, paediatricians and physician assistants were given.

"This is clearly a hot topic in our specialty and healthcare as the implications are one of change," Dr Reid said. HWA stated that the aim was to have the Australian medical workforce being self-sufficient by 2025. To achieve this, they plan to increase training, increase immigration and introduce innovation and reform. They acknowledged that workforce interventions are complex, expensive and involve long lag times.

"Overall, I learnt a huge amount from the meeting and I think this will be invaluable in guiding the anaesthesia community in New Zealand as to where PAs could be used. This is clearly a fast-moving topic and something to watch closely so we can continue to be informed of developments."

Medical Council of New Zealand

ANZCA was well represented at the Medical Council of New Zealand's annual branch advisory bodies (BAB) meeting on November 15. Drs Leona Wilson, Geoff Long and Vaughan Laurenson from the New Zealand National Committee and Director of Professional Affairs Stuart Henderson all attended. Also present were Executive Officer Heather Ann Moodie, Communications Manager Susan Ewart and Administration Officer Jan Brown from ANZCA's New Zealand office.

The BAB meeting brings together the various medical colleges and groups that advise and assist the medical council in its work. The MCNZ is the registration body for the New Zealand medical profession.

This year's agenda included the topics of what needed to be done to advance the assessment of cultural competence and professionalism; regulation and governance; regular practice reviews; and issues involved in the assessment of IMGS.



Foundation teachers course

The benefits of the ANZCA Foundation Teachers Course held in Wellington from October 18-20 were being lauded by early November.

The course was facilitated by Mary Lawson and Felicity Hutton from the Melbourne office, with administrative assistance from Juliette Adlam of the New Zealand office in Wellington. Ms Lawson said the New Zealand National Committee did an excellent job in selecting the 12 participants.

"We had some fabulous new blood on the course – great for the future of anaesthetic education in New Zealand," she said.

Participants were equally laudatory of those facilitating the course and its content. During the roadshow meetings being held around the country (see page 18), various participants have commented on the value of the course and are already putting its principles into practice. Mentioned in particular are the skills for providing trainees with effective feedback.

Above right: Education enthusiasts at the New Zealand Foundation Teachers Course. Back row from left: James Cameron (Wellington), Michaela Hamschmidt (North Shore), Kerstin Kruegar (Tauranga), Duncan Wood (Auckland). Middle row, from left: Campbell Bennett (Rotorua), Sharon Dempsey (North Shore), Neroli Chadderton (Hutt), Peggy Yip (Starship Children's, Auckland), Annick Depuydt (Middlemore), Tania Hunter (North Shore). Seated, from left: Amitha Abeysekera (North Shore), Mary Lawson (Course Facilitator), Felicity Hutton (Course Facilitator), William Young (Wellington).

Role of the doctor seminar

Deputy Chair of the New Zealand National Committee, Dr Geoff Long, represented ANZCA at a New Zealand Medical Association (NZMA) seminar about the role of the doctor in the 21st century. The NZMA organised the two-day seminar to bring a cross-section of medical leaders together to develop a consensus statement on the 21st century doctor's role. The two-day seminar was held in Wellington on November 1-2.

In his introductory remarks, NZMA Chair Dr Peter Foley said: "Without clarity on the role of the doctor, we cannot know how best we should select, educate and train doctors or plan the future of the medical workforce."

The first day comprised presentations addressing various aspects of the subject, with the second day devoted to working towards a consensus statement that will go to a small group for final editing. The document will then be sent to stakeholder groups for consultation and ratification.

"Of particular interest to anaesthetists was an affirmation of the apprenticeship model of training with a broad base, and recognition of the importance of the maintenance of technical expertise by doctors," Dr Long said.

CMC meeting

The Council of Medical Colleges meets in Wellington four times a year to discuss issues of mutual interest.

Key health sector organisations are invited to the morning session to update colleges on initiatives that could impact on college activities. Regular attendees are the chairs and CEOs of the Medical Council of New Zealand (MCNZ) and New Zealand Medical Association and Ministry of Health officials from various sectors such as Health Workforce New Zealand (HWNZ) and the National Health Board/Health IT Board.

ANZCA NZNC Chair Dr Vanessa Beavis and the New Zealand Executive Officer, Heather Ann Moodie, attended the last CMC meeting for 2010 on November 19. As well as a session on the strategic direction for CMC and its member colleges (including a role in recruiting into specialist training), other topics of discussion included:

- HWNZ's workforce service reviews; career planning directive; a proposal to create a New Zealand medical academy/college; and the development of postgraduate training hubs (see <http://www.healthworkforce.govt.nz/>);
- NZMA's seminar and consensus statement on the role of the doctor; training in the private sector; the Health Quality & Safety Commission report on serious and sentinel events; and regionalisation of services;
- The MCNZ workforce survey; vocational registration and whether all doctors need to reach this specialist level; an upcoming article from HWNZ Chair Professor Des Gorman in the MCNZ News regarding a New Zealand structure for colleges and a proposal to establish a New Zealand college along the lines of other countries such as Canada;
- The National Health IT Board's recently released plan that seeks to enable an integrated healthcare model, including streamlining transfer of care (see <http://www.ithealthboard.health.nz/>).

New Zealand ASM 2011

The New Zealand Anaesthesia Annual Scientific Meeting (ASM) 2011 will be held in Auckland at the Grand Convention Centre from November 2-5 next year. The ASM is a joint venture between ANZCA New Zealand and the New Zealand Society of Anaesthetists (NZSA), with the organising committee coming from Waitemata District Health Board in Auckland.

The organisers have themed the conference "New Horizons" and have challenged themselves, speakers and the healthcare industry to look into the future and push the boundaries of knowledge, education, teaching and even entertainment.

They have assembled a group of internationally renowned keynote speakers that reflect the organisers' desire to explore innovation and new thinking in anaesthesia. Nigel Latta, clinical psychologist, TV personality and ex-skiffle band star, will talk about coping with problem personalities. Ray Avery, New Zealander of the Year 2010, will take his own unique perspective on life, work and research and challenge the audience to undertake similar projects. The meeting also boasts Dr David Bogod (UK) ex Editor of *Anaesthesia*, along with Dr Ross Kerridge (Australia) and Professor Guy Ludbrook (Australia) who will provoke great discussion looking at innovative models of care as well as discussing new models of drug delivery.

Above right: Wellington region anaesthetists hear about the issues involved in planning for New Zealand's future anaesthetic workforce, including the possibility of alternative providers, at a meeting at ANZCA's New Zealand office on November 25.

The organising committee is keen to maintain close links with medicine. As such, Professor John Myburgh (Australia) will look at innovations in intensive care medicine, while Professor Ken Whyte (New Zealand) will add a "physicianly" perspective on topics such as sleep apnoea, pulmonary hypertension and sleep medicine.

The NZSA invited speaker is Professor Alan Merry who, fresh from a sabbatical, will discuss safety, improving outcome strategies and media issues.

Workshops will also be held looking at cardiac exercise testing using the CPX methodology, peripheral nerve ultrasound techniques, transthoracic cardiac echocardiography and sessions on the new WebAIRS online web-based incident recording system.

The research component of the meeting is also being emphasised. Not only are the Ritchie Prize and trainee free paper being given a combined session, the committee is also organising a free poster session under the "New horizons" theme, with wine and cheese at the conclusion of the Thursday session. The best poster (trainee or specialist) will be given a prize worth \$500.

As with all meetings, networking will be essential and the meeting is using the state-of-the-art, Grand Convention Centre as well as the Maritime Museum.

Education, research, entertainment and a bit of relaxation! For further information on this meeting visit www.nzaasm2011.co.nz



NZ's health workforce

Health Workforce New Zealand (HWNZ) has stated that it expects demand for health services to double in the next decade, but that funding will increase by only 40 per cent. Consequently, it is considering all options for meeting the increased demand, including alternative providers in such fields as anaesthesia. With that in mind, ANZCA and the NZSA have established a joint workforce subcommittee to consider the issues and respond to HWNZ.

In November and December, the committee has been holding a series of meetings around the country to discuss the various issues and what the anaesthetic workforce might, and should, look like in 2020.

The Wellington meeting was facilitated by ANZCA immediate past president Dr Leona Wilson and NZSA President Dr Rob Carpenter.

Dr Nigel Waters, NZSA's immediate past president, made a presentation outlining the key issues and the audience was asked to vote on a number of options as to how future anaesthetic workforce needs could be met. Also attending were ANZCA President Professor Kate Leslie, Chair Dr Vanessa Beavis and HWNZ Director Brenda Wraight and its Principal Policy Analyst Ruth Wiltshire.

Information from the nationwide meetings, along with survey data, will form the basis of a response to HWNZ in a report to be presented in December.



Disaster response planning

ANZCA continues to be involved in setting up a disaster response capability for deployment in New Zealand and Polynesia.

One of the topics discussed when then-ANZCA President Dr Leona Wilson met the New Zealand Minister of Health in February this year was how anaesthetists could contribute to New Zealand's ability to respond quickly to the medical needs arising from a disaster, whether in New Zealand or the Pacific. The issue has been raised by previous New Zealand National Committee (NZNC) chairs.

ANZCA was invited to meet Ministry of Health officials in July to discuss developments. Subsequently, the Ministry of Health conducted two workshops in September with representation from various stakeholders. Dr Maurice Lee represented ANZCA in relation to surgery/trauma.

An overview of the current deployable assets in New Zealand was discussed, primarily the capabilities of the NZ Defence Force and St John's. Also covered were the logistics of a disaster response, the diverse range of onshore and offshore disasters, and the scope New Zealand's responsibility for an offshore disaster.

Dr Lee, a FANZCA who works at Waitemata District Health Board (DHB) on Auckland's North Shore, said some preliminary conclusions were drawn relating to the appropriate level of any New Zealand disaster medical assistance team (DMAT), the development of various modules, the need for advanced training and exercising, and the assessment of volunteers or team members for suitability from a variety of perspectives. They will form the basis of a report to the Minister of Health.

Another conclusion from the workshop was the need for medical colleges to help identify key components of kits that form caches ready for deployment. DHB support would also be vital as staff would need to be released from normal duties for training, exercising and deployment. Workshop participants said this should be recognised in contractual arrangements with the DHBs.

Dr Lee said that ANZCA could contribute to the planning by working with the NZSA's Overseas Aid and Development Committee to maintain a database of suitable and willing volunteers for DMAT deployment and by providing training opportunities (for example, the RSDCDCA course in Australia, the Real World Anaesthesia course in Christchurch). The NZNC considered his report at its November 26 meeting. Further updates will be provided in future editions of the *ANZCA Bulletin*.

Auckland University thanks ANZCA

ANZCA was one of the organisations to receive recognition from the University of Auckland recently for its support. The New Zealand National Committee Chair, Dr Vanessa Beavis, represented ANZCA at a dinner in early November to thank those who had contributed funding. ANZCA was thanked for its contribution to research. ANZCA and the university's medical faculty have been working together to support medical research, with the College having awarded over \$500,000 in grants since 1999. As well as the dinner, ANZCA is being recognised in the Chancellor's publication, the university's website and by inclusion as a member of the Sir Douglas Robb Society. A former chancellor of the university, Sir Douglas Robb played a significant role in establishing its medical school in 1964.

Trainee career plans

Trainees in all professional groups funded by Health Workforce New Zealand (HWNZ) will be expected to have a personal career plan in place by 2012. This includes trainee anaesthetists. The development means that funding applications in late 2011 will need to have a career plan sitting behind them.

HWNZ's expectation is that district health boards (DHBs) and others will use 2011 to develop processes for career planning.

It says the initiative will ensure that trainees can identify a realistic career pathway and be offered the necessary training and advice, while employers will have more systematic information to help with workforce planning.

"Good career planning processes will support individual health professionals in achieving their full potential, provide the basis for DHBs and other employers to recruit, retain and develop the staff they need and ensure that training investment is matched to the needs of the health system," HWNZ Director Brenda Wraight said in a letter to ANZCA.

"The responsibility for ensuring that career plans are in place will lie with the organisation that HWNZ provides funding to, and the process will require individualised conversations between the trainee and manager and, where appropriate, other responsible person(s).

"Plans will combine both formal and informal learning and may include coaching, mentoring and experience-based programs and will complement rather than substitute for existing performance appraisal schemes.

"We are aware that some organisations already have their own career planning mechanisms in place and we intend to build on those, rather than replacing them.

"HWNZ will provide workforce information and will provide links to and/or develop resources to support decision-making about career development," she said.

HWNZ invited ANZCA's comments on some draft guiding principles about tailoring career plans to fit the needs of particular groups, useful resources and examples of good practice.

Postgraduate training hubs

Health Workforce New Zealand (HWNZ) is working with district health boards to scope the potential of developing a small number of regional training hubs to oversee and manage the training of health professionals.

In its October 2010 HWNZ stakeholder bulletin, HWNZ Director Brenda Wraight said that the RMO Commission and Medical Training Board had recommended new arrangements to enhance training opportunities, as well as overseeing deployment of the trainee workforce.

"The concept of training hubs or postgraduate deaneries has been proposed as a potential model to address the needs of trainees, while maintaining a focus on the priorities of health providers and the communities they serve," she said.

Although the focus initially would be on postgraduate medical training, the concept of an apprenticeship model, nationally consistent training, curriculum delivery and career planning would be appropriate for all workforce groups, she said.

Workforce innovations

Health Workforce New Zealand (HWNZ) is continuing to explore new ways of meeting health workforce requirements. Writing in a November newsletter, HWNZ Executive Chair Professor Des Gorman said that various workforce innovation projects had made significant progress in 2010.

