ANZCA
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

Australian and New Zealand College of Anaesthetists
Faculty of Pain Medicine

March 2010

ANZCA BULLETIN

Special report:

NATIONAL PAIN SUMMIT – A CALL FOR ACTION

Exclusive:

ANZCA SPEAKS TO NZ MINISTER OF HEALTH, TONY RYALL

ANZCA Bulletin

The Australian and New Zealand College of Anaesthetists (ANZCA) is the professional medical body in Australia and New Zealand that conducts education, training and continuing professional development of anaesthetists, intensive care medicine and pain medicine specialists. ANZCA represents more than 6000 Fellows and trainees across Australia and New Zealand and serves the community by ensuring the highest standards of patient safety.

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Cover: National Pain Summit at Parliament House, Canberra and interview with New Zealand Minister of Health.

Photos: Marina Neil and Simon Woolf.

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Western Australian anaesthetist and lawyer

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President's message

This is my last President's message, as I finish my term at the end of the Annual Scientific Meeting in Christchurch in May and the President-Elect, Professor Kate Leslie, will take over as President. It has been a privilege serving the College as its President, and I have been humbled by the wonderful work done by our committed Fellows and trainees. I am grateful to all of you for your support for our College. Our College depends on your support: its strength is its basis in those who practise our profession.

The ANZCA Strategic Plan for 2010-12 has been finalised. There are 10 priorities that we will focus on in this triennium. The plan is needed to guide our efforts and expenditure and indicates where we anticipate our professions will be heading and the issues that may face us. This does not, of course, mean that those topics not mentioned will be forgotten; rather, that this is where our energies will be focused.

The College's priorities are:

- Increase the engagement of the College's members and the interaction with key external stakeholders.
- Develop and communicate ANZCA'S position on the differing roles and professional training required of Fellows and others providing sedation and anaesthesia-related care.
- Address projected training and workforce shortages.
- Increase the support for research.
- Enhance the level of support provided to our Fellows and trainees in the areas of quality and safety.
- Provide support for indigenous health.
- Provide support for overseas aid.
- Ensure that our Fellows are supported in their clinical training and assessment activities.
- Undertake a constitutional review of the role of the Faculty of Pain Medicine within the College.

As outlined above, one of the key priorities is the continued need to support and communicate with our Fellows as they undertake the work that is central to our promoting safe and high quality care in anaesthesia, pain medicine and intensive care medicine. Engagement with the College's members is critical.

Shortly, we will be circulating a survey designed to enable us to better understand our Fellows' needs and expectations of the College. The independent survey by ANOP Research Services will identify our strengths and areas for improvement. The results of the survey will form the basis for discussion at focus groups at the Christchurch ASM. The Fellowship Affairs Committee is overseeing the project and will guide implementation of any recommendations. The quality of the recommendations developed as a result of this process will depend on the input from the Fellowship, and I would urge all of you to complete the survey.

The (Australian) National Pain Summit, which was held recently in the Great Hall of the Federal Parliament, (see pages 38-49) brought together more than 130 health professional and consumer organisations with the aim of developing a national strategy to improve the management of all forms of pain. It was led by Professor Michael Cousins and opened by the Australian Federal Minister of Health, the Hon. Nicola Roxon. The scene for the discussions was set by an excellent opening video clip produced by ANZCA and two very moving speeches, made by a pain sufferer and a carer for a pain sufferer. ANZCA played a lead role in the summit and intends making sure that governments tackle this critical issue by implementing the national pain strategy.

In this issue of the *ANZCA Bulletin* is an interview with the New Zealand Minister of Health, the Hon. Tony Ryall. The questions that we put to him are similar to those put to his counterpart in Australia, Health Minister Nicola Roxon, and published in the December issue, given the bi-national character of our College. Healthcare in New Zealand is going through reform, as the government seeks to rein in costs, introducing efficiencies into the back office functions of the District Health Boards, while seeking to emphasise the benefits of clinical leadership. Whether these reforms will deliver the desired results remains to be seen. Health reform is also on the Australian agenda, with the announcement by Prime Minister, Kevin Rudd, of the proposed changes. Again, we await the detail to assess the likely impact of these changes.

In closing, I would like to thank Mike Richards, our CEO, and his committed staff for their very loyal and professional service to our College. Over the last few years, Mike has led the College through a process of renewal. We now have increased our professional support for our volunteer Fellows and trainees, allowing us to take our proper place in the health sector, provide world-class vocational training in anaesthesia and pain medicine and promote the highest quality and safest healthcare for our community.

Dr Leona Wilson
President

Trauma the focus in Japan

The 4th International Trauma Conference was held January 17-22, 2010 at the Rusutsu resort in Hokkaido, Japan. Conference convenors, Associate Professor Daryl Williams (FANZCA) and Dr Timothy Webb (FANZCA), were delighted that once again the conference was fully subscribed with more than 200 medical delegates attending. The conference is a multi-discplinary event that aims to update clinicians on the changing practice of trauma. The themes covered this year were airway trauma, trauma reception and stratification, paediatric trauma, obstetric trauma, pre-hospital controversies, peripheral limb fractures, penetrating neck & torso trauma, brain injury and integrated angio-interventional theatres.

Professor James Holmes, Director of Emergency Medicine, University of California, was the keynote international speaker. Professor Holmes presented on penetrating torso (chest and abdominal) trauma and also the American experience on angio-interventional theatres. Dr Keith Greenland (FANZCA) and Dr Julian Hunt-Smith (FANZCA) spoke on laryngeal trauma and the place of tracheostomy in the the trauma patient. Professor Roy Kimble, Director of Paediatric Burns and Trauma, University of Queensland, delivered an informative talk on paediatric trauma management and Dr Philip Ragg (FANZCA) spoke on paediatric difficult airways and paediatric analgesia. In total, there were more than 20 varied presentations with half delivered by Fellows of ANZCA.

The social program included opening and closing ceremonies at the Rusutsu resort, a cultural tour to Otaru and two day-trips to Niseko. Of course the winter pursuits at the Rusutsu were on full display with fantastic snow conditions and unlimited visibility. The lift network at Rusutsu is spread over three peaks offering a wide variety of terrain catering to all levels of skiers and snowboarders. Mt Izola offered the best terrain with long and challenging runs combined with panoramic scenery.

The 5th International Hokkaido Trauma conference is planned for January 16-21, 2011 at the Rusutsu Resort. Registrations open in April 2010.

Clockwise from top left: view of Mt Yotei, looking from the top of Isola mountain; conference convenors, Dr Daryl Williams and Dr Timothy Webb; delegates enjoying a clear sky day at the Rusutsu Resort; course delegates in the main conference centre at Rusutsu Resort.

Festive season cheer in SA/NT

The SA/NT regional committee Christmas celebration was held in December last year to thank Fellows and trainees for their support.

Clockwise from top left: Dr Rowan Ousley (trainee committee member) and Dr Julia Coldrey (CME committee member); Dr Gerry Neumeister (member) and Dr Christine Huxtable (part 1 course coordinator); Dr Kym Osborn (member) and Dr Stephanie Armstrong (CME committee member); Dr Luke Murtagh (trainee committee chair), Dr Rebecca Lewicki (trainee committee member) and Dr Charles Clegg (member); Dr Bill Wilson (CME chair), Dr Samuel Willis (SA/NT rotational supervisor) and Dr Simon Jenkins (regional committee chair).

NSW refresher course

The NSW Regional Committee again conducted a very successful part II refresher course in anaesthesia at Royal Prince Alfred Hospital from February 15-26. The course, intended for candidates sitting for their final Fellowship examinations in 2010, included seminars, panel sessions and demonstrations, lectures, informal tutorials and concluded on the last day with an anatomy workshop at the Department of Anatomy & Histology, University of Sydney. Special thanks to all the lecturers who devoted a huge amount of time and effort in assisting the candidates prepare for their final examinations, especially Dr Timothy McCulloch, Dr Andrew Watts and Associate Professor Gregory Knoblanche.

Demonstrators and course participants at the anatomy workshop on the last day of the part II refresher course.






WA discusses obstetrics

The WA Autumn Scientific Meeting was held on Saturday, March 6 at the University Club of Western Australia. The theme of the meeting was "Choices and Challenges in Regional and Obstetric Anaesthesia". Professor Warwick Ngan Kee, Director of Obstetric Anaesthesia at the Chinese University of Hong Kong, spoke about "Best Practice Anaesthesia for Caesarean". Other speakers included Dr Neville Gibbs, Director of Anaesthesia at Sir Charles Gairdner Hospital, who made a presentation on "Formal and Informal Fallacies in Anaesthesia". Dr Kate Luscombe spoke about anaesthesia for non-obstetric surgery during pregnancy. Dr Don Stewart gave the D.R.C. (Bunny) Wilson Memorial Lecture on "Life's Highway: Lessons from People and Places".

The day also included ultrasound, epidural and feedback workshops and obstetric problem-based learning discussions presented by the following Fellows: Drs Nolan McDonnell, Suzanne Bertrand, Jodi Graham, Chris Mitchell, Barry Lim and Jamie Salter.

The first half year Nerida Dilworth Registrar 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 Lisa Hill. Dr Nerida Dilworth presented the prize.

Thank you to the presenters, session chairs, sponsors and Dr Prani Shrivastava and the WA CME Committee who worked very hard to make the day a success.


Above clockwise from left: delegates at the WA ASM; Dr Neville Gibbs presenting on "Formal and Informal Fallacies in Anaesthesia"; Dr Nerida Dilworth with Dr Lisa Hill; Dr Don Stewart giving the Bunny Wilson Memorial Lecture; participants at a workshop; Professor Warwick Ngan Kee, Dr Tim Pavy and Dr Neville Gibbs.

Above right: participants at a workshop; Dr John Martyr and Dr Simon Maclaurin.

National Pain Summit

More than 200 delegates from 130 organisations attended the National Pain Summit in the Great Hall of Parliament House, Canberra on March 11. The delegates were at the summit to put the final touches to a world-first National Pain Strategy (see pages 38-49).

Clockwise from top left: Professor Julia Fleming takes part in a group discussion; Associate Professor Ron Tomlins, Royal Australian College of General Practioners, leads a group discussion; Richard Booth, iNova Pharmaceuticals and Dr Peter Tuchin, Macquarie University; Dr Penny Briscoe (centre) with Annette Rijnbout and Elizabeth Carrigan from the Australian Pain Management Association; Fiona Farmer, College of Nursing, Dr Melanie Lovell, Hope Healthcare and Associate Professor Fran Boyle, Medical Oncology Group of Australia.

Left: Further round table discussion takes place at the summit.

Letters to the editor

Managing pain properly

I recently attended a meeting of the ANZCA Council's Finance, Administration and Risk Management Committee and when I recounted an experience with pain I was encouraged to repeat it as a letter to the *ANZCA Bulletin*.

In September 2009, I had a hip replaced at a private hospital in Melbourne. The hospital provided a substantial booklet on what to expect and how to cope with it, which laid considerable emphasis on the amount of pain patients should expect. It explained "it is unrealistic to expect to have no pain at all following your surgery", and it devoted nearly two pages to options and recommendations. Following the operation, the surgeon and the rest of the medical team paid a great deal of attention to the matter with various drips and oral medications.

As a result of this attention, and strict adherence to the recommendations, I had no pain at all – except for one occasion when a nurse made a mistake which was soon corrected.

This fortunate experience continued after I left hospital. As directed, I took eight Panadols per day and was careful with the exercise program with the result that there was some discomfort but nothing that could be called real pain.

On several occasions, the surgeon, and others, expressed surprise and following discussion came to the conclusions that "we have learned to manage pain properly" and "the key to pain treatment is prevention".

I offer my thanks to those who contributed to the scientific advances which led to this very satisfactory state of affairs.

Mr Henry Bosch
Member of the ANZCA Finance, Audit and Risk Management (FARM) committee

Training obstetricians to do epidurals

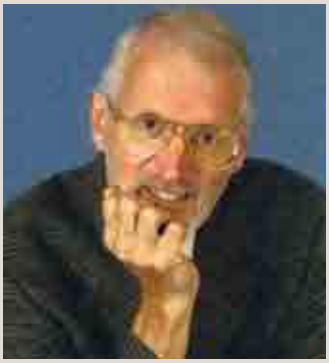
I would like to make a suggestion from left field. "Why don't we train obstetricians to do epidurals?". At present the profession is always under fire for being late for epidurals or not getting one at all. I understand all the resuscitation and pharmacological issues, but really a lot of our obstetric colleagues have been doing epidurals in other countries for years.

This would then free up anaesthetists for where are skills are more needed, i.e. sedation. We still have physicians providing sedation, and now we are training dentists to give sedation. My personal feelings are managing an airway requires more skill than placing an epidural.

Dr Jeff James
Queensland

Awards

Professor Peter John Ravenscroft AM, has been made a Member of the Order of Australia for service to the development of palliative care and medicine, particularly as an advocate for improved education of doctors and health workers in the therapeutics of palliative care.



Dr Hugh Timothy Spencer has been awarded the New Zealand Order of Merit (ONZM), Queen's New Year's Honours for services to medicine, in particular to anaesthesia.

Dr Robert Albert Boas has also been awarded the New Zealand Order of Merit (ONZM), Queen's New Year's Honours for services to medicine, in particular pain management.

Special report:

ANZCA speaks to Minister of Health, Tony Ryall

New Zealand health reform – issues and challenges

In the December edition of the *ANZCA Bulletin* ANZCA spoke to the Australian Minister for Health, Nicola Roxon, about some key issues facing Australia's health care system and, in particular, anaesthetists, intensivists, pain medicine specialists and the wider medical profession.

In this issue, ANZCA President, Dr Leona Wilson, speaks with the New Zealand Minister of Health, Tony Ryall, about some of the major issues facing New Zealand. While some of the challenges in New Zealand's health system are similar to those affecting Australia, there are some interesting changes occurring in New Zealand which are of relevance to the profession in both countries.

Since being appointed as Minister of Health what has surprised you most about the portfolio or the health sector, more broadly – and what do you see as your biggest challenge?

The true financial state of District Health Boards (DHBs). One of the first things I did when I became Minister was to write to DHBs and ask them for their true financial position and how they were tracking towards the end of the financial year. The debt was a lot higher than was previously publicly reported. This is alarming for several reasons. It means DHBs are purchasing things they are not funded to deliver, and that means they cannot guarantee the future of those services. That uncertainty is not good for patients, staff or the DHBs. It severely limits what the DHBs can do to improve what they are funded to offer, including new services, technologies and priorities.

The other issue that surprised me was the breadth of health issues that I and the Ministry need to address.

New Initiatives

Your support of clinical leadership has been welcomed by the medical profession. Anaesthetists currently take on many lead positions. How do you see these leadership roles changing and increasing?

The Chair of Health Workforce New Zealand (HWNZ), Professor Des Gorman, sees clinical leadership for anaesthetists in two areas. One area is clinical governance, which incorporates managing operating room procedures, health teams as appropriate; education, performance management, and pastoral care of students and other colleagues. The second area is corporate governance, which incorporates the hospitals where clinicians work, the Colleges and societies to which they belong, and at the national level to organisations such as the Medical Council and the Medical Association.

The Government has recently approved the Otago and Southland District Health Boards' plans to merge. In your press release about this merger you noted that the two DHBs have been working closely for several years, and the merger makes sense. Submissions from the consultation about this merger highlighted concerns about the potential loss of services in the smaller DHB area. How is this concern about the potential loss of services in the smaller DHB area to be addressed? Do you anticipate other DHB mergers occurring?

The main concerns expressed by people who made submissions in the consultation were the potential loss of services from Southland Hospital and a loss of representation for Southland.

Otago's population will make up just under two thirds of the new DHB and Southland's one third. The Board will be made up of four elected representatives from Otago and three from the Southland region and up to four appointed.

The new Southern DHB Board will have a clinical advisory committee, ensuring a strong voice for clinicians in planning new services, as well as providing a direct line to the DHBs governors.

"The District Health Board's debt was a lot higher than was previously publicly reported. This is alarming for several reasons. It means DHBs are purchasing things they are not funded to deliver, and that means they cannot guarantee the future of those services. That uncertainty is not good for patients, staff or the DHBs."

Tony Ryall,
Minister of Health

"As part of the elective surgery initiative the Government is looking to provide funding to train more anaesthetists."

Tony Ryall,
Minister of Health

We promised before the last election that we wouldn't force DHBs to amalgamate. That still stands. In this instance we are supporting the wishes of the DHBs. More broadly, DHBs have been told to plan and work more closely together, and it may be that we see more mergers in future if they see the potential benefits.

Trainee Positions

Output from medical schools will soon increase. The College's workforce study for Australia shows that we need to produce more specialists for the growing and ageing population. A similar workforce study has been undertaken for New Zealand and the report is expected to be completed in the first half of 2010. Statistics from the 2007 Organisation of Economic Development (OECD) survey has revealed that of the 28 countries surveyed, New Zealand has the lowest ratio of specialists (excluding general practitioners) per head of population. The OECD average is 1.8 specialists per 1,000 people, with New Zealand only reached 0.8. How do you plan to work with ANZCA to increase the number of anaesthetists in New Zealand?

As part of the elective surgery initiative the Government is looking to provide funding to train more anaesthetists. On 16 December 2009, Cabinet signed off on a business plan for new elective theatres in Auckland. The Government anticipates a roll-out of funding to train increased numbers of anaesthetic technicians and anaesthetists.

In February you confirmed the plans for four new operating theatres dedicated to elective operations in Auckland. Earlier you indicated that the Government is to invest $70 million in additional training and education to staff these theatres. The College is keen to work with the Government to train more anaesthetists to address this workforce need and to address shortages in other areas in the country. Our Fellows are willing and able to train more junior doctors. The missing link is funded positions for interns, prevocational doctors and specialist trainees in our public and private hospitals. Accepting that funding training positions in the hospital system has historically been only partly funded by the Clinical Training Agency with the balance being provided by the DHBs, what are the Government's plans regarding funding for medical specialist training?

Final allocation of the $70 million funding is still being planned, however as an interim measure the Clinical Training Agency (which is now part of HWNZ) has reprioritised existing training funds towards anaesthesia and anaesthetic technicians to get a jump-start on implementing the theatres initiative. An additional 51 registrar positions are now funded, and since July 2009 all eligible DHB anaesthesia registrars have been funded. An additional 16 anaesthetic technician positions are also being funded. These changes strengthen the current training capacity

"The Government anticipates a roll-out of funding to train increased numbers of anaesthetic technicians and anaesthetists."

Tony Ryall,
Minister of Health

of our anaesthetic services. In the long term, it remains that training funds across all medical specialties, and for anaesthetic technicians, will be based on workforce demand and supply projections undertaken as part of the Health Workforce Information Program.

Rural Health

We understand there is a maldistribution of specialists between metropolitan and provincial and rural areas and acknowledge there is a need to address this issue. Would the Government be in favour of creating special short-term rotational positions (3-6 months) in linkage with a teaching hospital to enable senior trainees to rotate to smaller hospitals where there is a need for specialists, but none or very few are available? Such a scheme would allow these senior trainees to gain valuable independent experience, and also provide the community with medical cover by a practitioner who was close to full qualification as a specialist. By linking to a teaching hospital this would enable effective distant supervision to be provided. Are there any other options that the Government is considering that aim to improve recruitment and retention for the rural and provincial specialist workforce?

The Government has made a total of $5 million available over the next five years to support the development of a multidisciplinary, rural immersion placement initiative. National and international workforce studies confirm that health professionals who have favourable training exposure in rural locations are more likely to consider careers in rural locations. The Ministry has released a request for proposal (RFP) seeking a provider for multidisciplinary, rural immersion health training placements. These would be available to medical, nursing, and other health professional students as part of their undergraduate programs, enabling them to train together in a rural setting.

Supporting Education and Training

Does the Government support protected educational and administrative time for clinical supervisors of training and clinical teachers to carry out educational activities in clinical medicine?

The CTA funds DHBs to undertake these educational activities. The DHBs are responsible for the disbursement of this funding under an agreed costing model. The system is subject to audit by the CTA, together with reporting by DHB trainees and supervisors.

In the new environment of an increased number of medical graduates and patient concerns about being "experimented on" by trainee doctors, we may rely more on medical simulation to prepare young doctors for emergency situations and to assess their progress. Do you see support for the development and maintenance of simulation centres as one way of addressing the issue of increased numbers of medical graduates where there are insufficient clinical training opportunities?

That sounds like an interesting concept for Health Workforce NZ to assess. I would be interested to visit a simulation centre to see first hand the clinical training potential these units provide.

ANZCA is undertaking a comprehensive review of its anaesthesia training curriculum to ensure it is best practice and meets the needs of the health system and the population it serves in the 21st century. Dr David Galler, Principal Medical Advisor with the Ministry of Health has provided valuable input to this review process. In your view, what key elements does the new curriculum need to address in shaping the new training program? With medical students, trainees and specialists dispersed across the country in the public and private sectors, we will be more reliant on distance education and web-based learning. Does the Government have a clear plan to support distance education and web-based learning educational activities?

"Many of the key elements the Ministry of Health would want to see are covered in the CanMEDS competencies which the College has adopted. However, for New Zealand, the Ministry is keen to see specialist staff that are fit for purpose to work in the New Zealand system."

Tony Ryall,
Minister of Health

I've been told the curriculum review is comprehensive and that an experienced group of educational experts ran the review. The review purpose is to meet current and projected future needs for anaesthetists.

Many of the key elements the Ministry of Health would want to see are covered in the CanMEDS competencies which the College has adopted. However, for New Zealand, the Ministry is keen to see specialist staff that are fit for purpose to work in the New Zealand system. The Ministry expects that the medical expert competency should be an entry level criterion, and supports the recommendation that the College training program should include a balanced emphasis on all roles within the College curriculum framework, with increased inclusion of and emphasis on roles other than the medical expert. The Ministry strongly supports the emphasis on Generalist training. The review would benefit from mention of the role of the College or the relationship of the review to International Medical Graduates (IMGs), as a more transparent and streamlined process to assess these people would be helpful. Furthermore, it would be a significant boost if trainees were required to spend time in hard to staff provincial or urban areas in the hope that they may return there to take up specialist positions at the end of their training.

In New Zealand, trainees are largely based in the public hospitals in departments accredited by the College and under the guidance of the College's Supervisors of Training. Trainees should have the opportunity to undertake distance education and web-based learning educational activities as part of that training. We look to the College to help guide us in this matter through their relationships with their Fellows in the departments which the College accredits. We believe that there is no barrier at our level to those things happening.

1 CanMEDS is a framework for medical education that sets clear and high standards for essential competencies expected of physician specialists in Canada. These include: medical expert, communicator, collaborator, health advocate, scholar, and manager.

A range of rural health professional development services is provided under the national contract between Mobile Surgical Services Ltd and the Ministry. These services include surgical skills programs for GPs and nurses (conducted on the surgical bus), and a range of courses and training days (independent of surgical bus visits) plus an annual conference for rural health practitioners. These education programs enable rural health practitioners to meet part of their professional obligations for continuing education without the need to travel to urban centres.

Remote collaboration through high-quality two-way video (telepresence) linkages contribute to these education programs and to the University of Otago's Rural Medical Immersion Program, and supports remote clinical peer support involving primary and secondary care providers in rural and urban settings. This technology also allows surgical or medical teams remote access to expert assistance and facilitates the introduction of new ideas and technologies. Remote collaboration between hospital specialists and rural GPs to provide first specialist assessment to rural patients being assessed for electives procedures is being explored.

Role of Medical Colleges

In New Zealand, the Medical Council asks its branch advisory bodies, such as ANZCA and other specialist medical colleges, to assess international medical graduates' comparability to New Zealand trained specialists (but is not bound by their advice). What are your views on these certification processes and are you confident that these processes will minimise the risk of doctors gaining registration here who are not competent to practise at the desired level in order to protect the health and safety of the public?

The Health Practitioners Competence Assurance Act 2003 (HPCA Act) gives registration authorities such as the Medical Council the responsibility for determining an overseas-trained

practitioner's competence to practise in New Zealand. In the case of IMGs seeking registration as a specialist, this includes consultation with the appropriate medical college, although the registration authority is independent of any college or professional organisation. The main purpose of the HPCA Act is to protect the public. The Government recognises the independence of the Medical Council.

In 2009 the Ministry completed a review of the operation of the HPCA Act. Two of the recommendations from this review are around developing key performance indicators and an annual reporting template to measure the performance of the regulatory authorities. The Ministry is working with the regulatory authorities to agree performance indicators and develop a template for annual reporting. For the first 12-18 months, we expect reporting will be done quarterly. It is expected this reporting will begin in the latter half of 2010.

In 2009, the Medical Council reported that it had assessed 22 countries as having health systems comparable to New Zealand or qualifications that were equivalent to New Zealand's medical degree. The Medical Council also reported that 73 percent of applications from IMGs were processed within four weeks. The Medical Council reported that it was making changes to improve its registration processes for IMGs but that public safety remained paramount.

The Ministry and HWNZ are developing a voluntary program to assist those IMGs who are residing in New Zealand but do not have registration to practise here. The proposed program will provide additional training for those IMGs who may benefit from it but will also identify and offer counselling on other health and non-health careers to those identified as unlikely to be suitable to practise medicine in New Zealand. Sector consultation on the proposed program will take place shortly (primarily with DHBs) and you will be provided with an update after feedback has been received. It is likely that this will be followed by an expressions of interest process before further development and implementation of the program.

Workforce

The National Health Board and the Clinical Training Agency Board will be responsible for the planning, coordinating and funding of pre-professional entry clinical training, workforce planning and policy development. How do you see these agencies working and what are the implications for medical colleges' training programs? How can the medical colleges best work with these two Boards, the Ministry of Health and the District Health Boards to ensure that in the future, the New Zealand public is served by a healthcare team of the same high standards as they are now?

Professor Gorman believes that we should all work in partnership with the colleges to shape regional and district plans. He sees HWNZ with a central intelligence role and invites the colleges to be partners. The colleges should be encouraged to provide solutions with which HWNZ will then assist. Professor Gorman recently met with the New Zealand Society of Anaesthetists to discuss their vision for 2020. The discussion covered such things as a blueprint for innovation, capacity building and role options. This should be led by clinicians themselves with a view to how HWNZ can participate and support anaesthetists in changing the way anaesthetics is provided.

In the new environment, New Zealand may be less reliant on international medical graduates (IMGs). What is the Government's longer term plan with respect to the immigration of medical practitioners?

The Government has set itself the goal of making New Zealand self-sufficient in doctor training over time. To move towards this goal, the Government will increase funded medical student places at universities by 200 by 2014 (beginning with an extra 60 places in 2010), expanded GP training by 50 places, and is encouraging more training in rural and provincial areas. While medical practitioners will continue to move

across our borders in both directions, the intention is that New Zealand will not be reliant on sourcing IMGs to deliver services due to a local undersupply of practitioners.

New Zealand has been at the forefront of utilising anaesthetic technicians and nurses as assistants as part of the anaesthesia care team – in the operating theatre and recovery room with more recent involvement in pre-anaesthesia clinics and acute pain services in the wards. New Zealand anaesthetists have also led investigations into the use of physician assistants within the anaesthesia care team. With New Zealand having one of the world's best safety records in this area, what changes, if any, do you envisage for the anaesthesia workforce?

The Counties-Manukau DHB is in the process of seeking agreement from key stakeholders before commencing a pilot of four overseas-trained physician assistants (PAs) in Auckland, for use in a range of settings which may include anaesthesia. Australia has already run a pilot for PAs in 2008, and two Queensland universities now offer PA training courses. PAs are now widely used in both England and Scotland, and there are 66,000 PAs practising in the United States.

The recent review of medical training identified a need to improve the training experience for junior doctors in the house surgeon years. It is hoped that the PA role will relieve house surgeons of some of the tasks that do not require a medical degree.

Pain Medicine

Pain Medicine is a recognised specialty in Australia. In New Zealand the College and its Faculty of Pain Medicine is currently proceeding through the Medical Council application process to gain specialist vocational recognition of pain medicine as a separate scope of practice. It is estimated that chronic pain (that is, constant daily pain for a period of three months or more) costs the Australian economy around $34 billion per annum with 36.5 million working days lost – a huge productivity loss. A similar situation will apply to New Zealand. Yet pain services seem to be unevenly spread with a small number of multidisciplinary pain clinics as well as a major shortage of doctors and other allied health professionals trained in this area. Do you see addressing the issue of pain as an important element in the government's health reforms? Would the Government support funded positions for training in pain medicine?

