September 2010

ANZCA BULLETIN

ANZCA
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

FPM
FACULTY OF PAIN MEDICINE ANZCA

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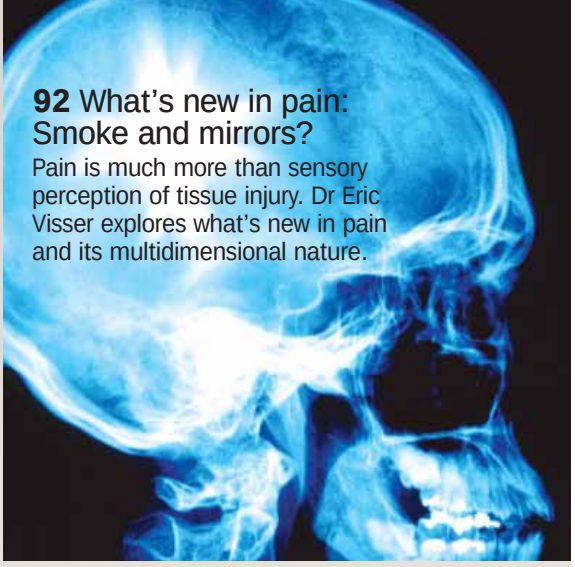

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ANZCA Bulletin

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.

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Cover: Glow of light and X-ray of human skull, conceptual.

Contents

President's message

Bill Clinton (and Julia Gillard) said *"The people have spoken, but it's going to take a little while to determine exactly what they said"*. Mercifully, ANZCA is not in that position. The ANZCA Fellowship Survey has delivered some very clear messages about what our Fellows expect of their College. Furthermore, they did so in record numbers, proving that the majority of our Fellows really are engaged in their professional lives as anaesthetists and pain medicine specialists. In this issue of the *ANZCA Bulletin*, we have mapped out our response to your feedback and our plan to increase the value of an ANZCA/FPM Fellowship for all our Fellows.

The Fellowship Survey

To briefly recap, ANZCA Council identified engagement of Fellows as a key strategic priority for 2010-12 and seeking the views of Fellows was seen as an important element in achieving that objective. The Fellowship Affairs Committee, chaired by Dr Michelle Mulligan, and ANZCA management, led by CEO Dr Mike Richards and Director of Communications, Mr Nigel Henham, planned the survey and commissioned independent research company ANOP to analyse the results. The survey was distributed to Fellows in March-April 2010 and focus groups were held at the Annual Scientific Meeting in May 2010. The response rate of the survey was nearly 50 per cent and the Executive Summary was published in the June *ANZCA Bulletin*. Some highlights of the results were:

- There was a good level of satisfaction with ANZCA overall with 71 per cent of respondents giving ANZCA scores of seven to 10 out of 10.
- ANZCA was perceived as being professional, credible and reputable (although sometimes a bit bureaucratic and remote).
- ANZCA's services, in particular the Continuing Professional Development (CPD) program, library, professional documents, Annual Scientific Meeting and communications were well used and highly valued.
- There is scope to increase the ease of access and overall participation in ANZCA's CPD program, to provide more diverse opportunities for CPD, and to be more supportive and more appreciative of the pro bono work of our Fellows.

The results of the survey were considered by the Fellowship Affairs Committee and ANZCA management and their comprehensive response can be found in this issue of the *ANZCA Bulletin*. In my message, I would like to highlight some important jurisdictional developments in CPD and the plans that the College has to improve our own CPD program. Dr Rod Mitchell, Chair of the ANZCA CPD Committee, will also be providing a series of articles on CPD in forthcoming issues of the *ANZCA Bulletin*.

CPD is now mandatory for all Fellows

The need for participation in continuing education and quality assurance activities by medical practitioners is self-evident and the vast majority of our Fellows are enthusiastically engaged in CPD on a voluntary basis.

Nevertheless, in order to meet the public's expectations for universal participation, mandation of CPD by Medical Councils and Boards has become the norm. For some time, our Fellows in New Zealand, and in several jurisdictions in Australia, have been required to participate in a CPD program. With the advent of the Medical Board of Australia (MBA) on July 1 2010, this now applies to all our Australian and New Zealand Fellows in active medical practice.

In New Zealand, Fellows are required to advise the Medical Council annually as part of the application for registration of their participation in an approved CPD program (ANZCA's CPD program is the only one approved for anaesthetists) and ANZCA confirms participation for those whose returns are audited by the Medical Council. In Australia, the specific rules for maintenance of specialist registration are under development. MBA Consultation Paper #5 maps out the Board's current proposals (see ANZCA's response at (www.anzca.edu.au/news/submissions-to-government). Their plan is to require specialists to meet the standards for CPD set by the relevant Australian Medical Council (AMC) accredited College in order to maintain specialist registration. For our Fellows, this will mean participation in the ANZCA CPD program or another program approved by the College. In addition, the MBA plans to obtain information from the College about participation in CPD.

ANZCA has also separately mandated CPD for all active Fellows. As the end of this triennium of the ANZCA CPD program approaches, I encourage all Fellows to review their CPD plan, enter their activity data and obtain their CPD certificate as they will require this to maintain good standing with both the College and their Medical Council or Board. More information is available at http://www.anzca.edu.au/fellows/cpd including contact details for the staff in our CPD unit.

Making ANZCA's CPD program easier to access and use

To be effective, CPD must be tailored to the practice needs of the individual practitioner and be presented in a format that best suits them. While the overall level of satisfaction with the CPD program was reasonable (7.2 out of 10), nearly four out of 10 respondents to the survey commented that they had difficulties with the program in terms of the ease of access and navigation of the website. Furthermore, the focus groups revealed that some Fellows wanted more guidance from the CPD printed materials and website about planning a CPD program, self-assessing the activities, logging them with the College and obtaining a certificate. As Council has recently resolved that advice about CPD points allocation for activities will no longer be provided prospectively, improved guidance about self-assessment is timely.

To that end, the College is planning a comprehensive review of the CPD section of the ANZCA website. This is part of an overall revamp of the website being undertaken by the Communications, IT and CPD units. Furthermore, the CPD Committee is developing a new, simpler CPD brochure that will explain in plain language everything you need to know to participate. Finally, there will be expanded coverage of CPD activities (including feature articles, tips and the latest clinical news) in the *ANZCA Bulletin* and E-newsletter. More detail is available in this issue of the *ANZCA Bulletin* and we look forward to your feedback as we roll out these initiatives.

The Fellowship Survey is just one part of our vision to *engage* the Fellowship in the future of our College. You can read more about other activities undertaken by the Council and management, and by our many enthusiastic Fellows and trainees around the regions, in this issue of the *ANZCA Bulletin*.

Professor Kate Leslie
President

How are we going with ENGAGE?

Embrace new training environments

- 25 anaesthetic training positions in private and rural settings short-listed for the Australian Federal Government's Specialist Training Program (STP) funding.

Negotiate and influence people

- 46 submissions to government (28 in Australia and 18 in New Zealand) so far this year.

Get involved

- 81 per cent participation rate in ANZCA's CPD program.
- 50 per cent response to the ANZCA Fellowship Survey.

Advocate quality and safety

- 15 hospitals participating in the pilot program for Webairs – the online bi-national incident monitoring project supported by ANZCA, the ASA and the NZSA.

Give your support

- Overseas Aid Committee and Indigenous Health Working Group established.
- 69 donors to the Foundation for 2010.

Educate yourself and others

- 40 Fellows engaged in the ANZCA Curriculum Redesign project.
- 136 Fellows completed Advanced Level Clinical Teacher courses so far in 2010 and 197 Fellows registered for future Foundation Level courses.

Pain in the Pacific project

ANZCA President Professor Kate Leslie accepted a cheque for a $20,000 donation from the trustees of the Ronald Geoffrey Arnott Foundation, managed by Perpetual Trustee Company Limited, in support of a Pain in the Pacific project within the Faculty of Pain Medicine.

Project sponsor, Dr Roger Goucke, former Dean of the Faculty of Pain Medicine, has written about essential pain management in the Pacific Islands and Papua New Guinea and his article can be found on page 100.

Left: ANZCA President Professor Kate Leslie accepted a cheque for a $20,000 donation from Michael Carroll, Senior Financial Consultant, Perpetual Trustee Company Limited, in support of a Pain in the Pacific project within the Faculty of Pain Medicine.

Supporting medical research

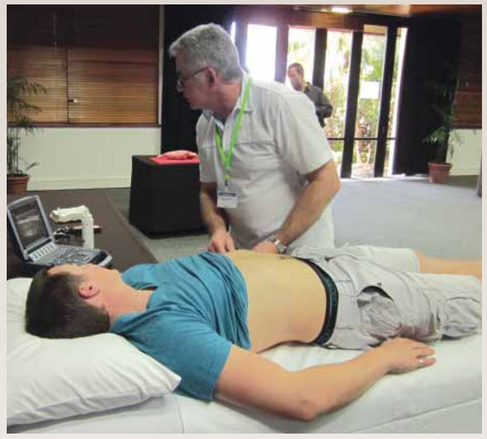
Since 2007, Mundipharma has given considerable untied annual funding to the Anaesthesia and Pain Medicine Foundation (formerly the ANZCA Foundation) to support the College's medical research and education programs. Each year we recognise Mundipharma's support with an award that is presented at the Annual Scientific Meeting. The Mundipharma ANZCA Research Fellowship for 2010 was awarded to Dr Paul Wrigley for his project "Regional changes in cerebral perfusion associated with persistent spinal cord injury neuropathic pain".

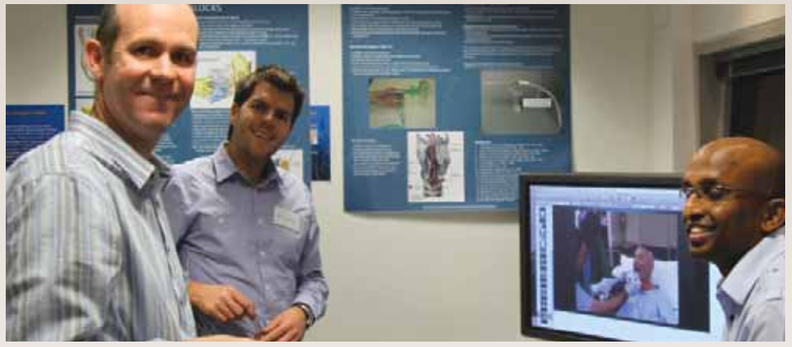
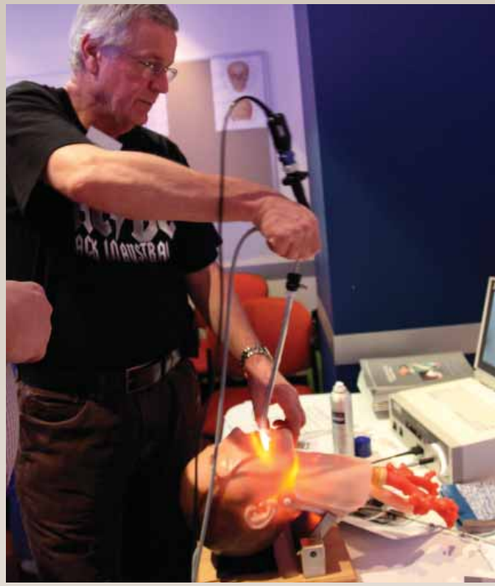
Left: The Director of the Anaesthesia and Pain Medicine Foundation, Ian Higgins presented the Managing Director of Mundipharma, Mr Rob Baveystock, with a foundation tie and cufflinks at a recent meeting in Sydney.

People and events








2010 Rural Special Interest Group meeting

The Rural Special Interest Group (SIG) held its third annual meeting on Hamilton Island from July 4-6 with the theme “The Jack of All Trades”. The meeting was well supported with more than 100 delegates, and a larger number of trade displays than in previous years, proving the concept of an annual meeting with a rural focus has support among Fellows of the College as well as GP anaesthetists, who accounted for almost a third of the delegates.

The three-day event covered a wide variety of topics, which for some in metropolitan practice are a daily or weekly occurrence but for a rural practitioner may crop up less than monthly. The first day covered pre-operative assessment with talks on pacemakers by Dr John Moloney, coronary stents and antiplatelet drugs by Dr Jenny Stevens, an audit of ECG abnormalities in pre-admission clinic from Quentin Tibbals, paediatrics by Dr Neil Paterson, diabetes by Dr Judith Killen and sleep apnoea by Dr Deb Gardiner. Day two had an intra-operative focus with talks on paediatric dental and ENT anaesthesia by Dr Neil Paterson, 10 tips for ophthalmic anaesthesia by Dr Lindy Cass, anaesthesia for urology by Dr Gay Clery, the fractured NOF from Dr Mathew Griffiths, shoulder surgery from Dr Dougal Miller and DVT Prophylaxis from Dr Steve O’Mara. The final morning had a pain focus with talks on post-operative nausea and vomiting from Dr Rod Martin, multi-modal analgesia by Dr David Rowe, intrathecal opioids for chronic pain by Dr Zamil Karim and analgesia for cancer pain by Dr Jenny Stevens.

Clockwise from left: Hamilton Island; Dr Gerard Meijier at the conference dinner; Helen Goodwin, Dr Steve O’Mara (guest speaker) and Dr Deb Gardiner during the conference; Dr Mike Haines and Ben Sinclair during the TAP Blocks Ultrasound workshop; Deb Martin, Dr Rod Martin, Lisa Rowe, Dr David Rowe at the conference dinner.

Annual Advanced Airway Management Refresher Course 2010

The second Annual Airway Management Refresher Course was held at the Australian Centre for Health Innovation at The Alfred hospital with 40 participants and 20 experienced airway instructors from around Australasia. There was a wealth of experience from many specialist groups, rural GP anaesthetists, intensivists and emergency physicians and anaesthetists. The course featured hands-on training in critical airway skills in small groups with a very high instructor to participant ratio, and expert advice that was designed to go beyond the ASA and DAS algorithms of difficult airway management.

The video laryngoscope session featured an overview by Dr Rishi Mehra, followed by an interactive session. Dr Chris Acott and Dr Joel Symons were on hand to offer practical advice on the different ways of using the devices. Dr Maryanne Balkin wrapped up the session with an objective review of literature. Dr Reny Segal and Dr Paul Mezzavia ran the dexterity training with the Storz fibrescopes on Dexter mannequins. Airway trainers Dr Jon Graham and Dr Balan Sivasubramaniam extensively covered the Topicalisation and Aintree conversion stations. Dr Andrew Heard’s team from Perth and The Alfred helped facilitate the participants’ learning of the new approach to surgical airway management for anaesthetists in the “can’t intubate, can’t oxygenate” scenario. Finally, the prospect of being exposed to some good adrenaline-provoking simulated difficult-airway situations drew positive comments. Dr Stuart Marshall and emergency physician Dr Peter Fritz developed scenarios that related strongly to current practice and potential situations.

Clockwise from top left: The simulation faculty preparing for the next participant; Dr Chris Acott demonstrating the Bonfils scope; Dr Stuart Marshall, Dr Mark Adams and Dr Andrew Heard in discussion about the simulation of an airway scenario; Dr Jon Graham, Dr Shannon Matzelle and Dr Balan Sivasubramaniam.











Death Under Anaesthesia meeting

Death Under Anaesthesia, a conference commemorating 50 Years of the Special Committee Investigating Deaths Under Anaesthesia (SCIDUA), was held at the Hilton Sydney Hotel on August 14. Co-hosted by the NSW Anaesthesia Continuing Education Committee and the NSW Clinical Excellence Committee, the meeting attracted more than 350 delegates from across Australia and New Zealand. The theme of the conference addressed mortality and related topics. Keynote speakers Professor Ross Holland, Dr Neville Gibbs and Professor Jan Davies presented talks on the history, trends and international practice of mortality reporting. Keynote speaker Professor Alan Merry presented on the World Health Organization Surgical Safety Checklist. Other lectures addressed mortality among anaesthetists from addiction, risk associated with transfusion and safety of home births. Group learning sessions addressed safe practice in high-risk areas that have been identified by SCIDUA such as endoscopy, orthopedics and obstetrics. Workshops addressed the topics of breaking news to a patient's relative of an unexpected death and advanced life support.

Clockwise from top left: Professor Ross Holland conducting a workshop; Professor Jan Davies, Professor Holland, Professor Alan Merry, Dr Neville Gibbs and Dr David Pickford; more than 350 delegates attended the meeting; morning tea; delegates participating in a workshop; Professor Merry, Dr Greg Knoblanche, Professor Davies.

Centre: Professor Holland and Professor Cliff Hughes.

Progression in Pain Day

The Faculty of Pain Medicine, in conjunction with the Royal Australian College of General Practitioners, hosted a continuing medical education day "Progression in Pain – From Hospital to Home" at the National Wine Centre of Australia, Adelaide, in May. Invited speakers Dr Michael Fredrickson (anaesthetist, Auckland) and Dr Malcolm Dobbin (public health physician, senior medical advisor on alcohol and drugs to Mental Health and Drugs Division, Victorian Department of Health) led the program.

Clockwise from top left: National Wine Centre of Australia, Adelaide; Julie Lanzendorfer from the Royal Adelaide Hospital and Susan Nickolai from the Lyell McEwin Hospital; morning tea; Dr Malcolm Dobbin and Dr Tim Semple.

ANAESTHESIA IN NSW

SPECIAL REPORT: HEALTH REFORM AND ANAESTHESIA DEVELOPMENTS IN NEW SOUTH WALES

In previous editions of the *ANZCA Bulletin* ANZCA interviewed Australian and New Zealand Ministers for Health regarding some of the key issues facing both countries' health systems and, in particular, anaesthetists and pain medicine specialists and the wider profession. In this special series, commencing with New South Wales, we look at some of the developments and challenges occurring in various state and regional jurisdictions. In this issue we look at what is happening in New South Wales post the Garling Report which found major deficiencies in New South Wales' health and hospital system.

NSW PUBLIC HOSPITALS AND ANAESTHESIA POST GARLING

DR JOANNA SUTHERLAND
DIRECTOR, ANAESTHETIC SERVICES, COFFS-CLARENCE NETWORK

BACKGROUND

Vanessa Anderson, aged 16, died in 2005 in a ward of a major New South Wales public hospital, from a closed head injury, having been struck by a golf ball. Following the coronial investigation into Vanessa Anderson's death, the New South Wales government established the "Special Commission of Inquiry into Acute Care in NSW Public Hospitals" led by Peter Garling, SC (the "Garling Commission"). This was certainly not the first wide-ranging inquiry into the practices and paradoxes of care in New South Wales public hospitals, but it appears to be having a far greater impact than any previous investigation.

THE REPORT AND RECOMMENDATIONS

The Garling Report was released in November 2008. It is a massive document, containing 139 recommendations, many of which refer to a subset of other resolutions. Area Health Services, networks and hospitals have been required to demonstrate how they are responding to each of the pertinent recommendations, and this response has been subject to external audit. For his part, Mr Garling recommended that restructure of delivery of care in NSW should be underpinned by four "pillars":

1. The pre-existing Clinical Excellence Commission (CEC), which aims to build capacity in quality and safety improvements.
2. A newly formed Agency for Clinical Innovation (ACI), which will be clinician led, and drive innovation and reform (recommendation 67).
3. A new Bureau of Health Information (BHI), to provide high quality data around the performance of the health system, and
4. The Clinical Education and Training Institute (CETI).

RESPONSE AND RESTRUCTURE

Response to the Garling Report has been widespread and enthusiastic. Recommendations are wide-ranging and cover areas of micro (albeit much needed) reform such as the mandating of name badges worn by all staff at chest height, and visible posters advertising the responsible "nurse/midwife in charge" for each ward area – to larger scale clinical improvements.

GARLING IMPLEMENTATION AND IMPLICATIONS FOR ANAESTHETISTS

1. Deteriorating Patients (Recommendation 91) and "Between the Flags" Program (BTF) – The BTF program, in order to provide a safety net for the early detection and management of the deteriorating patient predated the Garling Inquiry. The analogy used is the red and yellow flags of Surf Lifesaving Australia. Like the surf lifesavers, hospital staff aim to closely observe patients, and keep them in safe zones "between the flags". Standard criteria were developed, underpinned by a standard chart (Standard Adult General Observation Chart-SAGO chart, colour coded with yellow "at risk", and red "danger" zones), and a state-wide standardised response system promulgated to enable appropriate escalation and rapid response to the deteriorating patient. Widespread team training for nursing and medical staff was also introduced ("DETECT" training-**D**etecting **D**eterioration, **E**valuation, **E**scalation and **C**ommunication in **T**eams). The DETECT program was developed by Sydney anaesthetist/intensivist Associate Professor Theresa Jacques. Many other anaesthetists have led and/or contributed to this training. Most recently the SAGO chart has been adapted for paediatric use. Anaesthetists are required to assess patients on discharge from recovery in line with these charts, and may need to consider the need to modify or "sign off" variances from prescribed limits where appropriate and safe.

2. Handover (Recommendation 56) – Garling identified issues and areas for improvement in handover processes at every level in the New South Wales public hospital system. Many anaesthetists act as JMO supervisors (Directors of Pre-Vocational Education and Training), or are otherwise well placed to observe the function of a

hospital as a whole, and to recognise deficiencies in the system. JMO handover is one area which is undergoing innovation and improvement currently. Anaesthetists are also actively involved in patient handover. For example, the requirement to hand over trauma patients from day to day for non-elective scheduling, handover to ward staff of cases completed or finishing after hours, and appropriate handover of information arising from pre-admission assessment to procedural anaesthetists. These are areas where improvements in our handover procedures could substantially enhance patient safety and improve quality of care.

3. Clinical Supervision
It is well recognised by anaesthetists that there is a nexus between workplace-based training, and workforce activity and contribution. The common thread is clinical supervision. Garling has referred to the need for improvement in the mentoring, training and supervision of junior medical staff, and has made quite specific recommendations around clinical supervision of junior staff undertaking surgery (although not anaesthesia). Included in the recommendations is the requirement that New South Wales Health "define supervision" for all junior medical staff, and also define the "objectives and content of supervision" (recommendation 45).

With its document "Guideline for the Structured Assessment of Trainee Competence Prior to Supervision Beyond Level One" ANZCA has developed precisely the type of resource which Garling has foreshadowed in his recommendations, and which NSW Health is seeking. It is also worth noting that recommendation 33 of the Garling Report suggests that "all clinicians engaged in teaching and/or supervision of post-graduate clinical staff" should complete courses provided by the Institute of Clinical Education and Training. Garling's view appears to be that CETI will be the principle organisation responsible for "training the trainers". It will be interesting to see how CETI incorporates or reflects the role and contribution of the specialist Colleges, including ANZCA.

4. Hand Hygiene
At recommendation 88, Garling describes an "enforcement regime" to promote compliance with hand hygiene. This regime escalates from counselling, through education to disciplinary action for failure to comply with hand hygiene policies. There is no doubt Garling and NSW Health consider compliance with hand hygiene policies to be of the utmost importance in maintaining a safe work environment, in reducing the incidence of hospital acquired infections by patients, and reducing the likelihood of outbreaks of multi-resistant organisms in public (and other) hospitals. The Clinical Excellence Commission is devoting considerable resources currently to the widespread education and counselling of senior doctors (including anaesthetists) throughout NSW regarding hand hygiene, including audits of the compliance of senior doctors with the requirement to appropriately observe the "5 Moments of Hand Hygiene". Anaesthetists should expect to be challenged by these auditors, who may ask us why we are not conforming to the accepted hand hygiene protocols.

5. Clinical records and IT (Recommendation 51)
Garling recommends that within four years (from 2008) NSW Health will complete the current transition to an electronic medical record. For anaesthetists, work has been underway for many years to build a state-wide dataset to enable an electronic pre-admission document including pre-anaesthetic assessment, planning, consent and recommendations. The working party for the development of this document has been led by Sydney anaesthetist, Dr Roger Traill, and is incorporating input from current active users of the system. It is anticipated that the electronic pre-admission assessment document will be rolled out to all NSW hospitals.

6. Rural Recommendations and Training Issues
Recommendation 12 of the Garling Report states that NSW Health should consider "compulsory rural training terms" for junior medical officers beyond early training. He also links training in a rural environment with development of rural workforce, and suggests "formalised structures" to facilitate transition of clinicians between metropolitan and rural environments. ANZCA NSW has given some consideration to this issue and is progressing towards the alignment of rural positions with metropolitan-based training schemes, and mandating rural rotations for all trainees. With this realignment of training positions, a larger number of trainees will be able to complete their training in a timely fashion, with equality of access to sub-specialty modules. Additionally, workforce development will be enhanced in areas of current short supply.

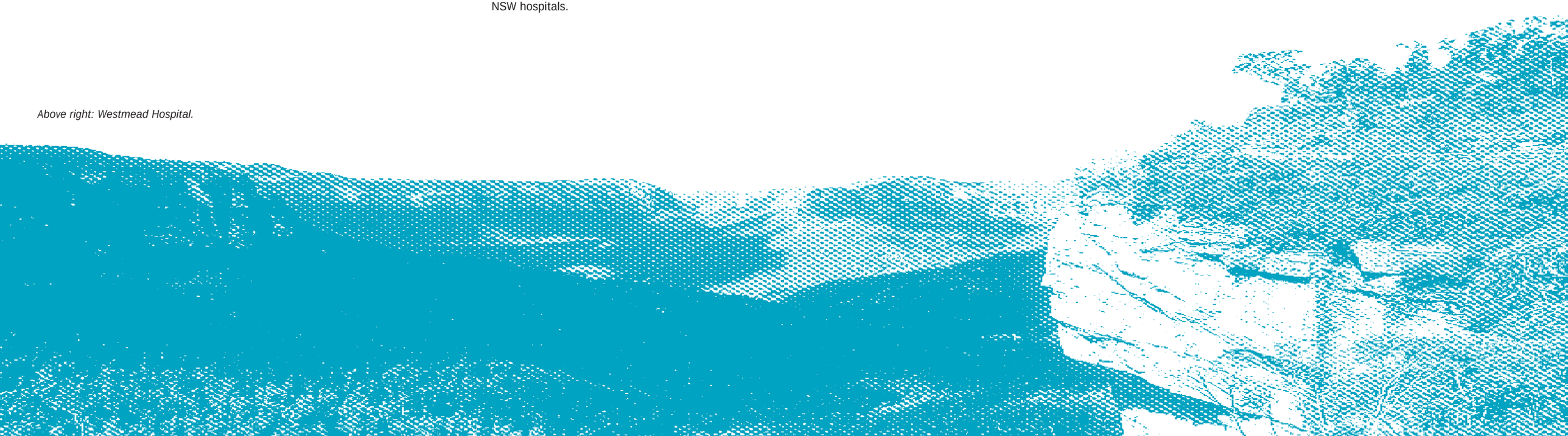
FUTURE DIRECTIONS

One of Garling's four pillars, The Agency for Clinical Innovation, was launched at Westmead Hospital on August 10. The ACI will grow from the work done over the last eight years by the GMCT (Greater Metropolitan Clinical Taskforce). For anaesthetists, the timing of the launch of the ACI is propitious. The most recent clinical network to be developed and incorporated is the "Anaesthetic and Peri-operative Care" Network, co-chaired by Sydney anaesthetist Dr Su-jen Yap. This network will provide interested clinical anaesthetists with the opportunity to lead and contribute to innovative models and systems of care, make recommendations regarding workforce development and training, and providing advice regarding new opportunities for improving patient outcomes. This network has identified key priority areas (see page 15).

Garling's report came at a time of real crisis within NSW public hospitals. Although some of the changes proposed by Garling were already underway or planned there is no doubt that the urgency and exposure generated by Garling has given considerable impetus to the process of reform. Increased resourcing could potentially accelerate this reform process. There is currently a significant amount of activity addressing Garling's many recommendations, and in many hospitals a sense that alongside clinical change and improvement will come the real cultural change that is so desperately needed at all levels within the hospital system in New South Wales.

"Garling identified issues and areas for improvement in handover processes at every level in the New South Wales public hospital system. Many anaesthetists act as JMO supervisors (Directors of Pre-Vocational Education and Training), or are otherwise well placed to observe the function of a hospital as a whole, and to recognise deficiencies in the system."

Above right: Westmead Hospital.



THE NSW AGENCY OF CLINICAL INNOVATION – AN ANAESTHESIA PERIOPERATIVE CARE NETWORK

DR MICHAEL AMOS
IMMEDIATE PAST CHAIRMAN,
NSW REGIONAL COMMITTEE

The New South Wales Agency for Clinical Innovation (ACI) was established by the NSW Government in January 2010 as a board-governed statutory health corporation, in direct response to the Final Report of the Special Commission of Inquiry into Acute Care in NSW Public Hospitals by Peter Garling SC.

Building on the valuable work carried out by the Greater Metropolitan Clinical Taskforce (GMCT) and its predecessors over the past nine years, the ACI uses the expertise of its clinical networks to collaborate with doctors, nurses, allied health professionals and consumers to develop evidence-based standards or "models of care" for the treatment of patients. It supports NSW Area Health Services and other public health organisations – including the soon to be established Local Hospital Networks (LHNs) – to implement these standards across the public health system in NSW. The ACI reports to both the NSW Minister for Health and the Director-General of NSW Health.

The newest clinical network to be formed under the ACI umbrella is the Anaesthesia Perioperative Care Network. It is comprised of anaesthetists, perioperative nurses, anaesthesia technicians, other medical, nursing and allied health professionals with an interest and consumers from hospitals and local communities from across New South Wales.

The Anaesthesia Perioperative Care Network is one of 23 ACI clinical networks that was established to recommend improvements to anaesthesia and perioperative services in NSW public hospitals.

Dr Su-Jen Yap, a staff specialist anaesthetist at Prince of Wales Hospital and Sydney Children's Hospital, is the medical Co-Chair of the Network and will be supported by an Executive Committee which includes seven other anaesthetists (Dr Michael Amos, Dr Jo Sutherland, Dr Tracey Tay, Dr Roger Traill, Dr Ross Kerridge, Dr David Scott and Dr Scott Finlay), consumers, nursing and allied health professionals and managers from the ACI. The aims of the network are to:

- establish a network including doctors, nurses and allied health professionals from across NSW Area Health Services and consumers from the NSW community that is best placed to represent a consensus view for service planning and development for anaesthesia and perioperative services. This network will include consumer participation and incorporate consumer input in all functions of the network;
- address equity of access and outcome issues and determine priority areas for anaesthesia and perioperative services across NSW;
- develop and promulgate evidence based or consensus driven models of care to address priority areas;
- be the peak source of advice on clinical matters relating to anaesthesia and perioperative care services to the NSW Department of Health and other NSW Health organisations; and
- ensure the network and any subcommittee/working groups have measurable and documented outcomes which will facilitate better patient outcomes.

Areas for Review by Network
The Anaesthesia Perioperative Care Network Executive will initially focus on the following areas:

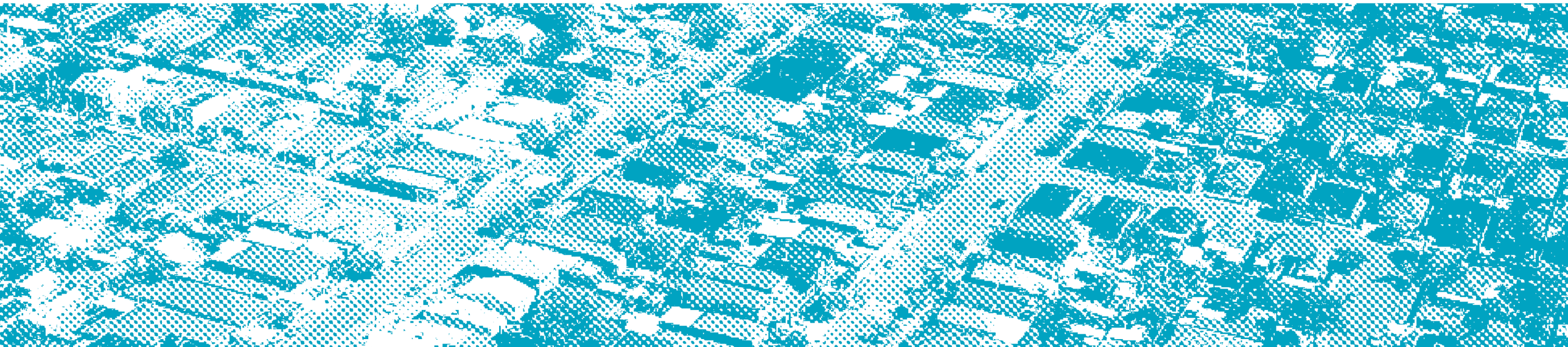
- Safe sedation practices.
- Assistants to anaesthetists.
- Perioperative care – shared guidelines for the management of patients' intercurrent medical conditions.
- Perioperative systems – perioperative units and other emerging models of care (day-only, extended day-only, day of surgery admissions), pre-admission clinics, acute pain management, recovery room care and high dependency units.
- Rural and remote anaesthesia and perioperative care.
- Metropolitan non-tertiary referral hospital anaesthesia and perioperative care.
- Paediatric anaesthesia and perioperative care.
- Anaesthesia perioperative care outcomes.
- Indigenous and diversity health.
- Consumer priorities.
- Education.
- Information systems.

The Executive has now met three times, including a meeting hosted by Dr Scott Finlay in Moree. This is an exciting project for our specialty as it utilises multi-disciplinary consultation and discussion to facilitate improved outcomes for our patients. It allows a clinician's voice into the planning of anaesthetic services and should allow anaesthetic issues to be more effectively communicated to government.

It also enables communication to other health groups about the expanded roles anaesthetists are taking outside the operating room. Finally, it is a wonderful opportunity to raise the profile of anaesthesia as a specialty in a forum side by side with all other areas of medicine.

"It allows a clinician's voice into the planning of anaesthetic services and should allow anaesthetic issues to be more effectively communicated to government."

Above from left: Concord Repatriation General Hospital; Nepean Hospital.



CONTINUING MEDICAL EDUCATION

ASSOCIATE PROFESSOR
LEONIE WATTERSON
CHAIR, NSW ANAESTHESIA CONTINUING EDUCATION COMMITTEE

Continuing professional development within New South Wales is overseen by the NSW Anaesthesia Continuing Education Committee (NSWACE). Jointly hosted by the NSW ANZCA Regional Committee and NSW Section of the Australian Society of Anaesthetists and administered by the NSW Regional Committee secretariat, the committee comprises 12 volunteer specialist anaesthetists from a range of metropolitan and regional hospitals within NSW.

The main aim of the NSWACE is to support CME activities for anaesthetists. To this end, every year the committee convenes two seminars: a one day Winter meeting held at the Hilton Hotel in Sydney, and a weekend meeting held in a regional centre in late Spring. After some experimentation we have settled on a model of delivery for these events which includes, along with lectures, a large component of concurrent small group interactive sessions, either "group learning" sessions for up to 30 people or workshops providing a facilitator: participant ratio of 6-8:1.

We have conducted detailed post seminar appraisals for many years and this approach appears to provide the optimal mix of learning formats that is able to be delivered to large numbers of delegates. ACE also coordinates the anatomy workshop, held annually at the University of Sydney and convened by anaesthetists Joe McGuinness and Liz O'Hare, along with a team of long serving anaesthetists with special expertise in this area. While our seminars have always been popular with specialist anaesthetists we have witnessed an increase in attendance over the last two years, possibly coinciding with the new ANZCA CPD program.

This year's Winter meeting held on August 14 entitled "Death under Anaesthesia – 50 years of the Special Committee Investigating Deaths Under Anaesthesia" focused on anaesthesia mortality reporting to coincide with the "golden jubilee" of the SCIDUA, which undertakes peer review of all deaths occurring within 24 hours of anaesthesia or sedation. Data obtained by SCIDUA has substantially contributed to mortality reporting internationally. The level of interest in this meeting (350 delegates) is a testament to the commitment anaesthetists have for patient safety.

Upcoming events include NSWACE's summer regional meeting entitled "Future Directions in Anaesthesia – where to next?", which is scheduled to be held in Port Macquarie on the weekend of November 20-21, 2010.

Ongoing challenges we face include attracting ANZCA trainees; improving access and relevance for regional anaesthetists; and scheduling CME activities to suit the variable schedules of metropolitan anaesthetists, particularly those working in the private sector.

This year we conducted a survey of CME preferences, the results of which have encouraged us to pilot a series of evening CME meetings. The first of these was held in May to coincide with a regional visit by Professor Talmage Egan, a keynote speaker at the 2010 ANZCA Annual Scientific Meeting. Held over two nights and venues (Westmead Hospital and Royal North Shore Hospital), Professor Egan and local anaesthetists Adam Rehak and Paul Sinclair delivered a series of talks and workshops on the theme in pharmaceutics and total Intravenous anaesthesia. We plan to run at least one of this style of meeting every year, probably in the Sydney CBD.

Providing access and relevant CME for regional anaesthetists has been another goal in recent years. This is beginning to pay dividends in the form of successful meetings at welcoming leisure-focused venues; a better understanding of issues for anaesthesia in regional centres and improved access to CPD for regional anaesthetists. We have a way to go and a number of challenges remain. For instance, we have not yet identified a means of using IT to reduce the need to travel. Podcasting is expensive and does not provide the level of interaction that anaesthetists seek.

Attracting trainees to the CME meetings is also a challenge that we have partly addressed by offering discount rates and encouraging participation as workshop facilitators. We continue to work on this.

"We have witnessed an increase in attendance over the last two years, possibly coinciding with the new ANZCA CPD program."