He referred to the physician assistants (PA) trial at Middlemore Hospital in South Auckland, which involves two US-trained PAs working in the general surgical area. In its October 2010 HWNZ Stakeholder Bulletin, HWNZ Director Brenda Wraight said that early feedback had made it clear that the PAs were adding real value to the surgical team.

"New roles and new ways of working are not without risk or uncertainty, and changing organisational dynamics will take time, but even a brief conversation with two individuals was confirmation of

the potential innovations projects such as this have for the New Zealand health sector," she said.

Other projects that Professor Gorman mentioned include nurse surgical assistants undergoing training in a number of centres; demonstration sites being selected for extension of prescribing powers for diabetes nurse specialists; and 15 sites having been chosen to allow community pharmacists prescribing of anticoagulant therapy.

Workforce service reviews

Health Workforce New Zealand (HWNZ) is undertaking 10 workforce services reviews, including one for anaesthesia. In an October 18 letter responding to a New Zealand National Committee (NZNC) request to be represented in that review process, HWNZ Director Brenda Wraight said that the reviews were being undertaken by small groups of clinical experts.

The anaesthesia review is led by Dr Andrew Reid. Dr Andrew Warmington and Dr Nigel Waters are also part of the review group.

"This is a new way of working that is not based on representation of professional groups, but utilises the combined thinking of groups of clinicians as "think tanks" developing a series of scenarios or vignettes for a 2020 vision of what New Zealand's health need, services and resulting health workforce should look like.

"The reviews will report their recommendations in an iterative process rather than a series of definitive reports, and we anticipate these will provide both fact and opinion to inform future workforce training and deployment. HWNZ's business unit is providing analysis, forecasting and modelling to each of the review teams," she said.

Referring to clinical leadership, Brenda Wraight also mentioned that by the end of 2010, HWNZ would, in partnership with others, have established an institute of health leadership. She said HWNZ expected to liaise directly with ANZCA as the institute developed its role and work program.

Queensland

ANZCA/ASA combined CME evening lectures

Honorary fellow and solicitor for the College, Michael Gorton from Russell Kennedy Solicitors was the invited speaker at the September 7 ANZCA/ASA combined evening lecture. Mr Gorton spoke on national registration and mandatory reporting. On Tuesday, October 12, Dr Judy Killen from Wagga Hospital spoke on anaesthetic assessment of patients with diabetes. The final evening lecture for 2010 was held on November 9. The invited speaker was Dr Mark Appleyard from the Royal Brisbane Women's Hospital who spoke on new techniques in gastroenterology.

Primary lecture program

The second semester of the primary lecture program came to an end on November 13.

The course convenor was Dr Gamini Wijerathne and 31 people registered.

The topics covered in the last quarter have covered:

Physics and principles of Clinical Measurement – Dr Cameron Hastie.

Renal physiology – Dr Peter Watt.

IV induction agents – Dr Chris Thomas.

Neuro-muscular blocking agents – Dr Bruce Hammonds.

Pharmacology of the autonomic nervous system – Dr Rebecca Ruberry.

Anticoagulants and anti-platelet agents – Dr David Trappett.

Cardiovascular physiology – Dr Gabe Mar Fan.

Nutrition and metabolism – Dr Bernadette Burke.

We thank all of our presenters for giving their time to provide the course.

Above right: Manning the ANZCA booth and speaking to prospective trainees at the recent Griffith University Medicine Society evening are, from left: Dr Alistair Kan, Dr Linda Sung and Dr Jeneen Thatcher.



FPM dinner meeting – Tim Geraghty

On October 20, the Faculty of Pain Medicine of the Queensland Regional Committee hosted its fourth and final continuing medical education dinner meeting for 2010. Dr Timothy Geraghty from the Spinal Injuries Unit at the Princess Alexandra Hospital spoke on neuropathic pain following spinal cord injury.

Primary practice vivas

Primary practice vivas were held on September 1 and 8. The convenor was Dr Taryn Naggs.

Thirty six people registered to attend the evenings. We would like to thank not only our Fellows but also trainees who have passed their primary exam and came along to help on the evenings. Mock examiners were: Dr Gerard Ariotti, Dr Rhonda Boyle, Dr Michael Cleary, Dr Steve Clulow, Dr Anthony Coorey, Dr Brendan Doherty, Dr Anthony Hade, Dr Sophie Jayamaha, Dr Jayasinghe Dumindu, Dr Alistair Kan, Dr George Kennedy, Dr Symon McCallum, Dr Jeff Mott, Dr Bronwyn Thomas, Dr Chris Turnbull, Dr Rebecca Ruberry, Dr Benjamin Howes, Dr Gamini Wijerathne and Dr Carradene Taylor.

Griffith University Medicine Society – futures evening

On October 21 Dr Jeneen Thatcher, Dr Linda Sung and Dr Alistair Kan from Gold Coast Hospital represented ANZCA at the Griffith University Medicine Society Futures Evening. This event is an opportunity for ANZCA and other specialty colleges to provide final year medical students with information relevant to them in the years following their graduation and subsequent entry into the medical workforce. Approximately 200 students attend this event as it is a great opportunity to speak to one on one with trainees and supervisors to gain a better understanding of the College. Thank you again to Dr Thatcher, Dr Sung and Dr Kan for volunteering their time.

Final practice vivas

Final practice vivas were held on October 6 and 13. There was no convenor for the 2010 course which was organised by course coordinator Leanne Emery, who was assisted by Silvia Martinez.

Twenty four people registered to attend. Thank you to mock examiners: Dr Sophie Jayamaha, Dr Martin Heck, Dr Shirley Cheung, Dr Petra Millar, Dr Elizabeth Gooch, Dr Stefan Ziege, Dr Symon McCallum, Dr Tania Lee and Dr Amanda Harvey.

New South Wales



Clockwise from left: Dr Glen Sheh, Dr Martine Holford, Professor Ray Garrick and Dr Charles Brooker; Dr Charles Brooker and Professor Laurence Mather; Dr Marc Russo, Dr Peter Cox and Dr John Ditton.

NSW Regional Committee's continuing medical education dinner meeting

On Thursday, September 16, FPM fellows and trainees from Sydney and the surrounding area gathered for the NSW Regional Committee's continuing medical education dinner meeting at Kam Fook Restaurant. The many disciplines fundamental to the practise of pain medicine were well represented, and there was an encouraging number of current and potential trainees. Dinner was a convivial banquet style, with ample opportunity for socialising and networking. The annual general meeting was conducted followed by a collaborative presentation of four cases with interactive discussion by Drs Martine Holford and Glen Sheh and Associate Professor Ray Garrick. Delegates discussed the challenges and nuances of opioid therapy in pain medicine in light of recently published efficacy and safety data. Overall, the meeting was a great success, achieving the committee's aims of providing an opportunity for education as well as fostering a sense of community and peer support among pain medicine practitioners in Sydney and the surrounding areas.

2011 dates

The NSW ACE committee is still in the early stages of planning for 2011, but the dates and locations of meetings have been set as follows:

1. Saturday, July 2, 2011 at the Hilton Hotel in Sydney. This will be an all day themed meeting.
2. Saturday, October 29 and Sunday, October 30, 2011 at the Orange Civic Theatre in Orange where we will continue the popular tradition of having a weekend meeting in a regional location.
3. Saturday, November 26, 2011, Anatomy workshop, the University of Sydney.

Australian Capital Territory



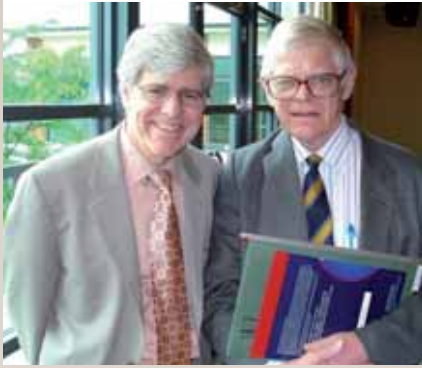
The ACT Regional Committee in conjunction with the ASA ACT Section held a trauma workshop in September. There was an intensive two hour evening workshop on Friday, September 10, titled "Ultrasound from A to anaesthezee" followed by a full day of lectures and hands-on stations titled "Simple but not easy: Anaesthetic management of acute trauma" on Saturday, November 11. The committee would like to thank to the excellent speakers and organisers. The ultrasound intensive was presented by Dr John Ellingham and Dr Ross Peake with assistance from Lynette Hassal of Sonosite Australia. Dr Damian MacMahon presented on integrated trauma care and teamwork, Dr Ellingham on the use of ultrasound in trauma, Drs James French and Philip Crispin hosted a massive transfusion discussion panel and Dr Simon Robertson presented on anaesthesia for the trauma laparotomy. The hands-on stations were focused on airway management, ultrasound and transfusion.

The committee will also be holding its AGM on December 14 at the regional office with all local Fellows invited to attend.

On a lighter note in the ACT, a group of trainees recently did their part for raising the community profile of anaesthesia. They managed to complete the 10km *Canberra Times* fun run in modified scrubs.

Above: ACT trainees participating in the 10km Canberra Times fun run.

South Australia and Northern Territory



Professor Steve Shafer in SA

The regional committee of South Australia was privileged to host Professor Steven Shafer of Columbia University, New York as the 2010 Burnell Jose visiting professor. Professor Shafer is editor-in-chief of *Anaesthesia and Analgesia*. He spent a week in Adelaide and visited all the major teaching hospitals as well as two private practice groups. He gave 18 lectures, including the Maurice Sando Memorial lecture entitled "Critical thinking in anaesthesia". He also addressed a very successful research workshop which was co hosted by Professor Vicky Clifton from Adelaide university.

Professor Shafer was also keynote speaker at the November 13-14 scientific meeting entitled "Anaesthesia fallout" which looked at both the long term implications of anaesthesia and the ethics of publication. The meeting at the Novotel hotel in the Barossa Valley was convened by the combined ANZCA and ASA regional continuing medical education committee, chaired by Dr Bill Wilson.

The scientific program was very interesting. An excellent line up of speakers included ANZCA president Professor Kate Leslie, Dr Erica Wood, Dr Andrew Davidson and associate Professor David Storey and Liz Evered from Melbourne. Professor Neville Gibbs, editor-in-chief of *Anaesthesia and Intensive Care* presented with Professor Shafer on the ethics of publication. Local speakers included Dr Pam Macintyre, Dr David Costi and Dr Mark Boesch. The amount of new data that was presented was impressive and provoked much useful discussion among the speakers and delegates that will certainly continue into the future.

The conference dinner was held at Jacob's Creek winery with Dr David Elliott from Sydney giving an excellent after-dinner presentation. The healthcare industry was well represented and their generous contribution to a very successful meeting was most appreciated.

Professor Schafer had been impressed by the "Movember" fundraising concept that benefits the Prostate Cancer Foundation and beyondblue and happily joined one of our participating CME committee members, Dr Nathan Davis' Movember team. At his farewell dinner, Professor Shafer felt his moustache growing efforts were lacking and after acquiring Dr Marion Andrew's mascara, proceeded to highlight his whiskers. He then encouraged the rest of the committee to do the same and before long there were moustaches all shapes and sizes, including "femos", much to the amusement of other patrons.

SA/NT ANZCA trainee dinner

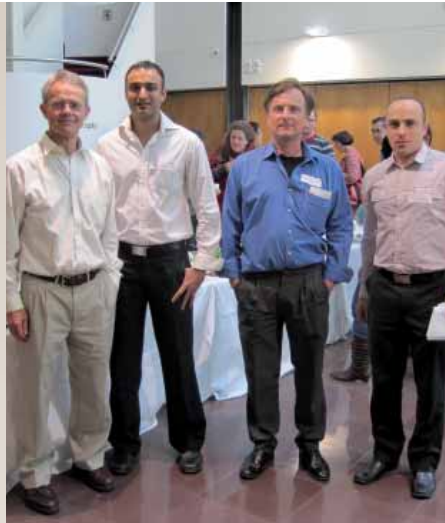


Forty trainees attended the SA/NT ANZCA trainee dinner at Jolleys Boathouse in Adelaide on November 19. The trainees enjoyed a rare opportunity to come together to socialise and share their training experiences.

Above from top left: Visiting Professor Steve Shafer and Professor John Russell; the conference dinner at Jacob's Creek winery; Dr Marion Andrew gets into the spirit of Movember; taking a break at the meeting; Professor Kate Leslie and Dr Dick Willis; the CME Committee Movember tribute.

Above: Trainee dinner at Jolleys Boathouse, Adelaide.

Victoria



Victorian registrars' scientific meeting

The Victorian Regional Committee held its annual Victorian Registrars' Scientific Meeting (VRSM) on Friday, November 19 at the College.

The program was a great success with 17 registrars presenting their research projects. The meeting was very well attended with 50 delegates and 20 healthcare industry representatives.

The VRC were fortunate to have had the input of Associate Professor David Story of the ANZCA Trials Group and Dr Adam Skinner, convenor of the primary full-time course, who adjudicated the presentations for the annual VRSM prize which this year was won by Dr Luke Wilson.

Dr Richard Horton, Convenor and Regional Education Officer, is congratulated and thanked for his guidance and support in bringing this meeting together.

Quality assurance meeting

Quality assurance meeting was held on October 23 and was convened by Dr Rod Tayler and Dr Derek Browell. The meeting commenced with an interactive session that discussed LA toxicity in a small hospital; Masseter spasm at GA caesarean section; chest pain in an obstetric patient and achieving remaining CPD credits. The second half of the meeting consisted of small group discussions and summaries from small groups. As in previous years, this quality assurance meeting was very well attended. Sixty Victorian Fellows participated and the program and format were very well received. The Victorian Regional Committee would like to thank the convenors for their time and effort in putting this meeting together.