In January 2010, the Ministry wrote in support of the College's application to the Medical Council for pain medicine to be recognised as a separate scope of practice. Hence addressing pain management is being investigated as part of the Government's health reforms. To date there has been no investigation of how training positions specific to pain management might be funded.

Conclusion

What is your proudest achievement, or a decision to date, relating to our health system that has given you the most satisfaction since being elected? What would you like New Zealand's health system to look like five years from now?

One of the things that is in its infancy, but will have a long term, positive influence is the instruction to District Health Boards to foster effective clinical leadership, and working with Boards to make that happen.

The document the Government commissioned and written by senior doctors, 'In Good Hands' provides guidance to DHBs on how they can institute a more participatory and less top down approach for their doctors, nurses and other health staff.

We know that, globally, clinical leadership is recognised as a fundamental driver of a better health service.

This is not about massive structural upheaval, it is about operating differently to develop and support strong clinical leadership and governance throughout the health system.

Australia's health reforms gather pace

The long-awaited response from the Rudd Government – *A National Health and Hospitals Network for Australia's Future* – was announced on March 3, 2010. This follows the release of the following three key reports in 2009 and extensive community consultation throughout Australia:

- ***National Health and Hospitals Reform Commission (NHHRC) Report***
- ***National Primary Health Care Strategy***
- ***National Preventative Health Strategy***

The Prime Minister hailed the proposed health reforms as the most significant since the introduction of Medicare nearly 30 years ago. The plan targets three main areas covering federal funding, a new national network and local hospital networks.

The Health Minister, Nicola Roxon, said:

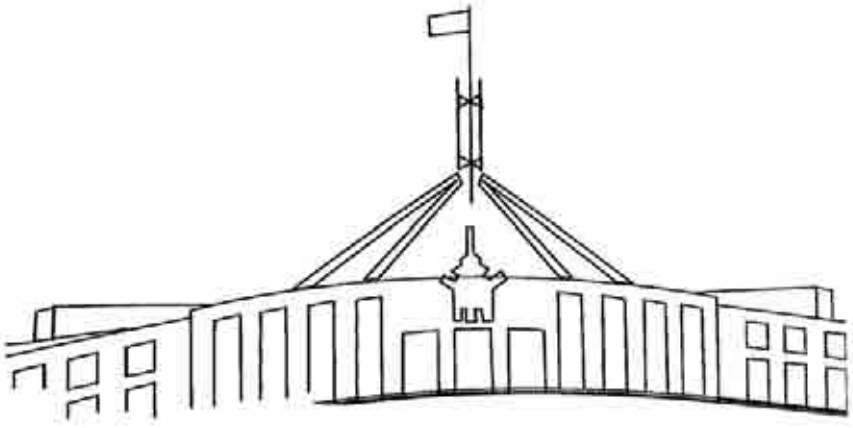
"The reforms will see for the first time one level of government – the Commonwealth – becoming the dominant funder of Australia's health and hospitals system.

The Commonwealth will establish a new National Health and Hospitals Network, which is funded nationally and run locally, with a single set of tough national standards to drive better health and hospital services.

The Commonwealth will take majority funding responsibility for the hospital system – funding 60 per cent of all public hospital services – and take full financial and policy responsibility for GP and primary care services.

Having one government as the dominant funder of health and hospital services will help end the blame game."

The new federal funding model proposed as part of the reforms means the Commonwealth will become the majority funder of public hospitals for the first time and will directly fund 60% of public hospital services, including research and training, and infrastructure maintenance. Also, the model will fund 100% of GP and primary health care services, including primary health care services provided to outpatients.



Funding will move to a different model directly allocated to Local Hospital Networks on the basis of an efficient price to be set by an independent body. Over time, the Commonwealth is expected to move to fund 100% of the efficient price, with additional costs to be met by the states and territories.

The Government intends to establish national standards that hospitals will have to meet and these standards will apply to access to public hospital care, particularly emergency departments and elective surgery, and access to GPs and other health professionals. In addition, there will be standards for financial performance and efficiency and health system safety and quality.

The proposed reforms call for local hospital networks to be established by the states and territories. These networks, consisting of small groups of public hospitals with a functional/geographical connection, will be responsible for day-to-day operations, planning and performance, and financial management.

Networks will be established as separate state authorities with a professional governing council (including local health, management and finance professionals) and a CEO who will be responsible for delivering services.

The Commonwealth's new direction implies a changed role for existing state/territory health departments to focus largely on system-wide service planning and performance management issues, and to work with networks to negotiate service contracts.

More specialist training places

Of interest to the profession is the recent announcement on additional specialist training places worth $145 million. ANZCA has welcomed this news. Numbers of training places in private and expanded settings will increase from 360 to 900 by 2014. Further, an additional 680 specialists will be added to the system by 2020. Training targets will be developed in consultation with the medical colleges and states/territories to ensure adequate spread of disciplines to meet service and training needs. The new Health Workforce Agency will assist with this process.

What's next?

The reforms require the cooperation and endorsement of the state and territory governments and will be discussed at the next Council of Australian Governments (COAG) meeting in April. If the Commonwealth cannot get the states' and territories' support, the Prime Minister may proceed to a referendum on the proposals at the next federal election.

The Commonwealth's National Health and Hospitals Network report can be accessed at **www.health.gov.au.**

The trials of separation

Trishna and Krishna, at least for a few days last November, were among that special group who are immediately recognisable by their first names. The media adopted the days and night of the final surgical separation of these craniopagus conjoined twins as their lead story with live updates of the unfolding drama. It was a dramatic couple of days but it was actually just the tip of an iceberg.

Dr Ian McKenzie, Director of Anaesthesia and Pain Management at Melbourne's Royal Children's Hospital, gives his behind-the-scenes account of the clinical aspects of a story that captured a nation's attention.

The separation of Trishna and Krishna was the culmination of two years of staged procedures, planning and preparation involving a huge and heterogenous team. From a hospital perspective, there was not only the predictable medical, nursing and allied health roles but key executive, administrative and domestic service roles. From a bigger perspective, the role of the Australian aid worker who initially drew attention to Trishna and Krishna's plight in a Bangladeshi orphanage and the responses of the team coordinated by Children First, a charitable aid organisation, were vital for the separation ever happening. Moira Kelly AO, who initiated Children First, and who has assisted thousands of children in medical need, along with Atom Rahmon became the guardians of these children and negotiated the complex path with a fierce determination to ensure the best interests of Trishna and Krishna were served. The Department of Anaesthesia and Pain Management at the Royal Children's Hospital (RCH) Melbourne was proud to be a key part of the saga. Medically, the story was actually extraordinary.

Like so many medical stories, the possibility of craniopagus twins coming from Bangladesh for separation at RCH began, for our department, as a rumour. It took a little while for the reality of the twins to be confirmed and further time for all the administrative aspects to be put in place. A full range of considerations were reviewed not only from a technical and bureaucratic perspective but also by the hospital clinical ethics committee. The final decision to accept the referral was not taken lightly. The rumours also suggested that one of the twins had a serious cardiac defect which had not been able to be fully diagnosed in Bangladesh. That twin, Krishna, was failing to thrive and appeared to be heading for a lethal outcome, which would clearly also lead to the demise of her conjoined sister.

The twins arrived at RCH 11 months old and were rapidly transferred to the PICU, as the condition of Krishna was even worse than expected. Krishna's cachexia contrasted with the apparent robustness of Trishna. Krishna had marked biventricular failure with dilated ventricles and severe pulmonary hypertension. Otherwise, Krishna's heart seemed anatomically normal with no structural cause for her severe cardiovascular disease. In a great example of the application of Ockham's Razor, the structural cause turned out to need a bigger view than that provided by echocardiography of Krishna. The cause was actually the circulatory consequences of being connected to her sister Trishna.

The anatomy and physiology

The anatomy of the twins' connection created their initial problems and understanding the significance of that anatomy became the key to planning the staged separation. The twins were joined approximately at the parietal region of the skull (Krishna's right and Trishna's left), which was solid all the way around the connection was essentially the size of their heads. The brain tissue of each twin abutted but appeared probably separated by a thin plane. The cerebral venous anatomy was complex. The crucial issue was that they shared a single sagittal sinus. The single sagittal sinus was more on Trishna's side. Amongst other connections, there was also a huge vein draining the sagittal sinus to Krishna.

The puzzle of the cause of Krishna's cardiac failure took some time to resolve and then the solution still left some questions unresolved. What is certain is that Krishna's huge venous connection to the shared sagittal sinus was playing a role in driving her circulatory system. It was clear that there was no high flow arteriovenous fistula (as occurs in Vein of Galen malformations) creating high output failure. Excess drainage into Krishna was not possible in an continuing way, so something else must have been affecting Krishna's circulation. There are mechanical and endocrine theories for what was happening and both may have played a part. The best description of the mechanical theory is that the huge vein draining to Krishna from the shared sagittal sinus was allowing Trishna to act as a pressure priming reservoir for Krishna's cardiovascular system. Krishna's heart was "seeing" a high venous pressure and was increasing its output in an attempt to lower the venous pressure to a more normal level. Being unable to empty the reservoir created by Trishna, the venous pressure would remain high and the cardiac output would increase in further attempts to lower the pressure. The result was that Krishna

was stimulated to fruitlessly increase her cardiac output in response to the high venous pressure, leading to biventricular dilatation, ultimately with biventricular failure, exacerbated on the right side by the development of pulmonary hypertension due to the high flows.

This understanding of the physiology allowed the anaesthesia team to implement some successful novel strategies when the physiology was reversed at the first vascular separation procedure. On occlusion of Krishna's large vein draining the shared sagittal sinus (by interventional radiology performed at the Royal Melbourne Hospital by Peter Mitchell) Trishna became hypertensive and Krishna hypotensive. Drug treatment could not be targeted specifically to either twin as the circulations mixed so rapidly and the twins needed opposite treatments. An alternative to drugs was required. Mechanical manoeuvres, positioning Trishna physically higher than Krishna, and applying large levels of PEEP to Trishna, caused the desired decline in Trishna's arterial blood pressure and reciprocal rise in Krishna's blood pressure.

Planning

A multidisciplinary team was assembled to plan the care of the twins and the various management strategies. The anaesthesia part of the team was led by Andrew Davidson, a neuroanaesthetist at RCH, who became Trishna's primary anaesthetist for most of her major procedures, and Ian McKenzie, with a cardiac interest, who looked after Krishna. Peter Howe, lead craniofacial anaesthetist at RCH with an interest in difficult airway management, provided expert advice and clinical support for those parts of the procedures. Many other anaesthetists were involved at various stages. The anaesthesia technology team was also intimately involved in both planning and clinical care, with the key players being Jenny Fuller, Eddie Cousinery and John Byrne. The pain management team provided acute postoperative care, whilst the Comfort Kids Program supported non-theatre procedures later in the sequence of events.

RCH Director of Neurosurgery Wirginia Maixner, and colleague Alison Wray, in consultation with the Chief of Craniofacial surgery, Andrew Greensmith and colleagues Tony Holmes and David Chong developed a strategy for staged separation. The biggest problems described in previous cases related to massive blood loss during epic single stage procedures, and inadequate venous drainage of the brain, resulting in severe brain swelling. Both of these complications had been associated with fatal outcomes. Overall the success rate had been low, although a neurosurgical group in the US provided important information about some recent successful staged procedures which they had performed. One report from the USA in the early 1980s provided a salutary reminder that the basics must also be managed carefully during complex surgery. Their patients, craniopagus twins

"This understanding of the physiology allowed the anaesthesia team to implement some successful novel strategies when the physiology was reversed at the first vascular separation procedure when the physiology was acutely reversed."

Above from left: Dr Ian McKenzie from Melbourne's Royal Children's Hospital; Trishna; Krishna.

The trials of separation
(continued)

"In principle, each of the anaesthesia issues seemed clear, but there were a lot of issues.Two patients needing two teams and two sets of equipment to look after them. The cross-circulation meant that both twins would become anaesthetised even if only one was receiving the drug. The twins had complex cardiorespiratory issues."

operated on in the first few months of life, succumbed to septic complications of burns received when prep solution that had pooled in drapes was ignited. The simultaneous draping of conjoined patients for neurosurgery is complex.

The concept of the surgical plan was to slowly, sequentially separate Krishna's cerebral venous drainage from the shared sagittal sinus. The staging would put smaller areas of brain at risk of inadequate drainage and allow time for collaterals to develop. The magnitude of any one procedure would be smaller than a single stage procedure making each procedure more manageable and decrease the chance of uncontrollable blood loss. Prior to final separation, tissue expanders would be placed to allow sufficient coverage of the large defect created by the separation. It was hoped that the program would be complete in about a year. In fact, it took two years.

Staged separation

After initial assessment, and PICU support, especially needed for the severely ill Krishna, the first step in the separation was performed at the Royal Melbourne Hospital interventional radiology suite by Peter Mitchell. The logistics for setting this up, including simultaneous two baby critical care transport and preparing the adult RMH radiology suite for two critically ill children being simultaneously anaesthetised, was something of a triumph for the huge team involved. The occlusion of the major vein draining to Krishna from the sagittal sinus had a profound effect on the interaction of the twins' circulations, with immediate reversal of the situation. Trishna became hypertensive and Krishna hypotensive (initially compounded by her poor myocardial function).

From that time on, Krishna's pulmonary hypertension and cardiac failure resolved. However, her physiology from that time until separation was now that of someone who was chronically hypovolemic. She remained hypotensive with poor urine output, with the situation worsening over the next two years. She was virtually anuric in the months prior to separation. She developed bladder stones, presumably as a consequence of her minimal urine output, and these required endoscopic surgery and antibiotics for acute infective episodes and prophylaxis. Krishna remained with normal creatinine as Trishna was the perfect dialysis unit.

Conversely, Trishna remained hypertensive until separation and slowly developed left ventricular hypertrophy. The hypertension was so severe that, despite the potential for Krishna's hypotension being worsened, Trishna was given antihypertensives.

Behaviourally, this cardiovascular situation had an easily observable and curious consequence. As someone who was chronically hypovolemic, Krishna was constantly thirsty and demanded water almost continuously. Trishna had little need to drink but a gigantic urine output as she offloaded all the water Krishna was drinking. There are possible endocrine mechanisms, but the idea that Krishna was chronically hypovolemic and Trishna hypervolemic does fit nicely.

Three craniotomies, each separated by months, separated all but a small portion

Below from left: Guardian Moria Kelly stands between the cots of separated conjoined twins Krishna and Trishna; A 3D model of the twins' skull and circulation; Anaesthetist Ian McKenzie works on the separation of twins Krishna and Trishna.

of the brain-related venous connection between the twins. One of these operations was 20 hours long, but most were largely "in-hours". Even with brain related venous conections minimised, the bony connections of the skull still would allow a slow intramedullary cross-circulation. The last brain related venous connection was left for the final separation operation.

A total of seven tissue expanders were placed, five in the head region and two on the thighs to maximize the tissue available. These were slowly inflated on an outpatient basis. One of the first set of expanders became infected. Despite initial antibiotic therapy, the twins developed generalised sepsis and all the expanders needed to be removed. After months to ensure the infection was clear, a revised plan with a smaller number of larger expanders was implemented. This succeeded and, two years from the time they arrived in Australia, the twins were ready for separation.

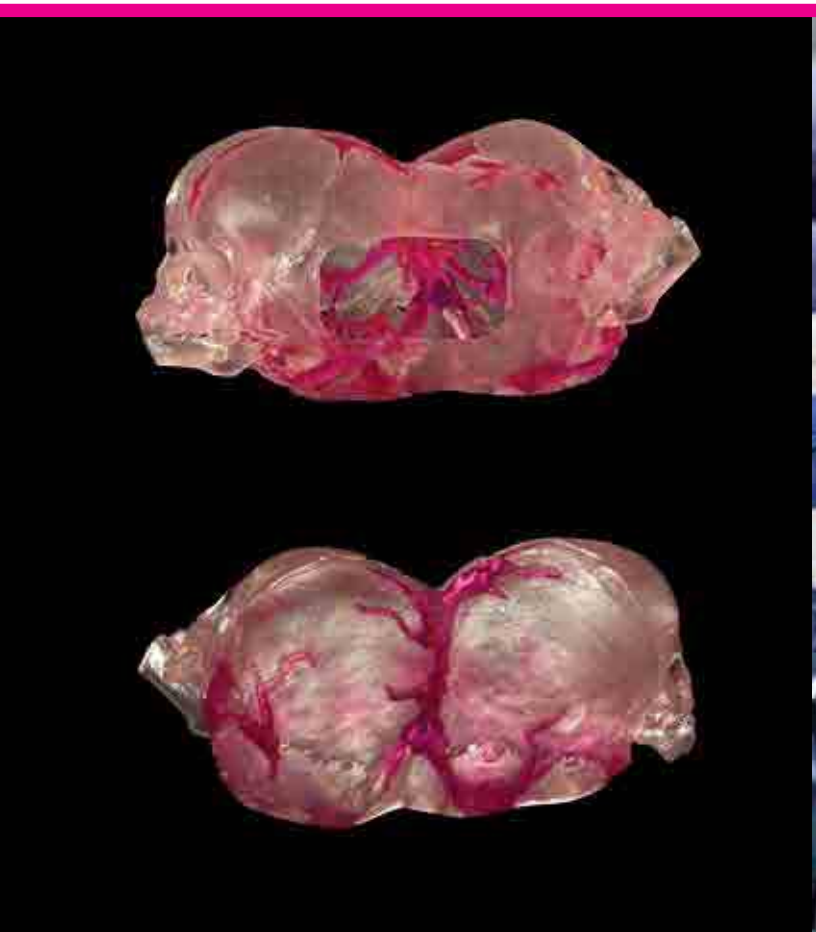
Anaesthesia issues

In principle, each of the anaesthesia issues seemed clear, but there were a lot of issues. Two patients needing two teams and two sets of equipment to look after them. The cross-circulation meant that both twins would become anaesthetised even if only one was receiving the drug. The twins had complex cardiorespiratory issues. The operations would be substantial and repeated with risk of massive blood loss. Some operations would be in the prone position, some would require prone and supine positions during the same operation. The airways were not straightforward to manage. Repeated major vascular access would be required for central and arterial lines and "big" IV peripheral access for each major procedure, whilst femoral vessel access would also be required for interventional radiology and cardiac catheter procedures. Jugular lines were contraindicated due to concerns that thrombosis might jeopardise the cerebral venous drainage that may already be precarious. Subclavian venous access was reserved for the final separation procedure. Repeated medical imaging procedures under anaesthesia were required, including MR imaging with the associated equipment issues. Theatre, staff and bed management (including PICU beds) scheduling needed to allow for facilities and staff to be made available, repeatedly. Fortunately, most procedures were planned and elective, but allowing for emergency out-of-hours interventions was also important (and required).

The initial PICU phase of management included Krishna having a tracheotomy. This did allow general ward management but delayed the twin's hospital discharge and created a huge nursing burden for Moira and her Children First team when discharge was achieved. The tracheostomy did simplify airway management for a number of procedures but always needed to be changed to an alternative with less leak to allow better control of the airway under anaesthesia. Eventually, Krishna was decannulated and we returned to having to sequentially intubate the twins for most anaesthetics.

It was relatively easy to control both twins' airway with a bag and mask. This could be continued with one while the other was intubated. Intubation was awkward and provided some insight into what makes intubation difficult. Intubation could appear difficult with the twins, but if care was taken to make sure the twin being intubated was in the correct "sniffing the morning air" position with good head and neck alignment, intubation was reasonably straightforward. If one attempted to use the laryngoscope blade to move the airway into alignment without getting the overall position right, it was difficult to obtain a good view. The weight and position of the conjoined twin meant that optimal positioning was difficult to achieve. The solution introduced was a combination of pillow supports to get approximate position then a separate assistant manually putting the head neck and shoulders of the twin to be intubated in "the perfect position". The lesson that was reinforced was classic anaesthesia teaching. Get the patient in the correct position before intubation. This is especially important when the pull of a laryngoscope won't be able to reposition a malaligned airway without excessive force (as with craniopagus twins).

The department was fortunate to have introduced ultrasound guidance for vascular access procedures before the twins arrived. It is likely that we would not have been able to gain repeated quality peripheral and central venous and arterial access without ultrasound guidance. Issues around communication and planning for emergencies were



The trials of separation (continued)

"By the evening of that first day, a strident media frenzy was demanding updates that went beyond the original plan"

highlighted on the night the twins became severely septic in association with the first set of tissue expanders. Appropriately, the ward called a "MET" call in the wee small hours of the morning. There was a need for urgent resuscitation, but a MET call calls a single team, so the equivalent of a second MET team had to be urgently scrambled to deal with the two sick patients.

The media

From the beginning, Children First had agreed with a production team that a documentary could be made about the twin's story. There was some exclusivity in the media arrangements and the resulting program was sold to Channel 7 and shown in February 2010. The exclusivity minimised other media interest over that time. The production team ended up with a much bigger and longer task than initially predicted. They really did follow every step of the way. They were patient and sensitive to the staff needs and maintained an excellent working relationship with the clinical team. Two years and hundreds and hundreds of hours of footage, became the 68 minutes of screen time required for the one-and-a-half-hour documentary on a commercial station at prime time.

In the run up to the final separation, the RCH executive had implemented a plan to minimise media pressure on the clinical team. This worked well. Once it was known that the date of the separation would become public (due to extensive support arranged by Children First involving prayer groups linking around the world), a formal press conference was arranged for the week before the separation. The media was given an opportunity to hear summaries of various aspects from a number of clinicians. From then, the plan was that the Director of the Division of Surgery, Leo Donnan, who was not directly clinically involved, was to be the official spokesperson for RCH on the day of the separation. The idea that the media would take up the story quite so vigorously and that the surgery would in fact go overnight and well into the next day complicated this arrangement.

By the evening of that first day, a strident media frenzy was demanding updates that went beyond the original plan. By arrangement with the RCH media team and the Director of Surgery, an anaesthetist (Ian McKenzie) was asked to face the media about 9 pm. This satisfied the late bulletins, and the expectation was that separation would occur in the next few hours. By 7 am the next day, separation had not been achieved and it was quite unclear how long it was going to take. There was now a "media pack" camped in front of the hospital and the morning radio and television programs were "running with the breaking story" of the twin's separation. They were baying for information and, as the full day executive team was yet to arrive and pretty much the only available person was last night's anaesthetist, who was still present (having had an overnight nap and handed clinical care to the next team of anaesthetists), he was trotted out again about 8am. This interview went complete and live to a number of TV channels as did phone radio interviews which followed immediately. This was in contrast to previous reports of the press conference which were less than a couple of minutes of sound bites from a one hour conference. Leo Donnan's announcement later that day that the separation had been completed was aired enthusiastically but briefly. One way or another, the planets had lined up and anaesthesia had become a central part of a big media story with substantial media exposure.

Having had that flush of publicity, the documentary was a good reality check. There were a lot of key story lines and only 68 minutes to tell the story. Anaesthesia, though mentioned, pretty much ended up on the digital cutting room floor.

The separation

Having learnt a lot over the two years, we felt well placed to plan for the final separation. Though hopeful of an operation of modest length (less than the previous 20-hour procedure was expected) we prepared for a longer procedure. We rostered anaesthesia teams to cover the day, the night and the next day. We staggered the team swaps so some members provided continuity. We ensured that "fresh players" were available at all times. We ended up using all those staff. After some machinations, it transpired

that Monday, November 16, 2009 would be the date for the (beginning) of the final separation.

The twins needed a final angiogram just before final surgery. Andrew Davidson made the inspired suggestion that, this should be done on the Sunday afternoon and that we should "set-up" the anaesthesia and lines in a less pressured environment the day before. This proved to be a great plan, though it did require the twins to be in PICU overnight before their formal commencement of surgery. It meant that what proved to be a marathon procedure started promptly with all members of the team fresh and tremendous progress was made during (extended) normal hours.

The first step after transfer from PICU was a craniotomy in the prone position to open most of the bony connections. This wound was closed and the twins turned and re-prepped and draped supine. Some bone had been left to keep the heads stable for the craniotomy in the supine position to separate the final venous connections. The dissection of the remaining deep venous connection which had previously been approached from the opposite side proved difficult even from this, the "easier" approach. The estimated time to finish kept shifting out later and later. At the previous craniotomy, a synthetic membrane had been placed to maintain separation of the brain tissue. The growth of the twins meant that the brains had become quite adherent around that membrane. The dissection proved to be much more challenging and a patient, meticulous approach eventually brought successful separation late in the morning of the second day. By the end of Tuesday, the defects left by the separation had been closed and the twins transferred to PICU.

Conclusion

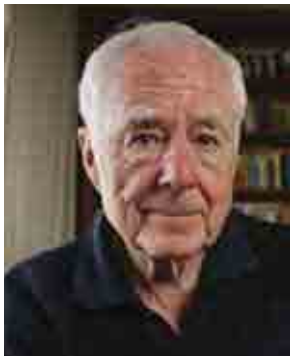
The twins have done well since separation. The medical and developmental issues due to the complex problems which arose during their conjoined years will be slow to come to their final resolution. The story is an extraordinary one. The success of the separation is a tribute to all the people who made it possible. It really was a pleasure and an honour for the anaesthesia team to be part of it.

Special thanks to Moira Kelly for an extraordinary number of things, but for the purposes of this communication, "Thank you Moira for allowing me to tell this story for the anaesthesia community".

Dr Ian McKenzie,
Director of the Department of Anaesthesia and Pain Management, Royal Children's Hospital, Melbourne

"The story is an extraordinary one. The success of the separation is a tribute to all the people who made it possible. It really was a pleasure and an honour for the anaesthesia team to be part of it."

Above from left: former conjoined twin Krishna giggles as her guardian Moira Kelly and Trishna enjoy a cuddle at the Royal Children's Hospital Melbourne; some members of the Royal Children's Hospital team who looked after the twins.



Reflections on four health policy questions

John Power

In a necessarily abbreviated form, a patient can form what the psychiatrists term a 'transference' to the anaesthetist. As an anaesthetist once put it to me: '*We don't just put people to sleep, and later wake them up. More importantly these days, we look after the overall welfare of the patient while the surgeons go about their business.*' Thus it came about that anaesthetists were the leading specialists in the formation of intensive care units.

This combination of intellectual interest and transference often results in the patient holding strongly positive impressions of discussions with his/her anaesthetist. (Of course, it's possible that patients' positive - if often vague and muddled - recollections of such conversations might be the result of the drugs that have been administered to them!)

In any event, it must often be frustrating for the anaesthetist to encounter a succession of favourably impressed patients with whom no ongoing discourse is feasible. Perhaps it's this frustration that explains why – according to another of my specialist informants – anaesthetists rarely visit their patients after operations!

In my case, however, it was my anaesthetist who suggested that I write a paper outlining some of the policy questions that had come to mind as I was surviving a major operation. I was particularly interested in whether my positive experience, which had at several key points depended on fortunate but largely informal arrangements, might be made more widely available through more formal public policies and programs.

My experience of surgery and anaesthesia

I first learned that I had a defective aortic valve about 15 years ago. Soon afterwards, my wife and I became patients of the physician who turned out to be the best GP either of us had ever had: Moira*, a superb diagnostician, with a first-class network of specialist contacts. Through her, I became a patient of a cardiologist, Jeff*, who soon formed the judgment that my disorder, being relatively mild and stable, might never require surgery. However, at the beginning of 2009, my echocardiogram disclosed a marked deterioration, and Jeff warned me to prepare for an operation within a year

As an important part of my preparation, I had some sessions at my own expense with Steve*, a meditation practitioner who specialised in supporting people faced with major surgery. At about the same time, I made careful inquiries before I decided to ask Jeff to approach a cardiac surgeon, Peter*, to request him to accept me as a patient. Through Peter, I came to know Duncan*, who was to act as the chief anaesthetist for the operation. In the course of several wide-ranging discussions, it was Duncan who invited me to prepare this piece for the College of Anaesthetists.

In the remainder of this brief article, I touch on four questions that deserve more attention:

- The reorganisation of general practice.
- Support for patients confronting the prospect of major surgery.
- Better information for patients facing choices on major surgery.
- Reshaping relations between anaesthetists and their patients.

The reorganisation of general practice

Moira is so good at her job that she attracts patients from all over the Melbourne metropolitan area to her CBD surgery. But of course she is not very accessible for the more day-to-day illnesses that afflict her patients. Many of her patients – my wife and I among them – are moving to a two-tiered arrangement, where these more modest complaints are dealt with in our local community, and our local GP shares intelligence with Moira.