REGIONAL AND RURAL SERVICES

DR SCOTT FINLAY
GP ANAESTHETIST/VMO
MOREE, NORTHWEST NSW

It seems all aspects of the health workforce are under great stress. This is particularly the case in rural areas where the objective of equitable access to medical services is becoming an increasingly distant ideal. While metropolitan and regional health services are driven by a specialist model of care, rural and remote medical services are led by rural generalist doctors. The terms regional, rural and remote are not clearly defined and are often used interchangeably. Health service delivery in each of these settings is often poorly understood unless one has had direct experience. The term "country GP" is familiar to many, but it fails to describe the range of work undertaken in rural hospitals that typically includes inpatient hospital care and emergency department services. In so-called "procedural towns", medical staff have further skills in obstetrics, anaesthetics and surgery and work alongside nursing staff with broad skills.

Anaesthetists bring an invaluable skill set to any health service. On many levels they are the under-recognised custodians of patient care for many aspects of a patient's journey through both elective and emergent paths. Similarly the GP anaesthetist brings an important skill set to the town in which they work and in addition to elective anaesthetics they have an important role in response to the critically ill patient. They are often required to extrapolate their knowledge to the sick neonate or child, obstetric crisis, trauma patients and other areas where a rapid, structured response is needed. In many acute situations there is often no time or capacity to transfer patients and at times even worse, a lack of personal resources or willingness from the patient to take part in their own risk management. Again, a generalist workforce must be available and appropriately skilled to escalate care in that setting.

The trend to more highly specialised medicine and skill sets has seen a loss of the generalist in many aspects of medical training and practice. This is most obvious in regional and rural areas. The proportion of rural practitioners providing procedural services in NSW has fallen from 21 per cent in 2003 to 15 per cent in 2008. GP anaesthetists providing general anaesthetic services in rural NSW fell by over 10 per cent in the same period.[1] There is clear evidence of further declines since 2008 with several services under great stress, on frequent by-pass or already closed, a trend seen across the state.

Increased medical school graduating numbers will not provide a solution to rural doctor numbers unless a clear-cut training and career path is visible and supported by all levels of the health service. A culture that values the role of the generalist in health care should be possible, in parallel with one that supports a more specialised path. There is a desperate need to generate a training and career path for the rural generalist, in both medicine and nursing, that develops an appropriate workforce to take on the varied work of the rural setting.

Good health services are fundamental to the ongoing success of any economic sector and the rural sector is no exception. The country is also home for much of Australia's Aboriginal community with their vulnerable health status. Rural hospitals are the principal, and often the sole health provider for the bulk of this population. It is self evident that loss of such services has a profound impact on the communities they serve and no account of the cost shift to patients is taken into account when rural services are closed or downgraded.

A positive step, with considerable potential has been the development of the NSW Agency for Clinical Innovation, which evolved out of the recommendations from Commissioner Peter Garling's review of Acute Care services in NSW. As a member of the newly developed Anaesthesia and Perioperative network I have joined a very skilled and committed group. While only in its early stages there are already good signs of progress. A contingent visited Moree in May this year allowing them to see firsthand some of the difficulties of service delivery in a rural setting.

The relationship developed with anaesthetists within our region has already created benefits. Access to good quality education is always difficult for rural staff. A commitment from Hunter New England Area Health to bring their anaesthetic simulator team and equipment 500km to Moree and deliver world class simulator training to teams of medical and nursing staff is a prime example. The education will be delivered in the region, recognising that many small rural services don't have the backup to allow staff to travel away for education. Bringing clinicians out of their silos to meet face to face and develop further networks is a by-product of this process, an example of innovation by clinicians as the former Commissioner Garling attested to.

There are several other rural objectives for the ACI network in the short-term including a rural perioperative workforce survey for NSW, developing support for a rural generalist training path and further developing the already strong association between GP anaesthetists and ANZCA. Well trained and supported GP anaesthetists can inject hard core medical skills into rural settings that can benefit whole communities.

Reference:
1. NSW Rural Doctors Network, Minimum Data Set Report, 30 November 2009.

"Anaesthetists bring an invaluable skill set to any health service. On many levels they are the under recognised custodians of patient care for many aspects of a patient's journey through both elective and emergent paths. Similarly the GP anaesthetist brings an important skill set to the town in which they work and in addition to elective anaesthetics they have an important role in response to the critically ill patient."

Above from left: Sydney Children's Hospital; Thomas Walker Hospital.

SEDATION PRACTICES IN NEW SOUTH WALES PUBLIC HOSPITALS

DR JOANNA SUTHERLAND
DIRECTOR, ANAESTHETIC SERVICES, COFFS-CLARENCE NETWORK

DR TRACEY TAY
DEPUTY DIRECTOR, DEPARTMENT OF ANAESTHETICS, JOHN HUNTER HOSPITAL AND CLINICAL LEAD INNOVATION SUPPORT, HNE HEALTH

A previous article in the *ANZCA Bulletin* (September 2009) referred to the ramifications of ANZCA Professional Document PS9, and the implications for training, support and governance of non-anaesthetists who administer sedation. Professional groups who have co-signed PS9 to date include surgeons (RACS), gastroenterologists (GESA), radiologists (RANZCR), emergency physicians (ACEM) and intensivists (CICM).

BACKGROUND

Members of ANZCA NSW Regional committee, and other ANZCA Fellows, have been involved in training and ongoing in-servicing of non-anaesthetist medical practitioners who have sought advice regarding their sedation practices, and how their practice complies with PS9. As previously published, a pilot course for experienced gastroenterologists was run at the Simulation Centre, John Hunter Hospital, in May 2009. The response from the course participants was overwhelming, and the gastroenterologists involved requested that such a course form part of the core training for gastroenterology trainees. Since the pilot course, other similar training courses have been delivered to experienced gastroenterologists, but lack of funding has precluded any such course for trainees.

RECENT ACTIVITIES

The Regional Committee is aware of many other groups of medical practitioners who routinely administer sedation. One such group is the radiologists. Representatives of ANZCA were invited to address an educational meeting of radiologists, radiographers and radiology nursing staff at Royal Prince Alfred Hospital, Sydney, in March 2010, under the auspices of GMCT (Greater Metropolitan Clinical Taskforce – now incorporated in the Agency for Clinical Innovation). Dr Tracey Tay discussed the background to PS9, and implications for practice. Dr Joanna Sutherland presented the pharmacology of commonly used sedation drugs, and a review of the evidence base covering complications and poor outcomes from sedation in radiology. Dr Greg O'Sullivan discussed the "difficult to sedate" patient. The evening was well attended, with more than 120 registrants. Some concern was expressed regarding the resource implications around full compliance with PS9. There was general agreement that PS9 addresses the concerns of this group, particularly the nursing staff who have felt unsupported regarding sedation decisions and practices in radiology suites for some time.

OTHER GROUPS INVOLVED IN SEDATION PRACTICE

Apart from the specialist groups who have already signed up to PS9 as a conjoint document, there are many other groups who regularly administer sedation. Such groups include dentists, cardiologists, paediatricians and haematologists. ANZCA Council is optimistic that PS9 will be the overarching document to provide a framework around safe sedation practice that will meet the needs of each of these groups. Discussion with these groups is ongoing.

CLINICAL EXCELLENCE COMMISSION REPORT – MIDAZOLAM

In early 2009 the CEC published a focus report on the use of midazolam in NSW public hospitals. This report analysed 915 IIMS reports, of which 377 were considered to be clinical incidents relating to the use of midazolam. The CEC made a number of recommendations, including the recommendation that hospitals should ensure that sedation is covered by an organisational policy, and that overall responsibility for sedation practice is assigned to a senior clinician (e.g., an anaesthetist). It is not known whether this recommendation has been widely implemented.

WHERE TO FROM HERE?

There is no doubt that many non-anaesthetists and health managers remain unenlightened regarding the sedation continuum, and the implications of potentially unsafe sedation practices for adverse patient outcomes. A sedation working party under the auspices of the ACI has recommended to NSW Health that PS9 be implemented as a minimum standard for safe sedation practice throughout NSW. The next step will be to examine the extent to which PS9 is currently being appropriately applied in terms of staffing, patient assessment, monitoring and governance of sedation practice. Anaesthetists view PS9 as a valuable "risk management" tool. It will therefore be necessary to collect high quality data around sedation practices. It will be essential that any such audit be viewed as a means to support clinical practice, and improve patient safety and outcomes.

"There is no doubt that many non-anaesthetists and health managers remain unenlightened regarding the sedation continuum, and the implications of potentially unsafe sedation practices for adverse patient outcomes."

Above from left: Royal North Shore Hospital; Sydney Hospital.

HEALTH REFORM IN NSW

Recently, the New South Wales government issued a discussion paper on implementing the National Health and Hospitals Network, which is an agreement between seven states and territories and the Commonwealth to reform health care. A key feature of the new health system includes the establishment of Local Health Networks to replace eight existing Area Health Services.

- Local Health Networks (LHN) to comprise a single hospital or group of hospitals and other health services that are geographically or functionally linked and increase local decision-making.
- 17 Local Health Networks will be created across NSW.
- The LHNs are Central Coast, Sydney, Nepean Blue Mountains, Northern Sydney, South East Sydney, South West Sydney, Western Sydney, Illawarra, Central West, Far West, Hunter New England, Southern NSW, Mid North Coast, Murrumbidgee, Northern NSW, and Specialist Networks (the Sydney Children's Hospitals Network at Randwick and Westmead) and the Forensic Mental Health Network.
- LHNs will be given decision-making authority and a range of governance and management functions. This will include emergency care, surgery, outpatients, medical services, critical care, anaesthetics and a range of other services.
- Clinical Councils to strengthen clinician involvement will continue. Some clinicians on Clinical Councils may also seek appointment to their local Governing Council.
- Key criteria for establishing LHN boundaries include: the new networks must be built around principal referral or specialist hospitals; metropolitan networks should have coverage of a population of 500,000; networks need to be self-sufficient in a number of services of high level complexity; economies of scale to ensure administrative overheads are not excessive; maintain existing clinical service network; the networks need to cater for growth.
- The State Government will be responsible for system-wide public hospital planning, hospital-wide performance, capital planning and purchasing of hospital services. It will make and amend Service Agreements with LHNs regarding funding.

Source: Health Reform in NSW – A Discussion Paper on Implementing the Federal Government's "A National Health and Hospitals Network for Australia's Future" in NSW, August 2010.

Fellowship survey – next steps

Enhancing engagement of Fellows with the College has been identified as a key strategic priority for ANZCA. Seeking the views of the Fellowship is an important element in achieving that objective. In the June edition of the *ANZCA Bulletin* we published the results of the ANZCA Fellowship survey conducted this year by leading research company ANOP Research Services. ANOP's executive summary, which was reproduced in full, shed light on a number of key areas.

The survey was completed by 50 per cent of Fellows. ANOP notes that this is a strong response that allows valid conclusions to be drawn from the data. It showed that the College is performing well in a number of areas with overall levels of satisfaction by Fellows with the College at high levels. ANOP Research Services, which has more than 30 years experience conducting research for state and federal governments and many leading companies, educational institutions and membership organisations, reported that the survey results represent a strong outcome, with the College performing favourably across a number of areas when compared to comparable organisations.

While the satisfaction ratings are pleasingly high, the results indicate that there is still work to be done to improve the level and quality of services that the College provides to its Fellows. The College Council has reviewed the findings and in this issue of the *ANZCA Bulletin,* we outline the steps the College will take to address the issues identified in the survey.

Key findings of the survey

The Fellows' survey found:

- A high level of satisfaction by Fellows with ANZCA overall (71 per cent satisfaction score).
- Strong usage of many of ANZCA's services indicating the College's relevance and value to the profession.
- A high level of satisfaction with College staff (77 per cent satisfaction score).
- Six in 10 Fellows regard the annual subscription fee as reasonable or at least acceptable.
- The College's most important roles are seen to be quality and safety, professional standards setting, as well as education and training.
- More than half the Fellowship – 55 per cent of respondents – report undertaking pro bono roles and nearly eight in 10 – 78 per cent – are involved in teaching roles.
- Fellows see particular strengths in the College's professional documents, the Annual Scientific Meeting, the library, publications and communications.
- Slightly lower levels of satisfaction were evident in survey responses relating to the College's CPD program, and ANZCA's role as the professional voice of anaesthetists.
- There is a reasonable level of satisfaction among Fellows with the ANZCA website.
- There is scope to improve the ease of access and use of ANZCA's CPD program.
- There was relatively low understanding among Fellows of the roles and responsibilities of officer holders in the College, and low awareness of the ANZCA Foundation, particularly among new Fellows.

Key implications

ANOP has advised that there are a number of implications that arise from the survey:

- ANZCA's core roles are quality and safety standards setting as well as education and training. Fellows are committed to high standards and quality and the maintenance of world-class standards is central to ANZCA's standing and the profession.
- The CPD program needs further fine-tuning and streamlining. While there is a good level of satisfaction with the CPD program, it emerges as one of ANZCA's more important services and its ranking in terms of satisfaction lags behind its importance ranking.
- Publications and communications need to continue to cater for a variety of delivery and content preferences. While there are no major issues with specific publications, the priority is on "important to know" information. The College also needs to cater for differing levels of computer proficiency by making publications available in print and online.
- Fellows see an important role for ANZCA in representing the profession. ANZCA's representations to government and the jurisdictions, and its role as the voice of anaesthetists needs to be enhanced. The professional standing and public profile of anaesthetists' roles and responsibilities needs to be strengthened.
- There is a desire for greater recognition of pro bono contributions by Fellows and for more assistance in carrying out these roles.
- There is a desire for greater speed, responsiveness and further streamlining of College administrative processes.

Next steps

ANZCA's Fellowship Affairs Committee and the College Council have approved a number of actions that will be implemented over six to 12 months. They include:

- A comprehensive review of the navigation of Continuing Professional Development (CPD) on the ANZCA website, as part of a wider website redesign, which will be completed by early 2011.
- A new brochure for the CPD program that will make the program easier for Fellows to understand.
- Expanded coverage of CPD clinical activities and opportunities in the *ANZCA Bulletin* and *ANZCA E-newsletter.*
- Continuing to increase the College's support and training for Fellows who provide teaching to ANZCA trainees, such as the recently introduced ANZCA Teacher Course, which is designed to support supervisors of training, module supervisors and anyone involved in the clinical teaching of ANZCA trainees.
- An improved system to acknowledge, recognise and thank Fellows for their pro bono contributions. This may include listings in the annual report, the *ANZCA Bulletin* and other activities, following consultation with regional committees.
- Development of a campaign to highlight the role of anaesthetists and the importance of the profession. This will include online patient information and other community education online activities, and increased media promotion of anaesthesia and pain medicine.

Fellowship survey – next steps continued

- Comprehensive redesign of the ANZCA website with an emphasis on enhanced functions, navigation and editorial content.
- The development of special new multimedia "mini" sites for Quality and Safety, Continuing Professional Development, Special Interest Groups and the Faculty of Pain Medicine with improved navigation and content.
- Redesign and improvements to ANZCA's New Zealand publications with the appointment in July 2010 of a communications specialist in the New Zealand office.
- Greater focus on government programs and associated funding opportunities, a stronger public advocacy role and improved communication of ANZCA government submissions and representations.
- Clarification and improved communication to Fellows regarding ANZCA's annual subscription fee.
- Improved information setting out more clearly the roles of Council and committees, and outlining how Fellows can participate and engage more fully in College affairs.
- Improved communication for new Fellows about the role and purpose of the Anaesthesia and Pain Medicine Foundation (formerly the ANZCA Foundation) and its fundraising activities.
- Further streamlining of College processes such as the new online in-training assessment process (ITA) and online registration.

The Fellowship survey, which will be repeated on a three-yearly cycle, will serve as an important base by which to measure progress and continuously improve all that we do to meet Fellows' needs. The points above represent some key actions the College will be taking over the short to medium term to address the issues Fellows identified. Updates will be included in future College publications.

The College appreciates the contribution made by the Fellowship in participating in the survey, and is committed to taking the action indicated above to address the issues identified. Feedback about the survey, the results and the steps being taken to address issues identified in the survey is very welcome and can be directed to the Chair of the Fellowship Affairs Committee, **Dr Michelle Mulligan**, at: **communication@anzca.edu.au**; or by writing to the Director of Communications, Nigel Henham, at **nhenham@anzca.edu.au**.

Workforce: Physician Assistants – way of the future?

A pilot program to evaluate the role of Physician Assistants (PAs) is underway in New Zealand, with clear indications that the New Zealand government could well see this sort of role as a way of meeting health service needs in the future. In this edition of the *ANZCA Bulletin* we take a look at what is happening in New Zealand and Australia and the potential implications for healthcare services.

On September 6, two physician assistants recruited from the United States commenced work in the Department of General Surgery at Middlemore Hospital in South Auckland, which comes under the ambit of the Counties Manukau District Health Board (CMDHB).

The CMDHB is running the pilot on behalf of New Zealand's four Northern Region District Health Boards (DHBs) – Northland, Auckland and Waitemata as well as Counties Manukau. This pilot is the first step of a wider regional pilot of the PA role. Once it is up and running, consideration will be given to pilots in other DHBs and other specialties in the Northern Region.

The overall project is a joint initiative between Health Workforce New Zealand (HWNZ), which has provided the funding, the four DHBs and the University of Auckland's Faculty of Medical and Health Sciences.

HWNZ is responsible for leading and coordinating the planning and development of New Zealand's health and disability workforce. Although housed within the Ministry of Health, it reports directly to the Minister of Health, advising on health workforce developments, and, as the provider of funding for clinical training, it wields considerable power. Its aim is to provide a single, coordinated response to improving New Zealand's ability to train, recruit and retain the health workforce.

The Chair of its Board and former Head of the School of Medicine at Auckland University, Professor Des Gorman, has had several discussions with ANZCA this year, both directly and in the College's capacity as a constituent of the Council of Medical Colleges of New Zealand (CMC). His comments have made it clear that HWNZ is looking keenly at alternative staffing options for meeting an expected massive increase in demand for health services coupled with health workforce shortages.

At the July meeting of ANZCA's New Zealand National Committee (NZNC) Professor Gorman said that with health workforce demand expected to double in 10 years, retaining the status quo for models of service and care was not an option. Current spending on health was tracking more than three to four times faster than GDP and was not sustainable.

Government objectives

New Zealand's Minister of Health, Tony Ryall, sees the PA role as having the potential to relieve house surgeons of some tasks that do not require a medical degree (see *ANZCA Bulletin*, March 2010, interview with then ANZCA President Dr Leona Wilson).

Briefing documents in relation to the pilot that was announced last December indicate that HWNZ had been liaising with the DHBs in relation to pilots of different models of care and/or different scopes of practice for health workers.

They said that the purpose of this initial first pilot at CMDHB was to determine whether PAs trained under the USA medical model and working under the delegation of a vocationally registered medical practitioner had a role to play in the future of surgery in New Zealand.

The government also hopes that the pilot will provide information that may assist with:

- determining the issues associated with undertaking a pilot of this nature.
- determining whether PAs may have a wider role to play in other medical specialties.
- determining future regulatory requirements, if the PA role is to be established in New Zealand.
- decisions regarding the potential development of a New Zealand-based education program for PAs.

It would also consider if PAs in New Zealand would:

- be safe and satisfactory to patients.
- fulfil a distinctive role that represents a gap in the clinical team.
- improve productivity and quality of service.
- be a cost effective option.

Key sponsors

The executive sponsors for the CMDHB-based pilot are Dr Don Mackie and Sam Bartrum. Dr Mackie, an ANZCA Fellow, is the Chief Medical Officer at CMDHB and Mr Bartrum is the General Manager, Human Resources for both the Counties Manukau and Waitemata District Health Boards. They see the pilot as "a very positive initiative with the potential to directly address what are increasingly real issues in our health workforce".

They have indicated that the Northern Region DHBs see making greater use of mid-level practitioners like PAs as one possible strategy for meeting growing health service demands. They said that the pilot was a direct response to the New Zealand Government's plan to establish 20 more operating theatres for elective surgery, for which a significant number of extra staff would be required.

"Accordingly, there is an urgent need to look at new types of health workers and new configurations of the health workforce for elective surgery.

"Overseas experience suggests that Physician Assistants may be one of the possible new scopes of practice that have the potential to address some of these workforce issues. In the USA, 25 per cent of Physician Assistants work in general surgery and surgery subspecialties."

In relation to the question: *If the pilot was successful, would Physician Assistants replace doctors and nurses?* the FAQ material supplied as part of the background information on the pilot states: "It is becoming clear that current and projected health workforce shortages cannot be addressed simply by training more doctors and nurses. Overseas, Physician Assistants are seen to be operating at a mid-level and are able to fill a distinct, complementary role within the multidisciplinary health team. One of the reasons for undertaking a pilot in New Zealand is to see how the Physician Assistant role might relate to, and fit with, existing health care roles like doctors and nurses."

They see the career of PAs as appealing to people who obtain undergraduate degrees in the biomedical and health sciences and to those who complete undergraduate year one but are not accepted for medicine.

The pilot

The New Zealand pilot involves having two USA-trained PAs work at CMDHB for 12 months in a mid-level role under the delegated authority and supervision of a Senior Medical Officer (SMO) and within the SMO's scope of practice.

The Middlemore PAs are working according to a locally developed scope of practice. Each PA's role is defined further in an individualised practice plan agreed with their supervising surgeons and a Clinical Governance Committee has been established to monitor adherence to the scope of practice, approve practice plans and review supervision reports.

Depending on the PA's experience, their role in the pilot includes:

- completing patient histories and physical examinations;
- assisting in the diagnosis and treatment of illnesses and injuries for which they have received appropriate training;
- developing and implementing a treatment plan as approved by an SMO;
- ordering and interpreting the laboratory tests and X-rays for which they have been trained;
- educating and advising patients;
- taking part in hospital rounds;
- writing patient orders and notes;
- managing the discharge of patients from hospital; and
- assisting RMOs in their routine work.

Evaluation

ANZCA attended a stakeholder briefing and discussion session in Wellington in February and was consulted on a suite of governance documents detailing the requirements to guide the recruitment, employment, supervision and management of the PAs.

ANZCA's response was expressed, along with that of other medical colleges, in a March 4 letter from the Council of Medical Colleges (CMC) to Professor Gorman. That letter noted that all CMC members recognised the need to enhance and support the current limited health workforce in New Zealand and were open to exploring new solutions.

However, for the CMC (and ANZCA) a major concern with introducing a PA role is "the potential flow on effect on the training and clinical experience for our medical students, junior doctors and their teachers – our senior doctors, if some of their current scope is removed". Consequently, the pilot needed to be evaluated rigorously, the CMC said.

"The evaluation should incorporate an analysis of the impact on medical student training, experience and supervision. Patient safety should also be considered in evaluation. This evaluation should be subject to peer review and involve comment from all Colleges," CMC said.

In late June, HWNZ advised that it had been contracted for an independent evaluation of the pilot's set-up and the impact of the PAs within the general surgery team. In her letter, HWNZ Director Brenda Wraight requested input as to what the evaluation should cover.

The NZNC said that for the quantitative evaluation there was a need to clarify the measurements and then have comparisons either with a historic baseline or with a concurrent, comparable and matched service. The NZNC suggested using the latter method as comparisons needed to be appropriate and meaningful.

The NZNC stated that elements such as time, clinical indicators and cost would be the easiest to measure but said the evaluators needed also to look at personality effects and long-term impact.

For instance, the characteristics of a person selected specifically for the trial could have a different effect than would be the case from a more mixed group of personalities coming into the role if it was adopted in New Zealand.

There was also a need to assess the long-term flow-on effect of introducing PAs into the New Zealand workforce, particularly the impact on recruitment and retention of junior doctors and nurses who were most likely to be affected by the change.

Australian experience

The CMDHB pilot is drawing heavily on the knowledge and experience of those involved in the pilot programs run collaboratively in South Australia and Queensland last year. Those one-year pilots saw American trained and registered PAs trialled in a hospital setting in Adelaide and in rural and urban primary health sites in Queensland, allowing the broad potential of PAs to be explored. Although reports about the South Australian and Queensland pilots have been completed, they have not yet been released publicly.

However, Dr Guy Ludbrook, Professor of Anaesthesia at Royal Adelaide Hospital and the University of Adelaide, and one of the instigators of the South Australian pilot, has written about the PA role in anaesthesia – see "Physician Assistants in Perioperative Medicine", in *Australian Anaesthesia 2009* (p111) in which he reports on the use of PAs in perioperative medicine in the South Australian pilot.

He says much remains to be explored before a PA role could be introduced into the Australian medical workforce.

"You need to get people to discuss what has been tried. You need to identify whether there are any shortfalls in the health workforce and what they are and then what role the PA has to play in meeting those needs. Then there are issues around education and governance of a PA profession, and issues about credentialling and registration.

"These are really difficult issues but we should not avoid them – having a robust discussion is really important," Professor Ludbrook says.

With that in mind, Professor Ludbrook has helped arrange a meeting between most of the key players in Australia to enable a comprehensive exploration of the issues which will be held in Adelaide on October 1.

Workforce: Physician Assistants – way of the future?

continued

The meeting will involve clinicians, health administrators, educators and representatives from bodies such as the Australian Health Professionals Regulatory Authority (AHPRA), Health Workforce Australia, the Australian Medical Council and various medical colleges. ANZCA and the Australian Society of Anaesthetists will be represented.

"It is a pretty broad nationally representative group," he says. "The aim is to get a good understanding of some of the opportunities and challenges of that sort of model."

Last year, ANZCA's then President Dr Leona Wilson noted (in a letter responding to a call for input into Victoria's Workforce Redesign project) that the South Australian pilot was demonstrating improved patient care as a result of a Perioperative Anaesthesia Care team, using specialist anaesthetists partnered with a PA. In the letter, she agreed with the pilot instigators that it presented an opportunity to investigate assistant roles to the anaesthetist in both perioperative medicine and health prevention strategies and, if successful, to consider adoption of a model in Australia.

Although the profession does not technically exist yet in Australia and there is no legal framework in any state to allow PAs to register or practise, Queensland is already offering PA training.

The University of Queensland offers a Graduate Certificate in Physician Assistant Studies (one year, part time) and a Master of Physician Assistant Studies (1.5 years, full time), for which the certificate course is a prerequisite. (For details of those courses, see **www.uq.edu.au/study/studyarea.html?area=hlth.**) The first cohort of 17 students is due to graduate in July next year with a second cohort of 19 students also taking the course.

Asked where graduates expected to find employment, the university referred to the Queensland PA trial and said: "Once the trial/report is complete, we will have a better idea of where PAs are going to fit in the health system. So far the trial results are very favourable but we need to wait until the final results are published before we can say with certainty that PAs will be able to work in Queensland."

The spokesperson went on to say that although it was early days for the PA profession in Australia, with details still to be clarified, "we are confident that the Physician Assistant profession will grow, but it will take time."

James Cook University in Townsville is also developing a three-year (two years instructional, one year clinical) PA course, due to commence in February 2012.

The Physician Assistant concept

As described in *Physician Assistants Policy and Practice*[1], the Physician Assistant (PA) concept developed in the United States in the 1960s and remains largely the preserve of that country, though it has extended elsewhere and there are small numbers in practice in Canada, The Netherlands and the UK, with other countries, including Australia, trying out the role.

Under the USA medical model, a PA will typically have an undergraduate qualification in health/health sciences and a postgraduate qualification tailored to the vocation they work within, and a scope of practice delegated to them by a supervising vocationally registered medical practitioner. The authors of *Physician Assistants* liken the development of the PA role to that of nurse midwives working in place of obstetricians.

Originally, the PA was seen very much as providing a solution to a huge new demand for clinical care and a shortage of general practitioners, particularly in small towns and rural areas, as medical graduates headed into post-graduate studies and an increasing number of new specialties.

As well as demand, there was a ready supply of potential PAs as highly experienced medical corpsmen returning from the Vietnam War found they could not utilise the skills they had gained and courses were developed to train them as PAs.

Although initially employed in general family practice, in the 1990s their work expanded into the hospital arena, where PAs have assumed tasks commonly performed by resident physicians because of their skills in clinical assessment, diagnostic acumen, medical and pharmacologic management, and procedural skills, *Physicians Assistants* says. Whereas in 1984, nearly 56 per cent of PAs worked in primary care, now over 57 per cent work in non-primary care.

The authors of *Physicians Assistants* also note "It is no coincidence that the period of rapid growth of employment of PAs, beginning in the early 1980s, closely parallels the time when hospitals were coming under increasing pressure to contain costs."

While the PA house officer salary is approximately twice that of interns and resident doctors, the authors say it is far below that of a fully licensed physician. *Physicians Assistants* states: "Hospitals have found that by adjusting the mix of attending physicians, residents, and PAs, they can reduce overall salary costs for inpatient staffing while preserving adequate levels of medical care." However, they also note that PAs work far fewer hours than resident doctors.

Today, the number of clinically active PAs in the US is more than 75,000 and PA graduates number more than one-quarter the number of physician graduates each year. They are able to practise in every US state. The cost of PA education is approximately one-fifth of physician education, and PAs graduate in 26 months compared with nine years of education and training for doctors, the book's foreword says.

NZ anaesthetists' views

The New Zealand pilot does not directly involve anaesthesia practice, but ANZCA NZ is watching it with interest because of the potential for it to lead to the introduction of the PA role generally.

As mentioned above, the NZNC is open to innovative ways of addressing workforce shortages and to new models of delivering health services. However, it stresses the need to evaluate very carefully just what those needs might be, how they should be addressed and, most particularly, any potential impact on the current workforce, especially the training of junior doctors.

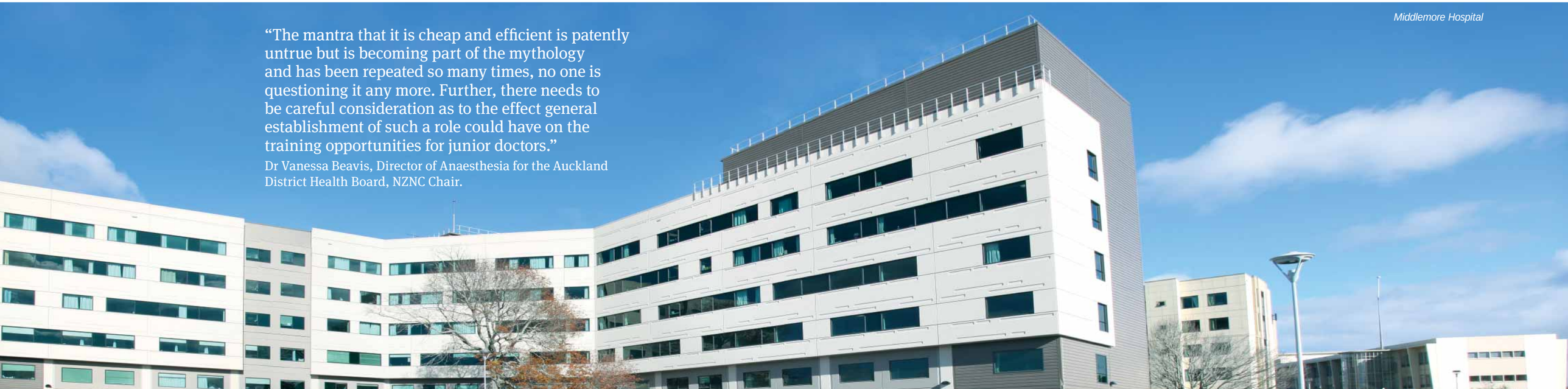
Following her visit to see the pilot program at the Royal Adelaide Hospital in action last year (a visit made in her capacity as Director of Anaesthesia for the Auckland District Health Board), NZNC Chair, Dr Vanessa Beavis, recommended that the concept of introducing PA roles to New Zealand should be advanced or at the very least supported.

She found the PA concept generally well accepted in Adelaide, though there was some resistance from those nursing staff who felt their role was being usurped.

"It seems that the perioperative and post-surgical settings would be an ideal place to employ PAs. The post-operative care of patients is an area which ANZCA has identified as an area of our interest and for expansion of anaesthesia's role in some formalised way," Dr Beavis said.

"Clearly, not every task needs the expertise and skills of a 'FANZCA', so a PA would be the ideal enhancement to the perioperative 'care team'."

Dr Beavis said much consultation would be required, with a process allowing education and dispelling of the abundant mythology that surrounds the role.



"The mantra that it is cheap and efficient is patently untrue but is becoming part of the mythology and has been repeated so many times, no one is questioning it any more. Further, there needs to be careful consideration as to the effect general establishment of such a role could have on the training opportunities for junior doctors."

Dr Vanessa Beavis, Director of Anaesthesia for the Auckland District Health Board, NZNC Chair.

Middlemore Hospital

Workforce: Physician Assistants – way of the future?

continued

Speaking as NZNC Chair, she has said PAs could make a useful contribution to the clinical team, including as anaesthesia assistants.

"The concept does need to be explored – to improve patient care in areas that currently have gaps."

However, ANZCA NZ's chief concern was standards of patient safety and maintenance of a high quality of practice, Dr Beavis says.

She also noted that "the mantra that it is cheap and efficient is patently untrue but is becoming part of the mythology and has been repeated so many times, no one is questioning it any more.

"Further, there needs to be careful consideration as to the effect general establishment of such a role could have on the training opportunities for junior doctors."

Dr Leona Wilson says the key issue for anaesthetists is the standard of care. "The anaesthesia care team has to be led by a fully qualified anaesthetist but, having said that, we are open to innovation in the team, as long as the standard of care is at least maintained and preferably improved.

"It is also very important that any innovation is properly described and evaluated before it becomes gospel," she says.

Responding to a HWNZ request that the NZ Society of Anaesthetists consider how PAs could be used in anaesthesia, a joint NZSA/ANZCA Workforce Committee has been established. Its Co-Chair Dr Andrew Reid, FANZCA, speaking in a personal capacity for the purposes of this article, says the questions that need to be addressed are:

- What are the problems we are trying to solve?
- What solutions are best for the problems identified?
- What tasks do New Zealand anaesthetists consider could be delegated?

Middlemore Hospital

Dr Reid considers there are potential risks associated with introducing allied health professionals such as PAs into the anaesthetist's realm and says that any such move must be made very carefully so as not to create resistance among the existing workforce.

He also has reservations as to how much PAs could alleviate the workforce shortages in health, considering that they, like other medical specialists, will ultimately be attracted away by much higher remuneration overseas.

He says there is an urgent need to debate the topic of healthcare workforce composition and sustainability in New Zealand – citing the factors of the loss of personnel to Australia, the ageing population/reducing workforce demographics and the New Zealand Government's aim of getting more output from the workforce with a particular focus on elective surgery.

HWNZ has discussed these staffing issues with various clinical groups, including anaesthesia, and has suggested that PAs might be a solution. Dr Reid says the NZSA/ANZCA joint working group is understandably cautious on the matter as this would represent a significant departure from current practice.

He believes widespread consultation with the anaesthesia community and debate is needed now to establish the best way forward.

"The joint working group is hoping to commence a national roadshow on this matter shortly with a view to getting an interim report on the matter written by Christmas. It is hoped that engagement with the workforce will give the matter energy and the attention that it needs to solve the challenging problem in front of us."

Referring to the pilot at Middlemore, Dr Reid says: "We will watch with interest as to any insights that can be gained."

This article was researched and written by ANZCA New Zealand Communications Manager, Susan Ewart, who interviewed a number of clinicians and government personnel.

References

1. *Physician Assistants Policy and Practice*, Third Edition; Roderick S Hooker, James F Cawley and David P Asprey; F A Davis Company, Philadelphia, 2010.

Still at the top of her game

One of Melbourne's first cardiac anaesthetists, Dr Margaret Griggs is a good example of a senior specialist still leading the way. Clea Hincks spoke to her.

Dr Margaret Griggs is somewhat of an institution at Royal Melbourne Hospital where she was a pioneer in cardiac anaesthesia and helped establish the cardiac anaesthetic service.

Aside from three years' in London, some private work at hospitals including Epworth, Melbourne Private, St Vincent's Private and a stint at Royal Victorian Eye and Ear Hospital, the Royal Melbourne Hospital has been the mainstay of the experienced anaesthetist's life.

She studied medicine at the nearby University of Melbourne, graduating in 1970. She was a resident at Royal Melbourne and in second year did three months of anaesthesia. Enjoying this so much, she became an anaesthetic registrar at the Royal Melbourne under Dr Russell Cole, "a great supporter of the Royal Melbourne Hospital, anaesthesia and myself".

Dr Griggs finished her Fellowship in 1976 and went overseas until 1980 with her husband, Rodney Judson, a surgeon who is now the head of trauma at the Royal Melbourne.

Dr Griggs worked as a locum in London at St George's Hospital, which had just appointed a new cardiac surgeon, Dr John Parker, with whom she worked in the public and private health system for three days a week for two years.

And so began a long-held interest in cardiac anaesthesia that continued on her return to the Royal Melbourne in 1980 where she worked with surgeons George Westlake and then Jim Tatoulis.

"I have been lucky – I have had good surgeons who I have worked with and it's very easy to be part of a good team if everyone around you is good. I think it makes you improve your own skills and be at the top of your game and get the best results for everyone," Dr Griggs said.

She also enjoys her teaching role at the hospital. "I enjoy having registrars with me – they keep me on my toes when they ask questions and I have to justify why we do the things we do. It keeps everyone honest."

In 1982, Dr Griggs did the first cardiac anaesthetic at Epworth Private Hospital.