Above clockwise from left: Trainee attendees; Dr Rod Tayler, Dr Rohan Hegde, Dr Derek Browell and Dr Rob Greenberg; Dr Adam Skinner, Dr Luke Wilson and Associate Professor David Story.

Tasmania



Tasmanian part 3 GASACT course

The world is your oyster when you finish your anaesthetic training, isn't it? Tasmanian anaesthetic registrars met on the sunny banks of Barilla Bay just outside Hobart on Saturday, November 6 to find out. As with GASACT part 3 courses in other states, the day consisted of topics to prepare for life as anaesthetists – billing, the RVG, medical indemnity, private practice, continuing professional education, teaching and mentorship responsibilities, ASA and ANZCA involvement and the work-life balance. The Pearl Room at the Barilla Bay Oyster Farm provided the perfect backdrop for the occasion, and oysters and wine provided the perfect lubrication for what could be considered rather dry topics. To finish the day the group reconvened at Cool Wine for some wine tasting.

Above: Dr Lia Freestone speaks at the course; oyster tasting.

Western Australia



WA "Updates in anaesthesia" meeting

The annual Western Australia Updates in Anaesthesia meeting was held at Bunker Bay in Dunsborough from October 29 to November 1. The meeting was organised by Dr Liezel Bredenkamp and the Joondalup Health Campus, Department of Anaesthesia in association with the Western Australia Continuing Medical Education Committee. The theme of the meeting was "EMERGENCY – stand back" and covered a great variety of emergencies that the general anaesthetist may come across in his or her career.

The Saturday morning program began with the traditional ABC and included a talk on an ENT airway emergency by Dr Ross Ireland, a lesson in how to manage deoxygenation by optimum ventilation with Dr Peter Baumgartner and then step by step management of uncontrolled bleeding by one of the invited speakers, Dr Steve Ward.

After morning tea, delegates looked at some major disasters with invited speaker Associate Professor David Playford and how to spot them by looking at an ECG. Dr Joe Ng covered the latest updates in resuscitation guidelines. ASM Australasian Regional Visiting Speaker Professor Paul Myles concluded the morning by discussing the perioperative management of primary pulmonary hypertension.

In the afternoon there was a choice of a cardiac workshop or problem-based learning discussion. The PBLD covered the young and old patient, with an insight into the paediatric and adult airway difficulties, how to best assess and prepare the aged with a serious cardiac problem and how to treat and manage the vascular patient with diffuse disease.

The workshop was an easy introduction to cardiac ultrasound and was a quick introduction into a progressive field in anaesthesia. The workshop presenters were Dr Michael Veltman and Dr Rob Collin and associate professors David Playford and John Faris.

The gala dinner was again held at Vasse Felix Winery where delegates and their partners were treated to beautiful food and fantastic wines in an amazing setting. Sunday morning began with a case presentation and discussion on "metabolic mayhem" with Associate Professor Luke Torre using an interactive electronic voting system. Dr Philip Nelson also gave a presentation on the management of a malignant hyperthermia crisis.

The meeting concluded with some special insight by Dr Eric Visser into the patient with difficult-to-manage pain, the transferring of patients by Dr Stewart Allan and, finally, management strategies for obstetric emergencies for the occasional obstetric anaesthetist with Dr Yasir Al-Tamimi.



Above from top left: Dr Angela Palumbo and Dr Lisa Khoo; Convenor Dr Liezel Bredenkamp, Dr Diana Fakes, Dr Yasir Al-Tamimi and Dr Stewart Allan; Dr Glenys Ismail and Dr Ross Ireland; workshop presenter Dr Michael Veltman and patient.



GASACT part III course

On Saturday, November 13, Western Australian advanced trainees gathered at St John of God Hospital in Subiaco for the ASA GASACT part III course titled “Life beyond training – making the transition”.

Organised by GASACT Western Australia senior representative, Dr Joe Ng, and aimed at fourth- and fifth-year anaesthetic registrars who will soon be completing their training, the morning featured speakers delivering topics ranging from the basic fundamentals needed in setting up a practice to the pros and cons of public versus private sectors.

Sponsored by Metro Midlands Financial Planners, Avant and MDA National, the course aimed to give trainees knowledge on the basics not learnt within hospital walls.

The first session began with Dr Stewart Allan who discussed “Life as a new consultant” then Dr Angela Palumbo covered the paperwork and practicalities of the transition to becoming a consultant. Dr Sai Fong and Dr Ralph Longhorn gave their views on “getting started in private practice” and the advantages and disadvantages of working full-time in private practice.

After morning tea Dr Rob Storer spoke on “billing and how to get paid”. Dr David Borshoff discussed the good and bad of public and private and why a blend of the two is sometimes a good option. This was followed up by Dr Chris Mitchell who shared his experiences working as a consultant full-time in the public hospital system.

The morning ended with an informal question time in which trainees were able to follow up with any of the discussed topics. All feedback received - from both trainees and speakers - was very positive and those involved felt that the talks succeeded in addressing the relevant topics in an appropriate format.

Above from left: Trainees at the GASACT Part III course; the new Western Australia ANZCA office.

Other WA events

In early October the Western Australia ANZCA office relocated to Unit 20, 127 Herdsman Parade, Wembley. The new premises has more space for examinations and courses and parking is much easier. The phone, fax and email contacts have not changed.

ANZCA President Professor Kate Leslie travelled to Perth on October 14 to meet with members of the Western Australia Regional Committee (WARC) and to attend the WARC meeting. Professor Leslie discussed CPD and medical registration in relation to WA. The meeting was followed by drinks with members of the regional committee and was used as an unofficial opening for the new office.

On Monday, October 18 ANZCA Vice President, Dr Lindy Roberts, presented a framed certificate to Dr John Boyd Craig in honour of him being installed as the inaugural governor of the Anaesthesia and Pain Medicine Foundation last year (see story on page 72). Dr Craig’s family, including his wife Bobbie, daughter Frances and son Boyd also attended the presentation with the ANZCA WA Chair Dr Jenny Stedmon, Professor Peter Drummond, and WA staff Sandra Box and Bree Toussaint.

Dean's Message



It's that time again – (nearly) the close to another year. This last quarter has seen a number of significant Faculty activities. As it is a global item, the 2010-2011 Global Year Against Acute Pain (GYAAP) gets first mention. This is promoted around the world by the International Association for the Study of Pain (IASP). Its focus this time is on acute pain – that following surgery, injury, childbirth and associated with acute illness. For Australia and New Zealand this involved collaboration between our bi-national pain societies, Society of Anaesthetists and ANZCA.

Hopefully you will have seen the poster developed in-house by ANZCA's communications department to print out at your location to help promote awareness. If you have not seen it and would like to do so please contact me, the Faculty office, ANZCA communications or see also the article opposite.

In the GYAAP media activities two prominent themes are the under-treatment of acute pain and the need for improved training in managing acute pain better. In parallel with those messages is the fact that anaesthetists are really at the forefront of dealing with much of what is becoming known as in-hospital pain. Some will recognise this is a move away from using time-related definitions such as acute and chronic/persistent pain to locality of the persons with the problem. Anaesthetists usually work in hospitals rather than in the community, so it is logical that with their unique expertise in relevant biology and applied pharmacology, especially of analgesics and local anaesthetics, they apply themselves to this large area of need in healthcare.

In addition to science and technical knowledge other attributes are required such as organisation of functional units

(teams), communications between staff and teams, as well as direct informative communications with patients.

Anaesthetists who are successfully engaged with management of pain have these attributes, with scope to help trainees develop even better skills and ability as the “perioperative physicians” of the future to anticipate where there will be need for extra measures to deal with the potentially more complex pain cases following surgery or injury.

Speaking of injury, rehabilitation is an important part of patient recovery. A significant number of Fellows of the Australasian Faculty of Rehabilitation Medicine (AFRM) are also FPM Fellows, and contribute much towards recovery of patients with painful conditions, as well as teaching in our accredited training units. The AFRM President met with the FPM board at its last meeting, with the offer for our Faculty trainees to have access to the AFRM Bi-National Training Program (BNTP) sessions of relevance to their training, gratis if from a site where there is also an AFRM trainee. The AFRM is also keen for its trainees to have exposure to pain management experience to further their knowledge. So if you are in a position to help with that you will, I am sure, reap rewards through interdisciplinary collaboration.

The Faculty of Pain Medicine Spring Meeting is now a popular item on the calendar. This year's well attended October meeting at Newcastle titled “Transitions in pain” was convened by Dr Chris Hayes. A range of novel topics was covered. From one of these, I was amazed by the huge spectrum of genetic and metabolic conditions with impact on pain, and the handling of many of our pharmacological treatments, much of which would be of equal value for anaesthetists to know about.

Following the success of the Australian National Pain Summit at Canberra in March, a new advocacy organisation [painaustalia](http://painaustalia.com.au) is in development, with significant (but not sole) support from ANZCA. A similar International Pain Summit was conducted immediately following the IASP World Congress on Pain at Montreal in September, led by Professor Michael Cousins. Many things could be said further about this, but for this message I would like to highlight the huge positive influence of people and

activities from our corner of the world, and our organisations, who are leading the way in so many ways. A further example is on the IASP GYAAP launch website, in which prominence is given to the ANZCA publication *Acute Pain Management: Scientific Evidence (third edition, 2010)*. We do live and work amongst achieving people who aim for the highest standards in our respective professional spheres. As this year closes, do give consideration to what you can contribute or engage in for the following year.

Fascinating new work connected with Sydney's Garvan Institute of Medical Research aims to divert pain signalling in the brain so as to be perceived instead as colour (“re-routed”) – and blue has been mentioned in the media releases. Apart from “black dog”, “blue” is associated with low mood – as in “touch of the blues”. Or is it music? As the co-morbidity of pain and depression is common I wonder, though, if a switch to blue could be like fat to fire? I would prefer a warmer friendlier colour switch! This work builds on the discovery of a pain gene which, when mutated, causes *synaesthesia*, meaning crossed senses, which occurs in about 4 per cent of the population. There is now MRI confirmation of brain activation differences between *synaesthetic* and normal humans¹. Life is never boring.

It remains for me to wish you all a safe and rewarding festive season. Festive celebrations typically invoke bright cheer giving colours, such as reds and greens. Do take care though not to get your reds and greens mixed – for example, at intersections, lest blue flashing lights approach from behind. That could be painful! And we need all your skills and efforts again in the future.

Dr David Jones

Dean
Faculty of Pain Medicine

Reference:

1. Neely GG, Hess, A, Costigan M, Keene AC et al. A Genome-wide *Drosophila* screen for heat nociception identifies $\alpha 2\delta 3$ as an evolutionarily conserved pain gene. *Cell*, Vol 143 (4), 628-638, November 12, 2010.

Global Year Against Acute Pain

The Global Year Against Pain began on October 18, 2010 with the focus this year on the impact of acute pain following surgery, injury, childbirth and acute illness.

An initiative of the International Association for the Study of Pain (IASP) and its affiliates, the Australian Pain Society and the New Zealand Pain Society, GYAAP was also supported by the Faculty of Pain Medicine (FPM) and the Australian and New Zealand College of Anaesthetists (ANZCA).

The IASP's GYAAP taskforce, which included Australians Professor Stephan Schug (co-chair) and Dr Pam Macintyre, prepared six information sheets. These were titled "What is the problem?", "Interventions: Benefits and barriers", "Mechanisms of acute pain", "Acute pain medicine: Where is the evidence?", "Why the gaps between evidence and practice?" and "How to implement change".

The GYAAP was also an opportunity to highlight ANZCA and FPM's world-renowned publication *Acute Pain Management: Scientific Evidence* (third edition, 2010).

ANZCA's communications unit designed a colour poster that could be printed by organisations and individuals for use to increase awareness of acute pain.

The communications unit also prepared a media release to coincide with the launch of GYAAP. It highlighted the need for better education in pain medicine education for some young doctors in Australia and New Zealand.

The media release attracted significant, widespread coverage including an interview with FPM Dean Dr David Jones that went to air on ABC radio morning news in Sydney, Melbourne and Perth. Interviews with Dr Jones and FPM Director of Professional Affairs, Professor Milton Cohen were also conducted on ABC Radio National and ABC programs in Newcastle and Adelaide.

The IASP was founded in 1973 and is the leading professional forum for science, practice, and education in the field of pain. Membership of the IASP is open to all professionals involved in research, diagnosis or treatment of pain. The IASP has more than 7500 members in 129 countries, 85 national chapters and 17 Special Interest Groups (SIGs).



It first launched the Global Day Against Pain in 2001 and this was expanded to the Global Year Against Pain with the official launch day taking place on the third Monday of every October. Past themes include "Right to pain relief" (2004-05), "Pain in children" (2005-06), "Pain in older persons" (2006-07), "Pain in women" (2007-08), "Cancer pain" (2008-09), "Musculoskeletal pain" (2009-10).

Acute pain was chosen as the theme for 2010-11 because, despite advances in this area of medicine, acute pain remains undertreated.

According to the IASP website, each year in the US nearly 100 million operations take place. More than 80 per cent of these surgical patients report postoperative pain. In addition, more than 70 per cent of emergency department visits are due to pain; acute headache alone accounts for 2.1 million of these visits.

Numerous studies show that fewer than half of postoperative patients receive adequate pain relief. Patients arriving at emergency departments with significantly painful conditions fare no better, as emergency medicine physicians tend to underuse pain medications. Acute pain is also a common problem in family practice, sports medicine, and especially in internal medicine.