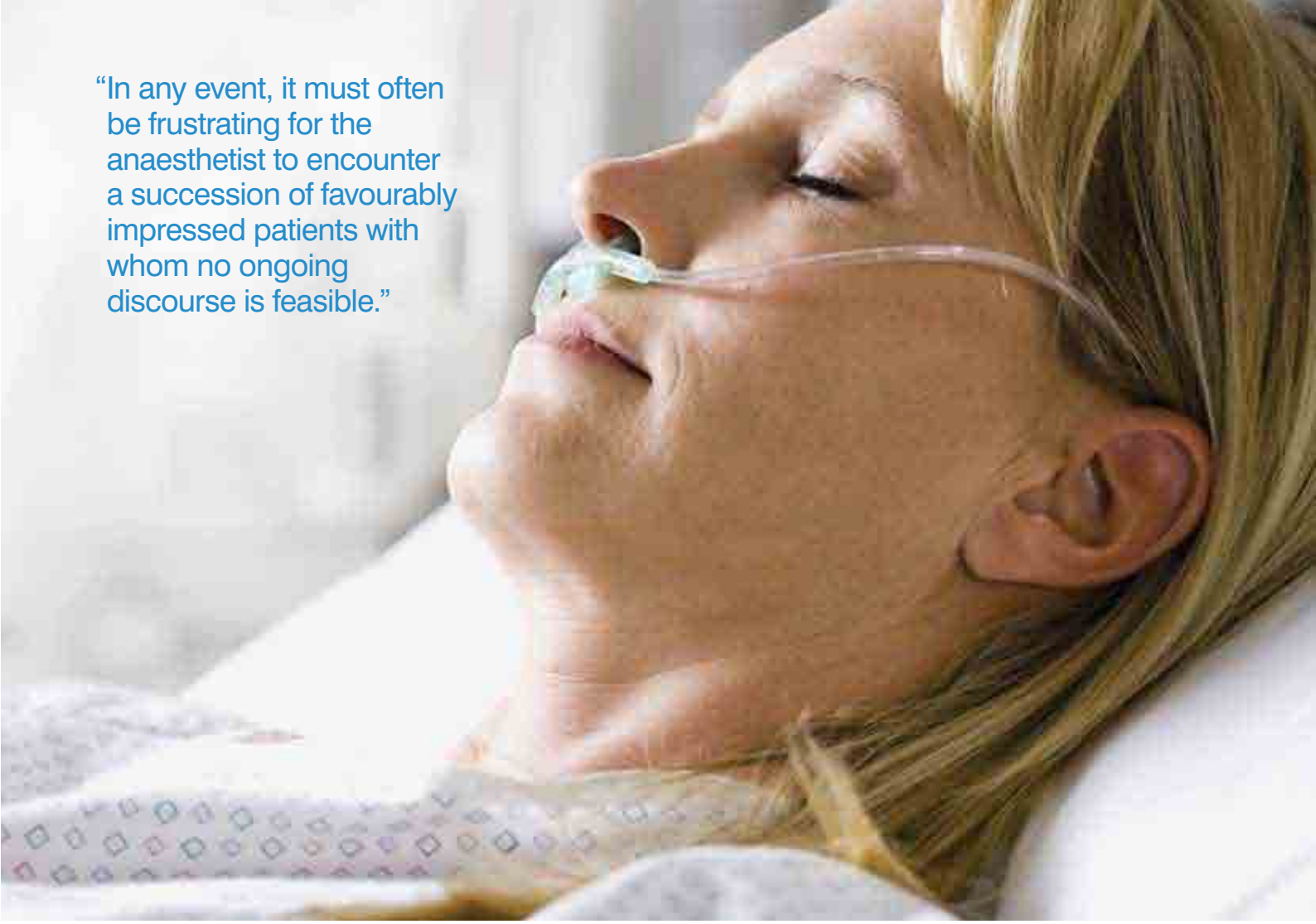
That such an arrangement might be considered demeaning by some local GPs could present a problem, but one that could readily be overcome. As we age, our central concern will be not so much with the gaining of specialist services, but rather with the ways in which we may die with dignity, and here – at this most important of junctures – we shall be relying more on our local community GP. The recent report of the National Health and Hospitals Reform Commission has devoted considerable attention to the ways in which differential inducements could be offered to GPs in order to further the reforms the commission favours. Perhaps two-tiered arrangements negotiated with the GPs of one's choice could be considered as a way of relieving the pressure on at least some overworked local doctors.

Support for patients confronting the prospect of major surgery

Most of the supports that the public sector provides for patients undergoing major surgery are directed to post-operative programs, such as those designed for cardiac rehabilitation (and which are somewhat uneven in quality). The pre-operative needs of very anxious patients confronting such surgery are largely ignored by governments. For example, my valuable sessions with Steve – counselling and meditation tuition – could have received public support only if I had been assessed by Moira as being mentally ill. Surely the public purse could do more to meet the needs of those who, while not being mentally ill, are suffering considerable anxiety as they confront life-threatening operations.

Better information for patients facing choices on major surgery

I made careful inquiries before I requested Jeff to refer me to Peter. I had satisfied myself that he was as good a cardiac surgeon as one could find in Melbourne, and he and Jeff were reading from the same page. Both attend similar in-hospital mortality and morbidity meetings, where deaths and complications from surgery are discussed. They also go to conferences where various surgeons' results in certain procedures are presented. However, it was not until after I had committed to Peter that I discovered the extent to which I had lucked out – for his particular 'sub-specialism' was valve replacements. Is there some way in which such intelligence could be made more readily available to prospective patients trying to identify the most suitable surgeons for their conditions?



"In any event, it must often be frustrating for the anaesthetist to encounter a succession of favourably impressed patients with whom no ongoing discourse is feasible."

Jeff and Peter provided me with two helpful comments on this subject. First Jeff: *The concept of more public information about procedures and choice of surgeon has been tackled in the US already with the publication of surgeon and hospital "league tables". However, it can cause more problems than it solves. As an example, there is a phenomenon known as "out-migration" where certain hospitals/surgeons refuse high-risk cases to keep their figures looking good. These patients eventually end up in neighbouring hospitals or states, skewing their outcome figures.*

Second, Peter has suggested that one way that this problem could be avoided. Information that could be publicly accessed could be gained through a search engine such as Google, which could be requested to provide information on recent relevant papers that may have been prepared by those surgeons being considered. Those surgeons who are sufficiently on top of their work to compose such outcome papers could be approached with confidence.

Reshaping relations between anaesthetists and their patients

After discussing a range of issues relevant to the relations between anaesthetists and their patients, Duncan stated that: *'Real meaningful informed consent should involve these issues'*. But how might this consent be most effectively secured?

Of the five central figures in this story, I have ongoing relations with two (Moira and Jeff) and necessarily episodic relations with another two (Peter and Steve). Until now, my relations with anaesthetists (including Duncan) have been episodic, for my choice of surgeon automatically carried with it the choice of one of his anaesthetist partners.

Such an arrangement has obvious advantages, for surgeons need to have confidence in those with whom they work most closely. But, as I approach the end of my life, should I be exploring the ways in which I might develop a continuing relation with an anaesthetist with a similar value base?

Conclusion

Not being a specialist in the field of heath policy, I have not ventured beyond posing a few modest questions. However, experience in my cardiac rehabilitation program has raised one troubling equity issue. I believe I am the only participant in my program whose progress to an operation was asymptomatic. Most of the other participants have already had unpleasant cardiac episodes, but the majority of them have not yet had an operation. Have I been unduly privileged by the high quality of the care and advice I have received and, if I have, what are the broader public policy implications?

John Power
Professor Emeritus of Political Science
Melbourne University

In October 2009, John Power underwent cardiac surgery to replace an aortic valve, and soon after composed this reflective essay.

* All the characters in my story – Moira, Jeff, Steve, Peter and Duncan – have agreed to respond to any issues that may be directed to any of them. Each may be contacted through me at john.power@unimelb.edu.au. These five individuals must here serve as representatives of a much wider set of medical and nursing professionals. In particular, the commitment of the staff in my ICU greatly impressed my family members. Each of the five was offered the opportunity to comment on a penultimate draft of this paper.

Dr Andrew Miller: Anaesthetist and lawyer in one

Dr Andrew Miller is an anaesthetist with a law degree – which puts him in a unique position of being able to help medical colleagues who are facing legal action. ANZCA's Clea Hincks spoke to him.

Dr Andrew Miller was drawn almost reluctantly into a career in anaesthesia.

Determined not to be influenced by the career choice of his late father, well-known Perth anaesthetist Dr Ian Miller, he tried his hand at several other specialties as a registrar, worked in general practice – and even did a law degree.

But the appeal of anaesthesia drew him back.

"I was initially reluctant to look to anaesthesia as a career because my father was an anaesthetist and I didn't want to be just following in his footsteps," Dr Miller explained.

"I tried everything else and whether it was through coincidence or genetics, I accepted in the end I was quite suited to it."

That was after finishing medicine, working for three years in the public hospital system and starting work part-time in general practice – when he also began a law degree.

"I'd been in general practice for a while and I didn't want to miss the opportunity of studying anaesthetics and intensive care so I put my law studies on hold," he said.

After a year working as a consultant in the US, Dr Miller returned to Perth in 1997 and finished his law degree, doing his honours in informed consent. In all, he spent about 15 years studying.

It put him in the unique position of being able to work as an anaesthetist and do medico-legal work for the medical defence organisation, MDA National.

"There's a natural link between the two professions," Dr Miller said. "Both are about risk management and I hope I'm able to act as an interpreter between them because I have a bit of an understanding of both."

More so than many other professionals, doctors found being sued very confronting, Dr Miller said.

"Lawyers spend their whole time in conflict with one another," Dr Miller said. "They're quite used to being in dispute but anaesthetists are not naturally attracted to being in dispute."

He said the anaesthetists he worked with found it helpful to talk to someone who understood what can go wrong in an operating theatre and who also had knowledge of the legal process – the part that was beyond their control.

"In the legal part of the process, they have very little control and that really goes against the grain – anaesthetists are used to having total control," Dr Miller said.

Anaesthetists were also rightly very proud of their safety record.

"If we have a bad outcome or face a complaint, it really jars with us because we really take pride in our safety in Australia," Dr Miller said.

Dr Miller said the best part of his work with MDA National, of which he is a past president, was being able to support colleagues.

"I really love being an anaesthetist and being part of the medical profession and the thing that attracted me to medico-legal work is that it is about mutually supporting and protecting each other through very stressful times," Dr Miller said.

Beyond that, as a medical case manager at MDA National, he is proud that the team ensures that supports are around doctors so that they do not feel isolated or vulnerable during the legal process.

Dr Miller said that in his 12 years at MDA National, the statistics have shown anaesthetists get a reasonably high frequency of low-value claims, such as dental damage, and occasional catastrophic claims (involving a death or a serious disability from nerve damage).

On average, an anaesthetist could expect to be involved in one significant claim in his or her career as well as several minor incidents, he said.

He said two other main issues involving anaesthetists were patient awareness while undergoing anaesthesia and complications from epidurals.

Dr Miller said he enjoyed being able to focus on one patient at a time in the operating theatre. Working in the legal field was more multi-faceted, making it more complex.

"It's a very different type of thinking," Dr Miller said.

"The legal process – and it's one of my bones of contention in the area I work in – is all about the attribution of blame.

"We've moved beyond that in medicine. When things go wrong, we look at the whole system and we do root cause analysis. We have moved towards a more sophisticated look at adverse outcomes. The law needs to catch up.

"But it's slow going because law, by its very nature, is a very difficult thing to change."

Dr Miller estimates 25% of his workload is spent on medico-legal work and his involvement with medical groups.

In addition to his role as a councillor of MDA National, he is also the chairman of the Medical Indemnity Industry Association of Australia and presents regularly at national meetings on medico-legal topics.

He is a councillor on the WA branch of the Australian Medical Association and chairman of its anaesthesia special interest group. He is also chairman of the WA branch of the Australian Society of Anaesthetists.

The other 75% of his working life is in private practice in Perth where

his work involves a range of plastic and reconstructive surgery, ENT (particularly airway surgery), urology and gastroenterology cases.

Last October, Dr Miller participated in his first overseas aid trip with the WA Surgical Mission in Tanzania. He and another anaesthetist, two surgeons and four nurses worked in Dar es Salaam doing cleft repairs and burns scar surgery.

"Being without some of the technology brought home to me how important it is to remain in touch with basic clinical medicine," Dr Miller said. "It's a tremendous thing to be a part of."

He said he would like to do more overseas work – although he is conscious that this will cost him time away from his wife and two children, aged 12 and eight.

"It's a fairly self-indulgent thing to do when you have a family," he said.

His earlier overseas experience in Pennsylvania, where he spent a year as a consultant, instilled in him the importance of always trying to improve.

"What I learned from the Americans is that things can always be done better," he said. "They have a strong commitment to the pursuit of excellence; even if we do something well, in medicine or in business, you can always improve on it."

Dr Miller is clearly focused on improving how doctors navigate the legal system through his two chosen fields of expertise – one which clearly has more appeal for him than the other.

"Nothing is as much of a challenge or as interesting as complex clinical problems. Anaesthesia is such an engaging way to spend your time," he said. "Law is an interesting academic pursuit but medicine always comes first."

"The legal process ... is all about the attribution of blame. We've moved beyond that in medicine."

From left: Dr Andrew Miller, the lawyer; and practising anaesthesia in Africa.


NATIONAL
PAIN
SUMMIT
Thursday March 11, 2010
Parliament House in Canberra

NATIONAL PAIN SUMMIT BACKS NATIONAL PAIN STRATEGY

More than 130 organisations, including leading authorities in pain medicine, other healthcare professionals, work safety, insurer, industry and consumer groups, came together at a successful National Pain Summit, which was held on March 11 at Parliament House, Canberra.

ANZCA and the Faculty of Pain Medicine took leading roles in supporting the summit which was held in the Great Hall and addressed by the Federal Health Minister, Nicola Roxon. ANZCA was represented by President Dr Leona Wilson, vice-President Professor Kate Leslie, ANZCA Councillor, Associate Professor David Scott, and Director of Professional Affairs, Professor Barry Baker. The Faculty of Pain Medicine was represented by the Dean Dr Penelope Briscoe, and board members Associate Professor Leigh Atkinson, Dr Carolyn Arnold and Dr Chris Hayes.

Chaired by Professor Michael Cousins and facilitated by Dr Norman Swan, the Summit featured a range of presentations from a diverse group of speakers, including international visitors who reported on progress in the United Kingdom and North America.

Inaugural Supporters

NATIONAL PAIN SUMMIT **BACKS NATIONAL PAIN STRATEGY** CONTINUED

The summit commenced with a moving opening video produced by ANZCA's communications unit that featured five patients' insights into dealing with chronic pain and interviews with Dr Penelope Briscoe, Dean of the Faculty of Pain Medicine, and Dr Malcolm Hogg, Head of Pain Services at the Royal Melbourne Hospital.

The Chair of the National Pain Summit Steering Committee, Professor Michael Cousins, said the summit was "a historic day in health" as the national pain strategy was the first comprehensive national strategy worldwide. "We must not allow the under-treatment of all forms of pain to continue to be Australia's largest undiscovered healthcare problem," he said.

Long-term cancer patient Helen Owens, a leading health economist, who during the week had undergone chemotherapy, gave a powerful presentation on her experiences in dealing with and managing pain and what governments needed to do to improve the situation for people with acute and chronic pain.

The carer's story was delivered by former swimming great, Kieren Perkins, whose wife Symantha has suffered from debilitating migraines for more than 17 years. Perkins gave insights into his family's journey through Australia's medical system and the challenges they have faced. While Perkins acknowledged the assistance his wife had been given, he elaborated upon what he saw as the deficiencies of treating people with pain and the emotional roller-coaster that affected his family as a result of differing standards of healthcare in New South Wales and Queensland.

Australia's Health Minister, the Hon. Nicola Roxon MP, outlined the Federal Government's health reform plans saying that the Commonwealth's funding contribution to hospital services would rise from 35 per cent to 60 per cent.

Tim Piper, from the Australian Industry Group, demonstrated the economic burden and cost to business, pointing out that 36.5 million days were lost due to chronic pain. "The cost of pain to society, to employers and to the workers compensation schemes is hard to fathom," he said. He said that education about long-term injuries and best-practice pain management was an issue for Worksafe and the Transport Accident Commission in Victoria and the equivalent bodies in other states.

International speakers such as Dr Mary Lynch, President of the Canadian Pain Society and the National Pain Initiative in Canada, said that Canadian studies echoed those in Australia. She said in 25% of prescription opiod-related deaths, the coroner found that suicide was the cause. "Shockingly and tragically, the final encounter with the physician in the days prior to suicide, identified that in every case it was either a pain, mental diagnosis or both." She said that Canada's health system rewarded "invasive non-evidence based treatments, while not funding evidence-based treatments".

Dr Cathy Price, Consultant in Pain Medicine and Director Pain Program Southampton Region, said that the United Kingdom was gradually beginning to recognise that chronic pain, particularly as a long-term condition, is "a condition in its own right and deserving of its own pathways". She said that in order for there to be major change, systems needed to change. "There needs to be change in the community, giving people resources and policies to access self-management support which is organised around the needs of the individual." Prescribing guidelines, care pathways, pain booklets and a national pain audit are all making a difference.

David Falconer, Director of the Pain Asssociation of Scotland said there were 32 self-management groups across Scotland to help address the impact of chronic pain. "It is not a replacement for medicine. Rather, it is a focus on highly relevant non-clinical issues. It can facilitate the change of locus of control, who is in charge."

Interactive sessions with speakers including Dr Penelope Briscoe (Dean, Faculty of Pain Medicine), Professor Stephen Gibson (President, Australian Pain Society), Coralie Wales (President, Chronic Pain Australia) and Professor Michael Cousins were well received.

Following some further discussion in the afternoon, the summit concluded with a unified position on the recommendations and implementation of a National Pain Strategy with participants calling on the Federal and state governments to implement its recommendations.

"The Federal Government's health reform plans must address the issue of chronic pain which is costing the Australian economy $34 billion per annum, not to mention widespread human suffering", Professor Michael Cousins, Chair of the National Pain Summit said.

"Just as governments have made inroads in destigmatising depression, they must now tackle the stigma attached to another disease afflicting Australia – chronic pain."

"The National Pain Strategy provides a roadmap for action. All that is required for governments – Federal and state – to show leadership in this area," Professor Cousins said.

The following pages feature excerpts of speeches given at the summit.

SUMMIT OUTCOMES

- Called on the Federal Government to support the formation of a national representative body to include all stakeholders in pain management.
- Called for recognition of chronic pain as a condition in its own right with access to treatment in the chronic disease model of care.
- Called for the introduction of standardised national interdisciplinary pain management networks to ensure linkages through all stages of treatment – from prevention of chronic pain, through primary and community care to secondary and complex tertiary care.
- Called upon Federal and state governments to back a community-led program to destigmatise chronic pain.
- Through better education, spread the message that a wider range of help – beyond painkillers – is available.
- Called for the introduction of pain as the fifth vital sign along with blood pressure, pulse, temperature and breathing rate.
- Called for a formal coding system for pain in hospitals to allow prevalence and other data to be tracked.

The National Pain Summit opened with a moving video presentation produced by ANZCA involving five patients speaking about their experiences in dealing with pain. The video is available at **www.anzca.edu.au**

NATIONAL PAIN SUMMIT

Circled: Dr Jay Ramanathan from the Australian General Practice Network, ACT asks a question of the panel; swimming great Kieren Perkins and Professor Michael Cousins; a panel discussion.

Clockwise from top left (this page): Pain summit delegates discuss the National Pain Strategy; ANZCA vice-President Professor Kate Leslie; Federal Health Minister, Nicola Roxon; chronic pain patient Renee Goossens asks a question of the panel; Judi Cogliati and Susan Evans during a break; also at the summit were Back: Peter Gregory, WA, Steve Thompson, NSW, David Butler, SA, Multon Colner, NSW, Chris Hughes, NSW and Mavely Nielsen, Qld. Middle: David Falconer, Scotland, Coralie Wales, NSW, Wanda Mitchell-Cook, Vic; Fiona Hodson, NSW, Rebecca Coghlan, WA and Stephanie Davies, WA. Front: Jenny Faulkner, SA and Renee Goossens, NSW.

Clockwise from top (this page): ANZCA President Dr Leona Wilson at the summit; a full view of the panel discussion; delegates at the summit; the panel, from left: Dr Mary Lynch, Canada; Dr Cathy Price, Southampton, David Falconer, Scotland; Dr Brenda Lau, Canada and Dr Penelope Briscoe, Dean Faculty of Pain Medicine.

"THE NATIONAL PAIN STRATEGY PROVIDES A ROADMAP FOR ACTION. ALL THAT IS REQUIRED IS FOR GOVERNMENTS – FEDERAL AND STATE – TO SHOW LEADERSHIP IN THIS CRITICAL AREA"."

PROFESSOR MICHAEL COUSINS CHAIR, NATIONAL PAIN SUMMIT STEERING COMMITTEE

This is a historic day in Australian health.

- Never before have health and consumer health organisations focused on a single health area, pain, with the objective of developing a comprehensive strategy to improve current inadequacies in the treatment of all forms of pain.
- The pain strategy to be considered today is the first comprehensive national strategy worldwide. Nevertheless, numerous other countries are now taking steps in this direction and we will hear about some of this today.

In 2005, the Australian Government took a crucial step in approving the multidisciplinary field of pain medicine as an independent medical specialty. At much the same time, palliative medicine was also accorded specialty status.

The interdisciplinary model of care, from community and primary to tertiary levels, that the summit strategy recommends, is carefully designed to meet the needs of pain sufferers. This model is also very much in keeping with the key recommendations of the National Health & Hospital Reform Commission Report and will be greatly assisted by the announcements last week of health reform by the Prime Minister and Minister for Health.

Much hard work has been expended by the Steering Committee, working groups, reference groups and via submissions from many organisations to produce the strategy that is before us today.

However, all of us present today have a very great responsibility:

- to the 3.2 million Australians with chronic and cancer pain, much of which is unrelieved, including the 45% of children in the last days of life.
- To the 11,250 people today who are undergoing surgery, 50% of whom will have inadequate pain relief. Today I announce the release of a major resource "Acute Pain Management: Scientific Evidence" produced by ANZCA and now used worldwide.
- To those with chronic pain who are stigmatised, disbelieved, demoralised and grossly under treated, resulting in complete destruction of quality of life, loss of employment and often impoverishment.
- To the Australian workplace, which bears the brunt of the 36 million lost workdays each year, representing a large slice of the total cost of $34 billion per annum.

Today we must embark on a course that irrevocably changes this lamentable situation – it cannot and must not continue.

- At the very least, I call upon the summit attendees to achieve final agreement on the National Pain Strategy.
- At the very least, I call upon the Federal Government to appoint a broadly representative taskforce or similar body, charged with a progressive implementation of the strategies that I hope will be finalised today.
- At the very least, I call upon Federal and state governments to back a community-led program to destigmatise chronic pain.
- At the very least, I call upon COAG to initiate a focus on pain by introducing pain as the fifth vital sign, as has already been achieved in the US healthcare system and in the US Veterans Administration health system.

Today we should achieve even more than this with our workshops which will prioritise the strategies and recommend the best cost effective methods of implementation.

In conclusion we must not allow the under treatment of all forms of pain to continue to be Australia's largest undiscovered healthcare problem.

"WE NEED ACCESS TO PAIN MANAGEMENT SPECIALISTS IN OUR OWN COMMUNITY. THIS ALSO APPLIES IN RURAL AND REMOTE AREAS. IT IS INEFFICIENT AND INCONVENIENT TO TRAVEL TO HOSPITALS ALREADY FACING MAJOR DEMAND PRESSURES TO GET HELP."

HELEN OWENS
PAIN MANAGEMENT: A CANCER PATIENT'S PERSPECTIVE

I was initially diagnosed with stage three breast cancer on March 11, 1994. I was found to have significant lymph node involvement and spread to skin. I have had stage four metastatic cancer for the past five years.

Over the past 16 years I have had numerous cancer treatments.

I have had five surgical interventions (an initial mastectomy and second mastectomy five years later followed by three additional surgeries to tidy up after a staf infection). I have had three bouts of chemotherapy, the first was high dose chemotherapy with stem cell transplantation as part of a trial at the RMH, the latter two chemotherapies as combination therapies with Herceptin (a monoclonal antibody I was given for three years.) Last week I embarked on a fourth round of chemotherapy involving a combination of Herceptin and Abraxane Nanoparticle Taxol. I have also had three separate radiotherapy treatments, the first in 1994 and two bouts of palliative radiotherapy in 2009 and January this year. I was on Tamoxifen for five years and have had numerous CT, PET, MRI and other scans plus blood tests over the period.

I have had access to the latest treatment technologies throughout whole process.

I have been fortunate that something new has always turned up just when I have needed it (e.g. GCSF, Herceptin, nanotechnology, targeted radiotherapies etc). I also have had access to high quality oncology, radiation oncology, medical and nursing care in most instances. I am sure I would not be here today without these technologies and dedicated practitioners.

Pain has been intrinsic to my 16 year cancer journey. I divide the pain I experienced into five categories.

1. Acute pain – immediately following the surgical interventions, a bone marrow biopsy, and the tumour pain itself.
2. Chronic nerve pain – following my second mastectomy I have suffered ongoing nerve damage and resulting pain on my chest well.
3. Chronic bone pain from early onset osteoporosis.
4. Episodic nerve pain directly resulting from treatment – peripheral neuropathy and shingles.
5. Other episodic pain resulting from treatment – mucositis (mouth ulcers), joint pain in the back and legs, loss of toe and finger nails from last Taxol, accessing collapsed veins from numerous PET, MRI, CT and gated heart scans, lymphoedema etc.

Despite being a well-informed consumer, heavily involved in the health sector over many years in a professional capacity, I have had a mixed experience.

Acute pain

Post surgery: my pain was handled very well after my first mastectomy at a well regarded Melbourne private hospital. But little to no pain management was available following the next four surgical interventions relating to my second mastectomy at a small private hospital, either immediately post-surgery or on return home.

Bone marrow biopsy undertaken without anaesthetic. Not recommended.

Tumour pain: My initial primary tumour caused some discomfort immediately prior to diagnosis but was not that painful.

However the pain associated with some of my more recently diagnosed secondaries has been severe. Spread occurred between the left adrenal gland and renal vessels in early 2009 and in my throat and neck later in the year. In both cases the pain was not relieved initially when the first symptoms appeared. It was only relieved after radiotherapy successfully shrank the tumours at both sites. The pain in both my renal area and neck was so severe I couldn't sleep, my ability to work and generally function were significantly impaired and I was unable to drive.

Chronic pain

I have had ongoing unrelieved pain on my chest scar tissue due to nerve damage since December 16, 1999 resulting from my second mastectomy and follow up surgery. It is hard to describe but one gets a tight squeezing sensation across the chest, sufficiently strong at times to wake me up regularly and cause extreme discomfort. I was never referred to a pain management specialist after surgery or offered drugs such as Gabapentin.

HELEN OWENS
PAIN MANAGEMENT: A CANCER PATIENT'S PERSPECTIVE CONTINUED

I have also endured osteoporotic bone pain that was sufficiently incapacitating that my husband and I had to move from our two-storey to single storey house as I could no longer manage the stairs.

Episodic pain from treatment

My general observation is that my pain management was adequate whenever I was treated as an inpatient. I remained in hospital for most of the five months I was involved in the 1994 high dose chemotherapy trial and had access to morphine, cocaine mouth wash (to deal with ulcers in my mouth and oesophagus so bad I couldn't eat solids and survived on milkshakes and jelly) and other pain relief. On the occasions I was able to return home before infections set in I faced the trade off of little adequate pain relief.

My more recent bouts of chemotherapy since 2005 have been undertaken as a day patient at a major public hospital. This has presented problems in terms of adequate pain management. I was only able to get some relief for the severe pain associated with losing my nails, peripheral neuropathy, and shingles through the hospital day centre, especially from the palliative care doctor. My GP was understandably tentative about prescribing the necessary drugs and would refer me back to the hospital.

How can the system be improved?

When first diagnosed with cancer one faces a range of fears – death, the dying process, pain, financial implications (of the treatment and job implications), for ones family etc.