"That was amazing because they had never done hearts at the hospital," Dr Griggs said. "We had a trial run a week beforehand – even to the extent of having a surgical registrar as the patient. It was lucky we did – we found we had no defibrillator paddles!"

The first procedure – a coronary artery bypass – was fairly straightforward and successful.

Later on in the 1990s, echocardiography became popular as another monitoring device for cardiac anaesthesia and Dr Griggs recognised the importance of upgrading her skills in this area, travelling to Baltimore in the US to gain initial echo knowledge. Later she began studying at Melbourne University for her postgraduate diploma in perioperative and critical care echocardiography, which she completed at the end of 2006.

"It has kept me up to date with the latest trends and we now use ultrasound for placing many of our lines in patients," she said.

Royal Melbourne colleague and ANZCA President, Professor Kate Leslie, said the examination had been tough.

"Margaret is greatly admired by anaesthetists and surgeons in Melbourne and maintains a very high level of practice and skill," Professor Leslie said. "She's a great example of a senior anaesthetist still at the top of her game."

For many years Dr Griggs has been on the Victorian Consultative Council on Anaesthetic Mortality and Morbidity which looks at all deaths due to or under anaesthesia. She sees this as playing a vital role in assisting learning processes and preventing deaths or adverse events in future.

When Dr Griggs started her career in anaesthesia, there were few female anaesthetists working but it was a career that suited her.

"I think I like the procedural part of it. It's technical and also it had a lot of clinical work and physiology," she said.

Dr Griggs said she had been lucky to land the St George's job soon after the hospital had appointed its first female consultant anaesthetist who married and moved to the US a month later. "See, you can't trust females" had been the annoyed reaction but when Dr Griggs left two years later, they appointed another female in a permanent position.

"I don't think I have had to work any harder or have been discriminated against – I don't think it is too difficult to be female and do anaesthetics," she said.

"Specialising in surgery is probably more difficult in that it is so structured and so intense that it would be hard to have a family and give your all to surgery. With anaesthesia you can do a session and go home and be with your family."

Indeed, Dr Griggs is a good example of a woman who has forged a strong career in anaesthesia and still has a life beyond the walls of a hospital. She and Professor Judson have a 25-year-old daughter, Elizabeth (who is also a doctor planning to specialise in radiology) and she and her husband enjoyed hunting with hounds (they brought a horse back from England) for many years and are both keen skiers.

She said she had never seen herself as a role model. "But it is nice when female anaesthetists say 'you're one of the reasons I did it because I can see that you maintain some kind of reasonable lifestyle'," Dr Griggs said.

Dr Griggs had several strong female mentors in the early years at the Royal Melbourne including Dr Patricia Mackay (who eventually became the head of anaesthesia at the Royal Melbourne) and Dr Nancye Edwards.

"When I had my child, Dr Mackay was very supportive and insisted I return," Dr Griggs said. "I was wondering when would be a good time to come back and Dr Mackay rang after six months."

At 63, Dr Griggs said she was slowing down a little now and felt she would probably retire within the next two to three years.

"You need to do a certain number of cardiac anaesthesias otherwise you really wouldn't maintain your expertise," she said. "It's like a footballer – you're better to go out when you're at your peak and not be asked to leave."

Dr Griggs said she would be leaving the specialty in a healthy state.

"Anaesthesia is now held in higher esteem than it has been by the community and the doctors coming through the Royal Melbourne are probably better trained than I was - so I will be leaving it a better place."

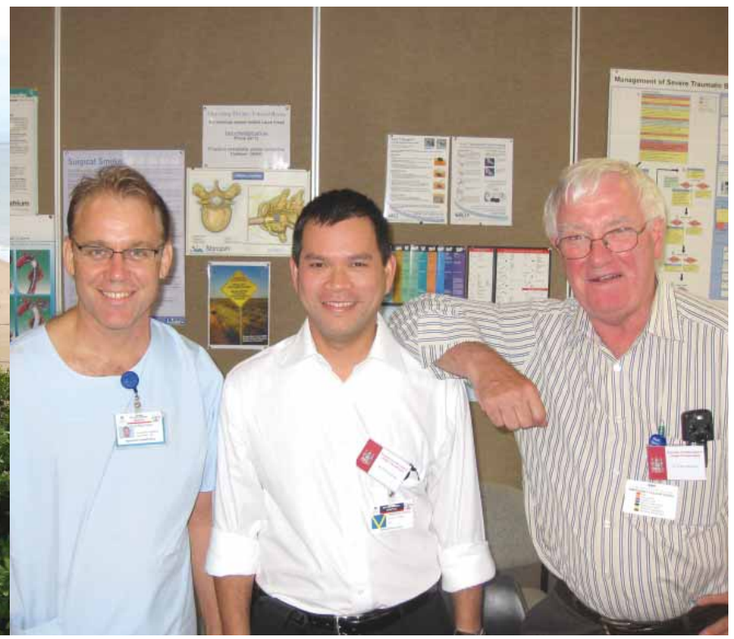
"Margaret is greatly admired by anaesthetists and surgeons in Melbourne and maintains a very high level of practice and skill. She's a great example of a senior anaesthetist still at the top of her game."

Professor Kate Leslie, ANZCA President.

Opposite page: Dr Margaret Griggs with a patient and (above) in theatre at the Royal Melbourne Hospital.

Satellite accreditation of Gove and Katherine hospitals

By Professor Kate Leslie, Training Accreditation Committee



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

Recently, the Training Accreditation Committee introduced "satellite accreditation" for training sites that provide sub-specialty experience for module completion or a broader range of training opportunities (such as sub-specialty, rural or remote, or private hospitals). Trainees may be rotated to these sites on a list-by-list or other limited basis. Supervision is usually one-on-one but may be remote in special circumstances. The satellite relies on the parent hospital to fulfil many of the requirements of an approved training department (such as educational programs and formal supervision of training functions). In essence, the satellite may be considered as a distant set of anaesthesia locations of the parent hospital. Time spent at the satellite counts as part of the maximum time in clinical anaesthesia that may be spent at the parent hospital.

The Department of Health and Families of the Northern Territory Government funds five hospitals (Royal Darwin Hospital, Katherine District Hospital, Tennant Creek Hospital, Alice Springs Hospital and Gove District Hospital). In their recent routine inspection of the Royal Darwin Hospital, Professor Kate Leslie, Dr Frank Moloney and Dr Thien LeCong were invited to visit the Gove District and Katherine District Hospitals with a view to satellite accreditation.

The Gove District Hospital is located in the town of Nhulunbuy and serves the East Arnhem region. Nhulunbuy is 1000 kilometres east of Darwin on the Gulf of Carpentaria and is accessed via commercial flights from Darwin and Cairns, charter aircraft and sea. It is inaccessible by road during the wet season (December to April). The hospital is a 32-bed acute-care facility providing medical, surgical, paediatric, respite and maternity services. There are 15 remote community clinics that refer patients to the hospital, which also provides a district medical officer service to the region.

The Katherine District Hospital is a 60-bed medical, surgical, paediatric and maternity facility. The hospital services the Katherine region and remote areas, covering an area of approximately 340,000 square kilometres between the Western Australian and Queensland borders. The population of the Katherine region is approximately 19,000 with an annual tourist presence of more than 500,000 visitor nights. Katherine is 320 kilometres south of Darwin and is accessible by road and air.

Both Gove District and Katherine District hospitals are staffed by procedural and non-procedural general practitioners, aided by visiting specialists from Darwin and elsewhere. Approximately 50 per cent of the patients at each hospital are children. The Australian Government intervention ("Closing the Gap") has resulted in an increase in procedures among indigenous children at both sites. Specialist anaesthesia services for these lists are provided by the Department of Anaesthesia at the Royal Darwin Hospital and occasionally by visiting groups from John James Foundation in Canberra and Westmead in Sydney.

Dr Brian Spain, Director of Anaesthesia at the Royal Darwin Hospital, says: "We saw the paediatric ENT and dental lists at the Gove District and Katherine District hospitals as a great opportunity for our trainees to complete their paediatric module and also to gain exposure to indigenous healthcare and remote medicine. The trainees will rotate to the satellites in one-week blocks and will be able to log six to eight paediatric sessions during each visit. This will add to the substantial paediatric experience they gain at the Royal Darwin Hospital. The visits also present a great opportunity to liaise with and upskill the GP anaesthetists."

For more information about the South Australian Northern Territory Rotational Anaesthesia Training Scheme (SANTRATS) or the Royal Darwin Hospital, please contact Dr Brian Spain (brian.spain@nt.gov.au). For more information on ANZCA's accreditation processes, please visit the accreditation pages at www.anzca.edu.au/trainees/hospital-accreditation or contact Treena Murphy on +61 3 8517 5325 or tmurphy@anzca.edu.au.

"We saw the paediatric ENT and dental lists at the Gove District and Katherine hospitals as a great opportunity for our trainees to complete their paediatric module and also to gain exposure to indigenous healthcare and remote medicine."

From top left: Beach at Nhulunbuy; Dr Brian Spain (Director of Anaesthesia, Royal Darwin Hospital), Dr Thien LeCong (SANT Regional Committee) and Dr Frank Moloney (ANZCA Councillor) at Royal Darwin Hospital; Gove District Hospital at Nhulunbuy; Dr Frank Moloney flew by light plane to Katherine; Professor Kate Leslie with members of the Nhulunbuy AFL team.

Essential Training for Rural General Practitioners Proposing to Administer Anaesthesia (PS1)

PS1 sets out key objectives of trainee selection, education and training, assessment, accreditation and continuing professional development for rural general practitioners proposing to administer anaesthesia. A revision of PS1 has recently been approved by Council and can be found at www.anzca.edu.au.

ANZCA Council supports the 12-month training program for GPs as outlined in the document and acknowledges that the goal of this program is to provide an anaesthesia service for rural and remote communities in Australia, with surgical services provided by visiting specialists or appropriately trained and experienced GP proceduralists as applicable.

A short history of ANZCA's involvement with GP anaesthetist training may be of interest. The Joint Consultative Committee on Anaesthesia (JCCA) originally consisted of four ANZCA representatives (two of whom were councillors) and two representatives from the Royal Australian College of General Practitioners (RACGP). In 1997, the JCCA expanded to a tripartite committee with the addition of the Australian College of Rural and Remote Medicine (ACRRM). I have been on this executive from the beginning, chairing the committee for the past four years. In 1993, the first trainees supported by the JCCA began a six-month training term at hospitals throughout the country. This soon became a 12-month program, but from the beginning, the JCCA was guided by a curriculum and a MOPS program (Advanced Rural Skills – Curriculum Statement in Anaesthesia and Maintenance of Professional Standards (MOPS) program). These documents are revised every triennium.

There have been highs and lows in the JCCA journey. On the positive side, training and assessment of rural GPs who wish to provide anaesthesia services, supported by post-training continuing professional development, has been provided throughout Australia. This has allowed rural GPs to provide a much-needed anaesthesia service in rural and remote areas. We have accredited non-ANZCA training hospitals to engage in training (for example, Goulburn, Bega and Bathurst in New South Wales), but there are many major hospitals involved as well (for example Darwin, Cairns, Townsville, Lyell McEwin, Joondalup Health Campus and, more recently, the Northern Hospital and Barwon Health).

What are the problems then? The JCCA is a lean operation that relies on the pro-bono contributions of a widely distributed and somewhat fragmented network of trainers and supervisors, and occasionally lack of consistency in teaching and assessments may arise. The JCCA is working to improve networking and consistency and also to ensure that ANZCA and non-ANZCA training hospitals are aligned in their understanding of the goals of JCCA program – that is, to train GPs to provide the anaesthesia services required in rural and remote Australia and not to train GPs to specialist standards.

I have received enquiries from many sources, around "let's have a DA (Diploma of Anaesthesia)". A formal DA may solve some of the assessment inconsistencies of the current system, but it would introduce other questions regarding the cost to the developer of the program (college or university), the cost to the trainees (including for a more centralised exam) and the increased chance that a formal qualification may allow diplomats to move into urban practice rather than into much-needed roles in rural and remote areas. All these factors would need careful consideration.

The JCCA is also asked to consider the credentials of GPs who have been practising anaesthesia in their own practice and who want to do locums that include provision of anaesthesia services. JCCA approval is a jurisdictional requirement. The JCCA requires that these GPs complete a placement in a suitable hospital with a supporting letter from the mentor and success in the JCCA exam. We are often asked to recognise prior learning and do so as appropriate, but insist on workplace-based assessment and the exam.

In summary, ANZCA is proud to be involved in standard setting and training for rural GPs who wish to provide anaesthesia services, but there are many challenges. I believe that the current system delivers a suitably trained and adequately assessed workforce for rural and remote Australia. However, we need to move with the times and I am urging the RACGP and ACCRM to join with ANZCA in exploring more uniform training and assessment, and increased appreciation by city anaesthetists of the realities of medical care in the bush.

Dr Frank Moloney
Chair JCCA
ANZCA Councillor
ANZCA Rural Officer

Profile: Adjunct Professor Martin Culwick

I am Medical Director of the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC). ANZTADC was formed in 2006 and is a joint endeavour of ANZCA, the ASA and the NZSA, to capture, analyse and disseminate information relating to anaesthetic incidents. Prior to my appointment to ANZTADC in November 2007, I had served on the ANZCA "Integrated Approach to Quality and Safety" Taskforce in 2005 and had provided advice to ANZTADC relating to data collection and analysis as an invited guest at two meetings.

In order to capture the information relating to anaesthetic incidents it had been decided to use a web-based system to record the data, which would be provided to members of the Tripartite Group free of charge. During 2008, the specifications for the system were completed as well as ethics approval and also approval for data protection by the Australian and New Zealand governments. The system was built and tested during early 2009 and the first incidents recorded by one of the pilot hospitals in September 2009. Since then, a further 12 hospitals have joined the pilot scheme and 252 incidents have been recorded from 206 cases at the time this article was written. Registration with ANZTADC to use the system is now open to all hospitals in Australia and New Zealand (see accompanying article "The ANZTADC project" on page 39).

My experience in private practice and as a senior specialist at Royal Brisbane and Women's Hospital, has been tremendously helpful in managing the ANZTADC project.

I am currently an Adjunct Professor in the discipline of Information Systems, in the Faculty of Science and Technology, at Queensland University of Technology (QUT) and I am grateful for the assistance we have had with program development from research students at QUT.

Family time is also very important. My wife, my two sons and I enjoy sailing, golf and music together.

I have very much enjoyed working with other members of ANZTADC and the Quality and Safety Committee of ANZCA. I hope that our methods will be effective in bringing demonstrable improvements in quality and safety during anaesthesia and the perioperative period.

Adjunct Professor Martin Culwick
Medical Director of the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC)

Recommended reading

Patient safety: time for a transformational change in medical education – William B. Runciman

MJA Volume 193 Number 1, July 5, 2010

The article concerns the role of junior doctors in initiating and sustaining clinical change and improvement. Runciman argues that in order to support junior doctors in such a role they will need not only an awareness of quality and safety issues, but also the tools to enable them to act as agents for change. In particular, Runciman mentions training in areas such as "graded assertiveness" and "situational awareness".

Dr Joanna Sutherland
Director, Anaesthetic Services, Coffs-Clarence Network

Patient Blood Management Guidelines: an update

A comprehensive review and update of the 2001 Clinical Practice Guidelines for the Use of Blood Components is currently underway steered by the National Health and Medical Research Council (NHMRC), Australia New Zealand Society of Blood Transfusion (ANZSBT) and National Blood Authority (NBA).

The guidelines have a clinical management rather than blood product focus. A series of six modules of evidence based Patient Blood Management Guidelines will be progressively developed: critical bleeding/massive transfusion, perioperative (elective surgery), intensive care, medical, obstetric and paediatric/neonatal populations. Patient blood management optimises the use of donor blood and reduces transfusion associated risk.

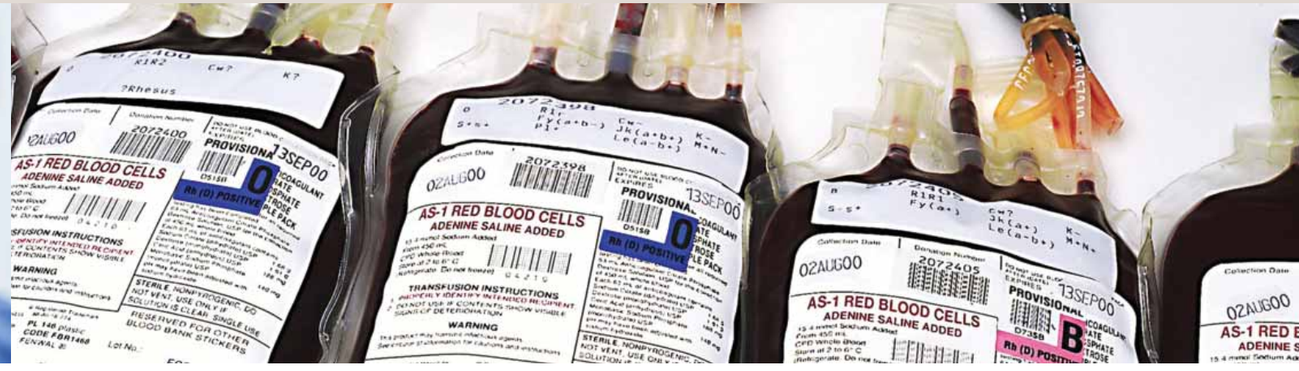
An Expert Working Group, which included representation from clinical colleges and societies, defined the scope of the new guidelines and constructed six generic questions, to be applied to each population. These questions included whether anaemia was an independent risk factor for adverse outcomes, the effect of transfusion of red cells and components, the thresholds at which blood components should be transfused and the use of non transfusion measures to improve haemoglobin. In addition, a number of specific questions for each population will also be addressed.

Using the formulated research protocol, systematic reviews of the relevant literature are being undertaken with the results synthesised to produce a series of evidence statements and evidence-based recommendations to guide clinical practice. In many situations where guidance is necessary, good quality evidence has been found to be lacking. In these situations, practice points, based upon consensus among the Clinical Reference Group members, are being developed. A NHMRC Guidelines Assessment Register expert ensures the systematic review and processes comply with NHMRC standards. A comprehensive communication strategy has been developed to ensure that the clinical community is kept informed and involved in the guideline development and to facilitate dissemination and implementation.

Due to the scope and extent of the work, the development process is necessarily prolonged, having begun in mid-2007. The Critical Bleeding/Massive Transfusion module is pending final approval by the NHMRC, the draft perioperative module is shortly to be released for public consultation and the systematic literature review for the intensive care and medical modules has recently commenced.

Associate Professor Larry McNicol
ANZCA representative on the Expert Working Group for the Patient Blood Management Guidelines Review.

Chairman of the Clinical Reference Group for Critical Bleeding/Massive Transfusion and Perioperative Modules (Phase 1) of the PBM Guidelines Review.



ECRI Safety Alerts

Smiths—Model 3010 and Model 3010a Medfusion Syringe Infusion Pumps: May Overinfuse if Software is Obsolete

Product identifier: Medfusion Syringe Infusion Pumps: (1) Model 3010, (2) Model 3010a *[Capital Equipment]*.

Software Versions: 2.0.2, 2.0.3, 2.0.4.

Manufacturer: Smiths Medical MD Inc [440772], 1265 Grey Fox Rd, St Paul, MN 55112-6967, United States.

Problem: In a June 22, 2010, Urgent Medical Device Correction Notice letter submitted by an ECRI Institute member hospital, Smiths states that if the above pumps are running obsolete software, they may continue to run beyond the set volume limit if all of the following conditions occur:

- The "volume over time" delivery method mode is used.
- The volume over time mode is reaccessed through the "Recall Last Settings" function.
- The syringe is overfilled (for example, the syringe is filled for >1 infusion dose).

Overfilling the syringe can result in overdelivery of infusion, which could lead to patient injury or death depending on the administration route, fluid delivered, and patient condition. Smiths has received no reports of serious patient injury or death related to this problem.

Action needed: Identify and isolate any affected product in your inventory. Determine the software version of affected product by checking the screen display when powering on the pump (refer to the illustration on page 1 of the letter). Regardless of whether you have affected product, complete the confirmation form and return it to Smiths using the information on the form. Upon receipt of the form, Smiths will process an upgrade kit order automatically for any systems running obsolete software indicated on the form. The upgrade kit will contain instructions on how to upgrade the software. After performing the software update, return the completed software upgrade test form on page 5 of the instructions so that your pump service records can be updated. Alternatively, arrange to return your pumps to Smiths for the upgrade.

Draeger—Neonatal Noninvasive Blood Pressure Cuffs: May Produce Artificially High Readings

Product identifier: Neonatal Noninvasive Blood Pressure Cuffs *[Consumable]*.

Sizes: 1 through 5; Part Nos.: MP00901, MP00902, MP00903, MP00904, MP00905.

Units distributed between January 12 and June 12, 2010.

Manufacturer: Draeger Medical AG & Co KG [374044], Moislinger Allee 53-55, Postfach 1339, D-23542 Luebeck, Germany.

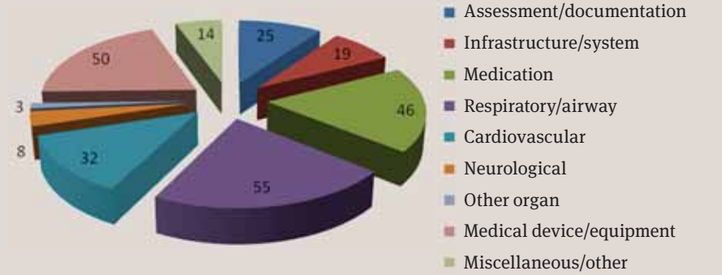
Problem: In a notice letter posted by the UK Medicines and Healthcare Products Regulatory Agency (MHRA), Draeger states that blood pressure measurements taken using the above cuffs may produce artificially high readings. Blood pressure readings generated using these cuffs may be ≤50 per cent higher than the actual blood pressure, potentially resulting in the neonatal patient being given the wrong medication. Draeger states that it has received no reports of patient injury related to this problem.

Action needed: Verify that you have received the June 2010 Important Safety Notice letter from Draeger. Identify, isolate, and discontinue use of any affected product in your inventory. For examples of affected product, see the picture in the Important Safety Notice letter. To arrange for product return and replacement, contact your Draeger local representative.

Professor John Russell
Member of the Quality and Safety Committee's Editorial Advisory Body

The ANZTADC project

The Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) is a joint endeavour and jointly funded by ANZCA, the ASA and the NZSA. This data committee has developed a system for recording anaesthetic incidents that has been in the pilot phase since September 2009. Over the past year, six hospitals in New Zealand and seven hospitals in Australia have joined the pilot phase. The chart (right) shows the way in which the pilot users of the program have coded the main categories. The three highest categories are Medication, Medical Device/Equipment and Respiratory/Airway. These three groups account for approximately 60 per cent of all of the incidents. ANZTADC is currently analysing and confirming this coding. This will involve drilling down to provide further sub categorisation and development of strategies to try to prevent similar events from happening in the future. The confirmed results will be published as a series of articles in future issues of the *ANZCA Bulletin* as well as the ASA and NZSA's publications and newsletters. ANZTADC has also received incidents flagged as "Alerts" during the pilot phase. The purpose of flagging an event as an "Alert" is to indicate a high priority in analysing the incident with a view to publishing alerts to the anaesthetic community. During the pilot phase incidents flagged as alerts have included problems with epidural catheters, epidural solutions, leaking valves on endo-tracheal tubes, leaks from CO^2 sampling tubes in anaesthetic circuits, similarities between ampoules of generic medications, hypoglossal nerve dysfunction following laryngeal mask insertion, electronic failure of anaesthetic machines and bronchospasm following adenosine. If you have personally also experienced similar problems, please forward the details to ANZTADC. If you are already registered, then use the ANZTADC website; if you are not yet registered and would like to send an alert or seek further information, please contact Giselle Collins, Quality and Safety Officer, at ANZCA by email GCollins@anzca.edu.au.



User coding by pilot sites 1/9/09 – 14/7/10

In addition to recording incidents and testing the program, the pilot phase has enabled ANZTADC to refine the process for ethics approval and for obtaining approval from hospitals joining the project. In New Zealand national ethics approval has been obtained, whereas in Australia individual applications have to be made using the ethics template that ANZTADC has developed. The latter process is normally straightforward as quality assurance activities are normally exempt from a full ethics application. ANZTADC will assist with this application if required. In both countries an agreement between ANZTADC and the hospital has to be signed as part of the registration process. These templates are downloadable from the ANZTADC website. If you would like to register your hospital please do so via www.anzca.edu.au/anzca1/structure/committees/anztadc.html or alternatively via the home pages of the ASA or NZSA. The ANZTADC program is provided at no cost to Fellows of ANZCA, members of the ASA or members of the NZSA.

We wish to thank all of the pilot sites for taking part in the ANZTADC project and for the useful feedback provided regarding the pilot version of the program. We are about to undertake a review of the dataset collected and we will release pilot results in the next issue of the *ANZCA Bulletin* as well as the ASA and NZSA's publications and newsletters.

Adjunct Professor Martin Culwick, Medical Director ANZTADC

A leaf out of their book

A personal experience of illness in Japan by Dr Pat Mackay OAM

It all happened in the Japanese city of Niigata, a provincial capital 300km north west of Tokyo. Niigata is on the Sea of Japan coastline of Honshu, the largest of the Japanese islands. The population is more than 800,000, and it serves as a major port, with commercial dependence on fishing and cultivation of rice. Niigata has few tourist attractions and western visitors are few. Little English is spoken and street and bus signs are predominantly in Japanese, all offset (for us at least) by a remarkable helpfulness of the city dwellers to bewildered foreigners.

We arrived at Narita Airport from Australia at about 7pm. In the process of departing the plane I was overtaken by severe breathlessness and could take no more than a few steps at a time. A wheelchair was obtained, enabling me to traverse the airport, negotiate the customs and immigration formalities and board a limousine bus bound for the Tokyo railway station, near where our pre-booked hotel was located. We checked in, still needing a wheelchair. The next morning I was no better.

What was to be done? Because I was quite comfortable when sitting or lying and was unsure of a diagnosis we decided to continue on with our rail travel by the comfortable Shinkansen to Niigata, the planned destination as the site of the conference to which we had been invited, and where we would be reunited with many good Japanese friends. At each sector of the travel a wheelchair was made available, and I settled comfortably into a luxurious hotel room overlooking a superb view of the Sea of Japan. With a deplorable lack of insight I thought I would be better the next day after a good night's rest – little did I realise that I had been skating on very thin ice. By evening the penny had dropped – a pulmonary embolus!

One of our Japanese hosts, alert and visibly alarmed, initiated phone calls to the Niigata University Hospital, after which he advised that we would be proceeding directly to the emergency department. Minutes later, to my surprise, there appeared in the hotel room three ambulance men dressed in fire fighter uniform, but complete with defibrillator, monitors and oxygen. Clearly their main purpose was to provide rapid transport to hospital rather than prolonged resuscitative care at the pick-up site or en route. I was most grateful that they did not attempt, likely to no good purpose, to cannulate my vaso-constricted veins (an unfortunate experience I had once endured in Australia when ambulance officers stopped the ambulance on a highway at midnight in midwinter to have another attempt as they were unwilling to arrive at an emergency department without venous access). On the short and rapid trip to the hospital I was aware of a muted ambulance siren and at first did not appreciate that it was from my own ambulance. Upon my arrival at the emergency department of the Niigata University Hospital I was about to experience from "ground level" Japanese medicine in a good university hospital.

The Niigata University Medical and Dental Hospital is an 11-storey modern teaching hospital with 800 beds that provides inpatient care in all clinical specialities as well as serving approximately 2100 outpatients a day. The medical staff of 842 comprises specialists with clinical and research responsibilities, clinical fellows and resident doctors. The nursing staff number approximately 430.

The emergency admission room was a large, well-equipped procedural area. It was populated with what seemed a veritable army of medical personnel (all very interested in my particular case), but the only identifiable figures to me were the emergency and intensive care unit physicians. Within minutes, intravenous and arterial lines had been inserted, and blood sent for multiple biochemical tests and blood gas analysis. The blood gas and electrolyte results were rapidly available (within 30 minutes) and displayed prominently on large wall monitors. These and the chest X-ray appearances all pointed to a pulmonary embolism. Transthoracic echocardiography was performed by one of the emergency staff and demonstrated severe pulmonary hypertension. Other imaging suggested probable venous thromboses in both lower legs. By now any hopes I had of returning to my comfortable hotel bed had dissipated rapidly – on the contrary, I was informed that I would be admitted to ICU that evening and could expect to be in hospital for at least three weeks!

My arrival in the ICU was an "eye-opener". It seemed so large yet so quiet that my first thought was that I was the only occupant. I soon learnt that this was not the case, but rather that each cubicle was partially separated and for each there was a dedicated nurse with computer at the bedside. All information collected on site was entered and stored electronically and immediately accessible. What was notable was the relative lack of noise apart from an occasional monitor, quite a contrast to the continuous frenetic and noisy activity that seems to characterise ICUs elsewhere. Subsequently I found that a tranquil ambience was likewise a feature of all of the hospital wards and departments of the Niigata University Hospital. On the morning after admission to the ICU, the diagnosis of venous thrombo-embolism was confirmed by further echocardiography by highly trained departmental staff, and a CT technetium lung scan that demonstrated not one but three separate areas of embolisation. Many investigations were performed which I could read off on my monitor, and anti-coagulant treatment was started. I had the feeling that I was in safe hands. The main downside of my stay in the ICU bed was the incredibly hard mattress and pillow, perhaps more bearable to Japanese than Western patients.

After three days in the intensive care unit I was transferred to a busy surgical ward and installed in a private room best described as a mini-suite, comprising a room with a monitored bed, an adjacent comfortable lounge room as a sitting and eating area, a mini-kitchen, cupboards and bathroom. Instead of proceeding to Europe, here I was to remain, following my early rapid improvement, for two weeks before returning to Melbourne. Fortunately my attending cardiologist was English speaking, having just returned from a two-year post-doctoral stay in Manchester, UK. The other medical staff had limited English, but were always attentive and thoughtful. I was even provided with a continuous water heater so that I could have a respite from the lukewarm green tea served at every meal, and with DVDs, as there was not an English channel on the TV in my room and I had long tired of the Japanese sports channels. The nurses were very devoted and cheerful, despite an almost complete lack of English, although they did have a phrase book which was used with much enthusiasm and merriment.

The safety aspects of my care were naturally of great interest to me, and once I was mobile I was able to examine details of the ward-management system as well as the overall facilities for patients and relatives. Each ward had a very large central station equipped with a bank of computers that could accommodate all the nurses and doctors on duty at any one time. All ascertained data and information were entered directly by the nurses at the bedside on a Personal Digital Assistant (PDA) as they performed their routine four-hourly observations. Thus continuous cardiac monitoring, blood pressure, temperature and pulse oximetry were transmitted directly to the central computers from the bedside. Each nurse also had their own mini-pulse oximeter. Results of all blood biochemistry tests, INR and others, were entered into the computer

system within 30 minutes, so that when the physician did his round quite early in the morning all the relevant results were immediately available.

One impressive feature of my many scheduled visits to the investigational departments was the strict adherence and organisation of appointments such that I was collected on time and the test was conducted exactly at the appointed time, with no waiting indefinitely in corridors or holding bays, as I have personally experienced during in-patient sojourns in Melbourne public and private hospitals. The investigational procedures were performed expeditiously, with a prompt relay of all results and scans to the ward computers. Another feature was the electronic management of drugs with bar coding corresponding to the bar code on my wristband, which was reassuring as I could not recognise my own name in Japanese script. In addition, parenteral drugs were double checked by nursing staff. An alarm conveyed to the central ward computer indicated when the syringe pump containing anticoagulant was non-functional.

While I could not deny I received special attention, I could observe that facilities for patients and their relatives in the four-bed wards units provided the same high standard of surveillance and supervision. As for relatives, there was a large pleasant day room where relatives and patients could convene, and it was evident that many of the elderly patients were well supported by their families. To this end, there was a utility room complete with washing and drying machines, stove, microwave, and electric jugs. The bathroom was also comfortably utilitarian, even including a tilting chair and basin to enable a hair shampoo for wheelchair-restricted patients. The hospital also had a shop, restaurant and a library for the use of ambulatory and wheelchair patients.

Of interest, there did not seem to be the same 'demarcation of duties' as in Australian hospitals. Orderlies were employed for trolley transfer, always accompanied by medical and nursing staff; however, as needed, either a nurse or doctor would readily undertake wheelchair transfer of patients to investigational departments. Meal trays were delivered and removed either by the catering or nursing staff, depending on the time of day. It might be thought that the electronic management system could lead to impersonal care, but I found that the nursing staff seemed to have more time for personal interaction, which made it seem more rather than less like the "good old days".

In Japan there is a health insurance system which is practically universal, hospital costs are kept low and I observed the same level of care in the four-bed wards as I experienced in my single-bed suite. The cost of my inpatient care was negotiated between the hospital, but from the figures I did obtain overall costs were comparable if not lower than would arise for similar care in Australia.

Despite my rapid recovery and stability on anticoagulants, my very concerned and conservatively inclined cardiologist was reluctant to allow me to take an early flight back to Australia. Much persuasion was required before he would consider signing the necessary documents to authorise an airline to provide transport back to Melbourne. This included evidence of adequate exercise tolerance, a clear chest X-ray and improvements in pulmonary artery pressure measurements by echocardiography, which he personally performed regularly. Interestingly, news of my plight had reached as far afield as the west coast of the USA, with a viewpoint from an expert intensivist colleague at UC Davis, CA including "notoriously unreliable" results of echocardiography as a measure of pulmonary artery pressure, and citing a state-of-the art article from the *New England Journal of Medicine*.[1] It is clear that transthoracic echocardiography is widely used and accepted in many centres as a non-invasive indication of pulmonary hypertension and understandably I did not fancy more invasive measurement by direct pulmonary artery catheterisation.

The Department of Cardiology wisely insisted that en route oxygen should be available. This required the special transfer of cylinders from Australia to Tokyo and even the provision of a dedicated business-class seat beside me (at some cost) to accommodate "Mr Cylinder" all the way back to Australia!

In the event, transport from the Niigata Hospital to Melbourne by taxi, train and airplane was seamless thanks to the highly efficient Japanese rail system, which made a wheel chair available at every transit from the Niigata station to the Qantas Lounge at Narita airport. Qantas staff were extremely helpful, and the trip was made all the more comfortable by a less than crowded aircraft. Although it was not needed, I felt I had to use some of my expensive oxygen during the night flight in preparation for the transfer to a Melbourne flight at the usually chaotic Sydney airport. So, instead of proceeding with our carefully planned and much-anticipated European sojourn, and to the relief of our family, I arrived back in Melbourne at midday on Mother's Day.

I have experienced personal care in both public and leading private hospitals in Australia, and now in Japan. I am left with the overall impression that the use of sophisticated electronic patient systems in Japan not only contributes to additional safety but improves direct contact of patients with medical and nursing staff, and provides for a pleasing degree of serenity in a busy surgical ward.

I recovered, and in so doing found that we in Australia could well take a leaf or two out of their book in critical and general medical care.

Reference:

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Communication/Liaison Portfolio Manager, ANZCA Quality and Safety Committee

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The Australian and New Zealand Registry of Regional Anaesthesia (AURORA)

By Dr Michael Barrington, St Vincent's Hospital, Melbourne

Australian and New Zealand anaesthetists have a long track record participating in projects that have improved the quality and safety of anaesthesia. The New South Wales Special Committee Investigating Deaths under Anaesthesia,[1] other major long-term safety initiatives,[2,3] the Australian Incident Monitoring Study[4] and the WHO Surgical Safety Checklist[5] are examples.

Recently, the importance of clinical registers as tools for systematically measuring outcomes in anaesthesia have been highlighted.[6-8] Clinical registers monitor and benchmark the quality and safety of routine clinical care and are critical for improving clinical practice. Actively measuring, benchmarking and reporting results can identify problems early, potentially preventing sub-standard care from developing.

The results obtained from clinical registries complement other tools of evidenced-based medicine, such as randomised controlled trials (RCTs), and importantly, clinical registers collect data from routine practice. Data is of such value that some experts have called for a registry for every medical condition.[9] Surgical specialties have long recognised the value of registries and the Society of Thoracic Surgeons National Database[10] and the National Surgical Quality Improvement Project[11] are two examples of successful large clinical registries credited with reducing morbidity and mortality in the United States.

Anaesthetists can also engage in this type of quality improvement process where core data is systematically collected from every eligible patient. In 2010, serious and sentinel adverse events, such as major local anaesthetic toxicity and wrong site anaesthesia, occur infrequently following peripheral nerve blockade (PNB), however these should be reported with valid denominator data and sufficient clinical detail to help prevent their re-occurrence.[12,13] However, it is not just the existence of adverse events that demand a registry of care, but the variability in outcomes including clinical effectiveness that provide the opportunity to improve the quality of care and reduce costs.

Ultrasound (US)-guidance for regional anaesthesia (RA) is a relatively new clinical technique that allows anesthetists to image the needle trajectory, target nerves and surrounding structures; injection of local anaesthetic while adjusting real-time to improve the spread of the injectate.[14,15] In expert hands, US-guided PNB significantly improves outcomes compared to traditional techniques.[15] US-guided PNB has resulted in new clinical techniques being described and performed by an ever-expanding number of enthusiastic novices.