Fellowship training and examination dates for 2011

Pre-Examination Short Course

Dates to be confirmed
Royal Adelaide Hospital

Examination dates

November 25-27, 2011
Royal Brisbane and Women's Hospital,
Herston, Queensland

Closing date for registration

October 7, 2011

Admission to Fellowship of the Faculty of Pain Medicine

By examination:

292	Suyin Giselle Marion Tan	NSW
293	Matthew Bryant	QLD
294	Jing-Chen Jason Chou	VIC

News continued



Examinations

The 2010 Faculty of Pain Medicine examination was held November 24-26 at the Barbara Walker Centre for Pain Management, St Vincent's Hospital Melbourne. Sixteen of the 20 candidates were successful. The Barbara Walker Prize for Excellence in the Pain Medicine Examination was awarded to Dr Rebecca Martin (NSW); Merit awards went to Dr Nicholas Christelis (Vic) and Dr Frank Thomas (NZ).



Above from top left: Chair, Dr Ray Garrick congratulates Barbara Walker Prize Winner, Dr Rebecca Martin; Merit Award Winner, Dr Nick Christelis with Dr Ray Garrick; Merit Award Winner, Dr Frank Thomas with Dr Ray Garrick; Court of Examiners and observers; Successful candidates.

FACULTY OF PAIN MEDICINE
AUSTRALIAN AND NEW ZEALAND
COLLEGE OF ANAESTHETISTS



PAIN MANAGEMENT: GETTING CLOSER TO THE DRAGON PEARL

**REFRESHER COURSE DAY AND FACULTY DINNER
HONG KONG CONVENTION CENTRE, HONG KONG
FRIDAY, MAY 13, 2011**

The provisional program is headlined by international guests, Professors Catherine Bushnell, You Wan and Spencer Liu, and complemented by national leaders in opioid management and outcomes in pain medicine.

The meeting will be of value for Fellows, trainees and other practitioners who have an interest in pain medicine and will precede the ANZCA/HKCA Combined Scientific Meeting.

KEYNOTE SPEAKERS:

Professor Catherine Bushnell of McGill University, Montreal, Canada.

Professor You Wan of Peking University, Beijing, China.

Professor Spencer Liu of the Hospital for Special Surgery, New York, United States.

PROVISIONAL PROGRAM:

Session 1: Neurobiology

Session 2: Challenges in Opioid Therapy

Session 3: Outcomes in Pain Management

Session 4: Eastern Influences

FPM ANNUAL DINNER:

Dragon Court, Jumbo Kingdom, Aberdeen.

REGISTRATION:

Registration brochures will be mailed in late 2010 and will be available for download from www.anzca.edu.au/fpm or contact the faculty office:

E: painmed@anzca.edu.au

T: +61 3 8517 5377

Opioid analgesics in chronic non-cancer pain



The use of opioid analgesic drugs in the management of patients with chronic non-cancer pain (CNCP) remains a controversial issue. Not only is there a paucity of good quality evidence in favour of, or opposed to, the efficacy of opioid analgesics in this situation, but also the propensity for problematic opioid use tends to attract a greater degree of attention.

Consistent with its role in education and standard-setting, the Faculty of Pain Medicine has articulated a set of five principles on which opioid prescribers might base their decision (Faculty document PM-1). These principles are pragmatic, supported by evidence but based on consensus.

The governing consideration is to ensure the effectiveness of opioid pharmacotherapy in the individual patient. In any patient with CNCP neither the responsiveness to opioid analgesic drugs nor the risk of misuse can be confidently predicted, so that the prescription of such agents must be regarded as an ongoing individual trial of therapy.

As opioid analgesics are tightly controlled drugs, the prescriber is

the “gate-keeper” and must balance clinical responsibility to the individual patient with broader responsibility to the community. Prescribers should be thoroughly acquainted not only with the clinical pharmacology of the various opioids available but also with the regulatory requirements imposed by the jurisdiction in which they practise.

1. Comprehensive assessment of the patient

Pharmacotherapy for the patient in pain is only ever part of a multimodal plan. Such a plan does not imply necessarily that many health care personnel need to be involved, especially where resources are limited. Rather it refers to the importance of recognising and, if possible, addressing non-somatic contributions to the patient’s predicament, especially the social environment, including work. This is not to ignore the somatic or biological contributions, where a confident diagnosis should be made if possible. Psychological assessment includes exploring beliefs regarding diagnosis and prognosis, expectations and mood. Social assessment embraces impact on activities of daily living including sleep, recreation and nutrition, effects on family and other relationships, and the influence of life events.

2. Adequate trial of other therapies

This principle raises the question of what constitutes an “adequate” trial. Non-drug therapies include accurate and detailed explanation, advice regarding the use of the painful part including structured exercise programs, and sleep hygiene, with input where possible from physical therapist, occupational therapist, psychologist, social worker or rehabilitation counsellor.

Drug therapy for patients in pain is mainly for symptom control, which is important not only for reduction in distress but also as an adjunct to non-drug therapy and thus as a passport to improved quality of life. Where the mechanism of pain can be confidently determined, such as inflammatory or neuropathic conditions, anti-inflammatory or anti-neuropathic agents respectively may be helpful in modifying pathogenesis.

First-line drug therapy remains paracetamol, ideally in regular around-the-clock doses using the extended-release form. Non-steroidal anti-inflammatory drugs (NSAIDs) offer little advantage over paracetamol and carry a significant set of interactions and adverse effects.

So-called adjuvant analgesic agents could be considered before opioids. These include tricyclic antidepressant drugs (amitriptyline, nortriptyline), serotonin-noradrenaline reuptake inhibitors (venlafaxine, duloxetine) and anticonvulsants (gabapentin, pregabalin, sodium valproate).

Invasive physical therapies (injections, implants) are often considered in parallel with the above approaches. A trial of opioid pharmacotherapy can be considered independently of invasive techniques.

3. Agreement regarding an opioid trial

The aim of a trial of an opioid analgesic is to discover the individual’s responsiveness to this therapy in terms of improved quality of life. This requires frank articulation of the goals of the trial, including an agreement that if the goals are not met, then the trial will be discontinued. The goals are beyond pain relief alone and emphasise improvement in physical, emotional and mental functioning, including an increase in activity. These goals can be negotiated according to the individual’s wishes and capacity.

In this respect, a therapeutic contract is established, which can be made explicit verbally, through entries in notes or in a formal written agreement. This contract reflects the seriousness of the undertaking between prescriber and patient. There should be only one prescriber of a patient’s opioids, with adequate back-up provision should that prescriber be unavailable. Ideally, the one pharmacy should dispense the opioid. Once opioid-responsiveness is established and side-effect profile addressed, the contract can be extended, with caveats such as no early repeats, no loss replacements and an option for random urine monitoring (where appropriate) until a stable dose regimen is established. The contract

may include an option for a time-limited maintenance period before staged withdrawal of opioid therapy.

4. Conduct of an opioid trial

Chronic pain should not be treated with short-acting drugs. Thus, long-acting or sustained-release oral or transdermal preparations are recommended.

As the use of opioid analgesics in the management of pain is an ongoing individual trial of therapy, regular assessment addresses and documents:

- Analgesia.
- Activity.
- Adverse effects.
- Affect.
- Aberrant behaviour.

Titration of dose according to this “5A” assessment need not be rapid: such a trial may take several weeks. An improvement in overall well-being in the opioid-responsive patient may incur “incident” pain, which can be addressed by a modification of the long-acting opioid dose rather than by adding a short-acting agent. The question of a “ceiling dose” has not been settled. Doses above the equivalent of morphine 120 mg per day require reassessment, including specialist advice if possible.

Once stability of dose and responsiveness have been achieved, regular review should be undertaken with repeat prescriptions contingent on ongoing satisfactory “5A” assessment. At least annual peer or specialist review is recommended.

5. Response to difficulty in achieving or maintaining goals of an opioid trial

Difficulty in achieving satisfactory “5A” assessments in the context of the individually tailored goals of an opioid trial may be attributable to pharmacodynamic, pharmacokinetic or behavioural factors. Pharmacodynamic factors, such as non-responsiveness of distress or development of intolerable side effects, and pharmacokinetic factors, such as insufficient (or excessive) duration of effect, may respond to change in opioid preparation (“rotation”) or change in dosing regimen.



Variations in stability of dose and responsiveness over time, including apparent increase in dose requirements (other than for “incident” pain), may reflect change in the underlying somatic (biological) contribution, development of tolerance (pharmacological, psychological or increased sensitivity to stimuli), change in mood, social circumstances or other stressors, or development of aberrant drug-taking behaviour. Such situations require comprehensive reassessment along the same principles as above.

Actions arising out of such reassessment may include recalibration of goals of therapy, tapering of opioid to withdrawal, reconsideration of other modes of therapy and consultation with colleague(s).

Professor Milton Cohen
Director of Professional Affairs, FPM

Key Readings

- Ballantyne JC, Shin NS. Efficacy of opioids for chronic pain: A review of the evidence. *Clin J Pain* 2008; 24:469-478.
- Ballantyne JC, LaForge KS. Opioid dependence and addiction during opioid treatment of chronic pain. *Pain* 2007;129:235-255.
- Chou R, Fanciullo GJ, Fine PG, Miaskowski C, Passik SD, Portenoy RD. Opioids for chronic non-cancer pain: Prediction and identification of aberrant drug-related behaviors: a review of the evidence for an American Pain Society and American Academy of Pain Medicine Clinical Practice Guideline. *J Pain* 2009;10:131-146.
- Cohen ML, Wodak AD. The judicious use of opioids in managing chronic noncancer pain. *Medicine Today* 2010, 11(2) (February):10-18
- Hunter New England NSW Health. Pain matters: opioids in persistent pain. March 2010 [http://www.hnehealth.nsw.gov.au/pain/health_professionals/medical_practice_guidelines]
- Passik SD, Kirsch KL. The interface between pain and drug abuse and the evolution of strategies to optimize pain management while minimizing drug abuse. *Exp Clin Psychopharm* 2008; 16: 400-404.
- The Royal Australasian College of Physicians. Prescription Opioid Policy: Improving management of chronic non-malignant pain and prevention of problems associated with prescription opioid use. RACP 2009. [<http://www.racp.edu.au/page/health-policy-and-advocacy>]

Report from the Faculty of Pain Medicine Board Meeting held on October 11, 2010

Faculty board

The Faculty board met on October 11 immediately following the Faculty's very successful Spring Meeting in Newcastle.

Relationships portfolio

2010-2011 Global Year Against Acute Pain

A coordinated media campaign had been developed in advance of the Global Year Against Acute Pain (GYAAP) launch on Monday, October 18. Plans for media releases and a poster (in collaboration with the APS, NZPS and ASA) to be widely distributed were developed.

AFRM (RACP)

Dr Kathy McCarthy, President of the AFRM (RACP) met with the board in Newcastle to discuss opportunities for collaboration and sharing of resources. The board was pleased to accept the AFRM's offer for Faculty trainees to have access to the AFRM Bi-National Training Program (BNTP) sessions of relevance to their training. There will be no site or individual fee for Faculty trainees attending BNTP sessions from a site where there is an AFRM trainee.

A combined future conference of the two organisations was explored.

Dr McCarthy also reported on the success of the Australian Rehabilitation Outcomes Centre, a joint initiative of the Australian rehabilitation sector (providers, funders, regulators and consumers) established by the AFRM (RACP) in July 2002. The Faculty Research Committee is considering the development of a pain outcomes initiative.

APS/NZPS

Following a recommendation at a recent teleconference meeting with the APS and NZPS, the Faculty Board resolved that a combined meeting of the Faculty and the two societies be considered for 2017, then every six to eight years thereafter. These dates were calculated so as not to compete with the IASP World Congress scheduled every two years.

Corporate Affairs

ANZCA/FPM constitution review

The board supported the amendments to the ANZCA constitution proposed by a working party for consideration by ANZCA Council to include extra

privileges for non-FANZCA Fellows of the Faculty and clarity on the position and voting rights of the Dean. The main effect of the recommendations, if subsequently passed by referendum, would be that non-FANZCA Fellows of the faculty would become members of ANZCA, and therefore have the same normal voting rights and right to stand for Council as existing members of ANZCA. This will not, however, apply to Associate Fellows of the Faculty.

Undergraduate student medical prize

As part of its strategic plan to increase the level of education and training in pain medicine, the board resolved to pilot an undergraduate medical student prize in ten medical schools across Australia and New Zealand. All medical schools will be offered the opportunity to apply for the award. Ten prizes, each of \$500 and a certificate, will be awarded to the best undergraduate students in pain medicine in the last two years of undergraduate training.

National Pain Strategy *painaustralia*

The board noted that a constitution for a national advocacy body for pain, painaustralia Pty Ltd, is well developed and includes a number of categories of membership. It is anticipated that painaustralia will start addressing objectives identified at the National Pain Summit in the New Year. The next steps will be to finalise the constitution, to sign up members and to identify prospective national board members.

National pain outcomes initiative

As it is anticipated that development of initiatives of painaustralia, including a national pain outcomes Initiative, might take some time to come to fruition, the board discussed opportunities to raise the profile on a national pain outcomes database. There was agreement that a sub-committee would be established and communications commence to explore the possibility of linking in with the recent boost to pain funding in Queensland.

A small pilot project in NSW and Victoria might be expanded to include the Royal Brisbane and Women's Hospital and Fremantle Hospital and, if good progress is made, further expanded to other states and New Zealand.

Noteworthy in such an initiative is that there has been a long lag time till the work came to fruition for other similar ventures (for example, palliative care).