I have been one of the lucky ones. My life has been extended beyond my use-by-date by having access to some brilliant technologies (not all cost effective) and wonderful clinicians to whom I am very grateful. It helps that, while I have an aggressive cancer, it has responded well to chemotherapy and radiotherapy and I have an understanding husband, children and friends.

I also feel fortunate to live in a country with a universal Medicare system that helps alleviate financial concerns.

Governments have done a commendable job in raising the profile of health prevention, mental health and end-of-life issues. And hopefully they will be able to agree on a sensible solution to our health funding issues.

But there are many more patients like myself who are receiving expensive ongoing treatment for conditions that were previously considered fatal. We need to achieve a better balance between quantity and quality of life concerns of these chronically ill patients. Access to adequate pain management is the missing piece of the jigsaw puzzle.

We need access to pain management specialists in our own community. This also applies in rural and remote areas. It is inefficient and inconvenient to travel to hospitals already facing major demand pressures to get help. I would like to see pain management specialists available in multidisciplinary clinics and all cancer centres and more GPs and nurse practitioners working in the larger clinics trained in pain management.

Chronically ill patients need better information about those facilities that already exist. There should be greater emphasis on coordinating care between hospitals, oncologists (or other relevant specialists), clinics and GPs.

And more research needs to be funded on issues relating to the physical and psychological aspects of pain. To me it seems inconceivable that the acute pain from something as common as shingles cannot be alleviated.

This calls for a national approach. The National Pain Strategy is an excellent start on this road and ANZCA, the Australian Pain Society, Chronic Pain Australia and other consumer organisations associated with its development are to be congratulated.

It gives me hope that in future, patients such as myself will enjoy not just a longer life but a higher quality, pain-free one.

"SO WHAT DOES THAT MEAN AS A CARER? WE NEED TO IMPROVE EDUCATION. WE NEED TO BE ABLE TO GET MORE INFORMATION OUT TO THE BROADER MEDICAL COMMUNITY ABOUT HOW TO DEAL WITH CHRONIC PAIN AND PERSISTENT PAIN. WE NEED TO HAVE PEOPLE THAT UNDERSTAND AND ARE ABLE TO LOOK PAST THEIR OWN STIGMAS AND PRECONCEPTIONS."

KIEREN PERKINS
HEAD OF BUSINESS DEVELOPMENT, NAB PRIVATE WEALTH QLD:
A CARER'S PERSPECTIVE

I find these sorts of situations somewhat disconcerting. As somebody who has spent most of his life in the public eye, generally what I'm talking about is my own personal experiences obviously in the sporting field and how they might pertain to how we can all improve our potential.

To launch into a personal story to talk about what you've seen loved ones go through and how they have been affected by the system is difficult. It's interesting having the video played of my Atlanta swim. When you talk to people about sporting endeavour and the subject of pain comes up, people say it must have hurt, and they ask what it is like putting your body through that. Knowing what I know now, of course, that's very easy.

I did that to myself purposefully. I trained for it. I prepared for it. I did it in training day in, day out for years. By the time I got out of the pool and was standing in front of the assembled media to speak to them I was no longer in pain. I was not breathing heavily, my heart rate was reduced to below 80 beats a minute and I was fine because of the training and effort.

It's very much self-inflicted and the culture of sport, I think in some respects the culture of Australia, is about toughening up. If you are hurt, you get on with it. You need to train. There are clichés about how pain is temporary, pride's forever and so on.

Then I met somebody who suffered a pain that I couldn't see, I couldn't explain, somebody who did her very best to hide it. When I met my wife, Sam, she was one of the strongest, most intelligent, free spirits that you have ever come across in your life. She was a television journalist and presenter and somebody who had worked very hard to achieve what she'd achieved but she certainly wasn't lacking in strength.

16 or 17 years on, I know when my wife is suffering from migraine just from the nuances of her face and her eyes.

As Sam's condition has progressed it's become more acute and more difficult to manage. She's had migraines since she was five years of age. As she reached puberty, the specialists at the time said that stress and hormones were two of the main indicators of migraines and that when you reach puberty, the hormone changes will probably make them go away. Puberty came around. Instead, they got worse.

With each pregnancy Sam's migraines have got significantly and progressively worse to the point that pregnancy number five (we have three children) nearly killed her. The hormonal change created such an acute escalation of her migraines that the nausea was so significant and uncontrollable that after approximately 12 weeks in hospital, her liver and kidneys were starting to fail.

As a carer moving through this process and having had to watch somebody go through that, the things that frustrate you and that makes it difficult are the daily battles that you face. They start with seeing the deconstruction of your partner's personality. As her migraines progressively got worse the feelings of guilt around having to change plans, rearrange lifestyle because of what she was going through increased. Watching her try and hide what was going on and pretend she wasn't in pain so that she wouldn't put people out increased and, of course, after becoming a mother watching depression start to build because of the obvious emotional impact that her condition was having on our children. That has also been something that we've had to deal with at quite a significant level because it does seem, at this point, that our middle child, my 11-year-old son, Harrison, also suffers from migraines.

But the things that contribute to her emotional state come entirely from the way that she's treated in the system.

There are pockets of genius and, again, my unease about embarking on a conversation like this in the company of medical practitioners. I don't want that to override or discount the absolute extraordinary help that we have had from select geniuses, and there's no other word for it. Miracle workers (if you're more spiritual in mind, fits as well), have had an impact on our lives and Sam's care.

In broad terms, your GP is somebody that you've built a relationship with and they've known you for many years, they have your file, and they appreciate all of the things that are occurring in your life through that specific relationship that you have. However, gradually, you see that GP, that trusted adviser, becoming overwhelmed because they have no idea what to do.

My wife and I appreciate that doctors are infallible. Nobody's perfect and sometimes being able to put your hand up and say "I don't know, I can't deal with this, I need to pass you on" is probably a good thing. But we find there's a great reticence to do that.

One pursues various courses of action which ultimately only lead to more frustration, lead to more emotional instability and depression.

Every now and again things escalate to a point where it's the middle of the night, one has got no choice and you have to go to hospital. The experience at hospital will vary depending on the individual that you come across at the time, but nine times out of 10 it involves a process of going through the history of Sam's condition again.

KIEREN PERKINS HEAD OF BUSINESS DEVELOPMENT, NAB PRIVATE WEALTH QLD: A CARER'S PERSPECTIVE CONTINUED

Three hours later, after Sam's been vomiting constantly and basically no longer able to see because of the impact on her vision, pain completely out of control, the doctor decides a course of action. As a carer I start to lose my patience, temper and all those things which I spent a lot of my swimming career having to control with great care.

One of the things in our experience that has been more shocking than anything else has been the disparity in medical care and expertise across the states. We lived for many years in New South Wales. We're Queenslanders by birth and we're back home again.

It's genuinely believed in this country that, by and large, expertise is fairly well spread. You assume that the experiences that you're going to have from one state to the next may not necessarily be quite so significantly different.

When we moved to Sydney initially it was very difficult because we had to rebuild all of the relationships that we had with doctors who understood Sam and what she was going through. It was a process of explaining yourself, trying to convince her doctor that she was not a drug addict looking for the next score and that she was somebody who has a medical condition that requires help.

Sometimes a fluke occurs. A person like Professor Cousins walks in and all of a sudden starts telling you that there is something very wrong and "I can't fix it. However I can give you a quality of life that hopefully will allow you to actually do things like go on holiday which hopefully will mean that you won't miss all of your children's significant milestones because you're in bed in a dark room vomiting. That those pills that you're taking by the bucket load every day and the injections and things long term aren't going to actually be very good for you so we might try and find ways to get you off those because there are some health implications that come with that."

Completely refreshing. An absolutely different point of view and somebody, who for the first time in our experience, didn't tell us that they would fix the problem. Professor Cousins ultimately implanted a stimulator for Sam, a little brain stimulation, which has absolutely revolutionised our life.

We hadn't been on a holiday that was more than a couple of kilometres from a medical centre that had already received her history. All of a sudden Sam was able to travel and live a relatively normal life because of this implant.

I didn't want to highlight or put Professor Cousins up on a pedestal because he gets that more than enough. I think you all know that.

However, it's so incredibly important to recognise the significance of him and his impact on Sam and the absolutely distressing and unhinging realisation that he will not live forever and there may be no one to replace him. That's how we feel. I know it's not true but that's how we feel.

For Sam, as she goes through the further tribulations of trying to manage her pain and trying to find medical care in a different state, the recognition that at some stage along the way she won't be able to pick up the phone and speak to that person who she knows will be able to deal with her case and what she's looking for, is very distressing.

So what does that mean as a carer? We need to improve education. We need to be able to get more information out to the broader medical community about how to deal with chronic pain and persistent pain. We need to have people that understand and are able to look past their own stigmas and preconceptions.

We are the lucky ones. I have the opportunity to pick up the phone and put pressure on the system to be able to give us the opportunity to receive treatment that the average person may not receive and yet we still get treated poorly a significant amount of the time.

What does that mean for the average person out there having to deal with these types of things? I shudder to imagine.

The thing that makes this forum and getting involved in wanting to promote and see pain management and issues around that put to the forefront of the public's consciousness are the policy decisions and how our system operates.

We need to be able to be resolute in the way we approach this issue of pain including lobbying and the information that goes out to the people who are involved in making these decisions. My experience suggests that while they will say the right thing and work with us to try and find solutions, many people fall back on the notion that we have the best health-care system in the world or close to it; that we have exceptional doctors and that our hospital facilities are fantastic.

I've travelled around the world enough to know that that's actually very true. But I grew up in a world where near enough wasn't good enough, where we had a responsibility to continue to push, to continue to break down the boundaries and continue to fight to ensure that the things that we knew needed to happen would continue to be brought to bear because just being the best wasn't enough, because it never is enough.

This is an issue that is significant, that needs far more attention than it currently receives and without significant changes in the system, the education of the medical community at large and changes to the way that people who have persistent chronic pain are treated, there will be many people who will continue to have emotional distress, families that will be destroyed and economic impacts that will reach far beyond just the simple pain that needs to be managed for an individual at any given time.

THE HON. NICOLA ROXON MP,
FEDERAL MINISTER FOR HEALTH

TIM PIPER, VICTORIAN DIRECTOR,
AUSTRALIAN INDUSTRY GROUP

DR CATHY PRICE, EXECUTIVE MEMBER,
CHRONIC PAIN POLICY COALITION,
BRITISH PAIN SOCIETY

DR MARY LYNCH, PRESIDENT,
CANADIAN PAIN SOCIETY AND CHAIR,
NATIONAL PAIN INITIATIVE OF CANADA

DAVID FALCONER, DIRECTOR,
PAIN ASSOCIATION OF SCOTLAND

To read the National Pain Strategy, excerpts of all presentations delivered at the National Pain Summit, as well as see the ANZCA video and access media coverage please visit **www.anzca.edu.au** or **www.painsummit.org.au**

Quality & safety

Introduction

The Quality and Safety (Q&S) Committee has as one of its prime objectives, the improvement in communication to Fellows on issues of safety. The aim in the Q&S section of the *ANZCA Bulletin* is to raise current issues on safety with contributions from both anaesthetists and other specialists.

In keeping with knowledge that safety in pain management continues to be a major issue, presented in this edition of the *ANZCA Bulletin* is Part 2 of an outstanding series on acute pain management by Pam Macintyre and David Scott (Part 1 was published in the December 2009 *Bulletin* and if you missed it due to the Christmas rush, be sure to go back!).

Contributions from other specialists are appreciated. The risks of a relatively rare airway management technique, submental endotracheal intubation, are presented by ENT surgeon Michael Dobson.

In addition relevant alerts are published in both the ANZCA E-Newsletter and the *ANZCA Bulletin* with follow up if necessary by more detailed information in the *Bulletin*. In this task I would acknowledge the able assistance in particular of John Russell, Margie Cowling, Liz Feeney and Neville Gibbs.

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

Submental Intubation – not a secure airway

What constitutes a secure airway in anaesthesia and surgery?

This is an airway that, if there is a failure due to cuff leak, kinking, displacement or blockage, the endotracheal tube (or other airway device) can be safely changed without putting the patient at risk during the procedure.

However, no matter how often a technique is used safely, there may always be that unexpected or unthought-of complication about which the practitioner thinks, "it won't ever happen to me".

Submental intubation was described in 1986 by Hernández Altemir.[1] The technique involves intubating the patient with a reinforced orotracheal tube. The tube is then exteriorised via an incision through the floor of the mouth submentally, avoiding the sublingual gland and ducts. This leaves the mouth free for intra oral manipulation and other manoeuvres such as orthognottic alignment.

The reasons cited for this in one paper by Davis C.[2] was described thus, "a tracheostomy has a high potential complication rate and in many patients an alternative to the oral airway is not required beyond the perioperative period."

Kim et al[3] report that submental endotracheal intubation is quite difficult to manage if adverse events such as tube obstruction, accidental extubation or a leaking cuff occur and could endanger the patient.

There are many reports of successful utilisation of submental intubation in craniofacial surgery. Biglioli et al[4] report 24 cases of successful use of the technique avoiding the complications of tracheostomy.

What is the real incidence of complications of surgical tracheostomy? In experienced hands they are not high and, the majority of complications are due to long term tracheostomy, Sicard M.[5]

These issues were highlighted in a recently reported death involving a patient who had suffered multiple trauma in a motor vehicle accident seven days previously. He had sustained multiple facial fractures, associated with chest trauma and mild brain injury. He underwent general anaesthesia using a submental endotracheal tube to facilitate fixation of facial fractures. Surgery was prolonged and several hours into the procedure the airway was severely compromised with all the complications described by Kim et al[3], resulting in cardiac arrest, difficult re-intubation and at least 15 minutes of hypoxia. The patient subsequently succumbed to hypoxic brain injury.

This case illustrates the danger of such a technique given the circumstances of the case. A tracheostomy would have avoided this crisis.

Is there a place for this technique? Surgeons and anaesthetists involved in such shared airway cases must assess the risk benefit analysis of the secure airway options and recognise the long standing safety record of planned tracheostomy. In highly selected low risk cases, perhaps there is a place for submental intubation

if conventional nasal or oral intubation is not suitable, and there is a good reason to avoid tracheostomy. However, contingency plans for a failed airway must be in place.

It should also be recognised that to secure an airway surgically in an emergency, the patient may require a cricothyroidotomy, which is relatively quickly and easily done. Once the airway is secured an appropriate tracheostomy can then safely be established. All anaesthetists and surgeons must be capable of securing an airway in a crisis with a cricothyroidotomy and training in this technique is an integral part of the EMST course for both surgeons and anaesthetists.

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ECRI alerts

The ECRI Institute (www.ecri.org/Pages/default.aspx) has issued the following warnings:

A12785 01 ZOLL–R Series Defibrillators: May Fail to Display Patient Electrocardiogram, Potentially Delaying Defibrillation or Pacing Therapy [Update]

The ECG displays a fault 7 message and not the ECG recording. ZOLL issued a recall to international customers in September 2009. Even if the machine appears to be working normally the fault may appear at a later date and ZOLL recommends daily visual inspection and Code readiness and weekly manual defibrillation testing.

A13330 Teleflex Medical–Oxygen Sensors Used with Intelligent Oxygen Monitors: May Cause Monitor to Prematurely Display Low Sensor Warning, Potentially Resulting in Interrupted Treatment

Teleflex Medical, USA issued a warning that oxygen sensors used with Intelligent Oxygen Monitors may cause the monitor to prematurely display a low sensor warning resulting in interruption of treatment. The warning was issued in November 2009 with a request for return of faulty equipment.

A13321 Nihon Kohden–Integrated Optional Non-Invasive Blood Pressure Modules Used with cardioLife Defibrillators: Alarm May Be Impaired or Prevented Completely in Neonatal Mode

In the Nihon Kohden CardioLife defibrillators the alarm on the integrated optional non-invasive blood pressure module may be impaired or prevented from action when in neonatal mode.

A13327 01 Baxter–INFUSOR Infusion Pumps: May Leak at Connection of Blue-Winged Cap and Distal Male Luer [Update]

Baxter Infusor infusion pumps may leak at the connection of the blue-winged cap and the distal male luer. Baxter reports that leakage only occurs after pumps are primed, recapped and stored for a period, typically overnight.

To view ECRI's alerts in full, please contact the ANZCA library at **library@anzca.edu.au**

Recommended reading

Implementation Guide for Organisational Introduction and Use of the Post Operative Orders Format, (November 2009), and *Audit and Evaluation Framework, Post Operative Orders*, (November 2009), which can be viewed at the Victorian Surgical Consultative Council (VSCC) website at www.health.vic.gov.au/vscc/development-of-a-universal-post-operative-order-form#D.

Quality & safety committee member profile

As the President of the Australian Society of Anaesthetists (ASA), membership of the Quality and Safety Committee "comes with the job". It is an area that has always been of interest to me so it is one of the presidential duties that I particularly enjoy. I am in private practice in Sydney. However, I still maintain a strong interest in the public sector through both my ASA roles and as a member of the AMA NSW Council as anaesthesia craft group representative.

My involvement in medical politics stemmed from an interest in health care policy developed while undertaking a masters degree in health law. I had been particularly interested in medico-legal matters and the related indemnity issues that were developing more than a decade ago.

The health and welfare of the profession is also of interest and began as an extension of my interest in quality and safety. In recent years I have been focused on these issues in relation to anaesthetic trainees and junior doctors and was involved in the establishment of the introductory course (familiarly known as the "Part Zero") that is run in NSW by the ASA NSW Committee of Management and the ANZCA Regional Committee for new trainees and their families. In the context of the reforms related to the National Registration and Accreditation Scheme involving mandatory reporting, the issue of doctors' health and well-being will, I think, come under much closer scrutiny in the future.

When I am not attending meetings, I enjoy travelling, cycling and skiing – though quality, safety and well-being in the latter two pursuits have, at times and I know will continue to, elude me.

I believe that the work that the Quality and Safety Committee carries out empowers anaesthetists to improve their professional lives at a local level (equipment, facilities, etc.) while providing input at a national level to the broader debate in quality and safety that is at the fore.

Elizabeth Feeney
New South Wales

Managing acute pain safely

Part 2: Minimising Risk with Regional Analgesia

Regional analgesic techniques are a key element in the effective management of many sources of acute pain. Neuraxial and perineural infusions provide better pain relief and reduced opioid-related side effects than parenteral opioids[1-3]. Consequently, they may also enhance patient outcomes by facilitating recovery and rehabilitation, and reducing other complications – especially those associated with immobility (such as respiratory complications and DVT/PE); those linked to stress (e.g. hypertension, myocardial ischaemia); and possibly also reduce the risk of long-term pain[4-6].

All interventional techniques have potential complications and in acute pain management the avoidance of adverse patient outcomes is a primary concern. Analgesic strategies need to be planned in the context of the patient's needs, the plans for perioperative care and recovery (e.g. early discharge, physiotherapy), and any co-morbidities and concurrent medications. Into this mix the potential risks to the patient posed by analgesic strategies following even relatively minor surgery must also be considered.

Adverse outcomes that cause patients significant physical injury or result in a threat to life are those that pose the most relevant risk in the personal and 'legal' sense. The most frequent life-threatening events are those associated with central nervous system depression from opioid medications either alone (in relative excess) or as part of a synergistic combination[7]. The most feared patient injuries are those associated with neurological damage from nerve blocks – either peripheral[8, 9-12] or neuraxial[13]. In all situations, the provision of appropriate patient information and obtaining relevant consent is necessary.

Opioid-induced respiratory depression is one of the most significant adverse events related to that class of drugs. This has been discussed in the preceding article in this series (*ANZCA Bulletin*, December 2009). Opioids given via epidural or intrathecal routes, either as infusions or as single-shot doses (e.g. intrathecal morphine), should be given in appropriate doses and monitored with a similar degree of vigilance as for systemic opioids.

A recent meta-analysis concluded that respiratory depression was more frequent when using intrathecal morphine than a range of parenteral control treatments; however, the doses used were often high (>= 300 mcg) and the criteria used to define respiratory depression were heterogenous[14]. Audit data suggests that the risk of central nervous system depression from neuraxial opioids when lipophilic opioids (e.g. fentanyl) or lower doses of morphine are used is similar to that caused by opioids given via other parenteral routes[7,15,16].

Unexpected escalation of analgesic requirements indicates a need for medical review. Although regional analgesic techniques are often cited as being relatively contraindicated in patients at risk from compartment syndrome because of the concern that symptoms may be masked, this is not supported by critical review which emphasises instead the importance of appropriate frequent clinical observation[17].

Epidural or perineural haematoma are of significant concern because of the risk of neurological injury including spinal cord compression, concealed haemorrhage or as a potential site for seeding of infection. Recent clinical practice guidelines published by the American Society of Regional Anesthesia and Pain Medicine (ASRA) are reasonably clear for neuraxial blocks with respect to the timing and use of standard unfractionated heparin, low-molecular weight heparin (LMWH) and other anticoagulant and antiplatelet agents[18]. However, translation to other regional blocks and the risk of newer anticoagulants (e.g. fondaparinux) is less clear.

Although these new ASRA guidelines are more comprehensive, they basically reduce to the same well-established precautions e.g. withhold low-dose LMWH for at least 12 hours prior to inserting, removing or manipulating an epidural catheter. Importantly, they advise that the same principles should also apply to deep nerve blocks as well e.g. paravertebral and lumbar plexus blocks and possibly to femoral and sciatic nerve catheters[18,19].

Guidelines for the perioperative management of patients with coronary stents who are taking potent anti-platelet medications (e.g. thienopyridines such as clopidogrel or prasugrel) are being developed by a committee of the Cardiac Society of Australia and New Zealand (CSANZ) which includes representatives from the Royal Australasian College of Surgeons, the Australian and New Zealand College of Anaesthetists, the Royal Australasian College of Dental Surgeons and the Australasian Society of Cardiac and Thoracic Surgeons. There is unfortunately limited information on the use of regional anaesthesia or analgesia in the presence of these drugs[20]. The effect of the thienopyridine drugs lasts the life of the platelets therefore time needs to elapse beyond the last dose for generation of sufficient numbers of new, unaffected platelets – this typically takes five to seven days for clopidogrel.

Although case reports of complications are few, this probably reflects caution of the anaesthetic community in avoiding exposure of patients to the potential risks of epidural or perineural haematoma. Epidural catheterisation is the highest risk procedure and should be avoided until platelet function is likely to be normal[18]. Neurological symptoms, confirmed by MRI, warrant early intervention (within eight hours) to maximise the chances of a full recovery[21].

Managing acute pain safely

Part 2: Minimising Risk with Regional Analgesia

continued

Epidural abscess is a serious complication of epidural analgesia, occurring in less than 0.1% of patients[13,22]. Unlike a haematoma, the presentation may be more indolent with backache and/or fever developing over many days preceding the development of neurological signs or symptoms. Note that fever may be absent in up to 30% of patients with an epidural abscess. Diagnosis may be based on an MRI prior to the development of neurological symptoms, in which case systemic antibiotic therapy might avoid the need for surgical intervention[22]. Clearly, meticulous aseptic technique during insertion of epidural catheters is important in prevention, and a high degree of suspicion will help early diagnosis. Patients with fever and epidural catheter insertion site infection should be watched very closely and considered for MRI if signs persist or other symptoms develop. The risk increases with the duration of epidural infusion[22].

Nerve injury during peripheral nerve block is uncommon, and when it occurs most injuries will recover over a six- to 12- month period[9,10]. Strategies to minimise risk include appropriate patient selection, meticulous aseptic technique and careful positioning of the needle. The use of ultrasound has not been yet shown to decrease the risk of nerve injury, although it has other benefits including decreasing accidental vascular injury[23]. It is likely, however, that direct visualisation of the position of needles during injection around nerves will reduce the risk of nerve trauma. It has been recommended that minimising pressure during injection of local anaesthetic[21] will avoid nerve damage due to intraneural injection. Further to this, performing neural blockade procedures in conscious patients whenever possible is desirable so they can report any discomfort during needle placement or injection[21].

Another risk associated with regional analgesia techniques is that of systemic local anaesthetic toxicity, especially during establishment of the block. Systemic toxicity is reported in 0.75 to 1 in 1000 patients[9, 24]. Thus it is important to use techniques to avoid intravascular injection (including, perhaps, the use of ultrasound guidance wherever possible[23]), keeping doses to a minimum, using the least toxic local anaesthetics (e.g. levobupivacaine and ropivacaine) and prompt resuscitation (including the use of intralipid if indicated) to minimise the risk of adverse outcomes.

Underpinning the above points is that any patient receiving potent medications or advanced therapies for acute pain management needs to be observed and assessed routinely and frequently for unexpected changes in pain intensity, conscious state and especially for motor block or back pain in patients with epidural catheters in situ*. There is little evidence to guide the frequency of such assessments but this should be based on clinical condition and any changes in state – for example, motor block should probably be assessed at least every four hours with epidural infusions, whereas sedation may require hourly assessments in the first eight to 24 hours following initiation of the infusion and then every two to four hours thereafter. Motor and sensory block should also be assessed after removal of an epidural catheter.

It cannot be emphasised strongly enough that all those involved with clinical care of the patient (doctors, nurses, physiotherapists) have a responsibility to ensure that the patient's condition is assessed regularly, documented carefully and reported appropriately. There must also be appropriate and timely action if abnormal parameters are reported. These points seem self-evident but communication failures amongst clinical staff are a major source of delays in diagnosis and treatment. One approach is to have clearly defined thresholds (e.g. sedation scores, motor block) for which escalation of clinical response is required.

Although many of the points listed are specific to the techniques being used, it must be emphasised that overall risk to patients is minimised by effective communication, careful preventative strategies and regular assessment with the support of adequate documentation. The latter, of course, is also essential for demonstrating that adequate care has been taken. Ultimately, analgesic plans are decided upon by balancing risk and benefit. Although evidence is not always available to help in such decisions, the failure to provide an appropriate analgesia strategy could of itself be considered negligent and it is our responsibility to ensure that we do our best to maximise the quality and safety of patients under our care.

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* Scott & MacDonald. Acute Pain Management Performance Measurement Toolkit. Victorian Quality Council. 2005 http://www.health.vic.gov.au/qualitycouncil/activities/acute.htm

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Natural disasters – planning ahead

China's Sichuan earthquake in May 2008 caused widespread destruction, both physical and pyschological. For medical authorities it represented a major challenge. Electricity was lost in more than 30 per cent of the hospitals in Sichuan province that were not destroyed.

The March 2010 edition of *Anesthesia and Analegsia* includes a report on the lessons learnt from the Wenchuan earthquake. Two analysts, an anaesthetist who lived in New Orleans during hurricane Katrina and a scientist whose house was destroyed in the 1994 Northbridge earthquake, give their perspectives on the lessons that can be learnt from such natural disasters.

Sometimes one becomes an "expert" by an accident of geography. I was asked to comment on the astonishing description of the 2008 Wenchuan earthquake[1] in this issue of *Anesthesia & Analgesia* because I lived in New Orleans during hurricane Katrina. I was stunned by the magnitude of suffering caused by the earthquake, as well as the remarkable efforts by individual physicians, the Chinese government, and outsiders to respond. I did not fully appreciate the magnitude of this disaster, and I am sure many others did not either.

There are similarities and significant differences between the Wenchuan earthquake and hurricane Katrina, and there are lessons to be learned from both.

"The first lesson . . . is that in such a disaster, one must remain safe to help others and not become an additional casualty." Both hospitals and physicians must be as selfsufficient as possible during a disaster. Necessities that we take for granted can disappear in seconds. For an individual, it means having the basics of life: food, water, cash, gasoline, communications, and credentials. My experience has made me paranoid, so I have meals ready to eat in my office and at home, extra gasoline in my garage, and cell phones based in 2 different area codes. For a hospital, it means being self-reliant in all the necessities of providing care. Electricity was lost in the operating rooms of >30% of the hospitals in Sichuan province that were not destroyed. The Chongqing medical rescue team quickly discovered the importance of a generator, water purification equipment, and satellite phones and had no way of knowing the extent of the destruction because the communication infrastructure failed. New Orleans hospitals that continued to have electricity after the storm functioned reasonably well. Others that lost power, such as Memorial Medical Center, became literal hell holes. How secure are your generators and how long can they run without resupply?

". . . Medical care must focus on those who are most likely to survive rather than those who are most critically ill, with emphasis on efficient use of available resources and minimizing waiting time for victims likely to survive."