More recently, the US focus has turned back towards the neuraxial and paravertebral regions and it appears that what we can image with US is being tested to the absolute limit.[16]

The diversity of US-guided regional anaesthesia is now substantial, its complexity increasing and although ideal, it is not feasible to perform RCTs to investigate the efficacy (let alone the effectiveness) of every technique and its permutations. US-guided regional anaesthesia is evolving at a rapid pace driven by advances in technology and equipment. For example, 4-D US-guided PNB and virtual reality imaging for US-guided facet joint injections exist.[17] Documenting the incidence of infrequent but serious complications, changes in practice and clinical effectiveness are important for any invasive procedure but especially one that is evolving.

The Australasian Regional Anaesthesia Collaboration has established the foundation for a large clinical registry by designing and implementing a web-based database and performing a prospective audit of over 7000 PNBs.[18] AURORA is its offspring and is a prospective, outcome-based observational (cohort) study with the primary purpose of informing the quality and safety of clinical practice. AURORA has documented trends in regional anaesthesia practice – a reduced proportion of PNB performed using nerve stimulation alone from 24 per cent in 2007 to 12 per cent in 2010, and an increase in PNB performed with ultrasound alone (34 to 53 per cent) during 2007-10 (Figure 1). Figure 2 shows a steady increase in PNB recorded with the total number recorded in 2007 equal to the number recorded in the first half of 2010, while the proportion of lower limb PNB steadily increases. The target study population for AURORA comprises *all* patients receiving PNB for anaesthesia and/or analgesia, performed by all anaesthetists in each site.

AURORA has distinctive features including: 1. Data elements that are clearly defined and collected into an online database close to the point of care facilitating ease and accuracy of data entry; 2. Data collected from individual patients so that risk-adjusted outcomes can be generated; 3. Rigorous postoperative follow-up of all patients using robust neurological follow-up and investigative pathways; 4. Preservation of patient, anaesthetist and hospital anonymity; 5. An "opt-out" consent process that facilitates complete (or near-complete) inclusion of all eligible patients; 6. Processes for data quality-control and project governance and 7. Training of data collectors. As a comprehensive contemporary register of procedures and outcomes AURORA is of value for clinical decision-making and development of practice guidelines.

All anaesthetic groups and practices that perform PNB (regardless of technology used to locate nerves) are invited to contribute to AURORA and continue our local tradition of participating in large quality-improvement projects. Your contributions are important for this project to reach its potential and our patients to gain the benefits. AURORA is generously supported by an ANZCA research grant for three years commencing 2010, therefore now is the time to collaborate. Our research team consists of David Scott, Danny Liu, Michael Barrington, Rowan Thomas, Roman Kluger, Steve Watts, Michael Fredrickson, Darcy Price, Steven Fowler, Martin Culwick and Valerie Tay. The team has significant expertise in clinical research, large outcome studies, biostatistics, data management, epidemiology, information technology and neurology. AURORA provides administrative and clinical support (for example, investigation of a suspected nerve injury), reports, training of data collectors and other assistance to collaborators. Please consider engaging with AURORA in 2010. For further information e-mail **michael.barrington@svhm.org.au**.

Figure 1

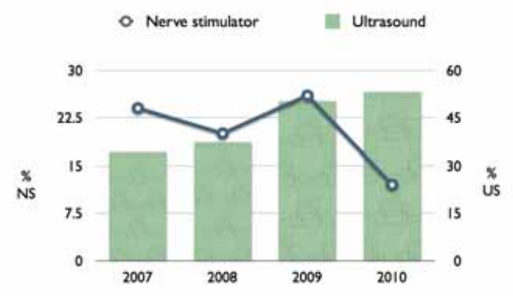
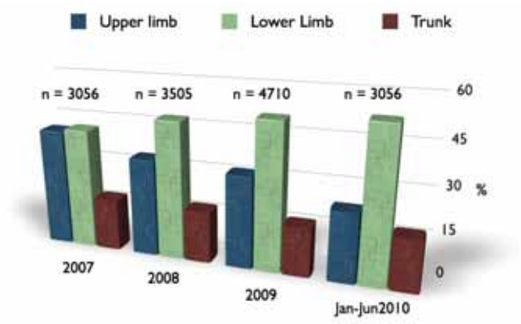


Figure 2



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A life in patient safety: A conversation with Professor Jeff Cooper

PART TWO

Professor Jeffrey B. Cooper, PhD, is the Executive Director of the Center for Medical Simulation in Boston, Professor of Anesthesia at Harvard Medical School and co-founder of the Anesthesia Patient Safety Foundation. Professor Cooper has dedicated his career to improving patient safety and is the author of several seminal works[1,2,3] on anaesthesia safety, his early work catalysing the formation of the Anesthesia Patient Safety Foundation and leading to the development of safety standards for anaesthesia.

This is part two of an interview with Professor Cooper by Dr Cate McIntosh, Director of Simulation at the Hunter New England Skills and Simulation Centre, and Consultant Anaesthetist in the Department of Anaesthesia, Intensive Care and Pain Medicine at John Hunter Hospital in Newcastle. Part one appeared in the June edition of the *ANZCA Bulletin*. In part two, Professor Cooper talks about optimism and the achievements in patient safety made to date, and outlines his thoughts on what needs to be done to improve patient safety.

From top left: Professor Jeff Cooper talking at a meeting; Professor Cooper and his wife Karma Kitaj have a shared passion for horses; Flashback – Professor Jeff Cooper in 1973.

What has it been like being a non-physician in a world of clinicians?

My relationships with physicians have run the full gamut over the years but most of it certainly has been positive. We had great cooperation from the many people who participated in the critical incident studies in the 1970s. My department Chair, Dick Kitz, was incredibly supportive. He deeply appreciated the value of multidisciplinary collaboration and assembled a department of researchers from varied backgrounds in pursuit of the many fundamental issues he sought to explore in anaesthesia. He was visionary and a model of a great leader: Supportive, loyal, appreciative, able to delegate, would back you up when times got tough. He and I are still close; he's been one of the critical forces in shaping my life. And there were many others who gave me wise counsel and collaboration.

Yet there were a few who didn't make it easy. Some of the anaesthesiologists resented what they thought was an intrusion of someone who wasn't a clinician, who didn't take care of patients. They saw me as affecting their lives, of calling for changes in their practices that I didn't have a right to do. Yet I always felt that I was merely facilitating what the leaders or majority wanted. I felt I was mainly asking questions of them and letting them decide what they felt best to do. A few got nasty about it. Despite feeling hurt by some of what felt like attacks, I learned not to ignore them. I wanted to win them over I suppose, something of a challenge, a competition with myself of sorts. And I respected those who were critical. They were generally smart and some of the best clinicians. So I listened to what they were telling me and, although they might never have realised it, I adapted my understanding and positions based on what they were telling me. I tried not to see them as enemies, which they weren't (perhaps there were some exceptions), but primarily as teachers. I suppose because I never saw myself as especially brilliant, I've always been open to learning from just about anybody. I don't start out with a firm position on most new issues. Rather I always look to expand and adjust my thinking based on what others have to teach me. The trick is to be a good listener. I wasn't always like that. Over the years, and especially more recently, I've been honing that skill. I especially like to do it with younger students. They often ask the best questions and bring new knowledge that keeps me on my toes. Deep listening is a learned skill for most of us. I still don't do it instinctively all of the time. I often recognise that I'm not doing it and then remind myself to do it, to just let go of my tendency to jump to conclusions, to problem-solve and instead just to listen. My most recent growth in that came from a workshop I did with Otto Scharmer of the Authentic Leadership Institute based on his "Theory U". I advise you to check it out (http://www.aliainstitute.org/institute/home.html).

Why do you think anaesthetists are more open to things like safety, simulation and teamwork training than other doctors?

The most obvious answer to this question is that anaesthesia is not itself therapeutic. Thus causing harm in the process of care can't be rationalised as easily as in specialties for which curing the disease is the main objective. And, from the time of the first report of an anaesthetic death, it was more obvious that the anaesthetic was the cause (although there are many instances where the anaesthetist is unfairly blamed). Thus anaesthetists had more reason to pay great attention to, and take responsibility for, being the cause of direct harm directly from what they do and were more receptive to doing things to prevent harm. I have no way of testing that theory but it seems to make some sense.

I do think there also was a certain amount of good fortune that led to anaesthesia taking a lead in the modern era of safety. I ascribe that to the leadership of Jeep Pierce. As President of the American Society of Anesthesiologists, he took the risk of stressing safety as the approach to reducing escalating malpractice costs versus the more popular approach of seeking changes to the legal system.

Why do you think incidents stay with, and shape, some people but not everyone? We've all had critical incidents but not everyone stays as focused on achieving change, why do you think that is?

There are two questions embedded here. I think that most clinicians learn a lot from their mistakes. Those mistakes probably shape their practice strongly. The ones who don't learn from those events probably find ways to blame someone else. Perhaps that's a protective defence mechanism, but those are the people I worry about. They don't learn and will repeat the behaviours that created the problems. I certainly have observed such clinicians. They are not the best clinicians and are likely to be the more problematic ones. Fortunately, they are the exception, not the rule.

As for why I pursued the path I did, I'm not really sure. There is no story of how I personally hurt someone or that a family member was injured by an adverse outcome. Those kinds of events often catalyse people to take on a cause. For me, it was more about following a path of curiosity and feeling that I could make a difference somewhere. And, I think I liked the idea of a being a bit different, of doing something that others hadn't done. You might call it a neurosis more than anything else. But, overall, it has seemed to work out for me and others.

What is the one most important thing you've done (or been involved in) that changed clinical practice to improve patient safety?

I can't point to any one thing I've done that is "the" important contribution. The initial work in identifying errors in anaesthesia was probably catalytic in some ways, particularly in getting people to see errors in a different light, that is not to put so much blame on individuals, but also to recognise the need for strategies versus exhortation to do better, as the solution. I have wondered if this wouldn't have happened anyway. We can't do that experiment. But, I suspect that by illuminating the issue in this way may have at least catalysed formation of the Anesthesia Patient Safety Foundation (www.apsf.org), which I am most proud of. For 25 years now, the APSF has maintained a single-minded devotion to preventing harm from anaesthesia. I think it's made a difference but I can't quantify it. The organisation itself is remarkable in that the culture of its executive committee, which does almost all of the direct work of the foundation, despite having turned over completely from the start (except for me), continues to be an exceptionally dedicated team that works well together, exceptionally well. We argue, but almost always reach consensus. And, we have fun together. It's just a great team.

What is the thing you are most proud of?

I'm also proud of what's happened with simulation and also the team we have at the Center for Medical Simulation in Boston. Watching the field mature has been incredibly satisfying. While I didn't invent the idea, I feel I had a role in helping to get it started off toward the tipping point, which I'm fairly certain it has now surpassed.

How has the patient safety movement changed with the times?

I'd say there were several waves of the movement so far but it depends on what you call patient safety. Those involved in infection control might think they were the first patient safety advocates and it just wasn't called that. Regulators, like the US Joint Commission, were involved in promoting safe care years before the term patient safety was used to describe

what they do. The Emergency Care Research Institute (now ECRI Institute) began addressing equipment safety issues in 1968. Yet, we in anaesthesia like to say that the movement started there. If you believe that, then I'd say that the early years in anaesthesia, started with the founding of the APSF in 1985. I like to think that the studies we did in the 1970s and published in 1978, 1982 and 1984 had something to do with catalysing that, as did the international meeting on anaesthesia mortality and morbidity that we organised in 1984 in Boston.

In the early years of anaesthesia patient safety (I'm not including the earlier actions in the 60s that involved things like the system for preventing switching oxygen and nitrous oxide cylinders or shutting off nitrous oxide when the oxygen ran out), there was emphasis on technology, especially pulse oximetry and then capnometry. But, I think that as much impact came just from surfacing the issue and putting it into the consciousness of anaesthesia professionals. There were a host of contributions to the improvements in safety.

In the larger world of patient safety, I think most would feel that the kick off was the US Institute of Medicine report on human error in 1999.[4] That's not too long ago. There has been an evolution in many ways since the first revelations, accusations, quick fix ideas, calls for mandatory reporting, and formation of many new organisations dedicated to safety. I think patient safety is now entrenched in healthcare organisations and will slowly continue to evolve, much slower than we'd all like, to help improve the culture. But, there are so many fundamental problems, so many barriers, so much to do, that it'll never get to where we'd like it to be I fear. Yet, many good things have happened already and we're on a good path.

How do you keep your 'fire' burning? Are you an optimist...and if so, how do you stay optimistic in the face of people trying to stymie progress through apathy or ignorance?

I certainly didn't start out as an optimist and don't see myself quite that way. I actually spent most of my life as a pessimist, worrying a lot about all that could go wrong. Safety people are generally like that after all. We know that no matter what we do there are still risks and that we don't know quite how close we are to the limits of safety until something goes wrong. I still have the frame of thinking about how things can go wrong and try to plan or at least think about how I would act if the worst happens. Paraphrasing James Reason, "the price of safety is chronic unease".[5]

Yet I have learned to have a fairly positive outlook on life. I see almost every problem now as an opportunity. I got that frame from Dick Kitz. I can recall many times setting up a meeting with him to tell him about some problem that he needed to get involved with to make things right. He is the consummate optimist. He would say, "there are no problems, just opportunities". It used to drive me nuts. I finally came to understand that he was right. It took a long time, but now I can almost instantly begin to see opportunity in just about anything that doesn't seem to be going the way I hoped or expected. It's a wonderful way to approach life.

As for dealing with people who don't seem to see things the way I do, who don't care as much as I do about what I think is important, that just doesn't bother me like it used to. There are so many important things in the world. We each decide what's important to us and that's what we take on. If I can get some people to care enough to make a cause out of safety I feel great satisfaction. In fact I get huge satisfaction pretty regularly just from the smiles and positive comments from the participants in our simulation clinical courses or educator programs. I just can't believe how many people have come to care about safety, about education, about simulation. It's remarkable. The fact that maybe I've made a positive difference in the lives of some people is a joy for me. When things aren't looking so good about some issue or challenge, that's what keeps me going. It doesn't take much. And I don't really know where it comes from. Perhaps it's from Dick Kitz, who was an important role model for me. And perhaps there was an influence of historical figures, Abraham Lincoln for one. He was fairly morose (with good reason considering the times he lived in) yet he actually did have a good sense of humour, and made a huge difference in people's lives, but never could just feel good about it. I took the lessons of persistence and perseverance but didn't want to take on the depressive side. Then again he had a lot of tragedies, especially the loss of his son, to get through. I've been fortunate to have few such crises and the ones I've had made me stronger.

What is your long-term vision for safer health care?

I already see that deep safety roots are growing into the foundations of healthcare. While some are disappointed that we haven't made progress more quickly, I feel that the glass is half full. Consider how many years it took to reduce the rates of smoking substantially. It was several decades. There were huge resources put to the task. The rates of smoking could be measured pretty easily so we knew how it was going. The danger was clear. Patient safety is a much greater challenge. It's much harder to measure success, for many reasons. The resources that can be put to it are much more challenging to capture, especially in these economic times. And it's not clear what exactly to do since there are so many ways that things can go wrong. So I feel that, all things considered, we're not doing as badly as many seem to think. Are we safer now than 10 years ago? I actually think so, at least for more routine care for healthier patients. If we had done nothing, things would have gotten much worse because we've continued to introduce new treatments and technologies. The systems are even more complicated than they were, amplifying the risks. We are chasing a moving target, always moving in the same direction it seems, toward more complexity and risk.

Yet I imagine that healthcare organisations will more and more put safety really high on their agendas. Sticking specifically to simulation as a patient safety topic, we'll see it being used to test all major new processes and technology introductions for instance. Teamwork training will become a normal part of every healthcare organisation, especially practice for unusual events. Simulation will become the primary mode of introductory training for all students in all healthcare professions. Leaders and managers will use simulations of various sorts in their own professional training (we have such a program in our own centre and based on early results of a study we've done, it appears to be effective for promoting safety attitudes and behaviours).

As for the top priorities, I don't see how I could be better at deciding what those should be than the Lucian Leape Institute of the National Patient Safety Foundation (http://npsf.org/lli/). They've identified six major strategic priorities. The first that they are taking on is to bring patient safety deeply into medical education. The others are:

- Medical education reform.
- Active consumer engagement in all aspects of health care.
- Transparency as a practised value in everything we do.
- Integration of care within and across health care delivery systems.
- Restoration of joy and meaning in work.
- The safety of the healthcare workforce.

These are high-level goals but they make sense to me. Simulation has practical and highly leveraged application in all of these. All but one of the priorities on my list fit in with these LLI goals and have very real tactical aims: using simulation at all levels of training and experience to protect patients and also to make learning more effective and efficient; improving handovers of care between providers (all handovers of every type); assessing competency and using assessment as a teaching tool (all providers, at all levels of training and experience); using simulation in the development and evaluation of new technologies and processes of care; using simulation to help providers learn to be more open about their errors with their colleagues and their patients; developing faculty to be better teachers and making their learners better learners.

My top priority isn't on the LLI list explicitly: creating deep culture change to put safety at the highest priority. Instantiating simulation everywhere will have a real impact on culture, for example, everyone will feel that they need to learn in simulation first because protecting patients from risks and unnecessary discomfort during the training of providers is the right thing to do, for the patients and the providers.

Where do you see your work taking you in the future? What are you going to be focusing on?

I currently have several areas that I'm trying to focus on with simulation as the main tool. They are among those I listed in the previous question: assessment of trainees to identify issues early in training; instituting effective training programs for practicing anaesthesiologists; using simulation more for evaluating new technologies and processes; and improving technology usability and expanding our training programs for using simulation to catalyse patient safety and simulation use by exposing leaders and managers more to it.

My main interest in simulation though is expanding the development of faculty. I think this is the key strategic imperative for simulation. If we teach healthcare educators to use simulation based techniques and their related methods, especially learning to give feedback and help make learners more reflective, then we can more greatly expand its influence. As you know, our Center for Medical Simulation (CMS) created the Institute for Medical Simulation (IMS) to do just this. We've got several efforts within CMS and IMS to amplify our efforts in creating more and better simulation educators.

But, for the longer term, I've been digging into learning about the neuropsychology of learning and behaviour change. I feel we aren't using simulation nearly as effectively as we could be. A step change in progress will come when we can put understanding of the brain to work. I'm an amateur (as I've been with everything I've done), but I've learned a bit from the work of Antonio Damasio and more lately, Dan Segal.[6,7] Segal's work is about psychotherapy, but he applies the idea of teaching how our behaviours are driven by the integration of the various parts of our brain. It's fascinating stuff and is directly applicable to improving the leverage of simulation, probably via how we construct scenarios and conduct debriefings. I'm not sure where, if anywhere, it'll lead me, but it's fun exploring.

What do you do to unwind outside of work?

My wife and I got into horses late in life. It's now our passion. We each have a horse and we ride almost every weekend. It's been a lifesaver. If you aren't into horses, it's hard to understand. There's something very special just being around them. I also use it as a vehicle to push myself beyond what is comfortable. So I compete a little in low-level dressage and do some stadium and cross-country jumping. It's a huge thrill every time I do any of these, especially the jumping. I've got a great horse now (my fifth in the 15 years since I started) so that makes it even more fun.

And, I work out regularly, got back into playing tennis after about 20 years off, and love to learn a new language. I've been working hard on my Spanish for about two years and my Spanish-speaking colleagues say I've gotten pretty good. I can hold a basic conversation in Russian too, which I pretty much self taught starting in the early '80s when I had this idea of building bridges to the then Soviet Union. I actually gave a couple of lectures in Russian there, which was a real thrill.

But, most of all, I really like hanging out with my wife. We're soul mates. You can't get any luckier than that. You can look her up at www.lifespringcoaching.com and see how cool she is. I get a lot of my best new ideas from watching what's she's doing next.

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Continuing Professional Development

CPD program awaiting qualified privilege

Australia
The Maintenance of Professional Standards (MOPS) program, which predated the College's current Continuing Professional Development (CPD) program, enjoyed qualified privilege in Australia. As such, information recorded by participants was protected by an Act of Parliament from being used as evidence in a court of law. The College has been unable to secure confirmation that the current CPD program is also protected by qualified privilege.

The CPD program (as did MOPS) includes activities which benefit from candid assessment of one's own practice, and the practice of colleagues. Such activities include clinical audits, reflection notes on one's experiences, and practice peer review. Self-evaluation at the commencement and completion of each triennium allow for identification of areas requiring self-improvement, and self-analysis of whether or not learning goals have been achieved.

Given that the CPD program has not been granted qualified privilege, Australian Fellows should be aware that while the likelihood is extremely low, information recorded in the online CPD portfolio could, in theory, be used as evidence in court.

The College is continuing to negotiate with the relevant government authority for qualified privilege to be applied to the CPD program in Australia.

New Zealand
The ANZCA CPD program continues to be a Protected Quality Assurance Activity in New Zealand under the Health Practitioners Competence Assurance Act 2003.

Convenient ways to collect CPD credits

The first CPD program triennium will conclude at the end of 2010. For those of us who have not yet achieved the minimum credits required, it's not too late.

The CPD program has been divided into four categories. A total of 10 credits are required from each of Categories 1-3 and a total of 40 credits must be achieved for each year on average. There is no minimum requirement for Category 4 (Education and Research).

Articles will appear in the *ANZCA Bulletin* over the coming months directing Fellows to convenient places to collect CPD credits. While the motivation of this series is to assist rural doctors who may find it difficult to collect CPD credits, the resources covered are available to all Fellows of the College. All that is required to access the resources discussed in this first article will be a connection to the internet, a computer with a speaker and a logon to the College website. Having a camera on your computer will add to the number of resources available to Fellows, so keep this in mind when updating your hardware.

The aim of this first article is to direct Fellows to the current resources available to collect CPD credits from Category 1. As a reminder, Category 1 activities are defined below:

Category 1 Level 1 – Passive Activities: These are activities that involve a number of participants, large or small. These activities provide information on knowledge and skills to improve clinical practice. Topics may cover any of the attributes of a specialist anaesthetist.

1 credit per hour: No maximum cap
Activities may include:
- Lectures
- Meetings
- Conferences (regional, national, overseas)
- Videoconferences

Documentation: In portfolio as per guidelines in *Toolkit on the CPD Portfolio*. Confirmation of participation.

Category 1 Level 2 – Interactive Activities: These are educational group meetings that have an objective and which emphasise audience participation and exchange of information, usually among a small number of participants. Topics may cover any of the attributes of a specialist anaesthetist.

2 credits per hour No maximum cap
Activities may include:
- Small group discussions
- Seminars
- Workshops with no practical skills learning

Documentation: In portfolio as per guidelines in *Toolkit on the CPD Portfolio*. Confirmation of participation.

As of 2010, the College has begun audio taping and video taping keynote speakers from the ANZCA Annual Scientific Meeting. While currently the video tapings remain brief and not appropriate for CPD credits, the audio tapings cover entire keynote speeches. In 2011, it is anticipated that these recordings will continue and be made available to Fellows.

The audio-taped speeches from the 2010 meeting are archived and accessible through the College website. From the College's home page, under the heading of Events, you will find a listing for Annual Scientific Meetings. If you click on this heading you will see a list of the past meetings by year. Clicking on the 2010 meeting, you will see subheadings, including audio.

There are 10 audio taped speeches available to be downloaded with a cumulative time of close to 10 hours. One could nearly collect their entire year of credits for Category 1 by listening to these audio-taped speeches and documenting the times. Each audio tape lists the length of time of the speech in the right-hand margin. The tapes can be paused, rewound and replayed as many times as desired. Below is a listing of the audio-taped speeches available from the 2010 meeting.

ANZCA ASM 2010 audio

Saturday May 1
Professor Talmage Egan – Pharmacodynamic interactions – hypnotics and opioids.

Professor Jeffrey S Mogil – What's wrong with animal models of pain?

Wallabies coach Robbie Deans address to graduates at the College Ceremony.

Sunday May 2

Professor Richard Rosenquist – Perineural catheter techniques for postoperative pain management at home.

Professor Michael "Monty" Mython – Why is it easier to get doctors to the top of Mount Everest than it is to change their clinical practice?

Tuesday May 4

Professor Paul Myles – Stochasticity in clinical medicine.

Professor Steve Shafer – Unsolved mysteries of anaesthesia.

Wednesday May 5
Professor Paul Myles - The last lecture I'll ever give (at this meeting) – life skills, anaesthesia and philosophy.

Professor Steve Shafer – The last lecture I'll ever give (at this meeting) – life skills, anaesthesia and philosophy.

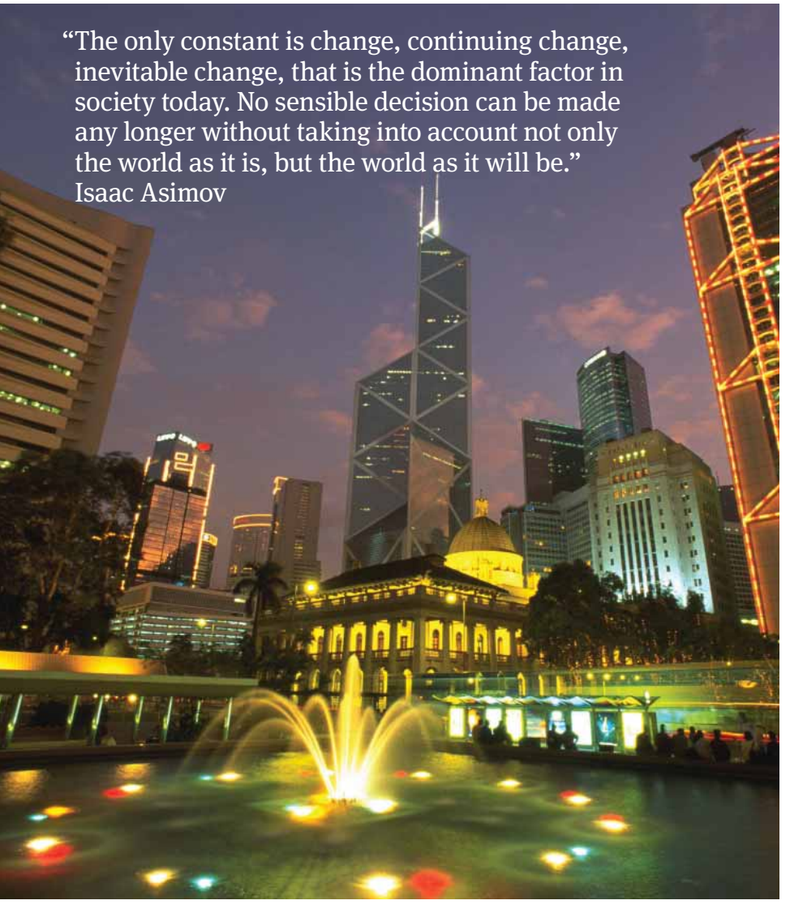
Professor Talmage Egan – The last lecture I'll ever give (at this meeting) – life skills, anaesthesia and philosophy.

I would encourage all Fellows who cannot attend the annual scientific meetings to make use of this valuable resource. At your own convenience, you can listen to both local and international keynote speeches and collect CPD credits the easy way.

In addition to this service, with the introduction of webinars soon to be rolled out, live speeches and workshops will soon be made available to Fellows. For more information about webinars, see the June edition of the *ANZCA Bulletin*.

Dr Vincent Sperando FANZCA
New South Wales

New Fellows Conference
May 11-13, 2011
Hong Kong



"The only constant is change, continuing change, inevitable change, that is the dominant factor in society today. No sensible decision can be made any longer without taking into account not only the world as it is, but the world as it will be."
Isaac Asimov

Life, by its nature, is a series of changes. Being a new Fellow does not only mark the beginning of our career, but also opens a new page in our life. We need to face numerous changes in the workplace as well as in personal life. Transition from a trainee into an independent specialist, providing supervision and training instead of being taught, increasing involvement with research, administrative work and college affairs, subspecialty training, entering marriage and parenthood, coping with the ever-changing world trends and cultures of different generations...the list simply never ends.

Changes can be both good and bad. It provides us an opportunity to evolve into a better self. However, it is invariably associated with uncertainty, fear and stress. Overcoming resistance to change demands self-realisation, motivation, planning and the courage to 'act' and to 'accept failure'. Although it appears to be difficult, can we do something to better equip ourselves for the challenges?

In response to the above concern, the theme of the 2011 New Fellows Conference is "Managing the change". Proposed sessions include:

1. Exploring ourselves
Through art jamming, we will explore our values and priorities in life. Sharing and discussion on the topic will be conducted in a pleasant and artistic atmosphere.

2. Equipped for the change
Workshop led by a clinical psychologist with emphasis on the psychological aspects of change management.

3. A Taste of the tradition
Traditional Chinese culture has a unique view on life. It stresses harmony with nature and peace of mind. Tai Chi is an internal Chinese martial art with well known benefits on stress management and general well-being. A Tai Chi workshop consisting of a short seminar, demonstration and practical session will be held to provide participants with a taste of traditional Chinese wisdom which can be applied in our daily life as well as clinical practice.

All the workshops will be interactive in nature. Delegates will be asked to prepare a brief presentation related to the conference theme. Hopefully, through various activities, sharing and discussion, we will gain more insight into the topic and be better equipped for our future.

Our conference will be held in Hong Kong Disneyland Hotel which is located on the Lantau Island, about 15 minutes drive from the Hong Kong International Airport. Lying along the shores of the South China Sea, the hotel is surrounded by lush green lawns and the charm of Victorian elegance. With modern amenities like luxurious swimming pools, gym and spa, its close proximity to Inspiration Lake Recreational Centre and the Disneyland theme park, will surely bring you a unique, relaxing and refreshing experience in the midst of the "rush and hush" city life in Hong Kong.

We encourage all new Fellows, within eight years of Fellowship, to submit an application to their regional or national committee to attend this exciting conference by October 4, 2010.

We look forward to seeing you in Hong Kong next year!

Dr Patricia Kan
Dr Timmy Chan
NFC 2011 Co-Convenors

New Fellows Conference 2011
"Managing the change"

May 11-13, 2011
Disneyland Hotel, Hong Kong

Applications now open

Applications are invited from Fellows in all training regions for selection to attend the 2011 New Fellows Conference in Hong Kong. To be eligible, Fellows must be within eight years from Fellowship and attending the 2011 Combined Scientific Meeting (CSM).

Selection will be undertaken by the Regional and National Committees and the Faculty of Pain Medicine.

The object of the New Fellows Conference is to provide each participant with skills to assist them in dealing with their professional lives and relationships during their work in anaesthesia and pain medicine. Special emphasis will be placed on professional excellence, leadership and involvement in College and Faculty affairs.

The 2011 conference theme is "Managing the change" and proposed sessions within this broad theme include:

Exploring ourselves
- Identifying change and exploring values and priorities

Equipped for change
- Leadership workshop
- Stress management workshop

A taste of the tradition
- Learn about the theory of Tai Chi and participate in a group session.

The College and Faculty will be responsible for the costs of this seminar; however, the applicant is responsible for the cost of travelling to and from Hong Kong and all CSM registration and associated fees.

Written applications, with accompanying curriculum vitae, should be forwarded to the relevant Regional Committee, National Committee or Faculty of Pain Medicine by Monday, October 4, 2010.

Enquiries should be addressed to:

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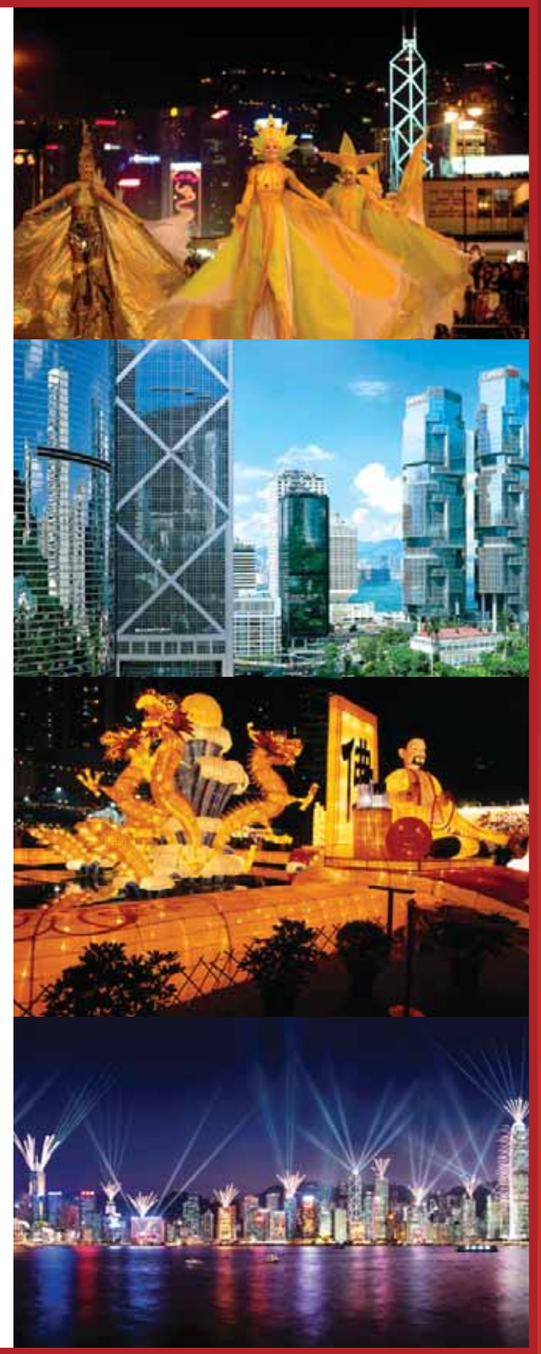
For further details of the Combined Scientific Meeting 2011 in Hong Kong, please visit the meeting website: www.csm2011.com



In the spotlight: Teacher training in medicine

By Felicity Hutton, Education Training and Development Manager, ANZCA
and Mary Lawson, Director of Education, ANZCA

Teacher training in medicine is the subject of discussion and debate across all disciplines in medicine and at all levels of medical education (including medical school, junior doctor and medical college levels).

ANZCA hosted a one-day symposium in April 2010 on supervision for the Confederation of Postgraduate Medical Colleges (CPMC). Participants actively engaged in debate around the following questions:

- **How can health environments support good supervision?** Discussion focused on the need for structural support for medical teaching to occur, including dedicated time and resources required. It was also acknowledged that teaching needs to be recognised as core business in health environments and that this may require significant cultural change.
- **How can supervisors be equipped for their task of providing effective educational supervision?** It was agreed that there are very few (if any) discipline-specific medical teaching skills.

At the end of the meeting, there was broad agreement that colleges share many of the same challenges and that a generic approach to teacher training may be both efficient and desirable. This challenge has been taken up by Health Workforce Australia (HWA) through the Clinical Supervision Support Program (CSSP). HWA are working to expand capacity and improve quality of clinical supervision through the development and implementation of a National Clinical Supervision Support Strategy and Framework.[1] ANZCA will submit a response to their consultation paper outlining the College's strategic goals and activities related to teacher training and support.

ANZCA teacher training and support

The College is using existing knowledge and frameworks for the development work at ANZCA. All courses are mapped against the competency framework for the 'Doctor as Educator' detailed in The Bridging Project[2]. The literature on what constitutes effective supervision in medicine has been used as the starting place for development action.[3, 4]

Above: ANZCA Director of Education, Mary Lawson (centre), with Fellows from the ACT, South Australia, Tasmania, Victoria and WA participate in the inaugural ANZCA Teacher Course: Foundation Level, ANZCA House July 2010.

With this information providing a sound base, ANZCA is taking a proactive approach to teacher training and support. There are a number of new initiatives. Existing provision has been revised, structured and standardised and is delivered equitably in all ANZCA regions and nations. This article provides a review of what is available locally.

What support is available for ANZCA teachers?

Support and training for clinical teachers has been identified as a key strategic priority of the College. ANZCA Council convened a Clinical Teacher Development Working Group (CTDWG) to oversee the review and redesign of support and training initiatives for Fellows involved in delivering clinical teaching to trainees.

The ANZCA Education Development Unit has reviewed and redesigned a suite of teacher training and support activities resulting in the development and implementation of the ANZCA teacher course.

What is the ANZCA teacher course?

Many ANZCA Fellows teach but few have received formal training and support. While they have shown passion and commitment to teaching, many have done so without formal recognition and have welcomed the introduction of a formal support program.

The ANZCA teacher course is an exciting initiative designed to support supervisors of training, module supervisors and any Fellow involved in the clinical teaching of ANZCA/Faculty of Pain Medicine trainees to develop their teaching knowledge, skills and professional behaviours. The ANZCA teacher course consists of two complementary options:

1) ANZCA teacher course: foundation level.
2) ANZCA teacher course: advanced level.

All courses have been developed on a set of principles that are shown in Box 1 (on page 57).

Who is the ANZCA teacher course – foundation level suitable for?
The ANZCA teacher course is suitable and made available to any Fellow involved in the support and supervision of an ANZCA trainee. The foundation level is a two and a half day course. The format is currently face-to-face but an online version will be developed in the future. Participants are required to complete pre-course preparatory work, engage in a range of interactive activities and complete a post-course assessment. The foundation level course is particularly relevant to those involved in teaching ANZCA/FPM trainees who have received little or no formal training in teaching in the clinical environment. Participants do not need to hold a formal role of teaching responsibility but rather demonstrate a commitment to teaching or have shown initiative in the teaching of trainees. Importantly, the focus of the course is the application of core teaching skills to the clinical environment.