International Pain Summit

The board was pleased to note the success of the first International Pain Summit, held at Montreal in September, modelled on the very successful Australian pain summit in March. Australia and New Zealand were well represented by several Fellows, as well as Professor Michael Cousins in the role of Chair and convenor. Two documents are in development following input from the 250 delegates – the Declaration of Montreal encompassed pain assessment and management as a fundamental human rights issue and a document on desirable characteristics of national pain strategies, which was with the Council of the International Association for the Study of Pain for final endorsement. The former follows the concepts in ANZCA/FPM professional document PS45: Statement on patient's rights to pain management and associated responsibilities (2010).

FPM regulations

Faculty regulations were revised to incorporate associate fellowship and a process for late registrations to the Faculty's training program.

ANZCA Quality and Safety Committee

Following the resignation of the Faculty's representative to this committee, the board is seeking a replacement representative.

2011 board election

An election will be held in 2011 for four vacancies on the board of FPM. Nomination forms will be circulated to the fellowship in December. Two vacancies must be filled by a FANZCA FFPMANZCA and one vacancy by a FRANZCP FFPMANZCA. The remaining vacancy may be filled by any FFPMANZCA.

Fellowship Affairs portfolio

Fellowship

New Admissions

Dr Suyin Tan, (NSW) was admitted to fellowship by examination. This takes the number of Fellows to 292.

Honorary Fellow

The board resolved to invite Dr Pongparadee Chaudakshetrin, Fellow of the Royal College of Anaesthesiologists of Thailand to honorary fellowship of the FPM. Dr Chaudakshetrin is a leader of research and education in pain management in Thailand. Dr Chaudakshetrin has been invited to present for conferment of fellowship at the Hong Kong Annual Scientific Meeting.

Professional

New Zealand application for specialty recognition

Subsequent to the board meeting, the New Zealand Office of ANZCA has received correspondence from the Medical Council of New Zealand confirming its decision to invite the FPM to submit to stage two of their application process for recognition of pain medicine as a separate vocational specialty in New Zealand. For the stage two submission some "additional" information will be required because MCNZ changed its policy part way through our submission process. The additional information relates to the sustainability of the FPM, and the extent we overlap with existing scopes of practice. It is expected stage two will take at least six months.

Terminology used to describe Faculty Fellows

The board discussed the correct terminology for Faculty Fellows to use. There was support for a consistent description. It had been notified that the term for use by the Medical Board of Australia (MBA) would be "specialist pain medicine physician". Fellows are encouraged to use this terminology. For their work in pain medicine, this is equally an acceptable term for all Faculty Fellows. The Faculty does not support the term "interventional pain medicine specialist" as used by some. That term is not included in the MBA's "Medical list of specialties, fields and related titles".

MBA CPD Requirements

The board noted that, under the new Medical Board of Australia (MBA), satisfactory compliance with a continuing professional development (CPD) program is mandatory for ongoing registration. This now replicates what has been in place in New Zealand for

some years. There has been further clarification that the MBA requires practitioners to maintain competence in each speciality in which they practice. The board recognised that participation in CPD should be streamlined to assist Fellows with compliance and able to meet external scrutiny. (Further discussion of the subject of double speciality practitioners took place at the November ANZCA Council meeting. Clarification is needed in an area which is still evolving. For the meantime it is recommended that Fellows should maintain skills relevant to their scopes of practice, and therefore carry out CPD activities relevant to what they do in practice.)

Submissions

The Director of Professional Affairs reported on the Faculty's contribution to a growing number of ANZCA/FPM submissions including:

- Risk profiling and doctors with multiple complaints (Health Quality and Complaints Commission).
- Competence-based medical education consultation paper (Australian Medical Council).
- National safety and quality healthcare standards and their use in a model national accreditation scheme (Australian Commission on Safety and Quality in Health Care).

It had been identified that pain had not been mentioned in the standard on the deteriorating patient. A subcommittee is now working to develop a submission on the opioid treated patient.

The Faculty also submitted annual reports to the Medical Training Review Panel and Australian Medical Council for the 2009 year. Work continues on a FPM neuromodulation document.

Continuing education and quality assurance Scientific meetings

2010 Spring Meeting – Newcastle

The 2010 Faculty of Pain Medicine Spring Meeting, "Transitions in pain" held at City Hall in Newcastle from October 8-10 was well received by the 120 delegates who attended. Feedback regarding the quality of the speakers, the problem-based learning discussions and topical sessions, and the scientific program in general has been very

positive. Media releases issued by the College attracted significant media coverage.

2011 CSM – Hong Kong

The Faculty will hold its ninth annual Refresher Course Day on May 13, 2011 in Hong Kong with a theme of "Pain management: getting closer to the dragon pearl". The registration brochure will be circulated with the Combined Scientific Meeting registration brochure and is also available for download from the Faculty website. The provisional program is headlined by international guests, professors Catherine Bushnell, You Wan and Spencer Liu and complemented by national leaders in opioid management and outcomes in pain medicine.

2011 New Fellows' Conference

Drs Duncan McKay (WA) and Teik Guan Tay (NSW) were appointed as the FPM delegates to the 2011 New Fellow's Conference (NFC) in Hong Kong.

Dr Penny Briscoe was appointed board representative to the NFC.

2011 Spring Meeting

Drs Geoff Speldewinde and Guy Bashford will convene the 2011 Spring Meeting at the Park Hyatt Hotel, Canberra. Dates have been confirmed as October 28-30, 2011. A draft program has been developed. The meeting theme is "An exploration of the pain/musculoskeletal polemics – policies, procedures and pragmatics".

2012 ASM – Perth

Dr Dan Bennett (USA) and Professor Henrik Kehlet (Denmark) have accepted the Faculty's invitation to be the 2012 FPM ASM Visitor and FPM Perth Visitor respectively. Professor Kehlet will also present for conferment of honorary fellowship of the Faculty, awarded in 2004. The local FPM organising committee, comprising Dr Max Majedi (FPM Scientific Convenor), Dr Lindy Roberts, Professor Stephan Schug and Dr Stephanie Davies have commenced work on program development.

2013 ASM – Melbourne

Dr Michael Vagg was nominated as the 2013 FPM ASM Scientific Convenor and has accepted the role.

Report from the Faculty of Pain Medicine Board Meeting held on October 11, 2010 continued

Trainee affairs portfolio

Education

Blueprinting Project

To progress the Faculty's blueprinting and curriculum review project, the board resolved to seek for appointment a non-clinical educationalist at 0.2 full-time equivalent for a period of 12 months to co-ordinate the future process. The appointee will report to the Education Committee through its chair. A position description is in development and expressions of interest will be called for. Additional support has been included as a request in the Faculty's 2011 budget bid.

Appointment of supervisor

Dr Melissa Viney FANZCA (Vic) has been appointed as the Faculty's new supervisor of supervisors of training as of January 1, 2011, replacing Dr Tim Semple (SA) who is stepping down from the role due to his imminent presidency of the Australian Pain Society.

Concord supervisor

Dr Glen Sheh FAFRM (RACP) has been confirmed as the supervisor of training at Concord Repatriation General Hospital, NSW.

Examination

The board was advised that 20 Faculty trainees had participated in a well received 2010 pre-exam short course at the Royal Adelaide Hospital on October 13-15.

Twenty candidates have registered for the 2010 FPM examination at St Vincent's Hospital, Melbourne, from November 24-26.

The 2011 FPM Examination venue was confirmed as Royal Brisbane and Women's Hospital, Herston. Dates have been confirmed as November 25-27, 2011.

Training unit accreditation

The Royal Melbourne Hospital, Royal Adelaide Hospital and St Vincent's

Hospital, Sydney were re-accredited for pain medicine training.

The board resolved to extend the maximum accreditation period from five to seven years, in line with ANZCA.

Finance

The Faculty board approved the draft 2011 budget.

2011 Calendar

Dates for the 2010/2011 Board meetings were confirmed as:

February 28 – Melbourne.

May 12 – Hong Kong.

May 16 (new board) – Hong Kong.

August 22 – Melbourne.

October 10 – Melbourne.



Research on elderly patients and teaching pain medicine to young doctors were two of the subjects that received widespread publicity throughout Australia and New Zealand during the last quarter.

The ANZCA Trials Group REASON study, published in *Anaesthesia* in October, attracted widespread publicity following a media release previewing the “Anaesthesia fallout” meeting in South Australia in mid-November.

The REASON study, which surveyed more than 4100 patients in 23 metropolitan and regional hospitals throughout Australia and New Zealand, found that one in five surgical patients aged 70-plus would suffer a major complication and one in 20 would die within 30 days.

Lead researcher Associate Professor David Story was interviewed several times including on ABC Radio National’s PM program with ANZCA President Professor Kate Leslie.

He was also quoted in a lengthy Australian Associated Press story that appeared on all major newspaper websites throughout Australia.

The South Australian meeting was also addressed by Professor Steve Shafer, the Burnell-Jose Visiting Professor from Columbia University, New York, who was interviewed at length on the afternoon program of ABC radio, Adelaide.

Similarly the NSW meeting “Future directions in anaesthesia” attracted media attention.

Pain medicine has also received widespread coverage in recent months. One of the invited speakers at the Faculty of Pain Medicine (FPM) Spring Meeting in October was Professor Brian Broom, an immunologist and psychotherapist from Auckland who is known as “the story doctor”. He did several interviews.

Following the FPM meeting, Professor Milton Cohen did a lengthy interview on ABC radio in Perth about chronic pain that reached a wide audience.

Soon after the Spring meeting was the launch of the Global Year Against Acute Pain and Professor Cohen and FPM Dean, Dr David Jones, were interviewed several times about how many young doctors were not being adequately taught how to treat severe acute pain.

ANZCA and FPM issued a media release on the night of an ABC TV *Four Corners* program on opioid abuse in September, saying pain specialists were concerned at the negative publicity surrounding opioids (which are effective for thousands of patients) but were strongly supportive of the views on the program that there is a need for better education of GPs and other practitioners in prescribing opioids.

Finally, the last edition of the *ANZCA Bulletin* attracted significant coverage with Christchurch anaesthetist Dr Wayne Morriss, New Zealand National Committee Chair, Dr Vanessa Beavis, and Melbourne’s Associate Professor Brendan Silbert interviewed.

The media releases and media coverage can be seen on the ANZCA website at <http://www.anzca.edu.au/news/media-centre/> under “Media activity - 2010”.

Clea Hincks
ANZCA media manager

Dementia link to anaesthetics

Janelle Miles
MEDICAL REPORTER

AUSTRALIAN researchers are investigating whether anaesthesia during heart-bypass or hip-replacement surgery in the elderly can trigger dementia. Anaesthetist Brendan Silbert, of Melbourne’s St Vincent’s Hospital, has been following heart-bypass patients aged 50 for several years. Previous research that about 15 per cent of patients experienced diminished memory ability to the tested 12 months



“As time progresses, it may become more severe to the point of dementia. “It may be that going through the process of surgery and anaesthesia has sped up what was going to occur naturally anyway. “Once we’ve identified what the situation is, it’s the first step in trying to



Media releases distributed by ANZCA (since mid-September)

“Epidurals, ironmen and the Seven Deadly Sins to be raised at meeting” (November 19, 2010)

“Death, complication rates high amongst older surgical patients: study” (November 12, 2010)

“Pain experts pushing to teach young doctors more about pain” (October 18, 2010)

“The story doctor” to speak at pain meeting (October 8, 2010)

“Moves to educate GPs in pain management discussed” (October 8, 2010)

“ANZCA Bulletin out now” (Aust) (September 30, 2010)

“ANZCA Bulletin out now” (NZ) (September 30, 2010)

“Prescription opioids must not be dismissed: pain specialists” (September 27, 2010)

Since mid-September, ANZCA has generated...

17 print and online stories • 15 radio interviews
15 radio news stories • 2 television reports

Pain summit video achieves national and international recognition



ANZCA has been recognised locally and internationally for its moving video presentation used to open this year's National Pain Summit that was held in Canberra in March.

Produced by ANZCA's communications department with media production company Immediacy, the film was awarded a certificate of merit in the inspirational/motivational category at the 2010 International Media Communications Media Competition (INTERCOM) on October 13. The competition attracted submissions from countries including the UK, Israel and Germany.

The following month ANZCA was also successful at the Australian Video Producers Association awards that were announced at a packed ceremony in Melbourne, winning a national award in a category for best promotional, educational, marketing or industrial documentary.

"To be recognised at the national and international level is pleasing. However, it is particularly special given the nature of the subject matter and the importance of pain as a public health issue," said ANZCA's Director of Communications, Nigel Henham.

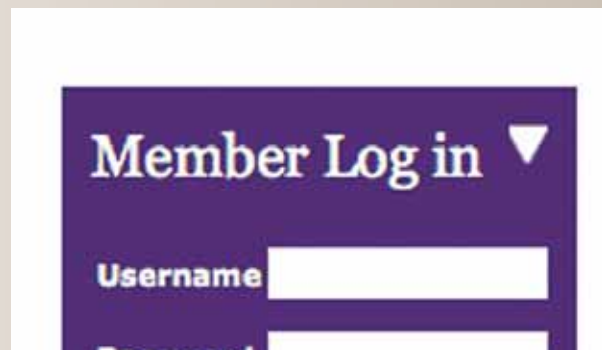
"We wanted a video that would provide the appropriate context for what was an historic occasion – the first National Pain Summit. We wanted a presentation that would have an impact on the audience yet inspire delegates. We believed we achieved that objective."

Mr Henham paid tribute to the patients who appeared on the film. "They willingly gave up their time to participate and contribute to what was an outstanding production. They were outstanding to work with. These awards are a testament to them for conveying their personal experiences with pain to a wide audience."