This is a very scary but very practical lesson. It is completely logical but becomes frightening when placed in an American context. Can you imagine your emergency room being flooded with not tens of injured patients but rather hundreds or thousands? Remember the New Orleans physician who was charged with murder for sedating patients at the above-mentioned Memorial Medical Center? The grand jury elected not to indict her, but the incident will have a chilling effect on those of us who are placed in the difficult position that our Chinese colleagues handled with such professionalism. How will you respond if you are forced to ration treatment and withhold therapy to those likely to die?

". . . In a disaster medical triage system, it is not only very important to give treatment to the most critically ill but also to triage the walking wounded out of the emergency department." The public views hospitals as safe retreats. Indeed, almost all of the time, hospitals will still be standing after a disaster because of rigorous construction standards and will have electricity, food, and water. But a Louisiana hurricane lesson emphasized by this quote from the article is that hospitals are not places of refuge for those who do not need significant medical care. During hurricanes, New Orleans hospitals are locked down with substantial security and only those workers (and their families) who are essential to the hospital's function are allowed admittance. This is another example of having to make hard decisions for the greater good in a difficult time.

"Not surprisingly, those who had received some previous emergency fire and earthquake training reported feeling calmer, more confident, and less helpless than those who had not received such training." Preparation counts and is certainly easier in a hurricane than an earthquake. The type of emergency training actually done may not be as important as having practiced the thought process of handling an emergency of any type. Did Captain Sullenberger practice

landing in the Hudson River after a bird strike or were his calm actions in those 208 seconds a culmination of training to deal with a myriad of other problems? His words were, "I knew I had to find a way out of this box I found myself in." Our operating room had a fire drill, and I was surprised at all the lessons I learned. Those lessons are also applicable to other emergency situations. Take your practice in dealing with uncommon situations (difficult airways, malignant hyperthermia, and fires) very seriously because the lessons learned will be valuable.

It saddened me to read that "shortly after the earthquake, the Chinese government moved thousands of troops into the Sichuan province." It reminds me of the suffering of all those stranded by a flood caused by government ineptness while a president and governor argued over control of National Guard troops. It also reminds me of all the stories of real leadership in the face of adversity. So, how does anesthesiologists' leadership make a difference?

We are natural leaders and know how to manage crisis both for individual patients and for multiple operating rooms. The calm and effective leadership of the anesthesiologists at the Ochsner Clinic as well as the entire Ochsner managerial structure during Katrina made a huge difference. The anesthesiology chair was the embodiment of leadership because he stayed in the hospital continuously for >3 weeks. In a crisis, will you be the calm and effective voice that others heed?

The most poignant sentence is near the end of the article. "The death of so many school-age youngsters throughout the province will have significant societal consequences, consequences that will be difficult to assess and challenging to ameliorate." Both the suicide rate and number of heart attacks in New Orleans tripled from pre-Katrina levels. The long-term psychological consequences of the World Trade Center attack have been well chronicled. However, this article's comment that these consequences are challenging to ameliorate is as true now as it was almost 10 years ago.

These massive disasters produce profound psychological effects on thousands of survivors and helping them cope is relatively uncharted territory.

This article is a genuine contribution to the literature. It offers real life lessons about dealing with the daunting issues faced by our Chinese colleagues. You are not likely to face an earthquake or a hurricane, but the odds that each of us will be faced with a natural or manmade disaster are pretty good. This article should prompt all of us to reconsider how our institutions will respond to these challenges, and more importantly, how each of us will react when in a similar situation.

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Natural disasters – planning ahead

continued

"Forewarned, forearmed; to be prepared is half the victory." —Miguel de Cervantes

More than half the world's population lives in earthquake-prone areas. Alaska's magnitude 9.2 shaker of 1964 remains the second largest quake in recorded history. Even those who dwell on stable continental plates and well away from subduction zones are not immune from temblors: some of the largest earthquakes in the continental United States were 4 large quakes from the New Madrid Seismic Zone in southeastern Missouri in 1811 and 1812. And the hundreds of thousands of deaths from the 2010 earthquake in Haiti and the 2004 Indian Ocean tsunami are still fresh in our memories.

For almost 4000 years, China has been famous for its earthquakes. The earliest documented quake comes from China, in 1831 bc from the Shandong province. The most complete historical records also come from China, starting in 780 BC during the Zhou Dynasty in China. It is likely that more people have died from earthquakes in China than from earthquakes anywhere else in the world.

On May 12, 2008, the ground in China's Sichuan province heaved and trembled for 2 minutes. Anyone who has experienced the terror of a mere 10-second earthquake can appreciate the destruction, both physical and psychological, of a hundred seconds of violent shaking. Yet, this is nothing compared to the human suffering that followed, as described in the article by Chen and coworkers.[1]

In the minutes and hours after a major quake, immediate rescue and medical assistance are the highest priorities. There are about 800,000 doctors in the United States, or about 1 doctor for 375 people. With 3 million nurses, it's roughly 1 nurse for every 100 people. With proper geographical distribution, this should be enough. But of course doctors and nurses will not be optimally dispersed after an earthquake. Perhaps more importantly, they will not have the clinical support necessary to aid the injured: hospitals, surgical supplies, anesthesia assistance, and pharmacological stores.

Chen and coworkers vividly recount the difficulties of moving doctors and medical supplies into disaster zones when roads and transportation systems are damaged. So why not take the opposite approach, at least initially? Why not organize and use the medical material already in place? Hospitals are not the only sources of medical supplies; schools, universities, commercial drug stores, military bases, large companies, manufacturing sites, neighborhood clinics, etc., all maintain medical provisions. It makes sense for the state and local communities to identify such stores and prearrange distribution from nontraditional caches of medical supplies in the event of a catastrophe.

Most people will survive an earthquake in relatively good physical shape, only to find a less pressing but no less threatening prospect facing them: thirst, hunger, exposure to the elements, and disease. As in most earthquakes, many deaths are not immediate, but rather come from the lack of proper health care and vital resources. This is where an oft-overlooked threat lies.

Chen and coworkers list a number of lessons learned from the Sichuan earthquake. Perhaps the most important, synthesized from their article, is this: Most people will not have ready access to vital resources. With transportation and communications in disarray, many and perhaps most earthquake victims will be on their own for days, maybe weeks: no electricity, no running water, no gas, no shopping, no Internet, no hospital, and no pharmacy. The best advice to people is to be prepared to live outdoors for 2 weeks. Think tents, sleeping bags, flashlights, dried/canned food, small stove, pots and pans, medicine, hats, gloves, etc.

Water, especially potable water, is by far the most important resource after an earthquake. Water is required for drinking, food preparation, wound dressing, and personal hygiene. This also means having pots and fuel for boiling contaminated water. By caching emergency supplies of water, both on an individual and state level, and installing proven and regularly tested communications, transportation and triage systems, the effects of earthquakes and other widely distributed natural disasters can be minimized.

A growing world population means there are more people in harm's way. The 1857 magnitude 7.9 Ft. Tejon earthquake in California killed only 2 people. Today, it would be many times this number. In 1994, 72 people died in the 6.7 magnitude Northridge (California) earthquake.

The same magnitude quake in Bam, Iran, in 2003 killed more than 26,000 because most structures were unreinforced mud dwellings that collapsed. The difference was building codes. California has construction requirements that explicitly address earthquakes. Building codes save lives. However, both in the third world and in some old and poor parts of the United States, such codes are either ignored or not enforced.

Earthquakes are most-sudden and unpredictable natural events that cause human suffering on a regional scale, but they are not the only ones. Hurricanes, blizzards, and volcanic eruptions spread devastation over large areas, although there are usually a few days' warning for these. Here again, preparedness is the key. And as with earthquakes, clean water is probably the most crucial to good health over periods of days and weeks.

Although the states and federal government have plans and resources for mitigating disasters, at some level they also recognize the futility in protecting every citizen. Indeed, California's firefighters have begun quietly telling people not to depend on them to save their lives and homes in wildfires. By shifting the burden of protection to the individual homeowners, California is telling its people, "We'll do the best we can, but it may very well be you who saves your house and your life, not us. Plan ahead!"

This is good advice, and it applies most directly to earthquakes. Earthquakes come with no warning. People and the medical community in seismic zones must be ready at all times. Additional information about earthquake preparedness can be found in Table 1.

Forewarned is forearmed. Plan ahead!

Table 1. Websites for more information about earthquake preparedness	
Centers for Disease Control and Prevention	http://earthquake.usgs.gov/learn/faq/?categoryID_14
U.S. Geological Survey	http://www.bt.cdc.gov/disasters/earthquakes/ http://www.shakeout.org/ http://quake.usgs.gov/prepare/prepare.html
Red Cross	http://redcrossla.org/preparedness/earthquake-preparedness
Los Angeles County	http://www.fire.lacounty.gov/SafetyPreparedness SafetyPrepEarthquake.asp
Southern California Earthquake Center	http://www.earthquakecountry.info/roots/

David K. Lynch, PhD
Thule Scientific, Topanga, California

Dr Lynch was part of the congressionally mandated team of scientists assembled by NASA to characterize the threat from Earthimpacting asteroids, analyze the effects on human civilization, and plan mitigation approaches. He is presently doing tectonic research on faults and earthquakes in southern California, especially the San Andreas fault. As it happened, Dr. Lynch's house was destroyed in the 1994 Northridge earthquake. With more than 1000 gallons of collected rain water on his property, he was able to help his neighbors during the first few days of water outages.

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ANZCA Webinars – the future of teaching and learning online

Susan Batur, Education Project Officer (e-Learning)
Mary Lawson, Director of Education

In the previous edition of the *ANZCA Bulletin*, we described the introduction of podcasts at ANZCA[i]. Since then, we have continued to grow the ANZCA library of podcasts that are available via the website. To see what is new, follow the quick link to 'Education podcasts' from the ANZCA homepage or visit:

www.anzca.edu.au/edu/projects/distance-education/rasts/podcasts/rasts-podcast-library.html.

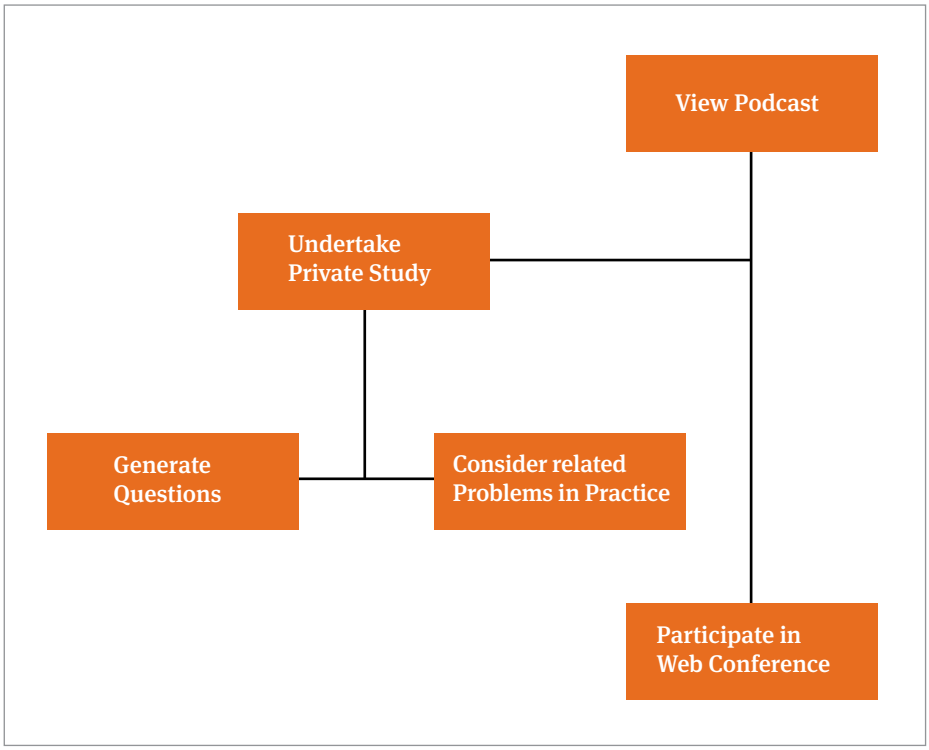
When you visit this site, you will notice that generally you can also download a set of the presentation slides and register to participate in a linked 'interactive webinar'. The purpose of this article is to let you know what a webinar is and the way we are running them at ANZCA.

In the past five years, advances in the speed of internet connections and web technology have resulted in a significant increase in the diversity of educational resources available to on-line learners. One example of this is the introduction of web-conferencing software, also known as webinars. A webinar is simply a lecture or workshop that is transmitted over the Internet. See Box 1 for a list of typical features of a webinar[ii].

Box 1: Typical Features of a webinar:

- Slide show presentations
- Live or streaming video
- VoIP (real time audio communication using speakers or headphones)
- Whiteboard functions
- Text chat
- Polls and surveys
- Screen sharing / desktop sharing / application sharing

In 2009, the ANZCA Education Development Unit introduced webinars as a teaching tool for trainees preparing to sit the ANZCA final exam. We were able to purchase a hosting licence for the software required through funds received through a grant from the Federal Government under the RASTS scheme (Rural Advanced Specialist Training Support Program).



Above: Model for e-Learning resources at ANZCA

There are many different service providers and types of software to support webinars and so our first task was to select one that was right for ANZCA. Staff undertook an extensive review which ultimately resulted in the choice of WebEX as our provider of choice. A number of criteria were used to make this selection including functionality, value for money, availability of technical support and hosting on the vendors server.

This technology is used to complement the newly introduced podcasts. Trainees are encouraged to view podcasts before they participate in a webinar so that they have sufficient background knowledge to engage at the highest possible level making the best use of the presenter's expertise. They also have the opportunity to relate the knowledge in the podcast to their own clinical practice and to submit difficult problems in practice for discussion and analysis in the webinar format.

Web-conferencing technology has significant benefits for the College and trainees;

- **Economical** – Webinars are significantly more cost effective than previously used resources delivered via distance such as video conferencing technology.
- **Far reaching contact** – web conferencing technology can be used anywhere a connection to the internet can be established. Recent webinars have involved participants from across all ANZCA regions and countries.
- **Participation can occur anywhere** – learners are no longer required to physically congregate in one area. All that is required for participation is access to the internet and a computer with speakers.

During the webinar, participants assume certain roles. The role of 'host' is usually ANZCA staff from the Education Development Unit whose main role it is to offer any technical support that might be required. The role of 'presenter' is an ANZCA Fellow who has made themselves available online to answer questions from the trainees.

Trainees are able to ask the online presenter questions by either typing them using the chat box feature or by requesting the microphone and asking their question using their web camera or in-built computer microphone. The process is exactly the same as it would be if one was in a tutorial asking the tutor a question. The only difference with this technology is that it is carried out completely online.

During the ANZCA webinars, the presenter normally begins by giving an overview of the podcast that they presented. They then invite attending trainees to ask any questions they had in relation to the podcast topic. There are many features in-built to the webinar 'meeting room' to encourage interaction amongst the trainees including the recently introduced 'polling' segment. This interactive component is similar to an online test where the presenter asks trainees pre-prepared short answer and multiple-choice type questions. The trainees answer the questions by using their mouse of keyboard to click on what they think is the correct answer. The results submitted by the trainees are then shared and viewed by all. The presenter can then discuss the results and clarify any misperceptions. Individual results are not shared, just a collective response which promotes participation as the trainees don't have to worry about having any lack of understanding publically exposed.

The hourly webinars were introduced in 2009 and will occur on a more frequent basis in 2010. The current schedule is for one webinar every three to four weeks and a later time-slot has been selected to accommodate the different time zones (19.00–20.00 AEDT). Already this year, trainees in Australia, New Zealand, Scotland, Malaysia, Singapore and Hong Kong have participated. This geographical spread indicates the far reaching capacity that this technology has.

The Education Development Unit is promoting the podcasts and webinars through a variety of communications channels. Trainees are notified of webinar events through personal email invitation, advertisements in the ANZCA trainee newsletter, ANZCA website and ANZCA E-Newsletter. Supervisors of training, regional education officers and ANZCA regional staff are also requested to notify the trainees that they supervise or liaise with. We hope that the podcast and webinar materials may also be used as the basis of local tutorial group or study group discussions.

To date, eight webinars have taken place with presenters located in Western Australia and Victoria. Future webinars will see include presenters located in other regions.

If you have any ideas for how the webinars could be enhanced or would like to volunteer to participate or suggest a topic, please don't hesitate to get in contact with the Education Development Unit staff:

W: www.anzca.edu.au/edu/projects/
E: education@anzca.edu.au
T: +61 3 8517 5361

Reference:

i Batur S and Lawson M (2009) "Podcasts – a new age of learning for Fellows and Trainees". *ANZCA Bulletin*. December 2009, pp 45

ii http://en.wikipedia.org/wiki/Webinar#cite_note-1

Use of video-assisted feedback to teach communication skills to trainees in paediatric anaesthesia

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Communicating with children is integral to paediatric anaesthetic practice but difficult for trainees to learn. This was confirmed in an educational needs assessment we performed within our department, where learning to communicate with children was identified as a major challenge during paediatric anaesthesia training by our trainees.

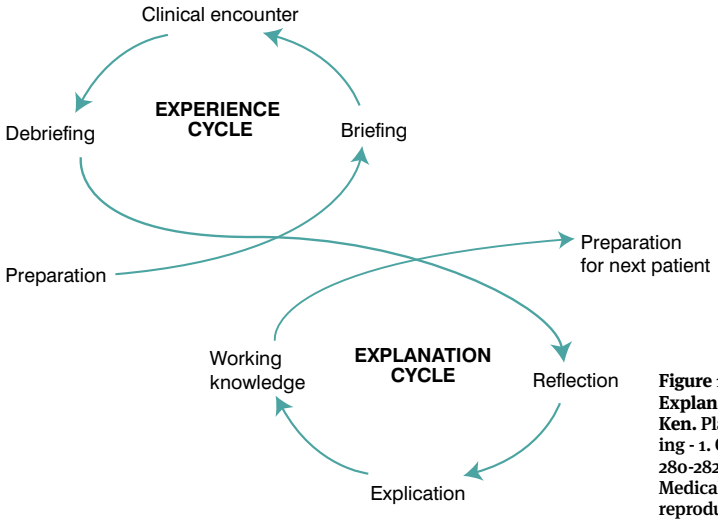

Figure 1: Experience and Explanation Cycle, from: Cox, Ken. Planning bedside teaching - 1. Overview. MJA 1993; 158: 280-282. ©Copyright 1993. The Medical Journal of Australia reproduced with permission

A review of communication skills teaching found that experiential teaching methods are more effective than didactic approaches[1]. Video-assisted feedback used to teach medical students has been shown to lead to improvement in communication skills that persisted at least five years into postgraduate work[2]. Because of this, the technique of video-assisted feedback is often used to teach communication skills with simulated or real patient encounters, particularly in undergraduate medicine and primary care[3-10]. However, a literature search did not identify any articles describing the use of this technique to teach patient communication in anaesthesia training.

An educational program was developed to support our trainees' learning in this area. Firstly, an interactive discussion-based lesson utilising role-play and video of actual consultations was developed. This included teaching a suggested structure for the pre-operative consultation based on the Calgary Cambridge guides used for general practice and undergraduate training[11]. A discussion of practical communication skills for use at induction of anaesthesia was also included, highlighting the different types of communication commonly used by experienced paediatric anaesthetists[12].

This activity was followed at a later date by the opportunity to participate in a one-to-one video review of the trainee performing a pre-operative consultation and inducing anaesthesia in a real patient. This was followed by a debriefing session structured using the principles of experiential learning[13].

Methods

Fourteen ANZCA trainees on a six-month paediatric anaesthetic rotation were offered participation in this educational project which was approved by our local ethics committee. All the trainees were in postgraduate year six and ANZCA Advanced Training Year 1.

The video recording was performed on paediatric surgery and paediatric gastroenterology lists to which the trainees were routinely rostered. Children older than two who were presenting for elective procedures were identified from the published theatre lists and the parents approached to provide consent. There was no attempt to select children and only those who did not have adequate English were not recruited. One parent declined to participate and service commitments did not allow another child to be recruited, so 13 trainees completed the video-recording and debriefing session.

Video of the pre-anaesthetic consultation and induction of anaesthesia was recorded on a portable video camera.

Structure of debriefing session

The aim was to capture the entire interaction between the trainee and the patient, so the video recording commenced before the trainee approached the patient to begin their pre-operative visit and ended after the trainee left the patient. Management decisions were left entirely to the trainee. Similarly, recording of the induction of anaesthesia began before the trainee interacted with the patient in the pre-operative holding bay and ceased when the patient was ready for surgery to commence. No children were pre-medicated and they all underwent inhalational induction of anaesthesia with sevoflurane. Anaesthesia was safely provided by the trainee in all cases without the need for intervention by the supervising researcher. The supervising consultant observed the clinical encounter and recorded the video while remaining uninvolved, avoiding engaging both the patient and trainee[4]. At the earliest opportunity the researcher provided the trainee with a private debriefing session.

The plan for the debriefing session was based on the process of experiential learning as described by Cox[13]. The session began with a review of what happened using the video recording, pausing the video as often as required so the trainee could describe what they were thinking and what they were observing in the patient. This was facilitated by the supervisor, when required, so that a shared understanding of what occurred was developed. A recognised benefit of the use of video in this way was that it allowed the trainee to see their own performance, minimising disagreement between the teacher and trainee on what had occurred[4]. The trainee was able to make their own assessment of what appeared to work and what didn't and compare this to the observation of the supervisor.

The next stage, reflection, involved shifting the focus from what happened to why it happened and what did it mean. The focus of this stage was actions, behaviours or events brought up in the review but the discussion was about what was felt and what it meant rather than what happened. In this part of the session, it was necessary to adapt to the trainee's prior experience. Questions used by the supervisor to encourage reflection include: *What did that mean? What did you feel? How do you think they felt? What do you think they wanted you to do then? Why do you think that worked? How does this compare with what you expected?*

After reflection came explication and development of working knowledge. In the explication phase, the supervisor helped the trainee compare what had happened to what they had been taught and what they had seen others do. Together the trainee and supervisor sought underlying concepts, theories and principles that might help explain what happened in the particular patient encounter and resolved any differences with what the trainee previously believed. A new framework of belief was then developed that incorporated the new learning so that the trainee's working knowledge was updated. The question "*What will you do differently next time?*" was therefore answered and the trainee was left at the end of the session with the task of preparing for their next patient encounter.

The feedback session required a relationship of trust and mutual respect with the trainee so that the trainee was prepared to listen[14]. The use of video of actual consultations performed by the supervisor in the communication skills lesson, demonstrating that the supervisor was prepared to undergo similar scrutiny of their own practice, made an important contribution to the development of this relationship.

Evaluation

An online survey was completed by all 13 trainees before the end of their rotation. This focused on the following areas:

- The role of the interactive lesson.
- The format of the feedback session.
- The quality of the feedback received.
- The contribution of the video to the feedback.
- The effect on the trainees of being video recorded.
- The overall rating of the experience.

Each item was rated on a five-point Likert scale, where the five points were 'strongly disagree', disagree', 'neither agree nor disagree', 'agree', and 'strongly agree'. The results of the evaluation are presented in Table 1.

The items evaluating the communications lesson indicate the trainees found this useful preparation for their interaction with paediatric patients and the debriefing session. The structure and delivery of the feedback session were rated highly by the trainees. Only a small number agreed that further video sessions would be useful. Only a few trainees agreed that the feedback would have been as believable or as useful without the video recording. The video did make most trainees more self-conscious, and a narrow majority felt that it affected their performance. Importantly, a high proportion agreed the video-assisted feedback process should be offered to future trainees, which provide positive recognition of the value they placed on it.

Use of video-assisted feedback to teach communication skills to trainees in paediatric anaesthesia (continued)

Table 1: Survey responses of 13 trainees completing online evaluation
Results expressed as median, range, and percent of responses that are either 'agree' or 'strongly agree'

	Median	Range	Agreement
The communication skills lesson:			
The communication skills lesson introduced a framework I could use for pre-operative assessment in children	4	3-5	77%
Provided techniques I could use when communicating with children	4	3-5	93%
Prepared me to participate in the video feedback session	4	3-5	77%
Structure of feedback session:			
The structure of the session allowed for self-review	4	4-5	100%
The structure of the session allowed for reflection	4	4-5	100%
Video of another case with a feedback session would have been useful	3	2-5	15%
Delivery of feedback:			
Was specific	5	4-5	100%
Was constructive	5	4-5	100%
Provided insights I could use in my practice	5	4-5	100%
Use of video in reflection allowed me to:			
Critique my own practice	5	4-5	100%
Identify aspects of my performance I could improve	5	4-5	100%
Identify behaviours I should remember to use in the future	5	3-5	93%
Value of video to feedback:			
Feedback would have been just as believable without it	3	1-4	23%
Feedback would have been just as useful without it	2	1-4	23%
Impact of video on practice:			
Made me anxious	4	3-5	85%
Made me conscious of my performance	4	3-5	85%
Affected my performance	4	3-4	62%
Overall judgment of program:			
Use of video-assisted feedback contributed positively to my learning	4	4-5	100%
Learning communication skills is an important part of paediatric anaesthesia training	4	4-5	100%
This video-assisted feedback process should be repeated for future trainees	4	3-5	85%

Discussion

This report documents the novel use of video-assisted feedback for the systematic teaching of communication skills during anaesthetic training. The project was designed to address an identified need of our trainees with an educational intervention based on the most effective methods identified in the literature. The evaluation was designed to provide evidence of the acceptability and utility of the educational intervention to trainees and thus support its ongoing implementation. As communication skills have increasingly been recognised as an important aspect of anaesthetic practice, this is an important issue. This is confirmed by the responses of the current trainees where they all recognised learning communication skills as an important part of their training in paediatric anaesthesia.

Provision of anaesthesia in children, together with surgery and hospitalisation, is recognised as stressful for both children and their parents[15,16], with the most stress experienced at induction[17]. In our needs analysis, anaesthetising children was unsurprisingly identified as stressful for our inexperienced trainees too. Important work has been done to investigate predictors and interventions to reduce parental and child anxiety at induction[15-18]. A different perspective comes from the work of Carlyle and colleagues in Adelaide, who have identified the successful communication strategies used by experienced paediatric anaesthetists at induction[12]. They have suggested that the use of appropriate communication methods may be important in decreasing stress associated with anaesthesia for both parents and children. An educational intervention such as the one described in this article could thus benefit not only trainees, but patients as well. As trainees become more comfortable with their communication abilities, they should be more relaxed and their patients less stressed.

This project also had a beneficial impact on the operating theatre environment. The use of video in the operating theatre was highly visible and generated much interest from non-participants. Awareness of the importance of communication skills was raised in the entire theatre staff. This has resulted in discussion amongst theatre nursing and paediatric surgical staff of appropriate communication strategies and the delivery of an in-service at nursing staff request. Anaesthetists do not work in isolation

and communication at induction is a team effort. A 17 per cent incidence of negative comments or 'sabotage' has been documented[12], so this heightened awareness may extend the benefits of the current project to a wider group of patients.

The most recognisable way trainees learn communication skills is role-modelling by experienced consultant staff. The current project has been intended to supplement rather than replace this important source of learning. It is to be hoped that raising the trainees' awareness of communication skills in this way should make them more observant in their interactions with consultants and facilitate this role-modelling.

The evaluation aimed to provide evidence of acceptability and ascertain the value placed on the training by the trainees. To this end, the evaluation confirms the usefulness of the communication skills lesson, with 93 per cent agreement that it provided useful strategies trainees could use in practice with children. Much work was devoted to developing a framework for the feedback session as this was identified in the design phase as a key component on which the effectiveness of the program would depend. The high ratings from the trainees for the structure and delivery of the feedback are therefore pleasing.

The critical role of the video recording is also confirmed by the evaluation results. Only 23 per cent of trainees agreed the feedback would have been as valuable without it. All the trainees found it allowed them to identify areas of their performance they could improve, while 93 per cent found it positively reinforced desirable behaviours. This project confirms video-assisted feedback is a useful tool in teaching anaesthesia. Although it is commonly used in simulation and has been used in epidural training[18], there may be more opportunities for the use of this technique in anaesthesia training in the future.

The effect of the video recording on trainee performance is an interesting area of speculation. While a small majority of trainees felt that it affected their performance, most of them reported some anxiety associated with being observed in this way. The idea that the act of observing a phenomenon influences that phenomenon is not new, e.g. Schrödinger's cat. Similarly, trainees might perform differently when supervised than when practising independently. However, it may be that video-recording has a greater impact than mere observation[18]. Though this was not explored in the current project, trainees may be more anxious because they know they will see their own performance, or because the experience of being video recorded is novel for them. The trainees did not feel they would gain additional benefit from a further video debriefing and this judgment may have been influenced by the anxiety they experienced.