In 2010 the pilot foundation level course will be delivered in Victoria, Queensland, New Zealand and an additional course will be held in Victoria for ANZCA/FPM Fellows working in regional and rural areas as well as those in expanded settings. Applications for the foundation level course have been overwhelming with almost 200 Fellows registering their interest. Regional and national committees have been responsible for reviewing the applications and nominating suitable participants from the respective regions. This system was put in place to ensure that regional committees were able to put forward their local key teachers and those who would be actively involved into the future.

Participation in the ANZCA teacher course – foundation level is fully sponsored by the College during this pilot phase.

Who is the ANZCA teacher course advanced level suitable for?
Any Fellow can take an advanced level workshop. There are no prerequisites for participation. The advanced level course comprises of a one day face-to-face workshop. The focus of each workshop varies and regions are able to choose from a suite of medical education topics to cater for the needs of their respective Fellows. Participants are required to complete pre-course preparatory work and engage in a range of hands on and interactive activities. Importantly, the advanced level course provides an opportunity for Fellows to share experiences and challenges and develop practical strategies to apply when teaching and supervising trainees in their workplace.

In 2010, the advanced level course has been delivered to all ANZCA regions, New Zealand, Malaysia, Singapore and Hong Kong. The course is freely available to ANZCA and FPM Fellows.

Details of the ANZCA teacher course foundation level can be found on the College website: www.anzca.edu.au/edu/teacher-programme/teacher-course

How has the ANZCA teacher course been received in 2010?
At the completion of each course, participants are required to complete an evaluation. Both qualitative and quantitative data is collected and analysed. The evaluation data is used to inform future course development and ensure that refinements to the course are relevant to the needs of ANZCA/FPM teachers. Box 2 contains some comments from participants indicating the benefit of course experiences and content.

What's available to support ANZCA teachers in 2011?
College support for teacher training is growing. In 2009, more than 150 Fellows received training and this number will increase in 2010. In 2011 it is anticipated that the support and teacher training activities will increase substantially. The ANZCA teacher course foundation level will be adapted for the online environment and will enable greater access to training opportunities for ANZCA/FPM Fellows in expanded clinical settings.

There will be increased opportunities to attend the advanced level course throughout the regions/nations and the foundation level course will also be offered as part of an educational stream at the ANZCA Annual Scientific Meeting (ASM). ANZCA Council approved an educational stream at the ASM, which demonstrates the continued commitment of the College to teacher training and support.

A major emphasis of training for 2011 will be in preparing Fellows for the implementation for a formal system of workplace-based assessment (WBA) so look out for the advertising for training in your local area.

All details of the work undertaken by the CTDWG can be found on the College website: **www.anzca.edu.au/edu/projects/teaching-review.**

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From top left: Malaysian Fellows learn about effective clinical supervision; Felicity Hutton teaches the principles of providing effective feedback.

Box 1: ANZCA's underlying principles for teacher training and support

In the context of an increasing number of ANZCA trainees, the clinical development, training and support activities should:

- be available in multiple delivery modes and accessible to all ANZCA trainees and Fellows.
- be aligned with the ANZCA training program.
- be recognised and resourced as a key responsibility of the College and provided on an ongoing basis.
- include core training for all clinical teachers with options for a more tailored approach to meet the needs of those who progress to increased educational responsibilities (for example, for educational leadership, scholarship, teaching and/or management).
- adopt an inclusive approach to recognition of prior learning (RPL) in terms of teacher training activity provided in other contexts and by other providers and establish clear articulation pathways for progression to other relevant programs/courses if so desired.
- be acknowledged and recognised by the College within continuing professional development (CPD) frameworks and via other appropriate mechanisms.
- reflect adult learning principles ensuring that initiatives are relevant to the interest and responsibility level of the clinical teacher.
- include active lobbying and advocacy for the importance of clinical teaching, on behalf of clinical teachers to funding, regulatory and health policy agencies.
- be continually reviewed to ensure ongoing improvement in quality, effectiveness and accountability to the College, trainees, the anaesthetic profession, patients and the wider community.

Box 2: Participant comments from ANZCA teacher course

"I found that hearing/sharing experiences of/with others – their tips and tricks to be the most beneficial aspect of the course."

"The course provided an excellent summary of education around the topic enlarging my vocabulary/knowledge."

"The interactive nature of the course increased learning – especially the role plays."

"It gave me an opportunity for discussion with colleagues about my own environment and practices."

"I found the discussion of techniques to overcome barriers to be extremely helpful."

Funding research in cognition and anaesthesia

"For 150 years anaesthesia has been totally focused on the here and now and the patient surviving. Over the last 20 years Australia has played an important role in improving immediate patient outcomes with innovative approaches such as the AIMS (Australian Incident Monitoring Study). Acute mortality due to anaesthesia alone is now less than one in 200,000. Although anaesthetists are ever-vigilant in trying to maintain and improve acute mortality, the current situation has allowed us to look at longer term associations with anaesthesia rather than being totally – and quite rightly – preoccupied with survival. The improvement in safety has allowed us to look at longer term outcomes."

Associate Professor Brendan Silbert, Senior Staff Anaesthetist, Centre for Anaesthesia and Cognitive Function, Department of Anaesthesia, St Vincent's Hospital, Melbourne.

Associate Professor Brendan Silbert and his colleagues at the Centre for Anaesthesia and Cognitive Function, Department of Anaesthesia, St Vincent's Hospital, Melbourne are conducting a number of studies aimed at more fully describing the cognitive changes which may result from surgery and anaesthesia.

ANZCA spoke with Associate Professor Silbert, Associate Professor David Scott (Director of the Department of Anaesthesia and Chief Investigator) and Lis Evered (Senior Scientist and Research Manager).

Cognitive changes after anaesthesia is an issue of great importance. Each year more than 2.5 million anaesthetics are administered in Australia to an increasingly ageing population. The elderly are most susceptible to cognitive change after anaesthesia and it is this group that receives the highest number of anaesthetics. Cognitive decline already represents a major health issue in the aged, but exacerbating this problem by increasing surgery and anaesthesia cannot be underestimated.

The first study by Associate Professor Brendan Silbert and his colleagues builds on previous work which documented the incidence of cognitive decline after cardiac surgery. The ANTIPODES (Australian National Trial Investigating Post-Operative Deficit, Early extubation and Survival) trial investigated the incidence of postoperative cognitive deficit after coronary artery bypass graft (CABG) surgery. The study included 350 patients aged 55 years or older who underwent CABG surgery. This trial resulted in the collection of cognitive test results from more than 320 patients.

In a follow-up study funded by ANZCA, the investigators are using the same methods used in the ANTIPODES trial to test this group of patients five years after the initial surgery to identify how many patients suffer from difficulties in thinking and memory. The study will go even further and see if any of these patients have deteriorated to the point of having progressed to dementia. Documenting the natural history after cardiac surgery is an important step as it will allow those patients at risk to be identified – a vital precursor to implementing preventive strategies.

Associate Professor Silbert says that retaining patients for the trial is very important. "If one drops out, your results become less useable because you are unsure whether you've lost them because they've lost cognition. Each one you lose takes away the strength of your result. We have included country patients, which helps contribute to the high retention rate of 94 per cent. There is a lot of travel involved for the three research assistants and it is labour intensive work, developing a rapport with the patients and spending one to two hours testing each one."

The tests fall into two categories. One method is the traditional way of testing with pen and paper which involves a word learning test where 10 simple, unrelated words are read to the patient who responds with as many as they can remember, in any order. Mild cognitive impairment has a high rate of developing into Alzheimer's disease. Other cognitive tests include joining the dots with a pen, which is timed and other exercises using symbols and letters, as well as a reading test. There is also an opportunity for patients and their partners to give feedback about their views on the patient's cognitive function. The second method of testing involves a computer using software designed by Cogstate. One involves a maze task that is sensitive to executive function via finding pathways one square at a time. Reaction time is measured in milliseconds by pressing a key on the board with the number of errors automatically recorded.

Associate Professor Silbert says that it is scientifically proven that the older people get, the greater the chance and severity of their cognition falling. Research has shown that the more intelligent and better educated people are, the less likely and less severe the cognition falls.

Associate Professor Silbert makes it clear they are not diagnostic tests. Nevertheless, "the Human Research Ethics Committee wanted us to refer patients to a memory clinic if we were concerned that they had severely declined".

In a second study, Associate Professor Silbert and his colleagues are examining thinking and memory after hip replacement surgery which is a common operation in the elderly. In particular, the study is measuring the number of small particles that find their way to the brain during an operation. There is recent evidence that suggests these may play a part in diminishing brain function. The particles are measured using a special ultrasound machine which, when placed over the skull, is able to detect the type and number of particles that travel in the arteries to the brain.

"An ANZCA research grant bought us the Transcranial Ultrasound Doppler machine that goes on the side of the head and measures the particles that go up into the brain. At the time, we thought these bubbles caused cognitive change; the more bubbles you get, the more change. We haven't published it yet, but it looks like the bubbles may not be as ominous as we first thought. When we applied to the College for a research grant we were certain that the bubbles were going to be the problem," Associate Professor Silbert said.

In August this year, Geert De Meyer of Ghent University in Belgium and colleagues in the Alzheimer's disease Neuroimaging Initiative announced that Alzheimer's disease can be predicted with up to 100 per cent accuracy years before patients experience symptoms of memory loss using biomarkers found in spinal fluids.

In relation to the hip surgery trial, most patients have spinal anaesthetics as a part of their surgery before they are unconscious. Associate Professor Silbert says that by chance, 18 months ago it was decided that before the spinal went in, his team would take a sample of the cerebral spinal fluid (CSF).

"We now have 100 samples of CSF in 100 patients who have all got cognitive results. If it works out, we will be able to correlate the CSF proteins with the cognitive results of the patients. This is purely conjecture now – not science – but the way it seems to be fitting together for us is that if patients have the Alzheimer's CSF profile then they are probably susceptible to anaesthesia in a way that normal patients wouldn't be," he says.

"So instead of taking 20 years for the onset of the disease to occur, they'd get it in six months or a year. There's no doubt that CSF will be universally accepted as a marker of Alzheimer's disease – the question of whether those patients are susceptible to cognitive changes after anaesthesia will require further research."

The study will conclude at the end of next year.

From top left: St Vincent's Hospital, Melbourne; Associate Professor Brendan Silbert, Lis Evered and Associate Professor David Scott; Associate Professor Silbert with a Victorian map where each flag represents one patient in the study; Lis Evered demonstrates the computer software that tests cognitive function.

The legacy of Konrad Jamrozik, The Master Trial and contemporary clinical research in anaesthesia

In the June issue of the *ANZCA Bulletin*, Dr John Rigg outlined his collaboration with the late Professor Konrad Jamrozik, which led to the publication of THE MASTER TRIAL, "The Multicentre Australian Study of Epidural Anaesthesia". Following consultation with co-authors, Dr Rigg has written a more detailed account of the trial and Professor Jamrozik's contribution (opposite). Dr Rigg hopes that this story will interest all Fellows, but more particularly, trainees and younger Fellows who may be involved in clinical research.

The Multicentre Australian Study of Epidural Anaesthesia (MASTER Trial) was the first major multicentre trial carried out predominantly in Australia. John Rigg was the driving force behind this trial that established Australia as a major player in outcome research of anaesthetic interventions. John has detailed the history of the trial in an article in this *ANZCA Bulletin*. The information is important to preserve, because it illustrates the huge amount of work, persistence and dedication required to complete such an ambitious task.

I was fortunate to be involved in the early stages of the project, which I felt could put Australian anaesthetic research on the international radar. A study we published in 1993 relating to epidural analgesia and outcome from abdominal aortic surgery was too small to show any difference in outcome, but made me appreciate how difficult these studies were and that the answer may be provided by a multicentre trial which was necessary to be adequately powered.

It was great to be approached in the early 1990's to become involved with the MASTER trial and we were delighted that Brendan Silbert from our Department at St Vincent's Hospital in Melbourne could play a major role. John Rigg was first awarded a grant from ANZCA in 1994 that allowed him to start the research and later to successfully receive the largest grant that the specialty of anaesthesia had ever been awarded by the NHMRC. After nearly 10 years of hard work the MASTER trial was published in *The Lancet* in 2002. Publication of papers related to anaesthesia are rare in this prestigious journal, and this was a great achievement by John and his colleagues.

The MASTER Trial concluded that analgesia was improved and respiratory failure was reduced with epidural analgesia. Although the project was subject to some criticism, the publication of the MASTER trial has led to a reappraisal of the use of epidural analgesia in this country.

The great legacy of John and his colleagues was that they set the template for new multicentre trials in Australia and many have followed. The ANZCA Multicentre Trials Group was established to foster such trials and to ease the burden on future researchers who seek to emulate the achievements of John and his team.

Associate Professor Michael Davies
Director of Anaesthesia
St Vincent's Hospital, Melbourne
1984-2009

"A large multicentre trial, limited to high-risk cases, was required. We knew we needed a lot of money. We also understood that across hospitals, we needed to standardise the concept of 'high risk'; detailed, non-ambiguous, organ specific definitions of pre-operative patient pathology were essential to standardise patient eligibility for entry to the study."

It is a common misconception that research is about conducting experiments, analysing data and publishing results. Experienced and successful scientists, however, recognise that human imagination and converting good original ideas into focused, testable hypotheses are more important ingredients for producing high quality research. The concept of testability and the distinction between 'science' and 'non science' on the one hand and 'proof' and 'refutation' on the other hand are important considerations for anyone grappling with ideas and 'hypothesis testing'.

I was fortunate early in my career to have been introduced to the philosophy of science as espoused by Karl Popper. It is not possible to expound on this subject here, so I provide two references for readers who might wish to explore this subject in depth.[1,2]

With respect to the Master Trial, most might assume that the project was primarily about epidural block; for me, however, the original idea was clinical outcome, an idea which goes back to my earliest year as a medical graduate.

In 1965, in my first year as an RMO (intern) at Royal Perth Hospital, I was assigned to the Neurosurgery Unit where I had to care for several severely head injured patients with compromised airways, and loss of respiratory control. The outcomes of these patients were dependent on a period of artificial ventilation. About 1963/64 the hospital had acquired several ventilators from the Bird Corporation, California, USA; simple, basic, pressure-cycled ventilators that anaesthetists of my generation remember. In 1965, there was no ICU, no department of respiratory technology, no blood gas service and no knowledge, experience or interest of either the registrar or the consultants in the management of these patients' respiratory problems. Accordingly, I learnt a great deal about pulmonary ventilation, gas exchange, mechanics of breathing, respiratory control and how to use and repair a Bird ventilator. Importantly, I learnt what influenced a good outcome for these patients.

In 1966, I was an RMO in the Anaesthesia Department. Non depolarising muscle relaxants were widely used to manage general anaesthesia and these drugs required 'reversal' to facilitate re-establishment of spontaneous breathing in the recovery period. This reinforced my interest in the physiology and patho-physiology of the respiratory system in sick patents after surgery. In 1968 I was appointed anaesthesia registrar at Prince Henry's Hospital, Melbourne. Tutorials in respiratory physiology for were given by Blair Ritchie of the Monash University Department of Medicine. After completing the primary examination, Blair asked my view of the most important clinical issue in anaesthesia and surgery. I replied, "a better understanding of the factors that determine successful restoration of spontaneous breathing after general anaesthesia". My introduction to my first research project began with an idea, a question that led to a testable hypothesis, a series of experiments in Blair's laboratory, and to my first publication in the *British Journal of Anaesthesia* in 1970.[3]

In my June obituary of Konrad Jamrozik, I referred to the role of chance in research and the notion of 'serendipity'. As Louis Pasteur wrote 150 years ago: "Chance favours only the prepared mind". In 1969, the Royal Australasian College of Physicians (RACP) Sims Commonwealth Travelling Professor was the distinguished British respiratory physiologist E J M (Moran) Campbell. Blair Ritchie organised a memorable three hour meeting with himself, Campbell and me, during which we discussed my research. This was a true moment of serendipity because it led directly to Campbell offering me a lectureship in the Faculty of Health Sciences at a new medical school in Ontario, Canada, McMaster University, where he had taken the Foundation Chair of Medicine.

From January 1972, Moran Campbell became an important influence in my development as an independent research scientist, which led to my life long passion for research. During the 1970s, the most dominant department, intellectually and scientifically in this medical school was the Department of Clinical Epidemiology and Biostatistics. The founding chair was David Sackett, later to receive international recognition as the godfather, or founder, of EBM – the evidence-based medicine movement. Sackett's department ran a diploma course, for clinical researchers, in design, measurement and evaluation, from which I acquired a basic knowledge and understanding of the principles of clinical epidemiology. This was important to me for two reasons; first, I gained an intuitive understanding of what was needed, logistically and scientifically, to establish a study like the Master Trial, and secondly, it facilitated achieving strong rapport with Konrad Jamrozik from our earliest meetings in 1989 and 1990.

In addition to my luck in acquiring Blair Ritchie, Moran Campbell and David Sackett as mentors, there were some important experiences in clinical anaesthesia that were pivotal in leading to the Master Trial. The first was during my training in anaesthesia at the Royal Women's Hospital in Melbourne in 1969. Advanced cervical cancer was common, often treated by Wertheim hysterectomy and radical cystectomy. Surgery could last over eight hours with radical cancer surgery in the morning and the urologist, in the afternoon, fashioning an ileal bladder. The basic anaesthesia technique was intermittent epidural mepivicaine. Patients were sedated by a preoperative dose of intra muscular PPA (pethidine, phenergan and atropine), supplemented intra-operatively by bolus doses of intravenous thiopentone. For eight hours, these patients 'slept', spontaneously breathing, a Guedel airway in situ. Monitoring consisted of an ECG, pulse meter, occasional manual blood pressure readings and a tiny strand of cotton wool taped to the lumen of the airway. Supplemental oxygen was given, but blood gases never measured. Outcome was universally excellent, patients woke rapidly, had minimal operative or post-operative bleeding and excellent post-operative pain relief. These cases led to the strong impression that central neuraxial block for abdominal surgery was a superior technique for surgical and anaesthetic outcome in pelvic cancer surgery; an idea that stayed with me for more than 30 years.

After my return to Perth, in the 1980s, I began regular clinical work with a gynaecological oncologist with whom I had first worked as a registrar in 1969 at the Melbourne Royal Women's Hospital. Naturally, we both favoured the use of combined regional (epidural) and general anaesthesia for major pelvic cancer surgery. From 1983 I began my association with Michael Davies at St Vincent's Hospital in Melbourne. Combined regional and

"For nearly seven years, Konrad and Karen Collins shared responsibility for carrying a mobile phone, 24 hours a day, seven days a week, dedicated to randomising patients to the Master Trial. Konrad randomised patients while rowing in the dark on the Swan River early in the morning, during lectures and even from his hospital bed recovering from an anaesthetic!"

general anaesthesia was the favoured technique at St Vincent's for colorectal, major abdominal vascular and upper gastro-intestinal surgery. Much discussion at that time centred on the lack of high quality research evidence as a consequence of the literature having only small, single centre, poorly designed studies, with inadequate statistical power. 'Inadequate statistical power' causes a high probability of not finding an important real difference in outcome as a consequence of the small number of patients studied.

Discussions intensified after the publication of another small study by Yeager, Glass and colleagues in *Anesthesiology* in 1987.[4] In this study of only 53 patients, the authors were ethically bound to terminate the study prematurely because of four deaths in the control group. In an accompanying editorial,[5] McPeek cautioned against generalising these conclusions because of the small sample size and the possibility of a Type I error; that is, the false finding of a difference in outcome. The study of Yeager et al was well designed and also had an important new design feature; only the highest risk patients were admitted to the study, with the express intention of enhancing statistical power. Because there were no standardised definitions of post operative morbidity, the authors developed their own detailed definitions of organ specific morbidities, based upon current 'best evidence'.

In 1993, Davies, Silbert and colleagues published another small study of epidural block which showed no difference in outcome. Michael Davies, Brendan Silbert and I came to the same inevitable conclusion.[6] A large multicentre trial, limited to high risk cases, was required. We knew we needed a lot of money. We also understood that across hospitals, we needed to standardise the concept of 'high risk'; detailed, non-ambiguous, organ specific definitions of pre-operative patient pathology were essential to standardise patient eligibility for entry to the study. We recognised that to gain clinician support for enrolling patients we needed simple, widely used and accepted definitions of anaesthesia and post-operative analgesia; in both the control and the epidural groups. We acknowledged that this was a challenge; we needed a circuit breaking event. Serendipity was again at hand.

In 1989, David Sackett was the RACP SIMS Travelling Professor (20 years after Campbell). At a private function for Sackett in Perth, I met Konrad Jamrozik for the first time. I soon introduced him to the ideas that Michael and Brendan and I had been discussing for the previous five to six years. We quickly established good rapport. Konrad was an epidemiologist with terrific clinical intuition. He was quick to recognise an important clinical question worthy of a well designed study and that I had a good background in clinical epidemiology. We soon agreed on the essential requirements for the trial and the need for NHMRC funding. First, though, we needed credibility. Credibility required seed funding to begin studies, acquire a track record and to develop a detailed and robust protocol that could generate wide acceptance by clinicians. Coincidentally, in 1990 I had just accepted, a three-month sabbatical in the Department of Anesthesiology at the Bowman Gray Medical School, Winston Salem, North Carolina. During this time I wrote a 'cook book' paper, outlining the rationale and basic structure of the trial.[7] I wrote a first draft of a NHMRC grant application and sent this to David Sackett in Canada and David Glass and Mark Yeager in New Hampshire. I followed this by visiting each institution for a couple of days of further discussion. In both cases, the discussions were invaluable and illuminating.

On returning to Western Australia, I was strongly motivated to press on with our plans. In 1991 and 1992, Konrad and I worked on the protocols and a trial instruction manual. In Perth we received excellent support and assistance from Wally Thompson, Vernon Van Heerden, Michael Paech and later, Tim Pavy and Chris Cokis. Vernon, in particular, found Karen Collins, an intensive care nurse who was to become Master Trial co-ordinator and database manager. To Karen, the trial became her vocation. For over seven years she was a loyal, hard working and passionate supporter. Konrad and I travelled, often independently, across Australia and to New Zealand, making numerous presentations to generate support for the trial. We encountered much opposition, mainly from anaesthetists. These were mostly in one of three groups: (1) the non believers felt that the trial was a waste of time and money and was unethical; (2) the believers also had their minds made up, all epidural and combined techniques were vastly superior to general anaethesia alone (the only certainty was that both groups could not be right); and (3) the apathetic, just not interested, for a variety of reasons.

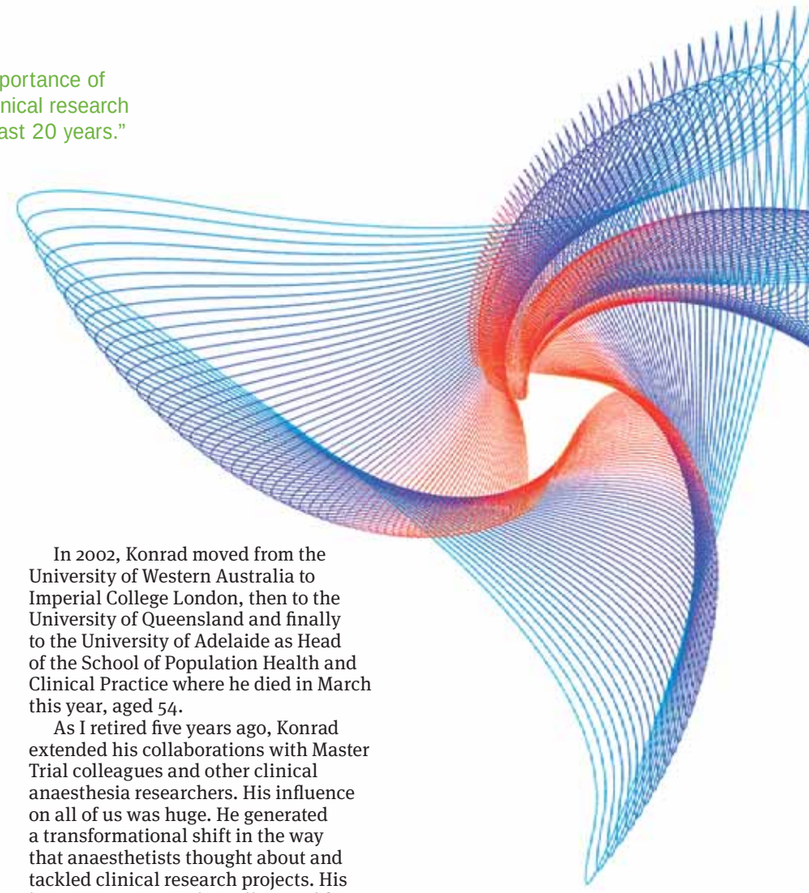
From 1995, through to December 1996, seed funding from Hoecst Pharmaceuticals, Mallinkrodt Medical, ANZCA (1995 John Rigg, 1997 Phillip Peyton) and the Health Department of Western Australia was critical to early enrolment of patients, particularly, in Melbourne, at the Austin and Repatriation Medical Centre (Phillip Peyton and Stephanie Poustie), The Alfred (Paul Myles, Jenny Hunt and Helen Fletcher) and St Vincents (Brendan Silbert and Carolyn Blyth). NHMRC funding began in January 1997 and finished in December 2001 (1997-9, $506,000; 2000 $140,887 and 2001, $70,000). For nearly seven years, Konrad and Karen Collins shared responsibility for carrying a mobile phone, 24 hours a day, seven days a week, dedicated to randomising patients to the Master Trial. Konrad randomised patients while rowing in the dark on the Swan River early in the morning, during lectures and even from his hospital bed recovering from an anaesthetic!

Konrad and I and other team members were interviewed twice, in 1994 and 1995 for ultimately unsuccessful NHMRC grants. In 1996, it was suggested that we promote Paul Myles to the frontline of the NHMRC project team. I readily agreed. We needed a circuit breaker and strong front line evidence of our very productive Melbourne connection. This was a master stroke and helped create the breakthrough. At the NHMRC interview, with the three of us in Perth a few months later, Paul was brilliant, with complete mastery of the subject, and our first NHMRC grant was assured.

Over the course of the seven years in which patients were enrolled, the trial became international. We were delighted with the willingness of many hospitals in East Asia to participate. I believe ANZCA, the faculty previously, and the ASA have generated this goodwill over the past 60 years through their outstanding leadership in our specialty in the region.

In 1997, I was invited to write a review paper in *Current Opinion of Anesthesiology*, a European journal, and this was published in 1998 with Konrad as co-author.[8] We finished this paper with three paragraphs, much of which bears repeating here:

"It is impossible to exaggerate the importance of Konrad Jamrozik to the advance of clinical research in anaesthesia in Australia over the past 20 years."



Other important interventions that might influence outcome:
"The issue of outcome is probably affected to an important extent by factors, other than anaesthetic or analgesic techniques, such as importance of intensive treatment preoperatively to optimise haemodynamic status, meticulous attention to minimising the loss of body heat intra-operatively, thus preventing postoperative hypothermia, and inducing perioperative sympatholysis using alpha adrenergic blockade to ameliorate the cardiac consequences of perioperative surgical stress.

"Many different moderate benefits may be important, individually and together. The precise role, in determining outcome, of different anaesthetic techniques and other aspects of perioperative management designed to minimise the physiological consequences of anaesthesia and surgery remains an issue of fundamental importance.

"Demonstrating clinically important real improvements in anaesthetic and perioperative management requires well-designed multicentre trials. Otherwise we cannot hope to detect moderate differences in treatment that are worth knowing about."

The last Master Trial patient was randomised in May 2001. Richard Parsons and Karen Collins conducted the full primary analysis and presented the results to Konrad and myself. Because of the intense national and international interest in the results of the trial, the seven co-authors decided to keep the findings secret until either the acceptance of the paper for publication or the presentation to the October 2001 Annual Scientific Meeting of the American Society of Anesthesiologists in New Orleans. As it turned out, the manuscript was accepted for publication in the *LANCET* within seven days of that ASA presentation. This meeting was held five weeks after the 9/11 terrorist attack in New York. Instead of the usual 16,000 plus registrations, fewer than 8000 registrants showed up.

In a special panel convened to discuss regional block, organised by David Glass, more than 200 anaesthesiologists attended presentations by Mark Yeager, Paul Myles and myself. Konrad, Karen, Stephanie and Jenny travelled to New Orleans to hear our presentations.

In 2002, Konrad moved from the University of Western Australia to Imperial College London, then to the University of Queensland and finally to the University of Adelaide as Head of the School of Population Health and Clinical Practice where he died in March this year, aged 54.

As I retired five years ago, Konrad extended his collaborations with Master Trial colleagues and other clinical anaesthesia researchers. His influence on all of us was huge. He generated a transformational shift in the way that anaesthetists thought about and tackled clinical research projects. His legacy to our specialty will extend for decades after his passing. Anaesthetists in research today recognise his legacy in the ANZCA Trials Group, the award to Paul Myles in 2003 of the prestigious NHMRC Clinical Practitioner Fellowship and his collaboration with many colleagues and important influence in subsequent multicentre trials such as Enigma I and II, Reason, Antipodes, ATACAS, and B Aware. It is impossible to exaggerate the importance of Konrad Jamrozik to the advance of clinical research in anaesthesia in Australia over the past 20 years.

Dr John Rigg
FANZCA
Retired Clinical Associate Professor
University of Western Australia

Acknowledgement:
I would like to acknowledge the assistance of several colleagues in the preparation of this paper. Stephanie Poustie has provided invaluable assistance at all stages of the preparation of the manuscript and I thank also Michael Davies, Karen Collins, Brendan Silbert and Philip Peyton for their comments and recollections of the events of the past 20 years. The design, implementation, execution and publication of the Master Trial would not have been possible without the encouragement, expertise, leadership and inspiration of our late colleague, Konrad Jamrozik, and I dedicate this article to his memory.

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ANZCA Trials Group

ENIGMA-II Trial

ATACAS Trial

ANZCA Trials Group Multicentre Research: the ATACAS and ENIGMA-II Studies

An essential component of any large multicentre research is the establishment of functioning committees that review and monitor data safety, and data quality. These are two distinct entities with separate charters, committee membership, functions and responsibilities, operating apart from the Data Management and Steering Group Committees.

Both the Aspirin and Tranexamic Acid for Coronary Artery Surgery (ATACAS) and the Nitrous Oxide Anaesthesia and Cardiac Morbidity After Major Surgery Trial (ENIGMA II) have separate data safety and monitoring committees (DSMC) and data quality committees (DQC). All of these committees are coordinated by the ANZCA Trials Group at Monash University.

The Chair of ATACAS DSMC is Professor Andrew Tonkin, while the Chair of ENIGMA II DSMC is Professor Henry Krum. Both are eminent cardiologists with extensive experience in large randomised trials. Professor Krum replaces the late Professor Konrad Jamrozik, who contributed a great deal to multicentre research in anaesthesia.

A DSMC is responsible for safeguarding the interests of trial participants, assessing the safety and efficacy of the interventions during a trial, and for monitoring the overall conduct of a clinical trial. The DSMC provides recommendations about stopping or continuing a trial and meet at specified time points of a trial.

Both ATACAS and ENIGMA II are about to have their first interim analysis.

Data quality committees are concerned with issues of data accuracy and data integrity. Both ENIGMA II and ATACAS have been set up for electronic data entry by participating sites. This system reduces data error, encourages timely data entry and allows analysis of data looking for evidence of data fraud or unusual data patterns as a trial progresses. In this environment the need for time consuming and costly onsite data audit is reduced. Both trials continue to have onsite monitoring, but the process is much reduced in complexity and concerns itself with patient verification and end-point validation. This method of end-point validation uses a blinded methodology where the auditor is unaware of whether a participant has incurred any endpoints and seeks to confirm that endpoints have or have not occurred. This allows the audit team to assess whether there has been any local site bias in recording outcomes.

Ensuring trial validity by data quality assurance and diversification of monitoring methods. Baigent C, Harrell F, Buyse M, Emberson J, Altman D. Clin trials 2008 5:49-55.

POISE-2 Trial

PeriOperative ISchemic Evaluation-2 Trial

A large, international, placebo-controlled, factorial trial to access the impact of clonidine and acetylsalicylic acid (ASA) in patients undergoing noncardiac surgery who are at risk of a perioperative cardiovascular event.

The POISE – 2 Trial is the next large multicentre trial to come to the ANZCA Trials Group from the McMaster Group at the Population Health Research Institute in Canada. This study follows on from the highly successful POISE – 1 Trial. Professor Kate Leslie is the national coordinator for Australia and New Zealand.

This research project is being run in Australia from the ANZCA-TG desk at Monash University's Department of Epidemiology and Preventive Medicine based at the Alfred Health campus. The Royal Melbourne Hospital (RMH) is the start up site, using the new National Ethics Application Form (NEAF) to begin the research ethics process.

The NEAF system enables the application process to be conducted online and facilitates a single centre HREC approval, which is then accepted by participating hospitals. This streamlined approach means that the RMH obtains initial Human Research Ethics Committee approval for seven nominated sites in Victoria. When each of these sites is ready to join the trial only "local" site specific documentation approval is required. We are yet to see whether this new system makes a difference to what can be a lengthy and arduous process for ethical review of multicentre research, and reduce much of the unnecessary duplication.

Strategic Directions Research Workshop

Keep your diaries free!

New and emerging researchers with ideas for future multicentre research are encouraged to attend!

Friday, October 1, 2010
9am-5pm
ANZCA House, St Kilda Road. Melbourne
Further inquiries:
trialsgroup@anzca.edu.au

The Anaesthesia and Pain Medicine Foundation
(Formerly the ANZCA Foundation)

Change of name for Foundation

The College Council at its August meeting approved a recommendation from the board of the ANZCA Foundation to change the Foundation's name to the Anaesthesia and Pain Medicine Foundation.

The reason for this decision was very much driven by the fact that "the ANZCA Foundation" a low level of awareness in the wider community. Experience has shown us that in trying to introduce the ANZCA Foundation and its purpose to those not familiar with the organisation the initial response is invariably, "what is the ANZCA Foundation?".

The College is not alone in having to address the issue of clarity and purpose. For example, the Royal Australasian College of Surgeons have established the "Foundation for Surgery". The Royal Australian and New Zealand College of Ophthalmologists have established "The Eye Foundation".

Apart from the change of name, the identity and look of the Foundation will remain much the same with the use of existing design, colours and the treatment of the College crest. There will be a progressive implementation of the new name to the wider community commencing in early 2011. It is proposed to run a parallel program (internal and external) whereby the existing name will be used internally among Fellows as we run down existing foundation material. The first piece of printed material featuring the new name will be the "Research Highlights for 2010". This is a 32-page full colour publication that the College and Foundation will use to introduce ANZCA and the Foundation to a much wider audience, outlining medical research successes that have been made possible by ANZCA support and seeking new areas of support.

The Foundation's Patrons Program, which was established in 2009, has received strong support from Fellows. The program aims to build the funds of the Foundation to support ANZCA's medical research and education programs. Past ANZCA president Dr Wally Thompson is the latest Fellow to join the program. The Director of the Foundation, Ian Higgins, recently had the opportunity to thank Dr Thompson for his continuing support of the College and the foundation and to welcome him to the Patrons Program.

Dr Leona Wilson joins the Foundation board

The former president of the College Dr Leona Wilson, ONZM, has taken up a three-year appointment to the board of the Anaesthesia and Pain Medicine Foundation effective from August 2010.

This appointment provides representation of another senior Fellow to the board as well as representation from New Zealand.

The global financial crisis and its impact on philanthropy and fundraising

When the College launched the ANZCA Foundation in September 2007, economic conditions were strong across much of the developed world. Virtually all the economic indicators were positive with strong corporate profits, record world trade, high employment and a high degree of consumer confidence.

The arrival of the global financial crisis (GFC) in 2008 ushered in a period of severe economic downturn. This has had a profound impact on philanthropy in the developed world. Companies have scaled back or eliminated much of their financial support. Trusts and foundations which rely heavily on dividend payments to fund their grants have been severely impacted.

To give Fellows a better understanding of how the GFC is affecting philanthropy fundraising and the ANZCA Foundation, the Director of the Foundation, Ian Higgins, recently sought the views of two independent directors, Michael Gorton, AM, and Kieren Perkins, OAM. Both have considerable knowledge and experience of the philanthropic sector in Australia and New Zealand. Ian also spoke with Bruce Argyle at Philanthropy Australia, the national not-for-profit peak body for philanthropy, to seek his assessment. The Foundation is a member and also a member of Philanthropy New Zealand.

Michael and Kieren, you have both been directors of the Foundation since 2007. How do you consider the foundation has progressed over the past three years?

Kieren Perkins:
To have steady growth over the last two years through the GFC has been quite an achievement. Many large established charities have struggled to retain their position during this time, growth being an impossibility.

From left: Kieren Perkins, OAM; Michael Gorton, AM; Bruce Argyle from Philanthropy Australia.

Michael Gorton:
The past few years have certainly been challenging, with the College investments, including the Foundation's, taking a rollercoaster ride. However, the Foundation itself has managed to substantially increase its profile, determine future strategy and enhance the "back office" systems to build capacity for a better future.

I think the Foundation is now well placed to be an effective voice for fundraising for, and support of, anaesthesia and pain medicine research and education in Australia and New Zealand.

With your experience and knowledge of the philanthropic sector in Australia and New Zealand, how difficult has it been for charitable organisations with the arrival of the GFC?

Kieren Perkins:
Those charities that have relied on corporate giving have been found wanting during the GFC. All companies have tightened their philanthropic spending, interestingly there hasn't been too much fall in individual giving. Over the next period of time though individual giving will also come under pressure as average Australians struggle with the rising cost of living, and the precarious position many SME's find themselves in.