The video can be viewed on ANZCA's website www.anzca.edu.au



CHRONIC PAIN COSTS THE AUSTRALIAN ECONOMY
\$34 BILLION EVERY YEAR.



AND 80% OF THESE PEOPLE
WILL MISS OUT ON EFFECTIVE TREATMENT.

South Australia's foundation Fellows

This article continues a series on foundation Fellows of the Faculty of Anaesthetists, Royal Australasian College of Surgeons, on this occasion, South Australia's foundation Fellows. Our focus is on the anaesthesia-related records bequeathed for research by Dr Gilbert Brown, Dr Mary Burnell and Dr Alan Lamphee.



Five South Australian medical practitioners took up invitations to become foundation Fellows of the Faculty of Anaesthetists, RACS during 1951 - 1952. Two of the five passed away very early in the history of the Faculty, Dr Joseph Cornish in July 1952, and Dr Stewart Hecker in September 1954. Both contributed over many years to practice in South Australia although details of their lives and work remain scant at the time of writing this article.

Dr Gilbert Brown was Adelaide's first specialist anaesthetist and is regarded as one of the key contributors to Australian anaesthetic literature, during the 1930s in particular. As founder in 1934 and first president of the Australian Society of Anaesthetists, his contemporaries included Geoffrey Kaye, Douglas Renton and Robert Orton of Melbourne, Mark Lidwill, Harry Daly, Stuart Marshall and Ivor Hotten of Sydney, and Gilbert Troup of Perth. Gilbert Brown arrived in Australia in 1912 from the UK, having the year before published his study "Notes on 300 cases of general anaesthesia combined with narcotics" in the *Lancet*. He worked initially as a GP in Bute to the north of Adelaide and was then appointed health officer for nearby Snowtown. After wartime postings in World War I he was appointed honorary anaesthetist to the Adelaide Children's Hospital in

1920, the Repatriation Hospital, and then concurrently in 1921 to the Royal Adelaide Hospital where he became the tutor in anaesthetics for the University of Adelaide. He continued working in Adelaide in general practice and anaesthetics until 1946, apart from wartime postings in World War II, and then in anaesthetics only until his retirement in the 1950s. His last anaesthetic record is dated September 8, 1954.

Gilbert Brown's life and work has been chronicled by a number of writers.¹ Ian Steven wrote in 2005 that Gilbert Brown showed a keen and organised scientific and academic approach to his work. Indeed, he was the first anaesthetist in Australia to devote an individual record sheet to each patient.² At the 1934 Australasian Medical Congress, British Medical Association, he presented a paper entitled "Premedication and basal narcosis: A review of 833 cases". This article and copies of many of Dr Brown's papers are held in the Geoffrey Kaye Museum of Anaesthetic History at ANZCA House in Melbourne and are available for research. His substantial collection of anaesthetic records resides at the Mortlock Library in Adelaide and is available for research at that facility.³ He was a prolific presenter and writer,

with some 34 publications between 1911 and 1950 in Australian and international journals. He wrote particularly on anaesthesia for general, thoracic, neuro, obstetric and dental procedures.

Gilbert Brown died in 1960. He had been awarded a CBE in 1953 and OBStJ in 1954. His memory is perpetuated within ANZCA through the Gilbert Brown Prize, awarded since 1963 to the Fellow judged to make the best contribution to the free research paper session known as the Gilbert Brown Prize Session at each annual scientific meeting (first recipient Dr Warren Gunner) and by the Gilbert Brown Award, ASA, since 1970 (first recipients Dr Douglas Joseph and Dr Judith Nicholas). His influence on fellow practitioners was profound. One example is the Mortality Committee he founded at Royal Adelaide Hospital. We note that his 1937 mortality report adopted similar categories to those used in ANZCA's current mortality report.⁴

Dr Mary Burnell, nee Angel, became a full-time anaesthetist at the outset of her medical career in 1932 when appointed resident medical officer at the Royal Adelaide Hospital. Born in 1907, she obtained her medical degree at the University of Adelaide in 1931, after originally enrolling in 1923 for a science degree with the intention of doing honours in botany. Mary Burnell has been described as a pupil and protégé of Dr Gilbert Brown who with Dr Allan



Lamphee inherited Dr Brown's work of teaching and recruiting anaesthetists in South Australia.⁵ She had been taught anaesthesia by Gilbert Brown, Allan Lamphee and Stuart Hecker.

Reflecting on her medical training and early career, Dr Burnell wrote: "I have always liked anaesthetics better than any other area of our training; why, I do not exactly know, although I have, since a very small child, had a horror of witnessing pain in others, which caused me much distress in my youth. As a spectator at surgical operations it was always the anaesthetist I watched. When I was permitted to administer them myself, I appreciated the responsibility, which was certainly greater than permitted to us in any other field".⁶

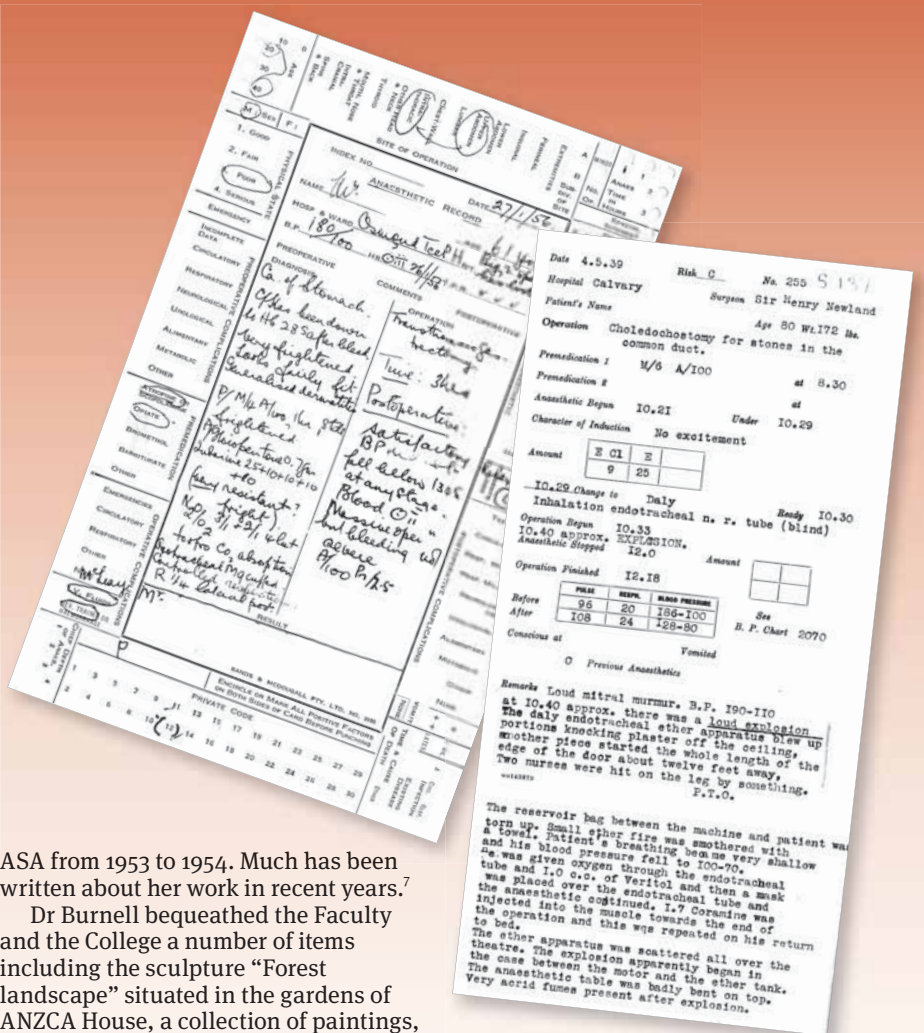
Mary Burnell was appointed Assistant Honorary Anaesthetist at the Adelaide Children's Hospital in 1934. During the war years she was the sole anaesthetist, on call day and night. Dr Burnell also served as Honorary Anaesthetist at the Royal Adelaide Hospital for many years. Dr Burnell died in 1996 and is remembered within ANZCA especially for her work as a member of the board of the Faculty of Anaesthetists from 1955 until 1967. This included membership of the Court of Examiners from 1961 to 1965 and her term as the first woman dean of the Faculty from 1966 to 1967, having been the first woman president of the

ASA from 1953 to 1954. Much has been written about her work in recent years.⁷

Dr Burnell bequeathed the Faculty and the College a number of items including the sculpture "Forest landscape" situated in the gardens of ANZCA House, a collection of paintings, her academic bonnet and a large set of case record cards which are available for research.⁸ The Burnell Jose Visiting Professorship commenced in Adelaide in 1975 and the Mary Burnell Lecture was established in 1995 and is delivered at ANZCA's Annual Scientific Meeting.

Dr Joseph Cornish was invited to become a foundation Fellow of the new Faculty in 1951. He replied in the affirmative on 18 August 1951, enclosing his signed exordium document and a cheque for ten pounds. Sadly Dr Cornish passed away less than twelve months later, only weeks before the official inauguration of the new Faculty. Dr Cornish had obtained his medical degree at the University of Adelaide in 1923 and then proceeded to fellowship of the Royal College of Surgeons, Edinburgh in 1926. He undertook a combination of general and anaesthetic practice in Adelaide until World War II intervened. After service in the south-west Pacific Dr Cornish returned to work in Adelaide, now restricting his practice to anaesthetics. He served as chair of the South Australian branch of the ASA in 1950.

(continued next page)



Above from left: Dr Gilbert Brown; Dr Mary Burnell; Dr Allan Lamphee; Anaesthetic record cards.

South Australia's foundation Fellows continued

Dr Stewart Hecker accepted the offer of foundation Fellowship and wrote a note of confirmation from his practice in Old Beach Road, Brighton, on August 15, 1951. Dr Hecker had gained his medical degree in 1919 and initially practised at Murrayville in Victoria. His part-time anaesthetic practice began in 1932 and, as noted above, he contributed to the anaesthetic training of Dr Mary Burnell. Dr Hecker's health declined in the early 1950s. He spent 1953 in England but passed away the following year after his return to Australia.

Dr Allan Lamphee is remembered, among many things, for his contribution to the ASA, to the Faculty of Anaesthetists, RACS, and to anaesthetic education in South Australia. Born in 1899 he gained his medical degree at Adelaide University in 1924. Post-graduate study took him to England where he obtained membership of the Royal College of Physicians, London in 1927. In Adelaide he entered general practice before moving to practice as a specialist anaesthetist. He served as Honorary Anaesthetist at the Royal Adelaide Hospital from 1928 to 1959 and lecturer in anaesthetics at the University of Adelaide from 1946 to 1959. Dr Lamphee served as the secretary and treasurer of the South Australian Branch, Section of Anaesthetics of the British Medical Association from its inauguration in September 1930 (Dr Gilbert Brown being the inaugural president) and later served as president of South Australian Branch, British Medical Association from 1948 to 1949.

Dr Lamphee assisted the Faculty of Anaesthetists, RACS as a member of South Australian State Committee from its inception in 1955 until 1958, and as a member of the Court of Examiners, Final Examination from 1957 until 1959. He published on the subject of teaching anaesthetics, and we hold a set of his lecture notes dating from 1958 at ANZCA Archives.⁹

Further Reading:

The two-volume set *One Grand Chain* [Wilson, G. et al, 1995 and 2004, ANZCA, Melbourne] provides a detailed and fascinating chronicle of the developments in anaesthetic practice and teaching in Australia through the period discussed in this article.

ANZCA Professional Document PS6 (2006), *The Anaesthesia Record. Recommendations on the Recording of an Episode of Anaesthesia Care.* [Originally published in 1984 as P6, *The Anaesthetic Record*]

References:

1. For example: Steven, I., "Gilbert Brown: A Prominent Australian Anaesthetist", *Anaesthesia and Intensive Care*, Vol 33, Supplement 1, June 2005, pp. 29-32; Wilson, G., *One Grand Chain*, Volume 1, ANZCA, Melbourne, 1995, pp. 594-595. On page 595 Gwen Wilson notes "In his Embley Memorial Lecture of 1939 Gilbert outlined his idea of the organisation of anaesthesia in Australia, which included a professorial department at each university and a department of anaesthetics at each hospital." See Brown, G., "The Evolution of Anaesthesia [E.H. Embley Memorial Lecture]," *Medical Journal of Australia*, 1939, 1:209-220.
2. Kay[e], G., "Brown of Adelaide", *British Journal of Anaesthesia*, Vol XXII (1950), p. 46; Gilbert Brown had remarked at the 1929 meeting of the Section of Anaesthetics, Australasian Medical Congress [British Medical Association], that records should be kept of every anaesthetic given: refer Wilson, G., *One Grand Chain*, Vol 1, p. 574.
3. Gilbert Brown Anaesthetic Records held at the Mortlock Library, Adelaide, South Australia as PRG 637, Series 1 to Series 6:
Series 1: Anaesthetic Records – Dental 1924-1944, 2 vols.
Series 2: Anaesthetic Records – General Surgery 1923-1945, March 1950 – Sept. 1954, 24 vols.
Series 3: Anaesthetic Records – Nose and Throat 1924-1945, 22 vols.
Series 4: Anaesthetic Records 1909-1911, 1920-1922, 1946-1949, 6 vols.
Series 5: Three reports on Anaesthetic fatalities:
'Report on Anaesthetic Fatalities in Adelaide Hospital, Jan 1932-Dec 1936'
'Anaesthetic Fatalities, 1950';
'Anaesthetic Fatalities, The Adelaide Hospital, Jan 1, 1932-Dec 31, 1936';
Series 6: Cards listing details of patients' conditions, 1938-1949, 34 cards.
To access these records permission must first be granted by the Chairman of the South Australian and Northern Territory Regional Committee, and then an application forwarded to the Mortlock Library in Adelaide.