The evaluation performed provides evidence to justify the provision of institutional resources to support ongoing implementation of this training. The number of trainees in the current project is small, though, and trainee self-report is conventionally accepted as the lowest level of evidence regarding effectiveness of educational programs[19]. Further evaluation could be performed to provide higher levels of evidence, with the involvement of more consultants and trainees and more robust evaluation designs. Parental and patient anxiety at induction appears a potential outcome measure that could be used to provide a higher level of evidence of efficacy for example. If this was done the contribution of the various aspects of the current training, for example the use of video or the preparatory lesson, to any change in performance could also be explored.

Recognising these limitations, this project systematically taught communication skills in paediatric anaesthesia using interactive methods that are supported by the medical education literature. In particular, feedback was provided on actual pre-anaesthetic consultations and induction of anaesthesia using video recording. The trainees recognized this as an important aspect of their learning and found the training both valuable and acceptable. While further evaluation could be performed, the results of this initial project justify continued provision of this training.

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The new In-Training Assessment process

Changes to help supervisors of training

It's time. ANZCA is updating its In-Training Assessment (ITA) process to modernise its training and take advantage of the latest technology.

The first thing Fellows will notice is that the ITA is going online. From mid-2010 supervisors of training will be able to submit the ITA directly to ANZCA online. The Approved Vocational Training (AVT) form is included within the new ITA form. Both of them will be submitted at once. This should simplify the process significantly for both supervisor and trainee. By doing this, the hope is that ANZCA will have updated information about trainees, supervisors will be able to access information about trainees who they are working with and trainees will know whether their forms have been submitted. Now we know where those forms go.

Being online is only one aspect of the changes that will help supervisors. The two biggest changes that will help supervisors of training are simplification of TE 14 and TE 18, and added support when you need it most. The ITA process has been simplified. When supervisors of training open up the form it will guide you step-by-step through the interviews required for the term. There are also toolkits to explain what to do each step of the way. This alone will make life a lot simpler for new supervisors (SOTs).

Professional Document TE 18, 'Guidelines for assisting trainees with difficulties' is also being reviewed. There is a Trainee Performance Review (Regulation 33) for trainees who are really having problems. TE 18 should appear less threatening and hopefully with support more supervisors will feel like they can offer help to trainees when they need it.

Specifically the Training & Assessments unit at ANZCA, and the supervisor network throughout the ANZCA region will support the new process with ITA forms going directly to the Training & Assessments unit at ANZCA in Melbourne. There is a global assessment on the new ITA form that asks supervisors whether the trainee is performing at the required level. If the answer is no, that they are underperforming for their level of training, then ANZCA will manage the process. Supervisors will be able to contact ANZCA for assistance. You will be able to ask what to do including contacting a supervisor who has done this before. The hope is that with added support you will feel more able to deal with these difficult situations.

The new ITA form is a lot more than just a new form. For supervisors it means clarification and simplification of your role, and help when you need it.

Jodi Graham
Supervisor of Training
Sir Charles Gairdner Hospital,
Western Australia

Changes to help regional and national education officers

The Regional and National Education Officers (REOs/NEOs) have a number of roles and responsibilities concerning:

- The In Training Assessment process (ITA).
- The "Assisting Trainees with Difficulties" process (TE18).
- The Trainee Performance Review process (TPR).

They are currently sent paper copies of all ITAs in their region for review. If a supervisor is dealing with a trainee experiencing difficulties, the REO/NEO is available for advice concerning TE18 and if this has not achieved the desired outcome, the REO/NEO is supposed to review the situation and, if necessary, make a request to the ANZCA Director of Training and Assessments (T&A) unit that a TPR should be conducted.

There are a number of changes and additions to the ITA process that should make their job easier and more effective:

- The ITA is being combined with the Approved Vocational Training (AVT) form.
- The process will be on line, with information fed into a central electronic data base.
- There will be documentation of initial and mid-term interviews (if the latter is required).
- The ITA domains of assessment will be more comprehensive and descriptive.
- The methods of assessment in the future (with the introduction of workplace-based assessment tools) will be more valid and reliable.
- There will be a global rating giving an indication of whether the trainee is meeting expectations overall.
- The T&A unit will monitor the ITAs, bring those of concern to the attention of both the rotational supervisors and the REOs/NEOs and will be available for assistance.

The changes outlined above will help the REOs/NEOs in a number of ways. ITAs should be lodged more consistently and quickly. This is because of the existing requirements of AVT lodgement for training recognition and the enhanced ability to track this within a central electronic database. This should minimise ITAs coming to the attention of ROTs and REOs/NEOs too late. REOs/NEOs will not have to personally review every ITA in their region. They should be better able to give advice concerning TE18 and TPR because of the documentation of interviews, the enhanced assessments, global ratings, assistance from T&A and because tracking of trainee performance during subsequent terms will be easier.

The changes outlined above and the formalisation of the introductory interview in setting out the goals and expectations of the term should enhance the whole training experience for trainees and their supervisors, and hopefully will decrease the need for TE18 and TPR and hence free up the REOs/NEOs for their other important functions.

Rick Horton
Regional Education Officer, Victoria

ANZCA Professional Documents TE14 Policy for the In-Training Assessment of Trainees in Anaesthesia and TE18 Guidelines for Assisting Trainees with Difficulties, available at www.anzca.edu.au/resources/professional-documents/

Regulation 33 Trainee Performance Review available at www.anzca.edu.au/resources/regulations

Trainees on College committees

Sitting in my first Education and Training Committee meeting in February this year, I was approached to consider writing an article about trainees on College committees. Plenty of questions came to mind about this. How do we get where we are, why are we here, what are we doing, do we feel we are achieving what we set out to and do we think we are able to represent such a large base of trainees adequately?

- There is a Trainees Committee (governed by regulation 16) for each region and nation within ANZCA.
- That committee comprises a defined number of trainees based on the total number of trainees. For example, we have 10 representatives in New Zealand because we have 200-300 trainees. Each elected trainee serves for a two-year term.
- Each committee has a chairperson who represents that region at their own regional/national committee and at also at the ANZCA Trainees Committee.
- There are trainee representatives on committees of the council of ANZCA including on the
  - Education and Training Committee
  - Training and Accreditation Committee
  - Workplace-Based Assessments Subcommittee
  - Assessment Subcommittee
  - Curriculum Review Working Group
  - Clinical Teacher Development Working Group
  - Distance Education Working Group
  - Welfare of Anaesthetists Special Interest Group

I joined the New Zealand Trainees Committee at the end of my first year as a trainee for a number of reasons. First, I was curious about the College and how it functioned. Second, I felt there was a lack of a trainee voice within the region I was working in. Third, because I firmly believe you have little right to complain if you are not somehow actively trying to improve. Moreover, work interests outside of theatre and the networking opportunities they provide are vital to a fulfilling career in anaesthesia. Most members of Trainee Committees throughout ANZCA are people motivated to improve the conditions in which people are trained.

As a New Zealand trainee, I have a limited understanding of the role of the Australian Medical Council (AMC) in the postgraduate medical environment, although I do understand that trainee/stakeholder input into the medical Colleges is considered important. The AMC expects trainee representation and input into the organisations that are responsible for postgraduate medical training and no College is exempt. In response to such, ANZCA Council passed a resolution to establish a Trainee Committee in 2003.

Apart from representing trainees at committee and subcommittee levels, we are also trying to develop resources for trainees. For example

- In New Zealand we have written a booklet, "Anaesthesia Training in NZ made easy", which will be given to every new trainee. This booklet is designed to replicate what some Australian regions are able to offer in a part 0 course as this is something that New Zealand would have difficulty providing because of the geographical dispersion of our trainees.
- Assisting with developing part 0 courses in Queensland and part 3 courses in South Australia
- Western Australia have developed a buddy program.
- Giving feedback to the College about training in private practice.
- Developing relationships with the Group of Australian Society of Anaesthetists Clinical Trainees (GASACT) and New Zealand Society of Anaesthetists (NZSA) trainee representative to foster good relationships between the three organisations. This has included the distribution of the GASACT handbook earlier this year.
- Disseminating information about College initiatives for trainees including the trainee email system, library and website-based resources and curriculum review and recommendations.

All of this work is outside our responsibilities to our employing departments, and I express gratitude to the rosterers who have given me a chance to make my work for ANZCA a priority on occasions.

In New Zealand this year, there were more people nominated for the trainee committee than there were positions. This was a first for ANZCA and we held a postal ballot among trainees. Even if trainees cannot participate in their regional or national Trainee Committee, your views and thoughts are welcome. Please check out your local committee under the Regional/National section of the ANZCA website, or email us at **trainee.committee@anzca.edu.au**

Dr Kathryn Hagen
ANZCA Trainee Committee

Overseas Trained Specialist Anaesthetists' Network

"The crucial shortfall in all components of the rural medical workforce in Australia means that much of the rural medical specialist workforce is made up of International Medical Graduate Specialists (IMGS)s and there is no doubt that some specialist services would not have survived without them. Indeed, in many of our major rural and regional towns, almost all specialist positions are filled by IMGSs." [1]

While providing a valuable contribution to quality health services, support mechanisms for IMGS (also known as Overseas Trained Specialists – OTS) are limited. Common issues identified by this group are:

- English as a second language
- Changes in social and professional status
- Change in self-esteem
- Presentation skills
- Cultural differences
- Advanced age
- Unfamiliarity with process of final examination
- Lack of educational networking
- Lack of suitable examination preparation

Those issues contribute to a significantly lower passing rate in the ANZCA final examination, as compared to Australian anaesthetist trainees.

The limited exposure to their peer group and subsequent problems of integrating into small study groups has been addressed with the establishment of a network. The Overseas Trained Specialist Anaesthetists' Network – OTSAN, is a self-help group formed by FANZCA's who have been trained overseas. "Their main aim is to allow good anaesthetists to become good examination candidates again." [2]

OTSAN was initially started with a strong bias towards education. It is, however, diversifying to encompass other facets affecting IMGS such as:

- Liaison with national and regional authorities (ANZCA, Medical Board, Department of Immigration)
- Industrial relations
- Examination preparation
- Social networking[3].

OTSAN conducts three educational weekend workshops per year. In 2009 those meetings were held in Brisbane, Melbourne and Adelaide with an average of 30 participants and 10 presenters. The first meeting for 2010 took place from February 27-28 in Twin Waters, Queensland. Exam-focused lectures and Vivas, identifying resources as well as building study groups and social networks are components of those meetings.

Valuable resources are additional educational meetings offered by OTSAN members in form of "trial exams" and regular themed sessions. A video conferenced interactive small group tutorial program links IMGS and local trainees. The video conferences are part of a PhD study with the aim to motivate people to actively manage their own education and to create network opportunities.

We encourage all IMGS anaesthetists working in Australia to join our group and to profit from this network. Contact can be made via: http://health.groups.yahoo.com/group/ots-anaesthetist/

Literature:

1. Rural Doctors Association of Australia 2009: The value of local specialist medical services to rural Australia.
2. K.B. Greenland: Overseas Trained Specialists and the Final ANZCA Examination, http://www.otsan.org/
3. http://www.otsan.org/

Kerstin Wyssusek MSc PhD FANZCA
OTSAN President
Staff Specialist, Princess Alexandra Hospital

Evaluating your CPD portfolio in 2010

At the end of 2010 the first CPD program triennium will conclude. At the end of each triennium of the ANZCA CPD program Fellows are required to complete an evaluation of their program.

Evaluation is a process that encourages Fellows to assess their achievements and to review if their CPD plan's objectives have been met. It also creates an opportunity to identify areas that may need to be addressed in the development of your CPD plan development that will improve future learning.

One approach is to assemble a portfolio and all documentation of your CPD over the past triennium. Review your portfolio, particularly your CPD plan that you have developed and note your activities and your reflection notes.

Assess all your activities and recorded reflection entries and use these to consider the learning value of your program to you. Fellows may also have encountered problems ("barriers to learning") in achieving their CPD goals and it is worth looking at these to evaluate how to do it differently in future years. It is also useful to evaluate each activity's effectiveness in modifying professional behaviour.

Your evaluation could be structured on a questionnaire about your portfolio and reflection entries. You could complete your evaluation by providing written answers to the online questionnaire in your CPD portfolio.

For example:

- Have you achieved the objectives in your CPD plan?
- If not achieved fully, why not?
- Did your needs change and, if so, in what ways?
- What activities do you consider the most effective in your learning?
- What improvements in your practice can you see from your learning?
- How are you going to use any key points that you have learned?
- How do you rate the quality and effectiveness of your own CPD program?
- What would you plan or do differently in your next CPD cycle?

An audit of participants is a necessary component of ongoing evaluation of the ANZCA CPD program. Audits ensure the ANZCA CPD program complies with requirements of Australian and New Zealand health regulatory bodies. It also helps to continually improve the program to meet its objectives and be relevant to Fellows' clinical practices

We also welcome feedback for the ANZCA CPD program and would be delighted to hear any constructive comments.

Please feel free to contact the CPD Unit at the College via email at **cpd@anzca.edu.au** or call us on **+61 3 9510 6299**.

Australasian Anaesthesia 2009

The 2009 edition of *Australasian Anaesthesia* has now been sent to all members. *Australasian Anaesthesia* contains a diverse range of topics of interest to anaesthetists, intensive care physicians and pain medicine specialists. This year's edition has been coordinated by Dr Richard Riley as editor, Teresa Brandau-Stranks (CPD unit) and Christian Langstone (Communications unit) and retains an easy-to-read style with a new modern format. *Australasian Anaesthesia* is available to download from the College website under "Resources – Books and Publications" and additional copies can be purchased. Please forward any orders or inquiries to the CPD unit.

ANZCA Trials Group

Strategic Directions Research Workshop

Following the successful strategic directions research workshop held in October last year, two research studies have emerged for development in 2010.

First, the balance study, whose principal investigator, Associate Professor Tim Short of Auckland, has been awarded the first pilot grant of $5000 for 2010. Congratulations Tim. The purpose of a pilot grant is to assist Fellows in the development of high quality projects that have the potential to acquire future NHMRC funding, and develop into a larger research study.

Each year The Trials Group allocates $25,000 ($5,000 per project). More information on the pilot grant scheme is available at:

http://www.anzca.edu.au/resources/trials-group/pilot-grant-scheme.html

Associate Professor Kate Leslie is the Australian Principal Investigator for POISE-II Trial: an RCT of aspirin and clonidine to prevent perioperative cardiac morbidity and mortality. This trial aims to recruit 10,000 patients and is being led by Population Health Research Institute, Hamilton Health Sciences and McMaster University Canada, Professor PJ Devereaux.

The ANZCA Trials Group will conduct this trial from the Department of Epidemiology and Preventive Medicine at the Alfred campus of Monash University

The next strategic directions research workshop will be Friday, October 1, 2010 at ANZCA House, Melbourne, and the Trials Group encourages new and emerging Fellows with research ideas to attend the workshop. Further details can be obtained by contacting the TG Coordinator: trialsgroup@anzca.edu.au.

ANZCA Trials Group Publications

Jones D, Story D, Clavisi O, Jones R, Peyton P. "Surveys: An introductory guide to survey research in anaesthesia". Anaesthesia and Intensive Care 2006:34:245-253.

Myles PS. "Antifibrinolytic therapy: evidence, bias, confounding (and politics!)". JECT 2007; 39:308-310.

McNicol L, Story D, Leslie K, Myles P, Fink M, Shelton A, Clavisi O, Poustie S. "Postoperative complications and mortality in older patients having non-cardiac surgery at three Melbourne teaching hospitals". Med. J Aust 2007; 186 (9):447-452.

Myles, P.S., Leslie, K., Chan, M.T.V., Forbes, A., Paech, M.J., Peyton, P., Silbert, B.S. and Pascoe, E. "Avoidance of Nitrous Oxide for Patients Undergoing Major Surgery". Anesthesiology, 107: pp 221-231 (2007).

Myles PS, et al. "Aspirin and tranexamic acid for coronary artery surgery (ATACAS) trial: rationale and design". Am Heart J. 2008 Feb:115(2):224-30.

Myles PS, Chan MTV, Leslie K, Peyton P, Paech M, Forbes A. "Effect of nitrous oxide on plasma homocysteine and folate in patients undergoing major surgery". Br JAnaesth 2008;100:780 786.

Myles PS, Chan MTV, Kaye DM, McIlroy D, Lau, Symons JA, Chen S. "Effect of nitrous oxide anesthesia on plasma homocysteine and endothelial function". Anesthesiology 2008;109:657 663.

Leslie K, Myles PS, Chan MTV, Paech M, Peyton P, Forbes A, Sinclair D, and the ENIGMA Trial group. "Risk factors for severe postoperative nausea and vomiting in a randomized trial of nitrous oxide based versus nitrous oxide free anaesthesia". Br J Anaesth 2008; 101:498 505.

Paech MJ, Scott KL, Clavisi OM, Chua S, McDonnell NJ, and the ANZCA Trials Group "A prospective study of awareness and recall associated with general anaesthesia for caesarean section". International Journal of Obstetric Anesthesia (2008) 17, 298–303.

McDonnell NJ, Paech MJ, Clavisi OM, Scott KL, and the ANZCA Trials Group "Difficult and failed intubation in obstetric anaesthesia: an observational study of airway management and complications associated with general anaesthesia for caesarean section". International Journal of Obstetric Anesthesia (2008) 17, 292–297.

The Annual Scientific Meeting 2010 Christchurch

The Trials Group will be holding a session at the forthcoming ASM on Saturday, May 1 at 10.30am. The session will be chaired by Associate Professor David Story, Trials Group Chair. The session includes three speakers: Associate Professor David Story on the REASON Audit results; Stephanie Poustie on research governance; and Associate Professor Andrew Davidson on running international trials.

The session will be followed by the annual Trials Group lunchtime meeting at 12 noon. Investigators, research nurses and staff involved with the REASON audit, enigma-II and ATACAS are invited to join us, along with anyone interested any of the trials group activities. The meeting will include updates on existing trials as well as information on coming multicentre research.

Strategic Directions Research Workshop

Keep your diaries free! New and emerging researchers with ideas for multicentre research are encouraged to attend.

Friday October 1, 9am to 5pm
ANZCA House, St Kilda Road, Melbourne

Further details contact:
trialsgroup@anzca.edu.au

Regions

Queensland

The Queensland Part Zero Course was held on February 6, 2010 at the Queensland Regional Office. The course coordinators were Dr Chris Breen & Dr Rob Miskeljin from GASACT. There were 20 registered participants on the day and trade sponsors included Investec Experien Pty Ltd, Olympus, CSL Biotherapies, Avant Mutual Group Ltd and Karl Storz. The program offered topics specific to the needs of the new trainee including welfare of anaesthetists; training program and modules, role of ANZCA and the ASA, College paperwork, passing the primary exam, exam preparation courses, surviving ICU and managing your consultant.

The primary lecture program for 2010 commenced on February 13 with 23 students. Program coordinator, Dr Gamini Wijerathne, designed the program to cover as much of the syllabus as possible enabling trainees to start the course at either semester and continue over a 12-month period.

The course will be held on the following dates:

Semester 1	**Semester 2**
February 13	July 10
March 13	August 14
April 10	September 11
May 8	October 9
June 12	November 13

The final exam preparation course was held in the Queensland Regional Office from February 22-27. The course convenor was Dr Helmut Schoengen. There were 31 trainees in attendance for the five days of the course, including a number of trainees from outside of Queensland. Thanks to Fellows who volunteered their time and knowledge to assist the trainees by presenting on the course:

Dominique Hopkins
Tania Dutton
Rebekah Ferris
Di Khursandi
David Trappett
Sue Lawrence
Anna Miedecke
Paul Gray
Pal Sivalingam
Michael Fanshawe
Kersi Taraporewalla
Louisa Smith
Peter Reid
Adrian Chin
Mark Lai
Rod Van Twest
Hau Tan
Peter Waterhouse
Steve Cook
Peter Moran

Above from left: participants taking a break from the part zero course; the primary lecture program.

New South Wales

Part o course

On February 6, 2010 ANZCA and the ASA/ GASACT at RPA hosted the yearly Part o "Induction to Anaesthesia Course" for new trainees and those interested in Anaesthetic Careers. Partners/ family of trainees and trainees themselves were invited to an afternoon of sessions aimed at clarifying some of the realities of what may be anaesthetic training and its impact outside the clinical setting – that is on "work life balance". Sessions were geared to clarifying roles of the modular learning system and paperwork for the college, roles of the ANZCA trainee committee and GASACT, representation industrially by HSU, clarifying approaches to depression and happiness in the workplace, career options, work life choices and what to do in crises.

Support was provided by ANZCA and ASA representatives, Supervisors of Training and department heads who graciously and selflessly provided time on a Saturday afternoon to be involved in a day designed to help trainees through the concerns they have at the beginning of their career/ vocational pursuit. Prof. Gordon Parker from the Black Dog Institute revised his excellent discussions on how depression can affect health providers (particularly anaesthetists) and provided insights into management and support structures in treatment of the conditions in which it manifests.

Special thanks for the day go to the ANZCA Trainee Committee, Tina Papadopolous from the NSW ANZCA Office, the ASA NSW Committee and the speakers on the day. Drs Natalie Smith, Ken Harrison and Assoc Prof Greg Knoblanche rate special mention for contributions as consultants who regularly participate in providing their insights and are involved in making the day possible. We also thank the SOTs and department heads who advertised the day to trainees and supported them by attending the well received day.

The day will be advertised to occur again in early 2011 for those trainees who are interested in attending and beginning their anaesthetic training.

Australian Capital Territory

The ACT Regional Committee held a workshop over the Canberra Day long weekend. Titled "Management of Difficult Airways". The day proved to be very interesting. There were hands-on workstations including videolaryngoscope, fibreoptic, topicalization, cricothyrotomy, bonfils and airway exchange catheters. There were also four very informative presentations on various issues relating to the management of difficult airways. Dr Stephen Brazenor spoke on difficult airway algorithm, followed by Dr Lisa Zuccherelli with a talk on the management of difficult airways in the morbidly obese. In the afternoon there were presentations by Dr Simon Robertson on nerve blocks and topicalization for awake intubations, and airway management and facial trauma, presented by Dr Chris Acott.

The ACT also recently held primary written exams on March 1.

Above right from top: Dr Simon Robertson with participants; Dr Lisa Zuccherelli talking on the management of difficult airways in the morbidly obese; participants at the workshop; Dr Candida Marane at the workshop.

South Australia/ Northern Territory

Professor James Isbister spoke on "Perioperative patient blood management: why, what and how?" at February's combined ANZCA/ASA continuing medical education committee meeting. More than 70 people attended the meeting.

Above from top: CME Chair Dr Bill Wilson and guest speaker Professor James Isbister; attendees being addressed by our new CME Chair Dr Bill Wilson.

Above right: GASACT Senior Chair, Dr Joe Ng; Dr Suzanne Bertrand, WA REO.

Western Australia

Part o course

The WA Part o Course was held at the St John of God Hospital, Subiaco, Conference Centre on the evening of Thursday, January 28, 2010. The course was convened by the GASACT Senior Chair, Dr Joe Ng, and was attended by 22 of the new anaesthetic registrars who recently commenced on the Western Australia rotational training scheme. For the first time partners/supporters were also invited to hear about what is involved with the training program and what to expect over the next five years. Topics presented included welfare of anaesthetic trainees, role of the supervisors of training and the regional education officer and general tips on how to behave and what to expect in theatre. Advanced trainees also gave presentations on the first year of training and what to expect, the part one examinations and beyond and the part two examinations and beyond. Thank you to the following Fellows and senior registrars who gave up their valuable time to speak to the new trainees: Drs Paul Rodoreda, Simon Maclaurin, Prani Shrivastava, Jodi Graham, Suzanne Bertrand, David Hoppe, Andrew Hunt and Joe Ng.

ANZCA advanced teacher course

On Friday, February 12, 2010 the ANZCA teacher course – advanced level was delivered to Fellows from ANZCA and FPM at the WA regional office. 13 Fellows attended the one day workshop focusing on "Delivering Feedback". The participants engaged enthusiastically during the day, sharing experiences and common problems when giving feedback to trainees. Small group work allowed Fellows to examine general principles for providing effective feedback and essential elements in providing feedback to enhance learning. Participants critically analysed different models of feedback and rehearsed techniques suitable to their clinical practice.

Thank you to Felicity Hutton, the ANZCA Education and Training Development Manager, who presented the course. The feedback from the Fellows who attended was very positive.

Visit by the ANZCA President

Dr Leona Wilson visited Western Australia on Thursday, February 18, 2010 to meet with Fellows and trainees to discuss any issues they may have and to present the ANZCA strategic plan. The evening was held at the St John of God Hospital, Subiaco, Conference Centre and Dr Wilson also attended the WA regional committee meeting which preceded the presentation.

Above: Felicity Hutton, the ANZCA Education and Training Development Manager, who presented the advanced teacher course.

Tasmania

Combined ANZCA/ASA Meeting

The Tasmanian combined ANZCA/ASA meeting was held on February 19-21 at the Old Woolstore Apartment Hotel in Hobart. The theme was "A Disaster of a Conference". Despite the title the meeting was a great success, attracting a large number of trade and delegates. Highlights included the presentation of the Gilbert-Brown Award to Dr Haydn Perndt by Dr Elizabeth Feeney (ASA President) and Kester Brown. ANZCA President, Dr Leona Wilson, also attended the conference and gave a presentation on the College's strategic directions for 2010-12.

Above top from left: Dr Ben Van Der Griend, Dr Simon Morphet, Dr Robert Bown, Dr Anna McDonald; Dr Elizabeth Feeney, ASA President presenting the Gilbert-Brown Award to Dr Haydn Perndt.

Victoria

The 2009 Victorian Trainee Committee (VRC) was very proactive during its term of office and put in place the buddy mentoring system for junior trainees. The VRC would like to commend members on their efforts in respect of trainee matters and for their participation in our activities. Their assistance and cooperation are greatly appreciated. We look forward to working with the 2010 VTC during the year.

Above from left (back row): Dr Sally Lacey (outgoing co-chair); Dr Ravi Ramadas (buddy mentor); Dr Suzy Cook (2009 executive secretary); Dr Michelle Spencer (GASACT chair); Dr Brad Hindson (buddy mentor); (front row): Dr Mahsa Adabi (chair 2010); Dr Kushlani Stevenson (outgoing chair).

The orientation to anaesthesia for Victorian trainees was held on Friday, March 5 at ANZCA House. The program, chaired by the regional education officer Dr Richard Horton, was structured to be as interactive as possible and focused on "what training requires and how to get the most out of it". Once again, the Victorian Trainee Committee played a prominent role in the proceedings and conducted its own panel discussion session, which is always a very popular segment of the program.

Above top from left: Senior trainees who facilitated at the orientation program, Dr Kushlani Stevenson, Dr Suzy Cook, Dr Raje Rajasekaram, Dr Deas Brouwer and Dr Michelle Spencer.

Above: Supervisors of training who participated in the program, Dr Abhay Umranikar, Dr David Pescod, Dr Richard Horton and Dr Liam Broad.

New Zealand news

ANZCA and NZSA NZ workforce survey and report

The 2009 New Zealand anaesthesia workforce survey had an exceptional response rate – with 75 per cent of all recipients responding. This survey data has been used to develop a draft report on the supply of anaesthesia services which has been provided to members of the NZ workforce steering committee.

Ian Collens, the ANZCA Director of Strategy and Operations, is now working on the demand data. Ian visited New Zealand in December and met with ministry and District Health Board officials who are involved in workforce data collection. A methodology for identifying the demand for anaesthesia services has been developed and a costing for extraction of the required national minimum dataset data is underway. The final workforce report should be available in the first half of 2010.

New Year Honours

In the 2010 New Zealand New Year Honour appointments by the Queen, Dr Hugh Spencer was made an Officer of the New Zealand Order of Merit (ONZM) for services to medicine, in particular anaesthesia.

Professor Bob Boas was also made an Officer of the New Zealand Order of Merit for services to medicine, in particular pain management.

New Zealand Director-General Of Health

The New Zealand Director-General of Health Stephen McKernan has resigned and will be finishing at the Ministry of Health on July 31.

Mr McKernan has been the country's top health official and Chief Executive of the Ministry of Health for almost four years. Before that, he was CEO of the Hutt Valley DHB followed by Counties Manukau District Health Board.