Michael Gorton:
All charities and not-for-profit bodies have had a tough time trying to get corporate and public support in the middle of the GFC. We look forward to better times and opportunities ahead.

The best thing we can do is position the Foundation and its profile to take advantage of the recovery. I think we are doing that.

Bruce Argyle:
The GFC had an impact on the philanthropic sector but not to the same huge extent as in other countries. Corporates did cut back and trust and foundation incomes were reduced, in many cases by 20 per cent or more while at the same time the demands from the community increased. This was particularly evidenced in 2009 by the large increases in requests from charities for material aid and immediate assistance to help with those most impacted by the financial climate. In Victoria, the advent of the bushfires placed huge pressure on trusts and foundations to respond locally.

The Anaesthesia and Pain Medicine Foundation

(Formerly the ANZCA Foundation) continued

There are so many "good causes" seeking support, how strong do you believe the "message" of the Foundation is?

Kieren Perkins:
I believe the Foundation has two distinct advantages in the philanthropic landscape. Firstly, the commitment of our Fellows ensures we have a large group of informed advocates pushing the messages of the Foundation, helping provide sustainable income. Secondly, the work being achieved in the public domain regarding pain management provides a platform for community engagement we haven't enjoyed previously.

Michael Gorton:
The Foundation is the only voice for "safe anaesthesia" and "pain relief" among all the other worthy medical causes. We need to educate the public on the future possibilities of anaesthesia in surgery, and the further advances that can be made. I think most people believe it has all been done. More research can provide dramatic improvements.

Additionally, we have seen a significant emphasis on pain relief, and the millions of people affected by pain in their daily lives. I believe that this is a "sleeper" (no pun intended) issue, which can capture the imagination and influence politicians. Any advances in pain medicine have the potential to affect so many people, and improve their lives and wellbeing. The cost-savings for business and the community from the ability to enhance pain relief must be great.

That is why we need to increase research and education in these areas.

Bruce Argyle:
The level of solid groundwork that has gone into the establishment of the ANZCA Foundation over the past couple of years will see it well placed to secure support for key projects in the future. There is growing interest among the philanthropic community in health and wellbeing and medical research – this is evidenced by the latest *Australian Journal of Philanthropy* having this as its key focus.

Looking to the future what is your assessment for the philanthropic sector here in Australia over the coming 12-18 months?

Kieren Perkins:
The next 12-18 months will continue to be extremely difficult for the philanthropic sector. The economy is still on a knife edge and this lack of confidence in the economic environment will make it difficult to convince corporations and governments to increase their charitable spending. I also believe individual giving will require a much higher level of transparency and credibility to gain any market share in the public's spending decisions.

Michael Gorton:
I hope that, economically, we are in for better times. I expect that Fellows, the public and the corporate sector will be able to better support the Foundation and its important work.

Bruce Argyle:
There is a growing interest in philanthropy in Australia – this is seen in the increasing number of private ancilliary funds established over the past eight years (now over 800 in total) and by the growth in members at Philanthropy Australia (over 10 per cent for each of the past three years). In the next 12-18 months we will see additional new structures being set up to support philanthropic intent. The longer term outlook for the Australian philanthropic sector is optimistic – continuing increases in activity, greater awareness of "hands on" giving possibilities alongside a huge transfer of intergenerational wealth over the next 20 years.

To make a bequest, become a patron and for all other inquiries please contact:
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ANZCA in the news


ENCOUNTER WITH KATE LESLIE

Switching off brain and pain

The new head of the College of Anaesthetists wants to raise the profile of a profession few can spell, let alone understand.

By KATE COLE-ADAMS

S

Anaesthesia and pain medicine have continued to receive widespread exposure over the past few months, mainly through lengthy features that have appeared in print and on radio.

The Age profiled ANZCA President Professor Kate Leslie in a 2100-word Encounter article published in its Saturday Insight section earlier this month. *The Age's* Saturday readership is more than 880,000.

Another ANZCA Councillor, Associate Professor David Scott was quoted at length in a feature on anaesthesia and its cognitive effects that appeared in the Men's Health section of the *Australian Financial Review* in July.

The Mercury in Hobart also ran a lengthy feature on anaesthesia in its weekend magazine later that month.

Associate Professor Andrew Davidson was quoted in a recent article in *The Weekend Australian* on research published in *The Lancet* which looked at the effects of asthma and other conditions on children having an anaesthetic.

Life as an anaesthetist in the Top End was discussed by Royal Darwin Hospital's head of anaesthesia Dr Brian Spain in a live studio interview with Annie Gaston on ABC radio in Darwin. This followed the publication of a profile piece on Dr Spain in the June *ANZCA Bulletin*.

Other lengthy radio interviews were done in Western Australia. Dr Chris Johnson was interviewed by Russell Woolf on the ABC's Drive program in early July and soon after an interview with Dr Andrew Gardner was heard on ABC radio's regional networks. The interview was aired in regions including ABC South Coast and ABC Great Southern.

Also in Western Australia, Dr Eric Visser was interviewed widely on mirror therapy as a method of treating pain following his keynote address at the combined ANZCA/Australian Society of Anaesthetists WA Winter Scientific Meeting in Perth. Articles appeared in the *Canberra Times*, *The Age*, the health section in *The West Australian* and *Australian Doctor*. A lengthy interview also went to air on ABC radio Perth's afternoon program.

In New Zealand, immediate past President, Dr Leona Wilson, was quoted in a story that appeared in *The Press*, Christchurch, in July on an improvement in the number of adverse events occurring in anaesthesia in New Zealand.

ANZCA's communications unit is always looking for good news or general interest stories that can be promoted in the media. If you have an idea or suggestions, please contact media manager, Clea Hincks, at ANZCA via e-mail **chincks@anzca.edu.au** or by phone **+61 3 9510 6299** or **0418 583 276**.

A Top End Experience

By Dr Raymond Nassar, Staff Specialist
Westmead Hospital

In May 2010 I was part of a team of healthcare providers from Westmead Hospital who visited Nhulunbuy in the Northern Territory.

Nhulunbuy is the Yolngu name for the township in north east Arnhem Land. The traditional landholders in this area are the Yolngu people. Gove is the official name of the airport and harbour and a commonly used name for the town. The Nhulunbuy township was built in the 1960s to service the bauxite mines of Rio Tinto. The population is currently 4000. The Gove peninsula, an area of 100,000km, has been populated by the Yolngu people for 40,000 years and has an overall population of 13,000.

The Westmead healthcare team was brought to the Top End as part of the Australian Government's "Closing the Gap" program for paediatric oral health care. Their aim was to provide dental care to paediatric Aboriginal patients in the east Arnhem Land area and it was the second time that a group of paediatric dentists and an anaesthetic team from Westmead had visited Nhulunbuy. It is only one of many trips that have been made by medical and dental teams since the Northern Territory Emergency Response (NTER), also referred to as "the intervention", began.

In June 2007 the "Little Children Are Sacred" report led to the announcement of the NTER to protect Aboriginal children. Part of this intervention involved child health checks. Nine thousand children were assessed and dental neglect was identified as the most widespread health problem among Aboriginal children with 40 per cent having untreated dental decay. One third of those were referred for further treatment and it was estimated that 10 per cent would require their treatment to be completed under general anaesthesia. This workload could not be managed by local hospitals so the treatment of these patients has been managed by sending outreach teams from Darwin, Canberra and Westmead. The teams have operated in Alice Springs, Katherine, Gove and Tennant Creek hospitals.

The reasons for the high rate of dental decay in the children are multifactorial. A diet with a high intake of carbonated drinks, poor oral hygiene and lack of availability of primary oral health care are major contributing factors.

The team consisted of two dentists with paediatric subspecialisation, a dental registrar, two dental assistants, Dr Jane McDonald (paediatric anaesthetist), Dr Raymond Nassar (anaesthetic Fellow), an anaesthetic (enrolled) nurse and a recovery (registered) nurse. Registration to practice in the Northern Territory and accreditation at Gove District Hospital were obtained. The township and surrounding area is owned by the local indigenous people and visitors require permits to travel to different sites. Dhimurru Land Permits were obtained from the Land Council to enable us to visit some of the surrounding areas. Hospital Visitors Permit only enabled us to travel between the airport, hospital and our accommodation in the town.

As the anaesthetic trainee, it was a great opportunity to gain some intense exposure to paediatric anaesthesia, as well as an insight into indigenous health issues. During the week of operating we anaesthetised 30 Aboriginal children between the ages of two and 12 years, who underwent general anaesthesia for dental extractions and repairs.

We were based at Gove District Hospital, a 32-bed hospital with two functioning operating theatres usually staffed by GP anaesthetists and local nursing staff. The hospital has a maternity and paediatric ward, as well as an emergency department and general wards. As a result of the geographic remoteness, any significant medical or surgical problems require evacuation to Darwin (600km away) which is only accessible by air. Children under the age of five are not normally allowed to undergo anaesthesia at the hospital.

Paediatric patients were booked for theatres through community dental clinics. A locally based dental technician travelled to the more remote communities in the lead up to the Westmead team's arrival and booked appropriate cases onto the GA waiting list.

Patients were from remote Aboriginal communities such as Elcho Island, Sandy Beach, Ski Beach, Yirrkala, Biranybirany, Gapuwiyak and Milingimbi. Patients and their carers were flown to Nhulunbuy the day before their operation and accommodated in local hostels. In order to ensure compliance, patients from each particular community were brought in on the same day so that they could remain within their own cultural and family groups. A few patients could not be found on the days they were to be collected from the more remote communities. Their places on the theatre list were filled at short notice by local patients.

In addition to the referrals from the community-based dental clinics other cases were booked by the dental registrar on our team. She spent the entire week at a dental-health clinic at Yirrkala, half an hour from Nhulunbuy. She treated simple cases on-site, referring more complex cases to Gove hospital for general anaesthesia. In order to maximise attendance to this dental clinic, a local health worker drove through the community in a minibus, announcing in Yolngu language the presence of a children's dentist through a megaphone!

For the hospital team, a typical day commenced with an eight o'clock start in theatres. The five minute drive to work from the Walkabout Lodge where we stayed was a pleasant change from the usual struggle through heavy Sydney traffic. Pre-anaesthetic assessments had been made the day before, and we would meet the children in a separate waiting room and escort them to the operating theatre accompanied by their carer.

An inhalational induction was typically performed. The children were enticed to blow up the "b'loon". Not being sure if these children were used to blowing up balloons as we may be used to when celebrating birthday parties, we were pleased to find that most of them were familiar with this concept. The majority of children were very cooperative but a few were tentative and needed more persuasion for the induction.

Overall, the behaviours of the indigenous children were similar to those of children that we see in very multicultural western Sydney. In contrast, the responses of the carers during anaesthetic inductions were varied. Some carers showed the common emotional response of tearfulness on seeing their relative fall asleep under anaesthesia. Others simply walked out of the room mid-induction with no display of emotion.

Another major difference to my previous experiences in paediatric anaesthesia was that the carers that accompanied the patients were usually aunties, grandmothers or sisters. Occasionally mothers were present, whereas fathers were rarely so. One child was accompanied by another child, his 15 year-old sister! Often the same carer would accompany several children into the operating theatre for their anaesthetics.

Patients and their families seemed grateful for their treatment which must have made their mouths feel better and eating less uncomfortable. Some of the kids loved their stainless steel crowns, which were perceived as a kind of "bling" for the mouth. Two children had been treated during the previous year's dental trip and presented for follow-up. Their overall dental health had greatly improved as a result of intervention and education.

The pre-anaesthetic assessments were especially interesting. Cultural differences included very limited knowledge of English by both carers and patients, vast differences in non-verbal communication and a great unreliability by family members to give an accurate medical history. On more than one occasion a medical history obtained from a carer would fail to yield any significant information. However, inspection of the medical records would reveal numerous admissions to hospital for medical conditions and surgical procedures.

Non-verbal communication was one of our biggest challenges in establishing rapport. Over the course of the week, we became familiar with the local "sign language". For example, raising the eyebrows meant "yes", tapping on an out pouched cheek meant "drink" and the bottom lip extended meant "no". To aid our understanding of the local sign language, a wall chart of commonly used signs was displayed in the pre-admission area with the suggestion that they were useful for us balanda (non-Aboriginal people) to learn.

Overall, the health of the children was very good. Numerous patients had undergone investigation for cardiac murmurs by "rheumatic heart disease" registrars, but the majority of murmurs were innocent.

(continued page 76)

"Part of this intervention involved child health checks. Nine thousand children were assessed and dental neglect was identified as the most widespread health problem among Aboriginal children with 40 per cent having untreated dental decay... it was estimated that 10 per cent would require their treatment to be completed under general anaesthesia."

From top left: James Yunipingu, Dawn Yunipingu (in wheelchair), Salome Dhurrky (wearing white shirt), Sharon Yunipingu, Adam (little child), Bronwyn Gurruwiwi (last on right); Mathius Ngurruwuthun with Dr Raymond Nassar.

A Top End Experience
continued

Fasting instructions were to "not eat or drink after the sun comes up" for all patients and carers regardless of their scheduled operation time. This was necessary as eating is done together as a community and the message of separate fasting was hard to explain.

The patients and their carers did not like the cool, air-conditioned environment of the hospital and were keen to get outside as soon as possible after their procedure. Post-op we could find most of them sitting on the ground outside the hospital, enjoying the "healthy" snacks they had been given to both patient and carer to aid recovery.

Anaesthetic equipment at the hospital was well stocked and of high quality. The only equipment that we brought with us were some spare paediatric T-pieces, Cass needles which were resterilised by the local CSSD, and some ondansetron. We also brought some disposable Yeescopes in case we had problems with having enough laryngoscopes. They were a useful back-up.

In early 2010 the Australian Indigenous Doctors' Association (AIDA) launched an impact assessment of the Australian Government's NTER. Many aspects of the NTER, such as imposition of external governance and control, compulsory income management, alcohol restriction and prohibition of substances, were found to be having a negative impact on psychological health, social health and well-being, and cultural integrity. However, interventions such as the child health checks and initiatives that increase access to specialist health services are seen as an area with potential positive impacts.[1]

Ongoing positive impacts of the Northern Territory medical programs are largely provisional on community involvement, long-term recurrent funding and support of primary healthcare services.

For the Westmead anaesthetic training scheme, involvement in the dental team offers a valuable opportunity for registrars to have a concentrated experience in paediatric anaesthesia along with exposure to the challenges of providing anaesthesia in remote Indigenous communities.

Dr Raymond Nassar, Staff Specialist Westmead Hospital with contribution by Dr Jane McDonald, Visiting Medical Officer Westmead Hospital and Westmead Children's Hospital and Elizabeth Todd.

Reference:

1. O'Mara, Peter "Health Impacts of the Northern Territory intervention" *MJA* Vol 192 Number 10, 17 May 2010 pp546-548.

Photos are with permission of the patients and the Department of Health and Families Closing the Gap Child Oral Health program, which is funded by the Australian Government under the Northern Territory Emergency Response.

New Zealand roadshow

The Chair of the New Zealand National Committee, Vanessa Beavis, is about to embark on a major exercise that will help fulfil one of the key priorities in ANZCA's 2010-12 strategy – that of increasing engagement with the College's members.

Over the next few months, she is planning to visit all 26 departments of anaesthesia in New Zealand's hospitals for face-to-face meetings with Fellows, trainees and other anaesthetists.

The "roadshow", as it is being termed, will build on ANZCA's Fellowship survey carried out earlier this year and provide Dr Beavis with the opportunity to outline initiatives ANZCA is handling on behalf of Fellows and trainees, and international medical graduates (IMGs).

More importantly, it will provide Fellows with the opportunity to let Dr Beavis know what issues they would like ANZCA's New Zealand National Committee to address. Each meeting will see Dr Beavis give a presentation about College initiatives and activities, and then invite a discussion from the floor.

The concept has been warmly received by departments and the national office is now putting together an itinerary that will provide the opportunity for as many anaesthetists and trainees in each department to attend as possible. The first meetings are expected to be held in early October with the program extending into early 2011.

The New Zealand office has set up a dedicated e-mail address for those who want to contact its National Committee Chair – chair@anzca.org.nz.

Other communication initiatives

The College is strengthening its communications activities in New Zealand with the creation of a new staff position, Communications Manager, New Zealand, to raise the profile of the College and its Fellows in New Zealand, and to work with the media to increase public understanding of the role of anaesthesia and pain management. Susan Ewart (above), has been appointed to the role, which includes media liaison, writing New Zealand content for ANZCA's printed and electronic communications and website, managing the New Zealand website and advising on communications strategies. An experienced journalist and legally qualified, Susan comes to ANZCA from a background of handling communications for professional organisations, most recently having been director of communications for the New Zealand Law Society, with responsibility for its publications, website, media relations, and external and internal communications

She will work closely with ANZCA's communications team in Melbourne and with the New Zealand executive officer, Heather Ann Moodie, and its national committee. She may be contacted on communications@anzca.org.nz.

Above right: Susan Ewart.
Opposite page: The NZNC with Professor Kate Leslie at its July meeting.

President's visit

NZNC members were delighted to welcome Professor Kate Leslie in her first visit as President of ANZCA. Kate attended both the joint meeting with the NZSA and the first session of the NZNC meeting. Her key message as President was for ANZCA Fellows and trainees to engage more and become more involved in the opportunities that the College offers them. At the NZNC meeting, she also spoke about the curriculum redevelopment and the new ANZCA merchandise available.

Workforce issues

At the NZNC meeting, HWNZ Board Chair Professor Des Gorman gave a brief overview of his background and then spoke about the work and future plans of HWNZ, a stand-alone business unit within the Ministry of Health. HWNZ aims to provide a single coordinated response to improving New Zealand's ability to train, recruit and retain the health workforce. During a lengthy discussion with the committee, Professor Gorman said that one of ANZCA's challenges would be how best to contribute to the changes being driven by HWNZ.

Since those meetings, the NZNC has been advised that HWNZ has established 10 workforce service reviews, which are to report by the end of the year. The NZNC is seeking further detail about what those reviews cover, who is conducting them and how ANZCA can contribute.

Clinical teachers courses

The New Zealand pilot of ANZCA's foundation level teachers course will be held at the New Zealand national office from October 18-20. There was keen interest in the course, with about 30 applicants for the 12 places. This two and a half day course is designed to equip participants with the fundamental skills, knowledge and attitudes to teach ANZCA trainees effectively.

New Zealand National Committee

The NZNC's July meeting was a busy time with the committee welcoming new committee members, ANZCA President Kate Leslie and other visitors to its meeting, farewelling outgoing members, electing officers for the next year and holding its annual joint meeting with the New Zealand Society of Anaesthetists.

The election saw Dr Vanessa Beavis (Auckland) appointed chair for a third year, with the previous deputy chair, Dr Paul Smeele (Christchurch), having chosen to step down from the committee. As well as Dr Beavis, the following officers were elected:

- Deputy chair and national education officer: Dr Geoff Long (Waikato).
- Honorary secretary and honorary treasurer: Dr Gerard McHugh (Palmerston North).
- Chair, New Zealand Panel for Vocational Registration: Dr Vaughan Laurenson (Christchurch).
- National quality and safety officer: Dr Joe Sherriff (Invercargill).
- Formal projects officer: Dr Jennifer Woods (Christchurch).

As well as various regular reports and agenda items, other matters considered at the meeting included:

- An update on the new online ITA process with Ian Collens, ANZCA's Director of Strategy and Operations.
- An update from Dr Leona Wilson, as Chair of the ANZCA IMGS Committee, on the revised IMGS process and discussion about the role of community representatives on IMGS interviewing panels.
- The attendance of Professor Des Gorman, Chair of the Health Workforce New Zealand (HWNZ) Board, with Professor Gorman outlining his background and speaking about the work of HWNZ and how ANZCA can contribute.

The next NZNC meeting is scheduled for Friday, November 26.

NZNC/NZSA joint meeting

The NZNC's annual joint meeting with the executive of the New Zealand Society of Anaesthetists (NZSA) was held in Wellington on Friday, July 23. The main topic of discussion was workforce issues.

Ian Collens presented preliminary results from ANZCA's New Zealand Workforce Survey. The extraordinarily high response rate to the survey (75 per cent) has provided worthwhile data. Although Ian has resigned as ANZCA's Director of Strategy and Operations, he is continuing to analyse the survey data. In particular, he is aligning its implications for supply with data from New Zealand's Ministry of Health so that he can complete a final report addressing both the supply and demand workforce elements.

NZSA's Dr Andrew Reid spoke about NZSA's work on health workforce planning.

National Registrars' Meeting

New Zealand's National Annual Registrars' Meeting will be held on Friday, December 3 at Auckland City Hospital. This all-day meeting is a forum for New Zealand trainees to present audit and research projects. The NZNC provides support to the registrars' meeting and prize. Trainees from centres around the country who cannot travel to Auckland because of work commitments are able to link to the meeting by videoconference.

IMGS

Between March and the end of August, ANZCA New Zealand's IMGS panels interviewed nine international medical graduates on behalf of the Medical Council of NZ and completed 10 ANZCA work-based assessments (WBAs). Planning is under way for seven more IMGS interviews on September 27 and a further three WBAs to be conducted in October-November.

Quality and safety

Dr Joe Sherriff has been elected to the new role on the NZNC of quality and safety officer, a position being established in all ANZCA's regions as well as at the national level for New Zealand. The main aims of the role are to:

- Act as a point of contact and as a conduit for relevant quality and safety information.
- Seek opinions for submissions relating to quality and safety reviews.
- Attend pertinent local quality and safety workshops/meetings where possible, and liaise with the quality assurance officers in accredited hospitals.

Recent publicity about claims under New Zealand's accident compensation (ACC) scheme showed anaesthesia practice in a good light with claims having halved in the last four years. ACC's figures showed that there were only 65 treatment injury claims in the anaesthesia category during the 2009-2010 year, continuing a steady reduction since 2006-2007, when there were 135 claims. Nearly all other categories showed considerable increases. Interviewed by *The Press* (Christchurch), ANZCA's immediate past president Leona Wilson stressed ANZCA's and the profession's commitment to patient safety and quality practice.

NZ Pain Society abstracts

Abstracts are invited for oral or poster presentations for the New Zealand Pain Society's Annual Scientific Meeting. To submit an abstract for consideration by the organising committee, you must also register to attend the conference. The theme is "Planning for Pain Management". The closing date for abstract submissions is January 3, 2011. See www.workz4uconferences.co.nz/Conference-Calendar/NZ-Pain-Society-Inc-Annual-Scientific-Meeting-2011.aspx for guidelines as to what is required for the abstracts, to submit an abstract or to register for the conference, which is being held in Christchurch, March 17-20, 2011. ANZCA's Faculty of Pain Medicine is associated with this ASM.

BWT Ritchie Scholarship winners

The BWT Ritchie Scholarship selection committee has awarded two scholarships for 2010 to Dr John Smithells and Dr Nina Civil, who are now both completing Fellowship years at Derriford Hospital, Plymouth, UK.

Dr John Smithells, (above) who is based at Waikato Hospital, has secured a 12-month position as International Training Fellow in Cardiothoracic Anaesthesia at Derriford Hospital. Dr Smithells hopes to expand his anaesthetic experience, particularly for patients requiring ventricular remodelling, atrial fibrillation ablation and percutaneous aortic valve replacement. He would also like to contribute to the department's research work in a number of innovative areas.

Dr Nina Civil (above) has recently completed her ATY-2 year as an anaesthetic registrar at Rotorua Hospital and will undertake her provisional year at Derriford Hospital. Dr Civil's Fellowship will be divided into two blocks: six months will be spent as the Regional Anaesthesia Fellow and six months as the Simulator Training and Medical Education Fellow, based at the Peninsula Simulation Centre. Dr Civil is looking forward to increasing her skills in regional block techniques and to developing skills and knowledge in her special interest of medical education, particularly with the use of simulation.

More productivity in operating theatres

On August 24, New Zealand's Health Minister Tony Ryall launched a new productivity program led by surgeons, anaesthetists and theatre nurses to improve quality and efficiency in public hospital operating theatres.

Teams from Waitemata, Auckland, Tairawhiti, Whanganui, Hawke's Bay, Hutt Valley and southern district health boards are working with experts from Britain's National Health Service (NHS) to improve operating theatre management.

The new program encourages frontline staff to identify problems with their operating procedures and find ways of solving them.

"Theatre staff are often frustrated by delays in starting the day's surgical list, and delays in preparing patients. These delays often mean less productivity with patients having their operations cancelled," Mr Ryall said. He said results from the NHS program suggested productivity improvements could be made in a number of key areas:

- Improving start time and turnaround, session uptake and utilisation, and staff wellbeing.
- Reducing time wasted searching for equipment.
- Improving rates of pain control in recovery.
- More smoothly running surgical lists with fewer glitches and improved safety culture with the introduction of briefing and debriefing, along with the WHO checklist.

"Theatre staff report fewer cancelled operations, up to 25 per cent reduction in start time delays, up to 60 per cent faster turnaround between each operation, and significantly improved job satisfaction.

"The public health service is making progress in doing things better, and making the most of our resources. This approach will help us provide even more operations with the same resources.

"It is very encouraging to see clinicians showing such enthusiasm for making even greater improvements to the way they work," Mr Ryall said.

The surgical teams start the program in their hospitals in September.

Medicine recall guidelines under review

On August 3, New Zealand's Health Minister Tony Ryall announced consultation on new recall procedures for medicines and medical devices following a number of medicine recalls earlier this year. The Ministry of Health had been looking at processes, procedures, contracting arrangements and the level of compensation for pharmacies when they are involved in recalls.

As a result, Medsafe had revised the recall guidelines. The revised guidelines, *Uniform Recall Procedure for Medicines and Medical Devices*, were open for consultation until August 27.

In parallel, the Ministry of Health is continuing to work on the issue of compensation for costs incurred by health professionals participating in a recall.

Both the guidelines and compensation work are expected to be finalised before the end of the year.

Targets met

New Zealand's Health Minister Tony Ryall says the first full year of the government's new health targets shows that district health boards (DHBs) are delivering more frontline services.

Among other highlights, he noted that for elective surgery, DHBs had delivered 105 per cent of their target, with all but one meeting its individual measure, and that one (MidCentral) still meeting 96 per cent of its target.

The Medical Council and district health boards agreement

On August 18, New Zealand's Medical Council and the country's 20 district health boards (DHBs) signed a Memorandum of Understanding (MoU).

The document was signed by ANZCA Fellow and former NZNC member Dr Don Mackie in his capacity as chair of the DHB chief medical officer group, and Mr Philip Pigou, the Medical Council's chief executive. It enables DHBs and the council to work collaboratively, clarifying their respective roles and responsibilities on the regulation of doctors in New Zealand.

Mr Pigou said that the MoU signing recognised the need for clinical governance and leadership between DHBs, the council and clinicians.

"The MoU will help achieve our joint objective of ensuring the competence and quality of our medical workforce," he said. It would also benefit patients by contributing to quality and safety in the health system.

The MoU outlines several new joint initiatives between the council and DHBs, including the development of processes for international medical graduates to assist with their orientation and induction into the New Zealand health system. A planned online portal will offer information and links on cultural issues, how the New Zealand health system works, immigration and other support services.

Dr Mackie said that time and money would be saved because the roles and responsibilities were clearly set out.

"There are now very clear expectations about the registration, reference checking and sharing of any information or concerns we might have about a particular doctor with the Medical Council," he said.

"We're also strongly committed to ensuring the orientation and induction of new doctors into our health system and to providing an environment which supports learning and development."

The MoU also addresses issues of competence and conduct with a notification process by DHBs (or other employers) to the council of concerns about a doctor's competence and the exchange of information by council to DHBs about competence and conduct processes.

It also provides clear processes for sharing information about doctors who are not DHB employees but may pose a risk to public health and safety.

The MoU contains information relevant to the council and DHBs in the employment of doctors within the service of the DHB. The next step is to work with the RNZCGPs and other stakeholders to explore how the MoU can be extended to include those doctors working in primary care.

Medical Council research

New Zealand's Medical Council has asked TNS New Zealand, a market research company, to replicate research it undertook for the council in 2007.

The research is looking at perceptions of the Medical Council's objectives and performance in various areas. The council wants the research to provide a better understanding of how it is perceived and recommendations on how communications with its different audiences can be improved. The research may also form the basis of social marketing or the development of consumer documents.

Regional news

Victoria

31st Annual Combined Continuing Medical Education meeting

More than 200 delegates attended the 31st Annual Combined Continuing Medical Education meeting at the Sofitel on Collins in Melbourne on Saturday, July 24. The theme was “Anaesthesia – tools of our trade”, and the sessions were devoted to discussions of drugs, monitoring, airway devices and quality and safety. It culminated in a fascinating insight into the recent separation of conjoined twins Trishna and Krishna.

Above from top: Dr Andrew Davidson, Dr Brian Cowie, Dr Adrian Hall and Dr Peter Seal; Dr Mark Hurley, Dr Rowan Thomas and Professor Kate Leslie.

South Australia and Northern Territory

Part 0 course for new trainees

On August 1, SA/NT held their Part 0 course for new trainees at the SA/NT regional college to assist them integrating into the SANTRATS training program. Dr Rowan Ousley, chair of the SA/NT Trainee Committee and Dr Rebecca Lewicki ASA/GASACT representative, facilitated the course. Topics covered included the role of ANZCA, ASA and GASACT, trainee welfare, role of SOTs, ANZCA accredited hospitals, training modules, formal projects, examinations and in-training assessments. The course receives excellent feedback from new trainees and begins their relationship with ANZCA feeling supported and confident to proceed with their training.

Above from left: Dr Rowan Ousley (Chair, Trainee Committee), new trainees Prasanna Ramachandran, Monica Li, Darrin McKay, Prashan Kuruppu and Adam Storey, Rebecca Lewicki (ASA/GASACT representative).

SA/NT Scientific Registrars CME meeting

The SA/NT Scientific Registrars CME meeting was held in mid-August. Five registrars presented their formal projects and the winning presentation was awarded to Dr Min-Chi Lee for her presentation on “Providing written information about anaesthesia to patients having elective surgery: A review of practice”. Dr Simon Roberts, past Regional Committee chair, was the course convener and there were 35 attendees. The meeting was also video-conferenced to Royal Darwin Hospital.

Above: Dr Min-Chi Lee

New South Wales

Port Macquarie ACEC – Future directions in anaesthesia

The NSW Anaesthetic Continuing Education Committee is venturing to Port Macquarie for its annual weekend meeting from November 20-21. Following a tumultuous federal election who knows what lies ahead for health care in Australia? Whatever the outcome, major health reform is coming to an operating theatre near you. This CME meeting, “Future Directions in Anaesthesia – where to next?” will explore some of the changes in health care that are likely to have an impact on your practice.

Professor Stephen Leeder will deliver the plenary address exploring the political aspects of health reform. There will be talks on anaesthesia as it occurs in remote and regional locations as well as some perennial favourite workshops such as the use of ultrasound in anaesthesia, failed intubation, use of the new “smart phones” and by popular demand a repeat of the “Harvey” simulator workshop demonstrating cardiac signs and symptoms in preoperative assessment.

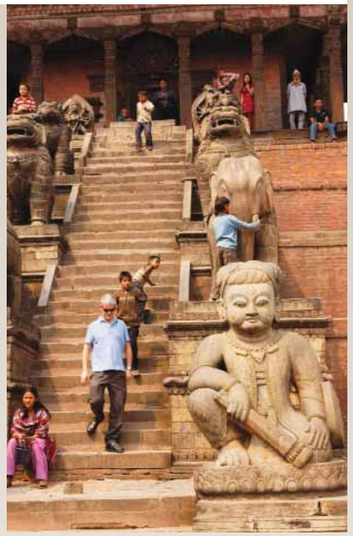
For more information please contact the Sydney ANZCA office on +61 2 9966 9085 or visit www.nsw.anzca.edu.au/events.

Australian Capital Territory

Advanced teacher course – delivering feedback

The ACT Regional Committee hosted an advanced teacher’s course on the topic “delivering feedback” on August 28. Local ACT and NSW Fellows were in attendance. The ACT Regional Committee and Australian Society of Anaesthetists ACT held a two-hour workshop on Friday, September 10, entitled “Ultrasound from A to Anaesthezee” providing an introduction to ultrasound with plenty of time for hands-on experience in small groups. This was followed on Saturday, September 11, by “Simple But Not Easy: Anaesthetic Management of Acute Trauma” – a combination of short lectures and hands-on stations focused on airway management, ultrasound and transfusion. The workshops were given ANZCA CPD program approval.

Tasmania



Kathmandu program

This year saw a continuation of the Royal Hobart Hospital's involvement with anaesthetic training in Nepal. Doctors Simon Morphett, Simon Pitt, Bill Miles and Roger Wong presented a series of lectures and workshops in Kathmandu at the SAN (Society of Anaesthetists of Nepal) Refresher Course in April (among other local and international speakers). The educational theme this year was the cardiovascular system, and the lectures and workshops (on basic TTE evaluation, CPR and problem based learning scenarios) were received enthusiastically by the Nepalese participants.

The hospital also took part in the scientific meeting at the SAN Congress. There were a number of very interesting audits presented by the Nepalese anaesthetists, including spinal anaesthesia for laparoscopic cholecystectomies and post dural puncture headaches with Quincke spinal needles. Dr Pitt reviewed the use of ECHO for haemodynamic assessment.

Dr Wong remained behind for a further two weeks working at the Kathmandu Medical Centre helping teach the Nepalese anaesthetic registrars. This was extremely valuable and helped give a better understanding of the very different working conditions in Nepal. It also provided feedback to our department on how one of the previous Nepalese anaesthetists the hospital had sponsored to stay in Hobart, was using the knowledge gained from his time with us.

The hospital will again sponsor a Nepalese anaesthetist to come to Hobart for a month this year, and plans to take part in next year's SAN Refresher Course. It is encouraging to witness the enthusiasm with which the Nepalese anaesthetists learn and apply themselves, and we hope that our relationship will continue to expand over the coming years.

From top left: Nepalese anaesthetists Dr Babu Raja Shrestha and Dr Amir Babu Shrestha on a ward of the Hospital for Disabled Children, Duhlikel, Kathmandu; Dr Simon Morphett on the steps of Nyatapola temple, Nepal.

Hobart paediatric update

A meeting entitled "Hobart paediatric update for the occasional paediatric anaesthetist" was held this year at the University of Tasmania Clinical School. This event was organised by Dr Ben van der Griend, paediatric staff specialist anaesthetist at the Royal Hobart Hospital. The full-day meeting was well attended, with more than 120 registrants from around Tasmania and interstate. The topics ranged from difficult paediatric airways, fluid management, resuscitation to congenital heart disease, with speakers from Tasmania and the Royal Children's Hospital, Melbourne. This meeting provided useful information and tips for non-paediatric anaesthetists.

Western Australia

WA Winter Scientific Meeting

The Annual Winter Scientific Meeting was held on Saturday, July 31, at the Perth Convention and Exhibition Centre. The theme of the meeting was "Current Challenges in Anaesthesia". The meeting was well supported with more than 150 anaesthetists and 34 trade representatives attending.

This scientific meeting is the first of the three-year WA lectureships named in honour of our esteemed colleague Dr Ian McGlew. Pain medicine specialist Dr Eric Visser gave the first in this series speaking on "What's new in pain: Smoke and mirrors" (see page 92). The morning session included a lecture from endocrinologist Dr Emma Hamilton who discussed the recent advancements in diabetes including new medications and treatments.

Morning tea was followed by the free paper session and the ANZCA Western Australia Annual General Meeting. The Dr Nerida Dilworth Prize, which is given to a registrar in anaesthesia in Western Australia who contributes significantly to the ASA and/or ANZCA, was awarded to Dr Manuel Wenk. Dr Nerida Dilworth attended the meeting to present the prize.

The first session after lunch was presented by Dr Mark Krumrey, a consultant anaesthetist from Fremantle Hospital, on "Optimal management of a patient undergoing joint replacement", followed by Dr Preeti Nirgude, previously an enhanced recovery anaesthetic Fellow at St Mark's Hospital, Harrow, UK, now based at Fremantle Hospital, who spoke about enhanced recovery following colorectal surgery. Delegates also had a choice of a concurrent impaired-colleague workshop presented by specialist addiction medicine physicians Dr Moira Sim and Dr Eric Khong.

The final session consisted of a choice of three workshops including "Airway toys and tools" with Dr Alex Swann, "Management of double lumen tubes" presented by Dr Bill Weightman and "Practical fluid management" with Dr Michael Ward. Thank you to those people who assisted with the workshops. There was also a case panel discussion chaired by ANZCA WA Chair Dr Jenny Stedmon and assisted by panel members Dr David Wright, Dr Brien Hennessy, Dr Craig Cox, Dr Luke Torre and Dr Malcolm Thompson in which a new electronic keypad voting system was trialled.

Above from top left: Delegates at the meeting; Dr Sarah Wyatt and Monzer Sadek; Dr Eric Visser and Dr Peter McLoughlin; Dr Markus Schmidt, Dr Stephen Hilmi, Dr Prani Srivastava and Dr Andrew Miller.