4. The 1937 report utilises the following categories: 1) Statistical Survey; 2) Analysis of Fatalities 1932 – 1936; 3) Critical Report on Individual Fatalities; 4) Preventability of Fatalities; 5) Recommendations for the reduction of Anaesthetic Fatalities; Also lists 51 cases with analyses of fatalities.
5. Anon, "The Gift of the College Fountain", *Australian and New Zealand Journal of Surgery*, Vol 40, No. 4, May 1971 pp. 327-328 [this article was probably written by Dr Gwen Wilson]
6. Mary Burnell, Curriculum Vitae, undated, copy held in the Gwen Wilson Archives Collection, ANZCA Archives Series 152, Item 1060; See also Wilson, G., *Fifty Years: The Australian Society of Anaesthetists 1932-1984*, ASA, Edgecliff NSW, 1987, page 250.
7. Refer for example Cass, N., Cooper, M., "Paediatric anaesthesia in Australia: origins and developments," *Paediatric Anaesthesia* 1996, 6, pp. 69-78.

Other writings about Mary Burnell include: Obituary by Dr Gwen Wilson, published in *The Australian*, 27 September 1996 and *ANZCA Bulletin*, November 1996, pp. 3-4; *The Hands of a Woman – Stories of South Australian Medical Women and their Society*, South Australian Medical Women's Society, 1994, pp. 60-62; Loughnan, T., "Mary Taylor Burnell", *ANZCA Bulletin*, June 2005, p. 10.

8. Set of 4000 anaesthetic record cards c. 1953 - 1966, held at ANZCA Archives as Series 554
9. Dr Allan Lamphee's publications on teaching included, "The Teaching of Anaesthetics in South Australia", *MJA* 1949, 2: 233 and "Influence of Modern Anaesthetics on the Teaching of Students", *MJA* 1952, 2:516.

The course of six lectures titled "Anaesthetics" and "Gas Anaesthetics" are held at ANZCA Archives as part of Series 152 and titled as follows:

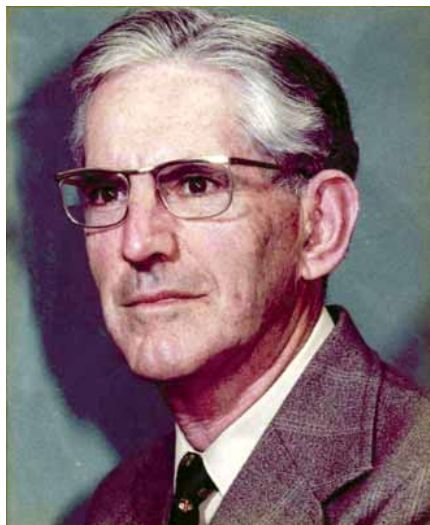
1. (a) The examination of the patient
(b) Premedication.
2. Ether. The Stages of Anaesthesia and Complications.
3. Ethyl Chloride.
4. Intravenous Anaesthesia.
5. Nitrous Oxide.
6. The Muscle Relaxants and Modern Anaesthesia.

Fraser Faithfull

ANZCA archivist with assistance from Professor Garry Phillips

Dr Wilfrid Christie Mills

1920 – 2010



Wilf Mills was the Director, Anaesthetic Department, Tauranga Hospital, New Zealand from 1970 to 1985 and made a significant contribution to the development of anaesthesia and intensive care in the region. He passed away peacefully on October 7, 2010 in his 91st year.

Wilfrid Christie Mills was born on January 21, 1920 at Mills Rd, Bruntwood, Cambridge, New Zealand. From the age of six he attended Hautapu School to which he rode the 3.5 miles on horseback each day. His secondary education was at Hamilton Boys' High School travelling from the Bruntwood station by train. He matriculated in 1936, with a pass in Latin giving him the preliminary examination in medicine and law. This success convinced him that he should try to study medicine. In his final year at school he was the captain of the 1st XV and head prefect.

In 1939 Wilf attended the University College, Auckland, a branch at the time of the federated University of New Zealand. He passed the medical intermediate examination and obtained entry to Otago University graduating MB, ChB in 1944. Wilf worked as a house surgeon at Waikato Hospital, Hamilton, and then entered general practice in 1947. At the same time he accepted an invitation from the medical superintendent at Waikato Hospital to become a visiting anaesthetist. In the same year, 1947, he married Mary Jackson Dunbar, from Wanganui who was working as a staff nurse at Waikato Hospital. In the ensuing years Mary was of great assistance to Wilfrid, both at home and throughout his medical career. Sadly Mary passed away in 2007.

Wilfrid is survived by their four children, seven grandchildren and four great grandchildren.

Wilf became interested in the advances taking place in anaesthesia, in particular the intubation of patients for operations in the chest, the use of curare and cyclopropane. He was the first anaesthetist to administer curare at Waikato Hospital. This was also the era during which the use of gas oxygen machines was replacing rag and bottle techniques. Having travelled to England in 1951, he passed the examination for the Diploma of Anaesthetics in England in 1952 and, after a further year of study at Edinburgh and Oxford, returned to New Zealand. Wilfrid was elected to FFA RCS in 1953 and was subsequently admitted to fellowship of the Faculty of Anaesthetists, Royal Australasian College of Surgeons in 1961. He continued in part-time anaesthesia combined with general practice but in 1962 the lure of anaesthesia was strong enough for Wilf to take up a full-time specialist post at Waikato Hospital.

In 1970 he was appointed Director of Anaesthesia at Tauranga Hospital. This move was a happy one but it resulted in Wilf working long hours and carrying a heavy workload in both the operating theatre and the intensive care unit. He further developed the intensive care unit in Tauranga that had been started in 1965 by Harry Watts and Basil Fergus. He introduced protocols for intensive care routines and trained the nursing staff to intubate patients in emergencies, perform IV cannulation and administer a variety of medications. Although it was technically an open unit, cases were in effect handed over to him and the nurses were expected to follow his protocols. If there was any deviation from said protocols the nursing staff were expected to phone him. You could say that Dr Mills was focused on delivering quality care, and innovatively using others to help him do that.

Wilfrid was a man of action; the following are some of his achievements:

- A supporter of skilled assistance for anaesthetists and insisting on one technician per theatre.
- Developed a close relationship with the ambulance service, teaching defibrillation to senior officers and negotiating their certification. He also arranged for ICU nurses to spend time in ambulances.
- Set up a system whereby the ambulance officers en route to hospital would ring ahead if they felt it was warranted so that the consultant surgeon and consultant anaesthetist could be ready and waiting in the A and E department.
- Instituted a comprehensive trauma call system well before many others and chaired the resuscitation committee. He made sure that a house surgeon was a standing member of the committee.
- Standardised and regulated the resuscitation trolleys in every clinical area and ward throughout the hospital. On every Friday afternoon the senior technician would check the trolleys.
- Ensured that there was a clean black rubber circuit on the machine for every new case. This was unusual at the time and was only made possible by having large stocks of tubing and busy technicians!
- Won the admiration and respect of the surgeons through precept and example.
- He was a gifted teacher. His expert tuition and guidance to medical officers and later registrars in anaesthesia was appreciated.

The staff, both anaesthetic and surgical, increased in numbers during Wilfrid's tenure commensurate with the stellar population growth in the region. Case complexity also increased as the hospital specialists began to deal with vascular, upper GI and major orthopaedic operations. Wilfrid retired from Tauranga Hospital in 1985 but remained in contact with his colleagues for many years.

Dedication, commitment, integrity, mana, hard work, attention to detail, fairness, punctuality, leadership, mentor, role model and friend; these are all words that have been used with reference to Wilf. His disposition was always phlegmatic but a quiet smile was never far away. Wilfrid created many good systems well before others invented safety and quality, quietly achieving many good things that were unsung and unrecognised. He had a deep faith that he expressed in the way he practised anaesthesia for the benefit of all beyond the call of duty. He has now passed on to his rest and any plaudits that we can bestow on him in this life have no doubt been superseded by that "well done thou good and faithful servant".

Dr Peter Cooke, Dr Denholm Crone,
Dr Mike Knapton and Dr Barry Partridge

Dr John Irwin Newstead

1936 – 2010



In writing this appreciation of John and all that he achieved, I realise that I knew relatively little of him at a personal level, particularly during his earlier years. I do recall him as a final year medical student in Dunedin in 1966. He was one of very few students who knew that he wanted to be an anaesthetist even before he started medical school. Perhaps this related to his work before training in medicine – unlike many of us at that time, he did not start his medical training for several years after leaving school.

From his early years, John approached his work from an original and questing perspective. He would always tackle a problem from a different angle to most of us. He trained in anaesthesia partly in New Zealand and partly in Australia. A final year spent at the Royal Women's Hospital in Melbourne with Dr Kevin McCaul was

important in shaping his professional interests. He recalled that time with considerable affection. In 1974, he returned to New Zealand to take up a position as a specialist anaesthetist at Southland Hospital in Invercargill where he worked until 1985.

One of John's lasting interests was in equipment used in anaesthesia, this leading to his work on technical standards and as a New Zealand representative on the relevant committees of the International Standards Organisation. His involvement with the teaching of trainee anaesthetists led to his appointment as a primary examiner in pharmacology in 1982.

In 1985, John moved from Invercargill to Christchurch where he took up appointments to the Canterbury Area Health Board and the Christchurch School of Medicine. He soon became comprehensively involved as a (highly regarded) teacher and with matters related to equipment for the Department of Anaesthesia. At a national level, his expertise was acknowledged by his election to the regional committee of the (then) Faculty of Anaesthetists of the Royal Australasian College of Surgeons.

John and I developed our friendship during his early years in Christchurch where he also had interests in the restorations of vintage aeroplanes at the Airforce Museum out at Wigram and working on the restoration of a steam railway engine. Of particular importance was John's meeting with Jenny, then the secretary to the Department of Anaesthesia. Their marriage resulted in John having a second family with Sophie, 18, and Hamish, 7, becoming major influences in his life. At the time of John's death, Jenny and John had spent 24 very happy years together.

The needs of his young family were a major factor in John's move early in 1994 to a consultant appointment at the King Khaled Eye Specialist Hospital in Saudi Arabia. During their time there,

I met up with John and Jenny and Sophie in Switzerland when we were able to indulge a mutual interest in train photography and travel. A 15km hike over a mountain range gave both of us blisters and a chance to share many thoughts. John and Jenny were wonderful hosts.

After leaving Riyadh in 1999, John and his family moved to Dubbo in NSW where he worked until bringing the family back to Christchurch in retirement in 2004. His health problems over his latter years did not prevent continuing professional associations in areas of interest. He had an ongoing association with Fisher and Paykel Healthcare in an advisory capacity, a relationship he valued enormously.

John was a direct man who did not suffer fools gladly. He was a loyal friend to many – more outside of medicine than within. He was greatly impressed and grateful for the skills of those caring for him during recent major surgery and had seemingly made a good recovery from some daunting procedures. When I met him about three months before his very sudden death while working at his computer, he was looking forward keenly to some outcomes from his work with Fisher and Paykel. He talked proudly of Sophie's move on from school to study law at Canterbury University in 2011, and about the much-loved companionship given to him by Hamish. Love and support for and by Jenny was also of great importance to him, as well as that of his four older children, Pippa, Robert, Tom and David, from his first marriage.

John has been a great colleague to many of us who are proud to have known him. He was notable for his friendship, his deep knowledge of many things, his wry humour and his honesty. He will be greatly missed by many colleagues and by his family. His funeral had to be deferred because of the Christchurch earthquake. John would have found that very funny.

Professor John M Gibbs
Queensland

Dr John Nigel Francis Breakey

1955 – 2010



John Nigel Francis Breakey, known to his friends and family as Nigel, was born in Northumberland on March 18, 1955, the first son of three of Bryan and Robin, both general practitioners. He was educated at Mowden Hall, a preparatory school, then at Fettes College in Edinburgh, before going on to study medicine at Cambridge University. In his early years he was not only a scholar but a fine all-round sportsman, with a golf handicap of four as a teenager, playing rugby for Scotland Schoolboys and being awarded a Blue at Cambridge for his skills as fly-half against Oxford.

After graduating from Cambridge he travelled to New Zealand, working in Wellington and Masterton, where he met Kaye in 1980. After further travel, including returning to the United Kingdom for a while, Nigel and Kaye settled in Perth, Western Australia, where they were married in 1986. Nigel completed specialist anaesthetic training there and soon developed a very busy private practice which occupied a large proportion of his time for the remainder of his professional life. Whilst not active in competitive sport in Perth, he remained very fit. Photos of Nigel running, bare-chested, with his much-loved King Charles spaniels demonstrate a physique reminiscent of a da Vinci painting.

Nigel had an eclectic set of interests outside work. He read very widely, became interested in eastern religions, biodynamic gardening and wine to name but a few. He had a passion for owning older cars that others were wary of Fiats, Renaults, Saabs and Jaguars. I recall many a weekend visiting Nigel to find the *Weekend Australian* newspaper and all its magazines had been spread from dining table to lounge chairs, each part already voraciously read.

He was an enthusiastic member of the local town council, always championing the rights of the ordinary ratepayer. He had a strong sense of justice and fair play, and had little time for the usual trappings of modern middleclass aspirational Australia.