New Zealand disaster response

The NZNC has urged the Minister of Health to establish a national medical disaster plan, with a central co-ordinating body with access to a register of appropriate health care workers, including anaesthestists, ready and available for deployment at short notice. The ANZCA President, Dr Leona Wilson, raised this when she recently met with the Health Minister, Tony Ryall. The minister appreciated the College's offer to assist with this plan and register.

ANZCA 2010 ASM

The ANZCA and FPM ASM will be held in Christchurch from May 1-5. Associate Professor Ross Kennedy, Dr Richard French and the others on the organising committee have planned a great program, so we look forward to seeing many of our colleagues there from both sides of the Tasman. The theme of the Meeting, "How Meets Why – Clinical Practice and the Science Behind it", will provide updates on contemporary clinical anesthesia practice mixed with the scientific rationale underlying that practice. Mark Waddington and the Scientific Subcommittee have assembled a cast of internationally respected speakers who will participate in a range of lectures, varied practical workshops, and small group sessions. More information can be viewed at www.conference.co.nz/index.cfm/anzca10.

NZ Anaesthesia ASM 2011

Staff members from the Department of Anaesthesia at Northshore Hospital in Auckland are organizing the 2011 New Zealand Anaesthesia ASM on behalf of the ANZCA New Zealand National Committee and the NZSA. Dr Michal Kluger is the convenor. It will be held at the Auckland Grand Convention Centre from November 2-5. The theme of the meeting is "New Horizons" and the internationally renowned keynote speakers reflect the ASM organising committee's desire to explore innovation and new thinking in anaesthesia. The event has been organised just two weeks after the Rugby World Cup 2011. More details can be found at www.nzaasm2011.org.nz.

2012 ICCVA/NZA ASM Meeting

The College and NZSA are co-hosting in Auckland the 13th International Congress of Cardiothoracic and Vascular Anesthesia (ICCVA) in conjunction with the 2012 New Zealand Anaesthesia Annual Scientific Meeting. The co-convenors for this event are Drs Marian Hussey and Ivan Bergman. There is strong support for this meeting from the CVP special interest group. More information can be obtained from Heather Ann Moodie at the ANZCA New Zealand office, email hamoodie@anzca.org.nz.

BWT Ritchie Scholarship Applications 2010

Applications close on June 30, 2010. The BWT Ritchie Scholarship is open to New Zealand trainees who have passed the final examination for the Diploma of Fellowship of the Australian and New Zealand College of Anaesthetists and who wish to take a further year of study outside New Zealand in their final year of training, or the year following the completion of their Fellowship. The Scholarship is also available to New Zealand trainees who have passed the Fellowship examination in the Joint Faculty of Intensive Care Medicine/CICM and who wish to pursue a further year of study outside New Zealand in their final year of training, or the year following the completion of their Fellowship. More information can be obtained from the following weblink: www.anaesthesia.org.nz/nzaec/News/tabid/140/Default.aspx.

International Medical Graduates

a) Workplace Based Assessments

ANZCA's new process of workplace based asessments (WBA) for eligible International Medical Graduates (IMGs) wishing to gain Fellowship is being implemented in New Zealand. For the first three months this year six WBA have been organised. This involves a significant commitment from College assessors.

b) New Zealand Vocational Registration Panel

The ANZCA New Zealand Panel for Vocational Registration continues to have a number of IMGs preliminary assessments and interviews to be completed on behalf of the Medical Council. Nine IMGs have been interviewed in the last three months with a further six preliminary reports prepared. The New Zealand office has been working with MCNZ to ensure the new MCNZ Vocational Practice Assessments are appropriate for anaesthesia.

Health Practitioners Disciplinary Tribunal (HPDT) appointments

Dr Leona Wilson was recently reappointed by the Minister of Health to serve for a further term on the Health Practioners Disciplinary Tribunal. Dr Graham Sharpe was also appointed.

Teachers courses

An ANZCA teachers advanced level course was held at the New Zealand office on March 10. The 12 attendees had a busy, interactive workshop presented by Felicity Hutton the ANZCA Education, Training and Development Manager on the topic, *Effective Supervision*. A Foundation course will be held later in the year (October 18–20).

ANZCA teachers advanced level course. Front row from left: Douglas Mein, Dr Alastair Mark, Felicity Hutton (facilitator), Dr Nadia Forbes; back row from left: Dr Stephen Pearce, Dr Sarah Nicolson, Dr Lance Nicholson, Dr Tania Hunter, Dr Jennifer Woods, Dr Lisa Horrell, Dr Sally Ure, Dr Mandy Perrin, Juliette Adlam (New Zealand staff), Dr Mohua Jain, Dr Amanda Dawson.

National workforce projects

Recently, NZNC members have attended meetings on workforce issues that are being progressed by the Ministry of Health and Health Workforce New Zealand. The Ministry project is addressing '24/7 acute care in provincial hospitals'. The Health Workforce New Zealand project involves a pilot of physician assistants in surgery.

The physician assistants pilot is being progressed by a working group from Counties Manukau District Health Board contacted by Health Workforce New Zealand and will involve hospitals in the Northern region DHBs (Auckland, Northland, Waitemata and Counties Manukau). It is intended to employ two USA trained physician assistants.

The Council of Medical Colleges (CMC) has written to the Chair of Health Workforce New Zealand, Professor Des Gorman, outlining Colleges' recognition of the need to enhance and support the current limited health workforce in New Zealand and the requirement to explore new solutions such as this physician assistants' pilot. The letter expressed a number of concerns including the potential flow-on effect on the training and clinical experience for medical students, junior doctors and their teachers if some of their current scope is removed. CMC strongly recommended that the pilot be rigorously evaluated, with peer review and Colleges' input, to assess the impact on medical student training, experience and supervision and also patient safety.

Vanessa Beavis
ANZCA New Zealand National Committee Chair

Faculty of Pain Medicine

Dean's Message

As pain specialists, we are often asked to authorise or manage patients on treatment that we believe is inappropriate.

Recently, I had a situation where a patient came from interstate arriving in our clinic late one afternoon with a letter asking that "we" provide the patient with the following medication:

- Morphine 30mgs subcutaneously, 6 per day.
- Diazepam 25mgs, 3 times a day.
- Gabapentin 300mgs, 3 times a day.
- Mirtazapine 30mgs nocte.
- Temazepam 20mgs nocte.

The patient informed me she was in South Australia as her grandmother was dying. Having been in Adelaide for one month, she had run out of all of her medication.

Apart from being surprised to find no effort had been made to contact our pain clinic by the prescribing doctors, I recognised that this patient was at significant risk if I ceased her prescription, particularly from benzodiazepine withdrawal.

Being very uncomfortable with this combination of medications (with significant risk of apnoea and possibly death), I contacted the Drugs of Dependence Unit in South Australia explaining the situation. I agreed to be her prescriber while in South Australia but also explained to the patient that over the period of several weeks, I would be weaning her down to what I considered safe doses.

By being firm, and explaining my reasons, I was able to wean her down and within six weeks had her managing well with Kapanol 50mgs bd, Diazepam 5mgs tds, Mirtazapine and Gabapentin, having ceased the Temazepam. At that point, the patient returned to her home state but expressed distress that she had been living in "a fuge state" for the last 20 years with the medications, and stating she was planning to sue the original practitioner. Subsequently, we have received a letter from her lawyers asking for copies of our medical records.

This raises an interesting question: will patients start to seek compensation for what we now recognise is inappropriate treatment. Practitioners must keep up to date with the literature.

Since 1986, the pendulum has swung from opiophobia in managing patients with chronic pain to very liberal dispensing of opioid medication. However, now the pendulum is swinging back with people recognising the adverse effects of high dose opioids[1,2,3] and also studies showing combinations of opioids and Benzodiazepine can lead to significant central sleep apnoea in over 30% of patients[4]. These patients are at risk of sudden death. Therefore, it is imperative that we as practitioners keep up with the current knowledge and information and make changes as the knowledge base also changes.

It is often difficult to convince patients (their carers and other practitioners) that they need to reduce medication, and that the medication may be having a harmful effect on them.

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In our clinic, we anecdotally have a number of patients in whom, by being firm, we have weaned down to more moderate doses, and they often express how much better they feel. One patient being assessed for dementia when weaned off various medications was cognitively normal, and once again (not surprisingly) extremely angry with his prescribing doctor.

The media are always highlighting new miracle pain treatments, possibly giving patients false hopes. They champion patients who can't get the treatments they (the patients) believe they deserve. Yet they will equally criticise the practitioner if treatments cause harm. The International Association for the Study of Pain (IASP) recommendation of "Pain relief as a human right" needs to be seen in the context of providing appropriate, timely and safe pain management.

Recently in the media there has been a lot interest again in the medical use of marijuana. However, the evidence base for the effectiveness of marijuana is still limited. Evidence of relief in pain conditions is below that seen with most other medications[5]. Benefits are controversial and the risks not fully exposed.

There does appear to be some minor benefit in terms of pain and spasticity in multiple sclerosis (MS) and it does give some sufferers some relief. Dr Bill Carroll, MS Research, Australia says "is worth a try".[6] Its effects are controversial and it also does have a number of significant risks that need to be taken into account.

Unfortunately, *all* drug treatments in chronic pain are not without risk.

High-dose opiates can cause hormonal suppression, osteoporosis, fluid retention, immune compromise and can make pain worse ("hyperalgesia"). Marijuana can lead to dissociative events, clouding of cognition and psychotic episodes. Benzodiazepines have significant cognitive effects. Long-term NSAIDs can cause renal and gastric damage. The tricyclic antidepressants are well known because of their anticholinergic effects to have a number of significant adverse effects particularly in the elderly. The antiepileptic drugs (can lead to hepatic dysfunction, which may not be reversible) and Stevens-Johnson Syndrome. The newer antiepileptic drugs (Gabapentin and Pregabalin) have less side-effects, but weight gain can be an issue and cost is still prohibitive for many of our patients.

So where do we go? All we can do is provide patients with all the information, both positive and negative, about the proposed treatments we are recommending and then leave them to make the informed decision. The patient can decide whether or not to accept a proposed treatment. However, the doctor also has the right to decide whether they believe a requested treatment is appropriate, and if they are uncomfortable with what is being requested to say no.

There is no right answer. "The right to pain treatment *is a right*, but not necessarily to the treatment you choose".

So medicine is a balancing act of the good, the bad and the ugly (that is what can go wrong). All drugs have side effects, and it is extremely hard to give patients black and white answers. All medicine is shades of grey working out what may happen both positively and negatively and therefore having to make a decision based on incomplete information.

Dr Penelope Briscoe
Dean

References:
1. Ballantyne JC: "Opioid therapy for chronic pain": NEJM: 2003: 349:20:1943.
2. McNicol E: "Opioid side effects: Pain: Clinical Updates": 2007: Vol XV: Issue 2
3. Colvin L: "Opioid induced hyperalgesia: a clinical challenge": BMJ: 2010: 104:2:125
4. Webster L: "Sleep disordered breathing and chronic opioid therapy: Pain Medicine: 2008": 9:4:425.
5. Frank B et al: "Comparison of analgesic effects and patient tolerability of nabilone and dihydrocodeine for chronic neuropathic pain": BMJ: 2008: 336.
6. Carroll B: Nightline 6PR Perth: 18/01/2010.

News

Acute Pain Management: Scientific Evidence (3rd edition 2010) now available online

The Faculty is pleased to announce that *Acute Pain Management: Scientific Evidence (3rd edition 2010)* is now available online and ready for download at http://www.anzca.edu.au/resources/books-and-publications/Acute%20Pain%20Management%20Scientific%20Evidence%203rd%20Edition.pdf.

The aim of the document is, as with the first two editions, to combine a review of the best available evidence for acute pain management with current clinical and expert practice, rather than to formulate specific clinical practice recommendations. Accordingly, the document aims to summarise the substantial amount of evidence currently available for the management of acute pain in a concise and easily readable form to assist the practising clinician. New and updated content has been incorporated with the content of the second edition.

Hard copies of the publication will be circulated to all ANZCA and FPM Fellows and trainees in due course. Additional hard copies will be available for order through the Faculty of Pain Medicine, ANZCA.

National Pain Summit website

A striking, new image has been uploaded onto the National Pain Summit homepage. Using real quotes and real images from people with pain, it helps to highlight the importance of the National Pain Summit and the people it will be helping. Feedback on the National Pain Strategy has been incorporated. The strategy was finalised at the National Pain Summit on March 11, 2010. The website, with several new "stories about pain" can be found at www.painsummit.org.au.

New Zealand application for specialty recognition

Communications from the Medical Council of New Zealand (MCNZ) advises that a convenor and lay person have been appointed by their education committee to assess the stage one application for recognition of the vocational scope of pain medicine. Feedback has been sought from external stakeholders and medical education institutes and initial assessment of the stage one application is due to commence. A draft report on the application will be provided to their Education Committee on March 24, 2010 and the Faculty will be given an opportunity to comment. The MCNZ Education Committee will then make a recommendation about whether the pain medicine application should proceed to stage two. This recommendation will be considered by the MCNZ at its meeting on April 13-14.

Honours & appointments

The board acknowledged the following awards and congratulated the recipients:

- Dr Robert A Boas ONMZ, Officer of the New Zealand Order of Merit.
- Professor Peter John Ravenscroft AM, Member of the Order of Australia.

Fellowship training and examination dates for 2010

Examination dates
November 24-26, 2010
Barbara Walker Centre for Pain Management at St Vincent's Hospital, Melbourne, VIC

Closing date for registration
Ocotober 8, 2010

Pre-exam short course
October 13-15, 2010
Royal Adelaide Hospital, SA

Closing date for registration
October 1, 2010

Admission to Fellowship of the Faculty of Pain Medicine

By training and examination:

Dr Aman Ahuja	IRELAND
Dr Chin-Wern Chan	WA
Dr Clifton Timmins	QLD
Dr Benoit Tousignant	CANADA
Dr Aston Wan	VIC

FPM Appointment - Director of Professional Affairs

The Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists is seeking to engage a senior specialist pain medicine physician of high standing to the position of Director of Professional Affairs, Faculty of Pain Medicine (DPA FPM). This is an advisory position to the dean, board and executive officer of the faculty on clinical and professional issues of importance to the faculty.

The position is part-time (0.2 full time equivalent) and is based within the Faculty of Pain Medicine, located at the ANZCA head office, 630 St Kilda Road Melbourne. Residence in Melbourne is not necessary for this position although presence is required from time to time.

The Faculty is seeking expressions of interest from Fellows and former Board Members of the Faculty who have had clinical experience within the past two years.

An attractive remuneration package will be negotiated with the successful candidate.

Expressions of interest should be communicated by April 16, 2010 to Sarah Hunter
Partner
Amrop Cordiner King, Level 44 Rialto
525 Collins Street, Melbourne, Vic 3000
Telephone: +61 3 9620 2800

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Report from the Board Meeting held on February 8, 2010

Faculty Board

At the February Board meeting of the Faculty, Dr David Jones was elected to the position of Dean-Elect. Dr Max Majedi, FANZCA was welcomed as the co-opted WA representative, following Dr Eric Visser's resignation in November.

Dr Kerry Brandis' term as the Co-opted Representative of ANZCA Council expires in May. As he is an apology for the April Board Meeting, Dr Brandis was warmly thanked for his enthusiastic and thoughtful contributions over the past three years.

Relationships Portfolio

Liaison with Medical Colleges

ANZCA

Dr Leona Wilson attended the February Board Meeting and spoke to the Terms of Reference for the ANZCA/FPM working Party to review the position of the FPM, its Dean and Board, and its Fellows in the governance structure of ANZCA. The Terms of Reference and Working Party Membership were endorsed.

It was noted that Faculty Fellows were well represented in the ANZCA Research Awards for 2010. Four of the twelve projects were pain projects and ANZCA's support in underwriting pain research was acknowledged.

RANZCOG

The Board was advised that RANZCOG is keen to see the FPM include a focus on gynaecological pain. The Dean spoke with the President of RANZCOG and it was confirmed that the Faculty is currently working a pelvic pain document with the input of a multidisciplinary group including Pain Medicine, Physiotherapy, Psychology and two RANZCOG Fellows. A 2500 word "clinical update" is planned for the MJA and also a Position Statement under the auspices of the FPMANZCA and RANZCOG if supported.

Dr David Jones (FPM Vice-Dean) and Associate Professor Wayne Gillett (the first FRANZCOG FFPMANZCA) have also co-written an article on *Chronic Pelvic Pain in Women: Role of the Nervous System*, published in Expert Review of Obstetrics and Gynecology 2009; Volume 4, Number 2. Other opportunities for collaboration will be explored.

Corporate Affairs

Strategic Planning

Following the Strategy Workshop in conjunction with the October Board Meeting, the Champions of the six agreed strategic initiatives for the 2010-2012 period are to take steps to move these initiatives forward. Progress will be reviewed six-monthly.

National Pain Summit

Invitations have been circulated for the National Pain Summit in Canberra on 11 March and a program is now available. The ANZCA Communications Department has been extremely active: putting out media releases, lining up a large number of media interviews (all of which will be published on the Summit website) and developing a powerful new homepage that includes several more "stories about pain". The latest version of the strategy is available for viewing at www.painsummit.org.au

FPM Director of Professional Affairs

A position description has now been finalised and a Call for Expressions of Interest from FPM Fellows has been placed this issue of the College *Bulletin* and will be included in the March issue of FPM *Synapse*. This will be a termed, contract position with the opportunity for renewal.

Trainee Affairs Portfolio

International Medical Graduates

The Board discussed draft Regulations for Associate Fellowship, for those who have completed the Training and Examination requirements of the Faculty but who are not eligible for Fellowship as they do not hold Fellowship of an approved Australian or New Zealand primary specialty. It was agreed that IMG trainee examination candidates will remain eligible for the Merit List and Barbara Walker Prize. Associate Fellows will be eligible to attend the AGM but will not eligible to vote or hold office, but will be eligible to hold membership of FPM Committees. The annual subscription for Associate Fellows will be 50% of the Fellowship subscription on the basis that they are unable to practise as Medical Specialists in Australia or New Zealand. The agreed post-nominals will be Assoc FFPMANZCA.

It was resolved that training could be concurrent with training overseas in one of the primary specialties, however Associate Fellowship will not be conferred before specialist registration is completed in the country of practice.

Eligibility for Training and Examination

Following an application from a dentist to train with the Faculty, the Board resolved that the Dental Specialties not be included in the term "Medical Specialists" and therefore will be ineligible for Fellowship either through Training and Examination or Election. The Board was keen to respond positively to interest in dentist involvement in pain medicine and it was agreed to start a communication with that group to help get pain into their curriculum.

Education Committee

Supervisors of Training

The Board resolved to accept a SoT Agreement developed by the Supervisor of Training Sub-Committee and this will be circulated to all SoTs for signature. The document includes a declaration of the SoTs responsibilities. A recommendation that a Long Case video be produced was not supported on the basis of being costly and time consuming to produce and view. Trainees are to be encouraged to attend the Pre-Examination Short Course which includes a Long Case.

Policy on Trainee Illness and Disability

The FPM Education Committee will finalise a Faculty document on trainee illness and disability for acceptance at the April Board Meeting.

Examination

Twenty four candidates sat the FPM Examination at the Royal North Shore Hospital, 25-27 November 2009. Twenty candidates, including two General Practitioners (the first to successfully sit the FPM examination) were successful; a pass rate of 83.3%. The 2009 Examination Report is available on the Faculty Website.

Dr Paul Wrigley's superb organisation was gratefully acknowledged. Merit awards went to Drs Max Sarma, Dr Kerry Thompson and Dr Clifton Timmins.

The 2010 examination will be held at the Barbara Walker Centre for Pain Management, St Vincent's Hospital Melbourne on 24-26 November and will be convened by Dr Jane Trinca.

Training Unit Accreditation

The Barbara Walker Centre for Pain Management, St Vincent's Hospital, Melbourne, Westmead Hospital (Adult), Westmead Hospital (Children's), Royal Children's Hospital, Melbourne and Geelong Hospital have been reaccredited for pain medicine training.

Fellowship Affairs Portfolio

Honours and Appointments

The Board acknowledged the following awards and congratulated the recipients:

- Dr Robert A Boas ONMZ, Officer of the New Zealand Order of Merit.
- Professor Peter John Ravenscroft AM, Member of the Order of Australia
- Professor Greg Whelan AM, Member of the Order of Australia

Fellowship

Dr Aman Ahuja, FCARCSI (Ireland) was admitted to Fellowship by training and examination.

Professor Andrew Somogyi, PhC, MSc, DHP, PhD (SA) was elected to Honorary Fellowship of the Faculty of Pain Medicine. Professor Somogyi, a Pharmacologist, has been involved with the Faculty both at an educational level and as a contributor to their Research Committee. Professor Somogyi has contributed to the pain literature especially looking at opioids induced hyperalgesia and glial cell inhibition.

Continuing Education and Quality Assurance

Scientific Meetings

2010 ASM – Christchurch

Programs for the Refresher Course Day and ASM Program have been finalised and are available on the website. Dr Jeffrey Mogil (Canada) is the FPM ASM Visitor and Dr Richard Rosenquist (USA) is the FPM New Zealand Visitor. Registration forms have been on line since December and brochures were circulated in January along with the ANZCA ASM Registration brochure.

2010 Spring Meeting

Dr Chris Hayes is convening this meeting in Newcastle and an Organising Committee has been established and is well advanced with a program. The theme is "Transitions in Pain" with prominence given to the Models of Care sub-theme. Dr Cathy Price (Southampton, UK) has agreed to speak at the meeting. Registration materials are enclosed with the March Bulletin.

2011 ASM – Hong Kong

Professor Catherine Bushnell (Harold Griffith Professor of Anesthesia and Professor in Dentistry and Neurology at McGill University) has accepted the invitation as 2011 FPM ASM Visitor. Professor Wan You (Professor of Neuro-biology, Peking University) has accepted the invitation as FPM Hong Kong Visitor following the unavailability of Prof J S Han.

2011 Spring Meeting

Canberra has been confirmed as the venue for the 2011 Spring Meeting and "Sleep in Pain" as a meeting topic.

2012 ASM – Perth

Dr Max Majedi has accepted the role of FPM Convenor for the 2012 ASM.

Professional Documents

Faculty Professional Document PM3 *Lumbar Epidural Administration of Corticosteroids* is currently under review. A review of ANZCA Professional Document PS9 *Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical or Surgical Procedures* has been completed and the update is now published on the website. This is now co-badged with the Faculty.

Research

National Pain Outcome Initiative

Outcome measurement has been on the Board agenda for some time and a proposal that a National Pain Outcome initiative be a specific priority for the National Pain Strategy was discussed and supported. Of the Faculty's six strategic priorities identified in October 2009, four would be advanced by this initiative.

A National Pain Outcome Initiative would require early funding to support a national workshop with key stakeholders and clinicians. The proposal has been submitted into the National Pain Summit strategy and included in the documentation to delegates. The initial aim would be to develop a business plan and design a scoping study. Agreement in regard to both clinical and system outcome measures would be required. The ultimate aim would be to establish an ongoing National Pain Outcome Centre. A costed proposal has been submitted.

The Board acknowledged such a proposal would be timely in view of the National Pain Summit, the changed model of care and the government's focus on outcomes.

Professor David Currow (Palliative Medicine) met with the Board and provided background on the Palliative Care Outcome Centre (PCOC) initiative which was established in 2006 and funded by the Commonwealth, in which the majority of Australian Palliative Care units participate. Professor Currow provided valuable advice on the process of establishing such an initiative and highlighted timely feedback (less than 3 months from receipt of data) as a key success.

Professional

New Zealand Application for Specialty Recognition

Communications from the Medical Council of New Zealand advises that a convenor and lay person have been appointed by their Education Committee to assess the stage 1 application for recognition of the vocational scope of pain medicine. Feedback has been sought from external stakeholders and medical education institutes and initial assessment of the stage 1 application is due to commence. A draft report on the application will be provided to their Education Committee on 24 March 2010 and the Faculty will be given an opportunity to comment. The MCNZ Education Committee will then make a recommendation about whether the pain medicine application should proceed to stage 2. This recommendation will be considered by the MCNZ at its meeting of 13 and 14 April.

National Accreditation

Terminology for National Specialist Registration was raised and it was resolved that "Specialist Pain Medicine Physician" be supported.

Acute Pain Management: Scientific Evidence

NHMRC endorsement was received on 4th February. The 3rd edition has been published on the ANZCA and FPM websites. Hard copies will be circulated to all College Fellows and financial trainees in due course. The Board expressed its appreciation of the enormous commitment of A/Profs Pam Macintyre and David Scott, Professor Stephan Schug and Drs Eric Visser and Suellen Walker in bringing this third edition to fruition.

Submissions to Medicare on Pain Related Issues

Following discussions at the October Board Meeting and an approach to the AFRM and Geriatricians to develop a collaborative approach, the Board supported a proposal to develop a case for Fellows to be able to make direct referral to psychologists, noting the psychological distress associated with high levels of pain. However currently it

Report from the Board Meeting held on February 8, 2010

continued

appears that Medicare will not support this initiative as the current budget has blown out excessively.

Submissions
The Faculty recently provided a submission in relation to the Department of Health and Ageing on the *Medical Specialist Outreach Assistance Program – Indigenous Chronic Disease (MSOAP-ICD) Guidelines*. A letter of acknowledgement and revised guidelines had been received. The Dean and the Board acknowledged that ANZCA's DPA, Professor Barry Baker, and Director PQ&A, John Biviano have been enormously helpful and supportive in the many recent submissions.

AMC Annual Report
The Board noted the feedback that the Faculty has no formal trainees' association. The next report will highlight the areas that trainees do have for email communication and point out the short duration of the training period.

Feedback relating to CPD development for Fellows participating in program's other than the ANZCA/FPM program will also be addressed with improved reporting becoming available.

Australasian Guidelines for Neurostimulation in Chronic Pain
The Board discussed a proposal that the Faculty support the development of a set of Australian guidelines for Neurostimulation in Chronic Pain in conjunction with HCI. The Board recognised the importance of clarifying this divisive issue, however there was agreement that guidelines should be developed by a multidisciplinary team, with academic independence and with the involvement of independent non proceduralists.

Dr Owen Williamson, who has experience in administering a register of implants for orthopaedic surgery, would be invited to participate. It was suggested that guideline development be tied to the development of an implant register, funded by implantable industries.

Resources Portfolio

Finance
A positive outcome against budget was reported for 2009 despite significant unbudgeted but approved costs associated with the National Pain Summit.

2010 Calendar
Dates for the 2010 Board meetings have been confirmed as:
29 April
2 May (New Board)
9 August
11 October

The ANZCA Foundation

An initiative of the Australian and New Zealand College of Anaesthetists

The ANZCA Foundation's inaugural Governor

The College and the ANZCA Foundation Board are delighted that Dr John B.Craig has accepted our invitation to become the inaugural Governor of the ANZCA Foundation.

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

The ANZCA Foundation advised Dr Craig recently that for the 2010 award the research committee recommended that the award go to Dr Phillip Finch for his project, "Adrenergic receptor involvement in an animal model of complex pain syndrome type".

In December 2009, the Foundation hosted a lunch in Perth to again thank Dr Craig for his magnificent gift to the College and to welcome him as the inaugural Governor.

Above from left: Foundation Director Ian Higgins presents Dr Craig with the ANZCA Foundation tie and cuff links in recognition of his wonderful support of the College; Family, friends and colleagues (including Dr Phillip Finch) attended the lunch in Perth.

To make a bequest, become a patron and for all other inquiries please contact:
Ian Higgins
Director, the ANZCA Foundation
ANZCA House
630 St Kilda Road
Melbourne VIC 3004
Tel: +61 3 9093 4900
Fax: +61 3 9510 6786
E-mail: ihiggins@anzca.edu.au

The ANZCA Foundation's patrons and bequest programs

The Patrons Program has been established to encourage and recognise those people who wish to support medical research and education by making a donation. All donations will be solely directed towards medical research and education with the Council of ANZCA determining the awarding of grants. All donations to the Foundation are tax deductible.

A bequest to the Foundation is a wonderful way to enhance ANZCA's ability to undertake important medical research and to support education initiatives. You might consider a bequest to the ANZCA Foundation whether as a specific amount of money, a proportion of your estate, the residual of your estate or other specific property.

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

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

Library update

Health and safety alerts - ECRI Institute notices

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

Recent notices include:

- OR Risk Management in the Age of Twitter (ORRM Newsletter, Dec 2009).