Queensland

Primary exam preparation short course

The primary exam preparation short course was held in late June. The course was fully subscribed with 35 participants who heard from Dr Frances Ware, Dr Paul Murphy, Dr David Sturgess, Dr Cameron Hastie, Dr Jules Maussen, Dr Alex Donaldson, Dr Mark Young, Dr Dean Haydon, Dr Peter Kruger, Dr John Morgan, Dr Wayne Sorour, Dr Gabe Mar Fan, Dr Steve Tavakol, Dr Andrew Udy, Dr Peter Moran, Dr Graham Mapp, Dr Michael Edwards, Dr Hamish Pollock, Dr Simone Malan-Johnson, Dr Chris Joyce, Dr Peter Scott, Dr Peter Watt, Dr Hau Tan, Dr Victoria Eley, Dr Nathan Goodrick, Dr Kathleen Cooke and Dr George Pang (convenor).

Primary Lecture Program

The Primary Lecture Program for semester two has commenced. The lectures are held monthly on a Saturday in the Queensland regional office and the convenor is Dr Gamini Wijerathne. Topics covered so far include fluid and electrolytes, neurophysiology, autonomic physiology and pharmacology, antiarrythmic agents, physiology and pharmacology of pain, opioid and non-opioid analgesics and apioid antagonists. Thank you to speakers Dr Matt Kelso, Dr Mark Lai, Dr Gamini Wijerathne, Dr Rebecca Ruberry and Dr Paul Franks and convenor Dr Gamini Wijerathne.

ANZCA Queensland Regional Committee AGM

The ANZCA Queensland Regional Committee AGM was held on July 21 and the guest speaker was Dr Tony O'Connell. Dr O'Connell is a Fellow of ANZCA and CICM and spent 28 years as an anaesthetist and an intensive care specialist. In 2009 Dr O'Connell was appointed CEO for the Centre for Healthcare Improvement in Queensland.

Final exam preparation course

The final exam preparation course was run in July. The course was fully subscribed with 31 participants, including participants from Perth and New Zealand who heard from Dr Dominique Hopkins, Dr Peter Moran, Dr Rebekah Ferris, Dr Genevieve Goulding, Dr David Trappett, Dr Mark Dilda, Dr Sue Lawrence, Dr Anna Miedecke, Dr Dean Haydon, Dr Paul Gray, Dr Victoria Eley, Dr Hau Tan, Dr Michael Fanshawe, Dr Simon Pattullo, Dr Mark Lai, Dr Adrian Chin, Dr Pal Sivalingam, Dr Peter Reid, Dr Victoria Eley, Dr Peter Waterhouse, Dr Steve Cook and Dr Helmut Schoengen (convenor).

FPM CME dinner meeting

On Tuesday, July 27, the Faculty of Pain Medicine Queensland Regional Committee hosted their third continuing medical education dinner meeting for 2010. Dr Michael Gattas from Brisbane Genetics Private Clinic spoke on genetics and musculoskeletal medicine and the event was well attended by pain medicine Fellows.

2010 Queensland retired anaesthetists' lunch

On Wednesday, August 25, the ANZCA Queensland office hosted a casual lunch for retired anaesthetists in Queensland. Thank you to Col Busby for initiating this lunch. It is a great social event for retired anaesthetists and a wonderful opportunity for those who have not visited our new premises in West End to see them.

Clinical training workshop

Friday, July 30 was the day of the clinical training workshop in Queensland facilitated by the Education Unit out of Melbourne. There were 15 attendees and the topic covered this year was delivering feedback.

34th Annual Combined ANZCA/ ASA CME meeting

On July 10 the 34th Annual ANZCA/ASA Combined Continuing Medical Education meeting was held at Victoria Park Golf Complex. The theme for the day was acute pain, the ongoing challenge. The day was well received by 95 attendees, who heard speakers Professor Julia Fleming, Dr Rob Thomas, Dr Peter Goodyear and Dr Paul Frank. Following lunch, the afternoon contained problem-based learning discussions facilitated by Professor Fleming, Dr Tania Morris, Dr Kathleen Cooke, Dr Janice Stafford, Dr James Craig and Dr Nathan Goodrick along with a workshop held by Dr Mike Haines and Dr Frank on ultrasound guided techniques.

From top: Dr Mike Haines presents his workshop on ultrasound guided techniques; A problem-based learning discussion session.

Dean's Message

Those engaged in Faculty and College affairs have been well occupied with the future, only some of which will be mentioned here. First for mention is the appointment of Associate Professor Milton Cohen to the role of Director of Professional Affairs (DPA) for the Faculty. Although this is a part-time position, it already has shown how much input organisations like ours have to make to many of important processes, such as the Australian Medical Council's request for input into their competence-based medical education proposals. The demand for input into this and similar submissions seems to be increasing. Engagement of DPAs within ANZCA and the Faculty ensures quality responses beyond what pro bono participants alone can keep up with these days. We are fortunate to have the benefit of Milton's extensive engagement with pain medicine over a long time, and as a former Dean of the Faculty, he is well versed in our activities and position on these subjects.

You may recall that a variety of opioid topics were referred to in my last message, cued by media items following our Christchurch ASM. We now have (a new) PM1 – "Principles regarding the use of opioid analgesics in patients with chronic non-cancer pain", which was approved by the board at its August meeting. Some may recognise PM1 was the identification of a previous Faculty professional document, but on becoming obsolete it was vacated, freeing this easy to remember number for this purpose – somewhat poetic! It has been a long time coming, partly because of the controversy necessitating significant consultation, partly due to decisions in relation to waiting for some of the recent educational meeting expert visitor presenters, and the need to review a significant amount of the recent literature. Around the world this is a hot topic. One important factor in developing this set of principles, based on the best evidence available no matter how imperfect that might be, was that primary care has one of the greatest needs for guidance on a robust approach to opioid treatment for pain (across the board, not just long term non-cancer pain). What is evident to pain medicine specialists is that the die is often already cast with opioid prescribing by the time we get to see cases. With that need in mind an easy to use single sheet guidance checklist for people such as GPs was included with other appendices as part of the package surrounding PM1. Patients on good, bad or ugly opioid prescribing are often surgical patients, so I would urge anaesthetists to also read through PM1, even if they are not generally managing long term pain cases. Anaesthesia practice includes a high component of opioid prescribing, so being widely informed has to be a plus.

On the subject of primary care, it is pleasing to note that RACGP has set up a fundamentals day on pain in their forthcoming Cairns annual conference ("GP10") in October. We live in times where the interest in managing pain better is on an exponential increase – and where the majority of pain is dealt with away from specialist facilities. So for the specialists – prepare yourselves to engage with helping them with that.

Another working group led by Associate Professor Leigh Atkinson is examining work on neuromodulation best practices and a document is nearly ready for publication for Australia and New Zealand; our DPA in parallel with this has made significant progress on a Faculty position statement based on that working group's recommendations. Again, given the diversity of opinions, it has been a creditworthy exercise that the group is looking for that which captures the best evidence, and there are some other sets of recommendations from elsewhere in the world that have saved much reinvention of the wheel. Without pre-empting their final deliberations, I can say that there is a list which has stratified conditions into those highly likely to respond, and a grey area in between those for which response is unlikely. This is highly relevant to minimisation of resource waste.

Highly connected with interventions such as referred to above, the board recently received a letter from a Fellow asking what was the definition of a pain medicine specialist. For the national registration body, it was earlier agreed that the term for such registered persons would be "specialist pain medicine physician". You can imagine many heated discussions over that term! However, aside from the fact that a blueprinting exercise on this very subject is underway, the board endorsed the underlying premise that such a person was one fully conversant with the full spectrum of the biopsychosocial components that make up pain and its impact, with knowledge enough to integrate and guide the patient through multiple modes of therapeutic help. This does not mean that any one person will be competent to engage in all of surgical, interventional or psychiatric help measures. Nor should surgical Fellows of our Faculty feel threatened that the specialised things they do to help those with complex pain (for example, hysterectomy as part of a wider package, not the sole means to an end in itself) mean they do not fit the definition. Wide knowledge and effecting integration of a range of treatment interventions, usually in a team setting, was felt to be what makes the pain medicine specialists stand out from those with single modes of intervention, focusing on only one facet of the patient's story and predicament.

Many of us attended the 13th World Congress on Pain in Montreal, which is the largest gathering of people with interests in pain, from basic science and health professional backgrounds. I am sure that everyone who attended the Congress came back with some new gems to improve care and made some new acquaintances. Shortly, our Faculty spring meeting in Newcastle will occur and I hope to see you there. Preparations are advanced for the ASM in Hong Kong next May, as well as visiting speaker identification for the year following at Perth. There is no shortage of opportunities for you to be further educated and interact with same interest colleagues.

Dr David Jones
Dean
Faculty of Pain Medicine

International Pain Summit

On September 3, clinicians, health ministers, senior health administrators, the World Health Organization and other organisations representing healthcare, not-for-profit and human rights organisations, from 84 countries met in Montreal at the first global meeting about crucial aspects of pain management, with a focus on advocacy and assistance for all countries to develop national pain strategies.

The World Health Organization estimates that over five billion people live in countries with limited or no access to medicine or treatment for moderate to severe pain. The management of acute pain after surgery or trauma is inadequate in more than 50 per cent of people in developed countries and 90 per cent of people living in developing countries.

The International Pain Summit was chaired by Professor Michael Cousins, who chaired the inaugural National Pain Summit in Canberra earlier this year that resulted in Australia's National Pain Strategy, the first comprehensive national strategy with the largest and most consistent focus on a single healthcare issue in this era. The Australian summit was a catalyst for this global initiative and Australia's National Pain Strategy was a key resource in the delegates' deliberations at the international pain summit.

"Chronic non-cancer pain occurs in at least one in five people worldwide. It can be triggered by surgery, injury, diseases such as HIV/AIDS, multiple-sclerosis, arthritis and shingles – and sometimes for no apparent cause. It is a disease entity that is inadequately managed in the majority of adults and patients worldwide," Professor Cousins said.

"Of people with cancer, 70 per cent experience pain yet it is inadequately managed in more than 50 per cent of adults – and, disturbingly, children – in the developed world and more than 90 per cent in developing countries.

"The reality is that most pain conditions can be effectively treated, if current knowledge can be shared and put into practice. The International Pain Summit is a major step forward towards achieving this."

Discussion at the Summit focused on two areas: the desirable characteristics for national pain strategies and the Declaration of Montreal – an agreement that access to pain management is a fundamental human right. While the Summit agreed in principle that access to pain management is a fundamental human right, there was ongoing discussion about the wording of the Decaration. This will be finalised by a steering committee in the coming weeks and circulated to participants for their endorsement.

Held under the auspices of the International Association for the Study of Pain (IASP), the Summit was attended by a number of Australian pain management specialists including Professor Milton Cohen, Associate Professor Pam Macintyre and Dr Penny Briscoe.

Clockwise from top left: Professor Milton Cohen, Coralie Wales – Chronic Pain Australia, Amanda Neilsen – Chronic Pain Australia; Delegates at the Summit; Dr Stephen Leow and Dr James Cleary Wisconsin University, formerly of Adelaide; Judy Leader President NZ Pain Society, Dr Penny Briscoe, Dr Francis Beeswick; Professor Michael Cousins.

What's new in pain: Smoke and mirrors?

Dr Eric Visser recently gave the inaugural Dr Ian McGlew Lecture at the Winter Scientific Meeting of ANZCA/ASA in Western Australia. The following is an edited version of his speech.

Nociception is not the same as pain

John Connor: *Does it hurt when you get shot?*

The Terminator: *I sense injuries. The data could be called "pain."*

– Terminator 2: Judgment Day (1991)

Although the definition of pain remains unchanged since 1979 (perhaps surprisingly given the massive strides in knowledge since that time), *nociception* was defined for the first time in a review of pain taxonomy in 2008.[1]

Pain is still defined as, *"an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage"*. This is distinct from nociception which is, *"the neural.....encoding and processing [of] noxious (tissue-threatening) stimuli"*; in other words, transducing the energy of tissue damage (mechanical, thermal, chemical, etc.) into neuro-electrical energy for processing in the nervous system. *"Pain is a subjective phenomenon whereas nociception is the object of sensory physiology."*[1]

Pain is a function of consciousness. There's no 'pain centre' in the brain and, strictly speaking, there are no 'pain pathways'; the spinothalamic tract transmits nociception and not pain. Pain doesn't cause changes in the nervous system, although various processes such as cortical changes on fMRI are *associated* with pain.

Nociception is the process that usually (but not exclusively) triggers and drives the multidimensional experience of pain. However, pain can clearly occur in the absence of nociception (tissue damage) (e.g., phantom pain or allodynia). This is a key message for patients, healthcare professionals and even insurance providers, searching for that elusive 'source' of pain on an MRI for example; you can't 'see' pain on an x-ray, and yes, it's quite plausible to have pain without tissue damage!

Nociception is comparable to the process of sound energy being converted into nerve impulses in the inner ear and transmitted to the auditory cortex. *Hearing* is the *conscious perception* of these auditory stimuli, and pain is like 'music', *the complex sensory and emotional experience*. Like pain, you can also 'experience' music in the absence of a sensory stimulus (a tune playing in your head).

The 'Yin and Yang' of nociceptive processing

Central sensitization (CS) is defined as, *"increased responsiveness of nociceptive neurons in the central nervous system to their normal or subthreshold afferent input"*, or simply put, 'increased output for a given input', a true *amplifier* effect. *Hyperalgesia and allodynia* are the clinical signs of CS.[1]

There is continuous modulation of nociceptive traffic in the nervous system, a 'yin and yang' of signal *amplification* (peripheral and central sensitization), and signal *dampening* by processes collectively termed *Diffuse Noxious Inhibitory Control* (DNIC). The balance is tipped in favour of DNIC which is tonically active, so we are not overwhelmed by a barrage of nociception (and pain); for example, the intense pressure (10 kg/cm^2) on our ischiums whilst seated during this lecture!

Patients experiencing severe acute pain and chronic pain syndromes (e.g., fibromyalgia) may have dysfunctional DNIC as a root cause of their problem. A recent trial demonstrated that patients with poor DNIC (determined experimentally), were at higher risk of developing chronic post-thoracotomy pain at six months. Such tests may become part of pain assessment in pre-anaesthesia clinics of the future!

Pain and the virtual body-self: smoke and mirrors?

Pain is a highly personalised sensory and emotional phenomenon which is experienced in our 'internal world' of the 'self' when our tissues are under threat, in turn motivating and conditioning us to take action to avoid tissue damage.

Neuroscientists believe that our sense of 'self' resides in a 'virtual body' (self) (VBS) generated by a brain neuromatrix that is modulated or 'nurtured' by a constant steam of sensory (eg. proprioceptive, visual, vestibular, nociceptive) and cognitive-affective inputs. In response, the neuromatrix 'generates' perceptions which we experience as 'self' (a sense of 'what is *me*' [e.g., *my* arm], our position in 3-D space, the weight and volume of limbs; also experiences such as nausea, heat, itch and pain). In all probability, the VBS operates *4-dimensionally*, with time perceived as 'slowing down' (more time to react?) at times of extreme threat (demonstrated experimentally by dropping psychology students into a net from a great height)!

With this in mind, our bodies might simply been seen as biological machines or 'vessels' that support and defend the viability of our 'true', experiential (virtual) self. Interestingly, this parallels descriptions of the 'soul' in some philosophies.

"Admiral Lord Nelson had a (painful) phantom hand, the presence of which convinced him of the immortality of the soul." (Gooddy W, 1970).

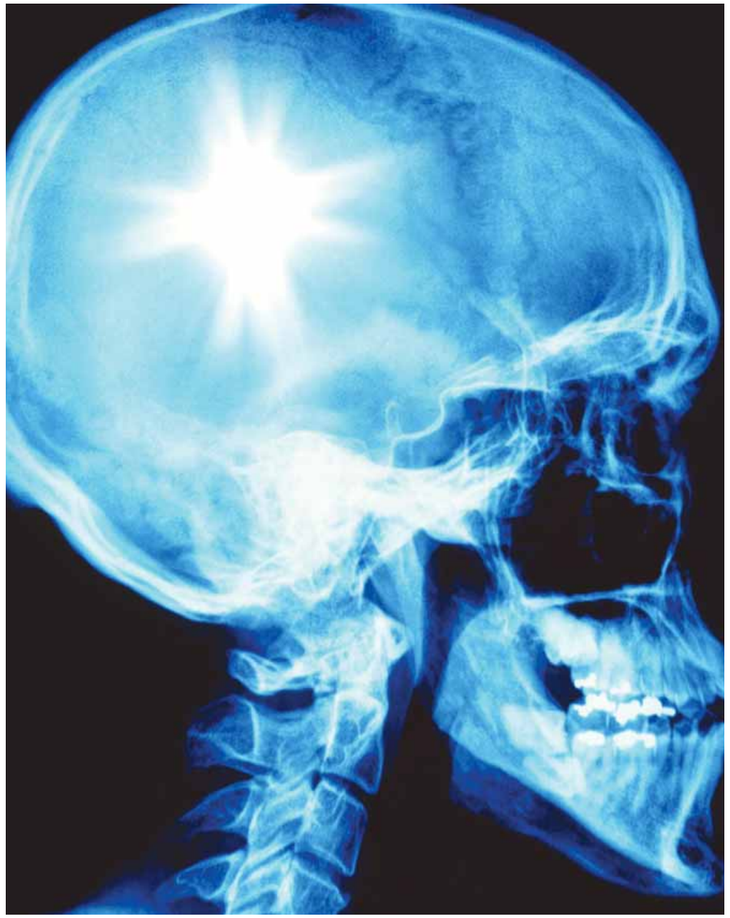
Ronald Melzack proposed that pain is generated by a *pain neuromatrix* in the brain (integrated within the VBS) in response to actual or perceived tissue threat.[2]

When sensory inputs to the neuromatrix are distorted or 'scrambled', the normal integrity of the VBS may likewise be distorted, resulting in altered perceptions. Regional anaesthesia provides a convenient means of 'scrambling' the VBS. The sudden loss of sensory input from a body part can produce strange sensory phenomena such as phantom sensations (the 'fat lip' of a local anaesthetic dental block or 'legs in lithotomy' after a spinal block) and pain. An interesting case report describes a female who developed 'phantom' chest pain after a brachial plexus block of the right arm for shoulder surgery. As the arm became anaesthetised, the right hand was positioned over chest; on waking she reported chest pain similar to the phantom pain she was also experiencing in her anaesthetised hand. Both pains resolved after the local anaesthetic block receded. More amazingly, a patient recently reported a 'painful hand growing out of his chest': Following a traumatic partial amputation, he splinted his injured hand tightly to his chest for many hours prior to surgery and subsequently awoke with it 'imprinted' there! (Visser EJ, 2009: personal communication) There's ample evidence of distorted sensory, motor, visual-spatial and pain processing in Complex Regional Pain Syndrome (CRPS), phantom limb pain and even low back pain.

Sensory-motor conflict (a mismatch of sensory input and motor output) to-and-from a body part (such as a limb) is frequently associated with the generation of pain and other 'distortions' of the VBS, just as nausea is produced when there's a mismatch in vestibular and visual inputs (motion sickness). The ultimate example of sensory-motor mismatch is *limb amputation* (phantom sensation and pain). In CRPS, repetitive strain injury and focal hand dystonia (writer's cramp), sensory-motor mismatch (for example, in violinists, who generate strong motor outputs on the fret board with limited proprioceptive feedback) may be interpreted as potentially 'tissue damaging' by the pain neuromatrix, thus producing pain and motor impairment to 'protect' the virtual (and thereby the *actual*) limb from damage (see Threat Matrix below). Recent trials by Moseley et al demonstrate significant therapeutic benefits in phantom limb pain and CRPS with *cortical retraining programmes* including 'mirror therapy', which serves to re-integrate a 'distorted' VBS.

The 'Threat Matrix' model

As an extension of Melzack's *pain neuromatrix* model, Visser and Davies



postulate the existence of a 'black-box' threat management super-system, integrated within the VBS of humans called the *Threat Matrix* (TM), which manages the entire *spectrum* of actual and potential threats to an individual's tissue integrity and homeostasis.[3]

Teleologically-speaking, various 'noxious' inputs such as cognitions, nociception, immunoception, chemoception, thermoception and conflicts in sensory or sensory-motor processing, are 'interpreted' as threats to the viability of the physical tissue substrate (and by extension the VBS) by the TM, which in turn generates a repertoire of *defensive responses* to deal with these threats.

Such responses include the 'experiences' of fear (anxiety), pain, itch, noxious heat and cold, nausea, dyspnoea (suffocation) and fatigue. They also include *motor and sensory responses* (non-dermatomal sensory deficits and neglect; seen as 'switching off' an 'at-risk' body zone), *pain behaviours* (signaling tissue damage to others in the 'tribe', to obtain help or as a warning) and even *dissociation and depersonalization* (an out-of-body experience is the ultimate means of 'escaping' the VBS when it is overwhelmed by threat, as in PTSD). These phenomena are often associated with significant biological and in particular psycho-social ('yellow flags')

What's new in pain: smoke and mirrors? continued

threat exposure (stress-loading) and are frequently diagnosed as somatoform and conversion disorders, but may actually represent TM responses.

As an *integrated* threat management super-system, it is postulated that *any* threatening stimulus could conceivably trigger *any-or-all* of the TM's repertoire of defensive responses, especially in conditions of 'overload' (as in major trauma). A TM overwhelmed by nociception may produce not only pain (the congruous response), but also fear and nausea. A panic attack shows how a *cognitive* threat not only produces a sense of fear and doom, but also pain, nausea, dyspnoea and depersonalization.

The TM is a teleological model that may help conceptualise the often puzzling variety of threat-related phenomena seen in humans, including pain, fear, sensory-motor dysfunction, illness behaviours and suffering, especially in situations of extreme threat or stress loading. The 'acute stress' ('fight-or-flight') and 'sickness' responses ('curl-up and conserve') are integral to these phenomena.

Chronic pain as part of a whole-organism (person) 'sickness response'

In evolutionary terms, organisms ranging from bacteria to humans exhibit a whole-organism response to (tissue) threat, which in humans may be expressed as a 'stress/sickness response'. The development of pain syndromes such as fibromyalgia/chronic fatigue, whiplash-associated chronic neck pain or irritable bowel, may be associated with the *persistence* of this (usually adaptive) whole-person stress/sickness response, usually in the face of a cumulative or overwhelming threat or stressor load.[4]

Patho-physiological ('wounding', infection, inflammation, cancer) and psycho-social ('yellow flags') *stressors* act as 'triggers' or 'drivers' of this response. A recently published study showed the probability of a patient developing chronic low back pain after an acute injury increased cumulatively with the number of 'yellow flags' to which they were exposed, perhaps reflecting the effects of stressor-loading.

Many chronic pain patients and those with other systemic illnesses such as inflammatory bowel disease, clearly exhibit many of the features of the 'stress/sickness response', *including* widespread and chronic pain, fatigue, cognitive dysfunction, sensory sensitivity and behavioural withdrawal (very much like having a dose of the 'flu' that goes on forever), with sufferers becoming a kind of 'walking-wounded'. Importantly, chronic pain is an *effect* of the sickness response, not a *cause* of it. This reflects complex changes in cellular, genetic, neurological (including psycho-cognitive and autonomic), endocrine, environmental and in particular immune (cytokines) systems, occurring in-and-around the sufferer.

Such patients may respond to modulation of these responses through 'whole-person engagement', using treatments as diverse as psychology (especially stress management), physical therapies, neural (drugs, 'blocks', mirrors, virtual-reality etc) and immune modulation, even placebo techniques. Multidisciplinary *educative* pain programmes ('knowledge is power') are being investigated to help persons 'modulate' their own pain experience through information and self-efficacy.

The fear-pain continuum

The associations between fear (anxiety) and pain are numerous (neuro-anatomy, physiology, pharmacology, psychology, epidemiology); they might even be considered a 'continuum'. To paraphrase the IASP definition of pain, *fear* may be considered, *'an unpleasant physiological and emotional experience associated with actual or potential ('total') tissue damage'* (an existential threat!). The development of 'widespread pain syndromes' such as fibromyalgia may represent a 'shift' in this continuum towards fear (all the tissues are perceived 'at risk'). It's also possible that in higher organisms such as man, fear *evolved* from phylogenetically primitive nociceptive (pain) systems.

Conclusion

Pain is much more than the sensory perception of tissue injury. Pain is a complex and unpleasant multidimensional experience of the 'self', associated with perceived tissue threat. Pain is as difficult to understand as consciousness, love or anxiety and yet is pervades the existence of many living things on this planet and in particular the human condition.

Acknowledgement: Many thanks to Dr Stephanie Davies, Fremantle Hospital and Health Service for her shared ideas and concepts which are presented in this text.

For more details, please see; *Visser EJ, Davies S. "What is pain?: Parts I & II" in: Australasian Anaesthesia, Riley R. Ed, ANZCA, Melbourne, Australia 2009; 29-43.*

Dr Eric J Visser MBBS FANZCA FFPMANZCA
Pain medicine specialist and anaesthetist at Fremantle Hospital and Joondalup Health Campus, Western Australia.

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Dr Ian McGlew was a distinguished Western Australian anaesthetist who served in the Department of Anaesthesia and Sir Charles Gairdner Hospital for more than 25 years. Dr McGlew was also Chairman of the Western Australia Regional Committee of the Faculty of Anaesthetists, chair of the Western Australia state committee of the Australian Society of Anaesthetists and served on the Western Australian branch council of the Australian Medical Association.

Professional documents: PM1 (2010)
Principles regarding the use of Opioid Analgesics in Patients with Chronic Non-Cancer Pain

1. Introduction

This document outlines principles to guide the prescription of opioid analgesic drugs in the management of patients with chronic (or persistent) pain of non-malignant origin, here referred to as chronic non-cancer pain (CNCP).

The principles outlined here are technically not a "guideline", as they do not direct the conduct of the prescription process itself. Rather they are intended to reflect the pragmatic, evidence-supported position of the Faculty of Pain Medicine.

The controversy in this area of medical practice is acknowledged, as is the paucity of good quality evidence either in favour of or opposed to the efficacy of opioid analgesics in the management of patients with CNCP. However the issue that underscores the need for this document is that of effectiveness of pharmacotherapy in the individual patient. The scientific literature and clinical experience both attest that the responsiveness to opioid analgesic drugs of any patient with CNCP cannot be confidently predicted, so that the prescription of such agents must be regarded as an ongoing individual trial of therapy.

The same consideration applies to the assessment of risk surrounding opioid prescription, referring particularly to the propensity for problematic opioid use by the individual to whom such an agent has been prescribed.

The Faculty of Pain Medicine asserts that prescription opioid analgesics are important therapeutic tools in the management of pain, and emphasises the responsibility of each prescriber to 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.

2. Summary of principles

The principles governing the use of opioids in patients with CNCP include:

- Comprehensive assessment of the patient.
- Adequate trial of other therapies.
- Agreement regarding an opioid trial.
- Conduct of an opioid trial.
- Response to difficulty in achieving goals of an opioid trial.

2.1 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.

2.2 Adequate trial of other therapies

This principle raises the question of what constitutes an "adequate" trial. Non-drug therapies include 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. In some situations 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. However, in most cases, symptom control itself 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.

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, especially in the most common situations when inflammation is not the relevant mechanism.

Adjuvant analgesics 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.

2.3 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.

2.4 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 120mg morphine 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.

2.5 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 re-assessment may include recalibration of goals of therapy, tapering of opioid to withdrawal, reconsideration of other modes of therapy and consultation with colleague(s).

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Harnessing system plasticity to meet the need: A step in the right direction?

By Dr Stephanie Davies MBBS FANZCA FFPMANZCA

The Fremantle Hospital Pain Medicine Unit has been involved in two research projects, both funded by the WA Department of Health, via the State Health Research Advisory Council grant scheme.[1] The Royal Perth Hospital Pain Medicine Unit contributed to both projects.

The first project, known as "In-STEP", is for people with persistent pain; the second is "gPEP", which aims at health professionals. Development of both projects, from content construction through to implementation, involved physiotherapists, occupational therapists, clinical psychologists, and pain medicine physicians. A hybrid program, the "Spinal Pain Rural Roadshow", has recently been implemented as an initiative from the WA Spinal Pain Model of Care. It is exciting that these projects align with the WA Health Network's Spinal Pain Model of Care[2] as well the recently released National Pain Strategy.[3]

Initiated Self Training Educative Process (In-STEP): "In-STEP" consists of pre-clinic inter-professional group education followed by patient-initiated outpatient clinic appointments. Self-Training Educative Pain Sessions (STEPS) is a two-day eight-hour program that runs weekly. The system redesign for In-STEPS was placing the two-day group education program STEPS program *ahead* of initial individual consultations. This was a "system inversion" of the usual sequence of health care delivery within tertiary pain medicine units.

Our aim was to empower patients to understand and use a range of evidence-based pain management strategies, as well to restructure the public system so that they can contribute to "driving" their own health care in a time and resource efficient manner. The weekly eight-hour STEPS program provides attendees with evidence-based knowledge and skills to increase their use of active strategies, to improve their outcomes and reduce the unit cost, per new patient seen.

The STEPS intervention began life on October 2, 2007 as a pilot program. System changes at that stage included the introduction of a structured "Patient Triage Questionnaire" (PTQ). This valuable innovation enabled health professionals to better triage referrals, in terms of their urgency, in line with the WA Clinical Priority Access Criteria[4] and to appoint patients to pre-clinic STEPS when: (i) they were non-urgent; (ii) their prescribed opioid dose was less than 100mg per day morphine equivalents; and (iii) their clinical presentation was not dominant diabetic neuropathy or post-herpetic neuralgia.

Three hundred and nineteen patients attended STEPS during the first nine months. Of these, 291 (91.2 per cent) were allocated directly (pre-clinic) to STEPS, while the remaining 28 (8.8 per cent) were allocated to STEPS following an an individual clinic assessment (post-clinic). The pre-clinic STEPS attendance rate was 60 per cent, while the post-clinic attendance rate was 100 per cent.

Over the following 15 months, 90 per cent of the patients not arriving at the booked pre-clinic STEPS subsequently contacted the pain service and had an individual outpatient appointment (the remaining 10 per cent of patients were not seen in the service); while 48 per cent of patients attending at least one or more STEPS sessions did go on to make a follow-up clinic appointment at either of the two tertiary pain services.

Wait times reduced from 105.6 to 16.1 weeks at one pain unit and from 37.3 to 15.2 weeks at the other unit. Unit cost per new patient appointed to the outpatient pain service reduced from AUD$1807 to $541 for In-STEP (STEPS with patient-initiated pain team assessments) or AUD$881 for the entire outpatient pain service. This is based on the number of new patients appointed per year to the outpatient service.

The benefits to patients were increased use of active pain management strategies, improved satisfaction and improved Global Perceived Impression of Change compared to baseline measures.[5] Patients subsequently referred to the units have benefited from the reduced wait times and broadening of services. A less measurable benefit appears to have been the destigmatisation of those with persistent pain (so often negatively stereotyped by the label "chronic pain patient").

Although the STEPS intervention required a doubling of financial resources it was associated with a four-fold increase in the number of new patients seen per year, as well as reduction in wait times from more than two years to less than four months.

In essence, In-STEP facilitated a system redesign to a more patient-centric model – optimistically thought of as "wHOle Person Engagement" and termed the "HOPE" model-of-care (thanks to Dr John Quintner).

GP Pain Education Program (gPEP) was designed to up-skill GPs working in primary care in best practice management of low back pain through a one-day program, delivered by an inter-professional team (accredited by RACGP with 40 CPD points). gPEP aimed specifically at the evidence-based management of non-specific low back pain (NSLBP) using (i) published guidelines, (ii) short didactic presentations, (iii) small group learning for case-management discussions and (iv) access to www.mylibrary.net.au which is a web-based filing cabinet. Our aim was to "fine-tune" timely, appropriate, individualised, evidence-based, and active self-management of NSLBP in primary care.

Following attendance at gPEP, GPs reported that in their clinical practice they would increasingly use options that are more "guideline consistent"[6] and evidence-based for the management of their patients with NSLBP. This included an increased use of early active self-management, paced activity rather than rest, and referral to other health professionals as appropriate.

The **Spinal Pain "Rural Roadshow"** is jointly sponsored by the Health Networks Branch (WA Department of Health), Rural Health West and Arthritis WA, with the evaluation being conducted by Curtin University. The weekend forums introduce basic pain education and practical pain management skills to health professionals and consumers in WA's regional and remote areas. gPEP is delivered to a wide range of health professionals on the Saturday, and STEPS to patients and carers on the Sunday. Its emphasis is on spinal pain, however, the principles of management are applicable to many of those with persistent pain. The forums start to address the inequity of access for those who live outside metropolitan Perth. The three pilot locations are Kununurra (August 7-8, 2010), Albany (November 27-28, 2010) and Kalgoorlie (February 26-27, 2011).

The remarkable team work from the many individuals and organisations involved in these three projects has shown how effective and important collaboration can be, both from an interprofessional perspective and partnerships with like-minded organisations. It has meant that the journey has been interesting, stimulating and educative for all (with just a "few" stressors). The question is "are we there yet?" or is this just one step in the right direction?

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Senior Lecturer, School of Medicine and Pharmacology, UWA.

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This page from left: The STEPS team 2007-08: Carl Graham, Tracy Antill, Professor Stephan Schug, Dr Stephanie Davies, Dr John Quintner, David Buchanan, Luke Parkitny, Penny Hamilton, Brendan Valente; Finding a new path in Kununurra: Elizabeth Forrester, Melanie Galbraith, Diana Barron, Dr John Quintner.

Essential Pain Management in Papua New Guinea and the Pacific Islands

The College was delighted to receive a $20,000 donation from the trustees of the Ronald Geoffrey Arnott Foundation managed by the Perpetual Trustee Company Limited. The funds will be used to continue work begun by the Australian Society of Anaesthetists and ANZCA on developing an effective pain-management educational strategy for the Pacific Islands and Papua New Guinea.

In Australia and New Zealand, pain often goes unrecognised and even when it is recognised it may be inadequately treated.

The situation in Papua New Guinea and the Pacific Islands, as in many developing countries, is worse. Among the myriad barriers to overcome in improving pain management are problems with staff shortages, an unreliable supply of drugs, limited educational opportunities and cultural differences.

Fortunately, many effective pain management strategies are "low tech" and cheap and can offer significant improvements to an individual's quality of life.

There is little good data about the prevalence of pain in developing countries. However, we know that trauma, especially from motor vehicles, is common and increasing, postoperative and obstetric pain is prevalent, and the World Health Organization has indicated that 80 per cent of new cases of cancer occur in developing countries. It is estimated that PNG has about 15,000 new cancer cases per year with 10,000 cancer-related deaths. Extrapolating from Australian data, it is probable that at least 75 per cent of these patients will experience moderate to severe pain during the course of their illness. This adds up to a lot of patients with significant pain.

During 2009, Dr Roger Goucke collected some anecdotal pain data in Fiji and Vanuatu from nurses and doctors in an attempt to quantify the frequency of significant pain in Pacific Island hospitals. Cancer pain and acute pain were both commonly seen. One further outcome from this small survey was that pain in cancer patients following discharge from the hospital was thought to be poorly managed.

Our discussions with local health workers about types of pain confirm that cancer pain, post-surgery pain, trauma pain and even chronic non-cancer pain are common and often inadequately treated.

Barriers to pain treatment that were reported included:

- Cultural beliefs (staff and community) that pain is expected or normal.
- Limited knowledge about pain and its treatment.
- Concerns about opioid side effects and addiction.
- Unavailability of drugs, including immediate release morphine tablets or syrup.
- Shortage of health workers, for example, one nurse for 20 patients on a post-surgical ward.

There are persuasive humanitarian reasons to offer effective cancer pain management in a country where prevention is minimal, patients frequently present with late stage disease and treatment options are limited. There are also compelling reasons to treat other types of pain, as better postoperative and trauma pain management should decrease post-operative complications especially in high risk patients.

For a couple of years now we have been developing a short course called the Essential Pain Management (EPM) course. The main aim of the course is to upskill doctors, nurses and other health workers in developing countries on pain management. The course uses interactive techniques to teach a simple approach to recognise, assess and treat pain, now known by the acronym RAT!

We have also developed a short instructor workshop that can be run the day after the initial course for individuals who want to take the program back to their own hospitals/communities. This idea follows the highly successful Primary Trauma Care program of "teaching the teachers" with the aim of getting some degree of sustainability.

To our knowledge, the Essential Pain Management course is the first pain management course of its type.

The morning session consists of a series of short interactive lectures and group discussions:

- What is pain?
- Classification of pain.
- Pain physiology.
- Pain pharmacology.
- Reasons to treat pain.
- Pain management barriers.

In the afternoon, participants use the RAT approach to guide small group discussions looking at a series of difficult pain problems (illustrating acute nociceptive, paediatric, cancer, and neuropathic pain).

Finally, the participants brainstorm possible solutions for overcoming barriers where they work. An appendix to the course material provides templates for acute and cancer pain management guidelines that can be modified to suit local situations. A feedback form and a number of multiple choice questions complete the day.

We ran two pilot courses in Papua New Guinea in April 2010, one in Lae and one in Port Moresby. Both courses were highly interactive and used similar educational principles to the Primary Trauma Care course that has been particularly successful in PNG.

We have had a number of discussions with health officials both at local and national level. This type of contact is always valued by our colleagues in the Pacific and PNG because it helps to get them and their problems (including pain) acknowledged. During the recent visit to PNG, we scored a one-hour talkback radio session in Lae on Morobe FM and also had two articles in the national newspapers.

While these are early days, we believe that this Essential Pain Management program will be cost-effective, especially when taken up and taught by local instructors. The main costs for the pilot courses were transport, catering and venue hire.

The course emphasises low cost management strategies and how quality of life can often be markedly improved with very simple treatments. Education and training to provide appropriate pain management early in a patient's disease experience is more effective than waiting for severe pain to become established.