Nigel worked hard, very hard – some would say too hard. He seldom took holidays. He was always good company, accepting of, and gentle towards, those around him. He could be contrary in discussions about politics, religions or social orders. He could be strong-willed, even stubborn at times.

The last several years were not easy for Nigel. He was troubled by a fear that he was physically ill and he became very depressed prior to the untimely ending of his life. But I never saw Nigel angry. Having lived and worked in Aotearoa and married and loved one of its finest progeny, I think he would have agreed with the sentiments of one of that county's most revered poets and pacifists: James K Baxter, who wrote in *High Country Weather*:

Alone we are born
And die alone;
Yet see red-gold cirrus
Over snow mountain shine.

Upon the upland road
Ride easy, stranger;
Surrender to the sky
Your heart of anger.

Nigel is survived by his ever-loyal and loving wife Kaye, three gorgeous children – Alice, Rupert and Hugo – both his adoring parents, Bryan and Robin and his two loving brothers, Richard and Peter. He will be sadly missed by all those who knew him and had the joy of experiencing his warmth, charm, intellect and his unique view of the world.

Dr Ian Jenkins
Western Australia

Dr Michael Carlton (Charlie) 1956 – 2010



Dr Charlie Carlton was a well known anaesthetist from Newcastle, NSW. He was born on January 7, 1956 and went to school in Newcastle at Hamilton Marist Brothers.

His family had a strong historical presence in the town of Dungog and Michael spent considerable time as a young man on the farm that his father owned. At school he excelled academically and at rugby. Following an excellent pass in the higher school certificate he started studying medicine at the University of New South Wales in 1974.

He sailed through university and part way through the course did a BSc (Med) in biochemistry under Leon Simons. His research looked at Lipoprotein A Levels in postmenopausal women and for a while he considered continuing this work with the aim of completing a PhD.

However, following advice from his bank manager father, he decided to finish his medical degree. This he did in 1979 and he graduated the following year.

Having done an elective term there and having strong family ties, Michael returned to Newcastle and started his internship at Royal Newcastle Hospital in 1980. He was a larger than life character, known for his sense of humour and for his ability to work

extremely hard. He did more terms as an orthopaedic RMO than anyone had ever done at the hospital and was almost lost to a career in orthopaedic surgery.

However, he decided on anaesthesia and intensive care following a term as an RMO in the department run by Dr Owen James. Despite a busy time during and after work, Michael passed the primary exam on his first attempt, something of a novelty for anaesthetic registrars in Newcastle at the time. Michael often spoke very highly of the training he received at Royal Newcastle Hospital, largely due to the level of responsibility and exposure that the anaesthetic trainees experienced in those days.

Anaesthesia and intensive care were essentially the same department, with the ICU being very influential in the hospital at the time due to the strong influence of Dr James and Dr Ivan Schalit before him. By the late 1980s, Michael had gained considerable experience in ICU as well as anaesthesia.

He had a few unsuccessful attempts at the final FFARACS exam during this time and following a personal family tragedy decided to relocate to Sydney. There he worked at Prince Henry Hospital completing his anaesthetic Fellowship in 1991. Michael stayed on as staff specialist working in the ICU and the hyperbaric unit, enjoying his time there greatly. He fondly recalled working with Professor Tom Todra, whom he described as a great innovative thinker.

For family reasons Michael moved back to Newcastle in 1993 and took up a staff specialist position at John Hunter Hospital and then at the old Royal Newcastle Hospital. In 1994 he became the founding director of ICU at Lake Macquarie Private Hospital in readiness for the commencement of cardiac surgery. Testimony to his hard work, the ICU and cardiac surgery both became very successful with the hospital doing on average 400 open heart cases a year. Michael, especially in the early

years, had a very strong presence in the hospital. He ran various committees and showed strong leadership in quality improvement. The back-up that he and the ICU provided gave the hospital a very good reputation among the medical fraternity for dealing with high acuity, high-risk and complex surgical cases. As a director he led from the front and inspired great loyalty from all ICU staff. Michael worked at LMPH for 16 years right up until his unexpected death on November 9, 2010.

Michael was loved by patients and staff alike. For the patients he had the unusual combination of gruffness, direct style, colourful language and incredible humour which surprised them but above all, they sensed how much he really cared about them and that he would do just about anything to help them through. For the hospital staff, whatever their role, he treated them all the same. Michael learnt and remembered everyone's name or had a nickname for them. He was one of life's characters. Michael's funeral was held at Christ Church Cathedral in Newcastle on November 15 and was attended by a huge crowd, an occasion of great sadness.

Michael's own premature death was a sad conclusion to a life that had been marred by the personal tragedy of losing two of his own children. He is survived by his beloved wife Pia and children Fergus and Bella.

Michael will be sadly missed by family, colleagues and patients. He was hardworking, compassionate and extremely humorous. He was one of a kind.

Dr Anthony Mullens
Newcastle

ANZCA Council meeting report

November 2010

Report following the Council meeting of the Australian and New Zealand College of Anaesthetists held on November 20, 2010

Death of Fellow and Trainees

Council noted with regret the death of the following Fellows:

- Dr Wilfrid Christie Mills (NZ), FANZCA 1992, FFARACS 1961
- Dr Michael "Charlie" Thomas Carlton (NSW), FANZCA 1992, FFARACS 1991
- Dr Genevieve Anderson (SA), FANZCA 1992, FFARACS 1978
- Dr Eva Ruth Seelye (NZ), FANZCA 1992, FFARACS 1968

Finance

Council approved the ANZCA budget for 2011, and the 2011 Schedule of Fees (which can be found at: www.anzca.edu.au/news/council-reports).

Key features of the 2011 budget which is in line with the President and Council's strategic priorities include:

- Greater support for Fellow-related professional activity by creating a Fellowship Affairs Department bringing together CPD, Quality and Safety, ANZTADC and the Trials Group
- Assisting Fellows to fulfil mandatory CPD requirements and greater ease of access to the CPD Program online
- Enhancing support to Fellows in their roles as clinical teachers, supervisors of training, module supervisor and regional/national education officers
- Implementing the action plans arising from the Fellowship Survey including a New Fellows kit and a community awareness campaign to highlight the valuable work undertaken by Fellows

- Appointment of a Deputy Assessor DPA to facilitate timely decisions about training
- Supporting a research grant proposal studying Fellow engagement with the College
- Providing a more user-friendly website by enhancing navigability and ease of use
- Providing a service for those Fellows who cannot attend the ASM through expanded online multi-media coverage of the event
- Providing enhanced Fellow support in the regions by adding to the regional staff resources and improving accommodation amenity for regional/national committees
- Increasing the resource within the ANZCA library in support of Fellows and trainees.

Fellowship Affairs Committee

2013 ASM – Melbourne: Council approved the appointment of Prof Kevin Tremper as the ANZCA ASM Visitor and A/Prof Timothy Short as the Australasian Visitor.

2012 ASM – Perth: Council approved a part-paperless meeting, acknowledging both the need to minimise the impact of the meeting and that some aspects require printed materials for the amenity of attendees and sponsors.

2011 New Fellows Conference: Council approved the following Regional/National New Fellow Nominations for the 2011 New Fellows Conference:

- Dr Elaine Lee, (ACT)
- Drs David Rowe and Emily Wilcox (NSW)
- Drs Indu Kapoor and Duncan Wood (NZ)

- Drs Kathleen Cooke and Kurichi Marudhachalam (QLD)
- Drs Remesh Balasingam and James Fowlie (SA&NT)
- Dr Jennifer Plummer (TAS)
- Drs Christopher Duffy and Kushlani Stevenson (VIC)
- Drs Kevin Elks and Denise Yim (WA)
- Drs Polly Lai Mei Chan, Diane On Yi Chan, Amy Kong, and Leo Chun Yin, Wat (Hong Kong)
- Drs Hari Krishnan, Sivanesan Subramaniam and Suresh Venugobal, (Malaysia)
- Drs Chee Yong Choo and Kwang Hui Tay (Singapore)
- Drs Ian Duncan McKay and Teik Guan Tay (nominated by the FPM)

Internal Affairs

Council was notified of the appointment of Dr Vaughan Laurenson (New Zealand) as Deputy Assessor, DPA.

2011 Council Calendar

The following amendments have been made to the 2011 Council Calendar: Executive Committee rescheduled to **Wednesday 23 February 2011**

Fellowship Affairs Committee rescheduled to **Thursday 24 February 2011**

Curriculum Redesign presentation to Council and others scheduled for **Friday 25 February 2011**

Hong Kong ASM 2011

ANZCA Council with Regional/National Committee Chairs, **Sat 14 May** 12.15pm to 1.15pm

ANZCA New Council Meeting, **Tue 17 May** 5.30pm to 7.00pm

Education and Training

Ray Hader Award for Compassion:

Dr Katherine Hagen (New Zealand) was this year's recipient of this Award, generously supported by Dr Brandon Carp, in recognition of trainees who promote a compassionate approach to the welfare of anaesthetists, colleagues, patients and within the community. Prof Leslie presented the award to Dr Hagen at the President's Christmas Drinks, which Dr Brandon Carp attended.

Admissions to Fellowship: The College will accept paperwork from trainees up to four weeks in advance of completion of their training, accompanied by a statement from the Supervisor of Training confirming that they will remain in post until the end of their training. A schedule for admissions over the next few months has been established to facilitate timely admissions to Fellowship.

Changes to ANZCA Regulations

Regulation 23 – Advice Regarding Recognition as a Specialist in Anaesthesia

Council approved further amendments to Regulation 23 with regards to Area of Need Assessments. The implementation date for the amended Regulation 23 will be 1st February 2011, at which point the updated regulation will be posted on the College website.

Regulation 33 – Trainee

Performance Review

Council approved a proposal to amend Regulation 33 to provide an "own motion power" to be instituted, residing in the majority of the President, the Executive Director of Professional Affairs and the Chair of the Education and Training Committee. A copy of the updated regulation can be found on the ANZCA website.

Professional Documents

PS40 - Policy for the Relationship Between Fellows, Trainees, and the Healthcare Industry

PS40 and the accompanying background paper have been approved by Council and are to be circulated to Regional/National Committees and relevant special interest groups for comment.

T3 Minimum Safety Requirements for Anaesthetic Machines for Clinical Practice

T3 has been approved by Council and will be circulated to Regional/National Committees and relevant special interest groups for comment.

College Awards and Election

Prof Paul Myles has been awarded the Orton Medal and invited to receive the medal at the CSM to be held in Hong Kong in 2011.

Professor Kate Leslie
President

Dr Lindy Roberts
Vice President

ANZCA Council meeting report

October 2010

Report following the Council meeting of the Australian and New Zealand College of Anaesthetists held on October 9, 2010

Death of Fellow and trainees

Council noted with regret the death of the following Fellows:

- Dr John Nigel Breakey (WA) FFARACS 1987, FANZCA 1992
- Dr John Newstead (NZ) FFARACS 1972, FANZCA 1992
- Dr Seamus Anthony Tuohy (NSW) FFARACS 1981, FANZCA 1992

Committee appointments

Q&S Committee

Council noted the following appointments made by the Quality and Safety Committee:

- Dr Leona Wilson, Deputy Chair
- Dr Elizabeth Feeney, Co-opted Member

IMGS Committee

Council approved the following appointments to the IMGS Committee:

- Dr Rajesh Brijball
- Dr Kerstin Wyssusek
- Dr Indu Kapoor

Training Accreditation Committee

Council noted the following appointment made by the Training Accreditation Committee:

- Dr Mark Reeves, Deputy Chair

Finance

The following trainees have been awarded ANZCA training scholarships for 2011:

- Dr Jaya Raj V K Manoharan
- Dr Mylvaganam Mylashan

Education and training

From October 9, 2010, for all trainees who have yet to complete training, while the completion of Module 2 during Basic Training is still recommended, the module's completion at any time subsequent to the first 26 weeks of BTY1 will be accepted, including during advanced training.

Fellowship Affairs

2014 Annual Scientific Meeting – Sydney

Dr Michael Paleologos has been appointed the convenor and Dr Timothy McCulloch has been appointed the scientific convenor for the 2014 ASM.

2011 New Fellows Conference

– Hong Kong

Dr Michelle Mulligan has been nominated the councillor for the 2011 New Fellows Conference.

2010 New Fellows Conference – Hamner Springs, New Zealand

Dr Nolan McDonnell presented a report on the NFC themed “Adventures in Anaesthesia” held prior to the Christchurch ASM.

Changes to ANZCA regulations

Regulation 6.3.2 – admission to fellowship by election via application

This regulation has been amended to include that applications must be supported by four referees (formerly three), one of whom must have had recent close familiarity of the applicant's clinical and professional work, and one of whom must be a senior administrative officer of the institution where the applicant has most recently worked clinically. A copy of the updated regulation is on the College website.

Research awards for 2011

The table of projects supported by Council, including second and third year funding and awards recommendations, can be found at: www.anzca.edu.au/news/council-reports

Professional Documents

Council agreed to the revision of Professional Document **PS31 Recommendations on Checking Anaesthesia Delivery Systems** with the Document Development Group to be led by Dr Patrick Farrell.

Please note that there was an error contained in the **August 2010 Report Following Council**, with regards to the following Professional Document. The deadline for compliance has been delayed until January 1, 2012 and not 2011 as previously indicated.

T3 Minimum Safety Requirements for Anaesthetic Machines for Clinical Practice

Due to a need to revise this document and the substantial lead-in times required by hospital departments for changes to anaesthesia workstations, the deadline for compliance has been delayed until 1st January 2012.

Professor Kate Leslie

President

Dr Lindy Roberts

Vice President