Operating Room Device Alerts

- Information Systems, Data Management, Anesthesia.

Health Devices, Vol. 38, No. 12, December 2009

- Understanding cardiac output monitoring.

Health Devices, 39, No. 1, January 2010

- Don't use industrial-grade gases for clinical applications.

Operating Room Risk Management

- Ambulatory Surgery.
- Communication.

Pain medicine book collection

The ANZCA Library has created a direct link to pain-related books held in the collection via the library catalogue.

Log-in to the ANZCA/FPM website and link to the library catalogue to view the large range of books in the pain area.

http://www.anzca.edu.au/resources/library/book-catalogue.html.

New addition to the journal collection – Journal of Opioid Management

Designed to meet the challenge faced by medical professionals as they prescribe opioids, increasingly powerful, quality-of life enhancing painkillers, *Journal of Opioid Management* fills what's been called "a dangerous gap" in medical literature at a time when the Federal spotlight has been switched on to the rising problem of abuse and addiction tied to these prescription painkillers.

Access via the journals webpage: http:/ www.anzca.edu.au/resources/library/online-journals.html.

New improvements to medical databases

Access via the databases webpage:

http://www.anzca.edu.au/resources/library/databases.html.

AusDI Advanced – new upgrade of drug information!

New features include:

- Product information
- Drug product images

Designed to give you convenient web-based access to multiple sources of reliable drug product information, AusDI Advanced includes full text, evidence-based drug, drug-class and complementary drug product monographs developed independently of pharmaceutical company influence, product information (PI), and consumer medicine information (CMI) leaflets and drug product images with fully searchable attributes.

OvidSP Medline

The Results Manager has been improved and a new feature called My Workspace will be launched to make keeping track of citations and research easier.

TRIP database – clinical search engine

Register with MyTRIP for free to keep up to date on new evidence and reviews effortlessly or even complete one of the 6000 self-assessment CPD packages.

News in medical publishing and research

Publishing ethics in medical education journals.

Brice J. Academic Medicine 2009 Oct; 84(10 Suppl): S132-

Available via the ANZCA Library online journal list.

PLoS Medicine Editors. Ghostwriting: the dirty little secret of medical publishing that just got bigger.

PLoS Medicine 2009; 6(9): e1000156.

http://www.plosmedicine.org/article/info:doi%2F10.1371%2Fjournal.pmed.1000156.

The Trouble with Wikipedia as a Source for Medical Information

This blog article first looks at the prevalence of Wikipedia use in the medical community and then reviews the literature regarding why Wikipedia is not the best or most reliable source for medical and scientific information. An amusing video entitled 'Professor Wikipedia' illustrates this argument.

http://laikaspoetnik.wordpress.com/2009/09/14/the-trouble-with-wikipedia-as-a-source-for-medical-information/.

MedicinesTalk, No. 31, Spring 2009 / National Prescribing Service

An article on finding good information on the internet, particularly for drug information for the patient.

http://www.nps.org.au/consumers/publications/medicines_talk/medicinestalk_no._31_spring_2009/Finding_good_information_on_the_internet.

How to find good [health] information online / U.S. Agency for Healthcare Research and Quality

A radiocast with transcript on how to find and identify reliable health information on the internet.

http://www.healthcare411.org/radiocastseg.aspx?id=1036&type=seg.

Having trouble finding the information you need?

Contact the ANZCA Library for guidance on searching OvidSP Medline, Embase, PubMed, TRIP and Cochrane databases.

The library staff are experts on literature searches and can even arrange for new references to be sent to you as soon as they are published on your topic of interest.

New research in anaesthesia and pain medicine

Latest Cochrane Library Systematic Reviews

http://www.thecochranelibrary.com

Sugammadex, a selective reversal medication for preventing postoperative residual neuromuscular blockade, 2009

Sugammadex was shown to be effective in reversing rocuronium-induced neuromuscular blockade. This review has found no evidence of a difference in the instance of unwanted effects between sugammadex, placebo or neostigmine. These results need to be confirmed by future trials on larger patient populations and with more focus on patient-related outcomes.

Hypertonic saline for perioperative fluid management, 2010

HS reduces the volume of intravenous fluid required to maintain patients undergoing surgery but transiently increases serum sodium. It is not known if HS effects patient survival and morbidity but it should be tested in randomised clinical trials that are designed and powered to test these outcomes.

Interventions at caesarean section for reducing the risk of aspiration pneumonitis, 2010

The quality of the evidence was poor, but the findings suggest that the combination of antacids plus H2 antagonists was more effective than no intervention, and superior to antacids alone in preventing low gastric pH. However, none of the studies assessed potential adverse effects or substantive clinical outcomes. These findings are relevant for all women undergoing caesarean section under general anaesthesia.

Ultrasound guidance for peripheral nerve blockade, 2009

In experienced hands, ultrasound provides at least as good success rates as other methods of peripheral nerve location. Individual studies have demonstrated that ultrasound may reduce complication rates and improve quality, performance time, and time to onset of blocks. Due to wide variations in study outcomes, we chose not to combine the studies in our analysis.

Neuraxial anaesthesia for lower-limb revascularisation, 2010

There was insufficient evidence available from the included trials that compared neuraxial anaesthesia with general anaesthesia to rule out clinically important differences for most clinical outcomes. Neuraxial anaesthesia may reduce pneumonia. No conclusions can be drawn with regard to mortality, myocardial infarction and rate of lower-limb amputation or less common outcomes.

Preoperative fasting for preventing perioperative complications in children, 2010

There is no evidence that children who are denied oral fluids for more than six hours preoperatively benefit in terms of intraoperative gastric volume and pH compared with children permitted unlimited fluids up to two hours preoperatively. Children permitted fluids have a more comfortable preoperative experience in terms of thirst and hunger. This evidence applies only to children who are considered to be at normal risk of aspiration/regurgitation during anaesthesia.

Library update

continued

Other Reviews

Preoperative Pulmonary Evaluation and Risk Reduction Strategies

by Steven Cohn, MD, FACP
Postoperative pulmonary complications (PPCs) are as common as cardiac complications, but consultants often fail to address pulmonary risk. This lecture will review the ACP guidelines and newer studies dealing with preoperative pulmonary risk assessment. Patient-related risk factors, surgery-specific risk factors, and laboratory testing to predict risk will be discussed.

This lecture is related to: Harrison's Online Chapter 8: Medical Evaluation of the Surgical Patient.

Access Harrison's Online via the ANZCA **Library Online Textbooks link, then register for a free profile to complete the CE activity.**

Association of Paediatric Anaesthetists: Good Practice in Postoperative and Procedural Pain

This guidance is intended to be used by professionals involved in the acute care of children undergoing pain management after surgery or for painful medical procedures. It is designed to provide evidence-based information on the assessment of pain and the efficacy of pain management strategies, such that an informed plan of effective analgesia can be formulated that is appropriate for the patient and clinical setting.

http://www.apagbi.org.uk/docs/APA_Guidelines_on_Pain_Management.pdf.

Inhaled Nitric Oxide in Preterm Infants

Evidence-based Practice Center Systematic Review Protocol. This controversy has resulted in wide variations in clinical practice, as reports of the longer term pulmonary and neurodevelopmental outcomes at two to six years are just emerging. There have been increasing efforts to market the use of inhaled nitric oxide in preterm infants to neonatologists, respiratory therapists, nurses and parents, despite its considerable cost ($3000 a day or more) and concerns about efficacy and safety. This situation argues for an updated comprehensive and systematic review of the literature, thoughtful analyses of currently available and emerging data, extensive peer review of the draft report, and further discussion at an NIH State-of-the-Science Conference in October 2010.

http://www.ahrq.gov/clinic/tp/inoinftp.htm

New ANZCA publications

All titles can be found online at: http://www.anzca.edu.au/resources/books-and-publications/

Acute pain management: Scientific evidence Australian and New Zealand College of Anaesthetists; Faculty of Pain Medicine. 3rd ed Melbourne: Australian and New Zealand College of Anaesthetists, 2010.

Australasian anaesthesia 2009 Invited papers and selected continuing education lectures. Riley, Richard [ed]. Melbourne: Australian and New Zealand College of Anaesthetists, 2009.

Safety of anaesthesia in Australia: A review of anaesthesia-related mortality 2003-2005: Report of the committee convened under the auspices of the Australian and New Zealand College of Anaesthetists. Gibbs, Neville [ed]. Australian and New Zealand College of Anaesthetists, Working Party on Anaesthetic Mortality. Melbourne: Australian and New Zealand College of Anaesthetists, 2009.

New IASP pain books

The Genetics of pain Mogil, Jeffrey S. [ed]. Seattle: IASP Press, 2004.

Hyperalgesia Molecular mechanisms and clinical implications. Brune, Kay [ed]; Handwerker, Hermann O. [ed].Seattle: IASP Press, 2004.

Opioids and pain relief A historical perspective. Meldrum, Marcia L. [ed]. Seattle: IASP Press, 2003.

Pain imaging Casey, Kenneth L [ed]; Bushnell, M. Catherine [ed]. Seattle: IASP Press, 2000.

The Pain system in normal and pathological stated A Primer for clinicians. Villanueva, Luis [ed]; Dickenson, Anthony H. [ed]; Ollat, Helene [ed]. Seattle: IASP Press, 2004.

Pediatric pain Biological and social context. McGrath, Patrick, J. [ed]; Finley, G. Allen [ed]. Seattle: IASP Press, 2003.

Psychological methods of pain control Basic science and clinical perspectives. Price, Donald D. [ed]; Bushnell, M. Catherine [ed]. Seattle: IASP Press, 2004.

Spinal cord injury pain Assessment, mechanisms, management. Yezierski, Robert P. [ed]; Burchiel, Kim J. [ed]. Seattle: IASP Press, 2002.

New general titles

Atlas of ultrasound-guided regional anesthesia Gray, Andrew T. 1st ed Philadelphia, PA: Saunders Elsevier, 2010.

Communication skills in medicine promoting patient-centred care. Groves, Michele [ed]; Fitzgerald, Jennifer [ed]. East Hawthorn, Vic: IP Communications, 2010.

How to display data Freeman, Jenny V; Walters, Stephen J; Campbell, Michael J. Malden, MA: BMJ Books, 2008.

Huddart Parker A famous Australasian shipping company, 1876 - 1961. Laxon, William Allan; Dick, H.W.; Farquhar, I.J.; Stevens, T.S. Caulfield South, VIC: Nautical Association of Australia, Inc., 2008. *Donated by Dr Basil Hutchinson – includes history of the ship, "Ulimaroa". ANZCA purchased the building "Ulimaroa" (named after the ship) in 1993 for the Head Office*

Ultrasound-guided regional anesthesia and pain medicine Bigeleisen, Paul [ed]; Orebaugh, Steven; Moayeri, Nizar; Groen, Gerbrand; Breneman, Stephen; Chelly, Jacques. Baltimore, MD: Lippincott Williams & Wilkins, 2010. (Book) 617.964 ULT

Books can be requested via the ANZCA Library catalogue

http://www.anzca.edu.au/resources/library/book-catalogue.html

ANZCA members are entitled to borrow a maximum of five books at one time from the College Library. Loans are for three weeks and can be renewed on request. Members can also reserve items that are currently 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 always remember to include your name, ID number and current 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
www.anzca.edu.au/resources/library
Phone: (03) 8517 5305
Fax: (03) 8517 5381
E-mail: library@anzca.edu.au

ANZCA in the news

Private hospitals to boost training

PRIVATE hospitals will become major training grounds for medical graduates as part of the Rudd government's $145 million package to boost specialist numbers.

With public hospitals at capacity, private hospitals will be called on to play a greater role in training as the government seeks to accommodate a surge in graduates from 2012.

Specialist colleges yesterday said they were planning to expand training numbers to alleviate looming shortages.

Royal Australasian College of Surgeons president Ian Gough said increases in training places of 20 to 30 per cent were planned for some areas, such as the orthopedic and general categories.

Professor Gough said the new recruits would probably have to be trained in the private system because "we've got as many as we can manage" in the public system.

Royal College of Pathologists of Australasia president Paul McKenzie said the discipline was bracing for a huge rise in demand for services as the ageing population produced an increase in diseases such as cancer.

Australian and New Zealand College of Anaesthetists president Leona Wilson said the college was "ready and willing to train as many specialist anaesthetists in the public and, increasingly, the private system, as there are funded positions".

"In fact, measures are already in place to meet the increased training demands that have resulted from the extra graduates coming out of medical schools. The number of medical graduates is expected to peak in 2012."

Dr Wilson said the college had been urging governments to fund an increased number of training places for years.

Catholic Health Australia chief executive Martin Laverty said the private sector had the capacity to significantly expand its role in training medical specialists.

He said most surgical procedures were performed in private hospitals.

"It made sense for them to play a greater role in training.

The profile of ANZCA – and the profession more broadly – continues to grow with nearly 150 stories, reports and interviews generated by the College appearing in the print and electronic media throughout Australia and New Zealand since mid-October last year.

An article in the previous *ANZCA Bulletin* on sexual hallucination that warned anaesthetists of an increasing number of complaints to medical boards from patients about sexual activity during or around the time of anaesthesia or sedation attracted much media attention in December.

ANZCA's Director of Professional Affairs, Professor Barry Baker, did several interviews, with articles appearing online throughout Australia. There were also at least a dozen newspaper reports and a similar number of radio interviews in Australia and several more in New Zealand.

ANZCA responded to the announcement in March of an increase in specialist training positions by the Australian Government with a media statement welcoming the increase. ANZCA President Dr Leona Wilson was interviewed by *The Australian* and *Australian Financial Review* newspapers.

Lengthy interviews about anaesthesia generally were done by Dr Rod Westhorpe on ABC Radio, Perth in November, and more recently, Dr Kim Jamieson, on Radio Live's "What's my line" that was broadcast throughout New Zealand.

In January Dr Graham Sharpe was also on Radio NZ's "Nine to Noon" program with Kathryn Ryan during the segment "Kiwis who should be famous", putting the case of Sir Robert McIntosh, the first professor of anaesthesia in the Commonwealth and second in the world.

Attention during much of the previous quarter focused on pain and on the National Pain Summit held in Parliament House, Canberra, on March 11.

The strategy in the lead-up to the summit involved the regular distribution of media releases targeting various aspects of pain – in older people, cancer patients and children. Many stories and interviews ensued.

Programs involving lengthy interviews were done on ABC Radio in Queensland with Professor Michael Cousins on Madonna King's "Ask an expert" segment. Professor Cousins and a patient were two of the guests on ABC Radio National's "Australia Talks" program and pain was the focus of the hour-long "Best Medicine" program on Bayside FM in Melbourne on two occasions.

On the day of the summit a media release detailing the findings from an interim report of the Australian Pain Society's "Waiting in pain" study was released. This showed that patients were waiting an average of six months to see a pain specialist following referral from their GP.

Conclusions from the summit were also outlined in a media release and distributed throughout Australia at the end of the day. Media coverage was wide – some of the highlights included an interview with Professor Cousins on the "7.30 Report" on ABC television and an interview on ABC Radio National's "The World Today".

Swimming great Kieren Perkins (who addressed the summit as a carer talking about his wife Symantha, a chronic migraine sufferer) did several interviews, including ABC Canberra's breakfast program. The same station's morning program interviewed the Faculty of Pain Medicine's dean, Dr Penelope Briscoe.

Media releases distributed by ANZCA (December – March)

"ANZCA welcomes increase in training places" *(March 15, 2010)*

"Summit calls for Government action on pain" *(March 11, 2010)*

"Pain management on national radar for the first time" *(March 11, 2010)*

"Too many children suffering unnecessary pain" *(March 4, 2010)*

"Media alert: National Pain Summit, Thursday March 11, 2010" *(March 2, 2010)*

"Cancer patients should not live or die in pain: experts" *(February 11, 2010)*

"ANZCA Bulletin out today" *(NZ media - December 22, 2010)*

"ANZCA Bulletin out today" *(Australian media – December 16, 2010)*

"Most vulnerable being denied rights, say pain experts" *(December 10, 2009)*

These media releases and other media coverage involving Fellows can be found at (**http://www.anzca.edu.au/news/announcements/**).

In the last quarter, ANZCA has generated...

49 print and online stories
45 radio interviews
40 radio news stories
6 television reports

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, please contact media manager, Clea Hincks, at ANZCA via e-mail chincks@anzca.edu.au or by phone (03) 9093 4917 or 0418 583 276.

Dr Agnes Mary Daly (Mary) AM

September 16, 1935 – November 6, 2009

Together with her three sisters, Patricia, Denise OSU, Stephanie, and her brother Geoff, anaesthetists with their wives and husbands joined surgeons, other medical colleagues, the Ursuline nuns, parishioners and friends to celebrate the life of Mary Daly and her outstanding contribution to medicine and the community. The Church of St Fabian at Yeerongpilly echoed to the hymns common to all faiths, but it was particularly significant that before the Requiem Mass commenced many heard for the first time the lovely hymn to St Ursula.

It is a special privilege for me to pay tribute to Mary's life and two careers because the friendship of our families dates from 1911 when my mother Jane O'Rourke, a young teacher, was appointed to Charters Towers Girls High School. Charters Towers was then the second city of Queensland and appointment to the Girls High School a prestigious position.

The parish priest decreed that it would be improper for a young woman to live at a boarding house so he arranged for my mother to live with the recently widowed Mrs Agnes Patricia Campbell, Mary's grandmother. Mary's mother Patricia Campbell was away at boarding school at St Ursula's Armidale but she and my mother became good friends. Years later, when I was privileged to have the Department of Anaesthetics staff parties at my home, Mrs Daly and my mother always attended as honoured guests. One of Mary's special friends Dr Jill Pozzi reports that another of Mary's close friends, Dr Joc Tranberg, made the comment that when she saw the two dowagers holding court, she was tempted to genuflect!

The influence of the Ursuline nuns was apparent not only in Mrs Daly but also in Mary and her sisters. Founded by Angela Merici in 1535, they are the oldest teaching order in the Catholic Church, espousing the philosophy of their foundress that the future of a nation is dependent on the education of women, the future wives and mothers. Angela Merici empowered her students to succeed because they believed in themselves – not because they imitated men but because they were competent, confident and compassionate. Of course like Milton's Maidens, they were also meant to be sober, steadfast and demure!

Mary was born in Brisbane on September 16, 1935 the eldest of the five children of Pat and Geoff Daly. She was baptised Agnes Mary, but she disliked the name Agnes and was always known as Mary. The family moved to the Townsville suburb of Oonoonba. The tranquil life was shattered with entry of Japan to World War II and the bombing of the animal health station where Mary's father was a senior research officer.

Mary was enrolled at St Patrick's on The Strand but her chaplain uncle Father Charles Daly returned from Tobruik en route to New Guinea and disapproved of the colourful language Mary and Patricia were learning from the soldiers. He suggested a convent boarding school in Brisbane would be a better environment for her! It is not surprising that her parents selected St Ursula's, Duporth Oxley – the site of the current Canossa Hospital. The school reinforced her independent and forceful personality and, progressing through the school, she became head girl. She was ever ready to acknowledge the influence of the Ursuline nuns in helping her achieve her goals. Hard work enabled her to attain

entry to the Faculty of Medicine and she graduated in 1960. She did her intern and resident training at Royal Brisbane Hospital before undertaking specialist training in anaesthetics at St George's Hospital, London, in 1962-1963. She obtained Diploma of Anaesthetics, Royal College of Surgeons in 1964, and in 1968 was admitted as a Fellow of the Faculty of Anaesthetists, Royal College of Surgeons.

Post Fellowship training at the Hospital of Sick Children, Toronto, under the tutelage of Dr Al Conn and Dr Jeremy Sloane gave her the opportunity to develop outstanding skills in paediatric anaesthesia that were to benefit countless Queensland children on her return to Brisbane – and to train consultants in paediatric anaesthesia. She was admitted as a Fellow of the Faculty of Anaesthestists Royal Australasian College of Surgeons in 1970 and the Australian New Zealand College of Anaesthetists in 1992.

Mary accepted the responsibility of Director of the Department of Anaesthetics at Royal Brisbane Hospital – a formidable role because of the many locations in which anaesthetics were given at the adult hospital as well as the Royal Women's and Royal Children's. It was the outlying areas that were the ongoing challenge for supervision and training. The luxury of a duty anaesthetist in one area was the impossible dream.

She received scant recognition of the role she and her department played in development of the Intensive Care Unit (ICU) and retrieval teams. Mary always attributed this and her legendary battles with the hospital administration to gender discrimination but I believe that it was speciality bias rather than gender bias that downplayed the role of the anaesthetist. Other specialities had the time to lobby in the halls of power while Mary and her colleagues met the demands of clinical care in theatre, in the recovery room and in ICU.

On one occasion after many attempts to have a leaking ceiling repaired, she decided on a more subtle approach and commenced the memo "Rain drops keep falling on my head". This achieved the desired result.

On another occasion she insisted that a sign on a defective toilet be changed. It originally read "Toilet out of action – use the floor below". Maybe the approach was somewhat pedantic but the administration needed the impetus to remedy the problem.

Mary dealt with all this administrative and clinical load, while she coped with progressive rheumatoid arthritis and it pulmonary sequelae. Despite incredible stoicism, this forced her retirement from clinical practice but it did not prevent her from developing to the full another career in her so-called retirement.

She became President of the University of the Third Age, a board member of the Council for the Aged (COTHA), a consultant to Older People Speak Out (OPSO), area coordinator for Neighbourhood Watch, Chair of Senior Citizens Week, and member of the Premier's Award Selection Committee.

She found time to serve on the council for the Royal Brisbane Hospital Health Service District bringing to the council insight into problems at a practical level. It was a delight to hear Mary interviewed on radio on a variety of topics of concern to the aged – or to see her in action as she debated or television the need to protect a park or other green space for "people use".

Above all, she was a family person, devoted to her parents and siblings and adored aunt to the Daly and Burdon children, encouraging them and rejoicing in their achievements.

Mary's memorial will be the standards she set for the residents and registrars she trained, the welcome she gave to practitioners from rural Queensland who wished to enhance their anaesthetic skills by refresher placements at Royal Brisbane and her unflinching commitment to the highest level of patient care. It was a fitting acknowledgement of her service to medicine and to the wider community that she was awarded a medal in the Order of Australia.

All who knew Mary acknowledged her unbelievable courage through pain and adversity, her ongoing thirst for knowledge and new skills and her readiness to give of her self – not only through the practice of medicine but equally as the advocate for the aged and the disadvantaged.

In offering our sympathy to Patricia, Denise OSU, Stephanie and Geoff and her extended family, we, her anaesthetist colleagues, record our appreciation not only of her skill as an anaesthetist but also our high regard for her integrity, her happy personality and sense of humour and her friendship.

Professor Tess Cramond

ANZCA Council meeting report

February 2010

Report following the Council Meeting of the Australian and New Zealand College of Anaesthetists held on 27 February 2010

Election of President-Elect

Prof Kate Leslie has been elected President-Elect and will take office as President during the ASM in May.

College Award And Election

Dr Hugh Timothy Spencer has been awarded the New Zealand Order of Merit (ONZM), Queen's New Years Honours for services to medicine, in particular to anaesthesia. Dr Robert Albert Boas has also been awarded the New Zealand Order of Merit (ONZM), Queen's New Years Honours for services to medicine, in particular pain management.

Death Of Fellow

Council noted with regret the death of New South Wales Fellow, Dr John R Stamell FANZCA (1992), FFARACS (1971).

A decision has been made by Council to record the deaths of Trainees as well as the deaths of Fellows in the Council Minutes.

Education and Training Committee

ANZCA Curriculum Framework

Council approved the ANZCA Curriculum Framework which will shortly be circulated to the Regional/National committees for comment and feedback, with a revised document to be brought back to April Council for approval.

Trainee Illness or Disability Policy

Council approved the attached policy (Appendix 1) and, as per the new development process for professional documents, the policy is to be placed on the website for further review over the next 12 months.

Examinations Committee

Council approved the establishment of an Examinations Committee which will report through the Education and Training Committee to Council. Regulation 2.7 and Regulation 4 have been amended and the Planning Group on Assessment Governance (P-GAG) has been disbanded.

Examinations Committee Membership Structure

Chair of Examinations	A/Prof David Scott
Chair of the Faculty of Pain Medicine Examination Committee	Dr Raymond Garrick
Chair of Education & Training Committee (or nominee)	Dr Lindy Roberts
Chair of New Programs Committee	Dr Michelle Mulligan
Chair of Assessments Committee	A/Prof Jennifer Weller
Chair of Primary Examination Sub-Committee	Dr Craig Noonan
Chair of Final Examination Sub-Committee	Dr Mark Priestley
Director of Education Development Unit (or nominee)	Mrs Mary Lawson
Director of Training & Assessments Unit	TBA
Fellow	TBA
Fellow	TBA

In Training Assessment (ITA) Revision

Council approved the revised ITA Process which is to be introduced from 2010 to coincide with the middle of the 2010 Training Year in Australia and New Zealand, and the start of the Training Year in Hong Kong and Malaysia (shortly after the start of the Training Year in Singapore).

Educational Innovation Funding Proposal for 2011

Council supported suspension of Educational Innovation Funding for 2011 in light of the Curriculum Review and the difficulty in identifying other educational funding priorities.

Finance

Management Accounts

The accounts are currently being audited with the auditors' letter to be provided shortly. Council will meet by teleconference on the 23rd March 2010 to consider and approve the Statutory Accounts for 2009 for inclusion in the Annual Report.

Internal Affairs

Joint Consultative Committee on Anaesthesia

With the withdrawal of Drs Peter Cook and Daryl Catt as ANZCA representatives to the JCCA, Drs Patrick Farrell and Andrew Michael have been appointed as two of the four ANZCA representatives to the JCCA.

ANZCA Community Representation Proposal

A new process for appointments of community representatives (for ANZCA in Australia) has been developed which is a significant departure from how appointments were previously made. The proposal addresses issues such as the duration of appointments, remuneration and the sourcing of community representatives. It is to be circulated to the Chairs of College committees that have community representation (i.e. Education and Training Committee; International Medical Graduate Specialist Committee; Research Committee; and Training Accreditation Committee), Regional and National committees and community representatives, for wider review.

Communication between Committees

A suggestion was made at Council to circulate Regional/National Committee Minutes between Committees. The President undertook to discuss this item with the Committee Chairs at the teleconference following the Council meeting. Regional staff are also reminded to view and post workshops and other meetings on the ACECC calendar to avoid duplication and clashes of events.

Fellowship Affairs Committee

New Fellows' Conference 2010

Dr Chan Chi Wing has been appointed the Hong Kong representative to the 2010 New Fellows Conference.

Subsequent to Dr Mulligan's withdrawal as the appointed Councillor in Residence at the 2010 New Fellows Conference, Dr Kerry Brandis has accepted the invitation to attend the conference which will be held in Hanmer Springs, NZ.

2011 Hong Kong Combined Scientific Meeting
Dr Patricia Kan and Dr Timmy Chan (as Co-Convenors) and Dr Natalie Smith (as Deputy Convenor) are to convene the 2011 New Fellows Conference in Hong Kong.

Dr John C C Chan has been appointed the Orator for the College Ceremony at the 2011 CSM. Dr Chan graduated from the University of Hong Kong in 1964 and was made an Honorary University Fellow in 2000. He remained active in the public service for many years and is now Chairman of the Hong Kong Jockey Club and President of the Riding for the Disabled Association and a leading figure in local charity activities.

Professional

PS9 - Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical or Surgical Procedures
Following a extensive review and consultation process, PS9 has been revised, and the updated version is appended to this report (Appendix 2).

PS20 - Recommendations on Responsibilities of the Anaesthetist in the Post-Anaesthesia Period
Council has agreed to review PS20 to be undertaken in conjunction with the review of PS10 - *Guidelines on the Handover of Responsibility During an Anaesthetic*.

TE18 - Guidelines for Assisting Trainees with Difficulties
Following the decision by Council in late 2009 to introduce a revised In-Training Assessment Process for 2010, it has become apparent that this will also require revision of TE18 *Guidelines for Assisting Trainees with Difficulties*. A small working party has been established to undertake the review, with Dr Goulding appointed as the Chair.

Training & Accreditation Committee

Retrieval Services Seeking College Approval for Vocational Training in Anaesthesia
Council approved the draft College Professional Document *"Accreditation of Retrieval Services"* for promulgation. A copy of the document is appended to this report (Appendix 3).

Dr Leona Wilson
President

Associate Professor Kate Leslie
Vice-President

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