We wish to thank ANZCA for its ongoing support of the EPM program.

Dr Roger Goucke
Head of the Department of Pain Management at Sir Charles Gairdner Hospital

Dr Wayne Morriss
Deputy Director, Department of Anaesthesia, Christchurch Hospital
Chair, ANZCA Overseas Aid Committee

Fellows who are interested in participating or assisting the project in the future can contact Dr Roger Goucke via email: roger.goucke@bigpond.com

From left: Dr Roger Goucke demonstrating subcutaneous morphine administration to a cancer patient in Lae, PNG; Dr Harry Aigeeling, Dr Wayne Morriss, Dr Gertrude Marun and Dr Roger Goucke in Port Moresby; Coconut palms dominate the Lae landscape; course participants, Lae EPM course.

Report from the Faculty of Pain Medicine Board Meeting held on August 9, 2010

Faculty Board

The Faculty Board met on August 9. Dr Lindy Roberts was welcomed to the board as the ANZCA Council representative, as was Associate Professor Milton Cohen as the first Director of Professional Affairs for the Faculty.

Later in the meeting the board was joined by Mr Graeme Campbell, Chair Fellowship Services Committee of RACS and the RACS representative on ANZCA Council.

Relationships portfolio

RACS

Mr Campbell reported on the recent formation of a pain section within RACS that will be open to every surgeon with an interest in pain medicine and will provide the opportunity for Fellows and trainees to share resources. In discussion it was suggested that an area for collaboration, over time, is the opportunity to develop pain as a module early in a young surgeon's training. Another key area identified is to increase current knowledge and education, particularly around persistent pain after surgery. Opportunities to share supervisor of training and examination resources can be explored. Associate Professor Leigh Atkinson will continue to work with Mr Campbell to identify opportunities for collaboration to work toward better patient care.

AFRM (RACP)

As a result of discussions between the executive members of the AFRM and AFRM representatives on the Faculty Board, Drs Carolyn Arnold and Guy Bashford, the AFRM President, Kath McCarthy, has written to offer the opportunity for Faculty trainees to attend AFRM's bi-national training program teaching sessions of relevance to their training. This offer was welcomed and opportunities for reciprocation will be explored.

APS/NZPS

2010-2011 GYAP

There has been strong support for collaboration on the 2010-2011 IASP Global Year Against Postoperative Pain. It is intended to get a coordinated approach for Australia and NZ, and involving other relevant organisations: FPM, NZSA, ASA, NZPS, APS and the Acute Pain Special Interest Group.

Endorsement of documents

A general sharing of documents/guidelines between FPM/APS/NZPS is accepted. A principles guideline document on the use of longer term opioid analgesics in patients with chronic non-cancer pain and an accompanying two-page appendix useful for primary care was approved by this August board meeting, and will accordingly be circulated for endorsement by the pain societies.

Corporate affairs

National Pain Strategy

Discussions have commenced on the formation of a national advocacy body for pain. Dr Penny Briscoe represented ANZCA and the faculty on the interim executive. The name "Pain Australia" has been agreed with a tag line of "Leadership to prevent and effectively manage pain" under discussion. A small board will be formed with expertise and skills and we will need to ensure that ANZCA and the FPM have a role.

National pain outcome initiative

A national pain outcomes initiative is seen as imperative, with the opportunity to develop political weight that might be driven by the FPM and ANZCA. There are two precedents for this, with, for example, palliative medicine gaining considerable funding contingent upon the Palliative Care Outcomes Collaboration (PCOC) initiative. A proposal is to be developed by Dr Carolyn Arnold and Dr Chris Hayes to progress this much needed measurement tool, which has the capacity to improve access to appropriate pain management funding for all Australians.

FPM regional committees

Queensland

On June 8 the Deputy Premier and Health Minister in Queensland, Mr Paul Lucas, announced that Queensland Health would provide $39.1 million over four years to establish and support the implementation of the persistent pain strategy in Queensland. This increase in funding has been achieved through the combined efforts of many people and organisations including the Faculty of Pain Medicine Board, Queensland Regional Committee of the FPM (several members were on the committee that developed the state wide Persistent Pain Strategy), the National Pain Summit and Strategy, consumer groups including Chronic Pain Australia and the Australian Pain Management Association, with the understanding and support of the Queensland Government and Queensland Health.

This significant boost to funding will make a tremendous difference to patients with persistent pain.

Communications

Correspondence was exchanged with Good Health Publications with regard to their plans to develop a "*Pain Management in General Practice*" publication. Subsequently, a number of Faculty Fellows have agreed to participate on the editorial board with the aim of improving knowledge and practice at a primary-care level. While the publication will not carry the Faculty's imprimatur, it is being driven at an editorial level by some of our Fellows.

Fellowship affairs portfolio

Fellowship

The following were admitted to Fellowship in June:

By training and examination:
Assad Hussain, FANZCA (HK)
Max Sarma, FRACGP (Tas)
Kerry Louise Thompson, FANZCA, (Vic)

This takes the number of Fellows to 291.

Election to Fellowship

The board resolved to introduce interviews with applicants, proposers and referees as part of the process for consideration of applications for Fellowship by election beginning January 2011. Interviews will be conducted by a board member from a different state and specialty background. The change in process will be announced in *Synapse*.

Continuing education and quality assurance

Continuing Education and Quality Assurance Scientific Meetings

2010 Spring Meeting – Newcastle

Registrations are now open for the "Transitions in Pain" meeting, October 8-10 to be held in Newcastle. Keynote speakers include Dr Cathy Price (UK), Professor Brian Broom (NZ) and Professor Garry Egger (Aus).

2011 ASM – Hong Kong

The Faculty will hold its ninth annual Refresher Course Day on May 13, 2011 in Hong Kong. The theme is "Pain Management: Getting Closer to the Dragon Pearl". 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 Spring Meeting

Dr Geoff Speldewinde and Dr Guy Bashford will convene the 2011 Spring Meeting in Canberra. Dates have been confirmed as October 28-30, 2011.

2012 ASM – Perth

Dr Dan Bennett (USA) has been formally invited as the FPM ASM Visitor and Professor Henrik Kehlet as the FPM Perth Visitor. By accepting the invitation, Professor Kehlet would also have the opportunity to present for conferment of Honorary Fellowship of the Faculty, awarded in 2004.

FPM Professional documents

The board approved the following new Faculty professional documents:
PM1 (2010) *Principles Regarding the Use of Opioid Analgesics in Patients with Chronic Non-Cancer Pain*. This has followed extensive review of the literature on both the goals of treatment and addiction medicine knowledge that has become more available for ongoing research, together with similar consensus statements in Europe, US and UK.

PS9 (2010) *Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical or Surgical Procedures* was endorsed subsequent to the last board meeting and ANZCA has been advised.

Professional

New Zealand application for specialty recognition

From the initial feedback to our application via the ANZCA New Zealand National Committee, there has been a positive indication of the recommendation that the Medical Council of New Zealand invite us to proceed with Stage II of the two-step process. There have been delays beyond our control, in that education subcommittee had an unexpectedly aborted meeting when our case was to be considered. The next meeting is believed to be in September, from which we expect to be formally invited to proceed to Stage II, anticipated to take the best part of six to 10 months.

Overseas aid – Pain in the Pacific

The two one-day Essential Pain Management (EPM) courses run by Dr Roger Goucke and Dr Wayne Morriss in Lae (April 20) and Port Moresby (April 22) were a great success with 22 people attending the Lae course and 15 people attended the Port Moresby course. Course aims included:

- Trial of a teaching system for recognising, assessing and treating pain.
- Identification of pain management barriers and exploration of possible solutions.
- Exploration of options for future courses.

Dr Goucke and Dr Morriss plan to further develop the EPM course materials with a view to repeating the course in PNG later this year and introducing the course into Fiji within one year. An application for support for this project was successful and a $20,000 grant has been made available to the College from the Ronald Geoffrey Arnott Foundation, managed by Perpetual Trustee Company Limited.

Trainee affairs portfolio

Training requirements for Fellows of other colleges

The board discussed the eligibility of radiologists for Fellowship of the Faculty. On the basis that radiologists are generally proceduralists and not clinicians and that their training program is not a clinical one, it was agreed that eligibility would be based very much on any extra clinical context of those applying. Precedents have been set for considering radiation oncologists, where the clinical application is different from diagnostic radiology.

Education

Blueprinting Sub-Committee

The Blueprinting Sub-Committee recently convened focus groups in Queensland, NSW and Victoria to assist with the development of a detailed statement that describes a pain medicine specialist, so that agreement can be reached on the core knowledge and skills specific to a pain specialist from any background. Participants were requested to complete a questionnaire in advance of the workshop to allow the facilitators, Dr Owen Williamson and Dr Frank New, the time to organise their review in advance of the meeting.

Feedback from these focus groups will be valuable in the ongoing development of the curriculum, training and examination processes to achieve the desired objectives.

Supervisors of training

Following recommendations from supervisors of training, through the Education Committee, the board resolved to make formal requests to the participating colleges for a sharing of SoT resources, and to make provision for a number of educational podcasts in its 2011 budget bid.

Examination

The faculty's annual examination will be held at the Barbara Walker Centre for Pain Management, St Vincent's Hospital, Melbourne from November 24-26, 2010. The Royal Adelaide Hospital will again host the faculty's pre-examination short course from October 13-15. Dr Ming Chi Chu (Hong Kong) and Associate Professor David Scott (ANZCA Chair Examinations) have been invited to observe.

Training Unit accreditation

Accreditations

Fremantle Hospital (WA) was accredited for pain medicine training for a period of three years. This takes the number of accredited units to 24.

Resources portfolio

Finance

The faculty continues to track closely to budget for 2010. The faculty is currently preparing for the 2011 budget bid.

Library update

Database upgrade

The OvidSP Medline and OvidSP Embase databases have undergone an upgrade and now have more flexibility and access options to support your online research activity. Major new features and changes include:

- My Projects allows you to manage a whole research project from a single interface. Create your own personal account and store citations, searches, full text articles, files from your computer, snippets and annotations.
- A toolbar application allows you to access My Projects from any external website.
- More citation styles and formats allows you to export and print using MS Word, PDF, EndNote, and more.

Contact the library if you are interested in learning more about managing a research project online or performing a literature search.

Login to the College website to access the databases: www.anzca.edu.au/resources/library/databases.html

Online textbooks

The ANZCA Library subscribes to a number of online textbooks including a package called Access Anesthesiology. This portal allows the user to search across all the textbooks in the package and even find images and videos – a great way to get an overview of a topic. Many books have been optimised for mobile device use.

The available online textbooks are:

- Anesthesiology: Examination & Board Review
- AusDI – Australian Drug Information for the Health Care Professional
- Basic and Clinical Pharmacology
- Clinical Anesthesiology
- Clinical Manual and Review of Transesophageal Echocardiography
- Critical Care Ultrasonography
- Goodman and Gilman's The Pharmacological Basis of Therapeutics
- Harrisons Online
- Longnecker – Anesthesiology
- Pain Medicine
- Principles and Practice of Mechanical Ventilation
- Principles and Practice of Pain Medicine
- Principles of Critical Care
- Procedures in Critical Care
- Review of Medical Physiology
- Stedman's Medical Dictionary
- Syndromes: Rapid Recognition and Perioperative Implications
- Textbook of Regional Anesthesia and Acute Pain Management.

Login to the College website to access the online textbooks:

www.anzca.edu.au/resources/library/online-textbook-access.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:

- Operating Room Risk Management, June 2010 – Simulation-based Training in Healthcare; Tools for Surgeons and Anesthesiologists to Help Patients Quit Smoking
- Health Devices, May 2010 – Networking Medical Devices
- Health Devices, June 2010 – The Ins and Outs of Servicing Equipment In-House
- Health Devices, July 2010.

New research in anaesthesia and pain medicine

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

Clinical Guidelines
Available via the National Guideline Clearinghouse: http://guidelines.gov/index.aspx

Practice advisory on anesthetic care for magnetic resonance imaging. A report by the American Society of Anesthesiologists Task Force on Anesthetic Care for Magnetic Resonance Imaging.
American Society of Anesthesiologists Task Force on Anesthetic Care for Magnetic Resonance Imaging

Practice guidelines for the prevention, detection, and management of respiratory depression associated with neuraxial opioid administration.
An updated report by the American Society of Anesthesiologists Task Force on Neuraxial Opioids.

Chronic pain
Occupational medicine practice guidelines: evaluation and management of common health problems and functional recovery in workers. American College of Occupational and Environmental Medicine. Elk Grove Village (IL): American College of Occupational and Environmental Medicine (ACOEM); 2008. p. 73-502.

Articles
Using Database Research to Affect the Science and Art of Medicine.[Editorial]
Lanier, William L. M.D.
Anesthesiology. 2010; 113(2):268-270.

Interventions for preoperative smoking cessation.
Thomsen T., Villebro N., Møller A.M.
Cochrane Database of Systematic Reviews, 2010, Issue 7.

Topical NSAIDs for acute pain in adults.
Massey T., Derry S., Moore R.A., McQuay H.J.
Cochrane Database of Systematic Reviews 2010, Issue 6.

Scandinavian clinical practice guidelines on general anaesthesia for emergency situations
Jensen, A.G., et al.
Acta Anaesthesiologica Scandinavica, 2010: 54(8): 922–950.

Crisis resource management and teamwork training in anaesthesia
Gaba D.M.
BJA: British Journal of Anaesthesia. 2010 105: 3-6.

Rapid sequence induction and intubation: current controversy.
El-Orbany M., Connolly L.A.
Anesthesia and Analgesia. 2010; 110(5):1318-25.

Anaesthesia for bariatric surgery
Sabharwal, A., Christelis, N.
Continuing Education in Anaesthesia, Critical Care & Pain 2010; 10: 99-103.

Ultrasound-Guided Interventional Procedures in Pain Medicine: A Review of Anatomy, Sonoanatomy, and Procedures: Part II: Axial Structures.
Narouze, S., Peng, Philip W. H.
Regional Anesthesia & Pain Medicine. 2010; 35(4):386-396.

Predicting Postoperative Pain Based on Preoperative Pain Perception: Are We Doing Better Than the Weatherman?
Raja, S. N., Jensen, T. S.
Anesthesiology. 2010; 112(6):1311-1312.

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.

Contact the library
Librarian: Laura Foley
www.anzca.edu.au/resources/library
Phone: +61 3 8517 5305
Fax: +61 3 8517 5381
E-mail: library@anzca.edu.au

The living museum – using history to raise the profile of anaesthesia

The commonly held view of small museums is that they are collections of "old stuff" sitting on crowded shelves with dusty labels. It may seem unlikely that one can use museum collections to enhance knowledge and education about modern advances in technology. But that has been the focus of activity at the Geoffrey Kaye Museum of Anaesthetic History, at ANZCA House in Melbourne.

Over the last three years, an increasing number of tours have been hosted at the College, using the Museum and the heritage building "Ulimaroa" to educate members of the public about anaesthesia and the role of ANZCA.

Each tour lasts about two hours and is hosted by a small number of Fellows including two former councillors and one former President, who give their time voluntarily. Tours begin with a presentation on the role of the College in training and standards, followed by a question and answer session. A tour of "Ulimaroa" is followed by a visit to the Geoffrey Kaye Museum, where the story of anaesthesia is presented, using the exhibits to illustrate the remarkable development of the specialty. Particular emphasis is placed on the development of anaesthesia and pain management over the past 60 years.

Most of the tour groups so far have consisted of retirees, usually members of Probus groups, but we have also hosted historical groups, a vision impaired group, and one Year 10 school group. Each group comprises 10 to 25 people, and the growth of the program has been entirely by word of mouth. In 2009, there were 27 tours catering for 536 visitors. In 2010, as this article is written, we have hosted 26 tours with another 15 scheduled over the next few months.

The response of those taking part has been overwhelmingly positive. The age of those attending makes them high consumers of anaesthetic services yet very few have any knowledge of anaesthesia when they arrive – indeed many describe recent or forthcoming procedures involving anaesthesia. They invariably leave the College with a much greater appreciation of the role of the anaesthetist.

To quote from one of many letters of thanks:

"Most of our members have little knowledge of the practice and history of anaesthesia. We had even less knowledge of the importance of the College in the training, continuing education, safety and standards of our hospitals."

The results of the recent College Fellows' survey revealed that the role of the College as a voice of anaesthetists was considered among its seven most important services. It is our belief that using the museum and our history to enhance knowledge about anaesthesia, building on the efforts of individual anaesthetists as they interact with their patients, is an extremely effective way of raising the public profile of the specialty and the role of the College.

Dr Rod Westhorpe and Dr Chris Ball
Honorary curators, Geoffrey Kaye Museum of Anaesthetic History

With grateful acknowledgment to Maria Drossos, Museum Collections Officer, who organises the tours on behalf of the College. To inquire about tours of the museum contact **Maria Drossos** at: **mdrossos@anzca.edu.au** or visit **www.anzca.edu.au/resources/museum**

Above left: Dr Rod Westhorpe (centre) conducts a tour of the museum.

ANZCA Council meeting report

June 2010

Report following the Council meeting of the Australian and New Zealand College of Anaesthetists held on June 19, 2010

Death of Fellow and trainees

Council noted with regret the deaths of the following Fellows:

- Dr Angus Mann (QLD) FANZCA 2002.
- Dr Virginia Shearer (QLD) FANZCA 2001.

The death of Dr Max Robertson, a former final examiner for the medical vivas, though not a College Fellow, was also noted.

Honours, appointments and higher degrees

Council acknowledged the following Fellows:

- Dr Leona Wilson (NZ), made an Officer of the New Zealand Order of Merit (ONZM) New Zealand Queen's Birthday Honours List.
- Professor Alan Merry (NZ), appointed to chair the Interim Board of the Health Quality and Safety Commission (HQSC).
- Professor Teik E Oh (WA), made a Member (AM) in the general division of the Queen's Birthday Honours List.
- Dr Haydn Perndt (TAS), made a Member (AM) in the general division of the Queen's Birthday Honours List.
- Dr Lindsay "Tub" Worthley (SA), made a Member (AM) in the general division of the Queen's Birthday Honours List.

Education and Training Committee

Curriculum redevelopment

Council agreed:

1. That the redesigned ANZCA curriculum be implemented at the beginning of the 2012 training year in all ANZCA training regions.
2. That the number of curriculum authoring groups be reduced from 12 to 10 and that the number of Fellows in each curriculum authoring group be reduced from five to three.
3. That all Fellows working as consultants on the Curriculum Redesign Steering Group and curriculum authoring groups receive an hourly remuneration rate of $75 being the hourly rate paid to a Monash University associate professor with clinical loading.
4. That, given the imperative to start the project forthwith, a condensed process for recruitment and selection of Fellows to be involved in the project be approved, involving:
   - 4.1 Appointment of the Curriculum Redesign Steering Group without a further selection process.
   - 4.2 A one-step process for the curriculum authoring groups.
5. That the following Fellows be appointed to the Curriculum Redesign Steering Group: Dr Damien Castanelli (VIC), Dr Peter Gibson (NSW), Dr Sarah Nicolson (NZ), Dr Brian Spain (NT), and Dr Jeneen Thatcher (QLD).

Examination Committee

Council has agreed to appoint a trainee representative to the Examination Committee. This representative will be appointed by the ANZCA Trainee Committee and will have passed both the ANZCA primary and final examinations.

Finance

Examination withdrawal fee

In order to reduce the significant administrative challenges created by late withdrawals from the College examinations, Regulation 14 has been amended to establish a fee for those who withdraw after the registration closing date. Medical or compassionate grounds will continue to be recognised as warranting full refund of the examination fee.

14.7 Withdrawal from the primary and final examinations

14.7.1 A candidate may withdraw his or her application in writing, before the date of the examination.

14.7.2 A candidate may withdraw on medical or compassionate grounds before the examination, or if he or she does not present for examination. He or she must submit a written notice and provide evidence of cause within seven days of the examination. A new application must be submitted if he or she wishes to present for a subsequent examination.

14.7.3 The examination fee may be refunded based on the following considerations:

14.7.3.1 The examination fee will be refunded in full, if the written notice is received by the CEO up to and including the closing date for registration for the examination.

14.7.3.2 Applicants who withdraw from the examination between the closing date for the examination up to and including 15 calendar days prior to the first scheduled day of the examination, will incur a 10 per cent administration fee unless this is modified on compassionate grounds.

14.7.3.3 Withdrawal from and after 14 calendar days prior to the first scheduled day of the examination will result in no refund of fees unless this is modified on compassionate grounds.

14.7.3.4 The presence of medical or personal compassionate grounds as justification for a reduction or waiving of this fee shall be determined at the discretion of the Chair of Examinations on behalf of the Council.

14.7.3.5 If the full fee is to be refunded on compassionate grounds, that amount will be accepted as a full application fee for the immediate subsequent examination at the candidate's request.

National Pain Strategy

The College has agreed to provide in-kind support from the Communications, IT and Policy Units, to the Australian National Pain Strategy executive.

Fellowship affairs

2011 New Fellows Conference

Council has approved one additional delegate from each of Singapore and Malaysia to attend the 2011 New Fellows Conference in Hong Kong.

2013 Annual Scientific Meeting

Associate Professor David Scott has been appointed to the Regional Organising Committee of the 2013 Annual Scientific Meeting to be held in Melbourne.

Internal affairs

Community Representation Policy (Australia)

A copy of the approved policy and schedule of fees is **Appendix 1 (available at www.anzca.edu.au in the "News" section under "Council reports").**

2011 Council calendar

A copy of the 2011 Council calendar is available at www.anzca.edu.au in the "News" section under "Council reports".

Revision of the ANZCA Constitution

Following establishment of the College of Intensive Care Medicine, Council has agreed that Dr Leona Wilson will lead a review of the ANZCA Constitution for a vote by the Fellowship.

Regulation changes

Regulation 2.10, Fellowship Affairs Committee has been amended to include the Director of Communications or his or her nominee and the Director of the Education Development Unit or his or her nominee as committee members.

Regulation 4 – Examination subcommittees and courts

In the past, two Council representatives have been included in the membership of the Primary and Final Examination Subcommittees. Regulation 4 has been changed so that the Chair of Examinations will be the only ex officio Council representative on the examination subcommittees.

Regulation 14 – Examinations in anaesthesia and Regulation 15 – Training in anaesthesia

To prepare for the revised in-training assessment (ITA) process commencing July 1, 2010, Regulations 14 (Examinations in Anaesthesia) and 15 (Training in Anaesthesia) have been amended with the new versions available on the ANZCA website.

Professional documents

Dr Peter Roessler, Director of Professional Affairs, will be responsible for input to professional document development and revision.

TE14 (2010) *Policy on the In-Training Assessment (ITA) Process*

TE18 (2010) *Policy for Assisting Trainees in Difficulty*

To facilitate the introduction of the revised ITA process and following extensive review and consultation, TE14 and TE18 have been accepted as PILOT documents to be posted on the ANZCA website for a 12-month review period. During this time, the documents will be operational and further feedback about them is welcomed.

ADP1 (2010) *Professional documents*

Following an extensive consultation process and review period on the ANZCA website, ADP1 (2010) Professional Document (and Background Paper) can now be used for the preparation of professional documents and can be found on the ANZCA website under the professional documents listing.

TE1 (Interim Review 2010) ***Recommendations for Hospitals Seeking College Approval for Vocational Training in Anaesthesia***

TE1 has been amended to include that all accredited training sites have a "policy on bullying and harassment that pertains to trainees".

Professor Kate Leslie
President

Dr Lindy Roberts
Vice President

ANZCA Council meeting report

August 2010

Report following the Council Meeting of the Australian and New Zealand College of Anaesthetists held on August 21, 2010

Death of Fellow and trainees

Council noted with regret the death of the following Fellow:

- Dr Kishore Nanda Jayanthi (NSW) FANZCA 2003.

Fellowship affairs

Disbandment of Rural Anaesthetic Recruitment Service (RARS)

With the introduction of GPALS and other professional locum services, and with the decline in enquiries for the RARS service, it was agreed that this service be disbanded.

Regional visit by ANZCA ASM Visitor and Australasian Visitor

In recent years it was recognised that attendance by Fellows and trainees at post-ASM regional visits by the ASM Visitor and Australasian Visitor has decreased. With the increased access to presentations on the ANZCA and ASM websites, it was agreed that regional visits by the ASM Visitor and Australasian Visitor will cease from the Perth 2012 ASM onwards.

Advanced life support capability at ANZCA House

Council approved the purchase of a defibrillator and self-inflating device for ANZCA House along with appropriate training for staff members.

ANZCA Foundation

Foundation change of name

In order to bring greater clarity and awareness to the wider community of the purpose of the foundation, it was agreed that the name for the ANZCA Foundation is to be changed to **"The Anaesthesia and Pain Medicine Foundation"**.

Foundation Membership

Council approved the appointment of Dr Leona Wilson to the foundation board for a term of three years in accordance with the Regulation 34.

Internal affairs

New Fellow Councillor

In August 2010, Dr Justin Burke was elected as the New Fellow Councillor.

Format of Council agenda and minutes

With the aim of producing shorter and more concise Council minutes, some changes will be made to the format of the Council agenda and minutes which are to take affect from the October 2010 Council meeting. Agenda items from the committees which report directly to Council will no longer be listed line by line in the Council agenda or minutes, and only unstarred resolutions that result from the committee minutes are to be listed. For any queries about this matter, please contact Anna Kleskovic (akleskovic@anzca.edu.au).

Indigenous Health Working Group

Council approved the formation of an Indigenous Health Working Group, with the aim of promoting indigenous health in Australia and New Zealand. The Committee will comprise five members, four ANZCA and/or FPM Fellows from Australia and New Zealand, and a councillor (Dr Rodney Mitchell) to chair the committee.

CPD points

Council has agreed that the College will no longer prospectively approve CPD points for CPD events. CPD participants will continue to self-assess CPD events and the College will continue its routine audits of CPD participation.

Regulation changes

Regulation 2.7 Education and Training Committee – Examinations Committee

In June 2019, Council agreed that the Examinations Committee should include a trainee representative nominated by the ANZCA Trainee Committee who has passed both College examinations. Dr Yvette Gainey (WA) was subsequently nominated and appointed to take on the role of trainee representative on the Examinations Committee. The regulation has also been amended to include the chair of the FPM Examination Committee.

Regulation 22 – the Formal Project Prize

Regulation 22 has been amended to bring it into line with current practice. The changes made are for clarity of process and do not alter the eligibility criteria or any other aspect of the formal project.

Regulation 23 - Advice Regarding Recognition as a Specialist in Anaesthesia

The changes made to Regulation 23 are intended to improve the criteria for the assessment of IMGSs. However, the wording for "area of need assessments" is still being developed and is to be addressed at the October Council meeting. The implementation date for the revised Regulation 23 will take effect from January 1, 2011.

(Copies of the updated regulations can be found on the ANZCA website.)

Professional documents

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 January 1, 2012.

PS1 Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia

Revisions to PS1 have been accepted and will be posted on the ANZCA website.

Professor Kate Leslie
President

Dr Lindy Roberts
Vice President

Successful candidates

The list of successful candidates for the second sitting of the Primary and Final Fellowship Examinations in 2009 was inadvertently omitted from the *ANZCA Bulletin*. ANZCA apologises to the successful candidates.

Primary Fellowship Examination – 2009 (second sitting)

The following candidates successfully completed the Primary Fellowship Examination:

Rohit Vijay Agrawal SGP, Jeremy James Archer NZ, Mark Michael Alcock TAS, Andrew Beck QLD, Gabriel Berra VIC, Susmita Bhattacharya NSW, Colin Thomas Brodie QLD, Colleen Therese Bruce NSW, James Raymond Broadbent NZ, Nigel Burnet QLD, Jakob Chakera WA, Helena Man Hing Choi NSW, Choy Wing Yee Lillian HKG, Chao-Yuan Chen NZ, Chen Xuanxuan SGP, Bronwen Chesterfield NZ, Cho Wing Keung HKG, Simon Alexander Collins NSW, James Stuart Clark NZ, Vicki Anne Cohen SA, Glen Warren Cook VIC, Rachel Elizabeth Cowell VIC, Nicola Robyn Crowley NZ, Kathryn Frances Dawson NZ, Lisa Deecke QLD, Kiran Deol NSW, Emily Digiantomasso NSW, Rachel Clair Dempsey NZ, Jessica Dorman NSW, Jethro Jason Dredge NZ, Lucas John Fox NSW, Caroline Liana Fung NSW, Martin Duffy VIC, Mary Pui Fung NSW, Wajdi Hadi Mohamad Ahmad Al-Salhi NSW, David Laurance Sai-Hung Heather NZ, Andrew Fah SA, Thomas David Flett WA, Suyen Ho NSW, Suet-Ling Goh VIC, Wilson Binh Quan Huynh NSW, Charlotte Jane Heldreich NT, Charlotte Jane Hill NZ, Claire Louise Hinton SA, Michael Kluger VIC, Benjamin Peter Howes QLD, Ravi Krishnamurthy SA, Sarika Kumar SA, Ryan Jinu Jang NZ, Christopher Simon Jones NZ, Melissa Judd NSW, Alistair Grant Kan VIC, Lee Yan Wei MLY, Michael Bruce Alexander Kerr NSW, David Koskuba NZ, Ku Ying Wai HKG, Kwok Fan Yin MLY, Lam Wing Yan HKG, Adrian Langley QLD, Fiona Maree Lathleiff VIC, Chuan-Whei Lee VIC, Lee Chin Lap HKG, Lee Chun Wai HKG, Leung Rebecca Wai-Chee HKG, Leung Ka Mei May HKG, Li Cheuk Yin HKG, Liang Sharon Ka Wan HKG, Gregory Chin Chih Liao QLD, Benjamin Charles Lincoln QLD, Thomas George Matthiesson NSW, Keng Hsin Lo SGP, Sheng Rong Low VIC, Lui Wilson HKG, Elizabeth Anne Merenda ACT, Adele Grace Macmillan VIC, Conrad John Macrokanis QLD, Sina Mahjoob VIC, Wai Ki Rachel Man HKG, Benjamin Louis Moran NSW, Kuan Lee Ng SA, Fiona Germaine McManus WA, Dilip Anand Nithyanandam TAS, William Thomas Meade QLD, Matthew Ronald Miller NZ, James Edward Moore NZ, Emma Jane Morris VIC, Craig Alan Plambeck NSW, Bruce David Newman TAS, Ewlee Kaylene Ng VIC, Ian Nguyen VIC, Phillip John Quinn NZ, Martin Nguyen VIC, Belinda Michelle Phillips VIC, Pong Fei Fung HKG, Raja Rengasamy SA, Sarah Preissler NZ, Hedda Kathrin Robinson VIC, Nicolas William Rogers NZ, Rachel Ruff NSW, Kym Nicole Saunders VIC, Lauren Joy Radford QLD, Raviram Ramadas VIC, Joel Michael Scott TAS, Michael Douglas Schurgott SA, Peter Redmond Shea VIC, Sarah Lauren Sew Hoy NZ, Julia Slykerman QLD, Stephen Graham Smith QLD, Philip Lloyd Stagg QLD, Andy Sisnata Siswojo VIC, Lucy Rebekah Stone NZ, Jillian Katherine Streitberg QLD, Gareth Iain Symons VIC, Christopher James Stokes VIC, Jennifer Shayne Jieh Tan NSW, Swapna Thampi SGP, Fredy Surianto NSW, Tung Hoi Ying Queenie HKG, Peter Graham Unwin WA, Heman Tse ACT, Wan Che Kit HKG, Lynda Glenys Veronica Wilson QLD, Dzung Hoang Vo NSW, Karen Wong NSW, Sam Wong NZ, Angela Mary White SA, Paul Francis Wigan QLD, Nadine Yamen NSW, Po Che Yip NZ.

Renton Prize: Dr Tung Hoi Ying Queenie HKG

Merit Certificates: Dr Jessica Dorman NSW, Dr Andrew Fah SA, Dr Rahul Garg NSW, Dr Nicole Khangure NSW, Dr Cheuk Yin Li HKG, Dr Benjamin Lincoln QLD, Dr Matthew Miller NZ, Dr Rachel Ruff NSW, Dr Chloe Tetlow NSW

Final Fellowship Examination – 2009 (second sitting)

The following candidates successfully completed the Final Fellowship Examination:

Fousia Manthodikulangara SA, Joshua James Hayes SA, Alison Brereton SA, Perry John Fabian SA, Nicholas John Knight SA, Dimitrios Konidaris SA, James Michael McGregor Dowling SA, Amanda Emily Kruys SA, Bindu Kizhakkevelikkakathu Vasu SA, Moloth Valappil Vinod Kumar SA, Robert Alistair Walker SA, Jeanette Mary Scott NZ, Joanna Louise Sinclair NZ, Estibaliz Arantzazu Blazquez Basarrate NZ, Timothy Holmes Hall NZ, Tania Marie Bailey NZ, Susan Jane Van Duren NZ, Shane Irwin McQuoid NZ, James Pak-Wei Wong NZ, Nina Maree Civil NZ, Phillip Kriel NZ, Kah Wei Teh NZ, Joreline Van der Westhuizen NZ, Katherine Anna Townend NZ, James Edward Craig QLD, John Robert Tippett QLD, Andrew James Clarke QLD, Jayne Elizabeth Berryman QLD, Cornelia Mueller QLD, David John Sturgess QLD, Linda Smith QLD, Dale Victor Kerr QLD, Muhammad Yaqoob Zia QLD, Claire Gifford QLD, Nathan Charles Goodrick QLD, Paul Francis Lee-Archer QLD, Dana Pakrou QLD, Michael Max Chappell QLD, John Michael Wilson QLD, Konara Samarakoon QLD, Vanessa Jane Rich QLD, Peter Kenneth Reid QLD, Justin Lloyd Smith QLD, Joeng Kin Ying Alice HKG, Yu Pak Chung HKG, Chalk Ming Alex Wan HKG, Chu Hiu Man HKG, Ng Lai Ming HKG, Tam Tak King Dhugal HKG, Ng Lip Yang WA, Wolfgang Fudickar WA, Matthew Leslie Keating WA, Hari Krshnan WA, Warwick David Clark WA, Rupert Christopher Charles Ledger WA, Yu-Ping Chen WA, Timothy Laing Paterson WA, James Patrick McGirr WA, Gobalakrishinan Rajan WA, Luke Baitch ACT, Marcus Neil Maller NSW, Ian Edmund Charles Maddox TAS, Daniel James Michael NSW, Siv Eing Lim NSW, Stuart James Lawrie NSW, Rayhaan Mussa NSW, John Young NSW, Manu Bose NSW, Fong Chee Koh NSW, Jonothon Brock NSW, Camie Wang NSW, Bruce Desmond Lenert NSW, Brett Chandler ACT, Anita Rahul Joshi NSW, Ajintha Pathmanathan NSW, Andries Hendrik Coetzer NSW, Zain Upton ACT, Jennifer Elizabeth Upton NSW, Magdalena Jedlicka NSW, David Emery Reiner NSW, Syed Obaidul Huq NSW, Simon John Robertson ACT, Michelle Maree Hughan NSW, Thomas George Russell NSW, Sandy Ling Hui Huang NSW, Louise Mary Ellard ACT, Clare Mary Farrell NSW, Georgia Frances Stefanko NSW, Isaac Wai Hon Cheung VIC, Andrew John Struthers VIC, Natalie Anne Gattuso VIC, Amanda Jane Honour VIC, Ranjita Sharma TAS, Rajeswari Devi Rajasekaram VIC, Trudia Disney TAS, Hella Deifuss VIC, Adebayo Taiwo Ezekiel Jolayemi VIC, Monica Catherine Joseph VIC, Liza Chin NSW, Andrew William Fenton VIC, Louise Serena Parker VIC, Osman Ozturk VIC, Katja Brede TAS, Sarah Elyse Kondogiannis VIC, Colin Duncan Bense VIC, Ewan James Wright VIC, Julian Graham Marshall VIC, Agata Ancypa TAS, Lisa Anne Zuccherelli ACT, Theodore Adraktas VIC

Cecil Gray Prize: Louise M Ellard ACT

Merit Certificates: Amanda E Kruys SA, Andrew W Fenton VIC, James M Dowling SA, Jennifer E Upton NSW, Nina M Civil NZ, Timothy L Paterson WA

22 candidates presented for the International Medical Graduate Specialist Performance Assessment held in August/October 2009 and 11 were successful: Dr Bindu Vasu SA, Dr Cornelia Mueller QLD, Dr Muhammad Zia QLD, Dr Konara Samarakoon QLD, Dr Lenert Bruce NSW, Dr Andries Coetzer NSW, Dr Adebayo Jolayemi VIC, Dr Liza Chin NSW, Dr Katja Brede TAS, Dr Colin Bense VIC, Dr Lisa Zuccherelli ACT

28 IMGS candidates presented for the Final Fellowship Examination, and the following 10 candidates were successful: Dr Fousia Manthodikulangara SA, Dr Vinodkumar Moloth Valappil SA, Dr Robert Walker SA, Dr John Wilson QLD, Dr Wolfgang Fudickar WA, Dr Gobalakrishinan Rajan WA, Dr Anita Joshi NSW, Dr Ranjita Sharma TAS, Dr Hella Deifuss VIC, Dr Monica Joseph VIC

Please note: Li Ann Teng was a successful candidate for the recent May Primary Examination 2010. Her name was inadvertently omitted with other successful candidates published in the June edition of the *ANZCA Bulletin*. ANZCA apologises to Dr Teng.